RCW 48.30.015
Unreasonable denial of a claim for coverage or payment of benefits.

(1) Any first party claimant to a policy of insurance who is unreasonably denied a claim for coverage or payment of benefits by an insurer may bring an action in the superior court of this state to recover the actual damages sustained, together with the costs of the action, including reasonable attorneys' fees and litigation costs, as set forth in subsection (3) of this section.

(2) The superior court may, after finding that an insurer has acted unreasonably in denying a claim for coverage or payment of benefits or has violated a rule in subsection (5) of this section, increase the total award of damages to an amount not to exceed three times the actual damages.

(3) The superior court shall, after a finding of unreasonable denial of a claim for coverage or payment of benefits, or after a finding of a violation of a rule in subsection (5) of this section, award reasonable attorneys' fees and actual and statutory litigation costs, including expert witness fees, to the first party claimant of an insurance contract who is the prevailing party in such an action.

(4) "First party claimant" means an individual, corporation, association, partnership, or other legal entity asserting a right to payment as a covered person under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such a policy or contract.

(5) A violation of any of the following is a violation for the purposes of subsections (2) and (3) of this section:

(a) WAC 284-30-330, captioned "specific unfair claims settlement practices defined";

(b) WAC 284-30-350, captioned "misrepresentation of policy provisions";

(c) WAC 284-30-360, captioned "failure to acknowledge pertinent communications";

(d) WAC 284-30-370, captioned "standards for prompt investigation of claims";

(e) WAC 284-30-380, captioned "standards for prompt, fair and equitable settlements applicable to all insurers"; or

(f) An unfair claims settlement practice rule adopted under RCW 48.30.010 by the insurance commissioner intending to implement this section. The rule must be codified in chapter 284-30 of the Washington Administrative Code.

(6) This section does not limit a court's existing ability to make any other determination regarding an action for an unfair or deceptive practice of an insurer or provide for any other remedy that is available at law.

(7) This section does not apply to a health plan offered by a health carrier. "Health plan" has the same meaning as in RCW 48.43.005. "Health carrier" has the same meaning as in RCW 48.43.005.

(8)(a) Twenty days prior to filing an action based on this section, a first party claimant must provide written notice of the basis for the cause of action to the insurer and office of the insurance commissioner. Notice may be provided by regular mail, registered mail, or certified mail with return receipt requested. Proof of notice by mail may be made in the same manner as prescribed by court rule or statute for proof of service by mail. The insurer and insurance commissioner are deemed to have received notice three business days after the notice is mailed.

(b) If the insurer fails to resolve the basis for the action within the twenty-day period after the written notice by the first party claimant, the first party claimant may bring the action without any further notice.

(c) The first party claimant may bring an action after the required period of time in (a) of this subsection has elapsed.

(d) If a written notice of claim is served under (a) of this subsection within the time prescribed for the filing of an action under this section, the statute of limitations for the action is tolled during the twenty-day period of time in (a) of this subsection.

[2007 c 498 § 3 (Referendum Measure No. 67, approved November 6, 2007).]

Notes:
Short title -- 2007 c 498: "This act may be known and cited as the insurance fair conduct act." [2007 c 498 § 1.]

WAC 284-30-330 Agency filings affecting this section

Specific unfair claims settlement practices defined.

The following are hereby defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, specifically applicable to the settlement of claims:

(1) Misrepresenting pertinent facts or insurance policy provisions.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(4) Refusing to pay claims without conducting a reasonable investigation.

(5) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

(6) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. In particular, this includes an obligation to effectuate prompt payment of property damage claims to innocent third parties in clear liability situations. If two or more insurers are involved, they should arrange to make such payment, leaving to themselves the burden of apportioning it.

(7) Compelling insureds to institute or submit to litigation, arbitration, or appraisal to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in such actions or proceedings.

(8) Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

(9) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made.

(10) Asserting to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring subsequent submissions which contain substantially the same information.

(12) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(14) Unfairly discriminating against claimants because they are represented by a public adjuster.

(15) Failure to expeditiously honor drafts given in settlement of claims. A failure to honor a draft within three working days of notice of receipt by the payor bank will constitute a violation of this provision. Dishonor of any such draft for valid reasons related to the settlement of the claim will not constitute a violation of this provision.

(16) Failure to adopt and implement reasonable standards for the processing and payment of claims once the obligation to pay has been established. Except as to those instances where the time for payment is governed by statute or rule or is set forth in an applicable contract, procedures which are not designed to deliver a check or draft to the payee in payment of a settled claim within fifteen business days after receipt by the insurer or its attorney of properly executed releases or other settlement documents are not acceptable. Where the insurer is obligated to furnish an appropriate release or settlement document to an insured or claimant, it shall do so within twenty working days after a settlement has been reached.

(17) Delaying appraisals or adding to their cost under insurance policy appraisal provisions through the use of appraisers from outside of the loss area. The use of appraisers from outside the loss area is appropriate only where the unique nature of the loss or a lack of competent local appraisers make the use of out-of-area appraisers necessary.

(18) Failing to make a good faith effort to settle a claim before exercising a contract right to an appraisal.

(19) Negotiating or settling a claim directly with any claimant known to be represented by an attorney without the attorney's knowledge and consent. This does not prohibit routine inquiries to an insured claimant to identify the claimant or to obtain details concerning the claim.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-330, filed 4/21/87. Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-330, filed 7/27/78, effective 9/1/78.]

WAC 284-30-350 No agency filings affecting this section since 2003

Misrepresentation of policy provisions.

(1) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

(2) No agent shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(3) No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

(4) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such a time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.

(5) No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(6) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which release the insurer or its insured from its total liability.

(7) No insurer shall make a payment of benefits without clearly advising the payee, in writing, that it may require reimbursement, when such is the case.

[Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 87-09-071 (Order R 87-5), § 284-30-350, filed 4/21/87. Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-350, filed 7/27/78, effective 9/1/78.]

WAC 284-30-360 Agency filings affecting this section

Failure to acknowledge pertinent communications.

(1) Every insurer, upon receiving notification of a claim shall, within ten working days, or fifteen working days with respect to claims arising under group insurance contracts, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgement shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer.

(2) Every insurer, upon receipt of any inquiry from the office of the insurance commissioner respecting a claim shall, within fifteen working days of receipt of such inquiry, furnish the department with an adequate response to the inquiry.

(3) An appropriate reply shall be made within ten working days, or fifteen working days with respect to communications arising under group insurance contracts, on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

(4) Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within the time limits specified in subsection (1) of this section shall constitute compliance with that subsection.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-360, filed 7/27/78, effective 9/1/78.]

WAC 284-30-370 Agency filings affecting this section

Standards for prompt investigation of claims.

Every insurer shall complete investigation of a claim within thirty days after notification of claim, unless such investigation cannot reasonably be completed within such time. All persons involved in the investigation of a claim shall provide reasonable assistance to the insurer in order to facilitate compliance with this provision.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-370, filed 7/27/78, effective 9/1/78.]

WAC 284-30-380 Agency filings affecting this section

Standards for prompt, fair and equitable settlements applicable to all insurers.

(1) Within fifteen working days after receipt by the insurer of properly executed proofs of loss, the first party claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(2) If a claim is denied for reasons other than those described in subsection (1) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

(3) If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within fifteen working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, within forty-five days from the date of the initial notification and no later than every thirty days thereafter, send to such claimant a letter setting forth the reasons additional time is needed for investigation.

(4) Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(5) Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the claimant's rights may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's rights. Such notice shall be given to first party claimants thirty days and to third party claimants sixty days before the date on which such time limit may expire.

(6) No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

[Statutory Authority: RCW 48.02.060 and 48.30.010. 78-08-082 (Order R 78-3), § 284-30-380, filed 7/27/78, effective 9/1/78.]

RCW 48.30.010
Unfair practices in general — Remedies and penalties.

(1) No person engaged in the business of insurance shall engage in unfair methods of competition or in unfair or deceptive acts or practices in the conduct of such business as such methods, acts, or practices are defined pursuant to subsection (2) of this section.

(2) In addition to such unfair methods and unfair or deceptive acts or practices as are expressly defined and prohibited by this code, the commissioner may from time to time by regulation promulgated pursuant to chapter 34.05 RCW, define other methods of competition and other acts and practices in the conduct of such business reasonably found by the commissioner to be unfair or deceptive after a review of all comments received during the notice and comment rule-making period.

(3)(a) In defining other methods of competition and other acts and practices in the conduct of such business to be unfair or deceptive, and after reviewing all comments and documents received during the notice and comment rule-making period, the commissioner shall identify his or her reasons for defining the method of competition or other act or practice in the conduct of insurance to be unfair or deceptive and shall include a statement outlining these reasons as part of the adopted rule.

(b) The commissioner shall include a detailed description of facts upon which he or she relied and of facts upon which he or she failed to rely, in defining the method of competition or other act or practice in the conduct of insurance to be unfair or deceptive, in the concise explanatory statement prepared under RCW 34.05.325(6).

(c) Upon appeal the superior court shall review the findings of fact upon which the regulation is based de novo on the record.

(4) No such regulation shall be made effective prior to the expiration of thirty days after the date of the order by which it is promulgated.

(5) If the commissioner has cause to believe that any person is violating any such regulation, the commissioner may order such person to cease and desist therefrom. The commissioner shall deliver such order to such person direct or mail it to the person by registered mail with return receipt requested. If the person violates the order after expiration of ten days after the cease and desist order has been received by him or her, he or she may be fined by the commissioner a sum not to exceed two hundred and fifty dollars for each violation committed thereafter.

(6) If any such regulation is violated, the commissioner may take such other or additional action as is permitted under the insurance code for violation of a regulation.

(7) An insurer engaged in the business of insurance may not unreasonably deny a claim for coverage or payment of benefits to any first party claimant. "First party claimant" has the same meaning as in RCW 48.30.015.

[2007 c 498 § 2 (Referendum Measure No. 67, approved November 6, 2007); 1997 c 409 § 107; 1985 c 264 § 13; 1973 1st ex.s. c 152 § 6; 1965 ex.s. c 70 § 24; 1947 c 79 § .30.01; Rem. Supp. 1947 § 45.30.01.]

Notes:

Short title -- 2007 c 498: See note following RCW 48.30.015.

Part headings -- Severability -- 1997 c 409: See notes following RCW 43.22.051.

Severability -- 1973 1st ex.s. c 152: See note following RCW 48.05.140.