



Denied, delayed, lowballed?

Recognizing actionable bad-faith actions by insurers and advising your client on available remedies

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Insurance companies thrive on slogans that evoke trust – “on your side,” “in good hands,” “like a good neighbor.” But behind the branding lies a simple truth: Their primary obligation is to shareholders, not policyholders. Profit – not protection – drives their decision-making.

The business model is straightforward: maximize premium intake, minimize claim payouts. When full payment threatens margins, carriers delay investigations, narrowly define scope, undervalue losses, and sometimes outright deny valid claims. These aren’t oversights – they’re deliberate strategies designed to frustrate, wear down, and outlast the insured.

In fire and toxic exposure cases, for example, insurers often send underqualified adjusters or biased consultants to conduct limited inspections that miss – or ignore – critical damage. When claims involving contaminated soil or smoke-damaged structures are superficially assessed, the real harm goes unaddressed, and the carrier walks away with reduced liability. Examples of this are seen today in the aftermath of the Pacific Palisades fire in Los Angeles.

These tactics must be recognized early – every delay or deflection should be documented, and both attorney and client must be prepared to pursue litigation if necessary. Because when insurers choose profit over people, evidence – and persistence – is your client’s best defense. To fight back effectively, attorneys and their clients must first understand what bad faith is – and how it differs from a simple breach of contract.

Understanding insurance bad faith in California

At its core, insurance is a contract: the insured pays premiums, and in return, the insurer agrees to provide coverage, investigate claims fairly, and pay what’s owed under the policy. But insurance is also a business – one increasingly driven by profit margins. As a result, many insurers deny valid claims or underpay losses in an effort to reduce payouts and increase shareholder value.

What many don’t realize – attorneys included – is that California law offers powerful remedies that go beyond a simple breach of contract. If an insurer unreasonably withholds benefits – whether by denying coverage, delaying payment, or offering far less than what’s owed – it may be liable for *bad faith*. This opens the door to consequential damages, attorneys’ fees, and even compensation for emotional distress.



Understanding when an insurer’s conduct crosses from breach to bad faith is critical. Identifying these violations early can significantly enhance the policyholder’s recovery – and ensure the insurer is held accountable for more than just the face value of the claim. That analysis starts with understanding the two fundamental types of insurance claims – and the duties insurers owe under each.

First-party vs. third-party claims and the duty of good faith

“First party” claims involve covered losses or damage sustained by the insured, such as injuries or liability covered by fire, theft, automobile, or disability insurance contracts. (*Montrose Chemical Corp. v. Admiral Ins. Co.* (1995) 10 Cal.4th 645, 663.) Common “first party” claims include uninsured or underinsured motorist claims. “Third party” coverage protects the insured



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from liability to third parties based on the insured's acts or omissions that are covered under the insurance policy.

(*Essex Insurance Co. v. City of Bakersfield*, (2007) 154 Cal.App.4th 696, 705.) For example, if a guest slips on an unmarked wet floor or is bitten by the homeowner's dog, they may file a third-party claim against the homeowner's liability insurance for their injuries.

In evaluating whether an insurer acted in bad faith, the critical issue is the reasonableness of the insurer's conduct under the facts of the particular case. To hold an insurer liable for bad faith in failing to settle a third-party claim, the evidence must establish that the failure to settle was unreasonable. (*Pinto v. Farmers Ins. Exchange* (2021) 61 Cal.App.5th 676, 676.)

The duty of good faith and fair dealing implied in every insurance contract includes a duty on the part of the insurer to investigate claims submitted by its insured. (*Safeco Ins. Co. of America v. Parks* (2009) 170 Cal.App.4th 992, 993.)

The duty of good faith and fair dealing also requires a third-party liability insurer to settle a lawsuit against its insured when there is a clear and unequivocal offer to settle within policy limits, liability is reasonably clear, and there is a likelihood of a recovery in excess of the policy limits. In *Comunale v. Traders & General Ins. Co.*, the Supreme Court held that "the implied obligation of good faith and fair dealing requires the insurer to settle in an appropriate case although the express terms of the policy do not impose such a duty." (*Comunale v. Traders & General Ins. Co.* (1958) 50 Cal.2d, 659.)

A liability insurer owes a broad duty to defend its insured against claims that create a potential for indemnity. The duty to defend applies to all claims, including those that are groundless, false, or fraudulent. A carrier must defend a suit that potentially seeks damages within the coverage of the policy. Implicit in this rule is the principle that the duty to defend is broader than the duty to indemnify; an insurer may owe a duty to defend

its insured in an action in which no damages ultimately are awarded. (*Dua v. Stillwater Ins. Co.* (2023) 91 Cal.App.5th 127, 127.)

An insurer must consider the interests of the insured at least as much as it considers its own interests. (*Jordan v. Allstate* (2007) 148 Cal.App.4th 1062, 1071-1072.) "The covenant of good faith can be breached for objectively unreasonable conduct, regardless of the actor's motive." (*Bosetti v. U.S. Life Ins., et al.* (2009) 175 Cal.App.4th 1208, 1236.)

Insurance companies love to say they're "like a good neighbor" or that you're "in good hands" – but too often, those hands are busy finding ways to deny, delay, or underpay valid claims. Against that backdrop, it's essential for you and your client to recognize the specific conduct that may constitute bad faith under California law.

Recognizing insurance bad faith practices/tactics

California law defines certain acts and conduct that can qualify as bad faith. They include the following:

- Unreasonable denial of policy benefits
- Misrepresenting facts or policy provisions to claimants
- Failing to respond or act promptly with respect to a claim
- Not having reasonable standards for the prompt investigation and processing of claims
- Failing to either approve or deny claims within a reasonable time period after the insured has submitted adequate proof of loss
- Refusing to make a good-faith effort to fairly settle claims when liability is reasonably clear or failing to settle one part of a claim in order to influence other parts of the claim
- Compelling the insured to litigate the claim because the insurance company has refused to make an adequate settlement offer
- Attempting to settle for an amount that appears unreasonable when compared to statements made in written or

printed advertising material that accompanied the application for insurance

- Attempting to settle claims using an application that was altered without the knowledge and consent of the insured or his or her agent
- Threatening to appeal an arbitration award in an attempt to compel the insured to accept a settlement less than what was awarded in arbitration
- Failing to provide prompt justification for the denial of a claim
- Advising a claimant not to hire an attorney
- Misleading a claimant as to the legal deadline for filing a claim or initiating a lawsuit

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What to advise your client when facing a potential bad-faith insurer

When dealing with an insurance company, the best defense is a good offense. The following advice applies to all types of insurance claims including motor vehicle accidents, wildfire claims, premises liability and product liability claims.

1. Document everything

No matter how cooperative an adjuster may appear, the insurer's primary obligation is to its bottom line – not to the insured. Clients must be proactive in creating a comprehensive paper trail that can later support a bad faith claim if necessary. Clients should:

- Save all written correspondence, policy documents, and claim-related paperwork in a centralized, secure location.
- Send follow-up emails after each phone call, summarizing the conversation with names, dates, and key points discussed. Include a request for confirmation of receipt and invite written correction of any inaccuracies by a specified



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deadline. This not only documents the insurer's conduct but also cuts off later denials based on alleged miscommunication.

- Retain copies of all claims submitted and written responses received.

The goal is to create a contemporaneous record that captures both the substance and timing of insurer conduct. Courts evaluating bad faith will look closely at how and when the insurer responded – or failed to respond.

2. Understand policy and coverage rights

Insurance companies love to say, “We know a thing or two because we’ve seen a thing or two,” but when it’s time to pay out, they suddenly forget everything. Insurance companies often take advantage of policyholders who don’t fully understand their coverage. This knowledge gap can be exploited by insurers, especially in complex coverage areas like wildfire losses. You must:

- Immediately request a certified complete copy of the insurance policy, including the declarations page, endorsements, and riders. Verify the coverage limits, exclusions, conditions, and notice provisions.
- Identify likely coverage disputes early. For instance, with fire damage, some carriers attempt to cover only direct fire damage while minimizing or denying claims for widespread smoke, ash, and soot contamination – especially where no structural ignition occurred.
- Educate the client on critical deadlines for notice, proof of loss, and appeal of denials. Many policies impose strict timeframes for compliance, and courts often enforce them rigidly.

3. Insurers will use these tactics to delay, deny, and undervalue claims

Insurance companies pride themselves on catchy slogans like, “15 minutes could save you 15%,” but when it’s time to pay a valid claim, they often rely on delay tactics designed to frustrate and devalue. These tactics aren’t just inconvenient, they’re strategic. The goal is to wear down

claimants and, in many cases, their counsel, in hopes of forcing an early or underpriced resolution.

Common delay tactics include:

- **Repeated requests for previously submitted information** – If an insurer persistently asks for the same records or forms, it’s often not due to oversight. Respond formally, cite the prior submission dates, and request a written explanation for the repeated demands.
- **Unjustified delays in communication** – Adjusters who routinely fail to return calls, provide updates, or process paperwork within a reasonable timeframe may be engaging in a calculated stall. Set clear deadlines in writing and cite applicable regulations (e.g., Cal. Code Regs. tit. 10, § 2695.7)
- **Unnecessary investigations or examinations** – Some insurers insist on excessive medical exams, inspections, or third-party opinions to justify delaying payment. Some scrutiny is appropriate, but each request should be evaluated for reasonableness – and objected to if it’s excessive, irrelevant, or not clearly connected to the issues in dispute.
- **Frequent adjuster turnover** – If a claim is reassigned to a new adjuster mid-process, ensure all prior correspondences are well-documented and re-send any critical documents to prevent “misplaced” files.

These stalling tactics can be just as damaging as outright denials. You must respond proactively by documenting all communications, setting firm response deadlines, and escalating to supervisors or the Department of Insurance when necessary. If those efforts fail to secure fair treatment, counsel must be prepared to litigate – armed with a clear understanding of the full range of remedies available in a bad-faith action.

Potential outcomes for cases involving insurance bad faith

When an insurer acts in bad faith, the consequences can extend far beyond the

original claim – opening the door to multiple categories of damages under California law. These include:

- **Contractual damages** – including compensation for the original claim amount that was denied plus interest.
- **Extracontractual damages** – including compensation for economic damages and emotional distress. This would also include attorneys’ fees “reasonably incurred to compel payment of the policy benefits.” (*Brandt v. Superior Court* (1985) 37 Cal.3d 813.)
- **Punitive damages** – If the insurance company’s conduct is particularly outrageous because it is malicious, fraudulent, or oppressive, the policyholder may also recover punitive damages. (2 Witkin Sum. Cal. Law Insurance § 354.)

When it comes to bad faith, clients are not “in good hands” – they’re in for a fight. For instance, in fire loss cases, insurers often send adjusters with limited training who misidentify damage or undervalue claims. If accepted, these lowball estimates can drastically undercut recovery. Insurers may also deploy biased industrial hygienists or environmental consultants to conduct narrowly scoped inspections – designed more to defend the insurer than to uncover the full extent of the loss. You must be prepared to challenge the adequacy and objectivity of these evaluations from the outset. In the face of delay tactics, biased inspections, and lowball offers, the path forward is clear: Arm the client with knowledge, expose the insurer’s misconduct, and demand the full measure of justice the policy – and the law – provides.

Conclusion

Insurers market trust – but slogans like “like a good neighbor” ring hollow when valid claims are delayed, underpaid, or denied. Whether you’re an attorney or a policyholder, the reality is the same: Insurance companies are in the business of protecting their bottom line, not you. The law imposes a duty of good faith, and when that duty is breached, documenta-



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tion and persistence matter. A thorough claim file, a timeline of delays, and a clear record of unreasonable conduct are often more powerful than any commercial jingle. When carriers refuse to do the right thing, it's not branding that delivers justice – it's litigation.

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