REPORT OF ELLIOTT S. FLOOD

Harold Murphy et al. v. First Protective Insurance Company d/b/a Frontline

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. **4:22-10113**

November 10, 2023

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Introduction and Disclosures

Subject matter of testimony

I have been engaged by counsel for Harold and Patricia Murphy to render my expert opinions on insurance customs, practices, and standards. In my testimony, I will:

- Provide background information on the insurance business, explain technical jargon and insurance concepts, and describe the standard practices that a reasonable insurer would have applied under the circumstances of the Murphys' claim with First Protective Insurance Company, d/b/a Frontline Insurance (hereafter referred to as "Frontline").

- Render my opinions on whether Frontline complied with generally accepted industry customs, practices, and standards in this case.

- Comment on testimony by Frontline's witnesses concerning their opinions on insurance customs, practices, and standards.

- Obtain and authenticate public documents on Frontline's financial net worth and provide my analysis and opinions on Frontiline's assets, liabilities, and net worth (surplus).

- Perform a data analysis (including profitability, cost-benefits, cost savings, and financial impacts) of Frontline's general business practices seen in this and similar claims, along with the impacts of Frontline's practices on its bottom line and the interests of its insureds.

Qualifications

I have 35+ years of experience with the insurance industry. Before becoming an independent consultant in 2011, my last employment was at Texas Mutual Insurance Company, where I served as Senior Vice President and General Auditor. I managed the Internal Audit Division, where I led teams of internal auditors to examine my company's compliance with insurance industry standards, internal operating policies, contracts, ethics, and regulations. I worked directly for the CEO and Board of Directors, to whom I reported my findings. Before my position as SVP and General Auditor, I was Vice President of the Special Investigations Department at Texas Mutual, where I managed the department in

charge of investigating suspicious or complex claims. Before joining the company in 1997, I had been in private law practice specializing in insurance and had worked as a CPA.

During my career, I held various professional licenses and designations, including Certified Internal Auditor (2005), Certified Fraud Examiner (circa 2000), Certified Public Accountant (1986), Insurance Adjuster (1996), and licensed to practice law (Arizona 1979, Texas 1982). I am inactive or retired as to all licenses and certifications.

I have a bachelor's degree (B.A. 1976), a law degree (J.D. 1979), and a master's in accounting (M.P.A. 1985). See Exhibit 1 for a copy of my CV.

Over the course of my career, I have:

- Participated frequently in national insurer industry groups related to auditing claim handling processes for compliance with industry standards and insurance fraud investigations.

- Taught seminars for my company and industry associations about insurance customs, practices, and standards.

- Testified in court on insurance industry standards while employed in the industry and after that as an independent consultant. Courts have admitted my testimony in 35 trials across the country. In addition, I have given 153 depositions providing expert testimony. Exhibit 2 is a detailed list of my trial and deposition testimony.

- Conducted peer reviews of other insurers' internal audit departments.

- Served as liaison to the state market conduct examinations of my company's compliance with industry standards and assisted the examiners with their work.

- As Senior Vice President reporting to my company's CEO and Board of Directors, I attended and participated in 70-80 Board of Directors meetings and 200-300 CEO staff meetings.

I have spent hundreds, if not thousands, of hours studying insurance industry literature. I have used these materials to guide my work in managing claim investigations, auditing insurance operations, and supporting the reliability of my expert opinions in court. Examples of industry literature include:

- Insurance industry textbooks used to train investigators, adjusters, agents, and underwriters.

- Internal auditing standards and guidance.

- Market conduct examination reports, manuals, and regulatory settlement agreements.

- Insurer in-house training materials for investigators, adjusters, and auditors.

- Internal insurer manuals for claim handling and underwriting.

- Insurance regulator-approved continuing education materials.

- Insurance industry periodicals and magazines.

I retired from the insurance industry in 2011. Since 2011, I have been a consultant specializing in the analysis of insurance matters. I have continued to examine and opine on insurance matters in my consulting practice. I keep current and continue to broaden and deepen my knowledge of the insurance industry through the following:

- Research of industry regulatory requirements in many different states in my national consulting practice.

- Review and study of insurers' internal documents obtained in discovery, such as policies and procedures, audits, manuals, and depositions of insurance company claim handlers, managers, and executives.

Prior expert testimony, fees, and publications

I have testified in deposition and trial as an expert witness in insurance cases since the 1990s. I have testified in state court, federal court, tribal court, administrative proceedings, and arbitration proceedings. I have given testimony about insurance issues via trial or deposition in the following jurisdictions: (trial testimony denoted via asterisk*) Alabama*, Alaska, Arkansas, Arizona*, California*, Colorado*, Florida*, Hawaii, Idaho*, Illinois, Indiana*, Kentucky*, Michigan, Minnesota*, Montana, Navajo Nation (tribal court), Nevada*, New Mexico*, New York*, North Carolina, Pennsylvania, South Dakota*,

Texas*, Tennessee*, Washington, Wisconsin, and Wyoming*. I have performed non-testimonial consulting engagements in most of the above jurisdictions and British Columbia, Georgia, Iowa, Maryland, and Massachusetts. Exhibit 2 lists the cases in which my testimony has been admitted at trial (35 times) and my deposition testimony (153 depositions).

The compensation for my study and testimony is $400 per hour for all services rendered. I have had no publications in the last ten years.

Facts and data considered

Exhibit 3 lists the documents provided to me for review.

Exhibits at trial

In my testimony, I may use as exhibits the documents, textbooks, charts, or diagrams depicted in this report or the attached exhibits.

Detailed Analysis and Support

Claim handling customs and practices

Having a reasonable basis for claim handling decisions is often referred to within the insurance industry as "good faith" or "fair claim handling," which are essential topics that are widely taught to claim handlers and their managers.

Exhibit 4 contains photocopies from a wide variety of peer-reviewed insurance industry textbooks that instruct claim handlers, their managers, and insurance company executives about the "good faith claim handling" customs and practices. Specific practices are set out for what these texts refer to as "Good faith claim handling."

Here are a few examples that give some perspective on claim handling practices widely taught in the industry. These are educational materials that address the basic professional and ethical job duties of claim handlers and their managers:

1. Maintaining public trust is vital

"Insurance companies provide such a <u>vital and necessary service</u> to society that the selling and servicing of insurance is imbued with a <u>public trust</u>." (Emphasis added)

– *The Claims Environment, James J. Markham, Kevin M. Quinley, Layne S. Thompson, (1st ed., Insurance Institute of America, 1993), 1st Ed., p. 28. Exhibit 4.1.*

"The insurance buyer does not know the true value of the product until there is a loss and the claim is made and adjusted…Prior to buying an insurance policy, the consumer has the power to shop among various insurance companies. However, once the insurance policy is bought and a loss occurs, the consumer must deal with one insurance company. This creates an <u>imbalance of negotiating power</u> at a time when the consumer's needs are greatest." (Emphasis added)

– *The Claims Environment, (1st ed.), Exhibit 4.1., pp. 17; 66.*

2. Good faith claim handling – specific practices and teachings

"Investigations that are thorough, timely, and unbiased are the foundation of good faith claim handling...Claim representatives investigate claims to collect all relevant evidence." (Emphasis added)

– *The Claims Environment (2nd Ed.), Exhibit 4.2, p.5.*

"Elements of Good-Faith Claim Handling. These are some of the primary elements of good-faith claim handling:

Thorough, timely, and unbiased investigation

Complete and accurate documentation

Fair evaluation

Good-faith negotiation..." (Emphasis added)

– *Claim Handling Principles & Practices (2012 edition), Exhibit 4.5, p.4.*

"Good claim handling and supporting evidence can help to establish that insurers acted in good faith by dealing fairly with insureds and claimants. Documentation in each claim file demonstrates how insurers conduct the claim investigation, evaluate claims, and negotiate. Activity logs, correspondence, and documentary evidence such as police reports and bills can indicate that claim representatives, supervisors, and managers are doing their jobs properly." (Emphasis added)

– *The Claims Environment (2nd Ed.), Exhibit 4.2, p.22.*

"Claim representatives should have a thoroughly documented claim file before denying a claim. Such a file will be useful in defending a bad faith claim. If a claim representative discovers that he or she has made an error, fair dealing and good documentation will help the claim representative to explain the error. In such cases, a sincere apology and quick action to fix the error go a long way in avoiding and defending bad faith claims." (Emphasis added)

– *The Claims Environment (2nd Ed.), Exhibit 4.2, p.22.*

"After a decision is reached regarding claim settlement or denial, the claim representative must inform the parties to the claim. If the decision is negative, <u>good-faith claim handling requires</u> the claim representative to <u>explain the rationale</u> behind it. Careful drafting of a denial message is an important component of good-faith claim handling." (Emphasis added)

– *Claim Handling Principles & Practices (2012 edition), Exhibit 4.5, p.3.*

"When claim handlers act in good faith, they:...Discuss coverages and benefits available to insureds under the policy..."The following actions by a claim handler can cause legal problems and result in a bad faith lawsuit against the insurer:...Failing to explain coverages and benefits available to insureds under the policy."

– *Claim Basics, Exhibit 4.4, pp.3-5.*

"Claim representatives are expected to truthfully explain the policy provisions and coverages to claimants and insureds."

– *Claims Environment 2nd Ed., Exhibit 4.2, p.21.*

"Investigations that are thorough, timely, and unbiased are the foundation of <u>good-faith claim handling</u>...Claim representatives should collect all relevant and necessary evidence. Investigation should <u>continue as long as new facts develop or become available</u>…Investigations should seek to discover the facts and consider all aspects of the claim in order to reach an impartial decision. Claim representatives should pursue all relevant evidence<u>, especially evidence that establishes the claim's legitimacy</u>, without bias..." (Emphasis added)

– *Claim Handling Principles & Practices (2012 edition), Exhibit 4.5, p. 5.*

"The primary [job] duty of the claim representative is to deliver the promise to pay. Therefore, the claim representative's chief task is to <u>seek</u>

and find coverage, not to seek and find coverage controversies or to deny or dispute claims."

– *The Claims Environment (1st Ed.), Exhibit 4.1, p.3.*

"To deliver the insurer's promises at all times in good faith, a claims department must have its own claim philosophy honoring the duty of good faith and fair dealing, independent of departments that do not perform the claim function. For example, if tighter control over loss ratios is needed, it must occur to a large extent at the underwriting stage by taking on appropriate risks for an appropriate premium amount."
(Emphasis added)

– *Claims Leadership and Organizational Alignment, 1st ed., Frappolli, eds., et al. (The Institutes, Providence RI, 2013), page 6.5. Exhibit 4.3.*

"It is important that insurers and claim representatives have well-defined codes of ethics that form the guidelines of good-faith claim handling." (Emphasis added)

– *Claim Handling Principles & Practices (2012 edition), Exhibit 4.5, p.1.*

"If there's any business where integrity is critical, it's the insurance business. After all, you pay us money--a good deal of money--and we give you a piece of paper with a promise on it. You trust us to have the money to pay your claim when you have one. And you trust us to pay you fairly and to pay you promptly. We need that kind of trust for our system to work." (Emphasis added)

– *State Farm CEO Edward B. Rust, Jr., Keynote Address, International Conference and Annual Meeting of the Association to Advance Collegiate Schools of Business, San Francisco, CA, April 21 23, 2005, Exhibit 4.6. page 4. [Not a textbook, but aligns with textbook teachings]*

"Lowballing is a negotiating tactic by which a claim representative knowingly offers far less than the merits of the claim warrant. Lowballing is undeniably effective in forcing claimants and insureds to accept settlements that may be lower than their claims deserve…Lowballing is

ethically indefensible, even in response to an outrageously high settlement demand. As a tactic, lowballing may be effective … yet it remains ethically unsupportable." (Emphasis added)

– *The Claims Environment, (1st Ed), Exhibit 4.1, p.12.*

"Unit 3 - Ethical Issues in Claim Handling…
"Handling Claim in Good Faith…
"Claim professionals must handle all claims in accordance with the state's unfair claims settlement practices laws and perform their other job–related duties ethically and fairly to avoid exposing their company to a bad faith lawsuit." (Emphasis added)

– *Claim Basics, (3rd Ed. 2006), Exhibit 4.4, p.3.*

"Bias in claim handling is a predisposition to a particular outcome. When investigating claims, claim representatives should pursue all relevant evidence, especially evidence that establishes the claim's legitimacy, without bias…In addition, claim representatives should work with service providers that are unbiased and have no conflict of interest…Investigations should seek to discover the facts and consider all aspects of the claims so that decisions are impartial and fair." (Emphasis added)

– *Claim Handling Principles and Practices, (2006 edition), Exhibit 4.5, p.8; Claim Handling Principles & Practices (2012 edition), Exh. 4.5, p.3. [Identical language in both editions]*

"Many insurers hire experts to assist in the investigation of the cause of loss and the amount of damages. How an insurer selects such experts and uses the information they provide can have bad-faith implications. Insurers must make a good-faith effort to find experts who are reputable within their profession and who will provide unbiased evaluations." (Emphasis added)

– *Claim Handling Principles & Practices (2012 edition), Exhibit 4.5, p.5.*

"For a time following a loss, people often experience a period during which rational decision making is impaired . . . The professional claim representative should be there to help."

– *The Claims Environment (1st Ed.), Exhibit 4.1, p.16.*

"Before discovery, there is an opportunity to withhold or fabricate evidence, but claim representatives should never do so. Such deceit takes advantage of the other party and has no ethical justification. Likewise, because claim representatives have an ethical obligation to perform the policy, they must never knowingly misrepresent policy provisions or coverages." (Emphasis added)

– *The Claims Environment (1st Ed.), Exhibit 4.1, p.12.*

"The National Association of Insurance Commissioners drafted a model Unfair Claim Settlement Practices Act, which most states have adopted… [P]ractices prohibited under the model act:

- **Knowingly misrepresenting facts or policy provisions regarding coverage**
- **Not attempting to effectuate fair, prompt, and reasonable settlement of claims in which liability has become clear.**
- **Compelling insureds to bring suit to recover amounts due under policies by offering less than what is ultimately recovered in suits brought by them.**
- **Denying a claim without conducting a full investigation..." (Emphasis added)**

– *Claims Leadership and Organizational Alignment, Exhibit 4.3, p. 29*

"The legal system is slow and expensive. It may take months or even years to see a case through the court system. Tens and even hundreds of thousands of dollars may be spent in legal fees, fees for experts, and other litigation expenses. These costs are more than almost any claimant or insured could realistically afford."

– *The Claims Environment (1st Ed.), Exhibit 4.1, p.13.*

". . . policyholders generally do not understand all of the circumstances that are or are not covered in the policy…claim representatives must have thorough and precise knowledge of coverages." (Emphasis added)

– *The Claims Environment (1st Ed.), Exhibit 4.1, p.6.*

3. Reliability of textbooks

The Prefaces and Forwards in the above textbooks appear in Exhibit 4. These introductory materials should be reviewed if there is any doubt about reliability. Among other things, the introductory materials make clear that these books have many different authors employed in the insurance business, have been widely used for decades, are part of industry-recognized certificate programs, are studied for certificate examinations like CPCU and AIC, are used in regulator-approved continuing insurance education need for insurance license renewal, and are used in college courses on insurance.

Anybody reading these textbooks will understand that they do not purport to be legal treatises or authoritative on legal questions. The texts themselves make this clear at various points, recommending that the reader consult their specific state laws or, if necessary, seek legal counsel.

My opinions are directed at customary business practices and are not intended to be legal opinions. I speak of claim handler and manager job functions or job duties, as ordinarily practiced in the business world, not legal duties. Conclusions of law are for the court and are not proper expert testimony. Rather, I describe the standard practices that a reasonable insurer would have applied under the circumstances of this case and render my opinions on whether the insurer complied with those customs and practices.

4. Non-exhaustive list

There are many other quotes from Exhibit 4 along the same lines as set forth above, dealing with customs and practices essential to good faith and fair claim handling. If called upon, I may refer to other quotes from the texts in Exhibit 4, but to save time and space, I will not make an exhaustive list in this report. However, Exhibit 4 should be considered incorporated herein as part of my opinions.

Opinions

In developing opinions, I applied the same methods and knowledge that a reasonable claim manager or auditor would apply – methods and knowledge that I routinely used while employed in the industry in those capacities. All opinions are expressed to a reasonable degree of probability.

1. Frontline has a general business practice in Florida storm damage claims that is illustrated in the Murphy claim and 8 other claims. In arriving at this opinion, I considered records produced by Frontline on 8 other storm damage claims, which were discussed in the 30(b)(6) deposition of Frontline:

    1.1. Fortune claim
        a. Hurricane Irma.
        b. Used preferred vendors to initially value the loss at $3,013
        c. CRN filed.[1]
        d. Frontline responded to the CRN on the 51st day of the 60-day cure period by summarily denying the allegations.
        e. Frontline demanded appraisal.[2]
        f. Appraisal Award $121,516.

    1.2. Kennedy claim
        a. Hurricane Irma.
        b. Used preferred vendors to initially value the loss at $28,791.[3]
        c. Three CRNs filed.
        d. Frontline responded to each of the CRNs on the 60th, 60th, and 58th day of the respective 60-day cure periods, by summarily denying the allegations.
        e. Frontline demanded appraisal.

[1] "CRN" refers to a "Civil Remedy Notice of Insurer Violations," which is filed by an insured with the Florida insurance regulator, the Dept. of Financial Services. This and the other CRNs generally complained of matters such as a lack of responsiveness, ignoring requests for additional living expense benefits, failure to consider the insured's documents supporting the claim, and overall delay.

[2] Frontline's claim notes for the Fortune claim are in Exh. 21 of the Holland 30(b)(6) deposition. At p. 25 of Holland dep Ex. 21, First Protective stated, "Sheehe [Frontline's law firm] filed an MTD/MSJ [Motion to Dismiss/Summary Judgement] that the pre suit demand for appraisal and payment of the appraisal award cured the CRN. The trial court granted the MSJ. OC [opposing counsel for the insured] appealed. The appellate court reversed, finding the demand for **appraisal did not cure the CRN**." The court stated: "an appraisal is not a condition precedent to [i.e., substitute for] the insurer fulfilling its obligation to fairly evaluate." [Emphasis and parenthetical comments added]

[3] Initial payment amount per letter from Frontline to its insured - Frontline Document Production (Kennedy Claim File) - Bates No. 000367.

f. Frontline paid $258,000.[4]

1.3. Ahern claim
   a. Hurricane Irma.
   b. Used preferred vendors to initially value the loss under the deductible.
   c. Three CRNs filed.
   d. Frontline responded to each of the CRNs on the 59th, 59th, and 60th day of the respective 60-day cure.
   e. After suit was filed by the insured, Frontline demanded appraisal.
   f. Appraisal award of $19,143.

1.4. Horvath claim
   a. Hurricane Irma.
   b. Used preferred vendors to initially value the loss and initially paid nothing.
   c. CRN filed.
   d. Frontline responded to the CRN on the 57th day of the 60-day cure period, by summarily denying the allegations.
   e. After suit was filed by the insured, Frontline demanded appraisal.
   f. Frontline ultimately paid $123,789 for the loss.

1.5. Weaver claim
   a. Hurricane Irma.
   b. Frontline valued the loss under the deductible and paid nothing.
   c. Two CRNs were filed.
   d. Frontline responded to the CRNs on the 60th and 59th day by summarily denying the allegations.
   e. After suit was filed by the insured, Frontline demanded appraisal.
   f. Frontline settled the claim for $177,000, approximately the amount of the insured's estimate of $179,144.

1.6. Magee claim
   a. Windstorm loss.
   b. Used preferred vendors to initially value the loss and initially paid nothing.[5]

[4] Final settlement at Bates 00009.

[5] Frontline never made a coverage decision. Frontline was in possession of estimates from its field adjuster of $25,211 and $21,525 (RCV/ACV) but did not disclose that fact to Magee. Magee's roofer provided an estimate for $22,468, which was fully in line with Frontline's own estimate. The Frontline preferred engineer reported that the roof needed

c. CRN filed.
d. Frontline responded to the CRN on the 60th day of the 60-day cure by summarily denying the allegations.
e. After suit was filed by the insured, Frontline demanded appraisal.[6]
f. After the claim was in litigation, Frontline settled the claim for $20,000.

1.7. Hunt claim
a. Windstorm loss.
b. Used preferred vendors to issue payment of $977.
c. CRN filed.
d. Frontline responded to the CRN on the 59th day of the 60-day cure by summarily denying the allegations.
e. After suit was filed by the insured, Frontline demanded appraisal.
f. After the claim was in litigation, Frontline paid $13,801 for the loss.

1.8. Hildebrand claim
a. Windstorm loss.
b. Used preferred vendors to not issue any payment to the insured initially.
c. CRN filed.
d. Frontline responded to the CRN on the 56th day of the 60-day cure period, by summarily denying the allegations.
e. After suit was filed by the insured, Frontline demanded appraisal.
f. After the claim was in litigation, Frontline paid $22,500 for the loss.

2. The other 8 claims described in 1.1 to 1.8, above, exhibit the following pattern:
a. All were Florida storm damage claims
b. Frontline hired preferred vendors to assess the loss, and in each instance, the loss initially evaluated was either below the deductible or resulted in a grossly inadequate initial payment.
c. In each instance, the insured filed at least one CRN alleging violations by Frontline related to delay, undervaluation, and other deviations from proper claim handling.

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replacement. Rather than simply pay the estimate of its own adjuster, Frontline asked the engineering firm to revise its report to indicate the damage was from Hurricane Irma, and the engineering firm complied. The effect of this change was to allow Frontline to assert a larger deductible for hurricane losses.

[6] Frontline's demand for appraisal, even where its estimate agreed with the insured's estimate, strongly indicates the general business practice of abusing the appraisal as a delay tactic, given that there was no material dispute about the estimated loss amount. Of note, Frontline settled the claim after litigation for **less than the amount of its own adjuster's estimate and the insured's estimate.**

d. Frontline responded to the CRN very close to, or on, the 60th day, the maximum period allowed for cure by summarily denying the allegations.
e. Frontline generally demanded appraisal only after suit was filed.[7] In all instances, no realistic evaluation of the claim occurred until after the insured was forced to file suit.

3. Insurers have long included an appraisal clause in insurance policies. Appraisal allows the policyholder and the insurer to resolve good faith disputes over the amount of damage or the cost of repairs. An appraisal is a potentially expensive and time-consuming adversarial process.[8]

4. The appraisal clause is not a substitute for adjusting a claim promptly by making an offer far lower than the merits of the claim warrant.

5. In the textbooks for adjusters, knowingly offering far less than the merits of the claim warrant is referred to as "Lowballing." While it is undeniably effective in forcing insureds to accept settlements lower than their claims deserve…Lowballing is ethically indefensible. Claim professionals must perform their job duties ethically and fairly. To do otherwise indicates a lack of good faith.

6. Insurance is based on the law of large numbers. Insurers employ a large number of actuaries, who can predict losses statistically. Nobody knows in advance which specific homes will be damaged in a given year, but in a large enough collection of homes, forecasts can be made as to how many homes in the group will experience a loss in a certain time frame. Likewise, in claim handling, insurers know that they cannot predict which claimants will hire law firms to pursue appraisal and/or litigation of claims, but they can know that a certain percentage will not pursue claims for various reasons, including costs and reluctance to go to court. This is especially true when the insurer makes the appraisal process adversarial, unduly

[7] Per the appellate court in Frontline's claim file for Kennedy, "in January 2018, Frontline provided the Kennedys with a sample estimate which left most of their questions and concerns unanswered. It was at this time, that the Kennedys advised Frontline of their intent to retain counsel. Several months later, Frontline issued, and the Kennedys received, a written demand for appraisal pursuant to the insurance policy. Frontline's demand, however, was delivered to the Kennedys before Frontline provided its written statutory notice to the Kennedys of their right to mediate, as mandated by Section 627.7015, Florida Statutes (2018). That notice followed the months of disagreement between Frontline and the Kennedys regarding their claim. The Kennedys filed suit on July 26, 2018, and Frontline immediately moved to compel appraisal.
Per exhibits 13 and 14 to the Frontline 30b6, Ahern demanded appraisal on 3/26/18, but Frontline ignored the request until after the suit, and then I filed for appraisal on 11/21/18.
[8] Cf Florida Statue 627.7015(1).

delayed, and expensive. The appraisal process is not a weapon to be used against the insured.

7. The effect of making inadequate low offers to insureds leading to an unnecessary appraisal is to force the insured to pay its appraiser and ½ the umpire fee to resolve a matter which, otherwise, should have been resolved without cost and delay of an unnecessary appraisal. Also, the insured will probably incur costs for expert witnesses such as roofers, plumbers, engineers, etc.

8. Textbooks make it clear that good faith claim handling practices do not include compelling insureds to bring suit to recover amounts due by offering less than what is ultimately recovered in suits. We are warned that such practices may also violate unfair claim handling statutes. "The legal system is slow and expensive. It may take months or even years to see a case through the court system. Tens and even hundreds of thousands of dollars may be spent in legal fees, fees for experts, and other litigation expenses. These costs are more than almost any claimant or insured could realistically afford." The Claims Environment (1st Ed.), Exhibit 4.1, p.13.

9. The pattern exhibited above in paragraph 2, subparts a-f, was also exhibited in Frontline's handling of the Murphys' claim.

   a. The Murphys' home, a valuable vacation home in the Florida Keys, was damaged in Hurricane Irma.
   b. Frontline valued Murphy's loss under the deductible and initially offered nothing, with no reasonable basis to do that.[9]
   c. The Murphys hired a law firm that filed three CRNs on their behalf.
   d. Frontline responded to the Murphys CRNs at or very near the due date, summarily denying the allegations.
   e. After suit was filed by the Murphys, Frontline demanded appraisal.[10]
   f. After the appraisal award was entered, Frontline paid $292,883, which is far more than it offered in the beginning, which was zero.

[9] See 10/26/17 "Below deductible" letter from Frontline to Mr. Murphy. Of note, at that point in time, Frontline had a highly defective estimate from its preferred adjuster. Later, when it became apparent that the adjuster had ignored photographs showing extensive damage from Irma and that the adjuster had not even considered the loss of rental income, which was an obvious loss. Frontline hired a "preferred vendor" engineering firm to issue a somewhat absurd opinion that there had been no storm damage. The insured was thereby forced to hire an engineer to rebut that ploy by Frontline. It was not until after the appraisal concluded in April 2021 that Frontline paid $292,883.

[10] Approximately 20 months elapsed from the Murphys' first notice of loss to the filing of the suit. During this time, there were no written explanations as to why Frontline was not paying any money, even for the loss of rent claim. Good faith requires that insurers explain their reasons for refusing to pay.

10. The Murphys had a deductible of $31,000. At the very beginning, before Frontline had even sent the initial adjuster to visit the Murphys' home, the claim notes indicated the reserve on the claim was set at $29,999[11], just shy of the deductible. This indicates that the plan from the beginning was to lowball the claim to an amount less than the deductible.[12]

11. The Murphys' claim is an example of Frontline's general business practice that recklessly disregards the rights of its insureds like the Murphys.[13]

12. My opinion on the recklessness of Frontline's business practice is not just supported by the insurance literature I have discussed. It is also supported by the basic Florida statutes Section 626.9541(1)(i) and 624.155.[14] Claim handlers and their managers must know and apply these statutes – this is the textbook teaching. The Florida statutes directly prohibit the following conduct:

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[11] 9/17/15 entry for "Open Loss Reserve" in Frontline Homeowners Insurance, Claims Management System report produced by Frontline in the Murphy claim.

[12] This happened on at least some of the other claims such as Kennedy and Weaver, which were both initially reserved for $29,999.

[13] FL ST §624.155. Civil remedy (5) No punitive damages shall be awarded under this section unless the acts giving rise to the violation occur with such frequency as to indicate a general business practice and these acts are…In **reckless disregard for the rights of any insured**." [Emphasis and brackets added].

[14] FL ST § 624.155 Civil remedy provides in relevant part:

"(1) Any person may bring a civil action against an insurer when such person is damaged...[by] (a) a violation of... Section 626.9541(1)(i)... [or] (b) By the commission of any of the following acts by the insurer: 1. **Not attempting in good faith to settle claims when, under all the circumstances, it [the insurer] could and should have done so, had it acted fairly and honestly toward its insured and with due regard for her or his interests**; … Notwithstanding the provisions of the above to the contrary, a person pursuing a remedy under this section need not prove that such act was committed or performed with such frequency as to indicate a general business practice...(3)(a) As a condition precedent to bringing an action under this section, the department and the authorized insurer must have been given 60 days written notice of the violation. [This is the CRN notice]." [Emphasis and brackets added].

FL ST § Section 626.9541(1)(i), [incorporated in 624.155 Civil Remedies]provides in relevant part:

"The following are defined as unfair methods of competition and unfair or deceptive acts or practices: ... (i) Unfair claim settlement practices...or 3. Committing or performing with such frequency as to indicate a general business practice any of the following: a. **Failing to adopt and implement standards for the proper investigation of claims**; b. **Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue**; c. **Failing to acknowledge and act promptly upon communications with respect to claims**; d. **Denying claims without conducting reasonable investigations based upon available information**..." [Emphasis and brackets added]

a. Not attempting in good faith to settle claims when, under all the circumstances, the insurer could and should have done so, had it acted fairly and honestly toward its insured and with due regard for her or his interests.

b. Failing to adopt and implement standards for the proper investigation of claims.

c. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue.

d. Failing to acknowledge and act promptly upon communications with respect to claims.

e. Denying claims without conducting reasonable investigations based upon available information.

13. Should the financial wealth of Frontline (First Protective) become an issue, I can provide the company's financial statements, which are public records. As a former insurance auditor and CPA, I am qualified to opine on the company's financial status. I personally obtained an official copy of the financial statements filed by First Protective with its regulators, which is the industry practice for checking on the competition – an activity I performed when I was employed in the industry. I can authenticate and establish the foundation of Exhibit 5, which contains the most recent financial statements filed with the National Association of Insurance Commissioners (NAIC), personally obtained by me directly from the NAIC.

14. First Protective's net worth (Frontline), as reflected in its most recent regulatory statements, is $117,523,339, per Exhibit 5.1, page 6.

15. I anticipate giving testimony on the profits derived by Frontline from its business practices discussed herein. This will require my examination of records that are yet to be produced. These records will include numeric data on other Florida claims and possibly include cost-benefit analyses performed by upper management, which often exist to measure the profitability of business strategies. I will supplement upon receipt of the additional data and records.

Supplementation

This report will be supplemented when additional documents become available for review. Further, if Frontline's staff, managers, or expert witnesses testify concerning insurance customs, practices, or standards, I will supplement to provide any rebuttal opinions.

Elliott S. Flood
November 10, 2023