In an ideal world, after an insured event impairs the policyholder’s business, the insurer and policyholder work together to measure the loss. They agree on the amount covered, and the insurer pays the claim. Of course, in the real world, it does not always work out that way. There are many reasons why an insurer might deny all or part of a claim, and in that circumstance the parties might resort to various mechanisms to resolve their differences, including traditional court litigation, appraisal, arbitration, mediation, and/or negotiation. This chapter reviews some of the basic steps that policyholders and insurers may consider in anticipation of a dispute arising from an arguably insured event and describes what the parties might expect once a determination has been made to adopt some form of dispute resolution process.

The Policyholder’s Predispute Checklist

Depending on policy language, an almost infinite variety of perils might result in a covered business interruption loss. Such perils can range from natural disasters, such as earthquakes, floods and hurricanes, to myriad man-made disasters, such as oil or chemical spills, underground gas leaks, and the unanticipated groundings of airliners. A business interruption can be fairly confined and uncomplicated in scope, as in the case of a brief, localized shutdown due to a utility outage; on the other hand, it can be catastrophic and immensely complex, such as in the case of a large-scale industrial explosion involving property damage, bodily injury, business interruption losses, on- and off-site contamination, and residential evacuations. In extreme cases, catastrophic events trigger state and federal
OSHA investigations, criminal investigations, and the involvement of other local, state, and federal authorities. They also often lead to third-party tort and contract litigation, including subrogation actions, in addition to the policyholder’s own property-related and business interruption losses. They may also create adverse publicity for the organizations involved. Such events may require a well-conceived comprehensive crisis management plan, in which the policyholder’s insurance recovery effort is but one part of multi-faceted response strategy. (Crisis Management is discussed in Chapter 6.)

Of course, a property and business interruption loss does not always translate into coverage litigation—let alone collateral civil, regulatory, and criminal proceedings. But after an event that, among other things, impairs the policyholder’s operations and thereby leads to a loss of profits or gross earnings and extra expense losses, a policyholder should consider a basic series of actions to maximize and expedite its insurance claim. A nonexhaustive checklist of these predispute steps and considerations follows.

**Don’t Write or Say Anything That Could Be Used Against You**

After a loss, even the smartest, most experienced persons (including risk managers or others involved in responding to a loss) will sometimes make premature, ill-considered, and incorrect proclamations about the coverage that later could be used as a basis for denying the coverage. Substantive evaluations of the coverage (such as “I never thought that was covered” or “We can’t get coverage for that,” etc.) generally should not be documented or otherwise communicated after a loss. Oftentimes, it is important to get in-house or outside counsel involved in any communications regarding the substantive issues, to establish and use the attorney-client privilege in order to protect such communications from compelled disclosure down the road. This issue is discussed further in this chapter in the subsequent extended discussion on *Privilege and Confidentiality Concerns*.

**Review the Coverage**

Not all policies cover the same categories of losses. A careful inspection of the policy—which can easily dictate multiple readings—is necessary to confirm that no coverages are being overlooked. The policyholder should obtain complete copies of its current first-party property policies from the broker or insurer if it does not already have them on hand. The policyholder then should carefully review the policies, any certificates or attached endorsements, and any and all correspondence about those policies between the policyholder, broker, and the insurer. In so doing,
the policyholder should note the various categories of losses and expenses that may be covered and the key conditions to coverage that will require some sort of action, such as notice or mitigation, from the policyholder.

Notice

Virtually every policy contains one or more provisions that describe the policyholder’s duties in the event of a potentially covered loss. One of the most important is the *notice* provision, requiring that notice be provided to the insurer “as soon as practicable,” “immediately,” “within a reasonable time,” or within some other time period specified under the policy. Frequently, all that is required is sending a description of the covered event to the broker with directions to forward the information to the potentially affected insurers. In such cases, the policyholder should be sure to confirm that notice was in fact sent to each insurer by requesting a copy of the broker’s transmittal letters. Often, but not always, the policy will provide directions on to who notice should be sent and the manner in which it can be provided (e.g., facsimile, electronic mail, via an Internet claims site, certified mail, or standard mail). Many brokers provide a claim-submission service.

A failure to timely notify the insurer can create difficulties. It may in some circumstances provide the insurer with a basis for denying coverage. In most states, however, a failure to provide timely notice will not bar coverage unless the insurer was “prejudiced” or “substantially prejudiced” by the late notice. In some jurisdictions, the insurer may avoid providing coverage by showing that the timing of the notice was unreasonable under the circumstances. Of course, the best way to eliminate untimely notice as an issue is to provide notice promptly after the loss, even if all details are not immediately known; additional details of the loss can be provided as they are learned.

Proof of Loss

Most property policies require the insured to prepare and submit a proof of loss, sometimes under oath. This document will outline the types of covered losses claimed and the amount claimed by category; it will also confirm the insured’s ownership interest in the property at the time of loss and include other information that the organization must attest is true and accurate. Additionally, the policy may provide a time deadline for submission of a proof of loss, and the submission of a proof of loss often will initiate a time limit within which the insurer is obligated to pay the claim. There is typically no prescribed format for a proof of loss, and the broker or insurer usually will provide a format.
In the property and business interruption claim context, it is common practice to submit a proof of loss only after agreement by the insurer and policyholder on the total loss or to document agreement on the amount of an advance payment requested by the policyholder (whereby the policyholder would submit a partial proof of loss). This practice contrasts with other types of first-party claims, such as fidelity claims, in which the policyholder generally submits a proof of loss prior to any agreement on the amount of loss.

A proof of loss submitted before the loss has been fully adjusted by the insurer, or before agreement on the amount of property damage or business interruption loss, is often described as a hostile proof of loss. Insurers often view such a proof of loss as hostile because (1) policyholders may submit proofs for tactical reasons, such as a desire to trigger action on behalf of the insurer (i.e., under the policy the insurer might have as few as thirty days to pay adjusted claims after a proof of loss is submitted), and (2) such a proof of loss may signal a lack of interest in working with the insurer to come to a mutually agreeable valuation for the loss. The result of such a proof of loss may be a claims adjustment that is more adversarial than cooperative, less likely to yield a mutually satisfactory resolution to the claim, and more likely to lead to alternative dispute resolution (ranging from appraisal to litigation). Insurers often view a premature proof of loss as hostile regardless of the policyholder’s intent. Thus, the policyholder should carefully consider the ramifications of filing a proof of loss prior to agreement on the amount of loss. In cases where the policyholder determines that a hostile proof of loss is in its best interests, a common issue is whether the policyholder has submitted something that constitutes a proof of loss, as opposed to some other document. An insurer may dispute whether the policyholder has filed a true proof of loss in order to avoid obligations triggered upon the filing. In such cases, insurance experts and/or legal counsel should be consulted.

Generally, the best way for the policyholder to deal with the proof of loss question (in a complex claim) is to raise the question with the insurer and get a written understanding of when and how to submit. This will avoid timing issues.

**Cooperation**

Most policies expressly require that the policyholder cooperate in specific respects with the insurer after a loss; cooperation may also be required under the common law of some states. This duty often extends to making facilities, witnesses, and relevant, nonprivileged documents available to the insurer. It also may require the insured to submit to an examination under oath by the insurer or its representative. Examinations under oath are rare but are becoming
increasingly prevalent in cases involving large or questionable losses. Failing to cooperate sometimes can provide an insurer with a basis for denying coverage, although, as in the case of untimely notice, an insurer may be required to show that a lack of cooperation was prejudicial to the insurer to avoid its coverage obligations on that basis.

After an event resulting in property damage, insurers with potential exposure for losses arising from the event typically will undertake some investigation (or will retain an independent adjuster to perform that function) to quantify the loss and to determine whether and to what extent the loss is covered. The duty to cooperate may require that the policyholder share information collected as part of any investigation of a covered event. It may further require that the insured provide proprietary or otherwise sensitive information to the insurer if that information is relevant to the adjustment of the loss. The policyholder may have concerns about relinquishing control—to anyone—of any information that could be used by other entities to the policyholder’s detriment. Such outside parties conceivably could include third parties who have an interest in establishing the policyholder’s tort liability or the policyholder’s competitors. Before providing any information in connection with the insurer’s investigation and adjustment, therefore, policyholders who have such concerns are well advised to request from their insurers an agreement that formalizes the latter’s obligation to maintain such information as strictly confidential. Even if the insurance policy does not expressly require the insurer to execute such an agreement, insurers often are willing to do so. Outside the litigation context, this generally can be accomplished through a confidentiality agreement that details the scope of such obligation, including the extremely limited circumstances under which such information may be released to third parties. In the litigation context, confidentiality agreements also can be effected through a judge’s protective order, after agreement by the parties on its terms.

After a loss, the focus of the insurer is usually twofold. First, the company will take the steps appropriate to assist its customer—the policyholder—in evaluating and responding to the loss. Second, the insurer will take the steps appropriate to ensure that it is protecting its own interests, for example, by providing coverage only to the extent that such coverage is provided under the policy form and by taking steps to perfect its subrogation rights, if any. Insurers often correctly conclude that executing a confidentiality agreement will not detract from either objective but instead will facilitate the loss investigation and adjustment process by providing the policyholder with some comfort regarding the confidentiality of its documents and internal information. Some policies affirmatively require that the insurer execute a confidentiality agreement in connection with any postloss investigation by the insurer.
While sometimes broad, the duty of cooperation is not unlimited. The insurance contract and applicable law should be consulted to ascertain the scope of such an obligation, but in general policyholders should not be expected to provide assistance beyond what is reasonable and practicable under the circumstances. Neither should they be expected to incur substantial expenses in response to an insurer’s requests for information. Arguably, such expenses should be borne by the insurer, and, indeed, many policies contain express provisions entitling the insured to be reimbursed for claim preparation expenses. Moreover, policyholders are sometimes asked to provide substantial assistance to counsel and experts retained by the insurer in connection with actual or potential insurer subrogation actions (see the discussion on subrogation that begins on page 291). The insurance contract generally will specify the policyholder’s duties to cooperate in connection with subrogation matters arising from the loss. However, there will be cases in which the insurer has asked for such cooperation even though it has yet to actually reimburse the policyholder for its losses or even agree to provide coverage. In such cases, it is at least questionable whether the policyholder should be required to provide any additional assistance relating specifically to subrogation matters, since the insurer has technically not been subrogated to the rights of the policyholder in pursuing third-party claims. Again, the terms of the policy and the applicable law should be consulted with regard to such requests for cooperation.

**Mitigation**

Many policies cover only those losses that could not be avoided through reasonable postloss mitigation efforts. With respect to business interruption coverage in particular, a policyholder is often required to exercise due diligence to repair covered property damage and resume operations. Thus, after a loss, the policyholder should evaluate whether there are reasonable steps it can take to avoid additional losses. Also, to the extent feasible and appropriate, the policyholder may want to involve or at least notify its insurer regarding mitigation efforts to provide an opportunity for input and to avoid complaints after the fact.

**Cost-Tracking**

In general, a policyholder bears the burden of measuring, documenting, and establishing its claim. To facilitate that claim’s handling, or to document proof of the loss should disputes arise with the insurer, the policyholder should systematically track all potentially covered losses. This includes establishing an internal accounting cost code, developing a system for collecting hard copies of invoices, and organizing and maintaining the data in a user-friendly format. This should be done as soon as possible following a loss—especially for complicated claims involving
large and diverse sets of costs. Otherwise, the policyholder could be faced with the daunting task of reconstructing costs from scratch months later. Collecting loss information is helpful in pursuing not only covered losses but also possible claims against third parties.

**Retention of Counsel**

Companies make different decisions about retaining outside counsel, depending on the size and severity of the event and the relevant experience of that counsel. At minimum, insurance coverage lawyers may add value by evaluating coverage and advising on its potential scope. Put differently, outside coverage counsel can help to identify possibilities for ensuring coverage in the policy terms for categories of costs that policyholders might not otherwise have included in their claims. Often, courts have interpreted insurance policy language in a way that may not be immediately obvious—which may in some circumstances favor the policyholder and, in other cases, the insurer. In the extreme case, an insured event raises the vast array of third-party liability and regulatory concerns noted previously, in addition to first-party property and business interruption losses. In such a case, it is advisable to retain outside counsel who can handle and coordinate a comprehensive postcatastrophe response. This can include responding to civil and criminal inquiries and actions by state or federal authorities, defending against third-party liability actions, handling jury trials or other adjudicative processes, and managing the policyholder’s public relations strategy. At the same time, counsel will shepherd the policyholder’s first and third-party insurance claims to negotiated or adjudicated resolutions. In the latter scenario, the outside counsel (and retained experts, such as are discussed later) generally must function as a highly coordinated team, to ensure that the company’s review of facts and development of theories remains consistent as they pull together the various pieces of the postloss puzzle. At the same time, outside counsel will strive to ensure that the team is working to minimize the policyholder’s potential liability and losses while simultaneously maximizing the policyholder’s insurance assets. (See the discussion on Crisis Management in Chapter 6.) Finally, and perhaps most importantly, it is often critical to involve counsel early in order to ensure that important discussions and documents are privileged and protected from forced disclosure. Part of this calculus is determining which individuals are part of the privilege and which are not and proceeding accordingly. Questions concerning privilege are addressed in detail later in this chapter.

**Retention of Experts**

Depending on the complexity of an insured event, one of the policyholder’s most important first steps is hiring the right experts. Some specialists focus on
determining the causes of a loss; others can help counsel and/or the policyholder to prepare claims and calculate damages. With respect to property damage and business interruption losses, the policyholder can retain independent loss adjusters, accountants, economists, forensic accountants, and engineers who can assist with tracking costs, developing and negotiating claim(s), and mitigating losses. It is important to select a group that is independent of the applicable insurance company and its agents. If the event implicates third-party liability concerns, the insured may turn to experts on cause and origin issues and/or to those who can address the potential multitude of third-party liability issues. An insured must consider the possibility of future litigation, both between the insured and insurer and between the insured and third parties. In most circumstances, the policyholder should consider retaining experts who are experienced and can present fact or expert testimony in connection with a formal adjudication of disputes arising from the event (see discussion on Testifying and Nontestifying Experts).

**TESTIFYING AND NONTESTIFYING EXPERTS**

A testifying expert is an individual who will provide testimony during a trial or hearing. Such an expert is subject to very expansive discovery rules. (See the discussion about Discovery on page 294). In general, they must reveal all of the bases for their opinions, including all of the calculations, assumptions, and factual data underlying those opinions as well as other information as required by the governing state or federal law. Because of this, any party to litigation must be very careful in disclosing to a testifying expert any information that is privileged or protected by the work-product doctrine. (See discussion regarding Privileged Communications on page 286).

It is a regular and highly advisable practice of litigants involved in large-scale, expert-dependent litigation to retain separate testifying and nontestifying experts. Nontestifying experts assist in investigation, claim development, etc., but, because they will not testify in court, they typically are not subject to the same broad discovery as testifying experts. Consequently, absent a waiver or some other legal principle overriding the privilege or work-product protection, a party to litigation often may share with the nontestifying expert information that is privileged or protected by the work-product doctrine without fear of discovery. So long as it is conducted at the direction of counsel and in anticipation of litigation, the work of the nontestifying experts is generally protected from disclosure, because the nontestifying expert will be considered an agent of the attorney. In that regard, the nontestifying expert is often retained by the outside counsel, even with the understanding that the consultant’s fees will be paid by the client.

**Public Relations**

Often a large insured event will lead to adverse publicity. At a minimum, it may dictate some communication to the public regarding the nature and efficacy of the policyholder’s response. Policyholders that do not have the requisite expertise in-house may want to retain a professional public relations consultant who, in concert
with in-house or outside counsel and policyholder representatives, can craft a message both appropriate for public consumption and consistent with the policyholder’s overall postloss strategy.

**Understanding Policy Provisions Bearing on Dispute Resolution**

Insurance policies frequently contain provisions relating to dispute resolution. Some contain time limitations on bringing suit, which purport to preclude any action against the insurer after a specified period of time has elapsed. Contractual suit deadlines are often dramatically shorter than statutory limitations periods (e.g., such contractual provisions often purport to require that suits against the insurer be filed within a period as short as one year from the date of loss). If such provisions were applied literally, however, they would often be impossible to meet, since other policy provisions often require time-consuming activities as a condition precedent to coverage. Such other activities could include provisions for mandatory appraisal, which would require a joint appraisal process that often can absorb a period of time that runs beyond the policy’s time limitation for bringing suit. They could also include policy provisions purporting to prohibit any legal action until the policyholder has fully complied with every condition in the policy (including the appraisal condition) or until the loss is fully liquidated—which, again, can use up much of the suit-limitation clock. Such built-in suit limitations periods, however, may be automatically tolled under state law until the insurer formally denies the claim or for other equitable reasons and may even be unenforceable in some states. After a loss, a policyholder should always evaluate the potential effect of such provisions and should consider seeking a mutual tolling agreement in writing from its insurers to ensure that potentially applicable suit deadlines do not elapse while the parties endeavor to resolve the claim outside of litigation.

Some policies also contain mandatory arbitration and/or mediation provisions, forum selection clauses (which designate the location for adjudication of disputes in court or through arbitration), and choice of law provisions (which designate the substantive law that is applicable to any coverage dispute). These provisions—or their absence—often bear on a policyholder’s insurance recovery strategy in the event of a disagreement with its insurers over the amount or existence of coverage.

**Calendar Key Dates/Events**

As a matter of organization, and to ensure that key deadlines that could result in loss of important rights are not overlooked, the policyholder should with the assistance of counsel carefully note applicable deadlines. These can include statutory suit deadlines, contractual suit deadlines (if any), the date for submitting a proof
Exhaustion of Informal Dispute Resolution Alternatives

Coverage litigation is rarely the appropriate first step after a loss. Even when it appears that the parties may disagree on material aspects of the insurance claim, it often is advisable to engage in reasonable informal efforts to resolve the claim with expensive insurance coverage litigation a strategy of last resort. Such efforts may involve: (1) meetings between the policyholder and insurer representatives to discuss the claim; (2) using the broker to help resolve disagreements; (3) using experienced insurance consultants who specialize in negotiated resolutions; (4) relying on in-house and/or outside counsel to negotiate a resolution; (5) nonbinding mediation; (6) working with a specialized team consisting of the two or more of the above experts; and (7) use of a tolling agreement to extend the time in which suit may be filed.

Privilege and Confidentiality Concerns

After a loss, insurers and other third parties may request information relating to the event. If litigation is filed, the policyholder’s adversaries will have a right to demand relevant documents and information, and the policyholder may have an obligation to comply with such requests, subject to some limitations. This process is called discovery, and is described beginning on page 294. Therefore, after an insured event, policyholders should take immediate steps to protect the confidentiality of proprietary business information. Moreover, they should anticipate the need to navigate the insurance claims process (and any collateral third-party liability and/or governmental processes) with a heightened sensitivity to the content of communications made and documents generated regarding the event. Put differently, the policyholder should not unnecessarily make its internal proprietary information available for the world to see. Neither should the policyholder make statements that it would not want repeated, nor should it create documents that it would not want read out loud and out of context in a courtroom at some later date.

Of course, there are measures a policyholder can adopt to protect itself when the insurer and/or other third parties start making demands for information. With respect to internal proprietary information such as trade secrets, other intellectual property, discussions of corporate strategy, and anything else that the policyholder deems confidential, the policyholder can be vigilant about what it makes available and the conditions under which it is made available. For example, the policyholder obviously should not carelessly provide to the insurer (or to any other third party)
information that is not possibly relevant or information that is subject to some privilege and thus immune from discovery in a litigation context so long as it is maintained as confidential.

Moreover, the policyholder can insist that any information provided to its insurers is encompassed by a confidentiality agreement that places broad limitations on the insurers’ ability to use such information or to communicate it to third parties. Should litigation be involved, the policyholder also can request that the court impose limitations on the use of such information. This is normally accomplished with a protective order that delineates conditions under which the information may be used and generally restricts the parties’ ability to divulge the information to third parties.

With respect to postloss statements and documents generally, the policyholder should at a minimum be aware that nonprivileged communications eventually might be subject to discovery. Privileged communications are those that—in light of a specific public policy rationale—are generally immune from discovery by third parties. An example would be an overriding public interest in fostering open communications between certain groups of individuals. Well-known privileges include the attorney-client privilege, which protects communications between attorneys and clients; the work-product doctrine; the physician-patient privilege; and the spousal privilege. (Further discussion is included in the subsequent highlighted discussion of Privileged Communications.)

In the postloss context, the attorney-client privilege generally is the most relevant to the policyholder and insurer. But a policyholder cannot presume that communications with anyone other than counsel (or those designated by counsel as litigation consultants) are privileged and therefore immune from discovery by third parties. In other words, a policyholder’s internal communications outside of the presence of counsel, internal documents not created at the direction of counsel, and communications with third parties—including insurers, brokers, and consultants—may be nonprivileged and therefore subject to discovery and use by adversaries in litigation. This issue has taken on added significance with the increased use of electronic mail, which has resulted in a culture of documented informal communications that were once reserved for oral discourse. It is not surprising that electronic mail is now viewed as one of the most fertile sources of useful information in litigation.

If litigation either against its insurers or against other third parties is a realistic possibility for the policyholder, the policyholder can take measures to protect the confidentiality of its statements and documents and limit the number of nonpriv-
ileged communications. These so-called prophylactic measures include instructing key individuals to limit their communications about the issues and taking extreme care with oral and written statements. They also would include ensuring that all key individuals are educated about the universe of issues and how the various pieces fit together (e.g., property insurance, liability insurance, third-party liability actions) to reduce the likelihood of inadvertent or careless statements or writings about one aspect of the loss (e.g., property insurance) that could be used to undermine other aspects of the loss (e.g., liability insurance and/or third-party suits). Further, such measures will include in-house or outside counsel on all communications regarding the claim to the extent practicable.

Finally, in some contexts it may be possible for the policyholder to establish a privilege (sometimes referred to as a privilege based on joint defense interests or a common interest) with insurers and their counsel. Doing so can be tricky and—depending on the applicable law and the circumstances—not without risk of some court ruling that the privilege did not attach. But such a step can be important in protecting against third-party claims and the like. It is a balancing act both to have a privilege with the insurers, while having other communications that are privileged as against the insurers, but in some cases it can and should be done.

**PRIVILEGED COMMUNICATIONS**

The term privilege is a shorthand legal term of art used to describe communications, documents, or other materials or information that are protected from forced disclosure by legal process. In the United States, federal courts employ civil rules of practice that allow broad discovery into any matters that may lead to evidence admissible in a litigation. Most state court systems have similarly broad discovery policies. (The distinction between federal and state courts is briefly summarized on pages 292-296; the concept of discovery is discussed on page 294.) Discovery requests under these broad rules may even be extended to third parties who are not plaintiffs or defendants in a litigation.

But privileges protect from this discovery process certain documents and oral and written communications that the law recognizes as highly important to a soundly functioning society and judicial system. Thus, for example, it is deemed beneficial to society to foster open and candid communications between clients and their attorneys. Therefore, the law privileges those communications with protection from discovery. Generally speaking, communications between a client and attorney in the course of a representation and for the purpose of representation are not subject to discovery or forced disclosure even if they are deemed potentially relevant to a particular matter. Other important relationships that are accorded privileged status include the spousal relationship, where one spouse cannot be forced to reveal the substance of communications with the other spouse; the doctor-patient relationship, in which a doctor cannot be compelled to reveal information given to that doctor in the course of a patient's treatment; the psychotherapist-patient relationship; and others.
Special considerations come into play when discussing the attorney-client privilege as it attaches to attorney representation of a corporation or other legal entity. In general, an attorney (including both in-house and outside counsel) represents the organization itself and not its directors, officers, or employees. Therefore, any privilege that attaches to communications between the attorney and employees of the entity belongs to the entity and not to the individual employees. This is an important distinction because it is possible to waive a privilege, either inadvertently or intentionally. This distinction also means that not every conversation between an attorney and an employee may be subject to a claim of privilege.

It is important to understand that privileges can be waived by the holder of the privilege—in some cases, even unintentionally. In an attorney-client relationship, the privilege belongs to the client. This means that the attorney generally may not waive the privilege; only the client may. Typically, a privilege will be waived when the confidential nature of the communication is violated by its holder. If a lawyer and client discuss issues in the presence of a third party who is not a party to the litigation in question, privilege may not attach to that conversation. After all, why should the law extend a special privilege to protect the confidentiality of a communication if the parties to that communication do not themselves protect it? Many jurisdictions will find a waiver of the privilege even where the disclosure of the confidential information or communication is inadvertent. So it is vitally important for employees of a corporation or other legal entity to be clearly instructed to maintain the confidential nature of communications with attorneys.

Closely related to the concept of privilege (specifically the attorney-client privilege) is a doctrine known as the work-product doctrine. Not technically a privilege, the work-product doctrine is driven by many of the same public policy concerns underlying the law of privileges. The work-product doctrine protects the thought processes, strategies, and legal work produced by an attorney or the attorney's agents or produced at or under the direction of an attorney. This doctrine does not protect all work performed by an attorney, only that performed in anticipation of litigation. The protection provided by the work-product doctrine is not as broad as that provided by the law of privilege and may be overridden in certain circumstances.

Obviously, much that an insured does after an insured event occurs will be covered by either the attorney-client privilege, the work-product doctrine, or both. Internal investigations, witness interviews, scientific analyses, and other matters performed by or at the direction of counsel and in anticipation of litigation are generally protected. Insurers often attempt to obtain access to their policyholder's attorney-client communications and work-product generated during these postevent investigations; courts vary as to whether insurers are entitled to them. Although it is presumed that an insured and insurer have a common interest in investigating the event and that the insured has an obligation to cooperate (usually a term in the policy), insurers often seek these materials not to assist the insured but to defeat coverage. It depends on the particular circumstances of the case, but courts have generally refused such insurer efforts, especially when it is clear that insurers seek the materials not for the legitimate purpose of investigating the claim but instead to defeat coverage or defend against a coverage action brought by the insured.
The Insurer’s Predispute Checklist

On receiving an insured’s notice of loss, insurers must take some basic steps as well, long before any potential dispute with the policyholder emerges. These include some of the same steps outlined previously: that is, to retain counsel, experts, and/or independent adjusters, to monitor communications to ensure that careless but substantively important nonprivileged communications are not being made, to calendar key dates, and to exhaust informal dispute resolution alternatives. In addition, insurers generally should consider the following issues.

Evaluate Coverage Obligations

Like the policyholder, the insurer should evaluate its coverage obligations after a loss to understand its potential obligations. What are the limits? What are the deductibles, retentions, and/or underlying limits? Does the policy also obligate the insurer to provide third-party liability coverage in any circumstances? If so, does the insurer have a duty to provide a defense against third-party claims? Does the policy contain nonstandard provisions that make this coverage broader than normal? Or more restrictive? In short, the claims person with lead responsibility for the claim should not make assumptions about what the policy provides. Neither should she completely delegate that task to a third party like an independent adjuster or outside counsel. Instead, she should take the time to understand the specific policy terms. Even policies issued by the same insurer can contain material variations by virtue of manuscripted terms, use of endorsements, and the use of different policy forms. Policies can also vary due to other reasons, such as inclusion of follow-form provisions that subject one insurer to terms contained in another insurer’s policy. It is often advisable to request a copy of the policy from the insured to make sure that both the insurer and policyholder are evaluating the claim under an agreed policy form.

Reserve Rights

When a claim is tendered to the insurer, that insurer generally has a legal obligation to make a coverage determination (i.e., to accept or deny coverage) within a reasonable period of time. In some jurisdictions, an insurer who merely reserves its rights will be deemed to have waived any coverage defenses that are not expressly reserved in writing after a loss. Thus, an insurer should ensure that its postloss response does not result in an inadvertent waiver of coverage defenses.
Be Responsive to the Policyholder

When a loss occurs, one of the insurer’s primary concerns should be the welfare of the policyholder. This is not only a rational business approach (after all, the policyholder is the customer); it is required under the law. Specifically, insurers generally have duties to conduct their loss investigation in good faith and to elevate their policyholder’s interests above their own. In some jurisdictions, insurers are even considered to be fiduciaries of their policyholders, meaning they owe duties of utmost loyalty to their policyholders. A breach of such duties—for instance, by taking some action that is harmful to their policyholder—can in some circumstances expose the insurer to compensatory and punitive damages. An insurer therefore should never conduct its investigation in a manner designed to minimize a claim, harm the policyholder’s interests, or otherwise subordinate the interests of the policyholder beneath the insurers’ self-interest. A fair, objective review of the facts, policy terms, and applicable law is not only required but is in everyone’s best interest. Moreover, responsiveness to the needs of the policyholder often will reduce the prospects for disputes and litigation by increasing the likelihood that the claim can be resolved amicably. This does not mean, of course, that an insurer cannot take reasonable and appropriate steps to protect its own interests, including litigation of disputes over the existence or amount of coverage with a policyholder. However, such actions must be taken with good-faith obligations in mind.

Evaluate Subrogation

Once an insurer pays a loss on behalf of its insured, it might have a right to proceed against the party that the policyholder (or the insurer) believes is legally responsible for the loss. This is called subrogation. A subrogating insurer steps into the shoes of the policyholder and may assert its legal rights with respect to any claims the policyholder might have against parties who may have contributed to the loss. Most property policies contain subrogation provisions detailing the parties’ rights and obligations in the subrogation context. Many policies, however, permit the policyholder to waive the insurer’s right to subrogation before loss. Often, if a third party is deemed to be at fault, the insurer will subrogate—and that action will provide the policyholder with the opportunity to collect additional funds, such as the deductible and other uninsured losses, splitting any recovery with the insurer.

When the Parties Cannot Amicably Resolve the Claim

Policyholders and insurers will at times disagree about the existence and scope of coverage and/or the calculation of the loss. Frequently disputed issues include whether the policyholder is an insured under the policy, whether certain aspects of
the loss fall within the insuring agreements of the policy, whether specific exclusions apply to some or all of the loss, whether the insured has complied with policy conditions, and whether the claimed losses have been properly quantified.

When the parties cannot agree on the policyholder’s insurance claim, one or more mechanisms may be required to help resolve the dispute. Typical options of dispute resolution are state or federal court litigation, appraisal, arbitration, mediation, and negotiation (the latter three often referred to as alternative dispute resolution or ADR). Often, policy language will mandate an approach to resolving disputes, including appraisal, litigation in a specific court, binding arbitration after nonbinding mediation, and/or litigation in a court after nonbinding mediation. Unless these requirements are waived or postponed by mutual agreement, the policy may constrain the parties’ options. Moreover, some of these options are not necessarily mutually exclusive. It is not unusual for parties for enter into nonbinding mediation during the course of formal litigation; neither is it unusual for parties to submit a matter to arbitration after litigating in state or federal court for some time. Often, too, in the first-party insurance context, the parties continue to negotiate certain aspects of the insurance claim—in effect, continuing to adjust the loss—while specific issues are being litigated.

A brief summary of the four primary dispute resolution approaches follows.

**Traditional Litigation**

The traditional forum for dispute resolution is a court of law. Roughly speaking, a judge presides over court proceedings; the parties are permitted to obtain information from each other according to specific rules, as part of the discovery process; and parties may attempt to win the case prior to trial based on technical or legal arguments. If the matter proceeds to trial, lawyers present evidence and make arguments, a judge or jury reaches a decision on the merits of the dispute, and the losing party may appeal to a higher court if they so choose. In the United States, when policyholders and insurers take their disputes to court, they end up in either state court, which is part of a particular state’s judicial system, or a federal court, which is part of the United States’ federal judiciary. Some important aspects of federal and state court litigation include the following:

**Federal Court Versus State Court**

United States federal courts may have jurisdiction over the subject matter of a dispute if the legal issues presented involve a federal question or if there is diversity of citizenship between the parties in the suit. Federal question jurisdiction refers to actions arising under the constitution, laws, or treaties of the United States and
involving a minimum dollar amount. Diversity of citizenship jurisdiction refers to cases involving citizens of different states; in broad terms, this requires that each party on one side of the case be a citizen of a state different from each party on the opposing side. Most insurance disputes are of the latter variety; they usually do not raise federal questions.

State courts determine jurisdiction based on the type of proceeding involved and the amount in controversy. To bring a claim in a particular state court, the plaintiff must satisfy the statutory requirements, which differ from state to state. Therefore, it is important to consult the local rules and statutes before deciding where to file a complaint. In addition to having jurisdiction over the subject matter of a suit, a plaintiff must satisfy the courts’ requirements of personal jurisdiction and venue. Personal jurisdiction refers to the power of the court to decide a case with respect to a particular individual. Whether a court has properly obtained personal jurisdiction over a defendant is governed by the federal constitution and statutes, state constitution and statutes, and court rules. Although it is not practicable to explain the principles of personal jurisdiction completely here, in general a defendant must have a sufficiently close nexus to the forum in which the court sits to be subject to the jurisdiction of that court. What constitutes a sufficient nexus depends on the facts and circumstances of each case and is informed by a large body of federal and state case law. Venue refers to the specific location of the courthouse. Generally, even where jurisdiction is proper, a plaintiff must still choose a court that has some relationship to the events that happened in the case or where a defendant is located or may be found. Again, venue is controlled by both statute and court rule.

**Applicable Law**

Given the dual federal and state governmental systems in the United States, it is not always immediately apparent precisely which law will apply in a given case. For cases governed by state law, as most insurance coverage cases are, a question of which state’s law applies often arises. In the event of disputes involving non-U.S. entities and losses, the question can even arise about which country’s law applies. Deciding which law applies in a given situation is not a merely academic exercise; it is often dispositive of the matter, since the law that determines the outcome on an important issue might differ from state to state or country to country.

For example, suppose a policyholder is headquartered in Michigan and has seven insurers variously headquartered in Maryland, Connecticut, New York, Florida, London, Bermuda, and Switzerland. What state’s law will apply to business interruption claims if a catastrophic event damages a supplier’s facility in California—and the damage to the supplier’s property adversely affects the policy-
holder’s operations in Oregon, Arizona, Maine, and Hawaii? To resolve questions like these, courts have evolved a doctrine known as the law of conflicts of laws, which involves an often-complex analysis of the facts and circumstances of the case. Moreover, in the United States, each state has its own rules for determining which law to apply to a given dispute brought in one of its courts. Therefore, it may be very difficult to determine precisely which law will apply until the matter ends up in a court and the judge decides the choice of law issue. For just this reason, parties often include choice of law provisions in their insurance contracts, specifying that when a dispute arises out of the contract, the parties agree that the law of a specific jurisdiction governs the dispute.

**Discovery**

As noted previously, discovery is the mechanism by which parties to a litigation exchange information in their possession, custody, or control that is relevant to the issues to be decided. In discovery, parties can demand from one another documents, written answers to written questions (called interrogatories), depositions of employees as well as the organization itself (called a corporate designee deposition or “30(b)(6)” deposition, referring to the federal rule that authorizes such depositions), and other information. Under certain circumstances, discovery can be extended to third parties. Federal court rules, and most state court systems, provide for very broad discovery, to allow both sides to a dispute to marshal the evidence they believe they need to litigate the matter. While this broad policy is beneficial to parties in that it reduces surprise in litigation, it can also be expensive. In a large insurance coverage dispute, gathering documents and data, answering interrogatories, and preparing for and attending depositions can run into the hundreds of thousands (or even millions) of dollars and place significant strain on employees’ time.

While discovery rules can be broad, they are not unlimited. In some cases, a party may seek to take discovery beyond permissible limits. For example, parties generally are not allowed to obtain from their adversary information that is protected by some privilege or information that is not relevant or even reasonably calculated to lead to the discovery of admissible evidence. Moreover, when discovery becomes burdensome, harassing, or overbearing, the party to whom the discovery is directed may seek relief from the court in the form of a protective order. Discovery in a large, complex case can last for months, even years.

**Motions**

Motions practice, which may begin as soon as a complaint is filed and served, is an important part of any large-scale, complex litigation including insurance cov-
erage disputes. Motions are the mechanism by which a party asks a court to take some action by issuing an order. In the early stages of a litigation, parties may bring motions to dismiss the complaint on various grounds. These can include lack of jurisdiction, a failure to properly serve the complaint, or a failure to state a legally cognizable claim in the complaint. Further motions can ask to strike portions of the complaint or answer or for temporary restraining orders and preliminary injunctions that either prevent the other side from taking some action or compel them to take some action during the lawsuit. During discovery, parties may bring motions to compel responses to discovery requests or motions to quash discovery demands or limit their scope. After discovery ends, parties often bring motions for summary judgment, which ask the judge to resolve the matter before trial on the grounds that no material facts are in dispute and that the material facts are such that judgment can be granted by the court as a matter of law. Prior to and during trial, parties may bring motions in limine, which seek to limit the types or amount of evidence that the other side may introduce during trial. During trial, parties may also file motions for directed verdict, which ask the court to resolve the matter prior to sending it to the jury for decision. After trial, parties may file motions for new trial or judgment notwithstanding the verdict.

**Trial**

Both federal and state courts use the trial system to determine contested facts and apply the appropriate law to those facts to reach a final judgment. Parties can choose either a jury or a judge trial. In the former, the parties can interview potential jurors, in the process called voir dire, and strike certain of them from the jury panel if they determine bias or other reasons for disqualification. During trial, the parties each present their evidence, typically as testimony from witnesses and by introducing documents and other evidence. Complex rules govern the introduction of both testamentary and tangible evidence in a trial, although those rules may be somewhat relaxed in a trial by a judge as opposed to a trial by jury. Each party also has the opportunity to object to the evidence offered by the other side and may file motions in limine. The plaintiff bears the burden of proving its claims; failure to do so results in a judgment for the defendant. Under most circumstances in a civil matter, the plaintiff must prove its claims only by a preponderance of the evidence, which usually is interpreted to mean that it is more likely than not that the allegations are true. More stringent burdens of proof may apply in certain unique circumstances.

Trials in large insurance coverage matters may be very complex, involving the testimony of multiple witnesses—including witnesses called to testify to facts of the case as well as expert witnesses called to render professional opinions. Such trials can last for many weeks or even months. If a complex insurance case involves mul-
tiple losses or multiple sites, the court may order an initial trial on test sites, so that results of the test case can hopefully be applied to the balance of the coverage dispute.

**Appeals**

Once all posttrial motions are resolved and the court enters a judgment, either side may appeal all or part of the judgment. There are specific (and typically short) time limits within which an appeal must be sought after entry of judgment. On appeal, parties often have only a limited ability to dispute a jury’s (or judge’s) factual findings. Appeals, however, generally are available to remedy errors of law that either tainted the trial process or simply resulted in an incorrect outcome—that is, had the law been properly interpreted and applied, the result would have been different. A litigant generally may appeal once as of right (in the federal court system to a Circuit Court of Appeals and in state systems to intermediate appellate courts). Appeals beyond that are usually only discretionary. For example, very few appeals are allowed to the Supreme Court of the United States as of right. Rather, parties must petition the Supreme Court to hear an appeal. The vast majority of such petitions are denied, so that—in the federal system—the Circuit Court of Appeals is effectively the parties’ last chance to change a result determined in a lower court. With few exceptions, the U.S. Supreme Court only hears cases involving federal questions, and therefore such an appellate step is rarely available for most insurance law disputes.

**Arbitration**

Arbitration is the most traditional form of alternative dispute resolution, where the parties present their case to one or more persons designated to resolve the dispute. Many arbitrations follow rules prescribed by the American Arbitration Association (AAA). Federal and state statutes also govern specific aspects of an arbitration, such as the method for choosing arbitrators and the appropriate way to have the courts confirm or vacate an arbitration award. For example, the Federal Arbitration Act, 9 U.S.C. §§ 1 et seq., provides for the enforceability of arbitration clauses in contracts involving interstate commerce. It includes procedures for the appointment of arbitrators by the court in those cases where the underlying contract fails to provide such a procedure or where the contract’s specified procedure for choosing an arbitrator fails to work. Similarly, various state arbitration acts vest the state courts with the power to confirm and enforce arbitration awards arising from arbitration and specify procedures that parties must follow to have these awards enforced. Some of the key characteristics of arbitration include the following:
Trial before One or More Arbitrators/No Jury

Arbitrations are akin to bench trials in a traditional court of law, in which the judge—without a jury—serves as the sole arbiter of the dispute. In an arbitration, one or more persons acting as judges fulfill that same function: they make factual findings, rule on motions, and ultimately deliver rulings and an award. In an arbitration, the litigants generally can select their arbitrator and often agree on a person (or persons) with expertise in the particular field concerning the dispute. A typical approach is for each side to the dispute to select one arbitrator (often referred to as party arbitrators), and then the party arbitrators select a third arbitrator (often called the neutral arbitrator) as the chairperson. Arbitrators often charge the parties an hourly or daily fee for their services.

Flexible and Limited Discovery, Evidentiary and Motion Rules

Arbitrations generally are conducted similarly to court litigation, although pre-trial and trial procedures (including discovery, motion practice, and rules of evidence) may be relaxed or modified in some respects. Under the complex rules of the American Arbitration Association for commercial arbitration, for example, parties may introduce any evidence that is “relevant and material to the dispute,” and arbitrators are expressly not required to conform their evidentiary rulings to legal rules of evidence. Similarly, under the AAA rules, arbitrators have wide discretion in how they choose to conduct the proceedings, as long as the parties are treated with equality, have the right to be heard, and have a fair opportunity to present their case. Under the Uniform Arbitration Act, adopted in one form or another by the majority of states, the scope of discovery may be limited by the Act’s express goal of making the proceedings expeditious and cost-effective. Thus, extensive discovery and depositions may be discouraged, depending on what rules apply in a given arbitration.

Limited Grounds for Appeal

Arbitrations may be nonbinding—in which case any party not satisfied with the result may opt out of the arbitration process and seek a trial de novo. This means they start all over again in the court system without regard to what happened in the arbitration hearing. Arbitrations can also be binding—in which case their rulings are generally final and enforceable in a court of law. Under the laws of many states, and under federal law, a binding arbitration decision may be reversed only on specific and limited grounds, such as a showing of arbitrator bias, corruption, or fraud, or a showing that the arbitrators completely failed to follow the substantive law applicable to the dispute.
Confidentiality

Arbitrations are often conducted in a manner that avoids the publicity inherent in a civil action. Indeed, under the rules of the AAA, arbitrators are required to maintain the privacy of arbitration hearings unless applicable law prevents them from doing so. The AAA’s Code of Ethics for arbitrators further requires arbitrators to keep confidential all matters relating to the proceedings and to the arbitrator’s decision. Under the Uniform Arbitration Act, an arbitrator may issue a protective order preventing disclosure of confidential or privileged information by any party.

Resolutions Are Often Reached More Quickly

For several reasons, decisions are often reached more quickly than in a traditional court. First, arbitrators are not often burdened with the same overwhelming caseload with which many trial court judges must contend. Second, arbitrators often are amenable to general case streamlining, including restrictions on the amount of discovery, accelerated pretrial motion schedules, and limitations on the time allotted for trial. Third, arbitrators often are required by the applicable rules to issue a decision within a specified time (such as thirty days after trial). Lastly, the parties in arbitration may have only limited grounds for an appeal, whereas in the traditional court system, appeal and postappeal activity can add years to a dispute.

Appraisal

Most property policies allow either the insurer or the policyholder to demand an appraisal if they cannot agree on the cash value of the amount of loss. The appraisal process generally is not intended to encompass disputed issues other than the amount of loss. In other words, an insurer’s defenses to coverage (such as the application of an exclusion) are not subject to appraisal. Many policies contain detailed terms regarding the appraisal process.

For example, under most policies, each party has the right to appoint a competent and disinterested appraiser. Questions sometimes arise regarding whether an individual nominated by a party is truly “disinterested,” such as an appraiser who has had previous business relations with the nominating party; an insurer-nominated appraiser who has previously held similar positions for many insurers, including the nominating insurer, but no policyholders; or even an appraiser previously retained by one of the parties to make computations on the very claim at issue. Courts faced with such issues often affirm the appointment of such an appraiser absent evidence of prejudicial misconduct or some indication that the appraiser is under the direction and control of the nominating party.
The two appraisers then may jointly select a disinterested umpire to resolve disagreements between them; many policies provide that a judge may select the umpire if the appraisers cannot agree on one. The appraisers may then make an award in writing that determines the amount of loss. Such an award often follows an evidentiary hearing, perhaps following a request for such a hearing by one or both parties. The policy generally will not specify the nature and applicable procedures for such hearings, and they are often rather informal. A court generally will not set an award aside unless it is tainted by fraud, collusion, or impartiality. Policies also often provide that each appraiser shall be paid by the party selecting her, and the expense of the appraisal and umpire are paid by the parties equally.

Whether to demand appraisal often raises strategic considerations that turn on the circumstances and applicable law. In many instances, both parties may agree that an appraisal is the quickest and most cost-effective way to resolve a dispute concerning the amount of covered loss. A party that believes it has relatively weak arguments on valuation may conclude that appraisal will provide an opportunity to obtain a better outcome than it could achieve through litigation or negotiation, on the (not always correct) assumption that an appraisal is likely to result in a split-the-baby outcome. A more difficult question is whether appraisal is appropriate when the parties’ dispute extends beyond the amount of loss or when the insurer has yet to agree to provide coverage subject to final valuation of the loss. At a minimum, an appraisal in such a context raises the possibility that nonvaluation issues could be inserted into the valuation process; that the insurer could use the appraisal proceeding as a means of developing evidence for use in connection with a later dispute on coverage issues; or that the insurer is simply interested in wearing down the policyholder, in the hope of securing a favorable settlement by utilizing multiple dispute resolution tools. Such a strategy could raise questions concerning the insurer’s good faith. Moreover, the applicable law could have a bearing on whether the parties can be compelled to appraise on demand of the other and the consequences, if any, of withdrawing from an appraisal once it is initiated (including potential loss of the right to maintain a suit on the policy).

Although often compared to arbitration, appraisal differs in many respects. Appraisal is often less formal, and it is far less like traditional litigation than is arbitration. Also, it is by definition limited in scope because it encompasses only the amount of loss, while arbitration is not subject to any such limitation of the breadth of issues that may be raised and resolved. As one court noted, in distinguishing the two:

Appraisement, in particular, is perhaps most often confused with arbitration. While some of the rules of law that apply to arbitration apply in the same manner to appraisement, and the
terms have at times been used interchangeably, there is a plain distinction between them. In the proper sense of the term, arbitration presupposes the existence of a dispute or controversy to be tried and determined in a quasi judicial manner, whereas appraisement is an agreed method of ascertaining value or amount of damage, stipulated in advance, generally as a mere auxiliary or incident feature of a contract, with the object of preventing future disputes, rather than of settling present ones. (Hartford Fire Ins. Co. v. Jones, 108 So. 2d 571, 572 (Miss. 1959) (internal quotations omitted)).

Mediation

Mediation differs from other forms of dispute resolution in that the parties, with the help of the mediator, generally have the freedom to explore a broad range of possible solutions. In mediation, a neutral third party—often jointly selected by the parties—generally facilitates candid discussion between the parties to help them settle their dispute. The mediator may be someone with relevant substantive expertise or simply someone with dispute resolution skills. In some jurisdictions, litigants must submit to mandatory, nonbinding mediation before trial. Frequently, however, parties who can resolve their disputes themselves resort to mediation voluntarily.

Though more formal than a settlement discussion, mediation is typically far less formal than traditional court litigation or arbitration and generally is not subject to formal procedural or evidentiary rules. Indeed, in a mediation, the parties are often allowed to make their own rules, and mediators themselves may impose their own unique rules. Moreover, unless the mediation proceeds pursuant to a court order, the parties generally may withdraw at any time.

Mediation also usually remains confidential to the parties involved. Communications between the parties (and with the mediator) are often protected settlement discussions, meaning that statements made and documents created for purposes of such settlement discussions typically are considered inadmissible in a formal litigation pursuant to evidentiary rules. Parties often enter into written agreements that make the confidential nature of the process explicit.

Mediation can be utilized at any point in the dispute resolution process, including after litigation has been instituted. A mediator may hear presentations, review written submissions, and tell each party what she thinks about the merits of their respective cases. However, as a general rule, the mediator’s views are not binding in
any way. Parties are generally free to structure a mediation in any way they want, including giving the mediator some power to issue a binding ruling, but that would be the exception rather than the norm.

**Negotiation**

Parties to a coverage dispute are always free to engage in settlement discussions, either face-to-face or through their representatives. Such discussions may encompass an entire insurance claim or only parts of a claim and can occur before or during litigation. Indeed, one of the unique aspects of disputes in the first-party insurance context is that insurers and policyholders can and often do adjust the claim with respect to issues on which there may ultimately be no disagreement or which may not readily lend themselves to formal adjudication. Such issues may include the measurement of the loss, which may be extremely complicated and expensive to litigate even if there are disagreements. Such adjustments can proceed even where the parties have disputes in litigation, such as an insurer’s assertion that an exclusion applies to some part of the loss. It is not entirely uncommon for the first-party insurer and policyholder to work together on certain issues, while at the same time facing off as adversaries in litigation. Settlement negotiations are understood to be confidential, whereby the parties’ settlement-related statements may not be used in any litigation, and this understanding is often documented in a written agreement.

**Conclusion**

The purchase of insurance should not be tantamount to the purchase of a lawsuit. When the policyholder claims what it is entitled to claim, and the insurer does not have a good-faith basis for disputing the claim, there is no reason why the insurer should not pay the claim promptly and without disagreement. Unfortunately, disputes—both large and small—often play a material role in the claims process, and policyholders and insurers must be ready for them by taking the right steps after a loss and ultimately by utilizing the dispute-resolution tools best suited to the circumstances. In all events, after a loss both policyholder and insurer should have in place the right team to ensure that their interests are fully protected, including the individuals who can guide them through the complexities of dispute resolution.