Tips for Dealing With Your Insurance Company

TAYLOR & BLAIR LLP

Experienced Vancouver Lawyers

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Chapter 1:
Yes, 'Your' Insurance Company Would Do That To You

One way or another, almost everyone pays for insurance. Insurance policies exist so that if disaster strikes, there's money there when you need it most. Whether it's long-term disability insurance, life insurance, critical illness insurance, mortgage protection insurance, accidental death and dismemberment insurance, or property insurance covering your home or business against fire, water damage, or other loss, you pay your premiums for peace of mind, trusting the coverage will be there when you need it.

The unfortunate reality is that many legitimate insurance claims are denied, delayed, or underpaid every year. On the disability side, roughly 60% of long-term disability claims are denied annually in Canada. On the property loss side, we see a different but related pattern of claims that drag on for months, disputes over what actually caused the damage, and settlement offers well below what it will actually cost to repair or rebuild.

Often when clients call our firm, they can't believe that their insurance company would do that to them. The truth is your insurance company doesn't care about you as an individual, or as a business, no matter how long you've paid your premiums or how legitimate your claim is. Insurers are in the business of collecting premiums and minimizing payouts. End a claim early? Great. Deny it, or pay as little as possible? Even better.

When rightful insurance claims are denied, delayed, or underpaid, the insurance lawyers at Taylor & Blair LLP work to make sure our clients get a fair deal and the benefits they're entitled to. We have over 30 years of experience fighting insurance companies across disability, life, critical illness, and property claims, and we bring that experience to bear for every client we take on. The purpose of this

booklet is to help make sure you don't need to become one of our clients in the first place, by giving you some of the information you need to deal with your insurance company on your own.

Chapter 2:
Getting Ahead Of The Curve

THE APPLICATION

Most denials, across every kind of insurance, trace back to something on the original application. For many claims it doesn't matter whether there was any intent to mislead the insurance company. It just matters that the information given was wrong.

For health-related coverage (disability, life, critical illness, AD&D), that usually means your medical history. Giving an insurance company the wrong information is easier than you'd think, since most people don't have a perfect memory of what their doctor wrote down years ago. What did you tell your doctor about your health seven years ago? How many drinks a week did you say you had five years ago? Most people can't answer these questions with confidence, but when you make a claim, the first thing your insurer will do is pull your clinical records and comb through them looking for inconsistencies with your application. If they find any, they'll use them to try to void your coverage.

The most frustrating part is that doctors' clinical records are notes, not transcripts, and are often recorded without context. A note reading 'alcohol counselling' could mean a passing conversation, a recommendation, or ongoing treatment for a real problem. It's almost impossible to tell without context, and you can count on your insurer to construe it in whichever way hurts your claim the most.

For property coverage (homeowner's, tenant's, or commercial

property insurance), the equivalent risk is misstating things like your claims history, the age and condition of the roof, plumbing, wiring, or heating system, whether the property is owner-occupied, rented out, vacant, or used for any business purpose, and any past renovations or known defects. Insurers ask these questions because they affect risk, and if your answers don't match reality when a claim comes in, they'll use the gap to deny or reduce it.

DO YOUR HOMEWORK

There's a simple, inexpensive way to guard against this, and it applies to any type of policy: check your own records before you apply, and again before you make a claim.

For health-related coverage, your doctor's clinical records belong to you, and you're entitled to a copy. Some clinics will provide them for free while others charge a modest fee for photocopying and staff time. Once you have them (going back at least ten years is a good idea), look for anything that could be a red flag such as notations about drug or alcohol use, significant pre-existing conditions, or more subjective issues like anxiety or depression. If you see anything that concerns you, talk to your doctor about it so you're both on the same page.

For property coverage, pull together your claims history, any inspection or appraisal reports, and documentation of significant repairs, renovations, or known issues before you fill out an application or renewal questionnaire. If you're not sure whether something needs to be disclosed, ask your broker in writing, and keep the answer.

So long as your application matches what's actually in your records, medical or otherwise, you're ahead of most people when it comes to stopping an insurer from voiding your coverage over an application issue.

Chapter 3:
Know Your Policy

Insurance is a contract. Whatever you feel is fair, or whatever your doctor, contractor, or common sense tells you, what actually matters is whether your claim meets the specific wording of your policy. Two people can have what looks like the same type of coverage and very different outcomes because of how their particular policy defines thing.

FOR DISABILITY, LIFE, CRITICAL ILLNESS & AD&D CLAIMS

Doctors & Definition

When you make a claim for anything relating to your health, illness, or injury, every insurance policy will require a medical report, and it's essential to have your doctor onside. The problem is that most doctors assume their word alone is enough, and that an adjuster will simply defer to their opinion about their patient's ability to function. In reality, a doctor's assessment is usually based on a general sense of how their patient is managing day to day, not on the specific language of an insurance policy.

Being disabled, medically, and being 'disabled' as your policy defines it, can be two very different things.

Every insurance contract has its own definition of what triggers coverage. If you're claiming long-term disability benefits, you need to know your policy's definition of disabled. If you're claiming critical illness coverage, you need to know the definition of a covered illness. If you're claiming under an AD&D policy, you need to understand that definition too. These definitions are the bar you have to clear, and understanding the wording matters.

It's not just important for you to understand your policy's definitions,

it's important for your doctor to understand them too. Good practice is to print the relevant sections of your policy and highlight the key definitions for your doctor before your initial application, so the language in your doctor's report tracks the language of your policy as closely as possible. It takes a little time up front and can save you a lot of hassle later.

FOR PROPERTY LOSS CLAIMS

Document Everything Before You Clean Up

Property claims live and die on documentation, and the biggest mistakes happen in the first few days after a loss, often before you've had a chance to call your lawyer.

Photograph and video the damage thoroughly, from multiple angles, before anything is cleaned up, repaired, or thrown out. Include areas that weren't damaged for comparison. If you can safely do so, don't discard damaged contents or building materials until your adjuster has inspected them, or has told you in writing that you can dispose of them. Where that isn't practical, for safety or health reasons, keep samples and photograph everything before it goes.

Prepare a detailed, itemized inventory of everything that was damaged or destroyed, with approximate purchase dates and prices, and pull together receipts, photos, or other proof of ownership wherever you can find them. This is tedious, but it's the single biggest driver of how much a contents claim actually pays out.

Understand whether your policy pays actual cash value (depreciated value) or replacement cost, and what conditions apply to replacement cost coverage. Some policies require you to actually replace the item, or complete the rebuild, within a set time before you get the replacement-cost top-up. Keep every receipt for additional living expenses, mitigation costs, and repairs. If your business was affected, keep clean financial records, revenue, expenses, and prior-year comparisons, to support a business interruption claim.

Ask your adjuster early for the insurer's requirements, including the proof of loss form and its deadline. That deadline is often shorter than people expect and missing it can be used against you later even if the rest of your claim is solid.

Chapter 4:
The Importance Of Faith

Good faith are two of the most important words in the insurance world. Your insurance company stands in a special position relative to you. You pay premiums so that if you ever need them to, your insurer will cover your losses under the policy you bought. That relationship gives them real power over you, and the law responds by requiring them to adjust and pay your claim in good faith.

That raises an obvious question: how does an insurer deny a legitimate claim in good faith? The honest answer is that it takes some fancy footwork. Adjusters know that a bad-faith denial can expose the insurer to a significant lawsuit on top of the underlying claim, so they work hard to make sure that when they deny or underpay a claim, it doesn't look like bad faith, even when the practical effect is the same.

As discussed above, insurers don't want to pay your claim, and if they can find a defensible-looking reason not to, they will. That often means taking medical records, application answers, or damage estimates out of context, or cherry-picking facts. This is when the words 'good faith' becomes useful to you. Insurers know they owe you that obligation, and if you catch them walking the line, they'll often soften their position rather than risk a bad-faith argument down the road.

ADVOCATE FOR YOURSELF

Don't be afraid to stand up for yourself. Tell your adjuster you know they owe you a duty of good faith, including an obligation to adjust your claim fairly and in a timely way. If you feel your adjuster is ignoring an important piece of information or documentation, say so, clearly and in writing. More often than not, this helps. Even when it doesn't, it puts you in a much better position if you end up having to sue over a denied or underpaid claim, which is where we go next.

Chapter 5:
If It's Not In Writing It Never Happened

You'll probably notice that insurance adjusters prefer to communicate by phone. Unlike almost any other industry, it's often surprisingly hard to get a mailing address or email for the specific adjuster handling your file. There's a reason for this. Insurers don't want a paper trail of what their representatives actually said, because they know it can be used against them later.

One of the most useful things you can do is get an email address for your adjuster. If they're reluctant to give you one, tell them the process is overwhelming and you need time to properly understand what they're telling you, so you'd like it in writing. If they say they can't, ask why, and remind them they have a duty to act in good faith in their dealings with you. If they keep refusing, ask to speak to a manager until you get one. There is no insurance adjuster on the face of the earth who doesn't have their own email address.

ALWAYS CONFIRM IN WRITING

Even once you have an email address, adjusters will often still try to handle things by phone to keep the paper trail thin. The easy fix is to follow up every call with an email confirming what was said. It's as simple as this:

Dear _____,

I'm writing to confirm what was discussed in our telephone conversation today. You advised me that:

• xxxxxxx

• yyyyyyy

• zzzzzzz

I asked ••••• and you answered •••••. I confirmed I would send you the further information that you requested.

If any of this is incorrect, please let me know. Otherwise I';; proceed on this basis.

Thanks,

_____

If your adjuster doesn't dispute what you've laid out at the time you send it, they'll have a hard time disputing it later. This is a simple, effective habit for any type of claim, disability, life, critical illness, or property, and it goes a long way toward making sure you're treated fairly.

Chapter 6:
Warning Signs

If you're currently receiving ongoing benefits, such as long-term disability or mortgage protection payments, or you have an open property claim that's dragging on, there are warning signs that a denial, termination, or lowball settlement may be coming.

FOR DISABILITY, LIFE, CRITICAL ILLNESS & MORTGAGE PROTECTION CLAIMS

The Independent Medical Evaluation

Your insurer can require you to attend an independent medical evaluation, or IME, to assess an ongoing inability to work due to illness or injury. Insurers often frame this as a routine step, but there's no real reason for an insurer to spend the money on an independent examiner, which can cost thousands of dollars, unless they're looking for a reason to end your benefits.

Keep in mind the examiner isn't your doctor and isn't your friend. Independent medical examiners are frequently retained by insurance companies and paid well for it, which gives them a financial interest in keeping their client, your insurer, happy. That often means putting the least favourable spin on your presentation. If you have to attend one, don't lie, but don't downplay your struggles either. Think through the likely questions and answer them honestly, in a way that reflects your day-to-day reality.

The Daily Schedule

One of the biggest red flags is being asked to keep a daily or weekly activity diary. Insurers give any number of reasons for wanting one, usually something generic about 'evaluating your continued entitlement to benefits,' but the real purpose is often to find a basis to cut off your benefits, either by arguing that what you can

do shows a residual ability to work, or by catching inconsistencies between your diary and what a private investigator observed.

Private Investigators & Independent Medical Examiners

Insurers commonly hire private investigators to assist with claims, sometimes interviewing friends, family, or coworkers, other times conducting surveillance and taking photos or video. If what you've written in a diary is significantly different from what surveillance shows, your insurer may use the gap to argue you've misrepresented your condition, and even to void your policy.

As with clinical records, insurers will construe any apparent inconsistency against you. If you believe you're being followed, the simplest response is to note the license plate and treat it like you would any other stranger following you: report it to police. What they're doing usually isn't illegal, but it will put a damper on the surveillance.

FOR PROPERTY LOSS CLAIMS

Independent Adjusters, Engineers & Cause-and-Origin Investigators

On larger or more complicated property claims, especially fire, water damage, and business interruption claims, your insurer will often retain its own experts: independent adjusters, structural or forensic engineers, cause-and-origin fire investigators, or forensic accountants. These experts are hired and paid by the insurer, which doesn't make their opinions wrong, but it's worth keeping in mind whose interests they're there to serve. On a significant claim, it's often worth retaining your own expert to respond.

The Examination Under Oath

Many property and business policies let the insurer require you to attend an Examination Under Oath, or EUO, a formal, recorded,

sworn interview about the circumstances of your loss. Treat it the way you'd treat a discovery examination in a lawsuit: tell the truth, don't guess at answers you're not sure of, and get advice before you go in if the claim is significant.

Repeated Document Requests and Delay

Being asked for the same documents more than once, or having new requests trickle in every few weeks, can be a sign your insurer is running out the clock on your proof of loss deadline, or building a paper record to support an argument that you didn't cooperate. Keep track of everything you send and when.

Lowball Estimates and Pressure to Settle Quickly

If your insurer's contractor's estimate is noticeably lower than others you've obtained, or you're being pushed to sign a full and final release before you've had a chance to properly assess the scope of the damage, get independent quotes and legal advice before you agree to anything.

Chapter 7:
Your Insurance Has Been Denied

Despite doing everything you were told to do, being honest with your doctor, your contractor, and your insurance company, your legitimate claim has been denied. Whether it was denied outright or your ongoing benefits were cut off partway through a claim, the effect is the same: you're without the benefits you paid for, at the time you needed them most.

You generally have two routes at this stage:

1. the internal appeal; or
2. starting a lawsuit to enforce your rights.

THE INTERNAL APPEAL

The internal appeal is the process where you ask the insurance company that just denied your claim to reconsider its own decision.

The insurer's internal appeal process usually asks you to submit any new information you think might change their mind. The insurer typically already has access to most of your records, medical or otherwise, so it's worth asking what, realistically, is left to provide that they haven't already seen.

Claims for denied insurance benefits often have strict limitation periods, and internal appeals can be slow, drawn-out affairs that eat into the time you have to prepare a lawsuit while the insurer is telling you they've already decided you're not entitled to benefits.

If you're going to attempt an internal appeal, it's good practice to get your adjuster to describe, in specific detail, exactly why your claim was denied, so you know precisely what you're appealing.

It's critical to hold your insurer to a timeline for the appeal decision. Do not let the appeal drag on. Many people wait for an internal appeal to be decided before considering legal action, only to discover their limitation period has already expired. Limitation periods can be especially short for property and fire claims, sometimes as little as a year from the date of loss, so don't assume you have more time than you do.

STARTING A LAWSUIT TO ENFORCE YOUR INSURANCE BENEFITS

When all else fails, you can retain an experienced insurance lawyer to start a lawsuit to enforce your rights under the policy.

Your ability to sue depends on the terms of your contract. Some policies require a lawsuit within one year of denial, others allow two, and some union group policies don't allow lawsuits at all, requiring disputes to go before a committee instead. Property and fire policies

commonly carry their own limitation clauses too, so check yours rather than assuming a general rule applies.

An experienced insurance lawyer will explain the process in plain language and use the right evidence and experts, medical, vocational, engineering, or accounting, depending on the claim, to get you the benefits you're entitled to.

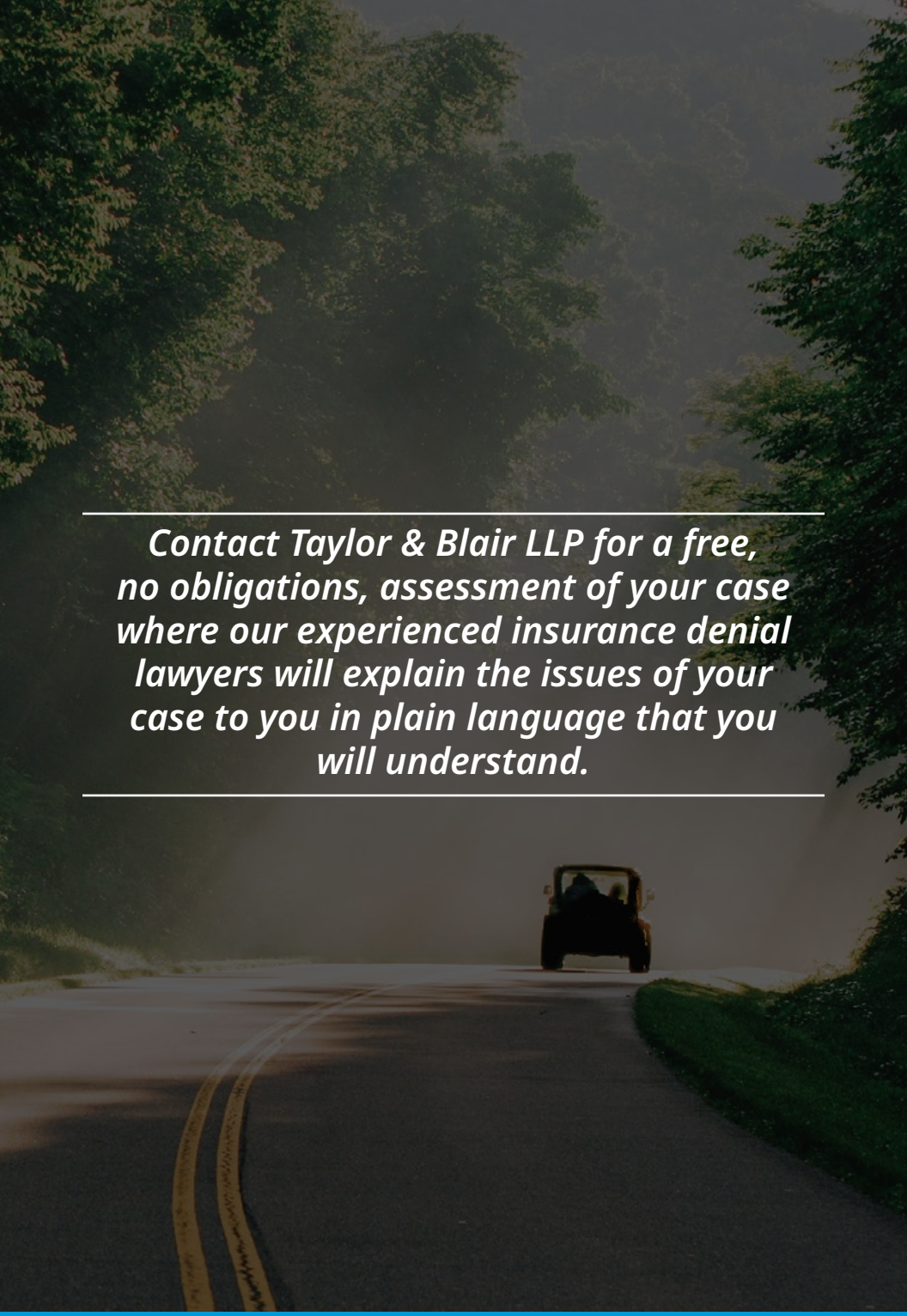
GET THE FILE

Whether you go the internal appeal route or start a lawsuit right away, the same advice applies: request a complete copy of your insurance file.

It's easy to lose sight of this once your claim is denied and your insurer starts to feel like 'the enemy,' but they're still obligated to act in good faith, and your file is still your information. Your insurer is required to give you a copy of your file when you ask for one, usually within about 30 days.

Your file will contain the information the insurer relied on to deny your claim. Requesting it as soon as you're denied gives you a clear picture of what they had in front of them and prevents them from quietly supplementing the record with information they didn't actually rely on at the time. After-acquired evidence generally doesn't matter, what matters is what the insurer had when it made the decision to deny your claim.

Your file is also essential if your appeal fails and your lawyer needs to run a lawsuit on your behalf.



Contact Taylor & Blair LLP for a free, no obligations, assessment of your case where our experienced insurance denial lawyers will explain the issues of your case to you in plain language that you will understand.

Summary

To sum it up: know your policy language, know your own records, medical or otherwise, document everything, don't be afraid to advocate for yourself, and don't let your insurance company intimidate you.

If, despite your best efforts, your claim is still denied, delayed, or underpaid, the insurance lawyers at Taylor & Blair LLP are here to help. With 7 convenient locations across the Lower Mainland and the ability to intake clients remotely from anywhere in British Columbia, the Yukon, and the rest of Canada, we're here to serve you.

Our fees are contingency-based, which means we don't get paid unless we recover your insurance benefits.

We have expertise in claims involving:

- Short-Term Disability Claims
- Long-Term Disability Claims
- Critical Illness Claims
- Life Insurance Claims
- Mortgage Insurance Claims
- Accidental Death & Dismemberment Claims
- Denied Property Loss Claims
- Wildfire and Fire Loss Insurance Claims
- Water Damage Insurance Claims
- Commercial Property Loss Claims
- Business Interruption Insurance Claims
- Insurance Broker Negligence
- And other types of insurance claims

There are time limits for bringing claims for denied, delayed, or underpaid insurance benefits. Once your limitation period has passed, even the best lawyer cannot help you. Make sure you **contact the experienced insurance denial lawyers at Taylor & Blair LLP** today.

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We can also intake clients remotely through teleconference, video conference or mail.