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NOT FOR PUBLICATION

IN THE UNITED STATES DISTRICT COURT  
FOR THE DISTRICT OF ARIZONA

Loren L. Howard, a single man,  
Plaintiff,  
vs.  
Certain Underwriters at Lloyd's of  
London, an alien, unauthorized insurer,  
Defendant.

No. CV-09-1042-PHX-GMS

**ORDER**

Pending before the Court are the following motions: (1) Plaintiff Loren Howard's Motion for Summary Judgment on Defendant's Counterclaim for Rescission (Doc. 41); (2) Motion for Summary Judgment (Doc. 43) filed by Defendant Certain Underwriters at Lloyd's of London; and (3) Plaintiff's Motion to Strike (Doc. 45). For the reasons stated below, the Court grants in part and denies in part Plaintiff's Motion to Strike, denies Plaintiff's Motion for Summary Judgment, and denies Defendant's Motion for Summary Judgment.

**BACKGROUND**

In January 2005, Plaintiff Loren Howard, a football player at Northwestern University, applied for disability insurance after being approached by an insurance broker, James Padilla, who told Plaintiff that he qualified for the insurance. (Doc. 42; 44, Ex. 1; 50). On January 7, 2005, Plaintiff submitted the application for disability insurance to Defendant. (Doc. 41). The insurance application contained the following question: Have you ever injured

1 or suffered pain or discomfort, or had surgery to . . . [your] Right Knee? (Doc. 42, Ex. 2).  
2 Plaintiff answered “no.” (*Id.*). Plaintiff did disclose that he had missed the first six games of  
3 the season after having surgery on his right ankle in January 2004 and his left ankle in  
4 September 2004 to treat peroneal ligament subluxation. (Doc. 44, Ex. 1). He also noted on  
5 his application that he had experienced muscle spasms of his lower back in March 2004 and  
6 a left PIP dislocation (left hand) in April 2004. Defendant approved the application,  
7 excluding coverage of Plaintiff’s ankles, and issued a policy, providing \$500,000 of  
8 coverage, with effective dates of December 17, 2004 through August 1, 2006. (Doc. 42; Doc.  
9 44, Ex. 1). Subsequently, Padilla approached Plaintiff again, offering to increase Plaintiff’s  
10 coverage by another \$500,000. (Doc. 42; 44, Ex. 2). To receive the increase in coverage,  
11 Plaintiff was required to submit a Letter of Health, which he dated February 27, 2005,  
12 indicating that there had been no change in his health since he submitted his original  
13 application in January 2005. (Doc. 42, Ex. 6). On March 7, 2005, Plaintiff received a letter,  
14 stating that his coverage had been increased to \$1 million, effective February 10, 2005. (Doc.  
15 42, Ex. 4).

16 In May 2005, based on the recommendation of an orthopedist at Northwestern  
17 University, Plaintiff underwent arthroscopic surgery to address “chronic quadriceps  
18 tendinitis” and chondromalacia patella of his right knee. (Doc. 42, Ex. 17). Plaintiff contends  
19 that, by August 2005, he began experiencing pain in his right knee again, and as a result,  
20 underwent another surgery later that month. (Doc. 42, Ex. 18). Unable to fully recover  
21 following several knee surgeries, Plaintiff contacted Padilla regarding a claim for disability.  
22 (Doc. 42, Ex. 22, 23). In August 2007, Padilla submitted Plaintiff’s claim, which appears to  
23 assert that as a result of an accident – the May 2005 surgery – he was totally disabled and  
24 suffering from right knee tendinitis, level 3 chondromalacia, and other complications  
25 following surgery. (Doc. 42, Ex. 24; 44, Ex. 2). The relevant provision of his insurance  
26 policy states:

27 In the event that the **Insured** sustains **Bodily Injury** caused in and of itself by  
28 an **Accident** occurring during the Certificate period and which, solely and  
independently of any other cause, results in the **Total Disablement** directly

1 culminating in the **Permanent Total Disablement** of the **Insured**, and  
2 providing the **Total Disablement** commenced within six (6) months of the  
3 date of such **Accident**, then the Insurer agrees to pay benefits stated in the  
4 Schedule to the Insured.

(Doc. 42, Ex. 3).

5 As of April 2009, Defendant had not issued a final decision regarding Plaintiff's  
6 claim. Accordingly, Plaintiff filed his Complaint. (Doc. 2, Ex. 1).

## 7 DISCUSSION

### 8 I. Motion to Strike

9 Plaintiff filed a motion to strike underwriter Colin Fairlie's July 23, 2010 affidavit  
10 pursuant to Rule 37(c) of the Federal Rules of Civil Procedure for Defendant's failure to  
11 disclose the subject of any discoverable information that Fairlie could offer to support  
12 Defendant's claims as required by Rules 26(a) and 26(e) of the Federal Rules of Civil  
13 Procedure. (Doc. 45).<sup>1</sup> Specifically, Plaintiff contends that Defendant never indicated that  
14 Fairlie would provide evidence regarding Defendant's decision to rescind Plaintiff's policy  
15 or supporting the rescission claim. Plaintiff requests that the Court exclude Fairlie's  
16 testimony in its entirety, award fees and costs to Plaintiff in connection with filing his Motion  
17 to Strike, and inform the jury of Defendant's failure to disclose the testimony at trial. Upon  
18 review of the affidavit in question, the Court issued an order requesting that each party  
19 submit a supplemental memorandum addressing the issue of whether Defendant was required  
20 to disclose Fairlie as an expert under Federal Rule of Evidence 702 because the subject of  
21 Fairlie's affidavit was derived from "specialized knowledge." (Doc. 59).

22 Defendant contends that Fairlie's affidavit and testimony should not be excluded  
23 because he is serving as a fact witness, not an expert witness. (Doc. 60). Defendant argues  
24 that Fairlie is "providing evidence as a party about facts and circumstances within his  
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26 <sup>1</sup> In his Reply, Plaintiff additionally requests that the Court strike Keith Scoffield's  
27 affidavit and preclude him from testifying at trial. (Doc. 58). The Court need not consider  
28 arguments raised for the first time in a reply brief. *Bazuaye v. I.N.S.*, 79 F.3d 118, 120 (9th  
Cir. 1996) ("Issues raised for the first time in the reply brief are waived.").

1 personal knowledge and about decisions he made regarding the issues in this litigation.” (*Id.*).  
2 If the Court interprets Fairlie as providing an opinion, Defendant asserts that the opinion  
3 would be within the scope of Federal Rule of Evidence 701.

4 To the extent that Fairlie’s initial affidavit describes the process and any  
5 determinations actually made with regard to the issuance of Plaintiff’s policy and the  
6 exclusion of Plaintiff’s ankles, specifically paragraphs 1-7, that portion of the affidavit will  
7 not be stricken. (Doc. 44, Ex. 9). However, in paragraphs 8 and 9, Fairlie describes a  
8 hypothetical situation, in which Plaintiff submits medical information about his right knee,  
9 and explains the steps he would have taken and determinations he would have made had that  
10 actually occurred. Defendant incorrectly describes these circumstances as fact. (Doc. 60).  
11 The circumstances described cannot be considered facts, by definition, because they did not  
12 actually take place. Without any underwriting guidelines or other similar materials,  
13 Defendant appears to be relying on Fairlie’s opinion as an expert who has specialized  
14 knowledge of underwriting standards to establish William J. Sutton & Co.’s standards for  
15 making determinations about insuring athletes with particular types of injuries.

16 Defendant attempts to describe any opinion expressed as “lay witness” opinion,  
17 subject to Federal Rule of Evidence 701. Rule 701 explains that lay testimony is limited to  
18 opinions or inferences which are “rationally based on the *perception* of the witness” and “not  
19 based on scientific, technical, or other specialized knowledge.” (emphasis added). The  
20 Advisory Committee’s Note to the 2000 Amendments further explains that the amendment  
21 incorporates the following distinctions: “lay testimony ‘results from a process of reasoning  
22 familiar in everyday life,’ while expert testimony ‘results from a process of reasoning which  
23 can be mastered only by specialists in the field.’” FED. R. EVID. 701 advisory committee’s  
24 note (quoting *Tennessee v. Brown*, 836 S.W.2d 530, 549 (Tenn. 1992)). It is clear from the  
25 language of paragraphs 8 and 9 of the affidavit that Fairlie is not providing testimony  
26 “‘common enough’” to require only a “‘limited amount of expertise.” *United States v.*  
27 *Figuroa-Lopez*, 125 F.3d 1241, 1245–46 (9th Cir. 1997) (quoting *United States v.*  
28 *VonWillie*, 59 F.3d 922, 929 (9th Cir. 1995)). Rather, paragraph 8 states: “Based upon my

1 25 years in the sports insurance industry, I know that tendonitis can be a chronic condition  
2 that does not develop overnight, but can be a condition that builds up over time.” Fairlie then  
3 goes on to describe, based on his extensive experience, what he would have required from  
4 Plaintiff and how he would have interpreted certain medical information to come to an  
5 ultimate conclusion about Plaintiff’s policy. (Doc. 44, Ex. 9).

6         Setting aside the issue of whether Fairlie is qualified by “knowledge, skill, experience,  
7 training, or education” to testify regarding Plaintiff’s knee condition and generally about a  
8 diagnosis of tendinitis, *see* FED. R. EVID. 702, Fairlie’s affidavit provides an opinion about  
9 a hypothetical situation based on Fairlie’s assertion of specialized knowledge in underwriting  
10 standards. *Cf. Cedar Hill Hardware & Constr. Supply, Inc. v. Ins. Corp. of Hannover*, 563  
11 F.3d 329, 343 (8th Cir. 2009) (witness testifying about underwriting standards and decisions  
12 was qualified as an expert due to his “specialized knowledge”); *Am. Gen. Life Ins. Co. v.*  
13 *Schoenthal*, 555 F.3d 1331, 1338–39 (11th Cir. 2009) (witness testifying about financial  
14 underwriting standards and risk management issues qualified as an expert based on his  
15 education and experience); *Hangerter v. Provident Life & Accident Ins. Co.*, 373 F.3d 998,  
16 1015–16 (9th Cir. 2004) (concluding that a witness testifying about claims adjustment  
17 standards who has “twenty-five years’ experience working for insurance companies” and has  
18 evaluated claims and insurance policies was correctly considered an expert witness).  
19 Therefore, Defendant was required to disclose Fairlie’s testimony to the extent that it  
20 constitutes expert testimony. *Cf. Hangerter*, 373 F.3d at 1015 (explaining that “the advisory  
21 committee notes emphasize that Rule 702 is broadly phrased and intended to embrace more  
22 than a narrow definition of qualified expert” (internal quotation marks omitted)).

23         The Ninth Circuit has explained:

24         In these days of heavy caseloads, trial courts in both the federal and state  
25 systems routinely set schedules and establish deadlines to foster the efficient  
26 treatment and resolution of cases. Those efforts will be successful only if the  
27 deadlines are taken seriously by the parties, and the best way to encourage that  
is to enforce the deadlines. Parties must understand that they will pay a price  
for failure to comply strictly with scheduling and other orders, and that failure  
to do so may properly support severe sanctions and exclusions of evidence.

28 *Wong v. Regents of the Univ. of Cal.*, 410 F.3d 1052, 1060 (9th Cir. 2005). Of course, such

1 rules should not be “enforced mindlessly.” *Id.* Here, the Court’s Amended Case Management  
2 Order made clear that Defendant was required to provide “full and complete expert  
3 disclosures” no later than February 26, 2010, and failure to comply with the Court’s Order,  
4 “absent truly extraordinary circumstances,” would result in the exclusion of undisclosed  
5 testimony. (Doc. 21). Defendant’s memorandum does not suggest that “extraordinary  
6 circumstances” prevented Defendant from disclosing Fairlie as an expert witness. Defendant  
7 simply did not consider him to be such a witness. Although Defendant listed Fairlie as one  
8 of its potential witnesses, Defendant did not disclose the subject matter of any testimony  
9 Fairlie would provide. From the documents disclosed to Plaintiff, it would have been clear  
10 that Fairlie would potentially testify as to the actual determinations he made with regard to  
11 Plaintiff’s policy and the exclusion of Plaintiff’s ankles. However, it would not have been  
12 clear that Defendant intended to use Fairlie’s testimony as a substitute for underwriting  
13 guidelines that Defendant apparently does not maintain. (Doc. 54). Moreover, Defendant did  
14 not disclose the information documented in Fairlie’s affidavit until it filed the affidavit with  
15 its Motion for Summary Judgment after the close of discovery. In any event, the burden is  
16 on Defendant to meet the exception to the Court’s Order, and it has not done so. Accordingly,  
17 paragraphs 8 and 9 are stricken from the initial Fairlie affidavit. (Doc. 44, Ex. 9).  
18 Additionally, paragraph 4 of Fairlie’s supplemental affidavit, which was filed after Plaintiff  
19 filed his Motion to Strike, shall be stricken for the same reason. (Doc. 50, Ex.2). The Court  
20 does not consider sanctions appropriate in this case.

## 21 **II. Motions for Summary Judgment**

### 22 **A. Legal Standard**

23 Summary judgment is appropriate if the evidence, viewed in the light most favorable  
24 to the nonmoving party, demonstrates “that there is no genuine issue as to any material fact  
25 and that the movant is entitled to judgment as a matter of law.” FED. R. CIV. P. 56(c)(2).  
26 Substantive law determines which facts are material and “[o]nly disputes over facts that  
27 might affect the outcome of the suit under the governing law will properly preclude the entry  
28 of summary judgment.” *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). “A fact

1 issue is genuine ‘if the evidence is such that a reasonable jury could return a verdict for the  
2 nonmoving party.’” *Villiarimo v. Aloha Island Air, Inc.*, 281 F.3d 1054, 1061 (9th Cir. 2002)  
3 (quoting *Anderson*, 477 U.S. at 248). Thus, the nonmoving party must show that the genuine  
4 factual issues “‘can be resolved only by a finder of fact *because they may reasonably be*  
5 *resolved in favor of either party.*” *Cal. Architectural Bldg. Prods., Inc. v. Franciscan*  
6 *Ceramics, Inc.*, 818 F.2d 1466, 1468 (9th Cir. 1987) (quoting *Anderson*, 477 U.S. at 250).

7 **B. Rescission**

8 Before the Court are cross motions for summary judgment on the issue of rescission.  
9 (Doc. 41, 43). Plaintiff asserts that Defendant has failed to meet its burden of establishing  
10 that Plaintiff’s omissions on the application form or the assertions on the Letter of Health  
11 were “fraudulent.” (Doc. 41). Plaintiff argues that nothing in the record establishes the  
12 materiality of his medical history as to his knee or indicates that Defendant would not have  
13 issued a policy covering the right knee had Plaintiff’s medical history been disclosed.  
14 Defendant counters that Plaintiff’s failure to disclose his knee problems constituted material  
15 misrepresentations, of which had Defendant been aware, it would not have covered  
16 Plaintiff’s right knee or increased the policy limits to \$1 million. (Doc. 43).

17 Under A.R.S. § 20-1109, misrepresentations, omissions, concealment of facts and  
18 incorrect statements shall not prevent recovery under the policy unless:

- 19 1. Fraudulent.
- 20 2. Material either to the acceptance of the risk, or to the hazard assumed  
21 by the insurer.
- 22 3. The insurer in good faith would either not have issued the policy, or  
23 would not have issued a policy in as large an amount, or would not  
24 have provided coverage with respect to the hazard resulting in the loss,  
25 if the true facts had been made known to the insurer as required by the  
26 application for the policy or otherwise.

25 Rescission of an insurance policy is permitted “only if all three subparagraphs of § 20-1109  
26 are satisfied.” *Greves v. Ohio State Life Ins. Co.*, 170 Ariz. 66, 72, 821 P.2d 757, 763 (App.  
27 1991); *see also Smith v. Republic Nat’l Life Ins. Co.*, 107 Ariz. 112, 115, 483 P.2d 527, 530  
28

1 (1971) (concluding that “in order for recovery to be prevented under a policy”, the elements  
2 of all three subparagraphs must be met); *Valley Farms, Ltd. v. Transcon. Ins. Co.*, 206 Ariz.  
3 349, 353, 78 P.3d 1070, 1074 (App. 2003) (“An insurer may not deny coverage under a  
4 policy unless the insurer can prove that all three conditions of § 20-1109 have been  
5 satisfied.”).

### 6 **1. Fraudulent**

7 In Plaintiff’s Motion for Summary Judgment, he states that following the 2004  
8 football season, he sought treatment with Dr. Moussa for “right knee pain.” (Doc. 41).  
9 “Specifically, on January 6, 2005, [he] was *experiencing pain and tenderness* over the  
10 quadriceps tendon, his *right knee hurt* when doing squats, and it hurt when bent for  
11 prolonged periods of time.” (Doc. 41 (emphasis added); 46). During that visit, the doctor  
12 ordered an MRI of Plaintiff’s right knee. (Doc. 42, Ex. 9). Dr. Moussa’s report from that day  
13 states that Plaintiff complained of “right knee pain”, and concluded that Plaintiff was  
14 suffering from “[r]ight knee quadriceps tendinitis, patellofemoral pain.” (*Id.*). Plaintiff further  
15 states “[n]otably, Dr. Moussa testified that his diagnosis of Plaintiff on January 6, 2005, was  
16 ‘probably the most common knee pain diagnosis there is in any orthopedic practice.’” (Doc.  
17 41). A few days later, Plaintiff underwent the MRI, which, he admits, “revealed a ‘very  
18 small, localized partial tear or strain pattern’ involving the distal quadriceps tendon over 10  
19 to 12 millimeters.” (Doc. 41; *see also* Doc. 47, Ex.10 (noting that Plaintiff’s clinical history  
20 includes “Knee pain”)). On January 14, 2005, Plaintiff was instructed to go to physical  
21 therapy 2-3 times per week for 4-6 weeks based on a diagnosis of right quad tendinitis. (Doc.  
22 44, Ex. 2, 1139). Dr. Moussa ordered the physical therapy after Plaintiff submitted his  
23 original insurance application, but before submitting the Letter of Health in February 2005.  
24 (Doc. 44, Ex. 2).

25 The fraud requirement of A.R.S. § 20-1109(1) may be satisfied by a showing of either  
26 legal or actual fraud. *James River Ins. Co. v. Hebert Schenk, P.C.*, 523 F.3d 915, 921 (9th  
27 Cir. 2008). If the insurance application question elicits a factual response, Defendant need  
28 only demonstrate legal fraud. *See Mann v. N.Y. Life Ins. & Annuity Corp.*, 222 F. Supp.2d

1 1151, 1154 (D. Ariz. 2002). However, if the response is “merely an expression of opinion”,  
2 the insurer must prove actual fraud to rescind a policy under the statute. *Med. Protective Co.*  
3 *v. Pang*, 606 F. Supp.2d 1049, 1057 (D. Ariz. 2008).

4 **a. Insurance Application**

5 The question at issue asks if Plaintiff had ever “injured or suffered pain or discomfort,  
6 or had surgery to” his right knee. Plaintiff appears to argue that because he believed his knee  
7 problems were not “significant”, he properly responded to the insurance application question  
8 in the negative. (Doc. 42, Ex. 1, 13). Plaintiff does not specifically assert that this question  
9 was ambiguous or that the question elicited an opinion, rather than a factual answer. *See*  
10 *Stewart v. Mut. of Omaha Ins. Co.*, 169 Ariz. 99, 103, 817 P.2d 44, 48 (App. 1991) (“Where  
11 the response is merely an expression of opinion, the insurer must prove actual fraud to  
12 rescind a policy under the statute.”). He simply states that “Defendant has failed to offer any  
13 evidence that the omissions on the application form or the assertions on the Letter of Health  
14 were fraudulent.” (Doc. 41).

15 “Whether a question calls for a factual response or an opinion depends on the  
16 evidence in the case and is a question of fact for the jury, unless reasonable persons could not  
17 differ regarding whether the answer was a statement of opinion or fact.” *Med. Protective*, 606  
18 F. Supp.2d at 1057 (citing *Equitable Life Assurance Soc’y of the U.S. v. Anderson*, 151  
19 Ariz. 355, 359, 727 P.2d 1066, 1070 (App. 1986)). The insurance application question asks  
20 if Plaintiff had ever “injured or suffered pain or discomfort, or had surgery to” his right knee.  
21 The question contains no qualifiers, such as “significant” pain or discomfort, which would  
22 call for a subjective determination on the part of the applicant. *Cf. James River Ins.*, 523 F.3d  
23 at 922 (explaining that a question that requires the insured to “exercise judgment in applying  
24 that standard to the facts” may be viewed as a question eliciting an opinion). Even if the  
25 question on the insurance application could be interpreted as requiring an applicant to  
26 exercise judgment in determining whether he had experienced such pain, the evidence in this  
27 case demonstrates that the question elicited a factual response. *See Equitable Life*, 151 Ariz.  
28 at 357–58, 727 P.2d at 1068–69 (determining that, based on an admission that the insured

1 had “withdrawn from heroin” within the relevant period, a question asking if the insured was  
2 a “habitual” user of drugs elicited a factual response). Plaintiff has already admitted in his  
3 Motion for Summary Judgment that the day before he submitted the application, he  
4 “experienced pain and tenderness” in the area of his right knee, and specifically that his  
5 “right knee hurt” when doing certain activities, and that as a result, he visited a doctor. Given  
6 this admission, no reasonable jury could conclude that the question of whether Plaintiff had  
7 ever suffered pain or discomfort in his right knee requested a statement of opinion.

8 “If a question on an insurance application seeks facts which are presumably within  
9 the personal knowledge of the insured and are such that the insurer would naturally have  
10 contemplated that the answer represented the actual facts and the answer is false, the insured  
11 has committed legal fraud.” *Stewart*, 169 Ariz. at 102–03, 817 P.2d at 47–48. No reasonable  
12 jury could conclude that facts regarding Plaintiff’s personal experience of pain or discomfort  
13 are not within Plaintiff’s personal knowledge. Because the question elicited facts arising out  
14 of Plaintiff’s personal experience, Defendant would have assumed that Plaintiff’s answer  
15 represented the actual facts. Finally, Plaintiff has admitted that just the day before he signed  
16 his application, he was experiencing pain in his right knee sufficient to warrant a visit to the  
17 doctor. And yet, Plaintiff stated in his application that he had not experienced pain or  
18 discomfort to his right knee. Thus, his answer was false, establishing legal fraud. The fact  
19 that Plaintiff believed he was correctly answering the question is immaterial. *See Equitable*  
20 *Life*, 151 Ariz. at 359, 727 P.2d at 1070.

21 **b. Letter of Health**

22 In February 2005, Plaintiff was required to submit a Letter of Health to increase his  
23 policy limits from \$500,000 to \$1 million. The Letter of Health states the following:

24 I, Loren L. Howard, am currently in good health and there has been no change  
25 in the state of my health since January 7, ‘05 (the date I complete my last  
26 sports application). I have not missed any games, tournaments or practices  
27 due to illness or injury.

28 **OR**

I have consulted the following doctor(s) or trainer(s) for the  
illness(es)/injury(ies) listed below.

(Doc. 42, Ex. 6). Plaintiff wrote “N/A” in the chart where he was supposed to list any

1 illnesses or injuries and signed the letter at the bottom. Plaintiff contends that his assertions  
2 were not fraudulent. (Doc. 48). Defendant argues that Plaintiff’s “failure to disclose the  
3 physical therapy treatments and visits to Dr. Galea in Canada” constituted fraud. (Doc. 43).

4 Because reasonable persons could disagree regarding whether Plaintiff’s assertions  
5 were fraudulent, this is an issue that should be resolved by the fact finder. Defendant has not  
6 presented any evidence that demonstrates to the Court that, as a matter of law, Plaintiff knew  
7 that his knee condition constituted an “illness” or “injury.” Defendant emphasizes Plaintiff’s  
8 physical therapy sessions and consultation with Dr. Galea in Canada. (Doc. 43). However,  
9 Dr. Galea actually told Plaintiff that his ultrasound showed no evidence of a tear in his right  
10 knee, and instead, revealed a fat pad impingement and inflammation. (Doc. 46; 47, Ex. 15).  
11 The Letter of Health appears to only request information about consultations related to an  
12 “illness” or “injury.” And even the statement about being in good health at the top of the  
13 Letter of Health, when read in its entirety, refers to “illness or injury.” Under Arizona law,  
14 ambiguity in insurance applications is generally construed in favor of the insured. *James*  
15 *River Ins.*, 523 F.3d at 922. Whether Plaintiff could have reasonably believed that his  
16 condition fell outside the terms “illness” and “injury” is appropriately viewed as an issue of  
17 fact. *Cf. Stewart*, 169 Ariz. at 103–05, 817 P.2d at 48–50 (plaintiff’s responses were not  
18 fraudulent where the insurer failed to present evidence that plaintiff was told he had a mental  
19 disorder and plaintiff’s understanding of the terms “mental disorder” and “ill health” may  
20 reasonably have differed from the insurer’s understanding of those terms). Accordingly,  
21 summary judgment on the issue of fraud is denied as to Plaintiff’s assertions on the Letter  
22 of Health.

## 23 2. Materiality

24 Defendant argues the specificity of the questions in the insurance application shows  
25 that the information requested was considered material to the insurer. (Doc. 43).  
26 Additionally, in its Response to Plaintiff’s Motion, Defendant argues that its treatment of  
27 Plaintiff’s ankle condition demonstrates that it would have at least been “cautious regarding  
28 potentially disabling conditions”, which demonstrates materiality. (Doc. 49). Plaintiff, on the

1 other hand, contends that the record contains no evidence of underwriting guidelines or other  
2 evidence from Defendant’s underwriters establishing that the information omitted would  
3 have been material to Defendant’s decision to issue the policy. (Doc. 41).<sup>2</sup>

4 The test of materiality of a misrepresentation in an insurance policy application is  
5 whether “the facts, if truly stated, might have influenced a reasonable insurer in deciding  
6 whether to accept or reject the risk.” *Med. Protective*, 606 F. Supp.2d at 1058 (citing *Cent.*  
7 *Nat’l Life Ins. Co. v. Peterson*, 23 Ariz.App. 4, 7, 529 P.2d 1213, 1216 (1975)). Plaintiff has  
8 not presented any evidence that would suggest that answering “yes” on the insurance  
9 application would not have at least influenced Defendant in making a determination about  
10 Plaintiff’s application. On the other hand, Defendant’s treatment of Plaintiff’s other physical  
11 conditions, at a minimum, raises a genuine issue of material fact as to the materiality of the  
12 undisclosed knee condition because it suggests that Defendant would have considered the  
13 nature of the specific complaints before deciding both whether to issue a policy and the  
14 amount of any policy issued.

### 15 3. Issuance of the Policy

16 Defendant contends that it has met its burden of demonstrating that, had it been aware  
17 of Plaintiff’s right knee condition, it would have excluded coverage of Plaintiff’s knees and  
18 denied a request for an increase in coverage. In the alternative, Defendant contends that the  
19 increase in coverage from \$500,000 to \$1 million should be rescinded. (Doc. 43). First,  
20 Defendant points to the fact that coverage under the insurance policy was subject to receipt  
21 of Plaintiff’s medical information. (Doc. 44, Ex. 2). Second, once Defendant reviewed  
22 Plaintiff’s medical records and discovered that Plaintiff had surgery on both ankles in 2004,  
23 Defendant excluded both ankles from coverage. (Doc. 43; 44, Ex. 1). Finally, Defendant  
24 relies on an affidavit of underwriter, Colin Fairlie, parts of which have been stricken as  
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26  
27 <sup>2</sup> Defendant has explained that there are no written underwriting guidelines. Instead,  
28 “[e]ach case is evaluated on its facts based upon the underwriter’s experience in the industry  
and knowledge of the client.” (Doc. 49; 50, Ex. 2).

1 discussed above.<sup>3</sup>

2 Defendant bears the burden of showing that any changes that would have been made  
3 to Plaintiff's policy upon discovery of his knee condition are among the changes listed in  
4 A.R.S. § 20-1109(3). *Greves*, 170 Ariz. at 73, 821 P.2d at 764. "The statute does not permit  
5 rescission if the insurer merely would have charged a higher premium for the coverage for  
6 which the insured applied." *Id.* Whether Defendant would have refused to issue a policy or  
7 would have issued a policy different from the one actually issued is a question of fact. *State*  
8 *Comp. Fund v. Mar Pac Helicopter Corp.*, 156 Ariz. 348, 353, 752 P.2d 1, 6 (App. 1987).

9 In the absence of underwriting guidelines or some other similar evidence showing that  
10 Defendant would have excluded coverage of Plaintiff's right knee or would not have issued  
11 a policy in as large an amount, Defendant's evidence does not establish as a matter of law  
12 that A.R.S. § 20-1109(3) has been met. *Cf. Mann*, 222 F. Supp.2d at 1155-56 (concluding  
13 that underwriting guidelines which listed cocaine use as a "risk not acceptable" conclusively  
14 showed that the insurer would not have issued the policy had plaintiff responded truthfully  
15 about his past drug use on the application). Regarding Defendant's first point, the fact that  
16 the insurance company reserved the right to amend the terms and conditions of the coverage  
17 upon receipt of supporting documentation of Plaintiff's medical history does not necessarily  
18 confirm that had the insurance company received information regarding Plaintiff's knee  
19 condition at that time, it would have amended the terms of Plaintiff's coverage. The  
20 description of conditions that would not be covered prior to Defendant's review of Plaintiff's

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21  
22 <sup>3</sup> With regard to this element, Defendant contends in its Response that "documents  
23 from Defendant's files also show that Colin Fairlie refused to consider the renewal of  
24 Plaintiff's policy until he had played at least a few football games to show that the knee was  
25 not a continuing problem." (Doc. 49). Defendant directs the Court to DSOF 1, which refers  
26 to a denial of a renewal of the insurance policy due to Plaintiff's ankle condition. (Doc. 50).  
27 Thus, the Court assumes that Defendant intended to refer to this condition, rather than his  
28 knee condition, in Document 49. In any event, the underwriter's conclusions in mid-2006,  
following a year in which Plaintiff was unable to play in any games, do not support the  
assertion that the underwriter would have come to the same conclusion regarding Plaintiff's  
knee condition with the information that could have been made available to Defendant in  
early 2005.

1 medical documentation does not establish, as a matter of law, that Defendant would have  
2 excluded Plaintiff's right knee or denied additional coverage. In fact, Defendant has  
3 suggested in several documents submitted to the Court, including the Counterclaim and  
4 Response to Plaintiff's Motion to Strike, *see* Doc. 11 & 54, that had it received  
5 documentation regarding Plaintiff's knee, a possible result would have been to increase his  
6 premiums, which under Arizona law does not meet the standard for establishing § 20-  
7 1109(3). *See Greves*, 170 Ariz. at 73, 821 P.2d at 764.

8 In the application, Plaintiff alerted Defendant to his ankle condition and also noted  
9 that he had experienced muscle spasms of his lower back in March 2004 and a left PIP  
10 dislocation (left hand) in April 2004. (Doc. 44, Ex. 1). Evidence in the record shows that,  
11 after reviewing this information, the underwriter determined that the ankles should be  
12 excluded from coverage, but made no reference to the other conditions/injuries. This  
13 evidence raises a genuine issue of material fact for the fact-finder because it demonstrates  
14 that Defendant viewed only certain conditions as sufficiently serious to warrant exclusion  
15 from coverage. The trier of fact should determine whether Plaintiff's knee condition at the  
16 time he submitted his application and Letter of Health is more comparable to his ankle  
17 condition or the other conditions. Accordingly, summary judgment is not appropriate as to  
18 the issue of rescission.

19 **C. Bad Faith**

20 Plaintiff's Complaint raises only one claim—that Defendant has acted in bad faith by  
21 failing to timely process Plaintiff's claim for disability benefits, which has been pending  
22 since June 2007. (Doc. 2, Ex. 1).<sup>4</sup> Plaintiff argues that, although he has complied with every  
23 request made by Defendant for additional documentation and examination, Defendant has  
24 continued to employ pretext to unreasonably delay the decision to pay or deny benefits,  
25 amounting to a breach of the implied covenant of good faith and fair dealing and thus,

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26  
27 <sup>4</sup> Plaintiff appears to be using the date on which he signed the Incident Report Form  
28 as the date he submitted his claim, although it appears that his insurance agent, Padilla, did  
not send the form and supporting documents to Defendant until August 1, 2007.

1 committing bad faith. Defendant moves for summary judgment, arguing that its extensive  
2 investigation of Plaintiff's claim was reasonable due to the omissions and misrepresentations  
3 on Plaintiff's insurance application and subsequent Letter of Health. (Doc. 43).

4 An insurer "may commit bad faith not only by intentionally and unreasonably denying  
5 a claim, but also by intentionally processing, evaluating, or paying a claim in an unreasonable  
6 manner." *James River*, 523 F.3d at 923 (citing *Zilisch v. State Farm Mut. Auto. Ins. Co.*, 196  
7 Ariz. 234, 237, 995 P.2d 276, 279 (2000)); *see also Trus Joist Corp. v. Safeco Ins. Co. of*  
8 *Am.*, 153 Ariz. 95, 103, 735 P.2d 125, 133 (App.1986). To establish bad faith, Plaintiff must  
9 show that the insurer (1) "acted unreasonably toward its insured" and (2) "acted *knowing* that  
10 it was acting unreasonably *or* acted with such reckless disregard that such knowledge may  
11 be imputed to it." *Trus Joist*, 153 Ariz. at 104, 735 P.2d 125, 134.

12 Defendant asserts that neither of these prongs have been met. Specifically, Defendant  
13 contends that its actions were reasonable because Plaintiff's Incident Report Form raised  
14 questions regarding the accuracy of the statements he made on his insurance application and  
15 subsequent Letter of Health supporting his request for an increase in coverage. (Doc. 43).  
16 According to Defendant, investigating Plaintiff's claims and obtaining the relevant medical  
17 records was "a time-consuming and iterative process." (*Id.*). Defendant also claims that  
18 Plaintiff's repeated misrepresentations about his medical history and treatment for tendinitis  
19 delayed the investigative process significantly. In sum, Defendant asserts that because the  
20 claim was fairly debatable, it cannot be liable for bad faith by thoroughly investigating the  
21 claim. (*Id.* (citing *Knoell v. Metro. Life Ins. Co.*, 163 F. Supp.2d 1072, 1075 (D. Ariz. 2001)  
22 ("[W]hen there is a question of fact as to liability on the underlying policy, then as a matter  
23 of law, the insurance company is not liable for bad faith.")).

### 24 **1. Fair Debatability of the Claim**

25 The Arizona Supreme Court has made clear that fair debatability is a "necessary  
26 condition to avoid a claim of bad faith," but "it is not always a sufficient condition." *Zilisch*,  
27 196 Ariz. at 238, 995 P.2d at 280. "While an insurer may challenge claims which are fairly  
28 debatable, its belief in fair debatability 'is a question of fact to be determined by the jury.'"

1 *Id.* at 237, 995 P.2d at 279 (internal citation omitted) (quoting *Sparks v. Republic Nat'l Life*  
2 *Ins. Co.*, 132 Ariz. 529, 539, 647 P.2d 1127, 1137 (1982)). However, “[i]f the plaintiff offers  
3 no significantly probative evidence that calls into question the defendant’s belief in fair  
4 debatability . . . the court may rule on the issue as a matter of law.” *Young v. Allstate Ins.*  
5 *Co.*, 296 F.Supp.2d 1111, 1116 (D. Ariz. 2003); *see also Lopez v. Allstate Ins. Co.*, 282  
6 F.Supp.2d 1095, 1100 (D. Ariz. 2003). Here, Plaintiff has not offered any evidence that  
7 raises a genuine issue as to Defendant’s belief in the fair debatability of Plaintiff’s claim. *See*  
8 *Young*, 296 F.Supp.2d at 1116 (citing *Knoell*, 163 F.Supp.2d at 1077 (“[B]ecause there are  
9 no questions of fact to present to a jury about whether the insurance company really believed  
10 it should investigate the claim verses [sic] just using the investigation as a pretext to avoid  
11 payment, this Court concludes that the Defendant did not act in bad faith by investigating the  
12 claim.”)).<sup>5</sup>

13 In 2007, Plaintiff submitted an Incident Report Form and some medical  
14 documentation in connection with his claim, in which he asserted that Defendant should pay  
15 disability benefits based on an “accident” to his right knee. (Doc. 47, Ex. 25, 26). Under the  
16 policy, an accident is “a single sudden and unexpected event, which” (1) occurs at an  
17 identifiable time and place; (2) causes unexpected bodily injury at the time it occurs; and (3)  
18 arises from an external source to the insured. (Doc. 44, Ex. 1 DEFT 0007; 46). Plaintiff  
19 indicated that “he had suffered an accident as a result of right knee tendonitis, level 3  
20 chondromalacia, and that his right knee pain started after surgery on May 5, 2005.” (Doc.  
21 46). After reviewing the documents submitted by Plaintiff, Margaret Oesch, the claims  
22 examiner had several immediate concerns. (Doc. 44, Ex. 2, DEFT 0178). The medical  
23 records, some of which referred to the January 2005 MRI, indicated that Plaintiff may have

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25 <sup>5</sup> Plaintiff relies on Mary Fuller’s expert report. The report fails to raise an issue of  
26 material fact as to Defendant’s initial belief of the fair debatability of Plaintiff’s claim  
27 because it is clear from her report that Ms. Fuller is unaware of a number of material facts  
28 in this case. For instance, Ms. Fuller does not appear to know that Dr. LaPrada, who  
conducted Plaintiff’s physical exam for insurance purposes, was not Plaintiff’s regular  
physician, and in fact, is a family member. (Doc. 47, Ex. 11).

1 been suffering from tendinitis in his right knee for years, pre-dating the issuance of his  
2 policy. (Doc. 43). Plaintiff had not disclosed this condition on his insurance application, and  
3 therefore, this information raised a red flag in terms of the possibility of rescission.  
4 Additionally, Plaintiff's description of his injury did not appear to fit within the policy  
5 definition of "accident." (Doc. 43; 44, Ex. 2). Defendant alerted Plaintiff of these concerns  
6 in a reservation of rights letter dated November 13, 2007 and proceeded to investigate the  
7 claim. (Doc. 44, Ex. 2 DEFT 2442). Based on the documentation provided by Plaintiff to  
8 Defendant, which raised concerns that Plaintiff had made misrepresentations on his insurance  
9 application, the Court concludes that Defendant had a reasonable basis for further  
10 investigating Plaintiff's claim.

11 Because the validity of Plaintiff's claim was fairly debatable, Defendant cannot be  
12 liable for bad faith for not paying the claim immediately. *See Knoell*, 163 F.Supp.2d at 1075;  
13 *see also Sciranko v. Fid. & Guar. Life Ins. Co.* 503 F.Supp.2d 1293, 1321 (D. Ariz. 2007)  
14 ("Liability will not attach if the insured's claim is 'fairly debatable' from an objective  
15 standpoint and is subjectively perceived as such by the insurer."); *Desert Mountain Props.*  
16 *Ltd. P'ship v. Liberty Mut. Fire Ins. Co.*, 225 Ariz. 194, \_\_\_, 236 P.3d 421, 442 (App. 2010)  
17 ("An insurer's failure to pay a claim is not unreasonable when the claim's validity is 'fairly  
18 debatable.'" (citing *Rawlings v. Apodaca*, 151 Ariz. 149, 156, 726 P.2d 565, 572 (1986))).

## 19 2. Claim Investigation

20 "[E]ven if as a result of a claim being fairly debatable Defendant is not liable for bad  
21 faith for failing to pay the claim immediately, Defendant might still be liable for bad faith if  
22 Defendant was unreasonable in processing the claim after the initial refusal to pay." *Milhone*  
23 *v. Allstate Ins. Co.*, 289 F.Supp.2d 1089, 1094 (D. Ariz. 2003) (citing *Zilisch*, 196 Ariz. at  
24 238, 995 P.2d at 280); *see also Clark v. Country Cas. Ins. Co.*, 2009 WL 6476781 \*4 (D.  
25 Ariz. Oct. 16, 2009) ("An insurer can be held liable for bad faith if it acts unreasonably in  
26 processing a claim. An insurer must immediately conduct an adequate investigation and act  
27 reasonably in evaluating the claim." (internal citations omitted)). Here, the main issue is not  
28 whether Defendant was reasonable in initially investigating the claim, but rather whether it

1 took an unreasonable amount of time to evaluate a claim that Defendant appears to have  
2 considered suspect within three days of receiving Plaintiff's Incident Report Form. Courts  
3 have rejected bad faith claims based on unreasonable delay when the insurer provided an  
4 initial offer or determination within a month or two after the claim was filed. *See, e.g.,*  
5 *Milhone*, 289 F.Supp.2d at 1097. However, summary judgment may not be appropriate where  
6 an insurer takes approximately a year to evaluate a claim, which has been considered by  
7 several courts to be "an unreasonable length of time" to evaluate a claim. *See Bjornstad v.*  
8 *Senior Am. Life Ins. Co.*, 599 F.Supp.2d 1165, 1174 (D. Ariz. 2009); *Zilisch*, 196 Ariz. at  
9 238, 995 P.2d at 280.

10 Here, approximately 20 months passed between the time Plaintiff filed his claim and  
11 when he filed this suit. During this time, Defendant did not make any offers to settle  
12 Plaintiff's claim or inform Plaintiff that it would be denying his claim. Defendant argues that  
13 what ended up being approximately a 22-month investigation was due to Plaintiff's  
14 misrepresentations. However, there is sufficient evidence in the record, offered by Plaintiff  
15 as well as Defendant, raising a genuine issue of material fact as to the reasonableness of the  
16 duration of this investigation, especially given that Defendant's suspicions were raised just  
17 days after Plaintiff filed his claim.

18 On August 1, 2007, Padilla submitted a letter to Oesch, notifying her that Plaintiff was  
19 making a "formal disability claim under" his policy and enclosing Plaintiff's Incident Report  
20 Form, signed on June 11, 2007, and medical records. (Doc. 47, Ex. 26). It took Defendant  
21 approximately six weeks to determine that it did not have a copy of the Incident Report  
22 Form, which in viewing the facts in light most favorable to Plaintiff, was submitted with the  
23 August 1 letter. (Doc. 44, Ex. 2 DEFT 2477). Plaintiff re-submitted the form and it was  
24 stamped as received by Defendant on September 14, 2007. (Doc. 44, Ex. 2 DEFT 2470). On  
25 September 19, 2007, five days after receiving another copy of Plaintiff's Incident Report  
26 Form, Oesch contacted a colleague for legal advice, reminding him of her June 6, 2007 email  
27 notification of Plaintiff's claim and forwarding him Plaintiff's Incident Report Form and his  
28 medical reports. (Doc. 44, Ex. 2). In that letter, she noted her immediate concerns with the

1 claim, including that the date of loss was reported as May 2005, two years earlier, that, based  
2 on the medical records, Plaintiff's symptoms may have begun before January 11, 2005, and  
3 that the "disabling factor" did not appear to be an injury or accident.<sup>6</sup>

4 According to records submitted by Defendant, it then took Oesch another three  
5 months, or until December 6, 2007, to discover that she did not have a signed authorization  
6 form from Plaintiff, permitting her to obtain additional medical records. (Doc. 44, Ex. 10).  
7 Defendant then appears to have spent a number of months gathering additional medical  
8 records. (Doc. 44, Ex. 2, 10). At the end of August 2008, Plaintiff participated in an  
9 examination under oath. (Doc. 44, Ex. 4). Several weeks later, Defendant requested that  
10 Plaintiff sign additional authorizations for release of records. (Doc. 44, Ex. 10). On October  
11 30, 2008, Defendant sent a letter to Arizona State University requesting Plaintiff's records.  
12 (Doc. 50, Ex. 1, 11). On that same date, Defendant also sent Northwestern University a  
13 general request for records. (Doc. 50, Ex. 11).<sup>7</sup> In February 2009, approximately 18 months  
14 after Plaintiff filed his claim, White, Fleischer & Fino, the law firm hired by Defendant to  
15 investigate Plaintiff's claim, requested that Plaintiff sign an additional authorization so that

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16  
17 <sup>6</sup> In Defendant's Response, Defendant notes that from September-October, the  
18 underwriters would not have been involved because Oesch "would have been [] investigating  
19 the circumstances of the claim, not the possibility of any misrepresentation." (Doc. 49).  
20 Although it may be true that Defendant did not involve any underwriters until much later in  
21 the investigation, Defendant's own statements and evidence suggest that Oesch was  
22 immediately considering the possibility of misrepresentation and rescission. Oesch's Sept.  
23 19, 2007 letter explains her "concerns", including that Plaintiff's symptoms began before  
24 January 2005. (Doc. 44, Ex. 2 DEFT 0178); *see also* Doc. 43 (stating that the "initial review  
of Plaintiff's Incident Report Form and supporting documentation immediately revealed two  
threshold questions", including "should the Policy be rescinded due to Plaintiff's failure to  
have disclosed his history of chronic tendonitis and right-knee pain in his application and  
Letter of Health").

25 <sup>7</sup> It appears from the letters included in the record that these are Defendant's first  
26 requests for records from Arizona State University and Northwestern University. Each letter  
27 requests the following general categories of records: athletic records; "medical records (he  
28 was on the football team and sustained injuries)"; physical therapy records; academic  
records; financial and scholarship records; dates of attendance; and any internship records.  
(Doc. 50, Ex. 11).

1 the firm may obtain records from Northwestern University. (Doc. 44, Ex. 2 DEFT 2708). In  
2 March 2009, the firm requested that Dr. David Fleiss provide an expert opinion of Plaintiff's  
3 medical records and condition. (Doc. 42, Ex. 26). On April 9, 2009, Plaintiff filed this  
4 lawsuit. (Doc. 2, Ex. 1).

5 Defendant claims that its investigation was reasonable, in part, because it took some  
6 time to identify the doctors and trainers with whom Plaintiff consulted and to obtain the  
7 relevant records from those individuals because Plaintiff failed to provide those documents  
8 when he filed his claim. However, Defendant knew that Plaintiff was enrolled at  
9 Northwestern University, and later Arizona State University, and that his claim was related  
10 to his time as a college football player at these schools. And yet, a review of the records  
11 submitted by Defendant suggests that Defendant did not contact either university until 13  
12 months after Plaintiff filed his claim and was still seeking authorizations to obtain records  
13 from Northwestern University in February 2009, 18 months later. Moreover, although  
14 Defendant was aware in November 2007 that Plaintiff had consulted with Dr. Moussa, who  
15 ordered an MRI of Plaintiff's knee around the time that Plaintiff submitted his insurance  
16 application form, *see* Doc. 44, Defendant does not appear to have requested Plaintiff's  
17 medical records from Dr. Moussa until October 30, 2008, more than a year after Plaintiff  
18 filed his claim. (Doc. 44, Ex. 2 DEFT 0751; 50, Ex. 11).<sup>8</sup> Considering the evidence presented  
19 by both parties, a reasonable jury could conclude that Defendant was unreasonable in  
20 evaluating Plaintiff's claim, and given the significant delay, Defendant knew it was acting  
21 unreasonably. *See Bjornstad*, 599 F. Supp.2d at 1174.

22 **IT IS THEREFORE ORDERED:**

23 1. Plaintiff's Motion for Summary Judgment (Doc. 41) is **DENIED**;

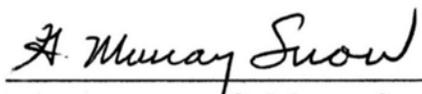
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24  
25 <sup>8</sup> In its Statement of Facts (Doc. 44), Defendant lists the additional documents  
26 requested by Oesch when she sent the November 2007 reservation of rights letter to Plaintiff.  
27 It is clear from the documentation requests that Defendant was already aware that Plaintiff  
28 had consulted someone in Canada about his condition and that Dr. Moussa was treating  
Plaintiff for his knee condition around the time he submitted his insurance application. (Doc.  
44).

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- 2. Defendant's Motion for Summary Judgment (Doc. 43) is **DENIED**;
- 3. Plaintiff's Motion to Strike and for Sanctions (Doc. 45) is **GRANTED IN PART AND DENIED IN PART.**

DATED this 25th day of March, 2011.

  
\_\_\_\_\_  
G. Murray Snow  
United States District Judge