

AAIS PERSPECTIVE

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INTERPRETING INSURANCE POLICY LANGUAGE

When contrary interpretations are possible, drafter loses

How insurance companies interpret policy provisions, particularly those that involve gray areas or that may be subject to more than one possible interpretation, can significantly affect the image of the individual company as well as the industry itself. Insurance policy contracts are subject to the same rules that apply to contracts in general. However, the uniqueness of the insurance product, compared to other economic goods, creates some distinctive features that are associated with insurance contracts. This article identifies those distinctive features and explains how they affect the way in which insurance policies are interpreted.

Insurance is an intangible

Because an insured pays a premium but technically does not receive something material or physical in return, insurance is characterized as being an “intangible” product. Although insurance brings many immediate benefits to individual insureds—peace of mind, loss prevention services, etc.—and to society in general—a basis for credit and creating investment capital—the characterization of insurance as an

intangible is accurate. The payment of a claim really consummates the insurance contract, but not all insureds have losses or make claims. But this is the nature of insurance. A premium is paid in return for the assurance that a potential loss will be covered.

Sometimes people ask: “What is the insurance product?” or, expressed another way: “What is the product embodied in an insurance policy?” A reasonable answer is that the insurance product is basically a promise—a promise to pay for a covered loss. To put it in perspective, it can be said that the agent or sales representative *makes* the promise when he or she sells the policy, the underwriter *decides to whom the promise will be made*, and the claims person *delivers* or fulfills the promise when payment is made for a claim.

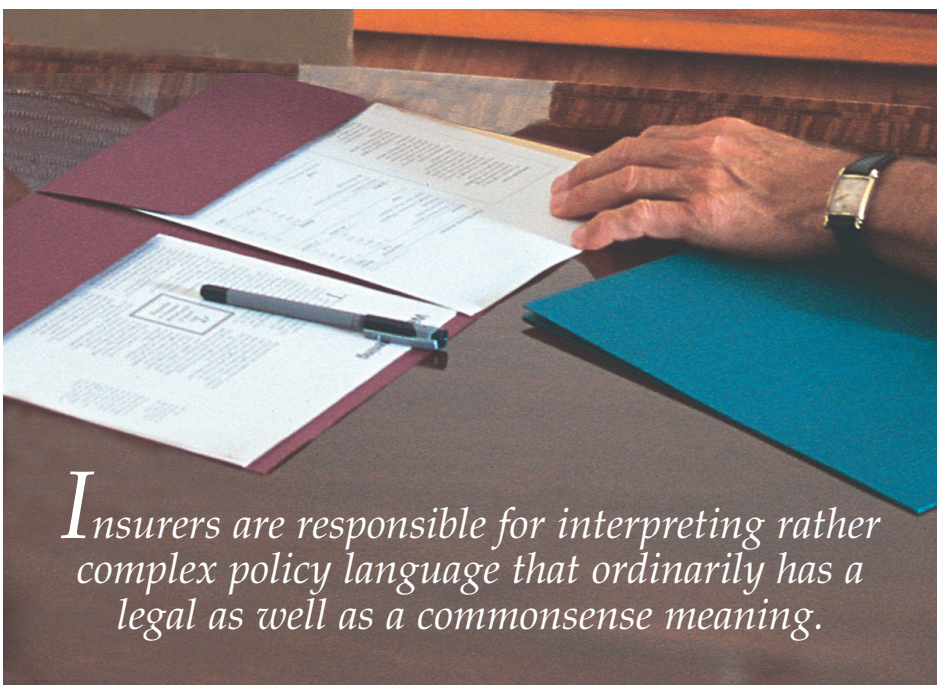
A contract of adhesion

Since an insurance policy is drafted or written by the insurance company (or an advisory organization such as AAIS or ISO) and accepted by the insured without any discussion or negotiation, insurance contracts are said to be contracts of adhesion. The insured ordinarily has no

voice in establishing the terms of the policy and simply adheres to the policy terms as drawn by the insurer.

Note, however, that many large commercial insureds with a sophisticated risk and insurance management staff are in a position to negotiate or bargain with an insurer regarding coverage. In these cases, the policy eventually agreed upon will likely not be considered a contract of adhesion. For example, a manuscript policy (usually prepared for high value or unusual risks by a brokerage firm or consultant with input from the insured) would ordinarily not be considered a contract of adhesion.

When policy language is clear and unambiguous, the parties to the contract are usually bound by its terms. In other words, no forced or strained interpretation of the policy that would defy reason would be permissible. Clear and



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unambiguous words and phrases should be interpreted in their plain, ordinary sense.

It is a generally accepted rule of contract law that a party to a contract is responsible for having knowledge of the contract provisions. In written contracts in general, an individual will be bound by the terms whether they were read and understood or not. Although an insured can be held to a knowledge of the provisions of the insurance contract even though he or she may not have read it,¹ the courts frequently have shown some reluctance to hold insureds responsible for having read or having understood their policies.²

This is because the courts are quick to recognize the highly technical nature of insurance and the fact that insurance policy language is often complicated and not easily understood by the average insured. Based on this view, there is often a tendency on the part of the courts to balance what they perceive as the unequal bargaining positions of insureds and insurers by giving the insured the benefit of the doubt.

What “contract of adhesion” means for insurers

That an insurance policy is a contract of adhesion means that any doubt or ambiguity in a policy provision will be resolved against the party that drafted it. Since the insurer drafted the policy, any question concerning its meaning will ordinarily be decided against the insurer and in favor of the insured. Courts have essentially adopted this position. The rationale behind this principle is that since the insurer chose the policy language, it can be assumed that the insurer has sought to limit its scope. Fairness dictates that any doubt as to the meaning of the language used should be resolved in favor of the insured. To do otherwise, and employ a narrow and technical construction, would result in an injustice.³

Most insurers do not take denial of coverage lightly. As a result, there is a compelling reason for insurers to take what can be described as a “positive claims attitude” toward policy interpretation, that is, to focus on looking for ways to cover a claim rather than for ways to exclude it.

Because of the nature of the insurance product—that is, its characterization as an unfulfilled promise by the insurer, unless or until a covered loss occurs—insurance companies are highly regulated. State insurance regulators monitor the solvency of insurers to ensure that the protection insureds have paid for

will be available if and when they sustain a loss. Regulators also accept and respond to consumer complaints and approve rates and policy forms, among other things.

Conclusion

Insurers are responsible for interpreting rather complex policy language that ordinarily has a legal as well as a commonsense meaning. This responsibility exists in an environment that is characterized by extensive competition in which customer service and good faith relationships with insureds are vital to a company’s success.

An interesting insight concerning the proper way to interpret policy language, and one that all insurers should take seriously, was expressed by claims consultant Elizabeth J. Shaw, CPCU, who said:

“The insurance policy is first and foremost a legal contract.... However, the ‘first party’ to that contract is the ‘average person’—an automobile driver, a property owner, or a business owner. Their expectations are based on their reasonable understandings of the policy language, what might be described as a commonsense meaning.

“Often when a claim is presented, the claims person calls in a legally trained expert.... who looks much deeper into policy language utilizing case law and a careful analysis to advise and support his or her client, the insurer.... We should dispute coverage only in cases where commonsense as well as legal advice leads to the conclusion that coverage should not be afforded.

“To do otherwise simply affirms the unfortunately popular notion that insurance companies try to avoid coverage at every opportunity regardless of what the policy states. If we as insurance professionals really wish to change the public’s perception, then we should be cognizant of the commonsense vs. legal interpretation conflict....”⁴ ■

1. *Blue Ridge Textile Co. vs. Travelers Indem. Co.* 181 A 2d 295 (Pa.) and *Universal Underwriters Co. vs. Semig* 182 NW 2d 354 (Mich.)
2. *Couch on Insurance* 2d 15:79, p. 389.
3. *Couch on Insurance* 2d 15:78, pp. 386-387.
4. This is excerpted from an article titled “Common Sense vs. Legal Interpretations,” which appeared in the *CPCU Claims Section Quarterly*, December 1995.