

**MISREPRESENTATIONS ON AN INSURANCE
APPLICATION NEED NOT BE WILFUL FOR
THE INSURER TO RESCIND THE POLICY**

In *Mitchell v. United National Insurance Company*, plaintiff, James Mitchell, owned a commercial building in Los Angeles. He sought fire insurance from defendant, United National Insurance Company through its authorized agent, Debra Messina. In that application, Mr. Mitchell represented that the property was 3,420 square feet, that it would be used as a video production studio, that the business conducted in the building had \$20,000 in payroll and generated \$300,000 in receipts, that there was no existing insurance on the building, that the building had no uncorrected fire code violations, and that the building had a burglar alarm. In fact, none of those representations were true. The building was smaller, was leased to a tenant who operated a garment business, generated \$6,500 in receipts, was insured by the California FAIR Plan, and was already subject to City of Los Angeles abatement orders due to numerous deficiencies and Code violations.

United National Insurance Company issued the fire insurance policy based on the information contained within the application. The uncontroverted facts were that neither Ms. Messina nor anyone at United National Insurance Company was aware that the application contained these misrepresentations. The building operated as a garment business for three months until the city inspector cited the tenant for failure to obtain a certificate of occupancy. The tenant was released from his lease agreement with Mr. Mitchell and the building went vacant. In November of 2000, Mr. Mitchell asked a business consultant to show the building to a prospective buyer. Mr. Mitchell turned over the keys to the building to the consultant. While Mr. Mitchell was on business in Chicago, the consultant started the building on fire, but was unable to escape before he himself perished in the flames. Mr. Mitchell then made a claim under his fire insurance policy.

While investigating the claim, United National Insurance Company discovered the discrepancies in the insurance application. Based on those discrepancies,

United National Insurance Company rescinded the policy and offered to return Mr. Mitchell's premiums. Mr. Mitchell refused and then filed a bad faith and declaratory relief action against United National Insurance Company. During the course of the litigation, United National Insurance Company moved for summary judgment on the basis that the rescission was proper. The motion was granted and this appeal followed.

In opposing the motion for summary judgment in the trial court, Mr. Mitchell conceded that while there were "inaccuracies" in his application, the inaccuracies were not material to issuance of the policy. He further claimed that United National Insurance Company waived their right to rely on these inaccuracies in rescinding its policy due to the fact that they did not perform any further investigation into the accuracy of the representations. The opposition contained a declaration from an insurance underwriting expert who claimed that the misrepresentations could not have been material to Ms. Messina in her decision to underwrite the policy. The expert's declaration was ultimately not considered by either the trial court or appellate court since it contained speculation.

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CHRIS WESIERSKI'S CONTINUED SUCCESS AT TRIAL

Wesierski & Zurek is quite proud of its trial background and abilities. Currently, the firm has five attorneys in the American Board of Trial Advocates, an organization that requires 20 civil cases to verdict and which requires a recommendation and vote of acceptance to join. There are two more attorneys in our firm that should be joining shortly because of the number of verdicts that they have obtained.

Additionally, Ron Zurek is at an advanced level in ABOTA. Chris Wesierski is currently under submission for the same advanced level. That level requires 50 cases brought to verdict as well as recommendation and agreement by the executive members of ABOTA.

In this issue of the newsletter, we chose to highlight Chris Wesierski, who has had four cases tried to verdict in the last three months. Three of the cases resulted in defense verdicts. The fourth case was an admitted liability case where the demand was \$400,000, the offer was \$40,000 and the verdict was \$4,500.

The first case that Chris Wesierski tried in 2005 was an employment case involving multiple causes of action. The plaintiff brought suit against an employer alleging that she contracted a sexually transmitted disease from one of the owners. She was then terminated (she said wrongly) because the company was uncomfortable with her there as an employee. Despite the foregoing, the company alleged that she was laid off because work had slowed down and they had no more work for her.

The case initially was brought against the employer, the president of the company individually, the individual who allegedly gave her the sexually transmitted disease, and the temporary employer. The individual who allegedly gave her the disease was dismissed from the case when it was proven that plaintiff had a sexually transmitted disease from other individuals as well. The temporary employer was dismissed from the case when he prevailed on summary judgment. The president of the company was dismissed from the case by way of non-suit at the time of trial and the case proceeded against only the employer on a couple of the causes of action remaining.

The jury found in favor of the defense after about five hours of deliberation and determined that plaintiff had not proved she had a disability due to the sexually transmitted disease and had not proved that she had been fired wrongfully. Defendant had a right to collect fees and costs.

The second case involved an employer who had allegedly given a recommendation for one of his ex employees. The new employer hired this individual and claimed that the first employer had overwhelmingly recommended her. This employee then stole \$800,000 over the course of eight years and embezzled from her new employer. When the new employer called the old employer to

advise of the embezzlement the old employer allegedly said "It happened to you too? She got me for over \$100,000."

The case went to trial on theories of negligence, fraud and intentional infliction of emotional distress and the jury returned a verdict in favor of the defense in 25 minutes, asserting the plaintiff had not proved that there was ever an initial telephone conversation where the first employer recommended the employee to the second employer. They did not believe that such a conversation took place and the defense denied same. Defendant was permitted to recover all costs in excess of \$25,000.

The third case involved an auto accident. Plaintiff claimed that she was rear ended by defendant traveling at 40 m.p.h. and that her vehicle was pushed 145 feet all the way through an intersection. She then started to treat for her injuries and two different orthopedic surgeons recommended neck surgery. Plaintiff brought in five experts to testify at trial. Plaintiff brought in a biomechanic, an accident reconstructionist, an orthopedic surgeon from Riverside and an orthopedic surgeon from Fullerton as well as her treating chiropractor. Defendant brought in a neuroradiologist, an accident reconstructionist/biomechanic and an orthopedic surgeon. Defendant contended that plaintiff had this neck problem before the accident and that there was no need for surgery due to the accident.

The jury believed the plaintiff only suffered soft tissue injuries and only awarded the sum of \$4,500 total. Defendant will recover over \$40,000 in costs.

Finally, the fourth verdict also involved a car accident case. Plaintiff asserted again that he needed neck surgery and that he had had multiple injections following the car accident. Defendant claimed it was a minor impact and plaintiff was not clear on whether or not the accident caused the need for the neck surgery. Defendant again asserted that plaintiff had preexisting problems that were the cause of his current complaints. The jury returned the defense verdict in that case in 15 minutes. The jury found that the defendant did cause the accident but was not responsible for the damages claimed.

At any time throughout the year, the firm usually has an attorney or two in trial or arbitration. We are happy to handle any case even at the last minute for trial, binding mediation or arbitration. That is what we do quite well and our record of success is unparalleled.

We have an excellent reputation in the Los Angeles and Orange County legal communities. If you have any questions in regards to our trial background please call at any time and discuss that with any of the partners or our administrator, Jennifer Lindskoog.

JURY IS ENTITLED TO HEAR TESTIMONY REGARDING PLAINTIFF'S OUT-OF-POCKET MEDICAL EXPENSES

Should a personal injury plaintiff be allowed to submit evidence that he/she paid some or all of the bills for his/her medical treatment? In *James Smalley v. Orville Ray Baty, Jr.* the Court of Appeal answered in the affirmative.

Mr. Smalley was rear ended by Mr. Baty while Mr. Baty was in the course and scope of his employment. At trial, the defendants conceded liability but contested the nature and extent of the injuries and the reasonableness of the medical charges incurred. Of the \$29,409 in medical charges attributed to the accident, the plaintiff himself had paid \$28,961 out of his own pocket. The defendants moved in limine to preclude the fact that plaintiff had made these out-of-pocket payments on the basis that the jury would improperly assign additional weight to that evidence to believe that the plaintiff's treatment was somehow more necessary and more important than had his medical insurance paid for it. In short, the defense argued that the jury would attach undue significance to this payment. The trial court granted defendant's motion.

Throughout the trial, the defense repeatedly attacked both the injuries being claimed and the medical specials that were incurred. Plaintiff's evidence showed that the day of the accident, the plaintiff was examined and released from an emergency room. He then sought the services of his own primary treating physician who referred him for physical therapy. By the time of trial, the plaintiff had undergone 118 physical therapy sessions. His physician not only diagnosed him with soft tissue neck and back injuries, but also with a hernia as a result of this collision. The plaintiff ultimately underwent hernia surgery at the recommendation of his physician. His doctor testified that all treatment was related to the injuries sustained in the accident, although he conceded that he had never seen another case of a hernia being sustained in an automobile accident. The physical therapist testified that she only treats patients for as long as she thinks it would benefit them. If she could no longer help, she would discharge them. Plaintiff also testified that he had to quit his job as a part owner of a car dealership to work for a former employer. While he was very active prior to the accident, his post-accident activities included coming home and watching television in a vibrating chair.

The defense presented the testimony of a retired orthopaedic surgeon. This doctor felt that there were no

objective signs of injury. In fact, the plaintiff's complaint of widespread, diffuse tenderness, raised a "red flag" in the defense doctor's head that the plaintiff may be exaggerating his injuries since the claimed injury normally occurs in discreet places. It was the doctor's opinion that any treatment after October (this accident was in March) was not related to the accident and should be ignored. He testified that there was self interest involved in the litigation which may have been influencing plaintiff to continue to complain of pain.

The jury awarded total damages of \$20,500. Of that, \$15,000 was attributed to past economic loss including medical expenses.

Plaintiff moved the court for a new trial on the basis that failure to admit evidence of paid medical bills would have been appropriate since plaintiff would not have incurred unnecessary medical expenses in anticipation of litigation since he had to pay those bills himself. The court denied this motion and the appeal followed. The Court of Appeal reversed.

Since plaintiff must prove that he received each medical service for which medical specials are claimed, a bill or request for payment is evidence of the amount of the expense. Moreover, the court held that evidence that the bill was paid is evidence that the charge was reasonable. The court reasoned that the fact that a plaintiff paid his own medical bills is highly relevant to the case, to the extent that it goes to the reasonableness of the amount charged. In this case, the court thought that particular evidence would have been useful for the plaintiff to rebut the charges by the defense doctor that there was self interest for monetary gain due to the pending litigation. Plaintiff had paid nearly all of his medical treatment to date without any reimbursement or any certainty that he would ever be reimbursed at trial. Furthermore, since the jury had already decided not to award plaintiff the full amount of his medical charges by their verdict, the jury would have the same opportunity to do that again even if they knew that the medical bills had been paid for by plaintiff himself. The court held that if the jury did not believe that the charges were reasonable, the fact that he paid the bills himself was irrelevant. The court rejected the defense's contention that the jury would place undue emphasis on the fact that plaintiff paid the bills himself.

- Thomas E. Martin

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Materiality

To rescind, the misrepresentation on the policy must be “material.” Some cases treat materiality as a matter of law, saying that if the question were asked on the application and answered, it was automatically deemed “material.” Other cases call this a question of fact, one for the jury to determine, in light of the circumstances. Interestingly, “the misrepresentation need not relate to the loss ultimately claimed by the insured” as long as it would have been important to questions as to what rate to charge overall, etc. The *Mitchell* court did not side with the cases which automatically label all application misrepresentations to be “material.” However, under the specific facts of *Mitchell*, the misrepresentations were in fact deemed material.

Intent

The Court of Appeals also noted that there is no need for the insurer to prove that the applicant actually intended to deceive the insurer. Misstatement or concealment of any material fact is grounds for rescission even if it is unintentional. An insurance company has the unquestioned right to select those whom it will insure and what risks it will cover. That decision can only be made upon the information provided in the insurance application. If that information is incorrect, then the insurance company is not fully informed as to the risk that it is insuring. Insurance Code §§ 331 and 359 govern the parties’ obligations during formation of the insurance contract and allow an insurer to rescind a fire insurance policy based on an insured’s negligent or unintentional concealment or misrepresentation of a material fact.

In this case, the misrepresentations went to the size of the building, the use of the building, the business generated by the building, and whether or not there were any existing fire code violations. It goes without saying that these are all quite material to a decision as to whether to underwrite that risk. The information that was misrepresented went directly to questions of insurability, risk and premium.

The Court of Appeals also dismissed the argument that United National Insurance Company had waived its right to rescind for failure to conduct further investigation. The court noted that an insurer does not waive its right to rescind a policy on the ground of false representations if it was unaware of the falsity of those representations. There was nothing submitted in opposition to the Motion for

Summary Judgment to convince either court that Ms. Messina should have been on alert to conduct further investigation of Mr. Mitchell’s representations. An insurer has the right to rely on an insured’s answers to questions on the insurance application without verifying their accuracy.

Finally, the court noted that the Insurance Code requires certain standard language to be included in all fire insurance policies in the State of California. Insurance Code §§ 2070 and 2021 require language suggesting that any misrepresentations must be intentional in order to entitle the insurer to rescission. The Court of Appeals disagreed. That language comes into play after the policy is in effect, not during the policy formation stage. It is at that later stage that §§ 331 and 359 apply.

They permit rescission on negligent misrepresentations. There is no requirement that misrepresentations be intentional to allow rescission based on misrepresentations in the application.

- Thomas E. Martin

NEW AT WESIERSKI & ZUREK

We are pleased to announce the addition of our newest attorney, Trenier A. Wright. Mr. Wright attended the University of California at Los Angeles, where he graduated with a Bachelor of Arts degree in Political Science in 1986. Mr. Wright received his Juris Doctorate degree from the University of Nebraska at Lincoln. He was admitted to the California State Bar and the U.S. District Court-Central District in 2000.

Prior to joining Wesierski & Zurek LLP, Mr. Wright worked in the areas of insurance defense, plaintiff’s personal injury, business litigation, toxic torts, and premises liability. Mr. Wright, recently married, enjoys listening to and recording music, reading and bicycling. Welcome, Trenier!

Editor

Paul J. Lipman