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THE DEVELOPMENT OF FIRST-PARTY
EXTRACONTRACTUAL
INSURANCE LITIGATION IN
OKLAHOMA: AN ANALYTICAL
EXAMINATION

Johnny C. Parker†

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The advance of tort principles into the traditional realm of contract law is most dramatic in the field of insurance law. The insurance policy has long been viewed as the ultimate contract, entitled to the utmost judicial respect, if not admiration. Carefully drafted by lawyers knowledgeable in insurance law, honed to perfection by years of stare decisis, with almost every paragraph regulated by statute, one can understand the shock the insurance industry must experience as it views its castle walls crumbling, clause by clause.¹

I. Introduction

Legal scholars have been plagued by the problem of articulating a concise all encompassing definition of the term insurance.² Nevertheless, an insurance policy may be conservatively defined as a contract wherein the rights and obligations of the insurer and insured are enumerated. The insurer, in exchange for the insured’s payment of premiums, is obligated to pay for losses of the insured upon the happening of specified contingent events. The specified events insured against, as well as the extent of the insurer’s liability, are enumerated in the insurance policy. In the event of a dispute between the

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insurer and the insured as to their rights and obligations under the policy, contract rules of construction are traditionally applied.\(^3\) Likewise, contract rules have been traditionally applied in determining the measure of damages in the event of a breach of the insurance contract.

Insurance contracts, unlike other private agreements, are unique because they implicate important public policy concerns. Consequently, the development of insurance principles and doctrines has been influenced by judicial "perceptions about the interests of society in the resolution of the dispute."\(^4\) These judicial perceptions led to the development of extracontractual remedies for breach of the insurance contract.

This article examines the development of extracontractual remedies for the breach of first-party insurance contracts in Oklahoma. Oklahoma’s approach to extracontractual remedies in this area is similar in many respects to that of California; however, it cannot be assumed that a complete borrowing of rules, doctrines, and principles has taken place. Rather, Oklahoma law reflects a number of novel and unique approaches to such issues as standing to sue, liability of agents and employees for extracontractual damages, and punitive awards. These issues, as well as others, will be discussed and compared throughout this article.

II. FIRST-PARTY INSURANCE

First-party insurance refers to insurance policies under which the insurer contracts to pay the policy proceeds directly to the insured.\(^5\) The policy involves only two parties, the insured and insurer; consequently, when covered losses occur the insured makes the claim. As stated in *Zephyr Park, Ltd. v. Superior Court.*\(^6\)

The policy is written to protect the owner or beneficiary of the policy, who is termed a "first party." If the owner of the policy concludes the insurance company has not complied with the terms of the policy or has engaged in unfair settlement practices, the claim he brings against the insurance company is termed a "first party" claim. Where the insurance is a liability policy, the protection afforded the

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owner is its provision for indemnification against claims of third parties for whose damage the insured is for some reason liable.  

The award of extracontractual remedies in first-party insurance actions can be traced to third-party insurance actions. The Supreme Court of Wisconsin has been credited with being among the first American tribunals to impose extracontractual liability on third-party insurers. In *Hilker v. Western Automobile Insurance Co.*, the plaintiff/insured sought to “recover the excess over the [policy limit] of an automobile indemnity policy which [the plaintiff] paid to satisfy a judgment for damages imposed when his automobile struck a child.” The policy gave the defendant/insurer full control to handle and adjust all liability claims made against the insured. In addition, the policy provided that the insured “shall not interfere in any negotiations for settlement or any legal procedure.” The defendant's exercise of its right to control the litigation resulted in judgments against the plaintiff for $10,500. Plaintiff paid the judgments and subsequently filed an action to recover $5,500 — the amount in excess of the policy limit.  

At trial, the jury found that the defendant could have settled the case before and during trial for an amount less than $5,000. Additionally, it found that the insurance company had acted “in bad faith toward the plaintiff” in three respects: (1) in failing to make settlements, (2) in its manner of handling the claims, and (3) in dealing with its insured. In affirming the jury verdict in favor of plaintiff, the court focused on the relationship between the parties. That relationship, the Supreme Court of Wisconsin determined, was tantamount to

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7. *Id.* at 107 n.2. “The elemental right accruing to any insured under a first-party policy is the right to be paid. To be sure, other persons and entities may sue under first-party policies, but the rights to be enforced at common law are those of the insured.” *Denis J. Wall, Litigation and Prevention of Insurer Bad Faith* § 9.01, at 385 (2d ed. 1994).  

Examples of first-party insurance policies include: life insurance; medical and disability insurance; health and accident insurance; title insurance; property damage insurance; lost income insurance; fire insurance; and other types of policies providing for payment of proceeds directly to the insured. *Id.* at 384.

8. *Id.* at 386.

9. 231 N.W. 257 (Wis. 1930), reh'g granted, 235 N.W. 413 (Wis. 1931).

10. *Id.* at 258.

11. *Id.*

12. *Id.*

13. *Id.*

14. *Id.*

15. *Id.*

16. *Id.*
principal and agent. Therefore, the insurance company had a duty to act in good faith toward its insured.

Upon rehearing, the Supreme Court of Wisconsin attempted to clarify the type of duty which indemnity companies owe to their insureds when making settlements. The court observed that while the contract itself created no express duty, one is implied from the relationship existing between the parties. Thus, because the insurance company contracted for full control of the matter, its decisions must be honest, intelligent, and informed "if it [is to] be a good faith conclusion." A good faith conclusion is determined by examining whether the indemnity insurer exercised "such diligence as the great majority of persons use in the same or similar circumstances. This is ordinary care."

The *Hilker* opinions were significant steps in the evolution from the traditional contract approach to a breach by an insurer of an insurance policy. The court's reference to an implied duty of good faith and fair dealing, measured by a standard of ordinary care, established a foundation for the application of tort principles in first-party insurance cases.

III. Development of Extracontractual Remedies for Breach of Insurance Contracts

A. Unique Nature of Insurance Contracts

The development of extracontractual remedies for breach of insurance contracts resulted from a growing appreciation that insurance contracts are not ordinary commercial agreements, and that principles of contract law are totally inadequate where an insured has been wrongfully denied an insurance claim or otherwise deprived of the benefits of the insurance policy. Insurance contracts differ from ordinary commercial agreements in several important respects. The first

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17. *Id.* at 259.
18. *Id.* at 261.
19. *See* Hilker v. Western Auto. Ins. Co., 235 N.W. 413 (Wis. 1931). At least two lines of authority existed in Wisconsin with regard to the duty owed by indemnity companies. One line of authority was of the view that indemnity companies could only be held liable for negligent conduct, while the other line held that liability would only follow when the companies' conduct or lack of conduct amounted to bad faith. *Id.* at 414.
20. *Id.* at 416.
21. *Id.* at 415.
22. *Id.*
and most obvious distinction is that an insurance policy is a contract of adhesion.\textsuperscript{24} The second major distinction is that insurance contracts are more personal than ordinary commercial contracts; the insured enters into such contracts for peace of mind and financial security, rather than economic gain.\textsuperscript{25} Given that personal nature, emphasis is often placed on the reasonable expectation of the insured.\textsuperscript{26} Finally, the insurance industry has undertaken to provide a service which affects the public interest. As a result, such contracts are viewed as a quasi-public industry— a proper subject for intense legislative and judicial regulation and scrutiny.\textsuperscript{27}

\begin{verbatim}
24. An adhesion contract is often described as a contract in which one party has a considerable bargaining advantage over the other in its formation. As early as 1943 Professor Friedrich Kessler noted:

Standard contracts are typically used by enterprises with strong bargaining power. The weaker party, in need of the goods or services, is frequently not in a position to shop around for better terms, either because the author of the standard contract has a monopoly... or because all competitors use the same clauses. His contractual intention is but a subjection more or less voluntary to terms dictated by the stronger party, terms whose consequences are often understood only in a vague way, if at all. Thus standardized contracts are frequently contracts of adhesion.

Friedrich Kessler, Contracts of Adhesion: Some Thoughts About Freedom of Contract, 43 COLUM. L. REV. 629, 632 (1943). Creation of the term “adhesion contract” has been credited to an article written by Edwin W. Patterson, who observed that the insurance contract “is drawn up by the insurer and the insured, who merely adheres to it, has little choice as to its terms.” Edwin W. Patterson, The Delivery of A Life Insurance Policy, 33 HARV. L. REV. 198, 222 (1919). For a detailed discussion of the nature of adhesion contracts see Shernoff et al., supra note 23, § 1.03; Paul J. Skok, Trial Attorney’s Guide to Insurance Coverage and Bad Faith § 7.2 (1994). See also Rodgers v. Tecumseh Bank, 756 P.2d 1223, 1226 (Okla. 1988) (defining “adhesion contract”).


\end{verbatim}
B. Inadequacy of Contract Measure of Damages

Compensation is the primary objective in measuring damages in both contract and tort law.\(^{28}\) However, the development of the measure of damages applicable to *ex contractu* and *ex delicto* actions originates from the interests sought to be protected and the purpose of the compensation of the respective action.\(^{29}\) Contract law seeks to protect a consensual relationship, that being performance of the promises.\(^{30}\) The law of torts however, developed to protect individuals from culpable interferences with person and property. Additionally, tort theories of liability were influenced by public policy and not necessarily by the will or intention of the parties.\(^{31}\) The primary aim in measuring damages in contract actions is to place the non-breaching party in the same position he would have been in had the agreement been performed by awarding a sum equivalent to performance.\(^{32}\) In contrast, tort law aims to award the plaintiff enough money to restore him, as nearly as possible, to the position he would have been in had the wrong not occurred.\(^{33}\) In essence, tort law seeks to compensate the plaintiff for a loss sustained rather than to give him the benefit of his bargain.\(^{34}\)

Prior to the recognition of tort liability, a breach of an insurance contract was treated as an ordinary contract action to which courts traditionally applied the rule of foreseeability developed in *Hadley v. Baxendale*.\(^{35}\) A non-breaching party could recover for breach of contract only that amount "as may fairly and reasonably be considered either arising naturally, i.e., according to the usual course of things, from such breach of contract itself, or such as may reasonably be supposed to have been in the contemplation of both parties, at the time they made the contract."\(^{36}\)


\(^{29}\) 2 Sedwick, *supra* note 28, §§ 141, 602.


\(^{31}\) Id.


\(^{33}\) McCormick, *supra* note 32, § 137.

\(^{34}\) 2 Sedwick, *supra* note 28, § 602.


\(^{36}\) Id. at 151.
As applied to insurance contracts, the rule in Hadley v. Baxendale was construed to restrict an insured's recovery for breach of an insurance policy to the policy limits, plus any damages foreseeable or contemplated by the parties at the time the contract was made.37 Even though consequential damages arose "naturally" from the breach, the contract measure precluded their recovery because they were viewed as too unforeseeable and remote.38 Recoverable consequential damages were fixed at the time the contract was made; thus, a subsequent willful breach could not "affect the damages, the measure of which was fixed at that time."39

The inadequacy of the contract measure of damages for breach of an insurance policy was most evident in cases where the insurer refused to settle a claim within policy limits.40 As a consequence of this refusal, the insured was exposed to liability in excess of the policy limits. Under the contract theory of recovery, the insured was not entitled to recover the amount of the excess liability from the insurer because the policy established the limits of the insurer's liability.41

C. Recognition of Extracontractual Remedies for Breach of Contract

Recognition of the economic and social policies inherent in the business of insurance, the unique nature of the insurance contract, and

37. Id. Even though the rule in Hadley has received severe criticism it is uniformly followed throughout the United States. The American Law Institute incorporated the rule as § 330 of the Restatement of Contracts which provides:

In awarding damages, compensation is given for only those injuries that the defendant had reason to foresee as a probable result of his breach when the contract was made. If the injury is one that follows the breach in the usual course of events, there is sufficient reason for the defendant to foresee it; otherwise, it must be shown specifically that the defendant had reason to know the facts and to foresee the injury.

Restatement of Contracts § 330 (1922).


One early common law exception to this general principle of contract arose where the nature and object of the contract was personal, rather than commercial in nature. The non-breaching party in such a contract was entitled to recover compensatory damages. See, e.g., Stewart v. Rudner, 84 N.W.2d 816, 824 (Mich. 1957); Hood v. Moffett, 69 So. 664, 666 (Miss. 1915).


41. See, e.g., Rumford Falls, 43 A. at 503; Wisconsin Zinc Co., 155 N.W. at 1085.
the inadequacy of traditional contract remedies caused courts to emphasize the special relationship between the parties when analyzing disputes over the denial of coverage or policy benefits. In this relationship, insurers ordinarily possess superior economic power, bargaining position, and subject matter sophistication. Judicial appreciation of these aspects of insurance contracts served as the foundation for imposition of extracontractual liability on insurers for breach of their duty to act fairly and in good faith. Simultaneously with recognition of the special relationship between insurers and their insureds, courts began applying tort principles to disputes between said parties. Currently five distinct tort theories of recovery have developed: (1) breach of the implied duty of good faith and fair dealing, (2) implied statutory cause of action, (3) fraud, (4) intentional infliction of emotional distress, and (5) tortious interference with a protected property interest. Each of these tort theories will be discussed below.

IV. DEVELOPMENT OF TORT LIABILITY FOR INSURANCE CONTRACTS

A. The Tort of Bad Faith: Breach of the Implied Duty of Good Faith and Fair Dealing

1. Recognition of the Tort of Bad Faith

Every contract of insurance contains an obligation to act in good faith in the performance of the duties expressly set out in the contract. Each insurance contract also contains the implied duty of good faith and fair dealing. Much of the confusion surrounding the availability of extracontractual remedies for breach of insurance contracts surround the tautological confusion between these two, distinct, obligations in the insurance contract.

42. See Couch, supra note 27, § 23.11.
43. Shernoff et al., supra note 23, § 1.03.
44. Id.
46. See Restatement (Second) of Contracts § 205 (1973) ("Every contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement.").
47. Early on, courts recognized that tautological confusion surrounds the issue of extracontractual liability for breach of insurance contracts. Much of this confusion springs from none too critical use of terms. Terms which are not strictly convertible or synonymous have been used by different courts to indicate the same thing. . . . Bad faith, especially, is a term of variable significance and rather broad application. Generally speaking, good faith means being faithful to one's duty or obligation; bad faith means being recreant thereto.
Extracontractual remedies are not available for simple breach of contract. Rather, such remedies are available only where a fiduciary, or other analogous relationship, is found to exist between the contracting parties. A fiduciary relationship between the insurer and insured is crucial to the existence of the implied duty of good faith and fair dealing—the breach of which constitutes the tort of bad faith. Currently forty-seven jurisdictions, including Oklahoma, recognize the extracontractual remedy of bad faith in first-party insurance actions.

California was the first jurisdiction to recognize the tort of bad faith for breach of the implied duty of good faith and fair dealing in first-party insurance contracts. The principle case in that jurisdiction, *Gruenberg v. Aetna Insurance Co.*, considered whether a plaintiff stated a viable cause of action by alleging that an insurance company had breached its duty to plaintiff by failing to wait to resolve a fire

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Courts initially rejected the notion that a fiduciary relationship existed between insurers and their insureds. See *WALL*, supra note 7, § 9.03. The traditional view was summed up as follows:

As a general rule, the relationship between the parties to a contract of insurance is that of debtor and creditor; that is, of one contracting party to another contracting party, rather than of trustee and cestui que trust, or such as would arise by virtue of a will or other testamentary instrument.

*COUCH*, supra note 27, § 23.11. The above cited treatise recognized the change in the traditional view and added:

However, insurance policies are contracts of the utmost good faith and must be administered and performed as such by the insurer. Good faith demands that the insurer deal with laymen as laymen and not as experts in the subtleties of law and underwriting. Particularly where the language expressing the extent of the coverage may be deceptive to the ordinary layman, there is an implied covenant in insurance contracts of good faith and fair dealing that the insurer will not do anything to injure the rights of the policyholder to recover the benefits of his contract.

*Id. See also* Egan v. Mutual of Omaha Ins. Co., 598 P.2d 452, 455-56 (Cal. 1979). *But cf.* American Fidelity and Casualty Co. v. Jones Trucking Co., 321 P.2d 685 (Okla. 1957); National Mut. Casualty Co. v. Britt, 200 P.2d 407, 411 (Okla. 1948). In these third-party insurance cases the Oklahoma courts relied on an agency type relationship to support the implied duty of good faith and fair dealing. 49. *WALL*, supra note 7, § 9.03, at 389. "Unless rights are given up to one person to act on behalf of another, there is no fiduciary relation. If there is no fiduciary relation, there can be no fiduciary bad faith." *Id.*

It has been suggested that the same result has been achieved in several states by recognizing an implied contractual obligation of good faith and fair dealing. *Id. at 390. See also* Allstate Ins. Co. v. Amick, 680 P.2d 362, 364-65 (Okla. 1984) (stating that the duty arises from the contractual relationship between the insurer and insured). This relationship is viewed as fiduciary in nature.

50. *See SHERNOFF ET AL.*, supra note 25, § 1.01, at 1-2 n.3.

51. 510 P.2d 1032 (Cal. 1975).
insurance claim until after the plaintiff, who was charged with arson, had resolved the criminal matter. According to the court, the duty alluded to by the plaintiff "sounds in both contract and tort," and "is imposed because there is an implied covenant of good faith and fair dealing in every contract [including insurance policies] that neither party will do anything which will injure the right of the other to receive the benefits of the agreement." The court held that, by refusing to wait until the criminal action was adjudicated to settle the insurance claim, the insurance company had forced plaintiff to choose between protecting his rights in the criminal matter and negotiating his insurance settlement. Such a choice denied the plaintiff the benefits of his insurance contract. The court found for the plaintiff, and imposed extracontractual liability on the insurer, not for a bad faith breach of the contract, but for failure to satisfy the implied covenant derived from tort law.

The implied covenant imposes upon first-party insurers a duty beyond that mandated by the express terms of the insurance policy. By refusing without proper cause to compensate for a covered loss, an

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52. Id. at 1035. Plaintiff's cocktail lounge and restaurant was insured against fire loss by Aetna Insurance Company, Yosemite Insurance Company and American Home Assurance Company. Id. When a fire occurred at Plaintiff's establishment, he argued with a member of the arson detail and was arrested. Id. The insurance company contacted a claims adjuster who investigated the fire and inspected the premises. Id. While at the premises, the adjuster stated to an arson investigator that plaintiff had excess coverage under his fire insurance policies. Id.

Plaintiff was subsequently charged with arson. Id. While these charges were pending, the insurance companies demanded plaintiff appear at the office of counsel to submit documents and be examined under oath. Id. Plaintiff's attorney responded that his client would not make any statements about the fire until the criminal matter was concluded. Id. at 1035. Thereafter, a preliminary hearing was held on charges of arson and defrauding the insurer. Id. The charges were ultimately dismissed for lack of probable cause. Id. Plaintiff soon thereafter informed counsel for the insurance companies that he would submit to an examination. Id. The insurers however, reaffirmed their earlier position that they were denying liability because of plaintiff's earlier refusal to submit to examination. Id.

53. Id. at 1036 (citing Comunale Traders & General Ins. Co., 328 P.2d 198, 200 (Cal. 1958)).
54. Id.
55. Id. at 1037.
56. Id.

58. That responsibility is not the requirement mandated by the terms of the policy itself—to defend, settle, or pay. It is the obligation, deemed to be imposed by the law, under which the insurer must act fairly and in good faith in discharging its contractual responsibilities. Where in so doing, it fails to deal fairly and in good faith with its insured by refusing, without proper cause, to compensate its insured for loss covered by the policy, such conduct may give rise to a cause of action in tort for breach of an implied covenant of good faith and fair dealing.

Id. 1037.
insurance company may face tort liability if it deals unfairly and in bad faith with its insured. In first-party cases the standard for determining whether extracontractual liability for bad faith should be granted under Gruenberg and cases following it is whether the insurer was "unreasonable" in handling the insured's claim by denying the proceeds for a covered loss to the insured without proper cause. 59 Bad motive, subjective intent to cause harm, or a conscious awareness that the conduct is unjustifiable is not required to satisfy the Gruenberg standard. 60 Liability for bad faith does not exist, however, when an insurer's denial of coverage is based upon a reasonable interpretation of the policy language. 61

The distinction between the contractual obligation of good faith and fair dealing and the implied covenant of good faith and fair dealing is perhaps most significant in one other important respect. The implied covenant, because it sounds in tort, is not conditioned upon whether the insured has fulfilled its obligations under the policy. "In other words, the insurer's duty is unconditional and independent of the performance of plaintiff's contractual obligations. This duty is independent of the contract and attaches over and above the terms of the contract." 62 The insurer's implied duty is a single "absolute one." 64 The insured's breach of contract claim is distinct from the bad faith claim; consequently, whether the insured satisfied its contractual obligations is relevant only in the breach of contract component of the case. 65

2. Oklahoma's Recognition of the Tort of Bad Faith

In Christian v. American Home Assurance Co., 66 the Supreme Court of Oklahoma officially recognized the implied covenant of good faith and fair dealing in a first-party insurance action involving disability insurance. The court expressly adopted the standard for bad faith established in Gruenberg and held that the "violation of the duty gives rise to an action in tort for which consequential and, in a proper case,

59. Id. "Accordingly, when the insurer unreasonably and in bad faith withholds payment of the claim of its insured, it is subject to liability in tort." Id. at 1038.
63. There is but one duty to act fairly and in good faith. Id. at 1037. Specific statements of this duty are merely different characterizations of the same duty. Id.
64. Id. at 1040.
punitive, damages may be sought." Since *Christian*, the implied duty of good faith and fair dealing has been expanded to cover all types of insurance contracts.⁶⁸

a. Standing to Sue

An insurer's liability for bad faith does not extend to every individual entitled to the insurance proceeds. Rather, the implied duty of good faith and fair dealing extends only to those persons sharing a contractual or statutory relationship with the insurer.⁶⁹ In other words, only individuals in a contractual or statutory relationship with the insurer have standing to sue for bad faith. The rationale underlying this rule is that "[i]n the absence of a contractual or statutory relationship, there is no duty which can be breached."⁷⁰

In the vast majority of cases, the answer to whether a contractual or statutory relationship exists will inevitably be obvious. However, the question is not always clear. For example, in *Roach v. Atlas Life Insurance Co.*,⁷¹ the Oklahoma Supreme Court was presented with the question of whether a life insurance beneficiary was entitled to assert a bad faith claim. The court recognized that a third person to whom life insurance proceeds are payable is a third-party beneficiary⁷² and an intended party to the contract. Likewise, Oklahoma statutory law recognizes the right of third-party beneficiaries, prior to

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⁶⁷. *Id.* at 904. The Supreme Court of Oklahoma's use of the words "in a proper case, punitive damages may be sought" was an intentional attempt to qualify the recovery of punitive damages in bad faith cases. *See McCorkle v. Great Atlantic Ins. Co.*, 637 P.2d 583, 587-88 (Okla. 1981).


⁷¹. 769 P.2d 158 (Okla. 1989).

⁷². *Id.* at 161.
rescission, to enforce any contract made for their benefit.\textsuperscript{73} Consequently, the beneficiary of a life insurance contract satisfies both criterion for an assertion of a bad faith claim.\textsuperscript{74}

\textit{b. Liability of Insurer for Conduct of Agents and Employees}

An agent of the insurer or any other third party who is a "stranger to the contract" may not be held liable for bad faith conduct.\textsuperscript{75} Nonetheless, the agent's conduct may be relevant in determining whether a breach of the duty owed by the insurer has occurred. For example, an insurance company employing an independent contractor cannot avoid liability for its breach because the insurer's duty of good faith and fair dealing is nondelegable.\textsuperscript{76} In Wolf v. Prudential Insurance Co. of America,\textsuperscript{77} the United States Court of Appeals for the Tenth Circuit addressed the issue of whether the rule prohibiting bad faith claims against agents and third parties was without exception. The court observed that Prudential, the administrator of the insurance plan, (1) was primarily responsible for investigating and servicing claims, (2) played a role in determining whether benefits would be paid, (3) received a percentage of the premiums paid, and (4) as losses decreased, Prudential's share of the premiums increased.\textsuperscript{78} Based on the nature of the arrangement and the extensive functions performed by Prudential, the court concluded that a special relationship existed between Prudential, the agent/administrator, and the insured.\textsuperscript{79} As observed by Judge Ebel, the author of the opinion:

The contractual obligation [of Prudential] combines with the fact that Prudential's benefit determinations could at least indirectly affect its profits and losses to create a special relationship between Prudential and plaintiffs. In other words, on the facts as presented by plaintiffs, Prudential had the power, motive and opportunity to act unscrupulously. We believe the Oklahoma Supreme Court

\textsuperscript{73} Id. Okla. Stat. tit. 15, § 29 (1991) provides that "[a] contract, made expressly for the benefit of a third person, may be enforced by him at any time before the parties thereto rescind it."

\textsuperscript{74} Roach, 769 P.2d at 161.


\textsuperscript{76} Timmons, 653 P.2d at 914.

\textsuperscript{77} 50 F.3d 793 (10th Cir. 1995).

\textsuperscript{78} Id. at 797-98.

\textsuperscript{79} Id. at 798.
would impose a duty of good faith on an entity in Prudential’s position for the same reasons it imposes the duty on “true” insurers.80

The Wolf opinion intimates that an exception to the general prohibition against asserting bad faith against agents exists where there is a special relationship between the agent and insured. This special relationship arises out of the contractual obligations of the agent to the insurance company. Consequently, agents may be treated as the insurer where they perform significant functions generally reserved to insurance companies and possess a pecuniary interest tied to the risks insured against.

3. Insurer’s Right to Dispute Claim

In Oklahoma, bad faith is treated as an intentional tort, the essence of which is the insurer’s unreasonable and bad faith conduct.81 Consequently, an insurer’s mere resort to a judicial forum, regardless of outcome, is not per se bad faith. Rather, the plaintiff must show that, under the circumstances of the case, there was no legitimate dispute surrounding its claim when the insurer instituted the legal proceeding.82 For example, in Mantis v. Hartford Fire Insurance Co.83 the plaintiff, owner of a bar which was damaged by fire, brought a bad faith action against his insurer who refused to pay the total amount of coverage.84 The insurer withheld payment because: (1) there was strong evidence that the fire was incendiary in nature, (2) there was circumstantial evidence that suggested that plaintiff had motive, and (3) the plaintiff was under suspicion by the Oklahoma State Bureau of Investigations for arson.85 The Supreme Court of Oklahoma reversed the award of punitive damages to the plaintiff noting that:

The defendant’s actions were reasonable and legitimate. Facts were in dispute as to the cause of the fire. The insurers had a right to have this dispute settled in a judicial forum. A Christian cause of action will not lie where there is a legitimate dispute. . . . Insurance companies have the right to dispute a claim in good faith.86

80. Id. (citing Christian v. American Home Assurance, 577 P.2d 899, 902-04 (Okla. 1977)).
84. Mantis, 681 P.2d at 761.
85. Id. at 761-62.
86. Id. at 762.
Reasonableness becomes a question for the trier of fact to determine where reasonable minds might draw different inferences as to the reasonableness of an insurer's conduct. Oklahoma seemingly applies an objective standard, and asks whether the insurer's denial or dispute of the claim was legitimate. This fact intensive question is answered on the basis of how a reasonable insurer would have acted under the facts and circumstances of the case. Whether the insurer's denial or dispute of the claim is legitimate raises the issue of whether the facts necessary to evaluate the claim were properly investigated, recorded, and acted upon or recklessly ignored.

The manner in which the claim is evaluated is also important, because the insurer's alleged bad faith decision will be examined in light of the circumstances and information possessed by the insurer at the time the decision to deny coverage was made. Events arising, or information obtained thereafter, are irrelevant and will not be considered in deciding the reasonableness of the insurer's decision.

4. Culpability and Damages

Though viewed as an intentional tort, bad faith is actually a hybrid tort. Therefore, a distinction must be drawn between the level of culpability or fault which will support a compensatory damage award with that which will support a punitive damage award. It is uniformly agreed that a higher degree of culpability is required to support a punitive award than is needed to support a compensatory award. The Gruenberg standard, however, does not require the insured to prove that its insurer's conduct was the result of bad motive, subjective intent to cause harm, or conscious awareness that its conduct was unjustified in order to prove bad faith for purposes of recovering compensatory damages. Rather, all that is required is evidence

90. Buzzard v. Farmers Ins. Co., 824 P.2d 1105, 1109 (Okla. 1991). "The action of the [insurance] company must be assessed in light of all facts known or knowable concerning the claim at the time plaintiff requested the company to perform its contractual obligation." Conti, 782 P.2d at 1362 (citing Buzzard v. McDaniels, 736 P.2d 157, 159 (Okla. 1987)).
92. Id. at 1115; Timmons, 653 P.2d at 918.
of an unreasonable denial of a covered loss without proper cause.\textsuperscript{94} Although Oklahoma courts have adopted the \textit{Gruenberg} standard of bad faith for the purposes of awarding compensatory damages, it has retained its traditional standard for determining whether punitive damages should be awarded.\textsuperscript{95}

In Oklahoma, punitive damages may not be awarded in the absence of actual damages.\textsuperscript{96} As a result of the actual damages requirement, the insured must prevail on the bad faith breach of contract claim in order to recover punitive damages.\textsuperscript{97} The standard for the recovery of punitive damages in a tort action in Oklahoma requires that:

\begin{quote}
[T]he proof must show some elements of fraud, malice or oppression. The act which constitutes the cause of action must be actuated by or accompanied with some evil intent, or must be the result of gross negligence—such disregard of another’s rights—as is deemed equivalent to such intent . . . Exemplary damages are allowed only in cases where fraud, oppression, gross negligence or malice, actual or presumed, enter into the cause of action, but a person may commit such willful acts in reckless disregard of another’s rights that malice may be inferred.\textsuperscript{98}
\end{quote}

The court must determine that the record shows clear and convincing evidence of the insurance company’s wanton or reckless disregard for the rights of another, oppression, fraud, or malice prior to submission of the issue of punitive damages to the jury.\textsuperscript{99}

5. Standards for Determining Bad Faith

The \textit{Gruenberg} standard, which focuses on the unreasonableness of the insurer’s conduct as a condition precedent to a punitive damages award, is said to be the minority view.\textsuperscript{100} The majority view was

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{94}  \textit{Gruenberg}, 510 P.2d at 1038.
\item \textsuperscript{95}  \textit{Timmons}, 653 P.2d at 918-19.  \textit{See also} McLaughlin v. National Beneficial Life Ins. Co., which stated:

Our [the Oklahoma Supreme Court's] recognition of the standard stated in \textit{Oden v. Russell} as applicable in \textit{Timmons} may only be read to indicate that the question of proof necessary to sustain a claim for punitive damages in a bad faith dealing case involving an insurance company is the same standard as necessary to sustain such a claim in any case where punitive damages are sought under 23 O.S. 1981 § 9.


\item \textsuperscript{98}  Slacum v. Phillips Petroleum Club, 678 P.2d 716, 718 (Okla. 1983).
\item \textsuperscript{100}  \textit{Skok, supra} note 24, §§ 7.14 - .15.
\end{itemize}
\end{footnotesize}
developed by the Supreme Court of Wisconsin in *Anderson v. Continental Insurance Co.* In *Anderson*, the plaintiffs/insureds were owners of a home insured by Continental Insurance Company. While the policy was in effect, a fire or explosion in a furnace occurred which caused oil and smoke residue to settle on the walls, clothing, furniture, draperies, and carpeting of the plaintiffs. Continental was notified of the loss and delegated Underwriters Adjusting Company to handle the claim. Underwriters employed cleaners who attempted to clean and renovate the premises. However, it was necessary for plaintiffs to repaint, clean, restore the premises, and replace the carpets. Plaintiffs alleged $4,611.77 in monetary loss. Plaintiffs sought to negotiate with Underwriters and Continental Insurance Company. Continental refused to negotiate on the amount of the claim, made very low settlement offers, and refused to accept the plaintiffs’ sworn proof of loss statements. Plaintiffs subsequently filed suit for bad faith.

In *Anderson*, the Supreme Court of Wisconsin identified the contours of bad faith as follows: “[t]o show a claim for bad faith, a plaintiff must show the absence of a reasonable basis for denying benefits of the policy and the defendant’s knowledge or reckless disregard of the lack of a reasonable basis for denying the claim.” This standard concentrates on the intentional nature of the insurer’s conduct and requires at least some conscious awareness of the lack of a reasonable basis for denial of the claim. In addition, this conscious awareness “may be inferred and imputed to an insurance company where there is a reckless disregard of a lack of a reasonable basis for denial or a reckless indifference to facts or to proofs submitted by the insured.” The insurer’s reckless disregard in *Anderson* was manifested in its refusal “to consider the nature and extent of the plaintiffs’ damages, and

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101. 271 N.W.2d 368 (Wis. 1978).
102. Id. at 371.
103. Id.
104. Id.
105. Id.
106. Id.
107. Id. at 372.
108. Id.
109. Id.
110. Id.
111. Id. at 376.
112. Id. at 377.
specifically rejected and spurned the opportunity to evaluate and consider the submitted proof of loss."\(^\text{113}\)

The *Anderson* standard is clearly more stringent than the *Gruenberg* standard. However, a subsequent opinion of the Wisconsin Supreme Court, *Fehring v. Republic Insurance Co.*,\(^\text{114}\) has diminished the distinction between the two standards. In *Fehring*, the court held that bad faith could be established by proof "that a reasonable insurer under the circumstances would not have acted as [the insurer] did by delaying payment of the claim and by offering amounts which are alleged to be unreasonably low."\(^\text{115}\) However, courts in states which have adopted the *Anderson* standard continue to require a more conscious or intentional wrongdoing on the part of the insurer than is necessary under *Gruenberg*.\(^\text{116}\)

6. Prima Facie Case Requirements

The first-party insured carries the burden of proof on all aspects of the bad faith claim.\(^\text{117}\) The insured must also plead and prove that it has performed all conditions precedent, together with all the other

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113. *Id.*
114. 347 N.W.2d 595 (Wis. 1984).
115. *Id.* at 601.
116. See Braesch v. Union Ins. Co., 464 N.W.2d 769 (Neb. 1991). The *Anderson* standard of care, which requires intentional or reckless conduct on the part of the insurer, strikes the proper balance between the respective rights of the insurer and the policyholder. *Id.* at 778. See also National Sec. Fire & Casualty Co. v. Bowen, 417 So. 2d 179, 183 (Ala. 1982) which states:

The plaintiff in a "bad faith refusal" case has the burden of proving:
(a) an insurance contract between the parties and a breach thereof by the defendant;
(b) an intentional refusal to pay the insured's claim;
(c) the absence of any reasonably legitimate or arguable reason for that refusal (the absence of a debatable reason);
(d) the insurer's actual knowledge of the absence of any legitimate or arguable reason;
(e) if intentional failure to determine the existence of a lawful basis is relied upon, the plaintiff must prove the insurer's intentional failure to determine whether there is a legitimate or arguable reason to refuse to pay the claim.


117. The expressed elements required to be proven are:
1. The insurer was required under the policy to pay plaintiff's claim;
2. The insurer's refusal to pay the claim in full was unreasonable under the circumstances, because [for example, that 1] it did not perform a proper investigation, 2) it did not evaluate the results of the investigation properly, 3) it has no reasonable basis for the refusal, or 4) the amount offered to satisfy the claim was unreasonably low];
3. The insurer did not deal fairly and in good faith with plaintiff; and
4. The violation by the insurer of its duty of good faith and fair dealing was the direct cause of the injury sustained by plaintiff.

*OKLA. UNIF. JURY INSTR. CIVIL* 22.2 (1993).
elements of the contract claim against the insurer. The burden thereafter shifts to the insurer to demonstrate that it had a legitimate or reasonable basis for its denial or dispute of the claim.\footnote{118}

While the test for good faith varies from jurisdiction to jurisdiction, courts throughout the country have always incorporated some form of the reasonableness standard. For example, in a number of jurisdictions a two-part test, referred to as the "fairly debatable" test, is used to determine bad faith.\footnote{119} Under this test, insureds must prove that: (1) the insurer's conduct was unreasonable; and (2) the insurer intentionally denied a claim, or delayed payment of a claim that it knew to be valid, or showed a reckless disregard of the fact that a valid claim had been submitted.\footnote{120}

In examining the reasonableness of the insurer's conduct, courts are determining whether a reasonable insurer, under the facts and circumstances of the particular case, would have denied or delayed payment of the claim. In those jurisdictions that adhere to the two-part test, the insured has the burden of proving the absence of a legitimate, arguable or debatable reason for the denial or delay as part of its \textit{prima facie case}.\footnote{121} In contrast, Oklahoma law does not place the burden on the insured to prove the absence of a legitimate, arguable or fairly debatable reason for denial or delay.\footnote{122} Rather, the existence of a legitimate reason is treated as a defense which must be proven by the insurer.

\textit{a. The Dutton Rule}

Although Oklahoma is among those jurisdictions that have either expressly or impliedly adopted the rule that an insurer may deny a claim without incurring liability if the denial was based on a legitimate

\footnote{120} \textit{Travelers}, 706 P.2d at 1272.
\footnote{121} National Sec. Fire and Casualty Co. v. Bowen, 417 So. 2d 179, 183 (Ala. 1982).
\footnote{122} See \textit{Manis}, 681 P.2d at 762. The court stated that "plaintiff failed to meet his burden of proof." \textit{Id}. This statement examined in context suggests that the plaintiff, by proving unreasonable, automatically disproves the reasonableness of the insurer's decision or conduct. However, this might not always be the case because plaintiff in satisfying his burden will use only such evidence as supports his positions. Consequently, it is left to the defendant to present such evidence as might demonstrate the reasonableness of his decision or conduct. \textit{Skok, supra} note 24, at §§ 7.14-15.
or reasonable basis (i.e. in good faith). Oklahoma has not addressed the specific issue of whether an insurer that produces sufficient evidence to create a jury issue on the question of coverage is entitled to a dismissal or directed verdict on the bad faith claim. Numerous jurisdictions have adopted the view that under such circumstances a legitimate, arguable or fairly debatable reason exists; therefore, the bad faith claim should be dismissed despite the fact that the jury may ultimately find for the insured on the coverage issue because "[w]here a claim is fairly debatable, the insurer is entitled to debate it and there is no bad faith on its part in doing so." In jurisdictions that have adopted this view, the insurer's production of sufficient evidence to create a jury issue constitutes good faith as a matter of law. A finding of good faith as a matter of law, during either the pretrial or trial phase, entitles the insurance company to be granted a motion for summary judgment or directed verdict, respectively.

The maxim "good faith as a matter of law" has been traced to the case of National Savings Life Insurance Co. v. Dutton. In Dutton, the Alabama Supreme Court established the standard to be used in determining whether the insurer had a reasonably debatable reason for denying the claim. This standard dictates that where the evidence produced by either side "creates a fact issue with regard to the validity of the claim and thus, the legitimacy of the denial thereof, the [bad faith] claim must fail." Thus, in jurisdictions adhering to the Dutton rule a bad faith claim should not be successful unless reasonable minds could not differ as to the insured's right to receive the policy proceeds and the court is prepared to enter a directed verdict for the insured on the insurance contract claim. The Dutton rule places upon the insured an extremely heavy burden of proof. However, the rule is not absolute, and was not intended as an insurmountable barrier to bad faith claims.

123. Manis, 681 P.2d at 762.
128. Dutton, 419 So. 2d at 1362.
129. Morton, 486 So. 2d at 1268; Safeco, 435 So. 2d at 1224.
130. Jones, 507 So. 2d at 401.
The "directed verdict [for the insured] on the contract claim" component of the standard is "intended as an objective standard by which to measure plaintiff's compliance with his burden of proving that defendant's denial of payment was without any reasonable basis either in fact or law."131 The "directed verdict on the contract claim" standard has been adopted or used in thirty-six jurisdictions and expressly rejected in only three.132 Neither the Dutton rule nor the "directed verdict on the contract claim" standard is applied in Oklahoma to determine whether an insurer had a legitimate reason for his decision. Rather, the Oklahoma Supreme Court in Conti v. Republic Underwriters Insurance Co.,133 observed that:

If there is conflicting evidence as to the reasonableness of the insurer's actions from which different inferences may be drawn, "then what is reasonable is always a question to be determined by the trier of fact by a consideration of the circumstances in each case." This court does not attempt to weigh the evidence, but examines the record only to determine whether the evidence and permissible inferences drawn therefrom reasonably sustain the jury's verdict.134

The insurer's breach of the implied duty of good faith and fair dealing may result from any one or more of the following: (1) improper investigation; (2) failure to investigate, or inadequate investigation; (3) fraudulent, intrusive or harassing investigative methods; (4) deceptive practices; (5) intrusive practices; (6) failure to consider information submitted by the insured or insured's expert prior to decision; (7) failure to communicate grounds for denial; (8) failure to communicate to the insured the procedure for reconsideration of a decision to deny; and (9) unreasonable delay in payment or handling of claim.135 Any unreasonable conduct engaged in without legitimate reason will support a claim for bad faith.136 However, the specific conduct which gives rise to the breach of the implied duty of good faith and fair dealing is not in and of itself the duty owed. Rather, the conduct represents a specific characterization of the implied duty of good faith and fair dealing.137 The implied duty of good faith and fair

131. Safeco, 435 So. 2d at 1224-25.
132. See Houser, supra note 124, at 669 & app. at 674-77 (listing jurisdictions that have adopted or rejected this test).
133. 782 P.2d 1357 (Okla. 1989).
134. Id. at 1360-61 (quoting McCorkle v. Great Atlantic Ins. Co., 637 P.2d 583, 587 (Okla. 1981)).
135. Sherwood ET AL., supra note 23, at § 5.03.
137. Id.
dealing is the only duty the breach of which will support a claim for bad faith. The duty of good faith and fair dealing requires that an insurer treat each insured's interest at least as equal to its own.

B. Implied Statutory Causes of Action

1. General Rule of Statutory Causes of Action

A majority of jurisdictions, including Oklahoma, that have addressed the issue of whether to recognize implied statutory actions against first-party insurers, have responded in the negative. Commentators have postulated that the reasoning underlying this response is best expressed in the judicial treatment of one or more of the four traditional questions examined by courts in determining whether to create a private cause of action from an otherwise silent statute. These questions are:

1) Whether the plaintiff belongs to a class for whose particular benefit the statute was enacted;
2) Whether the legislature evidenced an intent either to confer or to deny a private cause of action in a civil case;
3) Whether implication of the cause of action would necessarily serve to further the statutory purpose and be consistent with the statutory scheme;
4) Whether the implied cause of action would intrude into the domain exclusively reserved for either the federal government or a state administrative agency.

2. Oklahoma Decisional Law

The Oklahoma Supreme Court first addressed the issue of an implied statutory cause of action in the context of the Unfair Claim Settlement Practices Act and subsequently revisited the issue in the context of the Claims Resolution Act. In *Walker v. Chouteau Lime Co.*, the Oklahoma Supreme Court addressed the issue of whether a private cause of action arose against an insurer who violated title 36

138. Id.
140. WALL, supra note 7, § 9.15, at 415.
141. Id.
142. Id. at 415-16.
143. OKLA. STAT. tit. 36, §§ 1221 - 1228 (1991) (renumbered as OKLA. STAT. tit. 36, §§ 1250.1 - .16 (Supp. 1994)).
144. OKLA. STAT. tit. 36, §§ 1251 - 1260 (1991) (renumbered as OKLA. STAT. tit. 36, §§ 1250.2 - .16 (Supp. 1994)).
section 1222 of the Unfair Claims Settlement Act. The court used a three-pronged test to determine whether an implied cause of action might arise from a state regulatory statute. Consideration was given to whether: (1) the plaintiff belongs to a class for whom the statute was enacted rather than the public at large, (2) the statute either explicitly or implicitly gives some indication of legislative intent to create or deny a private remedy, and (3) recognition of a private remedy would be inconsistent with the purpose of the legislation. Analysis of these considerations led the court in Chouteau to conclude that no implied cause of action arose from a violation of the Act.

In McWhirter v. Fire Insurance Exchange, the court addressed this issue in the context of the Claims Resolution Act. Therein, the court adopted the analysis used in Walker to support its negative response. Oklahoma has clearly aligned itself with the majority of jurisdictions in regards to the issue of whether a private cause of action arises from an insurers breach of a regulatory statute. In addition, Walker demonstrates that Oklahoma courts utilize the traditional analysis used in the majority of jurisdictions.

3. Oklahoma Express Statutory Law

The Oklahoma legislature has enacted a penalty for delay statute which provides a cause of action when an insurance company delays payment of a claim. This statute is limited to claims involving accident and health insurance. It treats the failure of an insurer to notify a policyholder, in writing, of the cause for delay in payment of a claim as an unfair trade practice. The required notification must be mailed, return receipt requested, within thirty days after receipt of the claim. Failure to provide the statutorily required notice constitutes prima facie evidence that the claim will be paid in accordance with the policy. Furthermore, when an accident and health insurance provider fails to pay a claim within sixty days after proof of loss the insured is entitled to recover the policy proceeds plus interest based on

147. Walker, 849 P.2d at 1086-87.
148. Id. at 1087. See also Gianfifippo v. Northland Casualty Co., 861 P.2d 308, 310 (Okla. 1993).
149. 878 P.2d 1056 (Okla. 1994).
150. Id. at 1057-58.
152. Id.
153. Id.
154. Id.
155. Id.
the rate of the average United States Treasury Bill, plus two percentage points.

The delay in payment statute also provides that in the event of litigation based upon such a claim, the prevailing party is entitled to a reasonable attorney's fee.\textsuperscript{156} The American Rule, which is followed in a substantial majority of jurisdictions including Oklahoma, states that in the absence of a contract or statute attorney's fees cannot be recovered by the prevailing party.\textsuperscript{157} The Oklahoma legislature has, however, declared that:

Upon a judgment rendered to either party, costs and attorney fees shall be allowable to the prevailing party. For purposes of this section, the prevailing party is the insurer in those cases where judgment does not exceed written offer of settlement. In all other judgments the insured shall be the prevailing party. If the insured is the prevailing party, the court in rendering judgment shall add interest on the verdict at the rate of fifteen percent (15\%) per year from the date the loss was payable pursuant to the provisions of the contract to the date of the verdict. This provision shall not apply to uninsured motorist coverage.\textsuperscript{158}

This provision has been judicially construed to mean that attorney's fees are recoverable in all actions involving insurance contracts unless specifically proscribed elsewhere.\textsuperscript{159}

C. Fraud

The intentional tort of fraud or misrepresentation may also be alleged in conjunction with a bad faith action for failure to pay a first-party claim. There are four types of fraud actions: (1) common law fraud, (2) constructive fraud, (3) post-application fraud, and (4) fraudulent breach of contract.

1. Common Law Fraud

The elements of a common-law action for fraud are: (1) a material misrepresentation, (2) that is knowingly or recklessly made, (3) with intent that it be relied upon, and (4) injury to the party relying

\textsuperscript{156} Sect. 1219(d). \textit{See also} Cox v. American Fidelity Assurance Co., 581 P.2d 1325, 1326 (Okla. Ct. App. 1978) (holding that prevailing party was entitled to reasonable attorney's fee).

\textsuperscript{157} Holbert v. Echeverria, 744 P.2d 960, 965 (Okla. 1987).


upon the false statement.\textsuperscript{160} The circumstances constituting fraud must be stated with particularity.\textsuperscript{161} This particularity requires specification of the time, place, and content of an alleged false representation, but not the circumstances or evidence from which a state of mind can be inferred.\textsuperscript{162}

An action based on fraud is especially difficult to satisfy because circumstantial evidence cannot be relied upon to create a presumption of fraud. Rather, proof of fraud must be made with clear and convincing evidence.\textsuperscript{163} Furthermore, an insured may not rely upon false statements the truth of which could have been ascertained with reasonable diligence.\textsuperscript{164} Another difficulty with fraud actions is that the fraudulent conduct complained of ordinarily takes place during the application phase of the process. Consequently, an insurer’s post-claim conduct is typically not relevant.

2. Constructive Fraud

In addition to recognizing common law fraud, Oklahoma also recognizes a related doctrine known as constructive fraud. Unlike actual fraud, constructive fraud does not require an intent to deceive.\textsuperscript{165} Constructive fraud consists of:

1) In any breach of duty which, without an actually fraudulent intent, gains an advantage to the person in fault, or any one claiming under him, by misleading another to his prejudice, or to the prejudice of any one claiming under him; or,
2) In any act or omission as the law specially declares to be fraudulent, without respect to actual fraud.\textsuperscript{166}

In the insurance context, constructive fraud is ordinarily applied where the agent of the insurer and the insured mutually understood

\textsuperscript{160} Dawson v. Tindell, 733 P.2d 407, 408 (Okla. 1987); D&H Co. v. Shultz, 579 P.2d 821, 824 (Okla. 1978); Ramsey v. Fowler, 308 P.2d 654, 656 (Okla. 1957); Wingate v. Render, 160 P. 614, 617 (Okla. 1916).

\textsuperscript{161} \textsc{Okla. Stat.} tit 12, § 2009(B) (1991).

\textsuperscript{162} § 2009 (B), (F); Gay v. Akin, 766 P.2d 985, 990 (Okla. 1988).

\textsuperscript{163} See, e.g., Tice v. Tice, 672 P.2d 1168, 1171 (Okla. 1983); Barriner v. Stedman, 580 P.2d 514, 516 (Okla. 1978); Skelly Oil Co. v. Corporation Comm’n, 82 P.2d 1009, 1010 (Okla. 1938).


\textsuperscript{166} \textsc{Okla. Stat.} tit. 15, § 59 (1991).
the specific nature, object, or purpose for which the insured sought coverage.\textsuperscript{167} The state of mind required for constructive fraud will not support a punitive damages award. Nevertheless, the insured may recover actual and consequential damages, plus attorney’s fees.\textsuperscript{168} Additionally, the insured in a constructive fraud case may also have the policy reformed to include the initially agreed upon coverage.\textsuperscript{169}

3. Post-Application Fraud

The Oklahoma Supreme Court has not addressed the issue of whether fraud is a viable theory for post-application conduct on the part of an insurer. Such a case might arise where the insurer’s agent, after a loss has occurred but prior to filing the claim, communicates to the insured an improper procedure for filing the claim.\textsuperscript{170} For example, where the agent informs the insured that no proof of loss statement is necessary to recover on the policy or that the insured need take no further action to protect its rights to the proceeds under the policy. Insured follows the agent’s suggestions to its detriment, and the insurer subsequently denies coverage because of the insured’s failure to adhere to conditions precedent set out in the policy. Whether such conduct constitutes fraud depends upon the state of mind of the agent at the time the statements were made. If the agent negligently or innocently misleads the insured, constructive fraud, rather than actual fraud, would be the appropriate cause of action.

4. Fraudulent Breach of Contract

The Supreme Court of South Carolina developed a novel approach to fraud in Welborn v. Dixon.\textsuperscript{171} Therein, the court recognized that an award of exemplary damages was proper in an action arising out of breach of contract accompanied by a fraudulent act.\textsuperscript{172} This action is commonly referred to as fraudulent breach of contract and has been applied by South Carolina courts to breaches of insurance contracts.\textsuperscript{173} An action for fraudulent breach of contract requires

\begin{itemize}
\item See, e.g., Ohio Casualty Ins. Co. v. Callaway, 134 F.2d 788, 709-91 (10th Cir. 1943);
\item Gentry, 867 F.2d at 474.
\item Id. at 472.
\item 49 S.E. 232 (S.C. 1904).
\item Id. at 234.
\end{itemize}
proof that the breach of contract was committed with fraudulent intent and accompanied by a fraudulent act.\(^{174}\) This action differs from an ordinary common law fraud action based on false statements in that punitive damages have been awarded even though the conduct complained of occurred after the issuance of the policy.\(^{175}\)

It is unlikely that the Supreme Court of Oklahoma would entertain an action for fraudulent breach of contract because Oklahoma law has long recognized that punitive damages are not recoverable in a breach of contract action unless the breach of contract constitutes an independent tort.\(^{176}\) Under this rule, the award of exemplary damages is grounded in the tort action and not the breach of contract. Furthermore, fraudulent breach of contract adds nothing to the law not already provided by tort actions for actual and constructive fraud.

D. **Intentional Infliction of Emotional Distress**

1. Determination of Intentional Infliction of Emotional Distress

Recovery of damages for mental and emotional distress outside the scope of some traditionally recognized torts such as assault, battery and false imprisonment is relatively new.\(^{177}\) Generally states that have adopted the new tort of intentional infliction of emotional distress have followed the Restatement (Second) of Torts Section 46.\(^{178}\) This section sets forth the elements of the tort as follows: "[o]ne who by extreme and outrageous conduct intentionally or recklessly causes severe emotional distress to another is subject to liability for such emotional distress, and if bodily harm to the other results from it, for such bodily harm."\(^{179}\) Thus, the right to recover damages for mental and emotional injury is no longer dependent upon there having been a physical injury to the plaintiff.\(^{180}\)

Damages for mental or emotional injury may be recovered parasitically as an element of the bad faith claim, or in a separate independent tort action.\(^{181}\) Where emotional distress is asserted as an

\(^{174}\) Id. at 59.


\(^{178}\) See Dean v. Chapman, 556 P.2d 257, 261 (Okla. 1976).

\(^{179}\) RESTATEMENT (SECOND) OF TORTS § 46 (1965).

\(^{180}\) See Dean, 556 P.2d at 261.

\(^{181}\) KEETON ET. AL., supra note 30, § 12, at 57.
element of damages it is unnecessary to prove that the insurer's conduct was extreme and outrageous. 182 Otherwise, liability for intentional infliction of emotional distress can be "found only where the conduct has been so outrageous in character and so extreme in degree as to go beyond all possible bounds of decency." 183

Whether the conduct was extreme and outrageous is initially a question of law for the court to determine. 184 If reasonable minds might differ on whether the conduct was extreme and outrageous, the issue becomes a question of fact for the jury to resolve. 185 Following an affirmative finding that the conduct was extreme and outrageous, the jury has to determine whether severe emotional distress exists. 186 The severity of the emotional distress is not only relevant to the amount of recovery but is also a necessary element to any recovery. 187

The relationship between the parties is important in determining whether liability should be imposed for emotional distress. 188 Furthermore, the common law places upon public utilities, and other enterprises that affect the public interest, a special duty to refrain from interfering with the emotional tranquility of a consumer. 189 Liability for breach of this limited duty exists even in the absence of outrageous conduct. 190

2. Intentional Infliction of Emotional Distress Applied to Insurance Contracts

Fletcher v. Western National Life Insurance Co. 191 is one of the leading intentional infliction of emotional distress cases arising in the insurance context. This is due largely to the fact that the insured in Fletcher asserted intentional infliction of emotional distress as the sole theory of recovery. In Fletcher, Western National wrongfully refused

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183. Restatement (Second) of Torts § 46 cmt. d (1965).
185. Eddy, 715 P.2d at 76; Restatement (Second) of Torts § 46 cmts. h & j (1965).
187. Restatement (Second) of Torts §§ 46 cmt. j (1965).
188. Id. at cmt. d; id. at § 48; Keeton et. al., supra note 30, § 12, at 58.
189. Restatement (Second) of Torts § 48 (1965).
190. Id.
to pay the insured approximately $50,000 due under a disability insurance policy by contending intermittently that the disability resulted from a preexisting injury which plaintiff misrepresented in the application for insurance, or that plaintiff's injury was the result of a sickness for which only two years of benefits were provided, rather than an injury for which up to thirty years was provided. 192 The court in Fletcher noted that the plaintiff, in order to recover for emotional distress, had to prove that the defendant's conduct was outrageous 193 and that plaintiff suffered "severe" emotional distress. The court defined severe emotional distress as distress that is "of such substantial quantity or enduring quality that no reasonable man in a civilized society should be expected to endure it." 194 Additionally, the court considered the intensity and duration of the distress in determining severity. 195

Western National acknowledged the outrageousness of its conduct; 196 in doing so, it probably considered the evidence that it had actual knowledge of (1) the cause of plaintiff's injury, (2) the extent of plaintiff's injury, (3) the uniformity of the numerous medical conclusions that insured was disabled as a result the injury, and (4) conduct of its claim supervisor in attempting to minimize or avoid paying the plaintiff. 197 As a result of the claim supervisor's wrongful refusal to pay, the plaintiff's family was forced to do without food and clothing. 198 The insured was unable to make his house payments and was forced to pay late charges and delinquency fees. 199 In addition, insured lost a real estate investment as a result of his inability to make payments on the property. 200 His utilities were disconnected at various times. 201 Finally, the plaintiff's wife had to return to work and his daughter was required to stay out of school to care for the plaintiff. 202 All these facts were known by Western National which continued, over a period of nearly five years, to attempt to force plaintiff to forego the proceeds under the policy. 203 One can infer, from the

192. Id. at 80-81.
193. Id.
194. Id. at 90.
195. Id.
196. Id. at 88-89.
197. Id. at 88.
198. Id.
199. Id.
200. Id.
201. Id.
202. Id.
203. Id.
court’s acknowledgment of defendant’s admission, 204 that a court actually faced with a determination of whether such conduct was outrageous would probably answer in the affirmative.

The fact patterns of cases in which plaintiffs have successfully recovered damages for emotional distress in first-party insurance cases are strikingly similar. These patterns uniformly involve a wrongful denial of policy proceeds which causes the insured to suffer a combination of severe economic consequences such as going without food, clothing, shelter or necessary medical attention. 205 In addition, the existence of specific knowledge on the part of the insurer with regards to the impecunious conditions of its insured, and the tenuousness of its reason for denying the proceeds combined with bullying conduct operate to elevate the insurer’s conduct to the level of outrageousness necessary to justify an award for emotional distress. 206

Although intentional infliction of emotional distress provides a theoretical foundation for recovery in tort for breach of an insurance contract, it is not an ideal remedy for such practices. This is due mainly to the fact that liability for emotional distress “does not extend to mere insults, indignities, threats, annoyances, petty oppressions, or trivialities. . . . [P]laintiffs must necessarily be expected and required to be hardened to a certain amount of rough language, and to occasional acts that are definitely inconsiderate and unkind.” 207 The difficulty of proving outrageousness and severity substantially lessens the appeal of an emotional distress action as an extracontractual remedy for breach of an insurance contract.

E. Tortious Interference With Property

The court in Fletcher v. Western National Life Insurance Co. noted that:

[I]ndependent of the tort of intentional infliction of emotional distress, such conduct on the part of a disability insurer constitutes a tortious interference with a protected property interest of its insured for which damages may be recovered to compensate for all detriment proximately resulting therefrom, including economic loss

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204 Id. at 89.
206 Fletcher, 89 Cal. Rptr. at 93-94.
as well as emotional distress resulting from the conduct or from the economic losses caused by the conduct, and, in a proper case, punitive damages.\textsuperscript{208}

Under the theory of tortious interference with property, neither proof that the conduct of the insurer was outrageous nor that severe emotional distress resulted is required to recover damages for emotional distress.\textsuperscript{209} Likewise, other elements of damages such as economic loss are recoverable.\textsuperscript{210}

Tortious interference with property is analogous to the action for conversion.\textsuperscript{211} Conversion is concerned with substantial interference with property or with an individual's rights therein.\textsuperscript{212} In determining the seriousness of the interference and whether liability should be imposed on the defendant, consideration of "the extent and duration of the defendant's exercise of control over the chattel; his intent to assert a right which is in fact inconsistent with the plaintiff's right of control; the defendant's good faith or bad intentions; the extent and duration of the resulting interference with the plaintiff's right of control; the harm done to the chattel; and the expense and inconvenience caused to the plaintiff."\textsuperscript{213} Originally intangible rights could not be converted; however, this rule has been relaxed and rights themselves may be converted even in the absence of the conversion of something tangible.\textsuperscript{214}

Conversion occurs only when the defendant intentionally affects plaintiff's property or rights therein. This level of culpability does not necessarily require conscious wrongdoing.\textsuperscript{215} Instead, intent to exercise dominion or control over the property that substantially interferes with plaintiff's right therein is enough to satisfy the culpability requirement.\textsuperscript{216} In the insurance context the insured's claim is based on wrongfully withholding possession of the policy proceeds. In order to prevail on this theory the insured must show that a demand was made and he is entitled to the proceeds.\textsuperscript{217}

\textsuperscript{208} Fletcher, 89 Cal. Rptr. at 93-94.
\textsuperscript{210} Fletcher, 89 Cal. Rptr. at 93.
\textsuperscript{212} Keeton et al., supra note 30, § 15, at 90.
\textsuperscript{213} Id.
\textsuperscript{214} Id. at 91.
\textsuperscript{215} Id. at 92.
\textsuperscript{216} Id.
\textsuperscript{217} Id. at 99.
Tortious interference with a protected property interest has received scant judicial attention in the insurance context. This is probably due to the fact that this action "has apparently not been used extensively in subsequent cases." Rather, the preferred extracontractual remedy for improper insurance claims practices seems to be breach of the implied duty of good faith and fair dealing.

V. Conclusion

Conduct which once constituted a breach of contract may now be classified as a tort as well. The corresponding right to compensatory and punitive damages for breach of an insurance contract is simply the method used to achieve the objectives of fully compensating the insured and deterring insurers from willfully failing, without proper cause, to settle claims with their insureds. Determining whether a case is one for extracontractual remedies is really a matter of common sense; this determination can be made by merely ascertaining whether the insured has been treated fairly and reasonably. If not, an action for compensatory damages would probably be proper. Punitive damages, however, are another matter. The insurer's conduct, in order to justify a punitive award, must have been egregious. This does not, however, require the conduct to have been outrageous in the literal sense of the word.

Three levels of proof can be identified in every bad faith case. There are also three distinct measures of damages, each corresponding to the specific level of proof placed into evidence. The first level pertains to breach of contract actions. An erroneous denial of benefits alone entitles the insured to the policy proceeds plus interest. The second level of proof requires evidence of bad faith. An unreasonable, improper denial of benefits constitutes a breach of the duty of good faith and fair dealing for which consequential damages are recoverable. The third level of proof requires evidence of wanton, gross, malicious, or reckless conduct on the part of the insurer. It is only evidence of this nature that will support a punitive award.

The actions of agents and company employees can bind an insurance company for purposes of contract and compensatory awards.

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218. See Gruenberg v. Aetna Ins. Co., 510 P.2d 1032, 1041 (Cal. 1973); Christian v. American Home Assurance Co., 577 P.2d 899, 902 (Okla. 1977); KEETON ET AL., supra note 30, § 15, at 99. This cause of action is uniformly recognized in jurisdictions which follow Gruenberg, however, no court has elaborated on the prima facie requirements of tortious interference with a protected property interest. Rather, most courts cite to Fletcher for legal support of the tort.

219. SHERNOFF ET AL., supra note 23, § 1.06, at 1-29.
The same conclusion is true with regards to punitive damages. The legal malice of an agent or employee is treated, in Oklahoma, as the legal malice of the corporation.\(^{220}\) This rule has not, however, been applied to insurance companies. In contrast, California adheres to the view that a corporation is not responsible for punitive damages because of the actions of its employees or agents unless:

(a) the principal authorized the doing and the manner of the act; (b) the agent was unfit and the principal was reckless in employing him; (c) the agent was employed in a managerial capacity and was acting in the scope of employment, or (d) the principal or managerial agent of the [corporation] ratified or approved the act.\(^{221}\)

Under this approach it is necessary to establish ratification or to demonstrate that the employee or agent possessed sufficient managerial authority to bind the insurance company. This determination:

[D]oes not necessarily hinge on their “level” in the corporate hierarchy. Rather, the critical inquiry is the degree of discretion the employees possess in making decisions that will ultimately determine corporate policy. When employees dispose of insureds' claims with little if any supervision, they possess sufficient discretion for the law to impute their actions concerning those claims to the corporation.\(^{222}\)

The availability of punitive damages in extracontractual actions has given extracontractual remedies bite. It is this aspect of extracontractual remedies which is revolutionary. “Insurers view this development [the availability of punitive awards] as if it were some sort of plague. Insureds see it as an ‘equalizing club’ with which to battle the insurance carrier which is supposed to be the insured’s benefactor but is too often his antagonist.”\(^ {223}\)

Oklahoma’s law of bad faith is quite liberal and overwhelmingly favors the insured. However, in most instances insurance companies can avoid liability for bad faith by diligently training claims personnel and establishing and enforcing uniform procedures for handling claims. These procedures should prescribe the manner in which every ...
claim is to be handled.224 Adherence to a uniform procedure, however, does not necessarily guarantee that fewer bad faith actions will be filed. Rather, the procedures may merely lessen the likelihood of success at trial. Uniform procedures may encourage the filing of a lawsuit in which the plaintiff's counsel engages in vigorous discovery to demonstrate that: (1) company personnel did not follow the prescribed procedure at all times in handling the claim in issue, or (2) the claim should have been handled in another manner because of unique

224. It has been suggested that the procedure for handling claims include the following rules of conduct:

1. Investigate every claim promptly, carefully, and with an open mind. Do not hesitate to employ outside investigators and other experts where such expertise is needed.
2. To avoid delay, efforts to determine the amount of loss should proceed simultaneously with the liability investigation.
3. Adjusters and claim representatives should be instructed to, at all times, treat the insured with courtesy.
4. Adjusters' and investigators' reports, and all internal company memoranda relating to the claim, should stick to the facts, be precise as to the sources of any opinions and conclusions, and be void of any derogatory comments about the insured.
5. Make certain that, before any decision is made to deny liability, the results of the investigation have been carefully and objectively reviewed by a claims supervisor.
6. Particularly in complex matters, such as those involving potential arson and fraud defenses or novel questions of policy interpretation, the file should be reviewed by outside legal counsel before liability is denied. (Remember also: In many jurisdictions acting on advice of counsel negates the existence of malice.)
7. Respond in writing to all letters from the insured and his counsel.
8. All communications from the insured should be responded to promptly, and all communications to the insured should be courteous in tone. If you are waiting for a report or evaluation from outside counsel or other expert, so advise the insured.
9. Whenever you write to an insured (or his attorney), consider how the letter would sound if some day read to a jury.
10. If an insured asks for blank proof-of-loss or claim forms, send them; if the insured asks for an extension of time in which to file proof of loss or submit other information that has been requested, grant the request; if an insured asks for a copy of any statements given to the adjuster, or for a copy of the transcript given of his examination, or independent medical examination, provide it.
11. All request to the insured for additional information should, whenever possible, be in writing, and the insured should be given every opportunity to comply with such requests.
12. Avoid telling insured that he will be hearing from you in a specified time, unless you are absolutely certain that you will be able to comply with such a commitment.
13. Don't make any "low ball" settlement offers. When the issue is solely amount, offer the full sum that you believe to be owing under the policy.
14. If a decision is made to deny liability, be prompt in so advising the insured. Do not keep such a decision secret while insisting that the insured furnish additional data and submit to examination.
15. Explain to insured the reasons for denial . . .
16. If the only matter in dispute is the amount which the insured is entitled to recover under the policy, be willing to make payment to the insured of the amount not in dispute.
17. If the insured is caught in a controversy between two or more insurers as to the amount owed by each, make a diligent effort to work out an arrangement whereby the amount of the loss is paid to the insured, with the companies reserving the right to resolve their dispute by arbitration or litigation.

McCarthy, supra note 1, at 89-90.
circumstances, or (3) this claim would not have been handled the same way again by the defendant insurance company or another insurance company under similar circumstances, or (4) there was additional information which was readily available that the company did not have at the time it made its decision to deny. Despite their shortcomings, uniform handling procedures combined with strict company policies that limit the authority of the claim representatives to unilaterally deny benefits should provide insurance companies with an added level of protection.