A bill to amend 1956 PA 218, entitled "The insurance code of 1956,"
(MCL 500.100 to 500.8302) by adding chapter 30B.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

CHAPTER 30B

INSURANCE POLICYHOLDER BILL OF RIGHTS

Sec. 3071. This chapter applies to an insurance policy or contract other than a health insurance policy issued by an authorized or unauthorized insurer. This chapter is not exclusive, and other acts not specified in this chapter may also be considered to be a violation of this chapter. This chapter does not relieve an
insurer from its duties and responsibilities contained in other
provisions of this act or in case law. The duties and
responsibilities of an insurer under this chapter are cumulative to
preexisting duties and responsibilities.
Sec. 3072. As used in this chapter:
(a) "Agent" means a person authorized to represent an insurer
with respect to a claim.
(b) "Automobile insurance" means that term as defined in
section 2102.
(c) "Bad-faith failure to settle" means an insurer's failure
to settle a claim when, considering all of the circumstances, the
insurer could and should have done so had it acted fairly and
reasonably toward its insured and with due regard for the insured's
interests.
(d) "Claimant" means a first-party claimant, a third-party
claimant, or both, and includes the claimant's designated legal
representative and a member of the claimant's immediate family
designated by the claimant. Claimant includes an insured if the
insured is making a first-party claim or otherwise asserting a
right to payment under the insured's insurance policy or insurance
contract.
(e) "First-party claimant" means a person asserting a right to
payment under an insurance policy or insurance contract, or from a
person that has obtained permission from a regulatory agency to be
self-insured, arising out of the occurrence of a contingency of
loss covered by the policy or contract.
(f) "Insurance policy" or "insurance contract" means a
contract of insurance, indemnity, suretyship, or annuity issued or
proposed or intended for issuance by a person engaged in the
business of insurance.

(g) "Investigation" means all activities of an insurer directly or indirectly related to the determination of insurance coverage and determination of liability under coverages afforded by an insurance policy or insurance contract.

(h) "Third-party claimant" means a person asserting a claim against a person that is insured under an insurance policy or insurance contract.

Sec. 3073. After a claim is made under an insurance policy issued by an authorized or unauthorized insurer, the claimant is entitled to have the claim handled in accordance with this chapter.

Sec. 3074. (1) An insurer shall exercise good faith and fair dealing in the investigation, adjustment, evaluation, and payment of a claim to which this chapter applies.

(2) An insurer shall not do any of the following:

(a) Delay payment of a claim, deny payment of a claim, or fail to pay a claim, unless there is a reasonable basis for and support in a provision of the policy for the action.

(b) Set out with specificity the factual and legal basis for the action in writing and provide the writing to the claimant not later than 7 days after the action.

(c) After a civil action has been filed regarding the action, change the factual or legal basis for the action.

(d) Abuse its relationship with an insured or use an economic advantage that puts the insurer in a position of actual or apparent authority over the insured or gives the insurer power to affect the insured's interests.

(3) An insurer shall give at least equal consideration to the interests of the policyholder and claimant as it does to its own
interests in all aspects of investigating, adjusting, evaluating, and paying a claim.

(4) An insurer shall establish and maintain reasonable written standards for the prompt investigation, adjustment, evaluation, and payment of claims.

(5) An insurer shall investigate and evaluate a claim and the materials and evidence related to the claim in an objective manner.

(6) An insurer shall give all reasonable benefit of the doubt to the claimant in the investigation and evaluation of a claim.

(7) An ambiguity in an insurance contract or policy must be construed in favor of the insured.

Sec. 3075. (1) An insurer shall provide to a claimant a copy of all applications for insurance, policies of insurance including all endorsements and declarations, and all underwriting files applicable to the policies of insurance on request of the claimant not later than 7 days after the date of the request.

(2) An insurer shall provide to a claimant a copy of all statements made by the claimant, whether written, recorded, or in electronic format, not later than 7 days after a request by the claimant.

(3) An insurer shall provide prompt updates on the status of a claim not later than 7 days after a request by the claimant. An insurer shall provide, without a request from the claimant, written status updates to the claimant every 30 days advising of all of the following:

(a) The status of the claim.

(b) What additional information, if any, is necessary for the insurer to make a claims decision.

(c) When a claims decision can reasonably be expected to be
made.

(4) An insurer shall not deny or forfeit a claim for failure
to comply with a policy condition unless the insurer first provides
the claimant with written notice that a policy condition has not
been met and provides the claimant a reasonable period of time, not
less than 30 days, to cure the defect in satisfying the condition.

(5) An insurer shall provide reasonable notice for any
examinations under oath taken on a claim and permit attendance of
the claimant's attorney at all examinations under oath.

(6) An insurer shall provide a claimant transcripts of all
examinations under oath taken on a claim at any time during the
pendency of the claim. An insurer shall not interfere with the
claimant's efforts to obtain, or prohibit the claimant from
obtaining, at the claimant's expense, a transcript of the testimony
at the examination under oath from the court reporter or other
person who recorded the testimony. An insurer shall not instruct
any court reporter or other person to withhold the transcript from
the claimant if the claimant pays the court reporter's fee for a
copy of the transcript.

(7) An insurer shall provide the claimant all documentation
relating to the examination of any scene, artifact, or item not
later than 7 days after receiving a request for this information
from the claimant, if the examination occurred without the claimant
or a representative of the claimant being present at the time of
the examination.

(8) An insurer or the insurer's agent, employee, or
representative shall not make a statement to a claimant, either
directly or indirectly, suggesting or implying that the claimant
should, or encouraging the claimant to, not retain, or terminate a
contract for services with, legal counsel or other claims
professionals, including, but not limited to, public adjusters.

(9) An insurer shall not refuse to grant a request by a
claimant for an extension of time to provide information or
documents or to meet policy conditions, terms, or requirements,
unless the extension of time will result in actual material
prejudice to the insurer.

(10) An insurer shall pay a claimant's additional living
expenses under a fire policy and pay business interruption and
extra expenses under a commercial or business policy during the
investigation of a claim under the policy. If an insurer denies a
claim of a policy described in this subsection, the insurer shall
not terminate the payments described in this subsection before 14
days after the insurer notified the claimant of the denial. If an
insurance policy described in this subsection limits coverage based
on the amount of time that has elapsed after the date of the loss,
the time limit must be tolled until after the insurer has granted
the claim for property damage and paid the actual cash value of the
property damage. [Do you want the preceding sentence to also apply
to coverage of "extra expenses"?]

(11) If an insurer issues a fire insurance that provides the
replacement cost of damaged property as provided in section 2826 or
2827 or for the replacement cost of personal property, the insurer
shall provide the claimant a reasonable period of time after
payment of the actual cash value of the property without regard to
a time limit set forth in the [fire?] insurance policy for the
repair and replacement of the property.

Sec. 3076. (1) An insurer or an adjuster, agent, or other
representative of an insurer shall not misrepresent pertinent facts
or fail to fully disclose to a first-party claimant all pertinent
benefits, coverages, coverage limits, or other provisions of an
insurance policy or insurance contract under which the claim is
presented, regardless of the relationship of the claimant to the
policyholder.

(2) An insurer shall act in good faith to effectuate a prompt,
fair, and equitable settlement of a claim in which liability has
become reasonably clear.

(3) An insurer shall not deny a claim without conducting a
reasonable investigation based on all available information and
after conducting an objective evaluation of the available
information giving the benefit of any doubts and resolving any
disputes in favor of coverage.

(4) An insurer shall not deny a claim for failure to provide
written notice of loss or proof of loss within a specified time
limit unless the failure to comply with the time limit materially
prejudices the insurer's rights and unless the insurer has
specified ahead of time the reasonable materials that constitute
proof of loss and has provided adequate time to provide proof.

(5) An insurer shall not request that a first-party claimant
sign a release that extends beyond the subject matter that gave
rise to the claim payment unless specifically negotiated by the
claimant.

(6) An insurer shall not, in partial settlement of a loss or
claim under a specific coverage, issue a check or draft that
contains language that releases the insurer from its total
liability, liability for additional damages, or liability under
other coverages.

Sec. 3077. An insurer's investigation and claim files must be
deemed to be prepared in the ordinary course of business and are subject to production to a claimant after a claim has been denied. The files must contain all notes and documents pertaining to the investigation, adjustment, and denial of the claim regardless of an insurer's designation of what constitutes a claim file, and in such detail that pertinent events and the dates of the events can be reconstructed.

Sec. 3078. (1) This section applies in an action against an insurer for bad-faith failure to settle a third-party claim, whether under statute or common law.

(2) In handling a claim, an insurer has a nondelegable duty to its insured and a claimant to handle the claim in good faith by complying with subsection (3).

(3) In addition to the standards in sections 3073 to 3077, once an insurer receives actual notice of an event or loss that could give rise to a covered liability claim, and continuing until the conclusion of the insurer's duty to defend, the insurer must do all the following:

(a) Assign an insurance adjuster to investigate the claim and resolve any questions concerning the existence or extent of the insured's coverage.

(b) Advise the insured or claimant of any additional relevant information that is necessary for the evaluation of whether to settle a claim within the applicable policy limits.

(c) Exercise due diligence and good faith in advising the insured of any cooperation required to settle the claim, the purpose of the required cooperation, and the consequences of refusing to cooperate, and confirming that advice in writing to the insured.
(d) Provide reasonable assistance to the insured or the
insured's representative to comply with the insured's obligations
to cooperate and to satisfy any conditions to payment of a
claimant's settlement offer.
(e) On request, provide all communications related to a claim
against the insured or the insured's representative.
(f) Communicate all of the following to an insured or the
insured's representative:
   (i) The identity of any other person that the insurer has
       reason to believe may be liable.
   (ii) The insurer's evaluation of the claim.
   (iii) The likelihood and possible extent of an excess judgment.
   (iv) Steps the insured can take to avoid exposure to an excess
       judgment.
   (v) Any settlement offers, and anything required of the
       insured to accept a settlement offer.
   (vi) The basis for the insurer's rejection or nonacceptance of
       any settlement offer.
(g) Take all reasonable and available actions to avoid or
minimize excess exposure to the insured. The insurer shall give
fair consideration to any settlement offer that is not unreasonable
under the facts and accept it, if possible, if a reasonably prudent
person, faced with the prospect of paying the total recovery, would
do so.

(4) A claim for bad-faith failure to settle a claim or action
may be brought by the insured, a judgment creditor of the insured,
or an assignee of the insured, including, but not limited to, a
bankruptcy trustee, personal representative, heir, survivor,
receiver, or other successor in interest including the party
injured by the insured. If an insurer fails to make an offer within
the policy limits when liability is reasonably clear and it is
reasonably clear that damages may exceed the policy limits, the
insurer's liability is not limited to the policy limits.
Sec. 3079. (1) A person damaged by an insurer's violation of
this chapter or section 2026(1) may maintain an action against the
insurer and may recover all of the following damages:
(a) The unpaid benefits under the policy.
(b) Monetary loss or damage to credit reputation experienced
and reasonably probable to be experienced in the future.
(c) Emotional distress, humiliation, and anxiety experienced
and reasonably probable to be experienced in the future.
(d) Penalty interest of 12% per annum on all first-party
claims that have not been paid within 60 days after the insurer
receives proof of the amount of the claim.
(e) Exemplary damages.
(f) Punitive damages.
(g) A reasonable attorney fee based on whichever of the
following is greater:
(i) The amount of time expended by the attorney at a reasonable
hourly rate.
(ii) A contingent fee representing 33-1/3% of the amount paid
or owed by the insurer.
(h) The legal costs incurred, including expert fees and other
expenses incurred in pursuing payments owed by the insurer.
(2) If a person that is entitled to recover under subsection
(1)(d), (g), or (h) is also entitled to recover interest, an
attorney fee, or legal costs under another statutory provision,
including, but not limited to, a provision of this act, because of
the insurer's misconduct as described in subsection (1), the insurer shall pay to the person only whichever of the interest, attorney fee, or legal costs amount is larger.