INSURANCE LAW UPDATE 2021-2022
SELECT STATE AND FEDERAL CASE LAW

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I. NORTH CAROLINA SUPREME COURT

A. N.C. SUPREME COURT – PUBLISHED OPINIONS

N.C. Farm Bureau Mut. Ins. Co., Inc. v. Lunsford, 378 N.C. 181, 2021-NCSC-83

Judge Earls writing for the majority; Judge Barringer writing for the dissent in which Judge Newby and Berger joined.

North Carolina law applies in determining whether insured North Carolina resident is entitled to UIM coverage under her policy, and the UIM coverage limit in the driver's policy is an applicable limit subject of interpolicy stacking in determining UIM coverage under passenger's policy.

Judy Lunsford (Lunsford), a North Carolina resident, was a passenger in her sister Levonda Chapman's (Chapman) vehicle when a serious accident occurred as they were travelling through Alabama. Chapman negligently drove her vehicle across a highway median into oncoming traffic, where it collided with an 18-wheeler. Lunsford was severely injured, and Chapman was killed as a result of the crash. Chapman was insured by a Nationwide Insurance Company (Nationwide) policy purchased in her home state of Tennessee. As a passenger in Chapman's vehicle, Lunsford was entitled to recover – and did recover – $50,000 from Nationwide under the terms of Chapman's bodily injury liability coverage. Lunsford subsequently claimed entitlement to coverage under the underinsured motorist (UIM) provision of her own North Carolina insurance contract with North Carolina Farm Bureau Mutual Insurance Company, Inc. (NC Farm Bureau). NC Farm Bureau denied her claim and initiated a declaratory judgment action to establish its liability.

The trial court agreed with NC Farm Bureau's position and concluded that Chapman's vehicle was not an "underinsured highway vehicle" as defined under North Carolina's Financial Responsibility Act (FRA). It reasoned that because the Nationwide insurance contract was executed in TN, "Chapman's policy is governed by Tennessee law." *Lunsford*, 378 N.C. 181 at ¶9. Under TN law, an "uninsured motor vehicle does not include a motor vehicle . . . [i]nsured under the liability coverage of the same policy of which the uninsured motor vehicle coverage is a part." *Id*. Because Chapman's vehicle was "insured under the liability coverage of the same policy from which the claimant [Lunsford] is seeking UIM coverage," the trial court concluded that Chapman's vehicle "cannot be an underinsured motor vehicle under Chapman's policy, the UIM coverage of Chapman's policy does not apply to the accident in question, and, therefore, it is not 'applicable' UIM coverage within the meaning of the North Carolina UIM statute's definition of the 'underinsured highway vehicle.'" *Id.* Ultimately, the trial court found that "Chapman's vehicle does not satisfy [the FRA's definition of an underinsured motor vehicle] because the liability coverage of Chapman's policy ($50,000 / $100,000) is equal to (and not less

than) the UIM coverage of Lunsford's policy," and therefore Lunsford was barred from stacking the coverage limits. *Id.*

A divided panel of the Court of Appeals affirmed. It agreed with trial court that Chapman's Nationwide UIM policy was not "applicable at the time of an accident" under the FRA, but not because of the nature of Chapman's vehicle, but rather due to its belief that Lunsford did not "qualify as a 'person insured' [under the Nationwide policy] as that terms is defined by [the FRA]." *Id.* at ¶10. Because Lunsford was neither "the named insured [nor], while resident of the same household, the spouse of the named insured [or] relatives of either," she did not qualify as a 'person insured'" under Chapman's Nationwide policy, precluding Lunsford from stacking the Nationwide UIM coverage limit. *Id.*

Lunsford appealed the split appellate decision, invoking the North Carolina Supreme Court's automatic review due to the dissenting opinion.

The Court highlighted the pertinent question: is Chapman's Nationwide UIM coverage limit an "applicable limit of underinsured motorist coverage for the vehicle involved in the accident and insured under the owner's policy" in addition to Lunsford's NC Farm Bureau UIM policy? *Id.* at ¶15. The question was dispositive: if the Nationwide policy was applicable, then stacking would be allowed and Lunsford would prevail. On the other hand, if the Nationwide policy was not applicable, stacking would not be allowed and NC Farm Bureau would prevail.

The NC Farm Bureau argued that, when an individual is injured by a driver's tortious conduct, the driver's UIM coverage limit is not an "applicable limit of underinsured motorist coverage for the vehicle involved in the accident and insured under the owner's policy" which can be stacked with the injured party's UIM coverage limit if, under the terms of the tortfeasor's contract, the vehicle is not underinsured. *Id.* at ¶16. Here, it argued, because Chapman was a TN resident who entered into a contract with Nationwide in TN, that contract did not incorporate NC's FRA and thus FRA's applicable limit standard should not apply. *Id.* In applying TN's definition of an underinsured motor vehicle (as it requests the Court to do), Chapman's vehicle could not be underinsured and thus could not be used for stacking purposes. *Id.* at ¶18.

The Supreme Court rejected NC Farm Bureau's argument in its initial holding that, in determining whether Lunsford is entitled to collect pursuant to the contract she entered into with NC Farm Bureau, North Carolina law applies in interpreting the terms of a contract executed in North Carolina that necessarily incorporates North Carolina's FRA. The Court reasoned that "the availability of UIM coverage to the insured – which hinges upon the threshold determination of whether a vehicle is underinsured – should be dictated by the terms of the bargain struck by the insured and the insurer, not by the terms of the bargain struck by the tortfeasor with his or her insurer." *Id.* at ¶27. It noted, in line with Lunsford's argument, the persuasive authority of *Benton v. Hanford*, 671 S.E.2d 31 (N.C. App. 2009), which defined "underinsured motor vehicle" in accordance with the terms of the FRA and

not based on the definition of the term in the tortfeasor's policy. *Id.* at ¶23. The Court also underlined the importance of public policy interests:

> To give effect to the public policy considerations motivating the General Assembly's legislative choice [concern for consequences of leaving NC insureds vulnerable to financial ruin or undercompensation], and to honor the bargains struck by North Carolinians with their insurer in light of the NC FRA, we must apply the definition of an "underinsured motor vehicle" chosen by the representatives of the people of North Carolina, not the one chosen by the representatives of the people of Tennessee.

Id. at ¶29. Once choice of law concerns was resolved, The Court analyzed the meaning of "applicable limits" under the FRA:

> We understand the General Assembly's use of the phrase "applicable limits" to refer to the UIM coverage limits contained within the insurance policy covering the tortfeasor's vehicle, in a circumstance such as this one where the tortfeasor is the driver and the injured party is a passenger seeking to access the UIM coverage contained within his or her own policy incorporating North Carolina's FRA.

Id. at ¶25. Notably, The Court highlighted that this interpretation is consistent with "the spirit of the [FRA] and what the [FRA] seeks to accomplish." *Id.* (quoting *Lenox, Inc. v. Tolson*, 766 S.E.2d 513, 548 (N.C. 2001)). Indeed, interpreting the ambiguous language contained within the FRA to permit interpolicy stacking in this circumstance is "in keeping with the purpose of the [FRA]" because it allows injured North Carolina insureds to access the UIM coverage they paid for in a greater number of circumstances, reducing the likelihood that the costs of damage caused by an underinsured tortfeasor will be borne by the insured alone. *Id.* at ¶26. The magnitude of NC's interest in protecting insureds in no way depends upon the state in which the tortfeasor executed his or her insurance contract – nor is there any reason to look to another state's law in defining the circumstances under which a NC insured can access UIM coverage under his or her own insurance policy. *Id.*

The Supreme Court's fact-specific holding, based on the above prior determinations, is that when a passenger who has previously obtained UIM coverage pursuant to a contract executed in North Carolina is injured while travelling in a vehicle driven by someone else, and the injury results from that driver's tortious conduct, the driver's UIM coverage limits are "applicable" within the meaning of the FRA. *Id.* at ¶30. Thus, the injured passenger is entitled to stack the driver's UIM coverage limit with the limits contained in the passenger's own policy for the purposes of determining whether the vehicle is an "underinsured motor vehicle" within the meaning of his or her own policy, which necessarily incorporates North Carolina's FRA. *Id.*

Because the amount of the stacked UIM coverage limits exceeds the sum of the applicable bodily injury coverage limits, Chapman's car was an "underinsured motor vehicle" as defined by the FRA for the purposes of giving effect to Lunsford's contract with NC Farm Bureau. *Id.*

The Court ultimately reversed the decision of the Court of Appeals, vacated the trial court's order entering declaratory judgment for NC Farm Bureau, and remanded to the trial court for further proceedings consistent with its opinion. *Id.*

Judge Barringer in dissent, joined by Judge Newby and Berger.

The dissent accused the majority of "assum[ing] the role of the legislature in [the] matter," instead of giving credence to "our well-established principles for the construction of insurance policies and the determination of what law applies to insurance policies." *Id*. at ¶31. It argued that applying the plain language of the statute enacted by the North Carolina legislature to a policy entered in North Carolina, and Tennessee law to a policy entered in Tennessee, "consistent with precedent, clearly leads to affirming the trial court's grant of judgment on the pleadings" in favor of NC Farm Bureau. *Id.*

First, in disagreeing with the majority's choice of law decision, the dissent stated:

> This Court has held in accordance with the principles of *lex loci contractus* that an automobile insurance policy "should be interpreted and the rights and liabilities of the parties thereto determined in accordance with the laws of the state where the contract was entered even if the liability of the insured arose out of an accident in North Carolina."

Id. at ¶43. (quoting *Fortune Ins. Co. v. Owens*, 526 S.E.2d 462 (N.C. 2000)). It rejected the application of Benton by the majority, reasoning that the purported authority "did not involve or address a policy entered outside of North Carolina." *Id*. at ¶45. Rather, it cites *Owens* for relevant analogizing:

> This case is more analogous to *Owens* where this Court found no error in the trial court's conclusion that no significant connections existed between the tortfeasor's policy and North Carolina where the policy was issued to the tortfeasor in Florida, the insured vehicle involved in the accident had a Florida identification number and Florida license plate, the tortfeasor had a Florida license, the tortfeasor never had a North Carolina license, and the accident occurred in North Carolina.

Id. at ¶46. In *Owens*, the Court concluded that the policy "must be construed in accordance with Florida law," and in the same manner, the dissent concludes in the present case that Tennessee law should have been applied to the Chapman policy:

> It is undisputed that the policy was purchased in Tennessee, owned by a Tennessee resident, and covered a vehicle owned by a Tennessee resident. The accident also did not occur in North Carolina. Thus, all the significant connections occurred in Tennessee. The residency of the passenger at the time of the accident occurred by chance, just as the location of the accident occurred by chance in *Owens*. Thus, Tennessee law applies to the Chapman Policy. The residency of a passenger in North Carolina at the time of the accident by itself does not constitute a sufficient connection to warrant application of North Carolina law.

Id. at ¶47. The dissent concluded that:

> Applying the plain language of the statute dictates that the underinsured motorist coverage of the Chapman Policy must be capable of being applied to be stacked. As Tennessee law applies to the Chapman Policy and excludes underinsured motorist coverage in the facts of this case, the trial court's judgment in favor of the Farm Bureau should be affirmed.

Id. at ¶49.

N.C. Farm Bureau Mut. Ins. Co., Inc. v. Dana, 379 N.C. 502, 2021-NCSC-161

Judge Ervin writing for the majority; Judge Earls in concurrence; Judge Berger, Judge Newby, and Judge Barringer in concurrence.

In cases involving multiple claimants, the total amount of underinsured motorist coverage available to those claimants (considering both the available liability coverage and the available underinsured motorist coverage) is limited by the per-accident limit and the total amount of coverage available to any individual claimant is constrained by the per-person limit.

In February 2016, Ms. and Mr. Dana were struck in their moving vehicle (operated by Ms. Dana) by Mr. Bronson, who was driving while intoxicated. *Dana*, 379 N.C. 502 at ¶2. Ms. Dana's injuries were fatal, and Mr. Dana sustained serious injuries. *Id*. At the time of the crash, Mr. Bronson's vehicle was covered by a policy of automobile insurance that had been issued by Integon National Insurance Company (Integon) which provided bodily injury liability coverage with limits of up to $50,000 per person and $100,000 per accident. *Id*. at ¶3. Mr. Dana was apportioned $32,000, and The Estate of Ms. Dana was apportioned $43,750. *Id*.

At the time of the crash, Ms. Dana was insured under a policy of automobile insurance issued by Farm Bureau that included underinsured motorist coverage with limits of $100,000 per person and $300,000 per accident. *Id*. at ¶4. Farm Bureau offered to pay the full per-person limit to both Mr. Dana and the Estate, less the amount that had been

received from Integon's liability coverage. *Id.* Mr. Dana was apportioned $68,000, and The Estate of Ms. Dana was apportioned $56,250. *Id*.

Mr. Dana resultantly argued that he and the Estate were entitled to the full amount of per-accident underinsured motorist coverage set out in the policy, less the amount of liability coverage that had been provided by Integon. *Id*. at ¶5. The Farm Bureau would be obligated to pay a total of $124,250 to the Danas under its own proposal, while it would be obligated to provide a total of $200,000 in underinsured motorist coverage to the Danas under the proposal that they submitted (which consisted of the $300,000 per-accident limit provided under the Far Bureau policy less the $100,000 in liability coverage provided by Integon). *Id*.

Faced with this dilemma between obligation expectations, Farm Bureau filed a complaint seeking a declaratory judgment concerning the amount of underinsured motorist coverage that it was required to provide to the Danas. *Id*. at ¶6. Both parties filed competing motions for summary judgment, and the trial court entered an order granting summary judgment in favor of the Danas. *Id*. Farm Bureau appealed, and the Court of Appeals affirmed the trial court's order based on its prior decision in *N.C. Farm Bureau Mut. Ins. Co., Inc. v. Gurley*, 139 N.C. App. 178, 532 S.E.2d 846 (2000) that "established a straightforward analysis to determine in what amount if any, [underinsured motorist] coverage is available, given both the insurance policy in question and our [underinsured motorist] statute." *Id*. at ¶7.

The Court of Appeals went on to iterate that, "in deciding how much coverage the insured party or parties are entitled to, we must consider (1) the number of claimants seeking coverage under the [underinsured motorist] policy; and (2) whether the negligent driver's liability was exhausted pursuant to a per-person or per-accident cap." *Id*. (quoting *Gurley*, 139 N.C. App. at 181). The court went on to apply the *Gurley* subrule:

> "when more than one claimant is seeking [underinsured motorist] coverage, . . . how the liability policy was exhausted will determine the applicable [uninsured motorist] limit. In particular, when the negligent driver's liability policy was exhausted pursuant to the per-person cap, the [underinsured motorist] policy's per-person cap will be the applicable limit. However, when the liability policy was exhausted pursuant to the per-accident cap, the applicable [underinsured motorist] limit will be the [uninsured motorist] policy's per-accident cap."

Id. Because the parties stipulated that the Danas were entitled to collect some amount of underinsured motorist coverage and the fact that "the negligent driver's liability coverage was exhausted pursuant to the per-accident cap," the Court of Appeals held that "*Gurley* mandates [that] the [Danas] are collectively entitled to receive coverage pursuant to the per-accident cap of $300,000." *Id.*

The NC Supreme Court granted discretionary review of the Appellate Court's unanimous decision upholding summary judgment in favor of the Danas. *Id*.

Summary judgment is reviewed de novo; here, "in light of the parties' agreement that the present record does not reveal the existence of any material issue of disputed fact, the only issue that remains . . . is whether one party or the other is entitled to the entry of judgment in its favor as a matter of law." *Id*. at ¶8. The North Carolina Motor Vehicle Safety and Financial Responsibility Act (FRA) addresses underinsured motorist coverage via N.C.G.S. §20-279.21(b)(4), and applies "when, by reason of payment of judgment or settlement, all liability bonds or insurance policies providing coverage for bodily injury caused by the ownership, maintenance, or use of the underinsured vehicle have been exhausted." *Id*. at ¶11. The policy intent behind this language is to "address circumstances where the tortfeasor has insurance, but his coverage is in an amount insufficient to compensate the injured party for his full damages." *Id*. (quoting *Lunsford v. Mills*, 367 N.C. 618, 626, 766 S.E. 2d 297 (2014)).

In order to determine whether an injured party's underinsured motorist coverage applies in accordance with the FRA, the Court must (1) ascertain whether the tortfeasor's vehicle was an "underinsured highway vehicle" and whether the tortfeasor's liability policy has been exhausted, and (2) calculate the amount of coverage that is available. *Id*. On the first step, The Court notes that the parties agreed that Mr. Bronson's vehicle met the "underinsured highway vehicle" definition under the FRA. *Id*. Thus, the main issue before the Court was the calculation determination. *Id*.

First, the Court turned to the FRA's language for guidance. In the event that the "claimant is an insured under the underinsured motorist coverage on separate or additional policies, the limit of underinsured motorist coverage applicable to the claimant is the difference between the amount paid to the claimant under the exhausted liability policy or policies and the total limits of the claimant's underinsured motorist coverages as determined by combining the highest limit available under each policy," with "the underinsured motorist limits applicable to any one motor vehicle under a policy [to not] be combined with or added to the limits applicable to any other motor vehicle under that policy." *Id*. at ¶13. "In light of the fact that the expressions of 'limit of liability' and 'limits of liability' appear repeatedly" within the applicable FRA language, the Court determines that "it is difficult . . . to conclude that these expressions have no meaning." *Id*. at ¶14.

Because the "relevant statutory language is not silent, the determinative issue for purposes of this case is how the statutory referenced to the limitation of liability found in N.C.G.S. §20-279.21(b)(4) should be construed." *Id*. The FRA "clearly contemplates both a per-person and a per-accident limit of liability and makes the per-accident limit subject to the per-person limit," but does not incorporate such language into the relevant portions of it. *Id*. at ¶15. Faced with statutory lack of clarity, "legislative intent controls the meaning of a statute." *Id*. at ¶16. (citing *Brown v. Flowe*, 349 N.C. 520, 522, 507 S.E.2d 894 (1998)). The majority then holds:

> We are unable to discern any reason why the General Assembly would have intended to preclude the use of both per-person and per-accident liability limitations in determining the maximum amount of underinsured motorist coverage that is available for payment to any individual claimant and believe that the most reasonable reading of the relevant statutory language provides for a common sense resolution of the dispute that is before us in this case, which is that, in cases involving multiple claimants, the total amount of underinsured motorist coverage available to those claimants (considering both the available liability coverage and the available underinsured motorist coverage) is limited by the per-accident limit and that the total amount of coverage available to any individual claimant is constrained by the per-person limit.

Id. at ¶19. But what about the *Gurley* decision, which has been on the book for almost two decades without having been disturbed by the General Assembly? If the General Assembly was unhappy with the application of *Gurley*, wouldn't it have done something about it by changing the FRA language?

The Court departs from this legal canon "given that the Court of Appeals described the rule that is adopted in *Gurley* as having the effect of avoiding an 'interpretation of the statute that. . . would result in the defendants receiving more compensation than if the tortfeasor had been either fully insured or uninsured altogether.'" *Id*. at ¶22. Applying the rule adopted in *Gurley* to the facts in this case "would have exactly the effect that the rule in question was explicitly intended to avoid," and the Court therefore affords no deference to the General Assembly's failure to modify the relevant provisions "to account for the likelihood that *Gurley* would be applied in a mechanical manner to produce a result that *Gurley* itself appears to have been intended to avoid." *Id*.

However, the Court falls short of formally overruling *Gurley*: Although not the case here, "the principle enunciated in *Gurley* may well produce results that cohere with the likely legislative intent in many instances." *Id*. at ¶23. Ultimately, the NC Supreme Court reversed the decision of the Court of Appeals and remanded the case to the Superior Court for the entry of a judgment declaring that the total amount of underinsured coverage made available to the Danas collectively is to be set at the per-accident limit, with no individual claimant to receive more than the per-person limit." *Id*.

Judge Earls, in concurrence.

Judge Earls takes a step that the majority does not and writes separately in her conclusion that "the effect of this Court's decision is to overrule [*Gurley*]." *Id*. at ¶24. Even if "the principle enunciated in *Gurley* may well produce results that cohere with the likely legislative intent in many instances," Earls states that the Court "should not hide from the fact that the legal rule *Gurley* announces has been supplanted." *Id*. at ¶26.

Importantly, Judge Earls expresses cognizance of the "potential unfairness which arises when we disturb an interpretation of a statutory provision that has governed for two decades, especially when the statutory provision being interpreted is, by law, necessarily incorporated into every contract for automobile insurance executed in this state." *Id*. at ¶29. However, "these reliance interests alone do not displace our 'duty . . . to declare what the law is." *Id*. at ¶31. (quoting *S. Ry. Co. v. Cherokee Cty.*, 177 N.C. 86, 88, 97 S.E.2d 758 (1919)).

Judge Berger, in concurrence, joined by Judge Newby and Judge Barringer.

Berger's concurrence agrees with the disposition of the Court, but "disagree[s] with the majority about the reason why the claims in this case are governed by the per person limitations." *Id*. at ¶34. Rather than applying the FRA, which "does not address the particular question at issue in this case," the specifically enumerated terms of the insurance policy at issue "must control." *Id*. at ¶35.

When a statute is "applicable to the terms of an insurance policy, the provisions of the statute become a part of the policy as if written into it." *Id*. at ¶42 (quoting *Bray v. N.C. Farm Bureau Mut. Ins. Co*., 341 N.C. 678, 682, 462 S.E.2d 650 (1995)). "Thus," Justice Berger writes, "the policy is construed in accordance with its written terms unless a binding statute, regulation, or order requires a different construction." *Id*. (citing *Allstate Ins. Co. v. Shelby Mut. Ins. Co*., 269 N.C. 341, 345, 152 S.E.2d 436, 440 (1967)).

Berger points out that "the majority concedes the FRA does not specifically address this situation," and thus, "we should follow our precedent" and turn to the language of Ms. Dana's UIM policy to determine whether the UIM per accident limit is subject to the UIM per person limit. *Id.* at ¶43. The relevant potion of the UIM provision in Ms. Dana's policy provides:

> Subject to [the] limit for each person, the limit of bodily injury liability shown in the Declarations for each accident for [UIM] Coverage is our maximum limit of liability for all damages for bodily injury resulting from any one accident.

Id. at ¶47. The policy, Judge Berger contends, plainly states that the UIM per accident limit was subject to the UIM per person limit, and that the proper amount of UIM coverage available was subject to the per person limit. *Id.* at ¶48.

> Because the policy language is clear, and because our courts may not "rewrite the contract or impose liabilities on the parties not bargained for" . . . the $100,000 person limit applies, reduced by the recovery under the tortfeasor's policy.

Id. (quoting *Woods v. Nationwide Mut. Ins. Co*., 295 N.C. 500, 506, 246 S.E.2d 773, 777 (1978)).

B. N.C. SUPREME COURT – PER CURIAM OPINION

Hope v. Integon Nat'l Ins. Co., 2022-NCSC-20

Per curiam. Affirmed the unpublished decision of a divided panel of the Court of Appeals in Hope v. Integon National Insurance Company*, No. COA20-265, 2020 WL 7974003 (N.C.App. December 31, 2020).*

For cases involving breach of the covenant of good faith and fair dealing, and/or unfair and deceptive trade practices, an honest disagreement between parties, on its own, does not amount to bad faith or deceptive trade practices for purposes of surviving a motion for summary judgment.

Where the plaintiff-insured claims an unidentified vehicle backed into hers and drove away, but where the defendant-insurer claims the injury to plaintiff's vehicle was caused by her own negligence when she hit a stationary object, there is an issue of fact as to whether plaintiff's coverage was voided by a misrepresentation concerning the cause of the damage.

Plaintiff Tammy Hope (Hope), insured by Defendant Integon National Insurance Company (Integon), was involved in a crash in 2016. Hope claimed that her vehicle was "struck by an unidentified vehicle" in a hit-and-run accident, rendering her vehicle a "total loss." *Hope v. Integon,* 2020 WL 7974003 at 1. Hope surrendered her vehicle to Integon and sought coverage. *Id.* Integon, however, ultimately denied coverage as there was evidence that Integon's investigator surmised that the damage was caused by Hope running into a stationary object rather than the victim of a hit-and-run. *Id.* Hope filed suit, alleging breach of contract for not paying coverage under the terms of her policy as well as unfair trade practices and breach of the contract's covenant of good faith. *Id.* She sought punitive damages for the latter claims, and compensatory damages to the amount owed to her under the policy for the first claim. *Id.*

Both parties moved for summary judgment; after a hearing on the matter, the trial court entered its order on summary judgment in favor of Integon and against Hope and taxed costs against Hope.

On appeal, the Court of Appeals reviewed the trial court's decision de novo – "such judgment is appropriate only when the record shows that 'there is no genuine issue as to any material fact and that any party is entitled to a judgment as a matter of law.'" *Id.* (quoting *In re Will of Jones*, 362 N.C. 569, 573, 669 S.E.2d 572, 576 (2008)). The appellate court concluded that the trial court erred in granting summary judgment on Hope's claim seeking coverage under the policy:

> There is an issue of fact as to whether Plaintiff's coverage was voided by her misrepresentation concerning the cause of damage. She claims it was caused by an unidentified driver; Defendant claims that it was caused by her own negligence when she hit a stationary object. Accordingly, we reverse summary judgement as to this claim for coverage under terms of the policy. These issues must be resolved at trial.

Id. at 2. However, regarding Hope's claims for unfair and deceptive trade practices and for breach of the covenant of good faith and fair dealing, the Court affirmed the trial court's decision. *Id.* "Plaintiff," the Court reasoned, "offered no evidence to prove that Defendant did anything but act in an honest fashion in underwriting her claim." *Id.* Hope's claims were premised on bad acts, "but her affidavit in support of her motion allege[d] no bad acts – neither motive nor conduct." *Id.*

The Court underlined its prior holdings, which establish that "bad faith" means "not based on honest disagreement or innocent mistake." *Id.* (quoting *Lovell v. Nationwide Mut. Ins. Co.*, 108 N.C.App. 416, 421, 424 S.E.2d 181, 185, *aff'd per curiam*, 334 N.C. 682, 435 S.E.2d 71 (1993)). In other words, "an honest disagreement between parties does not establish bad faith." *Id.* Here, there was evidence only of an honest disagreement: "Defendant's records show that it considered Plaintiff's version of the accident, but simply concluded after investigation that the accident likely did not occur as Plaintiff claims." *Id.* Regarding Hope's unfair trade practice claim, which requires a showing of "an unfair or deceptive act or practice, or unfair method of competition," Hope failed in her burden to "forecast evidence showing that Defendant acted in any unfair or deceptive way." *Id.*

The Court of Appeals ultimately affirmed the trial court's grant of summary judgment for Integon on the claims for unfair and deceptive trade practices and for breach of the covenant of good faith and fair dealing, including Hope's claim for treble and punitive damages, and reversed the trial court's grant of summary judgment on Hope's claim for coverage under the terms of the policy, vacating the award of costs to Integon. *Id.*

Judge Murphy, concurring in part and dissenting in part.

Judge Murphy concurs with the majority opinion that the trial court erred in granting Integon's motion to dismiss on the breach of contract claim, but dissents regarding affirmation of the trial court's grant of Integon's motion for summary judgment on the claims of unfair and deceptive trade practices and breach of the covenant of good faith and fair dealing. *Id.* at 3.

Murphy states that, in reviewing a motion for summary judgment, "the trial court was required to consider all of the evidence before it and not just the parties' affidavits and Defendant's cherry-picked portions of its own records." *Id.* He notes the appropriateness

of Hope's reliance on the discovery obtained from Integon: specifically, admissions from Integon's logs that "if IP were driving and struck fixed object, there could be no UMBI claim for IP." *Id*. Judge Murphy concludes:

> Viewed in the light most favorable to Plaintiff, these logs reflect Defendant's active search for alternative factual theories that would change how and if the damage to the vehicle and injuries to passengers were covered by Defendant. Whether this document indicates Defendant searched for alternative theories to reduce coverage and landed upon the fraudulent behavior exemption, or was part of an authentic investigation, is a genuine issue of material fact.

Id. at 4. The issue is "genuine," Murphy contends, because there is substantial evidence of the alleged conduct reflected by Integon's own logs. *Id.* Further, the issue is "material" because "the intent to pursue an alternative factual theory to reduce coverage would constitute bad faith, as an action 'not based on honest disagreement or innocent mistake." *Id.* (quoting *Dailey v. Integon Gen. Ins. Co.,* 75 N.C.App. 387, 396, 331 S.E.2d 148, 155 (1985)). Judge Murphy notes:

> While Defendant may very well have a plausible explanation of its shifting theories to deny coverage and contingent plans that do not constitute bad faith, taking the forecast of evidence in the light most favorable to Plaintiff, she survives the drastic remedy of summary judgment on her bad faith claim, her unfair and deceptive trade practices claim, and her punitive damages claim.

Id.

II. NORTH CAROLINA COURT OF APPEALS

A. N.C. COURT OF APPEALS – PUBLISHED OPINIONS

North Carolina Farm Bureau Ins. Co., Inc. v. Hague, 2022-NCCOA-291

Unanimous decision written by Judge Griffin; Judge Carpenter and Judge Gore concur.

In cases involving personal liability coverage, a defendant's action of firing multiple shots in the direction of another is intentional for purposes of the Intentional Act Exclusion provision because intent to injure may be inferred as a matter of law from an act substantially certain to result in injury.

Defendant had a physical altercation with Baron Cass (Cass) in September 2020. *Hague,* 2022-NCCOA-291 at ¶2. Cass removed himself from the conflict by walking away,

but Defendant produced a handgun and fired multiple shots, some of which struck Cass and killed him. *Id*. Cass's Estate brought a wrongful death suit against Defendant alleging breach of duty of care and that Cass's death was the result of "grossly negligent acts." *Id*. at ¶3.

On the date of the shooting, Defendant was insured by North Carolina Farm Bureau (NC Farm Bureau) to provide personal liability coverage in the amount of $1,000,000 per occurrence. *Id.* at ¶4. The Insuring Agreement of the Policy reads:

> Coverage L – Liability – We pay, up to our limit, all sums for which an insured is liable by law because of bodily injury or property damage caused by an occurrence to which this coverage applies. We will defend a suit seeking damages if the suit . . . [is] not excluded under this coverage.

Id. An "occurrence" is defined as "an accident, which includes the loss from repeated exposure to similar conditions." *Id.* The Policy also includes an Intentional Act Exclusion, which reads:

> Farm Personal Liability Coverage does not apply to bodily injury or property damage which results directly or indirectly from . . . [an] intentional act or injury resulting from an intentional act of an insured or an act done at the direction of an insured.

Id. NC Farm Bureau filed a complaint for a declaratory judgment, asserting that the Policy does not provide liability coverage for the Estate's claim and that it has no duty to defend or indemnify Defendant, because:

> (1) Defendant's actions do not fall within the Policy's personal liability coverage because the shooting did not constitute an "occurrence," and (2) the Intentional Act Exclusion excludes coverage for Defendant's intentional acts that resulted in Cass's death.

Id. at ¶5. NC Farm Bureau filed a motion for Declaratory Judgment, and the trial court granted its motion. *Id.* at ¶6. The trial court concluded that the complaint could be interpreted as falling within the scope of the Policy's Insuring Agreement, but also that because the complaint alleges Cass's death was caused by an intentional act, Defendant's actions were included within the scope of the Intentional Act Exclusion. *Id.* Defendant appealed.

Defendant's first argument on appeal was that the facts surrounding the shooting "should not have been considered by the trial court, as they fell outside the scope of the Declaratory Judgment Act." *Id.* at ¶7. The Court of Appeals disagreed, holding that though determination of a duty to defend under an insurance policy requires interpretation of the written instrument, "our Supreme Court has construed the Declaratory Judgment Act such

that a court measures 'the facts as alleged in the pleadings' to ascertain an insurer's duty to defend." *Id*. at ¶11 (quoting *Harleysville Mut. Ins. Co. v. Buzz Off Insect Shield, L.L.C.*, 364 N.C. 1, 6, 692 S.E.2d 605, 610 (2010)). As a result, "it was within the purview of the trial court under the Declaratory Judgment Act to measure the facts as alleged in the pleadings; specifically, what transpired during the shooting." *Id.*

Next, Defendant argued that he "must have acted with intent to injure/kill" for his actions to fall under the Policy's Intentional Act Exclusion, and that Defendant's action of firing a pistol does not rise to the level necessary to infer an intent to injure. *Id.* at ¶12. The Court disagrees, citing a prior appellate decision *Commercial Union Ins. Co. v. Mauldin*, 62 N.C. App. 461, 303 S.E.2d 214 (1983) in which the insured fired multiple shots at a car in which his wife and her friend were riding, killing the friend. *Id.* at ¶14. The insurance policy in that case had an exclusion clause "similar to the one in the present case." *Id.* In *Mauldin*, the Court found that the insured's actions were intentional and therefore fell within the exclusion clause, because the insured should have "expected" the likelihood of his actions resulting in injury or death. *Id.*

Based on their prior decision in *Mauldin*, the Court holds that "from an intentional action of firing a pistol multiple times in the direction of another person, where injury is expected, (i.e. probable or certain), an intent to injure may be inferred as a matter of law." *Id.* Here, since the Policy does not contain a specific definition of "accident," so, for Defendant's actions to be construed as an accident, "the resulting injury must not have been intentional or substantially certain to occur." *Id.* at ¶15. In line with *Mauldin*, the action of firing a pistol in the direction of another is conduct from which the actor should expect resultant injury. Because intent to injure may be inferred as a matter of law from an act substantially certain to result in injury, "Defendant's action of firing a pistol multiple times in the direction of Cass was not an 'accident.'" *Id*. The Court holds that Defendant's conduct was therefore an intentional act. *Id.*

In evaluating NC Farm Bureau's duty to defend and indemnify, the Court applies the "comparison test" and reads the policy and the complaint side-by-side and, in a declaratory judgment action, measures the facts as alleged in the pleadings. *Id.* at ¶16. The Court concludes that, "as Defendant's act was intentional, reading the complaint side by side with the Policy's language, Defendant's conduct falls within the Intentional Act Exclusion" and that thus NC Farm Bureau "has no duty to defend Defendant." *Id.* at ¶17. Further, because an insurer's duty to indemnify is narrower than its duty defend, the Court finds that NC Farm Bureau does not have a duty to indemnify either. *Id.* at ¶18.

Finally, Defendant argued that a finder of fact must determine whether the allegations of the underlying lawsuit fall within the exclusionary provision of the Policy. *Id.* at ¶7. Specifically, Defendant contended that "because the complaint alleges different theories of recovery, including grossly negligent acts by Defendant, it cannot be ascertained whether Defendant acted with intent to injure Cass, and a finder of fact must resolve that uncertainty." *Id.* at ¶19. The Court disagrees, stating that under a declaratory

judgment action, "in addressing the duty to defend, the question is not whether some interpretation of the facts as alleged could possibly bring the injury within the coverage provided by the insurance policy; the question is, assuming the facts alleged as true, whether the insurance policy covers that recovery." *Id.* at ¶20. As such, the Court holds that Defendant's argument is without merit because "Defendant acted intentionally and there is no duty to defend nor duty to indemnify." *Id.*

The Court of Appeals affirms the trial court's order. *Id.* at ¶21.

Tutterow v. Hall, 2022-NCCOA-300

Unanimous decision written by Judge Dietz; Judge Murphy and Judge Jackson concur.

In cases involving the proper calculation of underinsured motorist (UIM) coverage with both multiple underinsured tortfeasors and multiple UIM insurance policies, the method to calculate the applicable limit of combined UIM coverage is to find the difference between the total amount paid under all exhausted liability policies and the total limits of all applicable UIM policies.

In 2014, Vivian Tutterow (Tutterow) was killed in a car accident wherein she was a passenger in a car driven by Pamela Crump (Crump). *Tutterow*, 2022-NCCOA-300 at ¶6. The crash involved a two car collision. The parties to the lawsuit stipulated that both Crump and Defendant Brian Hall (Hall), the driver of a second vehicle, negligently caused the accident. *Id*. The parties involved had the following relevant insurance coverage:

- ⇒ Crump had an auto policy issues by Horace Mann (Mann) with $100,000 per person liability limits and $100,000 per person UIM coverage.
- ⇒ Hall had an auto policy issued by Nationwide with $100,000 per person liability limits.
- ⇒ Tutterow, as a passenger in Crump's car, was covered under Crump's $100,000 per person UIM coverage.
- ⇒ Tutterow had an auto policy issued by State Farm with $100,000 per person UIM coverage.

Id. at ¶7-8. In 2015, as administrator of Tutterow's estate, Plaintiff brought a wrongful death action against Crump, Hall, and others. *Id.* at ¶9. In **October 2016,** Mann tendered the $100,000 limits of its liability policy on behalf of Crump and Nationwide tendered the $100,000 limits of its liability policy on behalf of Hall. *Id.* Several weeks later (**November 2016**), Plaintiff notified the UIM carriers of the tenders but advised that Plaintiff had not accepted them. *Id.* at ¶10. Later, **in June 2017,** Plaintiff informed the UIM carriers that he had accepted Mann's tender of the full $100,000 liability limit of Crump's liability policy. *Id.* at ¶11.

In **September 2017**, State Farm advanced $100,000 to Tutterow's estate under its UIM policy while expressly "reserving its 'right to recoup funds' should Plaintiff recover from Hall's liability insurer, Nationwide, 'whether such payments are made pursuant to a settlement, a judgment or otherwise.'" *Id.* at ¶12.

In **July 2019**, Plaintiff informed the UIM carriers that he reached a settlement with Hall that included a payment from Nationwide of the $100,000 limits of Hall's liability policy. *Id.* at ¶13. State Farm then requested that Plaintiff reimburse the $100,000 that it had advanced in late 2017. *Id*. Those funds were placed in escrow and Plaintiff brought a declaratory judgment action seeking a declaration of the UIM carriers' coverage obligations and State Farm's right to reimbursement. *Id.*

The parties filed cross-motions for summary judgment, and after a hearing, the trial court entered an order granting summary judgment in favor of the UIM carriers on the ground that the amount of UIM coverage available "is $0.00." *Id.* Plaintiff appealed.

"The crux of this case," according to the Court of Appeals, "is how to calculate that available UIM coverage when there are both multiple underinsured tortfeasors and multiple UIM insurance policies." *Id.* at ¶18. The calculation is governed by N.C. Gen. Stat. §20-279.21(b)(4), a section of the Financial Responsibility Act (FRA), which states in relevant part:

> In any event, the limit of underinsured motorist coverage applicable to any claim is determined to be the difference between the amount paid to the claimant under the exhausted liability policy or policies and the limit of underinsured motorist coverage applicable to the motor vehicle involved in the accident. Furthermore, *if a claimant is an insured under the underinsured motorist coverage on separate or additional policies*, the limit of underinsured motorist coverage applicable to the claimant is the difference between the amount paid to the claimant under the exhausted liability policy or policies and the *total limits of the claimant's underinsured motorist coverages* as determined by combining the highest limit available *under each policy*.

Id. at ¶19 (emphasis added). The Court, wrote, "Our State's appellate courts have not yet interpreted how this statutory language applies in a case involving both multiple underinsured tortfeasors and multiple UIM insurance carriers." Id., at ¶ 20. While factually correct, the Supreme Court case *Lunsford v. Mills* has many factual and legal similarities including two tortfeasors and multiple UIM policies (both with Farm Bureau), but only one tortfeasor who was underinsured. 367 N.C. 618, 766 S.E.2d 297 (2014).

The Courts of Appeals decision cannot be reconciled with the Supreme Court's decision in *Lunsford v. Mills*. Tutterow cited the *Lunsford v. Mills* case repeatedly in its brief. However, the Court of Appeals decision does not even cite the case. Instead it cites

to *N. Carolina Farm Bureau Mut. Ins. Co., Inc. v. Lunsford*, 378 N.C. 181, 2021-NCSC-83.

In *Tutterow*, the Court of Appeals agrees with the trial court that the "statutory language is unambiguous and support[s] entry of summary judgment in favor of the UIM carriers." *Id.* at ¶20. It determined, the trial court properly calculated the total amount paid under the exhausted liability policies as $200,000 and calculated the total limits of the claimant's underinsured motorist coverages as $200,000. *Id.* at ¶25. Likewise, its determination that the "available UIM coverage is $0.00" based on the difference between the two total limits was a correct implementation of the statutory language. *Id.* at ¶25. This is consistent with (now Chief) Justice Judge Newby's **dissent** in *Lunsford v. Mills* where he wrote:

> Two provisions in the UIM statute in particular demonstrate this intent by the legislature to make UIM coverage a source of compensation secondary to tortfeasors' liability policies. *Elec. Supply Co. of Durham v. Swain Elec*. Co., 328 N.C. 651, 656, 403 S.E.2d 291, 294 (1991) (observing that, inter alia, "we are guided by the structure of the statute" in determining legislative intent (citations omitted)). The first is the reduction provision, which states:
>
> > In any event, the limit of underinsured motorist coverage applicable to any claim is determined to be the difference between the amount paid to the claimant under the exhausted liability policy or policies and the limit of underinsured motorist coverage applicable to the motor vehicle involved in the accident. N.C.G.S. § 20–279.21(b)(4) ("reduction provision"). Under the reduction provision, a UIM carrier reduces its applicable policy limits by amounts paid to the claimant from tortfeasors' exhausted policies.

Lunsford v. Mills, 367 N.C. 618, 634, 766 S.E.2d 297, 307–08 (2014)

Without mention *Lunsford v. Mills*, the Court of Appeals affirms the trial court's order. *Id.* at ¶31.

Birchard v. Blue Cross Blue Shield of North Carolina, Inc., 2022-NCCOA-333

Unanimous decision written by Judge Tyson; Judge Wood and Judge Griffin concur.

In medical insurance cases brought against Utilization Review Organizations (UROs) involving a dispute of coverage and benefits arising out of the "State Health Plan for Teachers and State Employees Enhanced 80/20 PPO Plan," failing to utilize the statutory review process provided through N.C. Gen. Stat. §58-50-61 disentitles further review in superior court.

Katherine Birchard (Birchard) had a medical insurance plan entitled "State Health Plan for Teachers and State Employees Enhanced 80/20 PPO Plan" (Plan) due to her employment at the University of North Carolina School of Medicine as a licensed physician and faculty member of the Radiology Department. *Birchard*, 2022-NCCOA-333 at ¶2. The Plan was provided by contract administrator Blue Cross Blue Shield of North Carolina (BCBSNC). *Id.* at ¶3. The Plan requires a member to request "certification from the Mental Health Case Manager" before accessing coverage and benefits for care in a "Psychiatric Residential Treatment Center," and specifically states that there is no coverage for services that "are: not medically necessary." *Id.*

Birchard requested certification of coverage and benefits for her to be treated and monitored for severe depression and suicidal ideation in a "Psychiatric Residential Treatment Center." *Id.* at ¶4. After two rounds of internal reviews, BCBSNC denied her certification request in December 2017 due to finding that the request was "not medically necessary." *Id.* Birchard then sought an appeal of those decisions via external review by an independent review organization, which was assigned pursuant to N.C. Gen. Stat. §58-50-80(b)(5). *Id.* at ¶19. Notably, Birchard never asserted any claim before the Industrial Commission. *Id.* at ¶6.

Birchard brought suit in the superior court in 2021, and within her First Amended Complaint named North Carolina State Health Plan, the Board of Trustees of the State Health Plan for Teachers and State Employees, and BCBSNC as parties. *Id.* Birchard alleged breach of contract, unfair and deceptive trade practices, and bad faith refusal to pay health or medical insurance benefits against the aforementioned parties. *Id*. Defendants filed a "motion to dismiss Plaintiff's First Amended Complaint for lack of subject matter jurisdiction and for failure to state a claim for which relief can be granted." *Id.* The trial court ruled in favor of the Defendants, and Plaintiff appealed. *Id.* at ¶7.

First, in reviewing the decision to grant Defendant's motion to dismiss for failure to state a claim pursuant to N.C.R.C.P. Rule 12(b)(6), the Court of Appeals looked to the relevant statutory authority of N.C.G.S. §58-50-75(b). *Id.* at ¶11. According to the language, the General Assembly specifically determined that the "utilization review" for coverage and benefits under the Plan was regulated by Chapter 58 of the N.C General Statutes. *Id.* at ¶16. This was applicable because BCBSNC was the Plan's designated "utilization review organization" (URO) to which a "covered person" must seek review of all "medically necessary" care under the Plan. *Id.* at ¶15. In addition the statutes "created an avenue to review external 'utilization review' claims under the State Health Plan before the Industrial Commission. See N.C. Gen. Stat. §58-50-61; N.C. Gen. Stat. § 143-291(a) (2021)" *Id*. at ¶16.

The weight of an independent review organization's decision is highlighted through N.C.G.S. §58-50-84(a) (2021), which states in relevant part that "[a]n external review decision is binding on the insurer." *Id.* at ¶20. Additionally, the court notes that:

> An independent review organization . . . shall not be liable for damages to any person for any opinions rendered during or upon completion of an external review conducted under this Part, unless the opinion was rendered in bad faith or involved gross negligence.

Id. (citing N.C. Gen. Stat. §58-50-89 (2021)). The Court holds that here, "Plaintiff exhausted her remedies by seeking the external review by the independent review organization, and by failing to seek further review before the Industrial Commission." *Id.* at ¶21. Further, the Court notes that, in the absence of allegations of negligence or bad faith, both parties are bound by the decision to uphold the denial of coverage by the independent review organization. *Id.* Regarding the trial court's decision to dismiss for failure to state a claim, the Court of Appeals affirms, as "any asserted contract claim against BCBSNC is improper regarding the external review organization's decision to deny coverage." *Id.*

On the second matter regarding subject matter jurisdiction, Plaintiff relied on the North Carolina Supreme Court precedent of *Meyer v. Walls*, 347 N.C. 97, 489 S.E.2d 880 (1997), which allows a negligence claim against an agent of the state in superior court that is separate from the state agency asserted before the Industrial Commission under the State Tort Claims Act. *Id.* at ¶24. However, the Court finds that *Meyer*'s holding is inapplicable in this case for two reasons. First, the relevant amended complaint against BCBSNC alleged breach of contract and unfair and deceptive trade practices, not negligence. *Id.* Second, Birchard's right to review the independent review organization's decision lies by statute with the Industrial Commission, and BCBSNC is bound by that decision. *Id.* at ¶25. Birchard could have asserted claims against or joined the independent review organization as a party or pursued review of their decision before the Industrial Commission, but she did not. *Id.* As a result,

> The superior court does not possess subject matter jurisdiction to review the decision made by the independent review organization or the State Health Plan and claims against BCBSNC are properly dismissed.

Id. at ¶26.

Importantly, the Court highlights that "[e]ven if Plaintiff was entitled to further review [concerning] the denial of coverage, she did not initiate nor invoke the statutory 'utilization review' process the General Assembly expressly provided before the Industrial Commission." *Id.* at ¶27. Birchard, the Court holds, fails to meet "the burden on appeal of showing the superior court possessed subject matter jurisdiction over her claims review, or alternatively, she is entitled to another review for her admittedly contractual and statutory claims." *Id.* In not using the statutory review process, "she is not entitled to further review in the superior court." *Id.* at ¶29.

The Court of Appeals affirms the trial court's order. *Id.*

Osborne v. Paris, 2022-NCCOA-338

Unanimous decision written by Judge Inman; Judge Arrowood and Judge Hampson concur.

In 2017, Ms. Osborne (Osborne) was a passenger on a motorcycle involved in a crash while being operated by its owner, Defendant Heath Paris (Paris). *Osborne*, 2022-NCCOA-338 at ¶3. The crash occurred when Defendant Jordan Ashworth (Ashworth), driving his car, collided with Paris's motorcycle. *Id.* Osborne was ejected and landed on the ground, sustaining serious injuries which required and continued to require several surgeries and other extensive medical treatment. *Id.*

Paris's motorcycle was uninsured, and Ashworth's car was insured by a liability insurance policy through GEICO, with minimum-limits bodily injury liability coverage of $30,000 per person. *Id.* at ¶4. It was undisputed that Ashworth's vehicle was an "underinsured motor vehicle" as defined by the Financial Responsibility Act (FRA). *Id.* GEICO tendered $30,000 to Osborne under Ashworth's policy in March 2020. *Id.* at ¶5. Three days later, Osborne, through counsel, sent a written demand to GEICO for $160,000 of uninsured motorist coverage and $70,000 of underinsured motorist coverage under three different GEICO policies. *Id*. at ¶6.

First, her own liability insurance policy (Policy 42) provided uninsured motorist coverage up to $30,000 per person. *Id.* Additionally, through sharing a household with her parents, Osborne was also covered by their two GEICO policies (Policy 65 and Policy 06). *Id.* Policy 65, which covered two vehicles, neither of which were involved in the underlying accident, provided combined uninsured and underinsured bodily injury liability coverage of $100,000 per person and a total limit of $300,000 per accident. *Id.* Finally, Policy 06, which insured a single motorcycle owned by Osborne's parents not involved in the underlying accident, provided limits of liability for uninsured motorist bodily injury liability of $30,000 per person, with a total limit of $60,000 per accident. *Id.*

Four days after Osborne made the aforementioned demands from GEICO, she filed suit against GEICO, alleging that it had: (1) breached its obligation to pay underinsured and uninsured motorist benefits to her; (2) displayed bad faith in its refusal to settle with Osborne on reasonable terms; and (3) engaged in unfair and deceptive trade practices. *Id.* at ¶7. She alleged that because Paris was uninsured, she was entitled to benefits under her policy's uninsured coverage, uninsured coverage under Policy 06, and an additional $100,000 in underinsured coverage under Policy 65 (because Ashworth was an underinsured motorist). *Id.*

Approximately one month later, in April of 2020, GEICO remitted three checks to Osborne totaling $130,000 – $100,000 combined uninsured/underinsured coverage under

Policy 65, $15,000 uninsured coverage under Policy 42, and $15,000 uninsured coverage under Policy 06. *Id.* at ¶8. GEICO's counsel asserted that Osborne was entitled to $130,000 of uninsured motorist coverage, the total available coverage of $160,000 under all three policies, less a $30,000 "credit" for the amount paid to Osborne under Ashworth's liability policy. *Id.* GEICO contended that this allocation of credit was required by its policy language providing that "coverage shall be reduced by all sums . . . [p]aid because of bodily injury . . . by or on behalf of persons or organizations who may be legally responsible." *Id.*

The trial court entered summary judgment in favor of GEICO in September of 2020, and Osborne appealed.

On appeal, Osborne argued that the trial court erred in concluding she may only recover $130,000 from GEICO. *Id.* at ¶10. Specifically, she contended: (1) she [was] entitled to recover underinsured coverage in addition to uninsured coverage under Policy 65, and (2) GEICO improperly reduced its uninsured coverage by the amount remitted from Ashworth's policy. *Id.*

Regarding her first argument, Osborne believed that she was entitled to $160,000 of uninsured motorist coverage and an additional $100,000 of underinsured motorist coverage, less the $30,000 paid from Ashworth's policy, for a total of $230,000 in coverage. *Id.* at ¶17. She contended that subsection (b)(4) of the Financial Responsibility Act (FRA) mandated she recover "the highest limits of *both* the underinsured *and* uninsured coverage in Policy 65, $100,000 each and totaling $200,000, because the statute provides underinsured motorist coverage shall be 'in addition to' uninsured coverage." *Id.* §20-279.21(b)(4) provides in relevant part that the owner's liability policy:

> Shall, in addition to the coverage set forth in subdivisions (2) and (3) of this subsection, provide underinsured motorist coverage, to be used only with a policy that is written at limits that exceed those prescribed by subdivision (2) of this subsection. The limits of such underinsured motorist bodily injury coverage shall be equal to the highest limits of bodily injury liability coverage for any one vehicle insured under the policy.

Id. at ¶18. The Court of Appeals finds Osborne's argument "not persua[sive]," and instead:

> interpret[s] Subsection (b)(4) simply to reiterate that all drivers in North Carolina must purchase liability coverage of at least $30,000, . . . to include uninsured coverage at those limits, . . . and that drivers have the additional *option* to purchase underinsured coverage greater than the minimum liability limits, in the event a negligent driver's policy does not cover the cost of an insured's injuries or damage to their property.

Id. at ¶21. Contrary to Osborne's argument, the Court also finds that the "terms of Policy 65 do not conflict with the [FRA] or our caselaw." *Id.* at ¶22. The Court reasons that,

"though the purpose of the [FRA] is 'to provide protection for innocent victims of motor vehicle negligence,'" it will not "interpret the relevant statutory language to produce the maximum possible recovery for Osborne regardless of the terms of the policy or our canons of statutory construction." *Id.* (citing *N.C. Farm Bureau Mut. Ins. Co. v. Dana,* 379 N.C. 502, 2021-NCSC-161, ¶20). The Court upholds this portion of the trial court's order. *Id.* at ¶23.

Osborne's second contention was that the FRA precludes GEICO from reducing its $160,000 uninsured coverage by the $30,000 GEICO tendered from Ashworth's policy – and the Court agrees. *Id.* at ¶24. In interpreting subsection (b)(4), it is noted that "this Court has held *underinsured* carriers are entitled to set off the amount received by a claimant from a tortfeasor's liability carrier against any *underinsured* amounts the injured party's carrier owed." *Id.* at ¶27. On the other hand, however, "the [FRA] does *not* authorize a set off for *uninsured* coverage from payment received by a tortfeasor's policy." *Id.* at ¶30. This important distinction between statutory language leads the Court of Appeals to the conclusion that:

> GEICO, providing uninsured coverage, was not entitled to a set off for payment Ms. Osborne received from Mr. Ashworth's policy. Thus, we modify the judgment of the trial court to order GEICO to pay an additional $30,000 ($160,000 total) to Ms. Osborne.

Id. at ¶31. The Court affirms in part, and remands in part, the trial court's order.

Dean v. Rousseau, 2022-NCCOA-376

Unanimous decision written by Judge Gore; Judge Inman and Judge Zackary concur.

In cases where plaintiff wishes to include an uninsured motorist carrier as unnamed defendant, failing to serve such unnamed party within the applicable statute of limitations warrants dismissal under N.C. R. Civ. P. Rule 12(b)(6).

Unlike any other summons which would relate back issued prior to the SOL running but timely served while its alive or an A & P summons as long as timely reissued and the chain properly intact, the COA again requires the UM carrier to be ACTUALLY served prior to the SOL running.

It's a malpractice trap and as a result of sloppy draftsmanship of a prior COA opinion which the Supreme Court should overturn. It needs to grant the PDR in this case and fix the issue.

Plaintiff Ricky Dean (Dean), administrator of the estate of Olivia Flores (Flores), filed a complaint for wrongful death and survivorship damages against Ravon Walser Rousseau (Rousseau) on **12 November 2020**. *Rousseau,* 2022-NCCOA-376 at ¶2.

According to the complaint, Flores was involved in a collision with Rousseau while operating a taxi cab for Taxi Universal, Flores's employer, on **14 November 2018**. *Id.* Dean alleges that at the time of the collision, Rousseau was racing with a second vehicle and driving at excessive speeds. *Id.* Both Rousseau and the driver of the second vehicle fled the scene; while the second vehicle's driver was not identified, Rousseau was later apprehended and charged with second-degree murder and felonious hit and run (he pled guilty and was sentenced to fifteen years in prison). *Id.* Flores was pronounced dead at the scene. *Id.* Rousseau did not have car insurance, but Flores's insurance policies with Southern General and National General included uninsured motorist coverage. *Id.*

On **12 November 2020**, a Civil Summons was issued against Southern General. *Id.* at ¶3. Service of the Summons and Complaint as to Southern General and National General were made through the Commissioner of Insurance on **1 December 2020** and **26 January 2021**, respectively. *Id.* Both Southern General and National General claimed that Dean's relief should be dismissed pursuant to North Carolina Rules of Civil Procedure Rule 12(b)(6) because Dean failed to serve the unnamed defendants within the applicable statute of limitations. *Id.* It is unknown if the National General summons was issued timely as it's not in the ROA. Assuming it was, it was not timely served under the normal rules as it was served after 60 days as stale.

The trial court granted both unnamed defendants' motions to dismiss on **17 May 2021** and **20 May 2021**, respectively. *Id.* at ¶4. Dean appealed both orders.

On appeal, Dean argued that "decisions from this Court regarding similarly situated litigants are inconsistent." *Id.* at ¶5. The Court notes:

> This line of cases includes *Thomas v. Washington*, 136 N.C. App. 750, 525 S.E.2d 839 (2000), *Davis v. Urquiza*, 233 N.C. App. 462, 757 S.E.2d 327 (2014), and *Powell v. Kent*, 257 N.C. App. 488, 810 S.E.2d 241, *disc. rev. denied*, 371 N.C. 338, 813 S.E.2d 857 (2018). These cases have been interpreted as standing for the proposition that service of the complaint and summons on an unnamed defendant uninsured motorist carrier must occur before the expiration of the applicable statute of limitations.

Id. N.C. Gen. Stat. §20-279.21(b)(3)(a) (2021) states in relevant part that, in order for an uninsured motorist carrier to be bound by a judgment against an uninsured motorist, the insurer must "be served with copy of summons, complain or other process in the action against the uninsured motorist by registered or certified mail, return receipt requested, or in any manner provided by law." *Id.* at ¶7. Additionally:

> The insurer, being served as herein provided, shall be a party to the action between the insured and the uninsured motorist though not named in the caption of the pleadings and may defend the suit in the name of the uninsured motorist or in its own name.

Id. (quoting N.C. Gen. Stat. §20.279.21(b)(3)(a) (2021)).

The Court notes that while §20.279.21(b)(3)(a) does not specify a time limitation for service of the uninsured motorist carrier, the North Carolina Rules of Civil Procedure provide that "[a] civil action is commenced by filing a complaint with the court." *Id.* at ¶8 (quoting N.C. R. Civ. P. 4(c)). The rules also state that "[u]pon filing of a complaint, summons shall be issued forthwith, and in any event within five days," and that "[p]ersonal service or substituted personal service of summons as prescribed by Rule 4(j) and (j)(1) must be made within 60 days after the date of the issuance of summons." *Id.* (quoting N.C. R. Civ. P. 4(a), (c)).

The Court then briefly surveys the cases Dean referenced in his argument on appeal. In *Thomas*, the plaintiff filed her complaint for recovery arising out of a car accident before the statute of limitations expired and properly issued summons against both *individual* defendants. *Id.* at ¶9 (emphasis added). Although the uninsured motorist carrier was not served within the statutory time limit, she had issued and directed a series of alias and pluries summons to the named individual defendants. *Id.* Based on this, plaintiff argued that "because her action against the uninsured motorist carrier arose from a contract of insurance, the statute of limitations did not apply, and that her action was kept alive through alias and pluries summonses." *Id.* This Court rejected that argument, holding "that the applicable statute of limitations, 'which begins running on the date of the accident, also applies to the uninsured motorist carrier' and that 'the provisions relating to issuance of alias or pluries summonses did not apply, as both individual defendants were served personally with the original summons.'" *Id.*

In *Davis*, the plaintiff filed a claim for personal injury arising from a collision against the defendant, an uninsured motorist on 31 May 2012. *Id.* at ¶10. On 5 June 2012, counsel for plaintiff mailed a copy of the summons and complaint to a representative of the uninsured motorist carrier (which was improper for service of process). *Id.* On 2 January 2013, six months after the uninsured motorist carrier filed its answer asserting the defenses of insufficiency of process as well as the statute of limitations, the plaintiffs sent an alias and pluries summons and complaint via certified mail to the Commissioner of Insurance to be served upon the carrier. *Id.* This Court affirmed the trial court's dismissal of the plaintiff's complaint, reasoning that "mere notice to the uninsured motorist carrier is insufficient under N.C. Gen. Stat. §20-279.21(b)," which states that "the carrier must be formally served with process." *Id.* This Court held that "where a plaintiff seeks to bind an uninsured motorist carrier to the result in a case, the carrier must be served by the traditional means of service, within the limitations period." *Id.*

Finally, in *Powell*, this Court attempted highlight the issues concerning its holdings in *Thomas* and *Davis* while simultaneously following such precedents. *Id.* at ¶11. In *Powell*, the relevant uninsured motorist company moved for summary judgment after being served with summons and the plaintiff's third refiled complaint. *Id.* On appeal, this Court

concluded "that our holdings in *Thomas* and *Davis* required this Court to affirm the trial court's grant of summary judgment." *Id.* Importantly, though, this Court in *Powell* expressed some reservation with its prior, binding lines of reasoning:

> The holdings in *Thomas* and *Davis* appear to be inconsistent with other applications of the statute of limitation which hold that cases are timely when filed within the statute of limitation, with service of process permitted within the time frames set forth in Rule 4 of the North Carolina Rules of Civil Procedure, even when service is accomplished after the statute of limitation has expired. While we are unable to discern any requirement in N.C. Gen. Stat. § 20-279.21(b)(3)(a) that specifically requires in an uninsured motorist action that service of process also be accomplished before the date the statute of limitation expires, we are bound by the prior determinations in *Thomas* and *Davis*. Given this inconsistent application of the statutes of limitations for similarly situated litigants, this situation appears ripe for determination or clarification by our Supreme Court or Legislature.

Id.

Here, the Court notes that Dean's action for wrongful death was filed on 12 November 2020, before the applicable two-year statute of limitations expired on 14 November 2020, and the civil summons was issued that same day. *Id.* at ¶12. Southern General and National General were then served with the summons and complaint through the Commissioner of Insurance on 1 December 2020 and 26 January 2021, respectively. The Court states:

> Neither our Supreme Court nor General Assembly has addressed this issue since this Court's holding in Powell. Thus, just as we were in *Powell*, we are bound by this Court's prior decisions and must affirm the trial court's dismissal of plaintiff's actions because both Southern General and National General were served after the statute of limitations expired. See *In re Civil Penalty*, 324 N.C. 373, 384, 379 S.E.2d 30, 37 (1989) ("Where a panel of the Court of Appeals has decided the same issue, albeit in a different case, a subsequent panel of the same court is bound by that precedent, unless it has been overturned by a higher court.").
>
> However, just as in *Powell* we note that the rule established by this Court in *Thomas* and *Davis* seems inapposite and inconsistent with this State's Rules of Civil Procedure and how the statute of limitations is evaluated in other civil matters. **Thus, we once again request clarification and further guidance from either our Supreme Court or General Assembly.**

Id. at ¶12-13.

The Court affirms the trial court's order. *Id.* at ¶14.

B. N.C. COURT OF APPEALS – UNPUBLISHED OPINIONS

Capps v. Cumberland Cty. Bd. of Educ., 279 N.C.App. 683, 2021-NCCOA-538 (unpublished)

Unanimous decision written by Judge Murphy; Judge Dietz and Judge Gore concur. Report per Rule 30(e).

When a government entity's liability insurance policy contains a self-insured retention that must be paid by the government entity before insurance coverage is triggered, the government entity has not waived immunity for purposes of barring negligence, negligent infliction of emotional distress, and agency claims brought against it.

In 2014, Plaintiff Serena Capps (Capps) was attacked by another student at her middle school. *Capps*, 2021-NCCOA-538 at ¶2. Capps, upon reaching the age of majority in 2019, filed a complaint against Defendant Cumberland County Board of Education (the Board) alleging in relevant part negligence, negligent infliction of emotional distress, and agency. *Id.* at ¶3. The complaint alleged "that at all relevant times the Board had 'purchased and maintained liability insurance, and thereby waives its privilege of governmental immunity.'" *Id.*

After the trial court denied the Board's motions for Judgment as a Matter of Law and Summary Judgment, the Board appealed, arguing entitlement "to governmental immunity because the [liability insurance] policy requires a self-insured retention [to] be paid by the Board before there is coverage," a fact which North Carolina courts have held in prior cases to uphold immunity. *Id.* at ¶6, 7.

On appeal, the Court outlines that "[a] county board of education is a governmental agency, and is therefore not liable in a tort or negligence action except to the extent that it has waived its governmental immunity pursuant to statutory authority." *Id.* at ¶10. Further, "immunity is waived only to the extent of the coverage obtained under an insurance policy." *Id.* at ¶11 (quoting *Magana v. Charlotte-Mecklenburg Bd. of Educ.*, 183 N.C. App. 146, 149, 645 S.E.2d 91, 92). In other words, the court reiterates that:

> [I]mmunity is waived only to the extent that the county is indemnified by the insurance contract from liability for the acts alleged. If the liability policy, by its plain terms, does not provide coverage for the alleged acts, then the policy does not waive governmental immunity.

Id. at ¶12 (quoting *Ballard v. Shelley*, 257 N.C. App. 561, 565, 811 S.E.2d 603, 606 (2018)).

The Court also turns to its holding in *Bullard v. Wake Cty*., 221 N.C. App. 552, 729 S.E.2d 686, *disc. rev. denied*, 366 N.C. 409, 735 S.E.2d 184 (2012), to determine where the line should be drawn in the waiver analysis. Because the insurance company's obligation to pay "arises *only after there has been a complete expenditure of the county's retained limit by means of payments for judgments, settlements, and costs*," the *Bullard* court found that the insurance company would be liable "only for that portion of damages in excess of the county's retained limit up to the policy Limits of Insurance." *Id.* at ¶15 (quoting *Bullard* at 529, 729 S.E.2d at 690-91 (emphasis in original)).

The settled rule based on this case law, according to the Court, "is that the purchase of a liability insurance policy will not waive governmental immunity when insurance coverage is triggered only upon the government entity's payment of the entire self-insured retention or retained limit." Here, the pertinent portion of the Board's insurance policy states:

> [The insurance company's] duty under the policy shall be to indemnify [the Board] for ULTIMATE NET LOSS in excess of the applicable SELF INSUIRED RETENTION, maintenance deductible, or any other applicable deductible or deduction; and not more than the EXCESS LIMIT OF INSURANCE. [The insurance company's] duty to indemnify ends when the applicable EXCESS LIMIT OF INSURANCE is exhausted by the payment of the ULTIMATE NET LOSS.
> …
> SELF INSURED RETENTION means that United States Dollar amount specified in the SCHEDULE OF SELF INSURED RETENTIONS which [the Board] is obligated to pay because of loss or damage covered under any Section of this policy, before this policy indemnifies [the Board] for the same loss.

Id. at ¶19. "According to this language," the Court holds, "liability insurance coverage for Capps' claims is contingent upon the Board's payment of the $100,000.00 self-insured retention," and therefore the Board did not waive its governmental immunity as to Capps' claims. *Id.* at ¶20, 22.

Ultimately, the Court of Appeals determines that the trial court erred in denying the Board's motion for summary judgment based on governmental immunity and accordingly reverses. *Id.* at ¶22.

Provident Life & Accident Ins. Co. v. Brown, 2021-NCCOA-573 (unpublished)

Unanimous decision written by Judge Jackson; Judge Arrowood and Judge Collins concur.
Report per Rule 30(e).

In cases involving partially-compliant life insurance beneficiary change forms and competing claims to life insurance proceeds, the form will not be processed if more than mere ministerial acts remain to process the decedent's request, and/or if the beneficiary change request form is not in substantial compliance with the insurance company's procedures.

Decedent Ms. Neely (Neely) was the owner of a life insurance policy with Provident Life and Accident Insurance Company (Provident Life). *Brown*, 2021-NCCOA-573 at ¶1. Prior to her death, the beneficiary of this policy was Neely's ex-husband Eric Neely (Appellee), even though they had been separated for multiple years. *Id.*

The contract stated:

> **Beneficiary.** At any time prior to the death of the Insured, you may name or change a revocable Beneficiary. If no Beneficiary has been named, you will be the Beneficiary. A change of Owner or Beneficiary must be made in writing. To be binding on us, the change must be signed by you and any irrevocable Beneficiary and must be filed at our Home Office. Any such change shall take effect as of the date it was signed, subject to any payment made or other action taken by us before the change was filed. Unless otherwise provided, the proceeds to be paid at the death of the Insured shall be paid in equal shares to those named beneficiaries who survive the Insured. Payment will be made in the following order: (1) The primary beneficiaries;(2) Any secondary beneficiaries, if no primary Beneficiary survives the Insured; (3) You; and (4) Your executors, administrators, or assigns, if no named Beneficiary survives the Insured.

Id., at ¶*2*.

On 12 June 2019, a few days before her death, Neely completed Provident Life's policy change form, "apparently attempting to designate Shatia Brown, her niece, and Thomas Lindsay, her partner, as beneficiaries under her life insurance policy." *Id.* at ¶3. After Neely's death, proceeds of $60,615 plus interest became payable under the policy; however, when Shatia Brown and Thomas Lindsay (Appellants) submitted their claims therein, Provident Life stated that the beneficiary change request could not be processed because:

> (1) The beneficiary names were not legible and one person appeared to be listed twice, (2) the relationship between the insured and the beneficiary was not indicated for one of the beneficiaries, (3) the percentages of benefits for each beneficiary were not listed, and (4) the spelling of Ms. Neely's name on the form did not match Provident Life's records.

Id. at ¶4. Because Appellee also submitted a claim form for the proceeds of Neely's life insurance policy, Provident Life sent letters to both Appellee and Appellants advising them of their competing claims. *Id.* at ¶3, 4.

Because the parties could not reach an agreement about the proceeds, Provident Life filed an interpleader action, asking the trial court to determine which claimant was entitled to the funds. *Id.* at ¶5. At close of discovery, both parties moved for summary judgment; the trial court granted Appellee's summary judgment motion and denied Appellant's summary judgment motion, and discharged and dismissed Provident Life from the action. *Id.* Appellants appealed. *Id.* at ¶6.

The Court notes:

> "[A]n insurance company may make reasonable rules and regulations by which the insured may change the beneficiary named in the policy of insurance ... and [ ] such rules and regulations become a part of the contract." Wooten v. Grand United Ord., O. F., 176 N.C. 52, 55, 96 S.E. 654, 656 (1918). An insured attempting to change the named beneficiary "must make the change in the manner required by his policy and the rules of the association, and [ ] any material deviation from this course will render the attempted change ineffective." Id. at 56-57, 96 S.E. at 656. A beneficiary change "may be accomplished by an insured who has 'expressed a clear, unequivocal intent to change the beneficiary' and 'performed every act in his power to perform.' " Adams v. Jefferson-Pilot Life Ins. Co., 148 N.C. App. 356, 361, 558 S.E.2d 504, 508 (2002) (quoting Sudan Temple v. Umphlett, 246 N.C. 555, 558, 99 S.E.2d 791, 793 (1957)).

Id. at ¶ 8.

On appeal, Appellants argued that the trial court erred in granting summary judgment because "Neely intended and attempted to change the beneficiary of her policy before her death, thus 'substantially complying' with Provident Life's requirements." *Id.* at ¶9. The Court of Appeals, however, disagrees. The Court outlines that "under the substantial compliance doctrine, '[t]he insured has substantially complied with change of beneficiary requirements if "all that remains to be done are ministerial act."'" *Id.* at ¶10 (quoting *Teague v. Pilot Life Ins. Co.*, 200 N.C. 450, 456, 157 S.E.2d 421, 424 (1931)) (internal brackets omitted). Further, "[a]n act is ministerial when it 'leave[s] nothing to the

exercise of judgment or discretion.'" *Id.* (quoting *Teague*, 558 S.E.2d at 508). The Court contends that:

> Here, in the light most favorable to Appellants, it appears that [Neely] intended to change her policy's beneficiary and attempted to do so in conformance with the insurance company's requirements. However, [Neely] did not perform "every act in [her] power" to perform, and more than mere ministerial acts remained to process her beneficiary request. Therefore, the substantial compliance doctrine has not been satisfied.

Id. at ¶12. Provident Life, according to the Court, had more than mere ministerial acts remaining to effect Neely's request because at the time Neely submitted the form, "the identities of the intended beneficiaries were not completely clear to Provident Life, nor was the percentage of payment each beneficiary would receive under the policy." *Id.* at ¶14. In order to process the change:

> Provident Life would have had to exercise "judgment or discretion" to determine (1) why one of the intended beneficiaries was listed twice on the form and (2) what percentage each beneficiary should receive under the policy. Instead of exercising this discretion, Provident Life notified [Neely] that it could not process her request, and further action was needed from [Neely] to clarify her beneficiary designation.

Id. Ultimately, the Court holds that the trial court did not err by granting summary judgment in favor of Appellee because "more than mere ministerial acts remained to process [Neely's] request, and the beneficiary change request form was not in substantial compliance with Provident Life's procedures." *Id.* at ¶15.

> The Court affirms the trial court's order. *Id.* at ¶17.

North Carolina Farm Bureau Mut. Ins. Co., Inc. v. Kerby, 2022-NCCOA-71 (unpublished)

Unanimous decision written by Judge Murphy; Judge Hampson and Judge Jackson concur.
Report per Rule 30(e).

In cases involving insurance policy coverage from alleged acts of negligence and/or invasion of privacy, and where the policy provisions are unambiguous in their exclusion of "intentional acts," the insurance company does not have a duty to defend the insureds (and thus no obligation to indemnify the insureds).

Plaintiff North Carolina Farm Bureau Mutual Insurance Company, Inc. (Farm Bureau) began the current action via *Complaint for Declaratory Relief* against Defendants

Caron Kerby (Caron), individually and d/b/a Caron's Daycare; Robert Kerby (Robert), individually and d/b/a Caron's Daycare; Arlene; and Cindy, individually and as the parent and natural guardian of Arlene. *Kerby*, 2022-NCCOA-71 at ¶2. The complaint was made in regard to abuse and molestation Arlene suffered at the hands of Robert between 2009 and 2014 while enrolled in Caron's Daycare. *Id.*

Arlene and Cindy had sued Caron's Daycare and Caron (d/b/a Caron's Daycare) for **negligence and invasion of privacy (offensive intrusion / appropriation of name and likeness)** in Gaston County. Within their complaint they allege "neither Arlene nor Cindy would have sustained any injury if Caron, individually and d/b/a Caron's Daycare, had warned of Robert's pedophilia and taken steps to prevent Robert from interacting with and spending private, unsupervised, and unmonitored time with Arlene." *Id.* That action had been stayed pending the ultimate outcome of Farm Bureau's declaratory judgment claim. *Id.* The issue faced at both the trial and appellate levels is:

> Whether Farm Bureau is required to defend and indemnify Caron Kerby, individually or d/b/a Caron's Daycare, against any claims by Arlene and Cindy under the Homeowners Policy issued by Farm Bureau to "Robert Y. Kerby" and "Caron Kerby" and/or the General Liability Policy issued by Farm Bureau to "Robert Kerby & Caron Kerby DBA Caron's Day Care."

Id. at ¶3. The trial court granted Farm Bureau's motion for summary judgment and declared that Farm Bureau "has no duty to defend or obligation to indemnify Caron . . . or Caron's Daycare . . . against the [Gaston County action]." *Id.* at ¶4.

On appeal, Arlene and Cindy argued that the trial court erred because "Farm Bureau has a duty to defend the insured under its Homeowners Policy and/or its General Liability Policy for (A) their negligence claims; and (B) their invasion of privacy claims." *Id.* at ¶6. Further, they argue that "because Farm Bureau has a duty to defend the insureds, the issue of whether Farm Bureau has an obligation to indemnify should be stayed pending the resolution of the Gaston County Action." *Id.*

As with the N.C. Supreme Court in *Hague*, this Court implements the "comparison test" to determine whether the acts of the insureds are covered by the provisions of the Homeowner's Policy and/or the General Liability Policy. *Id.* at ¶7. Specifically, "the pleadings are read side by side with the policy to determine whether the events as alleged as covered or excluded." *Id.* (citing *Waste Mgmt. of Carolinas, Inc. v. Peerless Ins. Co.*, 315 N.C. 688, 693, 340 S.E.2d 374, 378, *reh'g denied*, 316 N.C. 386, 346 S.E.2d 134 (1986)). Additionally, "where an insurance policy's language is clear and unambiguous, our courts will enforce the policy as written." *Id.*

In evaluating the policy language, the court siphons that "personal liability coverage under the policies extends to cover claims brought against an insured for bodily

injury resulting from an 'occurrence.'" *Id.* at ¶10. An occurrence, according to policy definitions, is "an accident." *Id.* "Accident" is not defined. Here, the Court highlights:

> The question here is not whether some interpretation of the events could possibly bring Arlene and Cindy's injury within the coverage of the policies, but "whether the events as alleged" are enough to bring the injuries within the coverage of the policies.

Id. at ¶11 (citing *Harleysville Mut. Ins. Co. v. Buzz Off Insect Shield, L.L.C.*, 364 N.C. 1, 6, 692 S.E.2d 605, 610 (2010)). Citing *Plum Props., LLC v. N.C. Farm Bureau Mut. Ins. Co.*, 254 N.C. App. 741, 802 S.E.2d 173 (2017) the court notes:

> Our Supreme Court has previously interpreted what constitutes an occurrence within the context of an insurance policy issued by [Farm Bureau] containing the same operational definition of "occurrence" as is contained within the [p]olicies. Based on the nontechnical definition of "accident," the Court described an "occurrence" as being limited to events that are not expected or intended from the point of view of the insured. While acknowledging that it is possible to perceive ambiguity in determining the type of events that constitute an accident, the Court noted that under a commonsense reading of the language it strains logic to do so. Accordingly, where the potentially damaging effects of an insured's intentional actions can be anticipated by the insured, there is no "occurrence."

N. Carolina Farm Bureau Mut. Ins. Co., Inc. v. Kerby, 2022-NCCOA-71, ¶ 10, 867 S.E.2d 594.

"Where the potentially damaging effects of an insured's intentional actions can be anticipated by the insured, there is no 'occurrence.'" *Id.* The Court holds:

> Caron and Robert's conduct, as alleged in the Gaston County Action, do not qualify as unexpected or unintended from the viewpoint of Caron or Robert . . . [a]s such, the insureds' actions do not meet the definition of an occurrence, and the policies do not provide personal liability coverage for Arlene and Cindy's negligence claims.

Id. at ¶12.

> The Court notes further,
>
> As an adequate and independent reason to affirm the trial court, the Homeowners Policy also contains exclusionary clauses to the personal liability coverage. Under Section II(E),8 coverage of Section II(A) is

> excluded where the bodily injury that occurs "**is intended by or which may reasonably be expected to result from the intentional acts or omissions or criminal acts or omissions of one or more 'insured' persons.**" This exclusion applies regardless of whether the insured is charged with or convicted of a crime. Assuming, arguendo, that Section II(A) of the Homeowners Policy provided coverage for Robert's intentional actions resulting from the negligence or negligent supervision of Caron, individually and d/b/a Caron's Daycare, Farm Bureau would still not have a duty to defend because Section II(E) excludes coverage for damages that occur as the reasonably expected result of an insured's intentional acts.

N. Carolina Farm Bureau Mut. Ins. Co., Inc. v. Kerby, 2022-NCCOA-71, ¶ 14, 867 S.E.2d 594

Regarding the Gaston County Action's allegation of invasion of privacy, the Court notes that the General Liability Policy controls the extent of coverage for "personal and advertising injury," which is defined as "injury, including consequential bodily injury, **arising out of** one or more of the following offenses: . . . [o]ral or written publication, in any manner, of material that violates a person's right of privacy." *Id.* at ¶17. Turning to the Gaston County Action's complaint, Arlene and Cindy alleged that "'[Robert] was allowed to videotape [Arlene] without permission or authority and publish such material on the internet,' and their personal and advertising injuries arose out of this publication, which violated Arlene's right to privacy." *Id.* at ¶18.

The Court determines that while their claims fall within coverage under the General Liability Policy because "they are injuries that arose out of '[o]ral or written publication, in any manner, of material that violates a person's right to privacy:'" the Policy also contains specific exclusionary clauses to the personal and advertising injury liability coverage. *Id.* Specifically, coverage under the General Liability Policy "is excluded where the personal and advertising injury that occurs 'arises out of oral or written publication of material, *if done by or at the direction of the insured with knowledge of its falsity*.'" *Id.* (emphasis in original). The Court holds:

> Arlene and Cindy explicitly allege that the publication "of material depicting the image of [Arlene] violated [Arlene's] right of privacy and was done by or at the direction of [the insured] with knowledge of its" falsity or false nature and commercial impropriety. As there claims are excluded from coverage under the General Liability Policy, Farm Bureau does not have a duty to defend the insureds against Arlene and Cindy's invasion of privacy claims in the Gaston County Action.

Id. at ¶19 (quoting *Buzz off Insect Shield*, 364 N.C. at 28, 692 S.E.2d at 623).

Finally, the Court holds that, since the duty to defend is "broader than the duty to indemnify," and Farm Bureau has no duty to defend here, "it follows that it also does not have a duty to indemnify." *Id.* at ¶20, 21.

The Appellate Court affirms the trial court's order granting Farm Bureau's motion for summary judgment, and holds that Farm Bureau "has no duty to defend or obligation to indemnify" Caron in Arlene and Cindy's Gaston County Action. *Id.* at ¶23.

III. UNITED STATES DISTRICT COURT

A. EASTERN DISTRICT OF NORTH CAROLINA

Elrod v. WakeMed, 561 F.Supp.3d 592 (E.D.N.C. 2021), appeal docketed, No. 21-2203 (4th Cir. Oct. 25, 2021)

Decision written by District Judge Louise W. Flanagan.

Plaintiffs, a putative class of three individuals who received treatment at a hospital emergency room operated by WakeMed, filed their operative complaint in November 2020, asserting "1) declaratory judgment against all defendants; 2) breach of fiduciary duty against defendant WakeMed; and 3) fraud, conversion, and unfair and deceptive trade practices against defendants Argos Health, Inc. (Argos) and WakeMed." *Elrod*, 561 F.Supp.3d at 600. In addition to WakeMed, Plaintiffs named Allstate Property and Casualty Insurance Company (Allstate) and Pennsylvania National Mutual Insurance Company (Penn National) as the underlying car insurance companies to the action. *Id.* All defendants filed motions to dismiss for failure to state a claim under Rule 12(b)(6). *Id.*

The first Plaintiff, Peggy Elrod (Elrod), was involved in a motor vehicle accident wherein she sought treatment immediately at "one of defendant WakeMed's emergency rooms." *Id.* at 601. While there, she was "presented with numerous forms that needed to be signed in order for her to receive emergency medical treatment." *Id.* The document at issue was a "general consent form" that contained an "Irrevocable Assignment of Insurance Benefits" provision. *Id.* At the time of the accident, Elrod had a motor vehicle insurance policy with Penn National that included "coverage of $5,000 for medical payments." *Id.* at 602. Three days after WakeMed generated charges totaling $20,065.48 for treatment and care, defendant Argos, representing itself as an agent of WakeMed, "faxed a claim" on behalf of Elrod to Penn National for the total amount, stating in pertinent part: "[a]ttached is a valid North Carolina Lien, UB's for med pay/PIP coverage, and an executed Assignment of Benefits." *Id.* at 603. The following day, Penn National "issued a check for $5,000 to WakeMed and WakeMed Specialty Physicians, completely exhausting [] Elrod's coverage under the MedPay provisions in her motor vehicle insurance policy." *Id.*

The second Plaintiff, Justin Palmer (Palmer), "had a similar experience with treatment in [] WakeMed's emergency room." *Id.* The only divergence was that Janine, Palmer's mother, signed the forms on behalf of Palmer. *Id.* at 604. At the time of the accident, Palmer was "a named insured on his mother's automotive policy issues through Allstate that contained $1000 of MedPay coverage, payable to the insured and each passenger in [his] vehicle." *Id.* Defendants allegedly represented this form to Allstate as a valid assignment of benefits in order to exhaust Janine's MedPay coverage. *Id.*

Finally, the third Plaintiff, Yvonne Bertolo (Bertolo), experienced a similar exhaustion of her MedPay funds under her car insurance policy with Allstate, which allowed coverage of $2000. *Id.* Allstate, "after intervention by [counsel for plaintiffs], issued a check for $2000 to WakeMed . . . completely exhausting Bertolo's MedPay coverage." *Id.*

All Plaintiffs alleged that Argos assisted WakeMed with developing the current general consent form in use – the prior form, used pre-2015, "imposed a duty upon the patient to facilitate the hospitals' reimbursement for the reasonable value of the healthcare services rendered from patients' primary health insurances." *Id.* at 605. Additionally, the prior version "allegedly did not include any statements about assigning medical payments under an automotive insurance policy." *Id.*

The relevant portion of the Court's decision relates to Plaintiffs' first claim for declaratory action. Plaintiffs specifically **sought a declaration that the "[Irrevocable Assignment of Insurance Benefits] provisions in the general consent forms are 'illegal, void, and against public policy as a matter of law."** *Id.* The Court disagrees, basing its decision on contract rules:

> Under North Carolina law, "[t]he essence of any contract is the mutual assent of both parties to the terms of the agreement so as to establish a meeting of the minds." *Snyder v. Freeman*, 300 N.C. 204, 218, 266 S.E.2d 593 (1980). "By affixing her signature to the document," the signing party "manifest[s] her assent to enter into [a written] contract." *Branch Banking & Tr. Co. v. Creasy*, 301 N.C. 44, 53, 269 S.E.2d 117 (1980). "Freedom of contract, unless contrary to public policy or prohibited by statute, is a fundamental right included in our constitutional guaranties." *Allstate Ins. Co. v. Shelby Mut. Ins. Co.*, 269 N.C. 341, 345-46, 152 S.E.2d 436 (1967). Where "the contractual provision is, as related to the facts of this case, a valid one, the parties are entitled to have it enforced as written," and the court "cannot ignore any part of the contract." *Id.*
>
> Here, the general consent manifests mutual assent by each plaintiff to its terms, including the assignment of benefits, through their signature to the attestation at the conclusion of the form. In addition, the terms of the assignment of benefits are clear and unambiguous, in that each plaintiff

> agrees to "assign and authorize direct payment of all surgical and medical benefits," defined to include "medpay" benefits. Thus, "there is no reason it should not be valid," where it assigns a claim for payment using language akin to other assignments upheld as valid under North Carolina law. *Charlotte-Mecklenburg Hosp. Auth. v. First of Georgia Ins. Co.*, 340 N.C. 88, 91, 455 S.E.2d 655 (1995); see, e.g., *Barnard v. Johnston Health Servs. Corp.*, 270 N.C. App. 1, 2, 839 S.E.2d 869 (2020) (affirming dismissal of claims challenging assignment of benefits executed by emergency room patient as part of hospital's "admission paperwork"); *Alaimo Fam. Chiropractic v. Allstate Ins. Co.*, 155 N.C. App. 194, 197, 574 S.E.2d 496 (2002) (determining validity as a matter of law of provision that assigned insurance benefits, including "medical payments benefits").
>
> Therefore, the general consent, including the assignment of benefits, is a valid and enforceable contract, on its face.

Id. at 606.

Additionally, the Court agrees with Penn National and Allstate's motions to dismiss "for two reasons." *Id.* at 616. First, "the facts alleged do not 'show that there is a substantial controversy, between parties having adverse legal interests, of sufficient immediacy and reality to warrant the issuance of a declaratory judgment.'" *Id.* at 617 (quoting *White v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 913 F.2d 165, 168 (4th Cir. 1990)). Because Plaintiffs do not seek relief from either insurance company, nor assert breach of their auto policy terms, "plaintiffs do not allege an 'actual controversy' with [Allstate and Penn National] to permit exercise of the court's jurisdiction against them under the Declaratory Judgment Act." *Id.* Second:

> where plaintiffs' declaratory judgment claim fails as a matter of law, for the reasons stated above, and where defendants Allstate and Penn National have not brought a claim for separate relief in the form of a declaratory judgment in their favor, the declaratory judgment claim properly is dismissed for failure to state a claim upon which relief can be granted.

Id.

The District Court grants all defendant parties' motions to dismiss pursuant to Rule 12(b)(6). *Id.* **An appeal has been filed with the 4th Circuit (submitted October 25, 2021).**

Certain Underwriters at Lloyd's, London v. Stock Bldg., 556 F.Supp.3d 559 (E.D.N.C. 2021)

Decision written by District Judge Terrence W. Boyle.

This insurance dispute arose from alleged construction defects at a New Bern, North Carolina condominium development called SkySail Luxury Condominiums (SkySail). *Underwriters,* 556 F.Supp.3d at 563. The pertinent parties and their involvement in the project are as follows:

⇒ New Bern Riverfront (New Bern), as the developer of the project, retained Weaver Cooke Construction, LLC (Weaver Cooke) as the general contractor to coordinate construction of the condominiums.
⇒ Weaver Cooke subcontracted the installation of windows and sliding glass doors to Stock Building Supply, LLC (Stock).
⇒ Stock further subcontracted the installation to Carlos O. Garcia (Garcia).

Id. In March of 2007, Garcia, due to his contractual obligation to Stock, obtained comprehensive general liability insurance with Certain Underwriters at Lloyd's, London (Underwriters) via Woomer Insurance (Woomer) between 2007 and 2009 which would show that Stock and its affiliates were additional insureds and include both contractual liability and completed operations liability. *Id.* at 564. Between 2007 and 2009, Underwriters issued three Commercial General Liability Policies to Garcia:

(1) Policy No. TCNR001338, effective from January 26, 2007 to January 26, 2008 (2007 Policy).
(2) Policy No. TCNR005665, effective January 26, 2008 to January 26, 2009 (2008 Policy).
(3) Policy No. TCNR012269, valid from May 14, 2009 to July 30, 2009, when it was effectively canceled (2009 Policy).

Id. at 563. Garcia's 2008 and 2009 Policies contained an endorsement naming Stock and its affiliated subsidiaries as an additional insured party; however:

> the nature of the coverage was modified to include insurance "only with respect to liability for 'bodily injury', 'property damage' or 'personal and advertising injury'" that might occur during construction and as a result of the primary insured party's actions. **Once the actual construction at the project site was completed, the policies' coverage for bodily injury and property damage ceased to exist for the additional insured party**.

Id. [citations omitted]. As for the 2007 policy, Woomer believed that it had procured additional insured coverage for Stock with Underwriters, but "due to human error it failed

to notify the proper party that Stock needed to be added to the policy." *Id.* Woomer did secure Stock's additional insured status under the 2008 and 2009 policies. *Id.*

In the underlying action, New Bern filed suit against Weaver Cooke in May 2010 in the United States Bankruptcy Court for the Eastern District of North Carolina for numerous deficiencies in the condominium's construction, including faulty windows and doors. *Id.* In June 2012, Weaver Cooke filed a third-party complaint naming Stock, among others, as third-party defendants. *Id.* Stock then filed its own third-party complaint against Garcia in January 2013, contending that the project's functional and structural problems were due to the work of the subcontracted party, Garcia, "and accordingly pursued coverage and indemnity as an additional named party on Garcia's insurance policy with Underwriters." *Id.* All rulings in the underlying action were in Stock's favor; thus, Stock no longer sought indemnity from Underwriters. *Id.* at 564.

In this action, Underwriters sought a declaration that it "ha[d] no duty under the relevant policies to defend Stock in the [u]nderlying [a]ction," while Stock contended that "Underwriters d[id] have a duty to reimburse Stock's defense costs." *Id.* Stock specifically filed counterclaims against Underwriters and a third-party complaint against Woomer. *Id.* In October 2020, Underwriters filed a motion for summary judgment and, on the same day, Woomer, as an agent of Underwriters, claimed no breach of duty or responsibility for Stock's alleged damages, and also moved for summary judgment. *Id.* at 562.

In support of its motion, Underwriters stated that Stock does not qualify for coverage as an additionally insured party for four reasons:

> (1) the 2007 Policy contained no such endorsement, (2) the 2008 and 2009 Policies failed to designate New Bern, North Carolina as the location, (3) the Underlying Action does not concern "property damage" caused by a specific occurrence, and (4) any damage to the property that may have occurred was not a result of Garcia's ongoing operations for Stock.

Id. at 565.

On Underwriters first argument, the trial court agrees that Stock was not an additional insured under the 2007 Policy due to Woomer's failure to procure Stock's coverage. *Id.* However, the second issue proved to be slightly more complex – "the endorsement at issue," the Court notes, "includes a box in which the name of the additional insured person or organization is requested." *Id.* This issue was relevant, notwithstanding the 2007 Policy mishap, because Stock was named in the 2008 and 2009 Policies. *Id.* The provision included in these policies stated, in relevant part:

> A. Section II - Who Is An Insured is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule, but only

> with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused in whole or in part, by:
>
> 1. Your acts or omissions; or
> 2. The acts or omissions of those acting on your behalf;
>
> in the performance of your ongoing operations for the additional insured(s) **at the location(s) designated above.**

Id. (emphasis in original). Underwriters argued that "the location listed above is a Hemet, CA address, not the location of the SkySail project in New Bern North Carolina," and thus Stock could not be covered under the policy for any work done at the SkySail project. *Id.* at 565-66.

The Court disagrees, stating that:

> **to apply Underwriters' construction of the endorsement would be to, in essence, find an illusory contract**. **The endorsement never expressly asks for the location of a project, it merely asks for the name of the additional insured or organization.** That an insurance compliance address for Stock was listed does not change that fact, nor should it result in Underwriters being granted a construction of the endorsement which would cause the endorsement to fail. If not illusory, the phrase is ambiguous in light of the remainder of the endorsement page. Indeed, an ambiguity can exist even where, as here, the words themselves are clear ("at the location(s) designated above"), but the facts of the case create more than one reasonable interpretation. *Reg. v. White,* 358 N.C. 691, 695, 599 S.E.2d 549 (2004). Because the insurance company or its representative was responsible for drafting this endorsement, any ambiguity must be construed against it. *Hunter v. Town of Mocksville, N. Carolina,* 897 F.3d 538, 548 (4th Cir. 2018).

Id. at 566. Accordingly, the Court concludes that "the failure to designate a covered location, in light of the failure of the endorsement to include a space for doing so, does not bar Stock from being an additional insured on the 2008 and 2009 Policies." *Id.*

The Court further holds that Underwriters's third argument fails because, while the parties agree that **"under North Carolina law, property damage does not include the cost to repair defective workmanship or complete a project that was done incorrectly,"** the complaint within the underlying action **"plainly alleges damage to other property caused by the water intrusion into residential units and areas."** common *Id.* at 567. "There is no suggestion," the Court adds, "that the windows and doors installed by Garcia were not present in either residential units or common areas." *Id.* The Court analyzes the procedural history in drawing its conclusion:

> New Bern Riverfront's allegations describe water intrusion as causing both damage and the potential for mold problems in the residential units and common areas. Weaver Cooke then alleges that Stock is liable for these damages. Accordingly, in Weaver Cooke's complaint against Stock, both shoddy workmanship and consequential damages are alleged. **This is sufficient to trigger Underwriters' duty to defend.**

Id. (citations omitted).

Finally, Underwriters argued that "the policies limit the availability of additional insured coverage to those instances where the property damage in cause in whole or in part by Garcia's acts or omissions in the performance of ongoing operations, not after the work is complete." *Id.* at 567-68. However, the Court points out that "**New Bern's complaint is silent as to when that water intrusion causing damage occurred . . . nor is there any indication of when water intrusion causing damage occurred in Weaver Cooke's complaint against Stock."** *Id.* at 568. While Underwriters relied on the rule underlying *Harleysville Mut. Ins. Co. v. Hartford Cas. Ins. Co*., the Court distinguished it, "foremost because *Harleysville* concerned and applied a multiple trigger of coverage test, which is not at issue here." 90 F. Supp. 3d 526 (E.D.N.C. 2015) (determining that where property damage alleged in an underlying action has no date certain, insurers whose policies were in effect between the date the project was completed and the date of the lawsuit would be required to defend). *Id.*

Instead, the Court aligns with principles which hold that, **"unless the facts alleged in the underlying action are not even arguably covered, the insurer has a duty to defend."** *Id.* (citing *Waste Mgmt. of Carolinas, Inc. v. Peerless, Ins. Co.*, 315 N.C. 688, 340 S.E.2d 374 (1986); *Travelers Indem. Co. v. Miller Bldg. Corp.*, 97 F. App'x 431 (4th Cir. 2004) (allowing the insured "the benefit of any doubt or ambiguity" arising from claims in the underlying action)). In conclusion:

> [b]ased upon the pleadings in the Underlying Action, and the parties' admission that Garcia was working on the SkySail project **at minimum in April 2008, the Court determines that there is a mere possibility that Stock would be liable for property damage alleged in the Underlying Action, and Underwriters therefore have a duty to defend.**

Id.

Lastly, the Court agrees with Woomer's argument that "a decision by the Court that Underwriters have a duty to defend Stock would entitle Woomer to summary judgment in its favor." *Id.* Based on the parties' positions and the Court's holding concerning Underwriters's obligation, the Court holds its ruling on Woomer's summary judgment motion "in abeyance for a brief period to allow Stock to more fully state its position as to the necessity of adjudicating the motion on its third-party claims against Woomer." *Id.*

The District Court denies Underwriters's motion for summary judgment, grants Stock's motion for summary judgment concerning Underwriters's duty to defend Stock in the Underlying Action, and holds in abeyance Woomer's motion for summary judgment for fourteen days. *Id.*

Whitmire v. S. Farm Bureau Life Ins. Co., 538 F.Supp.3d 591 (E.D.N.C. 2021), appeal docketed, No. 21-1643 (4th Cir. June 3, 2021)

Decision written by Chief United States District Judge Richard E. Myers II.

Plaintiff Robert Whitmire (Plaintiff), a North Carolina resident, filed suit as his deceased wife's (Whitmire) life insurance beneficiary seeking the enforcement of a $500,000 policy issued by Defendant Southern Farm Bureau Life Insurance Company (Farm Bureau). *Whitmire*, 538 F.Supp.3d at 593.

The pertinent timeline of events are as follows: the relevant life insurance policy was issued by Farm Bureau on May 23, 2005, with a "face amount of $500,000." *Id.* at 594. Whitmire's application for insurance was dated April 16, 2005, wherein Whitmire was identified as a "proposed insured," **living at 205 Hyde Park Drive, Goldsboro**, NC, 27530. *Id.* Section 4 of the application, titled "Beneficiary," named Plaintiff as the "primary beneficiary of benefits payable under the Policy." *Id.* Section 12 of the application, titled "Premium," "provided that premium notices were to be sent to the Policy's 'Proposed Insured' and 'Owner,'" both of which were solely attributed to Whitmire. *Id.* Section 12 also listed Plaintiff above the line for "Depositor/Premium Payer." *Id.* The policy contained a "Grace Period" provision which stated:

> [a] grace period of 31 days will be allowed for the payment of each premium after the first. This policy will continue in force during the grace period. If any premium due remains unpaid at the end of the grace period, this policy will lapse as of that premium's due date.

Id. Further, the policy contained a "Reinstatement" provision which stated:

> [t]his policy may be reinstated within five years after the date of lapse and before the final expiry date if each of the following conditions is satisfied: (a) Satisfactory evidence of insurability of the Insured is furnished ...; and (b) all overdue premiums are paid with interest from the due date of each premium, at the rate of 6% per year, compounded annually.

Id. The policy premiums were payable semi-annually, in May and November. *Id.*

Beginning in **2005, Farm Bureau mailed "Notices of Premiums Due" addressed to Whitmire's Goldsboro address each May and November**. *Id.* From 2005 to May

2016, "all but one of the premiums were paid by personal check from a checking account jointly owned by Plaintiff and [Whitmire]." *Id.* Importantly:

> On or about **May 21, 2016**, [Whitmire] filed an Official Individual Mail Forwarding Change of Address Order with the United States Postal Service ("USPS"), changing her address to **2506 Celanese Road, Apt. A, Rock Hill, South Carolina 29732**. [Farm Bureau] received notice of [Whitmire]'s change of address from the USPS on **June 3, 2016**. The USPS confirmed to [Farm Bureau] that [Whitmire]'s change of address was an Individual Permanent record. On **June 6, 2016**, [Farm Bureau] sent an Internal Audit Address Change Confirmation to [Whitmire] at her Hyde Park Drive address in North Carolina. The Address Change Confirmation stated: "our records indicate that your address has recently changed. If you **did not** request a change of address, please call the toll[-]free number or send an email to the address below." Neither [Whitmire] nor Plaintiff contacted [Farm Bureau] in response to this correspondence. On **June 7, 2016**, [Farm Bureau] sent a letter to [Whitmire]'s South Carolina address stating: "[w]e have recently received notification of your change of address and hope you are enjoying your new home. Although your servicing agent on your existing life insurance policy has not changed, we do want to make you aware of the Farm Bureau agency located in your area .... Please be sure to contact this agency if you need any assistance." This letter was not returned as undeliverable, and [Whitmire] did not contact [Farm Bureau] in response. Furthermore, [Whitmire] never proactively contacted [Farm Bureau] during the span of the Policy.
>
> On **November 7, 2016**, [Farm Bureau] sent a semi-annual Notice of Premium Due to [Whitmire] at **her Rock Hill, South Carolina** address. The due date for this premium was **November 23, 2016**. This Notice was not returned as undeliverable, and the November 2016 premium was not paid. On **December 28, 2016**, [Farm Bureau] sent a Notice of Lapse to [Whitmire] at her Rock Hill, South Carolina address, noting that it had not received the premium payment due on November 23, 2016, and that the Policy's grace period had expired. [Farm Bureau] extended a "special offer" to keep the Policy in force if the premium payment was made by **January 22, 2017**. The premium was not paid. On **January 27, 2017**, [Farm Bureau] sent a letter to [Whitmire] at the Rock Hill, South Carolina address, informing her that the Policy had lapsed and encouraging her to consider applying for reinstatement of the coverage. [Whitmire] did not apply to reinstate coverage. [Whitmire] passed away in South Carolina on **March 10, 2017**.

Id. at 594-95 (emphasis added). The Court also notes as a non-material insight into the circumstances of Whitmire's actions that "Plaintiff and [Whitmire] entered into a

Separation Agreement on April 12, 2016." *Id.* at 595. The Agreement stated that Plaintiff and Whitmire were separated as of March 29, 2016, and "intended to live separate and apart permanently." *Id.* While there were factual disputes as to Whitmire and Plaintiff's reconciliation, the Court finds them immaterial, since **both parties agreed that "Whitmire was living in South Carolina in November 2016 –** the time of relevance, as will be explained below, regarding the notice on nonpayment of premium due." *Id.* at 597.

On April 27, 2017, Farm Bureau informed Plaintiff via letter that his claim for benefits was denied because the policy lapsed due to the non-payment of a premium. *Id.* As a result, and after "several failed attempts at settlement negotiations," Plaintiff filed suit in the Court on January 16, 2020 arguing that:

> **because [Farm Bureau] failed to comply with North Carolina's applicable statute, N.C. Gen. Stat. §58-58-120** "**Notice of nonpayment of premium required before forfeiture," by sending notices to [Whitmire]'s last-known address in North Carolina (and instead sent notices to her then-current address in South Carolina), the Policy was improperly forfeited and the Plaintiff impermissibly denied benefits.**

Id. On the other hand, Farm Bureau argued that:

> **it was not required to comply with North Carolina's statute in the first instance. [Whitmire] moved to South Carolina one year prior to her demise (due to an abusive relationship with Plaintiff) and remained a resident of South Carolina until her untimely passing.** Because all relevant communications regarding the lapse in payment were mailed to the South Carolina residence, the Policy was properly forfeited and all of the Plaintiff's claims necessarily fail as a matter of law. [Farm Bureau] also argues that Plaintiff's interpretation of the relevant North Carolina statute should be barred by the absurdity doctrine.

Id. Both parties moved for summary judgment. *Id.*

Because "regulation of the insurance industry is a sovereign prerogative that Congress has expressly reserved to the states . . . because of the states' fundamental interests in protecting their citizens," the **Court sua sponte analyzes whether it should abstain.** *Id.* at 598, 599 (citing 15 U.S.C. §§ 1011-12). **Specifically, the Court notes that the *Thibodaux* abstention is appropriate in diversity cases where: "(1) state law is unsettled, and (2) an incorrect federal decision might embarrass or disrupt significant state policies."** *Id.* at 598 (quoting *Nature Conservancy v. Machipongo Club, Inc.*, 579 F.2d 873, 875 (4th Cir.) (per curiam), *cert. denied*, 439 U.S. 1047, 99 S.Ct. 724, 58 L.Ed.2d 706 (1978)). Additionally, the Court highlights the fact that "this Court has previously applied *Thibodaux* abstention in the insurance context and stayed damages accordingly." *Id.* at 599. With these principles in mind, **however, the Court declines to abstain "given**

that Plaintiff elected to file suit in this court and no forthcoming North Carolina decision on the issue is apparent, rendering a stay of this proceeding futile." *Id.* at 599-600.

Moving onto the merits of the cross-motions, the Court systematically addresses two broad issues: (1) choice of law, (2) compliance with the relevant state statute. On the first issue, Plaintiff argued that North Carolina law governs the policy. *Id.* at 600. On the other hand, Farm Bureau argued that it was not required to comply with the particular North Carolina statute that is the subject of the cross-motions because at the time the November 7th notice was sent, Whitmire – "as owner of the Policy and the life insured" – did not reside in North Carolina. *Id.* The Court agrees with Plaintiff:

> [h]ere, the application for life insurance was made in the state of North Carolina and therefore the resulting contract became subject to the laws of the state, pursuant to the plain terms of North Carolina General Statute Section 58-3-1. North Carolina is also the location where most of the premium payments were made over the course of the Policy's eleven-year history, where the Plaintiff and [Whitmire] resided for most of that period, and where the Policy servicing agent was located. This sufficiently establishes the requisite close connection between the insured's interests and North Carolina.

Id. The Court then analyzes the second issue, applying **the relevant North Carolina statute. *Id.* N.C. Gen. Stat. §§58-58-120 creates a "<u>one-year grace period for life insurance</u> policies if the insurer fails to send the required notice ahead of a premium's upcoming due date indicating the date of the premium payment is due and that the failure to pay the premium can result in the policy's forfeiture**." *Id.* at 601. The relevant portion of the statute states:

> <u>No life insurance corporation doing business in this State shall, within one year after the default in payment of any premium</u>, installment, or interest, <u>declare forfeited or lapsed any policy hereafter issued or renewed</u>, except policies on which premiums are payable monthly or at shorter intervals and except group insurance contracts and term insurance contracts for one year or less, nor shall any such policy be forfeited or lapsed by reason of nonpayment, when due, of any premium, interest, or installment or any portion thereof required by the terms of the policy to be paid, within one year from the failure to pay such premium, interest, or installment, <u>unless a written or printed notice</u> stating the amount of such premium, interest, installment, or portion thereof due on such policy, the place where it shall be paid, and the person to whom the same is payable <u>has been duly addressed and mailed</u>, postage paid, <u>to the person whose life is insured, or to the assignee or owner of the policy</u>, or to the person designated in writing by such insured, assignee or owner, if notice of the assignment

> has been given to the corporation, **at his or her last known post-office address in this State**, by the corporation or by any officer thereof or person appointed by it to collect such premium, at least 15 and not more than 45 days prior to the day when the same is payable, as regards policies which do not contain a provision for grace or are not entitled to grace in the payment of premiums and at least five and not more than 45 days prior to the day when the same is payable as regards policies which do contain a provision for grace or are entitled to grace in the payment of premiums.

Id. at 601-02 (emphasis in original). Here, the Court notes that "[t]he premium that Plaintiff failed to pay was due on November 23, 2016. [Farm Bureau] timely mailed the November 23 Premium Notice on November 7, 2016, sixteen days before the premium was due." *Id.* at 602. As a result:

> That [Farm Bureau] sent the required notice is not in question. **This case turns on whether or not [Farm Bureau] complied with the statute when it sent the required notice to [Whitmire]'s South Carolina address as opposed to her last-known address in North Carolina.**

Id. at 603.

Federal courts sitting in diversity must "**predict how the Supreme Court**" of the controlling law's state would rule in making its determination. *Id.* (citing *Twin City Fire Ins. Co. v. Ben Arnold-Sunbelt Beverage Co. of S.C.*, 433 F.3d 365, 369 (4th Cir. 2005)). Further, "[w]hen there does not appear to be a North Carolina Supreme Court case precisely on point, this court may consider the opinions of the North Carolina Court of Appeals, treatises, and the practices of other states." *Id.*

Here, the Court found the North Carolina Appellate case, *Allstate Ins. Co. v. Nationwide Ins. Co.*, 82 N.C. App. 366, 346 S.E.2d 310, *review denied*, 318 N.C. 505, 349 S.E.2d 858 (1986), to be particularly instructive in its analysis. *Id.* In *Allstate*, that court was asked to review the denial of motions for directed verdict and "determine whether the insurer, required to mail an automobile insurance cancellation notice to the insured's 'last known address,' effectively cancelled the policy by mailing the notice to the last residence address provided by the insured." *Id.* at 604. The *Allstate* Court held:

> Giving the words their usual and ordinary meaning, we interpret the phrase "last known address" to mean the **most recent mailing address known to the insurer**.

Id. (emphasis added). With this in mind, the Court also refers to "[t]angentially analogous caselaw from other jurisdictions" that suggest that "sending the relevant notice to [Whitmire]'s South Carolina address was proper and effective." *Id.* at 606. (citing *Clark v. Progressive Max Ins.*, No. 04CA597, 2005 WL 1245474 (Ohio Ct. App. May 23, 2005);

Merrimack Mut. Fire Ins. Co. v. Scott, 219 Ark. 159, S.W.2d 666 (1951); *Monaghan v. Adkins*, 117 F. App'x 923 (5th Cir. 2004) (unpublished); *Sbarbora v. Equitable Life Assur. Soc. of U.S.*, 171 Misc. 1036, 14 N.Y.S.2d 295 (N.Y. Sup. Ct. 1937)).

The Court states:

> Taking all of the above into consideration, and notwithstanding North Carolina's general position favoring coverage, the court finds that [Farm Bureau] was required to comply with N.C. Gen. Stat. § 58-58-120 and that **it did in fact comply with the statute's requirements by sending the notice of nonpayment of premium to [Whitmire] at her most recent mailing address known to the insurer, which happened to be in South Carolina**. While the parties focus on the clause "**in this state**" the court finds that the term "**last known**" deserves more weight. As the North Carolina Court of Appeals did in *Allstate*, giving the words "last known post-office address in this state" their usual and ordinary meaning necessarily implies the existence of a new address *unknown* to the insurer. In such a case, an insurer would be required to send notice to the most recent mailing address in North Carolina known to the insurer. Where, however, an insurer has actual knowledge of the changed address—**whether that new address is in the state of North Carolina or elsewhere—the insurer should be required to mail notice to that new, *known* address**. This reading of the statute is in keeping with the legislative goal of ensuring that the policy owner is on notice of the consequences of non-payment of the premium.

Id. at 606-07 (emphasis in original).

The District Court denies Plaintiff's motion and grants Farm Bureau's motion for summary judgment. *Id.* at 608**. An appeal has been filed with the 4th Circuit (submitted June 3, 2021).**

First Protective Ins. Co. v. Noonan, No. 7:20-CV-253-FL (E.D.N.C. Aug. 16, 2021)

Decision written by District Judge Louise W. Flanagan.
Slip Copy.

Plaintiff First Protective Insurance Company (First Protective) provided homeowners insurance to Defendants Mark and Tracy Noonan (the Noonans) for a property located at 1101 Merchant Lane, Carolina Beach, North Carolina from August 14, 2019 to August 14, 2020. *First Protective*, slip op. at 2. On December 17, 2019, the Noonans notified First Protective of damage sustained due to a house fire on the property. *Id*. First Protective's subsequent "cause and origin analysis" of the fire found that the fire originated in "an outdoor kitchen area, where a Wilmington gas grill had been installed

into wood framing." *Id.* According to First Protective, "the installation of the grill within wood framing violated the grill's owner's manual, as well as local building codes." *Id.*

Additionally, during the post-claim investigation, the Noonans represented to First Protective that "he built the wood framing around the grill and installed the grill himself," but subsequently represented that either the general contractor that constructed the house, or one of their subcontractors, installed the framing and grill instead. *Id.* First Protective, after following up on these representations, alleged that "the architectural plans [for the house] do not depict the framing or the grill, and [the general contractor] denied any involvement in installing them." *Id.*

First Protective then commenced an action in federal district court seeking a declaratory judgment that the Noonans were "not entitled to coverage under a homeowners policy issued by First Protective, due to an alleged material misrepresentation, and alternatively, [Noonan] [was] not entitled to additional coverage under an endorsement in the policy." *Id.* at 1. Noonan then filed a motion to dismiss for failure to state a claim, "seeking to dismiss First Protective's declaratory judgment claim regarding additional coverage under the policy's endorsement." *Id*. Most relevant, however, is Noonan's additional motion under the Declaratory Judgment Act, "arguing that a balancing of state and federal interests weighs in favor of dismissing this action, or alternatively, staying this action pending resolution of a related lawsuit filed on January 20, 2021, in the General Court of Justice, Superior Court Division, New Hanover County, North Carolina." *Id.*

The insurance policy between First Protective and the Noonans in effect at the time of the fire provided in relevant part:

> **R. Concealment Or Fraud**
> We provide coverage to no "insureds" under this policy if, whether before or after a loss, an "insured" has:
>
> **1**. Intentionally concealed or misrepresented any material fact or circumstance;
> **2**. Engaged in fraudulent conduct; or
> **3**. Made false statements;
>
> relating to this insurance.

Id. at 2 (emphasis in original). The policy "impose[d] a liability limit under Coverage A of $459,000.00." *Id.* The policy also included a "Specified Additional Amount of Insurance Endorsement," which "provides additional coverage, at an amount of 25 percent of the liability limit in Coverage A, subject to certain terms." *Id.* The endorsement provided in relevant part:

> To the extent that coverage is provided, we agree to provide an additional amount of insurance in accordance with the following provisions:
>
> **A.** If you have:
>
> **1**. Allowed us to adjust the Coverage **A** limit of liability and the premium in accordance with:
>
> **a**. The property evaluations we make; and
> **b**. Any increases in inflation; and
>
> **2**. Notified us, within 30 days of completion, of any improvements, alterations or additions to the building insured under Coverage A which increase the replacement cost of the building by 5% or more;
>
> the provisions of this endorsement will apply after a loss, provided you elect to repair or replace the damaged building.

Id. (emphasis in orginal). During the post-claim investigation, First Protective determined that the "replacement cost of property equaled $551,340.28, which exceeds the liability limit under Coverage A by approximately $100,000.00." *Id.* Further, at the inception of the policy, First Protective "valued the replacement cost of the property at $503,108.64, which also exceeds the $459,000.00 liability limit in Coverage A." *Id.* Even though the Noonans paid more than the Coverage A limit for construction of the house, and allegedly "knew that the value of the property exceeded the liability amount under Coverage A," First Protective alleged that "nether [the Noonans], nor [their] agent, informed First Protective that the value of the property exceeded the face amount of Coverage A." *Id.*

The Court's discussion begins with the Declaratory Judgment Act, which provides that the court "may declare the rights and other legal relations of [the parties]." *Id.* at 3 (quoting 28 U.S.C. §2201(a)). In cases, as here, where there are parallel state proceedings, the Court notes the "weighing test" based on four factors as enumerated by *Penn-America Ins. Co. v. Coffey*, 368 F.3d 409 (4th Cir. 2004) in analyzing whether the Court should abstain or stay the instant federal suit:

> **(1) whether the state has a strong interest in having the issues decided in its courts; (2) whether the state courts could resolve the issues more efficiently than the federal courts; (3) whether the presence of "overlapping issues of fact or law" might create unnecessary "entanglement" between the state and federal courts; and (4) whether the federal action is mere "procedural fencing," in the sense that the action is merely the product of forum-shopping.**

Id. With guidance provided by *Centennial Life Ins. Co. v. Poston*, 88 F.3d 255 (4th Cir. 1996), a case with similar facts, the Court walks through the four factors. Specifically, on the second factor, the Court states:

> Here, as in *Poston*, First Protective instituted a declaratory judgment action, seeking declarations regarding insurance coverage, and shortly thereafter, defendants initiated the state court action, asserting a breach of contract claim against First Protective and related claims against the insurance agent, Gerdes. Therefore, the pending state court action addresses issues raised herein and involves the parties to the instant action, while also addressing supplemental issues and involving additional parties not present here. Although the instant action could resolve some of the issues between the parties, "it certainly would not settle the entire matter. The state litigation, on the other hand, could resolve all issues." *Poston*, 88 F.2d at 258. **This factor weighs heavily in favor of declining to exercise jurisdiction.**

Id. at 4. The other factors, according to the Court, "lead to no obvious conclusion." *Id.* For example, the first factor could go either way since the Fourth Circuit has held both that "the most authoritative voice [to] speak on the meaning of applicable law . . . belongs to the state courts when state law controls the resolution of the case," (*Mitcheson v. Harris*, 955 F.2d 235, 237 (4th Cir. 1992)), while also frequently approving "the use of federal declaratory judgment actions to resolve disputes over liability insurance coverage." (*Nautilus Ins. Co. v. Winchester Homes, Inc*., 15 F.3d 371, 377 (4th Cir. 1994)).

Under the third factor, the Court notes that "there are overlapping issues of fact and law, since [the Noonans] assert a breach of contract claim against First Protective in state court." *Id.* Because the state court would have to perform the same interpretation analysis of the policy as this Court, there is a "possibility of entanglement." *Id*. At the same time, however, the Court also points out that "the potential preclusive effect of this suit is unclear, where is it currently unknown if First Protective will succeed on the merits." *Id.*

Further, under the "procedural fencing" factor, the Noonans argued that First Protective engaged in "improper gamesmanship because it commenced this declaratory judgment action before communicating its coverage position to [the Noonans]." *Id.* On the other hand, First Protective argued that its counsel "made clear to [the Noonan]'s attorney that an action was forthcoming to address the remaining coverage issues." *Id.* "Given the parties' factual dispute," the Court states, "the court 'declines to place undue significance on the race to the courthouse door.'" *Id.* (quoting *Poston*, 88 F.2d at 258).

The Court concludes:

> After weighing the relevant factors with due flexibility, the court finds that they **weigh in favor of discretionary abstention**. First Protective argues the court should retain jurisdiction, relying upon *Wahome* and *Coffey*.

> Those cases are inapposite, however, because the insurance companies were not parties to the respective state court actions, which involved tort claims rather than insurance coverage issues. See *Coffey*, 368 F.3d at 414 ("[T]o defer to the state court tort case in the circumstances before us will not advance the State's interests significantly because (1) the contractual coverage issue will not be decided by the state tort case, and (2) Penn–America is not a party to the state case."); *Wahome*, 2016 WL 3093889, at *2 ("[H]owever, plaintiff is not a party in the underlying state action, and there is no indication in the record that the coverage issue also is pending before the state court."). Here, in contrast, **First Protective is a party to the state court action, and the insureds have asserted a breach of contract claim against it**, which raises coverage and policy interpretation issues.

Id. at 5 (emphasis added).

The District Court **grants the Noonan's alternative motion to stay the action** under the Declaratory Judgment Act, and terminates as moot the Noonan's partial motion to dismiss.

B. MIDDLE DISTRICT OF NORTH CAROLINA

State Farm Mut. Auto. Ins. Co. v. Lawson, 543 F.Supp.3d 260 (M.D.N.C. 2021)

Decision written by District Judge William J. Osteen, Jr.

On May 2, 2017, a car accident killed **31-year-old** Amber Lawson (Amber) while she was driving her 2004 Mazda. *Lawson*, 543 F.Supp.3d at 261. In the wrongful death action following the crash, her father, Defendant Timothy Lawson (Lawson), alleged that Amber was insured under his policy with Plaintiff State Farm Mutual Automobile Insurance Company (State Farm). *Id.* State Farm filed suit against Lawson in response, "seeking a declaration of its rights and responsibilities under two policies of insurance issued by State Farm to Defendant Lawson." *Id.* Importantly, "the parties [did] not dispute any of the facts at issue, merely whether the stated facts [were] adequate for Amber [] to constitute a 'resident' of her parents' home at the time of the accident. *Id.*

The relevant policy issued by State Farm covered Lawson and his wife from April 29, 2017 through October 29, 2017. *Id.* Amber was "not an explicitly-insured driver under the policy, nor was her Mazda directly covered by the policy." *Id.* However, "her name did appear on associated documents that State Farm sent to the Lawsons," specifically as either a "Principal Driver" or "Other Household Driver." *Id.*

The Court notes the addresses associated with Amber at the time of the crash:

- ⇒ **1630 South Stokes School Road, Walnut Cove, N.C.** (Stokes House) – Lawson's home where Amber, as an adult, would permanently stay between various rentals.
- ⇒ **605 Hwy. 65** – Amber and her fiancé Leon Fulp's (Fulp) rental where they lived for over one year until August of 2016.
- ⇒ **1054 Crestview Drive, Walnut Cove, N.C.** (Crestview House) – Fulp's parent's home, where Amber and Fulp moved in August 2016.

Id. at 262 (emphasis added). When Amber moved to the Crestview House, she "**switched her address on various official documents from 605 Hwy. 65 to the Crestview House**." *Id.* On the other hand, however, the parties agreed that "[d]uring all of this time, Amber still kept some personal belongings at the Stokes House, along with her two dogs that she regularly fed and took care of." *Id.* She kept clothing, nursing uniforms, shoes, personal items, pictures, and photos at the Stokes House. *Id.* She listed the Stokes House as her home address on her driver's license at the time of the crash, had her own key to the home, and frequently drove all of the Lawsons' vehicles. *Id.* While she went to the Stokes House almost every day, she "rarely spent the night." *Id.*

On cross-motions of summary judgment, State Farm argued that "Amber should no longer have been considered a resident of her parents' home under the State Farm policy at the time of her passing." *Id.* at 263. Lawson argued, "to the contrary, that Amber was indisputably a legal resident of her parents' home." *Id.* In order to resolve this question of law, the Court turns to the relevant language in the State Farm policy agreement with Lawson:

> We will also pay compensatory damages which an insured is legally entitled to recover from the owner or operator of an underinsured motor vehicle because of bodily injury sustained by an insured and caused by an accident. The owner's or operator's liability for these damages must arise out the ownership, maintenance or use of the underinsured motor vehicle. We will pay for these damages only after the limits of liability under any applicable liability bonds or policies have been exhausted by payments of judgments or settlements, unless we:
>
> 1. Have been given written notice in advance of settlement between an insured and the owner or operator of the underinsured motor vehicle; and
>
> 2. Consent to advance payment to the insured in the amount equal to the tentative settlement.
>
> ....
>
> Insured as used in this Part means:

> 1. You or any family member.
>
> 2. Any other person occupying
>
> a. your covered auto; or
> b. any other auto operated by you.
>
> 3. Any person for damages that person is entitled to recover because of bodily injury to which this coverage applies sustained by a person listed in 1. or 2. above.

Id. at 264. **"Family member"** is defined in the policy as **"a person related to you by blood, marriage, or adoption who is a resident of your household."** *Id.* While there was no dispute that Amber is a relative of the policyholder (Lawson), the Court distinguishes that "in order to be deemed residents of the same household**, parties must have lived in the same dwelling for some meaningful period of time under circumstances demonstrating an intent to form a common household**." *Id.* (quoting *N.C. Farm Bureau Mut. Ins. Co. v. Martin*, 376 N.C. 280, 295, 851 S.E.2d 891, 901 (2020)).

In interpreting the policy agreement as North Carolina courts would, the Court refers to multiple useful cases that have "previously addressed the question of adults' residency at their parents' home where they keep some personal effects and spend substantial time." *Id.* In cases such as *Jamestown Mut. Ins. Co. v. Nationwide Mut. Ins. Co.*, 266 N.C. 430, 146 S.E.2d 410 (1966), the adult child was found to be a resident of his father's home because "he had no other home and thought of his father's house as his home." *Id.* Further, in *Integon Nat'l Ins. Co. v. Mooring*, No. COA14-1303, 2015 WL 2062042, at *5 (N.C. Ct. App. May 5, 2015), the court found that "even though the daughter lived in a separate home – owned by the policyholder – she was 'wholly dependent' on the parental policyholder and was deemed a resident of the policyholder's household." *Id.* at 265.

The Court then highlights another N.C. case, *Bruton v. N.C. Farm Bureau Mut. Ins. Co.*, 127 N.C. App 496, 490 S.E.2d 600 (1997), wherein the adult child in question spent the majority of his time with his girlfriend in his mobile home and listed that mobile home address on his health insurance, bank account, taxes, and other bills. *Id.* The *Bruton* court found that, though he spent "two to three weekends per month at his father's house and stored some toiletries there, the court found that he was not a resident of his father's home." *Id.*

Based on its case survey, the Court finds:

> This case is far more comparable to *Bruton* than *Mooring* or *Jamestown*. While some of Amber's belongings were at her parents' home, the majority

> were at the Crestview house. Amber listed 1054 Crestview as her address on every official document she filled out, further supporting the conclusion that she was not a resident at her parents' home. On her school registration, 1054 Crestview is listed as her mailing address. Amber Lawson's 2016 W-2 form listed 1054 Crestview as her address for tax purposes. Her credit card bills also came to 1054 Crestview. In his deposition, Mr. Lawson acknowledges that "with her living over there," Amber's billing address for her car payments "had been changed to that address." Amber also slept at 1054 Crestview most nights and spent most of her days there. During her deposition, Mrs. Lawson admitted that 1054 Crestview is where Amber "went most days every day," when not at work or school. Even prior to moving to 1054 Crestview, Amber did not use her parents' home as her address – her official documents list her previous address as 605 N.C. Highway 65 East in Walnut Cove, the home she shared with Fulp before moving into his parents' house.
>
> Finally, **the fact that Amber was listed as a driver on the other, non-policy documents from State Farm does not alter this court's finding**. The policy itself is the binding document: the court has a "duty to construe and enforce insurance policies as written, without rewriting the contract or disregarding the express language used." *Fid. Bankers Life Ins. Co. v. Dortch*, 318 N.C. 378, 380, 348 S.E.2d 794, 796 (1986). Defendant's coverage expectations do not alter the court's analysis, as those expectations contradict "the express language of the insurance contract." *Bruton*, 127 N.C. App. at 498, 490 S.E.2d at 602 (denying coverage where plaintiff "argues that he was covered under his father's policy because he had a reasonable expectation of coverage because his name was listed on the declarations page of the insurance policy as a driver").

Id. (citations omitted).

The District Court grants State Farm's motion for summary judgment, and denies Lawson's cross-motion for summary judgment. *Id.* at 266.

Mass. Bay Ins. Co. v. Impact Fulfillment, No. 1:20-CV-926 (M.D.N.C. Sept. 24, 2021)

Decision written by District Judge William J. Osteen, Jr.
Slip Copy.

This dispute over Plaintiff Massachusetts Bay Insurance Company's (MBIC) and Hanover American Insurance Company's (Hanover) duty to defend and indemnify its insured, Defendant Impact Fulfillment (Impact), a limited liability company, arose from an underlying suit alleging that Impact violated the Illinois Biometric Information Privacy Act

(BIPA). *Impact Fulfillment*, slip. op. at 1, 2. **Specifically, Impact "used their employees' fingerprints as part of their payroll time-keeping procedures at one of [Impact's] facilities in Illinois**." *Id.* at 2. Impact did "not inform their employees of the purpose, length of collection, or use of employees' biometrics, and the employees never consented to or waived the storage and use of their biometrics," nor were they aware of what Impact did with their fingerprints. *Id.* The underlying class action suit filed by employee representative Bradley Taylor in 2020 sought both liquidated damages and injunctive relief. *Id.* Impact resultantly requested coverage from MBIC and Hanover, leading to this declaratory judgment action. *Id.*

At the time of Impact's allegedly illegal use of employee fingerprints, Impact was insured under certain policies provided by Hanover and MBIC. *Id.* at 1. Specifically, Impact purchased a commercial insurance policy from MBIC effective May 1, 2018 through August 1, 2019; a commercial insurance policy from Hanover effective August 1, 2019 through August 1, 2020, and; Commercial Follow Form Excess and Umbrella Policies from Hanover "with identical effective dates to the general insurance policies." *Id.* One exclusion within the policies was relevant to the Court's analysis. *Id.* The "Recording And Distribution Of Material Or Information" exclusion stated, in relevant part:

> This insurance does not apply to:
>
> ....
>
> "Personal and advertising injury" arising directly or indirectly out of any action or omission that violates or is alleged to violate:
>
> (1) The Telephone Consumer Protection Act (TCPA), including any amendment of or addition to such law;
>
> (2) The CAN-SPAM Act of 2003, including any amendment of or addition to such law;
>
> (3) The Fair Credit Reporting Act (FCRA), and any amendment of or addition to such law, including the Fair and Accurate Credit Transactions Act (FACTA); or
>
> (4) Any federal, state or local statute, ordinance or regulation, other than the TCPA, CAN-SPAM Act of 2003 or FCRA and their amendments and additions, that addresses, prohibits, or limits the printing, dissemination, disposal, collecting, recording, sending, transmitting, communicating or distribution of material or information.

Id. at 1-2. Notably, the Court points out that the Umbrella Policies also contain this provision as well. *Id.*

On evaluating MBIC and Hanover's motions for Judgment on the Pleadings, pursuant to Rule 12(c), "this court may consider only the pleadings, any exhibits thereto that are essential to the allegations, and matters of public record susceptible to judicial notice." *Id.* at 3.

The Court first addresses that MBIC and Hanover's motion pertaining to their duties to indemnify Impact "is not ripe for adjudication," since "[c]ourts have held that a duty to indemnify is generally resolved after the underlying lawsuit concludes." *Id.* at 4. Applying North Carolina common law, the Court finds that "an insurer's duty to indemnify cannot be determined until the conclusion of the case if necessary facts remain in dispute." *Id.* (citing *Harleysville Mut. Ins. Co. v. Buzz Off Insect Shield*, L.L.C., 364 N.C. 1, 692 S.E.2d 605 (2010)). Here, "there have been no allegations (or evidence showing) that the [underlying] complaint is resolved. Because it appears the [underlying] complaint is still pending, this court will stay ruling on the duty to indemnify claim." *Id.* at 5.

MBIC and Hanover's duty to defend, however, required a more thorough analysis. The Court enumerates that the recording exclusion "applies to alleged violations of statutes which limit the 'printing, dissemination, disposal, collecting, recording, sending, transmitting, communicating or distribution of material or information." *Id.* at 6.

While to citing tangentially applicable North Carolina case law, the Court mainly relies on the principle of *ejusdem generis* – the proposition that "general, catch-all language that directly follows a list of specific items is construed to include 'only those things of the same kind, character and nature as those specifically enumerated." *Id.* (quoting *N.C. Ins. Guar. Ass'n v. Century Indem. Co*., 115 N.C. App. 175, 191, 444 S.E.2d 464, 473-74 (1994)). The recording exclusion contains such "catch-all" language: "[a]ny federal, state or [sic] [local] statute," following the list of specifically enumerated statutes (the TCPA, CAN-SPAM, and FCRA/FACTA). *Id.* The Court concludes:

> Here, alleged violations of BIPA come directly within the scope of the Recording and Distribution of Material or Information Exclusion. This exclusion . . . applies to any statute that prohibits or limits "the printing, dissemination, disposal, collecting, recording, sending, transmitting, communicating or distribution of material or information." BIPA regulates the retention, collection, disclosure, and destruction of biometric identifiers or biometric information. The language of the exclusion in this case, which bars the "collect[ion]" and "dissemination" of information, is consonant with BIPA's prohibition against collection and disclosure of biometric identifiers and biometric information.

Id. (citations omitted). Additionally, the Court finds that "**BIPA is of the same kind, character and nature as the enumerated statutes.**" *Id.* at 7. In support, the Court refers to *OneBeacon Am. Ins. Co. v. Urb. Outfitters, Inc.*, 21 F.Supp.3d 426 (E.D. Pa. 2014) and

Hartford Cas. Ins. Co. v. Greve, No. 3:17CV183-GCM, 2017 WL 5557669 (W.D.N.C. Nov. 17, 2017), which found the recording exclusion "applied to a statute governing drivers' personal information and to a statute governing credit card users' personal information." *Id.* Based on these common law insights, the Court interpolates:

> This indicates the main purpose of this exclusion is to exclude from coverage statutes that protect and govern privacy interests in personal information. Like those statutes, BIPA protects and governs a person's privacy interest in their biometric information. 740 Ill. Comp. Stat. 14/15. Applying the principles of *ejusdem generis*, because BIPA is of the same kind, character and nature as the listed statutes, this court finds that the Recording and Distribution of Material or Information Exclusion applies. Therefore, the [underlying complaint] is excluded from coverage under Defendants' Insurance Policies.

Id.

The District Court grants MBIC and Hanover's motion for judgment on the pleadings. *Id.*

Fortson v. Garrison Prop. & Cas, Ins, Co., No. 1:19-CV-294 (M.D.N.C. Jan. 13, 2022), appeal docketed, No. 22-1192 (4th Cir. Feb. 25, 2022)

Decision written by District Judge Catherine C. Eagles.
Slip Copy.

Plaintiff Elizabeth Fortson (Fortson) had a car insurance policy with Defendant Garrison Property and Casualty Insurance Company (Garrison), when her car was totaled in an accident with an uninsured driver. *Fortson*, slip. op. at 1. Fortson alleged that Garrison engaged in unfair and deceptive trade practices "in the way it calculated the actual cash value of her vehicle when settling her claim." *Id.*

Fortson's policy with Garrison contained a provision that "required Garrison to pay for losses stemming from an accident with another vehicle, including paying the 'actual cash value' of the car if it was totaled." *Id.* After the accident, Fortson made a claim with Garrison for the value of the car and other losses covered by her insurance policy. *Id.* (citations omitted). In developing its offer for the value of Fortson's car:

> Garrison relied on its inspection of Ms. Fortson's car and the list price information on four comparable used vehicles in the same or similar geographic area obtained from a report prepared for Garrison by CCC Information Services, Inc., a third-party service. CCC obtained the pricing information from its database of comparator vehicles. **Because CCC is of the view that comparator vehicles in its database listed for sale by**

> **dealerships are generally in better condition than average cars on the road, like [Fortson]'s car, CCC usually deducts a set amount of money from the actual cash value of all comparator vehicles listed for sale by dealerships**. For a given report, the same deduction is applied to all dealer vehicles. This deduction, called a "comparable vehicle condition adjustment" by CCC and Garrison, thus reduces the value of the comparator vehicles.

Id. (citations omitted). While CCC did not inspect the comparator vehicles used in valuating Fortson's car, "**it [did] physically inspect some seven to nine percent of the comparator vehicles in its database."** *Id.* at 5. CCC also applied condition adjustments to the value of the insured's total loss vehicle by first requiring "Garrison's inspection of the vehicle; these adjustments may raise or lower the vehicle's actual case value." *Id.* at 4.

Additionally, CCC implemented third-party services to analyze "the validity of its condition adjustment descriptors when determining the recommended fair market value of used vehicles." *Id.* at 6. **A consultant used in a 2012 survey concluded that "CCC's condition adjustment factors yielded higher vehicle values than vehicle values using condition factors derived from subject matter experts**." *Id.* Another study found that "CCC's vehicle condition descriptors were valid, accurate, and appropriate." *Id.* The Court also highlights the fact that in North Carolina, "**approximately 75% of the top ten automobile insurance carriers by market share use CCC reports to determine actual cash value of total loss vehicles**." *Id.* Further, "[t]here is no evidence that any state regulator or court has ever found CCC's evaluations to be improper, illegal, unethical, unfair, or otherwise inappropriate." *Id.*

In Fortson's case, CCC "applied the condition adjustment to the list prices of the four vehicles it located to compare to [Fortson]'s car, and it used the reduced amount as part of the process when determining the actual cash value of [Fortson]'s car." *Id.* at 1. Additionally, Fortson received a $130 "**positive condition adjustment** because Garrison's inspection of her vehicle showed it had better mechanical components than the average car in good condition." *Id.* at 4. Ultimately, Garrison made a written offer to pay Fortson $6,962.70 to settle her total loss claim – "**$6,690 for her vehicle's actual cash** value, and $272.70 for taxes and fees." *Id.* at 3.

After receiving the offer letter, Fortson's attorney "disputed to valuation and sought coverage for other losses under different provisions of the policy." *Id.* After some back and forth, Garrison sent Fortson three checks – "one for loss of use, one for the difference between deductibles under different parts of her coverage, and one for the total loss payment, which included the actual cash value of Fortson's vehicle plus taxes and fees." *Id.* Importantly, Fortson cash all three checks. *Id.* **A year passed before Fortson contacted Garrison again, this time questioning the "condition adjustment**" method Garrison used in valuating her car. *Id.* After **Fortson filed this suit**, **Garrison "immediately invoked the appraisal provision in [Fortson]'s policy**, which resulted in a determination

that the, **actual cash value of her car was $7800**." *Id.* Garrison then "promptly tendered the difference" to Fortson. *Id.*

Fortson argued that **Garrison's routine deduction for a "condition adjustment" to comparable vehicles was "automatic, artificially understate[d] the actual cash value of insured vehicles, including her own, and result[ed] in consistent underpayment on claims, including her own."** *Id.* at 1. Fortson points out four duties within North Carolina's unfair insurance claim settlement practices statute, codified at N.C. Gen. Stat. § 58-63-15(11), that Garrison violated in support of her claim of Garrison's unfair and deceptive trade practices:

> (1) to act in good faith to effectuate a prompt, fair and equitable settlement of claims in which liability has become reasonably clear, N.C. Gen. Stat. § 58-63-15(11)(f);
>
> (2) not to compel the insured to initiate litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions by such insured, § 58-63-15(11)(g);
>
> (3) to reasonably investigate claims based upon all available information before refusing to pay a claim, § 58-63-15(11)(d); and
>
> (4) to adopt and implement reasonable standards for the prompt investigation of claims arising under its insurance policy, § 58-63-15(11)(c).

Id. at 2. Garrison moved for summary judgment on Fortson's claims, and the Court addresses each of these statutory duties in turn.

On the first statutory provision, N.C. Gen. Stat. **§ 58-63-15(11)(f),** the Court notes that there was "no dispute that Garrison's liability for [Fortson]'s total loss claim was reasonably clear under her insurance policy, but the parties disagree as to whether Garrison acted in good faith." *Id.* at 7. To succeed under the bad faith settlement provision, there must be "more than honest disagreements over the value of the claim." *Id.* (citing *Clear Creek Landing Home Owners' Ass'n, Inc. v. Travelers Indem. Co. of Conn*., No. 1:12-CV-157, WL 6641901, at *4 (W.D.N.C. Dec. 20, 2012)). The Court holds, based on the fact that Garrison "promptly inspected [Fortson]'s car," made an offer "[r]oughly two weeks after she submitted her claim," subsequently "negotiated with [Fortson]'s attorney and promptly mailed checks to [Fortson] for claims made under various provisions of her policy," and "immediately sought to resolve her claim by invoking the appraisal provision" upon Fortson filing suit, that **"[t]he undisputed evidence shows that Garrison did not act in bad faith." *Id.* at 8.**

Fortson, beyond claiming bad faith from Garrison's offer, **claimed that Garrison "failed to adequately explain the basis for the condition adjustment it applied to comparator vehicles**." *Id.* However, the Court clarifies that **"subsection (f) is not a disclosure provision**, and **nothing in that subsection of the statute or in any regulation in effect at the time required** Garrison to provide the kind of detail justifying its offer that [Fortson] says should be required." *Id.* The Court concludes:

> [n]othing else appearing, offering an amount of money based on a report prepared by an independent third party approved by regulators and used by many other insurers in many states is not a bad faith refusal to settle.

Id. The administrative code now contains the following that was apparently not in effect at the time of her total loss:

> (h) When a motor vehicle's total loss is settled on a basis which deviates from this Rule, the deviation must be supported by documentation within the claim file detailing the total loss motor vehicle's condition and the reason for the deviation. Any deductions from the actual cash value of the total loss motor vehicle, including deduction for salvage or prior damage, shall be itemized and contain the amount of the deduction. The documentation that supports the basis for the settlement shall be shared with the claimant. The insurance company's record shall include documentation of the total loss settlement.
> http://reports.oah.state.nc.us/ncac/title%2011%20-%20insurance/chapter%2004%20-%20consumer%20services%20division/11%20ncac%2004%20.0418.pdf

11 N.C. Admin, Code 04.0418(h) (2020). The court does not say whether this provision if it had been in effect would have impacted the outcome of the case.

On the second statutory provision, N.C. Gen. Stat. § 58-63-15(11)(g), Fortson asserted that Garrison's "**'tactics of undervaluation'** compelled her to 'institute litigation just to recover what she was owed.'" *Id.* at 9. However, the Court points out that the provision prohibits an insurer "from compelling an insured to institute litigation to recover *amounts due* under a policy." *Id.* (emphasis in original) (quoting *Cent. Carolina Bank & Tr. Co. v. Sec. Life of Denver Ins. Co*., 247 F.Supp.2d 791, 801 (M.D.N.C. 2003)). Here,

> there is no evidence that Garrison had any reason to believe that [Fortson] was not satisfied with the amount of the check it sent her until approximately a year after she cashed the check. In any event, [Fortson] did not have to resort to litigation to recover any amount due under her insurance policy – she **could have invoked her policy's appraisal provision.**

Id. There is no discussion in the opinion as to the cost of the appraisal which consists of each party hiring an appraiser and if they cannot agree, an umpire.

On the third statutory provision, N.C. Gen. Stat. § 58-63-15(11)(d), it is an unfair trade practice "for an insurer to **'refus[e] to pay claims without conducting a reasonable investigation based upon all available information**.'" *Id.* Here, however, the Court highlights the fact that **Garrison "did not 'refuse to pay**.'" *Id.* Garrison sending a check based on CCC's valuation, the check being subsequently cashed, and upon appraisal promptly tendering the difference "does not constitute a refusal to pay." *Id.*

Finally, on the fourth statutory provision, N.C. Gen. Stat. §58-63-15(11)(c), the Court states that here, **"its is undisputed that Garrison had standards in place; the question is whether those standards were 'reasonable.'"** *Id* at 10. Further, "[w]hatever 'reasonable' means, **it does not mean 'perfect' or 'the best practice**.'" *Id.* (citing *Whitworth v. Nationwide Mut. Ins. Co*., No. 1:17-CV-1124, 2018 WL 4494885, at *7 (M.D.N.C. Sept. 19, 2018), *report and recommendation adopted*, No. 1:17-CV-1124, 2018 WL 6573472 (M.D.N.C. Oct. 19, 2018)). Here, "[d]etermining the 'actual cash value' of an item that has been destroyed is always a hypothetical exercise subject to some amount of unavoidable uncertainty." *Id.* at 11. The Court concludes that:

> [Fortson]'s theory ignores the benefits from Garrison's standards, such as a very large pool of comparator vehicles, quick processing time, and common use of list prices rather than actual sales prices—benefits that would be lost, or at least affected, by requiring inspections of all comparator vehicles or by an arguably more accurate process. She does not account for feasibility or for the trade-offs required in developing standards for processing claims efficiently and quickly. She wrongly assumes there is only one reasonable way to determine actual cash value, and she ignores the facts that Garrison increased the value of her car after personally inspecting it.
>
> Garrison relied on an estimate provided by a national independent company with no negative regulatory history that is used by many insurers. That independent company based its estimate on recent sales of similar vehicles taken from a large database, adjusting the estimate because dealer-listed vehicles are generally in better condition than cars on the road and based on the condition of [Fortson]'s car after a detailed inspection. **The undisputed facts establish that there was nothing unreasonable about Garrison's standards for investigating [Fortson]'s claim. A reasonable juror could not conclude Garrison violated § 58-63-15(11)(c).**

Id. at 12. In a footnote, the Court was critical of Plaintiff's arguments stating:

> Ms. Fortson in her pleadings, evidence, and briefing has **made it difficult to figure out exactly what she contends is unreasonable about**

> **Garrison's use of the negative condition adjustment by regularly adjusting and changing her claims and arguments.** At different times, she has mentioned, for example, the methodology used to calculate the adjustment, the fact that the comparator vehicles were not personally inspected, the inadequacy of the inspections of the subset of vehicles in the database that were inspected, and the different standards Garrison and CCC applied when inspecting totaled vehicles and comparator vehicles. **It is difficult to evaluate whether the evidence supports an argument that a particular standard of investigation is unreasonable when the plaintiff fails to clearly and consistently identify both the particular standard at issue and the location of evidence to support her theory**. **The Court has evaluated the arguments the plaintiff has clearly made but declines to spend substantial time on conclusory arguments made in passing or to scour the record to find unidentified support for her claims.**

Id. The District Court grants Garrison's motion for summary judgment. *Id.* An appeal has been filed with the 4th Circuit (submitted February 25, 2022).

Am. Gen. Life Ins. Co. v. Shamberger, No. 1:19-CV-1064, 2022 WL 624450 (M.D.N.C. Mar. 3, 2022)

Decision written by District Judge William J. Osteen, Jr.

Plaintiff American General Life Insurance Company (American General) filed an interpleader action "seeking the proper beneficiary" of Tyasha Person (Tyasha) following her death. *Shamberger*, 2022 WL 624450 at *1.

Tyasha designated her uncle (Shamberger) as 100% primary beneficiary, and her mother Sarah Person (Person) as 100% contingent beneficiary of the $400,000 policy when instituted on **September 8, 2008**. *Id.* Tyasha married Donnell Pearson (Pearson) on **August 9, 2009**. *Id.* On **April 22, 2019**, American General "**received a Change of Beneficiary form** related to the Policy requesting to change the primary beneficiary to Pearson." *Id.* However, "the form was **missing the signature page**." *Id.*

On May 8, 2019, Pearson reported Tyasha's death to American General, and on May 15, 2019, American General advised Pearson that the "primary beneficiary under the Policy was Shamberger, and Person was the contingent beneficiary." *Id.* Pearson advised American General on May 23, 2019, that "he wished to pursue a claim under the Policy," and upon retaining counsel further informed American General that "Pearson was entitled to the entire benefit, either under a theory that [Tyasha] signed the signature page on the Change of Beneficiary form, or alternatively that [Tyasha] substantially complied in changing her beneficiary designation." *Id.*

American General also sent Shamberger a letter "advising him of his right to make a claim under the Policy." *Id.* Shamberger "allege[d] he contacted American General no later than August 16, 2019, and American General informed him he was the primary beneficiary under the Policy and would send Shamberger claim forms." *Id.* at *2. On October 2, 2019, American General informed Shamberger that "Pearson had also submitted a claim under the Policy, and American General would contact Shamberger with an update within seventy-two hours." *Id.* On October 9, 2019, "Shamberger was again advised his claim was in review." *Id.*

Following these interactions, on October 15, 2019, **American General:**

> **paid Pearson $166,740 plus interest**, representing "his community property share of the Policy death benefit **... for 83.38% of $200,000 ... which equaled the amount of time Pearson was married to the Decedent starting on August 3, 2009, versus the amount of time the Policy was in force beginning September 8, 2008."**

Id. (citations omitted). On October 17, 2019, Shamberger called American General, "who advised him that his claim was still in review and did not inform Shamberger that American General had paid Pearson a portion of the Policy." *Id.*

On October 17, 2019, American General filed **suit seeking interpleader relief**, and subsequently filed a motion to deposit funds and for dismissal with prejudice seeking that:

> this court order American General **to deposit $233,260.00 plus interest** (the remaining death benefit), dismiss American General from this litigation and determine that American General is "fully discharged from any further liability which in any manner may arise under or relate to the subject policy," and order that "Defendants are restrained and/or prohibited from instituting or prosecuting any proceeding ... against [American General] related to or regarding" the Policy.

Id. (citations omitted). Additionally, on April 10, 2020, American General sought to dismiss Defendant Person. *Id.* On August 21, 2020, Shamberger filed a motion to dismiss American General's complaint for lack of jurisdiction, as well as counterclaims. *Id.* at *3.

Necessarily, the Court first analyzes whether it has jurisdiction over American General's claims. *Id.* **Shamberger argued that the Court lacked jurisdiction "because American General failed to interplead the full amount of the policy, $400,000**." *Id.* The Court notes that "[t]he Fourth Circuit has not considered whether an insurer's payment of an amount less than that claimed by a defendant is sufficient under $1335," and thus turns to other circuit interpretations. *Id.* Specifically, the Court notes:

> **"As a general rule, when a sum of money is involved, a district court has no jurisdiction of an action of interpleader if the stakeholder deposits a sum smaller than that claimed by the claimants."** ***Metal Transp. Corp. v. Pac. Venture S.S. Corp.*****, 288 F.2d 363, 365 (2d Cir. 1961**) (affirming the district court's dismissal of §1335 interpleader case where the plaintiff failed to deposit a portion of the funds claimed by the claimants); accord *Acuity v. Rex, LLC,* 929 F.3d 995, 998, 1000 (8th Cir. 2019) (affirming lack of subject matter jurisdiction where the plaintiff did not deposit the $21 million claimed by the defendants but instead only deposited $1 million).

Id. In following that enumerated rule, the Court concludes that:

> In this case, the Policy unambiguously states that the primary beneficiary should be paid the face amount of the policy if the insured dies prior to the expiration of the policy. Shamberger made American General aware he was pursuing a claim under the Policy. Even if Shamberger's allegations were not true, American General alleges it was aware that Shamberger was listed as the primary beneficiary under the Policy. American General was required to deposit $400,000—the value of the Policy—into the registry of the court. §1335(a)(1). American General did not do that, and instead seeks to "deposit the remaining life insurance benefit from the Policy, plus any earned interest due and owing," or $233,260 plus interest. Shamberger claims the entire $400,000 under the Policy. Because American General does not seek to deposit the full amount of the Policy, this court does not have subject matter jurisdiction. *Metal Transp*., 288 F.2d at 365.

Id. (internal citations omitted).

Further than common law guidance, the Court notes two tangential reasons why American General's interpleader action cannot be heard. First, the Court "**finds American General has usurped this court's role in statutory interpleader cases.**" *Id.* at *4. Specifically:

> [b]y determining that Texas law applied to the Policy and further determining Pearson was entitled to a portion of the Policy despite American General's awareness of Shamberger's competing claim, American General has **attempted to determine the rights of Shamberger and Pearson to the Policy, a determination reserved for this court.**

Id. Second, the Court highlights equitable concerns:

> If this court were to allow American General to pay the full $400,000 in an interpleader action and then dismiss American General, not only would

> Pearson receive a windfall if he is in fact not entitled to the insurance proceeds American General has already paid him, but such a ruling would allow American General **to have made a payment to Pearson and thereby favor one claimant over the other claimants, arguably financially supporting his expenses in making a claim.** This court finds that outcome inequitable.

Id.

While the Court will dismiss for lack of jurisdiction over the interpleader action, it "finds it has the authority to exercise jurisdiction over Shamberger's counterclaims." *Id.* at *5. However, even with this authority as well as Shamberger's allegation that diversity of citizenship gives the Court jurisdiction over his counterclaims, "jurisdiction over Shamberger's counterclaims is not mandated." *Id.* (citing *Travelers Prop. Cas. Co. of Am. v. M.B. Kahn Constr. Co.*, C/A No. 3:20-CV-0304-SAL, 2021 WL 1177861, at *26 (D.S.C. Mar. 29, 2021)).

Because Shamberger disputed jurisdiction of the federal forum by filing a motion to dismiss for lack of subject matter jurisdiction, the Court finds its facts here similar to facts faced by the Fourth Circuit in *Columbia Gas Transmission Corp. v. Drain*, 191 F.3d 552 (4th Cir. 1999). *Id.* at *6. In *Drain*, the court held:

> [w]e are not aware of any case in which the district court retained jurisdiction over such a compulsory counterclaim where the plaintiffs in counterclaim [i.e., the defendants] have disputed the jurisdiction of the federal forum all along the way, and where the merits of the counterclaim are inextricably intertwined with the merits of a federal defense to the plaintiff's non-federal claim.
>
> ....
>
> ... To force [counterclaimant], by virtue of her counterclaims that the federal rules of procedure compelled her to bring our risk forfeiting to remain in federal court after the original complaint has been dismissed for want of jurisdiction would be to subvert the very notions of judicial economy and fairness to the litigants that underlie this rule of procedure.

Id. "As a result of these findings," the Court concludes, "**its decision to dismiss the interpleader action leaves this case in an awkward procedural position."** *Id.*

> It appears to this court that **Pearson, as a claimant to the life insurance proceeds, was a necessary party to the interpleader action and was properly joined pursuant to Federal Rule of Civil Procedure 19(a).** That interpleader action has now been dismissed because of the conduct by

> American General in paying out part of the proceeds before filing the interpleader action. The counterclaims filed by Shamberger are now the operative claims in this case, but those claims do not presently involve Pearson; Shamberger has sued American General and alleges an independent basis for jurisdiction—diversity—because his counterclaims are against American General only.
>
> However, Pearson has filed an answer to the Complaint and claims the remaining proceeds of the insurance policy at issue. In light of the dismissal of the interpleader action for lack of jurisdiction, this court is concerned that multiple cases might be filed involving the same operative facts, and that American General could be subject to multiple, inconsistent judgments. **Nevertheless, Pearson's answer is no longer procedurally joined to a complaint.** Pearson has been served with process and filed an answer. As a result of these actions, it appears Pearson has consented to personal jurisdiction in this court for purposes of this case.

Id. (internal citations omitted). In view of "this unusual procedural posture," the Court orders the parties to proceed in the following manner:

> First, this court will stay this case for thirty days. Within that thirty-day period, the parties shall confer and file a notice with this court outlining how, procedurally, this case should proceed. The parties should discuss whether this court should exercise its discretion and retain jurisdiction over Shamberger's counterclaims or dismiss the counterclaims. If the parties believe this court should retain jurisdiction, the parties should explain in their notice whether any claims or answers should be amended. Additionally, the parties should discuss Pearson's role in these proceedings and whether he should file a motion to intervene given he is not a party to the claim between Shamberger and American General, and further determine whether this court can and should retain jurisdiction depending on Pearson's involvement in these proceedings—namely, whether this court will continue to have jurisdiction under diversity of citizenship.
>
> If the parties are unable to agree as to how this case should proceed, then the parties shall file individual motions setting out their respective positions and the manner in which the case should proceed. No responses will be permitted; following review, the court will direct the parties as to any subsequent procedure.

Id. at *6-7.

Lastly, the Court holds that, because "contingent beneficiary Person may have a claim if Shamberger disclaims his interest," that "this court will deny the motion to dismiss Person." *Id.* at *7.

The Court grants Shamberger's motion to dismiss for lack of subject matter jurisdiction, denies American General's motion to deposit funds and for dismissal, and denies American General's motion to dismiss Person. *Id.* The Court further stays the case for thirty days during which the parties will "confer and file a notice with this court outlining (1) how, procedurally, this case should proceed; (2) whether any claims or answers should be amended; and (3) Pearson's role in these proceedings." *Id.*

C. WESTERN DISTRICT OF NORTH CAROLINA

Estate of Rink by Rink v. Vicof II Tr., No. 5:20-CV-00039-KDB (W.D.N.C. Dec. 20, 2021)

Decision written by District Judge Kenneth D. Bell.
Slip Copy.

This dispute centers on Ann Rink's (Rink) transactions insuring her life, and Defendant VICOF II Trust's (Trust) ultimate recovery of the insurance proceeds upon Rink's death. *Estate of Rink,* slip. op. at 1. Specifically, Plaintiff Rink's Estate (Estate) filed an action alleging "that it is entitled to the proceeds of [Rink]'s life insurance because the insurance contract was illegal and prohibited by public policy as a 'wager' on her life lacking a proper insurable interest." *Id.* On the other hand, the Trust contended that its actions were entirely lawful. *Id.*

The parties agreed that in 2005, John Bryan Setzler (**Setzler), an insurance agent** in Hickory, North Carolina, approached the Rink family about purchasing life insurance. *Id.* at 2. At that time, Rink was 73 years old, and her husband was retired. *Id.* Setzler proposed that the Rinks "**consider a policy through the alleged 'Coventry program,' which involved purchasing the policy using a non-recourse loan (which meant there would be no financial risk to the Rinks) to pay the premiums for the first 26 months of the policy**." *Id.* After the 26 months, "Rink would have the option of selling the policy or paying off the loan and keeping the policy (although the parties disagree on how much keeping the policy was a real option for the Rinks)." *Id.*

On January 26, 2006, Coventry sent a letter to Rink "enclosing the transaction package for the proposed policy and loan." *Id.* at 3. The transaction included the creation of "the Ann Rink 2006 Insurance Trust," a Delaware statutory trust, "so the Trust could apply for and own the Policy." *Id.* The transaction also created the "Ann Rink 2006 Insurance Trust, Premium Finance Sub-Trust." *Id.* The Court notes:

> The transaction contemplated that the insurance policy on Ms. Rink's life, once applied for and issued, would not be held by the Trust, but would instead pass directly to the Sub-Trust, which would in turn take out a loan to pay the premiums and simultaneously pledge the "Policy, and all proceeds thereof," as the sole collateral for a non-recourse loan. During the term of the loan, the Trust was prohibited from holding any property other than the "Initial Trust Estate" (set at $1) and the Sub-Trust was prohibited from holding any property other than Ms. Rink's insurance policy.

Id. The package also included a "Note and Security Agreement," which established:

> a non-recourse loan between the Sub-Trust as borrower and LaSalle Bank as lender for 26 months (not coincidentally 2 months past the Policy's legal contestability window). The executed Note financed over $250,000 in premiums, which, plus fees and interest, required a payoff of approximately $370,000 at maturity (reflecting a listed interest rate of 17.79%) or relinquishment of the Policy.

Id. Finally, the Court highlights two power of attorney forms:

> The first required appointing Coventry as Ms. Rink's attorney-in-fact "with full powers of substitution to act in [her] name," place and stead for the purpose of "(i) authorizing the release of [her] Medical Records" and "(ii) originating and/or servicing any life insurance policies insuring [her] life" including the "power to complete and execute any applications or other documents in connection with the maintenance, or liquidation of the Policies." The second required appointing Coventry as attorney-in-fact for Michael Rink [Rink's son], in his capacity as the named co-trustee of the Trust and Sub-Trust respectively, with "full powers of substitution to act in [his] name, place and stead for the purpose of it originating, maintaining, servicing, and/or liquidating ... any life insurance policies ... which are owned by the Trust.

Id.

On or around **February 6, 2006, Rink, through Setzler, applied to Phoenix Life Insurance Company (Phoenix) for a $5 million policy on Rink's life**. *Id.* The trust was the owner and beneficiary of the policy, and the beneficiary of the trust was Francis Rink (Rink's husband). *Id.* Phoenix rejected the $5 million proposal and, instead**, offered a $1.5 million policy.** On February 23, 2006, PHL Variable Insurance Company (PHL) issued policy No. 97516364, "providing $1.5 million in coverage with a rider for the return of premiums paid." *Id.* The sub-trust paid the first year's premium of $78,363 by wire on February 27, 2006. *Id.* The Court notes too that **"[n]either [Rink], nor anyone in her family, paid any amount toward the premiums at any time**." *Id.*

In March of 2008, **the Rinks unsuccessfully attempted to sell the policy, and worked with two separate life settlement brokers to do so**. *Id.* at 4. Following, rather than pay off the note and keep the policy, the Rinks decided to relinquish the policy to the lender. *Id.* The following transactions occurred:

> Pursuant to a Loan Satisfaction Letter dated May 6, 2008, the Sub-Trust "executed documents necessary to effectuate relinquishment and satisfy [the] outstanding obligations under the Loan," which meant that the Sub-Trust's "indebtedness under the Note and Security Agreement [had] been satisfied in full...." **On July 25, 2008, the Trust (owned and controlled by Coventry Capital) sold the Policy to Coventry First for $84,000**.
>
> In May 2018, Vida Capital, an investment firm acting through VICOF, purchased the Policy from Coventry-owned and controlled entity LST III, LLC. At the time of the sale, Ms. Rink had a life expectancy of only 40 months and a high dementia rating of 450%. Based on these statistics, VICOF paid approximately **$1.4 million for the Policy that then had a death benefit of $2.2 million.** Ann Rink died on October 5, 2018, less than five months after VICOF purchased the Policy and before it paid any premiums. **VICOF filed a claim for the Policy's death benefit, which Phoenix paid on January 2, 2019**. **The death benefit totaled $2,243,612.24, from which VICOF realized a profit of $756,612.24.**

Id. On March 24, 2020, Rink's Estate, created and existing under North Carolina law with a North Carolina Executor, **filed an action asserting two counts**:

> The first count, **"recovery of insurance proceeds due to lack of insurable interest," alleges a) that the Policy is "controlled by and subject to Delaware law," b) that the Policy lacks insurable interest, and c) under Delaware law, "[w]here an insurance company pays the death benefit on a policy lacking insurable interest the 'executor or administrator' of the insured is entitled to recover such benefits from the beneficiary ...** that received the benefits as a matter of common law and statute." The second count, unjust enrichment, alleges that VICOF's "acceptance and retention of the Policy's death benefit has enriched [VICOF], to the detriment of the Estate."

Id. (internal citations omitted). The Court notes that, from the Estate's perspective:

> the insurance policy sold to Ms. Rink is the byproduct of a complex "scheme" promoted by the "Coventry" family of companies to "to manufacture policies through the use of short-term non-recourse premiums finance loans" for later sale as "life settlement" investments.

Id. at 2. **On the other hand, the Trust viewed that**:

> Rink simply bought an **insurance policy as part of her estate planning, obtained a favorable loan to pay for the policy premiums and decided to relinquish the policy when it became (in her family's view) a bad investment that could not be profitably sold.** Then, years later, the [Trust] purchased the policy as a commercial investment and redeemed it when [Rink] died.

Id.

On cross-motions for summary judgment, the Court **first determines whether North Carolina or Delaware law governs the Estate's claims.** In North Carolina, "under the principle of *lex loci contractus*, the substantive law of the state where the **last act to make the binding insurance contract controls the resolution of disputes relating to the contract.**" *Id.* at 4. The "last act" typically points to the delivery of the policy to the insured. *Id.* However, the Court states, "by statute North Carolina dictates that **certain insurance policies are deemed to be 'made in the State'** and thus governed by North Carolina law based on the interests being insured." *Id.* Specifically, the Court looks to N.C. Gen. Stat. **§58-3-1**, which provides that:

> All contracts of insurance on property, lives, or interests in this State shall be deemed to be made therein, and all contracts of insurance the applications for which are taken within the State shall be deemed to have been made within this State and are subject to the laws thereof.

Id. Due to this provision and the undisputed fact that the insurance policy at issue insured the life of Rink, a lifelong North Carolina resident, the Court finds **that §58-3-1 will apply unless there is not a "close connection" between North Carolina and the interests insured** by the policy. *Id.* at 5.

While "the Court acknowledges the substantial connections between Delaware and the transaction and the potential resulting 'disconnect' between North Carolina and the policy, **the Court finds that there is a sufficiently close connection to North Carolina** to apply North Carolina law consistent with due process." *Id.* "Clearly," the Court proffers, "North Carolina has an interest in protecting the legality of life insurance policies sold to and potentially redeemed by North Carolina residents to the extent they might differently be construed to be illegal under the law of another state." *Id.*

Having determined the applicable law to be that of North Carolina, the Court turns to the merits of the cross-motions. To begin, the Court immediately discounts **VICOF Trust's contention that applying North Carolina law means "that it must prevail.**" *Id.*

at 6. Quite the contrary, the Court holds that though not codified like in Delaware, **North Carolina has long held that:**

> **while an insurance policy supported by a proper insurable interest is valid and may be freely sold and assigned, "wagering contracts on the duration of a human life are not allowed to stand." *Hardy v. Aetna Life Ins. Co.,* 152 N.C. 286, 67 S.E. 767, 768–69 (1910), citing *Warnock v. Davis,* 104 U. S. 775 (1881).** "Where an insurant makes a contract with a company, taking out a policy on his own life for the benefit of himself or his estate generally, or for the benefit of another, the policy being in good faith and valid at its inception, the same may, with the assent of the company, be assigned to one not having an insurable interest in the life of the insured; provided this assignment is in good faith, and not a mere cloak or cover for a wagering transaction." *Id.* Accordingly, **if Plaintiff establishes that the insurance contract at issue is a "wagering contract" covering a "mere speculative risk" rather than a proper insurable interest then the Policy is unlawful and void.**

Id. The Court determines that, due to the "substantial factual dispute between the parties on whether the policy reflects a wagering contract," a "reasonable jury could weigh the evidence and the credibility of the witnesses on this 'subjective' issue and find either that the policy was an unlawful 'wager' on Rink's life or that it was a valid and lawful policy supported by a proper insurable interest." *Id* at 7.

The Court holds that there is a material fact that must be decided by a jury, and denies both parties' cross-motions for summary judgment. *Id*

Thoughts: If the jury determines the life insurance contract was an illegal wager and is thus void, what is the remedy? Delaware law says the estate would get the money, if the policy pays out, but N.C., law does not have a similar statute. If the life insurance policy is void, is return of premium the remedy? If so, to whom? Ms. Rink paid none of the premium. However, in this case, the insurer already paid out.

Allied Prop. & Cas. Ins. Co. v. C.S., No. 3:21-CV-00121-RJC-DCK (W.D.N.C. Feb. 1, 2022)

Decision written by District Judge Robert J. Conrad, Jr.
Slip Copy.

Plaintiff Allied Property and Casualty Insurance Company (Allied Insurance) instituted a declaratory judgment action against Defendants C.S., **Dianna L. Rhodes (Rhodes), and others arising from incidents pertaining to its automobile liability insurance policy with Rhodes covering her 2011 Kia Soul.** *C.S.*, slip. op. at 1. Rhodes resided **in Ohio**, but **"at some point"** allowed her daughter, Defendant Dianna Wilson

(Wilson), who resides in North Carolina, to drive the vehicle to North Carolina for personal use. *Id.* Importantly, **Rhodes did not give C.S., her grandson, who also lives in North Carolina, permission to operate the covered vehicle**. *Id.*

On January 18, 2021 **C.S.**, while operating the vehicle "on a highway in North Carolina **unlawfully without a driver's license**," "was involved in a motor vehicle accident when he **struck Nathan Keziah's (Keziah) vehicle**." *Id.* Both were injured, in addition to three others within C.S.'s vehicle at the time of the crash. *Id.* Allied Insurance subsequently filed the declaratory judgment action at issue, asking the Court to determine that **"(1) there is no liability coverage under the Policy for any claims arising out of the accident; and (2) there is no liability coverage under the North Carolina Motor Vehicle Safety and Financial Responsibility Act for any claims arising out of the accident."** *Id.* After Allied Insurance and **Keziah entered a stipulation of dismissal (dismissing Allied Insurance's claims against Keziah only and dismissing Keziah's counterclaim against Allied Insurance), Allied Insurance sought a judgment on the pleadings as to the remaining Defendants (C.S., Rhodes, Wilson, and the three passengers in the car with C.S. at the time of the crash). *Id.***

In deciding on Allied Insurance's motion, the Court looks to the language of the policy at issue. *Id.* The Court notes:

> The Policy provides that Plaintiff will pay damages for bodily injury or property damage "for which any 'insured' becomes legally responsible because of an auto accident." "Insured" is defined to include any person using the Vehicle covered under the Policy. However, the Policy contains certain exclusions from coverage for insureds. Relevant here, the Policy provides that it does not "provide Liability Coverage for any 'insured': ... 8. Using a vehicle: a. **Without a reasonable belief of being entitled to do so." "An 'insured' shall not be held to have a reasonable belief of being entitled to operate a motor vehicle if that person's license has been suspended, revoked, or never issued."**

Id. at 2.

Although not stated in the opinion, the policy is clearly not an N.C. insurance policy as the above language is not in an N.C. policy.

The Court also walks through **the FRA**: pursuant to N.C. Gen. Stat. § 20-279.21(b)(2), "a liability insurance policy shall insure any person using the insured motor vehicle 'with the express or implied permission of such named insured, or any **other persons in lawful possession, against loss from the liability imposed by law for damages arising out of the . . . use of such motor vehicle**.'" *Id.* When a person is operating the vehicle "without the express or implied permission or other lawful possession then the statute does not

require coverage." *Id.* (citing *Newell v. Nationwide Mut. Ins. Co*., 432 S.E.2d 284, 287 (1993)). The Court reasons:

> Here, based on the pleadings, C.S. was an "insured" under the Policy when he was operating the Vehicle during the Accident. However, C.S. operated the Vehicle without a driver's license or other permit allowing him to legally operate the Vehicle. **Moreover, Rhodes did not provide C.S. with permission to operate the vehicle. Thus, C.S. was operating the Vehicle without a reasonable belief of being entitled to do so**. Under the plain language of the Policy, liability coverage for C.S., an insured operating the Vehicle without a reasonable belief he was entitled to do so, is excluded. Furthermore, coverage is not mandatory under the North Carolina Motor Vehicle Safety and Financial Responsibility Act because Defendants admitted C.S. was not operating the vehicle with permission and operated the vehicle unlawfully without a driver's license. Accordingly, Plaintiff has no obligation to provide liability coverage under the Policy or under the North Carolina Motor Vehicle Safety and Financial Responsibility Act for any claims by Defendants arising out of the Accident.

Id. Notably, the Court points out in a footnote that:

> Under the Policy, this exclusion does not apply to, among others, a "family member" of the named insured. However, "family member" is defined as a person related to the named insured by blood, marriage, or adoption and who is a resident in the named insured's household. Here, Rhodes, the named insured, resides in Ohio, and C.S., the driver of the Vehicle at the time of the Accident, resides in North Carolina. Thus, the coverage exclusion applies.

Id. The Court grants Allied Insurance's motion for judgment on the pleadings.

FS Food Grp., L.L.C. v. Cincinnati Ins. Co., No. 3:20-CV-00588-RJC-DCK, 2022 WL 385165 (W.D.N.C. Feb. 8, 2022)

Decision written by District Judge Robert J. Conrad.

Plaintiff FS Food Group (FS) owns and operates fourteen restaurants and catering companies in North and South Carolina. 2022 WL 385165 at *1. FS entered into an insurance contract with Defendant, The Cincinnati Insurance Company (Cincinnati) on August 3, 2019, with a policy period effective August 3, 2019 to August 3, 2022. *Id.* The policy is an "all risk" policy, "which provides coverage for all non-excluded business losses." *Id.* The policy defined loss as "accidental physical loss or accidental damage." *Id.* **The policy did not define "damage" or include a "virus exclusion provision."** *Id.*

On March 10, 2020, "North Carolina Governor Roy Cooper declared a state of emergency in response to the **COVID-19** pandemic." *Id.* at *3. Then, on March 17, 2020, Cooper issued Executive Order No. 118 **limited the "sale of food and beverages to carry-out, drive-through, and delivery only."** *Id.* On March 27, 2020, Cooper issued a "Stay at Home" Order, which "permitted restaurants to serve food 'for consumption off-premises." *Id.* Further:

> All indoor dining services were suspended until May 20, 2020 when North Carolina commenced Phase 2 of its reopening plan. Under Phase 2, restaurants could operate indoor dining at fifty percent occupancy. South Carolina Governor Henry McMaster issued similar executive orders.

Id. On June 10, 2020, FS submitted claims to Cincinnati "for its ten locations and its catering company" for "business interruption, civil authority, and/or extra expense coverage to recoup substantial, ongoing financial losses directly attributed to a series of COVID-19 closure orders." *Id.*

On September 14, 2020, Cincinnati notified FS via letter that their losses were not covered, stating:

> The Cincinnati policy provides coverage for direct physical loss or damage to Covered Property at the premises. This direct physical loss or direct physical damage must be to property at the covered premises. Cincinnati's investigation has found **no evidence of direct physical loss or damage at your premises**. Similarly, there **is no evidence of damage to property at other locations, precluding coverage for orders of civil authority.**

Id. FS then filed an action seeking a declaratory judgment that "the policy provides coverage for their 'covered losses caused by loss of access to the Insured premises, including business income, extra expense, contamination, [and] civil authority." *Id.* FS's action also alleged breach of contract on the "basis that [Cincinnati's] denial of coverage runs afoul of the language of the policy and/or public policy." *Id.* Cincinnati subsequently filed a motion to dismiss for failure to state a claim under Rule 12(b)(6), and the Magistrate Judge entered an M & R recommending the Court grant Cincinnati's motion to dismiss. *Id.* FS objected to the recommendation. *Id.*

In evaluating whether the Magistrate Judge's recommendation should be upheld, the Court looks to the relevant policy language. *Id.* at *2. The policy's "Coverage Extensions" section includes provisions for Business Income, Extra Expense, and Civil Authority, in relevant part stating:

> **(1) Business Income**

We will pay for the actual loss of "Business Income" and "Rental Value" you sustain due to the necessary "suspension" of your "operations" during the "period of restoration." The "suspension" must be caused by **direct "loss" to the property at a "premises" caused by or resulting from any Covered Cause of Loss.**

…

(2) Extra Expense

(a) We will pay Extra Expense you sustain during the "period of restoration." Extra expense means necessary expenses you sustain (as described in Paragraphs (2)(b), (c) and (d)) during the "period of restoration" that you would not have sustained if there had been no direct "loss" to property caused by or resulting from a Covered Cause of Loss.

(b) If these expenses reduce the otherwise payable "Business Income" "loss", we will pay expenses (other than the expense to repair or replace property as described in Paragraph (2)(c)) to:

1) Avoid or minimize the "suspension" of business and to continue "operations" either:

a) At the "premises"; or

b) At replacement "premises" or temporary locations, including relocation expenses and costs to equip and operate the replacement location or temporary location; or

2) Minimize the "suspension" of business if you cannot continue "operations".

(c) We will also pay expenses to:

1) Repair or replace property; or

2) Research, replace or restore the lost information on damaged "valuable papers and records";

but only to the extent this payment reduces the otherwise payable "Business Income" "loss". If any property obtained for temporary use during the "period of restoration" remains after the resumption of normal "operations", the amount we will pay under this Coverage will be reduced by the salvage value of that property.

> (d) Extra Expense does not apply to "loss" to Covered Property as described in the BUILDING AND PERSONAL PROPERTY COVERAGE FORM.
>
> **(3) Civil Authority**
>
> When a Covered Cause of Loss causes damage to property other than Covered Property at a "premises", we will pay for the actual loss of "Business Income" and necessary Extra Expense you sustain caused by action of **civil authority that prohibits its access to the "premises", provided that both of the following apply**:
>
> (a) Access to the area immediately surrounding the damaged property is prohibited by civil authority as a result of the damage; and
>
> (b) The action of civil authority is taken in response to dangerous physical conditions resulting from the damage or continuation of the Covered Cause of Loss that caused the damage, or the action is taken to enable a civil authority to have unimpeded access to the damaged property.
>
> This Civil Authority coverage for "Business Income" will begin immediately after the time of that action and will apply for a period of up to 30 days from the date of that action.
>
> This Civil Authority coverage for Extra Expense will begin immediately after the time of that action and will end:
>
> 1) 30 consecutive days after the time of that action; or
>
> 2) When your "Business Income" coverage ends; whichever is later.

Id. at *1-2.

FS, in support of its claim, argued that the term "loss" in the Business Income and Extra Expense provisions was ambiguous "because the definition of 'loss' provided in the Policy is reasonably susceptible to different meanings." *Id.* at *5. The Court explains FS's textual argument:

> For Business Income coverage to exist under the Policy, the suspension of business operations "**must be caused by direct loss to property** at the premises caused by or resulting from any Covered Cause of Loss." Likewise, for Extra Expense coverage to exist, there must be "**direct loss to property** caused by or resulting from a Covered Cause of Loss." **"Loss" is defined as "accidental physical loss or accidental physical damage."**

> Plaintiffs assert that because the Policy's definition of "loss" separates "accidental physical loss" from "accidental physical damage" by the word "or," the terms must have different meanings.

Id. FS also cited *North State Deli v. The Cincinnati Insurance Co*., No. 20-CV-02569, 2020 WL 6281507 (N.C. Super. Oct. 9, 2020), in which the court "found the term 'direct physical loss' ambiguous" because it was "reasonably susceptible to different meanings." *Id.* However, the Court agrees with Cincinnati's response that *North State Deli* is not "a reasonable decision because it ignores the North Carolina Court of Appeals' binding precedent established in *Harry's Cadillac-Pontiac-GMC Truck Co. v. Motors Ins. Corp*., 126 N.C.App. 698, 486 S.E.2d 249 (1997)." *Id*. In *Harry's,* the court held that:

> the term "direct physical loss" as listed in an insurance contract for business interruption coverage required actual physical loss or damage to property and did not apply where the insured's loss of income was caused by a snowstorm that only prevented access to the insured's covered premises and did not cause any physical loss or damage to the covered premises.

Id. The Court states that the facts within Harry's are:

> akin to the impact of COVID-19, which did not cause any physical loss or harm to property, but only prevented normal access to establishments.

Id. The Court further establishes:

> Defendant also cites *Summit Hospitality Group, LTD v. Cincinnati Ins. Co.*, a recent case from the Eastern District of North Carolina applying North Carolina law, to support its argument that physical loss or damage to the business premises is required to trigger business interruption insurance coverage. *Summit Hospitality Group, LTD. v. Cincinnati Ins. Co.*, No. 5:20-CV-254-BO, 2021 WL 831013 (E.D.N.C. Mar. 4, 2021) (holding that a business interruption insurance policy requiring direct physical loss or damage was not triggered by COVID-19 closure and access restriction orders). *Summit Hospitality* is especially persuasive because the court applied North Carolina law to decide an ambiguity challenge to contract language substantially similar to the language at issue here.

Id. In conclusion, the Court holds:

> The Court agrees with the M&R's finding, which is supported by North Carolina precedent, that the Business Income and Extra Expenses provisions are not ambiguous. Although the Policy does not define "accidental physical loss" or "accidental physical damage," these terms' plain and ordinary meanings require actual, physical damage to the covered

> premises. The majority of Plaintiffs' cited cases are unpersuasive because they do not apply North Carolina law. Moreover, Plaintiffs' reliance on *North State Deli*—the only case cited that applies North Carolina law—is misplaced. The definition of "direct physical loss" relied on in *North State Deli* ignores binding North Carolina precedent that physical loss or damage is required to recover business interruption coverage.

Id. at *6. As pertained to FS's argument regarding the Civil Authority Provision, the Court further holds, in line with the M & R,

> that for coverage to exist under this provision access at covered locations must, at a minimum, be denied. The Policy plainly states that for coverage to exist under the Civil Authority provision "[a]ccess to the area immediately surrounding the damaged property" must be "prohibited by civil authority as a result of the damage."
>
> …
>
> Here, Governor Cooper's and McMaster's executive orders did not prohibit or deny access to Plaintiffs' covered properties. Instead, they encouraged the public to stay at home. Applying North Carolina law to its interpretation of a similar Civil Authority provision, the Eastern District of North Carolina in *Summit* held that "[a]lthough the executive orders identified in the complaint may have restricted access to plaintiff's business locations, for example by preventing or restricting in-person dining, restricted access is not the same as denied access." *Summit*, 2021 WL 831013, at *4. Because Plaintiffs fail to allege that the orders prohibited or denied access to their premises, Plaintiffs have failed to state a claim that the Civil Authority provision provides coverage.

Id. at *6-7.

The Court grants Cincinnati's motion to dismiss for failure to state a claim under Rule 12(b)(6), and adopts the M & R. *Id.* at *7.

Nationwide Mut. Fire Ins. Co. v. Nagle & Assoc., P.A., No. 3:20-CV-00578-FDW-DSC, 2022 WL 628519 (W.D.N.C. Mar. 3, 2022), appeal docketed, No. 22-1395 (4th Cir. Apr. 12, 2022)

Decision written by District Judge Frank D. Whitney.

Plaintiff Nationwide Mutual Fire Insurance Company (Nationwide) filed a declaratory action regarding its insurance coverage obligations to Defendant Nagle & Associates (Nagle) in connection with an underlying lawsuit (Hatch Lawsuit) alleging that

Nagle "knowingly violated the Driver's Privacy Protection Act (DPPA)." 2022 WL 628519 at *1. The DPPA "bans disclosure, absent a driver's consent, of 'personal information,' *e.g.* names, addresses, or telephone numbers, as well as 'highly restricted personal information,' *e.g.*, photographs, social security numbers, and medical or disability information." *Id.* (quoting *Maracich v. Spears*, 570 U.S. 48, 48-49, 133 S.Ct. 2191 (2013)).

The **Hatch Lawsuit alleged that Nagle violated the DPPA "by accessing the underlying claimants' personal information for certain motor vehicle reports, known as DMV-349 forms, and using the personal information to send the claimants marketing materials** for [Nagle's] legal services." *Id.* at *3. The putative class action further alleged that Nagle "the DMV-349 forms contained personal information from a motor vehicle record, but still 'regularly and knowingly' obtained and used the personal information to market their services to [the class]." *Id.* **The Middle District of North Carolina issued a memorandum opinion and order on January 22, 2021, finding that Nagle "did not violate the DPPA when they obtained, disclosed, or used the personal information at issue."** *Id.* (quoting *Hatch v. DeMayo*, 2021 WL 231245 (M.D.N.C. Jan. 22, 2021)). After the court granted Nagle's motion for summary judgment, **the class filed an appeal that, at the time of this Court's review, is currently pending**. *Id.*

Nationwide had been defending Nagle in the Hatch lawsuit pursuant to **"a full reservation of rights,"** but "now seeks a declaration that it owes no insurance coverage obligations to [Nagle] in connection with the Hatch suit." *Id.* In its motion for summary judgment, Nationwide argued that:

> the Policies dictate that it has no duty to defend or indemnify [Nagle] because the allegations in the Hatch [Laws]uit do not allege any of the three types of injury covered by the Policies: "bodily injury," "property damage," or "personal and advertising injury." Further, [Nationwide] argues, even if the allegations in the Hatch [Laws]uit were covered by the Policies, [Nationwide] still has no duty to defend or indemnify because the allegations fall squarely within the Exclusion.

Id. On the other hand, Nagle argued that the Hatch Lawsuit does state a covered claim for "bodily injury," "property damage," or "personal and advertising injury," and that the exclusions of the policy do not apply. *Id.*

The relevant business owner liability insurance policies Nationwide issued to Nagle were in effect from April 1, 2012, to April 1, 2021. *Id.* at *1. Under "Coverage A" of the policies:

> coverage is provided for those sums that the insured becomes legally obligated to pay as damages for certain **"bodily injury" and "property damage"** occurring during the policy period that is caused by an "occurrence." The Policies define "bodily injury" to mean, "bodily injury,

> sickness or disease sustained by a person, including death resulting from any of these at any time." The Policies define "property damage," in pertinent part, to mean, "[p]hysical injury to tangible property, including all resulting loss of use of that property ..." and "[l]oss of use of tangible property that is not physically injured...."

Id. Further, under "Coverage B," the policies provide:

> coverage for those sums that the insured becomes legally obligated to pay as damages for certain "personal and advertising injury" caused by an offense arising out of the business, provided that the offense was committed during the policy period. The Policies define "personal and advertising injury" as "injury, including consequential 'bodily injury,' arising out of one or more of the following offenses:
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> a. False arrest, detention or imprisonment;
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> b. Malicious prosecution;
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> c. The wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies, committed by or on behalf of its owner, landlord or lessor;
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> d. Oral or written publication, in any manner, of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services;
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> e. Oral or written publication, in any manner, of material that violates a person's right of privacy;
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> f. The use of another's advertising idea in your 'advertisement'; or
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> g. Infringing upon another's copyright, trade dress or slogan in your 'advertisement.'

Id. at *2. Finally, the "Recording and Distribution of Material in Violation of Law" exclusion (the Exclusion) that applies to "Coverage A" and "Coverage B" precludes coverage, including any duty to defend, for any "personal and advertising injury:"

> Arising directly or indirectly out of any action or omission that violates or is alleged to violate:
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> (1) The Telephone Consumer Protection Act (TCPA), including any amendment of or addition to such law;

> (2) The CAN-SPAM Act of 2003, including any amendment of or addition to such law;
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> (3) The Fair Credit Reporting Act (FCRA), and any amendment of or addition to such law, including the Fair and Accurate Credit Transaction Act (FACTA); or
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> (4) Any federal, state or local statute, ordinance or regulation, other than the TCPA, CAN-SPAM Act of 2003 or FCRA and their amendments and additions, that addresses, prohibits or limits the printing, dissemination, disposal, collecting, recording, sending, transmitting, communicating or distribution of material or information.

Id.

In evaluating Nationwide's motion for summary judgment, the Court first determines whether "Coverage A" is applicable to the Hatch Lawsuit. *Id.* at *4. Nationwide argued that "because the **Hatch [Lawsuit] contains no allegations of bodily injury, sickness, or disease, as required by the Policies' definition of 'bodily injury,'" nor any allegations of "physical injury to or loss of use of tangible property, as required to satisfy the Policies' definition of 'property damage,'**" Nationwide was entitled judgment in its favor. *Id.* The Court agrees with Nationwide's reasoning; because there were no allegations in the Hatch Lawsuit pertaining to "bodily injury" or "property damage," "the Court finds the relevant language of Coverage A is unambiguous and [Nationwide] does not owe a duty to defend under such coverage." *Id.* at *5.

Next, the Court contends with "Coverage B," pointing out that the relevant enumerated offense is "Offense E: (e) oral or written publication, in any manner, of material that violates a person's right of privacy." *Id.* Beyond the initial issue of the Court's skepticism that Nagle "published" the material in the underlying suit, it still finds that Nagle's claim for coverage under "Coverage B" fails "because the allegations set forth in the Hatch Lawsuit do not support a violation of a recognized right of privacy under North Carolina law." *Id.* **Nagle argued that the underlying suit "should be construed as alleging a claim for violation of the right of privacy because, in their view, the suit states facts which would support a common law claim for violation of the right of privacy." *Id.* However, the Court rejects this argument, determining that "the Fourth Circuit has specifically rejected this assertion."** *Id.* (citing *Hartford Cas. Ins. Co. v. Ted A. Greve & Assoc. P.A.*, 742 F. Appx. 738, 741 (4th Cir. 2018)). The Court states:

> *Greve* involved a coverage dispute in which another law firm was sued for violation of the DPPA. The insurer in *Greve* denied coverage based, in part, on an exclusion for personal and advertising injury arising out of the violation of a person's right of privacy created by any state or federal act,

> unless the liability would have occurred even in the absence of a state or federal statute. In an effort to escape the exclusionary effect of this provision, the law firm in *Greve* argued that the exception to the exclusion should apply because the firm would have faced liability even in the absence of the DPPA, owing to the potential for common law claims for violation of privacy rights.
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> In rejecting the Greve firm's contention, the Fourth Circuit first noted that **North Carolina recognizes only <u>two types of invasion-of-privacy torts</u>: (1) intrusion upon a person's seclusion, solitude, or private affairs; and (2) appropriation of a person's name or likeness for commercial advantage**. The Fourth Circuit rejected the assertion that the allegations in the underlying complaint could be construed as supporting a claim for intrusion upon seclusion, because the accident reports at issue are public records under North Carolina law. Thus, the law firm's actions "– obtaining information from public records to facilitate the mailing of legal advertisements – may have been unwelcome, but they do not constitute an intrusion upon seclusion under North Carolina law."
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> The Fourth Circuit also found that the allegations in the underlying suit did not support the second type of privacy tort—appropriation of likeness. Id. The court noted that "the gravaman of the underlying actions is that the defendants sought to advertise to the plaintiffs, not use the plaintiffs to advertise." **Consequently, *Greve* unequivocally establishes that facts supporting the two recognized common law privacy torts under North Carolina law are *not* alleged in the Hatch Suit**.

Id. at *5-6. The Court holds:

> Based on the Fourth Circuit's analysis in *Greve*, a duty to defend cannot apply under the Policies absent allegations of publication of material that falls within a tort of invasion of privacy. The claimants in the underlying Hatch Suit have not asserted a claim for invasion of privacy, have not sought damages for invasion of privacy, and have not alleged facts to support a claim for the tort of invasion of privacy. **Consequently, the underlying claimants have not alleged any of the torts enumerated in the definition of "personal and advertising injury," and [Nationwide] does not owe a duty to defend [Nagle] for the underlying Hatch Suit**.

Id. "Even if [Nagle] had established one or more of the key definitions were satisfied," the Court goes on to state, Nationwide "still would not owe a duty to defend because the Exclusion fully bars coverage." *Id.*

> The Court notes that:

> Numerous cases applying North Carolina law have found that the language set forth in the Exclusion bars coverage for DPPA claims such as those at issue here. *See, e.g.*, *Main Street America Assurance Co. v. Crumley Roberts, LLP*, 2021 WL 1195804 (M.D.N.C. March 30, 2021) (holding that a similar exclusion barred coverage for the Hatch DPPA suit); *Peerless Ins. Co. v. Law Offices of Jason E. Taylor P.C.*, 2020 WL 4370941 (W.D.N.C. July 8, 2020) (holding that a similar exclusion barred coverage for another DPPA suit); *Hartford Cas. Ins. Co. v. Gelshenen*, 387 F.Supp.3d 634, 641–642 (W.D.N.C. 2019) (holding that a similar exclusion barred coverage for another DPPA suit); *Hartford Cas. Ins. Co. v. Ted A. Greve & Associates*, P.A., 2017 WL 5557669 (W.D.N.C. November 17, 2017) (holding that a similar exclusion barred coverage for another DPPA suit). **In light of the unambiguous policy language, the underlying allegations, and the wealth of authority upholding the Exclusion, the Court agrees with [Nationwide] and finds the Exclusion bars coverage here.**

Id. at *7. The Court grant's Nationwide's motion for summary judgment "to the extent that it seeks a declaration regarding the duty to defend under the Policies," dismisses Nationwide's motion pertaining to its duty to indemnify (without prejudice, due to lack of ripeness), and denies Nagle's motion for summary judgment. *Id.* An appeal was filed in the Fourth Circuit on April 12, 2022.

Meek v. Unitrin Safeguard Ins. Co., No. 3:21-CV-257-RJC-DCK (W.D.N.C. Mar. 21, 2022)

Decision written by United States Magistrate Judge David C. Keesler.
Slip Copy.

Plaintiff Calvin Meek (Meek) initiated an action against Defendants (1) Unitrin Safeguard Insurance Company (Unitrin) and (2) Trinity Universal Insurance Company (Trinity), doing business as Kemper Preferred (collectively Kemper). *Meek*, slip. op. at 1. Meek, as Executor of the estates of his parents, both of whom died in a car accident in April 2018, **claimed that Kemper, the at-fault driver's insurance company, mishandled his insurance claim as a third-party beneficiary**. *Id.*

The teenage at-fault driver, Dylan Gibbs, lost control of his car while driving 95 miles per hour in a 45 mile-per-hour speed zone and crossed the center line of the roadway, "striking Plaintiffs parents' car that was traveling in the opposite direction." *Id.* Meek's father died on the day of the accident, and his mother died in the hospital nine days later. *Id.* Kemper provided the Gibbs family's insurance policy, which "contained bodily injury liability limits of $300,000 per accident and property damage limits of $100,000 per accident." *Id.*

The relevant facts outline that **in June 2018, Kemper offered payment for the full value of the bodily injury policy limit – $300,000 – and offered $10,500 for the property damage claim**. *Id.* The $10,500 in property damage came from a prior email sent from Meek's attorney to Kemper, "**offering to settle at least the property damage claim for the car for $10,500."** *Id.*

After the trial on Meek's wrongful death claim in spring 2019, "[j]**udgment was entered against the Gibbs defendants . . . for the total sum of $3,250,000.**" *Id.* at *2. Meek contends that "Kemper refused and continues to refuse to pay any amount towards satisfaction of the [$3,250,000] Judgment entered against its insureds beyond its $300,000 bodily injury policy limit and $2,962.12 in taxable court costs." *Id.* "In essence," according to the Court, "**Plaintiff seems to argue that Kemper owes the estates of his parents the remainder of the $3.25 million judgment entered against the Gibbs defendants in state court in the wrongful death lawsuit – that is, an amount over and above the full policy limits that Kemper has already paid out**." *Id.*

Meek argued that he was in privity with Kemper as a result of the judgment, and that he was further an "intended third party beneficiary" of the insurance contract between Kemper and Gibbs. *Id.* Meek's complaint contained two claims against Kemper: (1) for breach of contract; and (2) for violation of the North Carolina Unfair and Deceptive Trade Practices Act (UDTPA). *Id.*

In deciding its recommendation to the presiding district judge, the Court embraces the "high level" argument proffered by Kemper:

> Moving Defendants did not insure Plaintiff. Moving Defendants tendered the bodily injury limits of their insurance policy to Plaintiff approximately 60 days after the accident. Moving Defendants paid the full bodily injury limits of their insurance policy to Plaintiff after judgment was entered. Moving Defendants agreed to pay the full amount of property damage Plaintiff demanded within 90 days of the accident and issued such payment prior to a judgment being entered. Put simply, Moving Defendants did what they were supposed to do.

Id. at *3. The Court reasons:

> Defendants' arguments are persuasive, and Plaintiff's attempts to rebut such arguments fall short. Each of the cases that Plaintiff identifies to support his arguments are factually distinguishable from the present case in some way, as Defendants point out**. Plaintiff is correct that once he obtained a judgment against the Gibbs (Defendants' insured party), he at that point became a third-party beneficiary to the insurance contract between Defendants and the Gibbs**. See *Craven v. Demidovich*, 615 S.E.2d 722, 724 (N.C. Ct. App. 2005). Plaintiff is *not* correct, however, that

> his status as a third-party beneficiary outlasts Defendants' payment of its full policy limit amount – $300,000. Indeed, the North Carolina Court of Appeals has indicated that an injured party's **"privity with [the at-fault driver's insurance company] and status as a third-party beneficiary to the insurance policy existed only until [the insurance company] satisfied its contractual obligations to the extent of the insurance policy provisions."** *Taylor v. North Carolina Farm Bureau Mut. Ins. Co., Inc.*, 638 S.E.2d 636, 637 (N.C. Ct. App. 2007).
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> Here, just as in the *Taylor* case, since **Kemper "pa[id] out the limits of [its] policy," Defendants "fulfilled [their] contractual obligations," removing any privity that once existed between Plaintiff and Defendants**. Thus, Plaintiff's breach of contract claim for the remainder of the $3.25 million judgment obtained against the Gibbs in state court must fail, just as it did in the *Taylor* case. As Defendants state, "Plaintiff has failed to cite to a single case[ ] which holds that a stranger to an insurance policy remains a third party beneficiary to an insurance policy after the insurer has paid the limits of its policy." The undersigned is aware of no case that holds what Plaintiff urges this Court to adopt. Plaintiff here has "received all that [he was] entitled to recover as [a] third-party beneficiar[y] under the insurance policy, i.e., the full measure of protection afforded by the policy within designated limits." *Rowe v. United States Fidelity and Guaranty Co.*, 421 F.2d 937, 940 (4th Cir. 1970). The undersigned respectfully recommends that Plaintiff's breach of contract claim be dismissed.

Id. at *3-4. Turning to the UDTPA, the Court notes that "[o]rdinarily, in North Carolina, claims for "violations of the EDTPA cannot be asserted by a third-party claimant against the insurer of an adverse party." *Id.* at *4 (quoting *Turso v. Installs, LLC*, 2018 WL 6182056, at *2 (W.D.N.C. Nov. 27, 2018)). However, "there is an exception to this rule – if the third-party can establish 'privity with an insurer,' then a UDPTA claim may be asserted by the third party." *Id.* (quoting *Murray v. Nationwide Mut. Ins. Co.*, 472 S.E.2d 358 (N.C. Ct. App. 1996)). Based on these rules, the Court turns to the facts:

> any privity that once existed between Plaintiff and Defendants on account of the state court judgment in the wrongful death lawsuit has now been extinguished, as explained in the breach of contract section. Plaintiff, as a third party then, has no cognizable UDTPA claim against Defendants. The undersigned respectfully recommends that this claim be dismissed as well.

Id. The Court recommends that Kemper's motion to dismiss be granted. *Id.*

<u>Thoughts</u>: There are basically two ways judicially recognized way to one of these type cases can be pursued, if the claim was mishandled and resulted in an excess verdict. 1) Put the defendants into a receivership and have the receiver pursue. 2) The tort defendant can pursue the claim directly themselves.