

**ORIGINAL**

In the  
**Supreme Court of Ohio**

DON B. KINCAID, JR.,

Plaintiff-Appellee,

v.

ERIE INSURANCE COMPANY,

Defendant-Appellant.

Case No. 2009-1936

On Appeal from the Cuyahoga County  
Court of Appeals, Eighth Appellate  
District, Case No. 92101

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**REPLY BRIEF OF AMICI CURIAE PROGRESSIVE PREFERRED INSURANCE  
COMPANY, PROGRESSIVE DIRECT INSURANCE COMPANY,  
PROGRESSIVE CASUALTY INSURANCE COMPANY, AND  
PROGRESSIVE SPECIALTY INSURANCE COMPANY IN SUPPORT OF  
APPELLANT**

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A. **PLAINTIFF HAS IGNORED THE RULE OF LAW THAT PARTIES SHOULD USE GOOD FAITH TO FILL THE GAP OF A SILENT CONTRACT**

In its Merit Brief, plaintiff-appellee Don Kincaid avoids mentioning several of the key arguments presented in the several briefs filed by amici curiae and in the Merit Brief of defendant-appellant Erie Insurance Company. This is not entirely surprising, since those arguments severely undercut (and indeed, refute) the arguments made by appellee.

For example, a principal thrust of plaintiff's Brief is that, since the "Additional Payments" clause of the Erie policy does not contain any **express requirement** that "an application for expenses [ ] be submitted in a particular manner or within a certain timeframe" (Brief of Appellee, p. 8), there is no legal basis for **implying** a requirement that policy-holder give the insurance company notice of such a claim before filing suit (*Id.*, pp. 1-2, 5, 14, 15, 16, 19, 20, 21). However, as amicus Progressive pointed out at pp. 7-8 of its principal Brief, the fact that a contract may not contain an **express** requirement of notice does **not** mean that the contract should be interpreted as intending the opposite, *i.e.*, that **no notice** of any kind need be given. Rather, the absence of an **express** provision on a particular matter simply means that a **good faith interpretation** should be utilized to fill the gap created by the silence of the written contract. See, in this regard, *Savedorff v. Access Group, Inc.* (6<sup>th</sup> Cir. 2008), 524 F.3d 754, 763, where the U.S. Court of Appeals for the Sixth Circuit stated that, "[i]f the contract is silent, as opposed to ambiguous, with respect to a particular matter," the parties to the contract

"are required to use good faith to fill the gap of a silent contract." *Burlington Res. Oil & Gas Co. v. Cox*, 133 Ohio App. 3d 543, 729 N.E.2d 398, 401 (Ohio Ct. App. 1999);

accord *Myers v. Evergreen Land Dev. Ltd.*, 2008 Ohio 1062, 2008 WL 650774, at \*5 (Ohio Ct. App. 2008) (unpublished) (“An obligation of good faith generally arises only where a matter was not resolved explicitly by the parties. . . {T}his duty is implied only under limited circumstances, such as when the contract is silent as to an issue. In such a case, the parties must use good faith in filling the gap.”)

Progressive further pointed out that a “good faith interpretation” is particularly appropriate in this situation, where the Eighth District admitted that its interpretation of the policy’s “silence” with respect to notice – *i.e.*, that the policy should be interpreted as requiring the insurance company “to pay for expenses that the insured supposedly incurred but about which it never notified the company” – leads to a result that would “seem illogical.” (Opinion ¶ 20). Such an “illogical” result should have caused the Court of Appeals to have applied relevant rules of construction (such as the “good faith interpretation” rule) when interpreting the contract.

Significantly, plaintiff Kincaid, in his Brief, ignores this argument entirely, thereby tacitly acknowledging that he has no answer to it.

**B. PLAINTIFF IGNORES THE OHIO REQUIREMENTS FOR A CLAIM OF BAD FAITH**

An essential element of a cause of action for insurance company bad faith is that the insurance company wrongfully refused to pay a claim that was presented to it. See, for example, *Spremulli’s Am-Service v. Cincinnati Insurance Co.* (Cuyahoga 1992), 91 Ohio App.3d 317, 322)

Therefore, all of the amici (as well as defendant Erie) pointed out in their Briefs that it is totally contrary to Ohio law to allow a plaintiff to proceed with a claim for bad faith where the defendant insurer never refused to pay (and, in fact, never received) a particular claim. Yet this argument is never mentioned by plaintiff Kincaid. Indeed,

plaintiff never even mentions that it has asserted (and that the Court of Appeals' decision specifically allows it to pursue) a claim for "bad faith." To the contrary, in the Brief that it has filed in this Court, plaintiff has taken what is headed in his Complaint as "Count II (Bad Faith and the Covenant of Good Faith and Fair Dealing)"<sup>1</sup> and transmogrified it into a claim for "breach of fiduciary duty." (See Brief of Appellee, p. 21: "Count II of the Complaint alleges a claim of breach of fiduciary duties.") The only reasonable inference to be drawn from plaintiff's abandonment of the "bad faith" language is that plaintiff has recognized that any argument that an insured can sue an insurance company for a bad faith refusal to pay a claim that has never been presented to it is legally untenable.<sup>2</sup>

**C. PLAINTIFF IGNORES THE PROOF OF LOSS REQUIREMENT CONTAINED IN THE OHIO ADMINISTRATIVE CODE**

While ignoring key arguments made in the briefs filed **in this Court** by defendant Erie and by the amici, plaintiff Kincaid devotes portions of its Brief to attacking statements made by defendant Erie **in the courts below** that the Erie policy contained a provision stating that no lawsuit could be brought against it "until thirty days after proof of loss is filed." According to plaintiff, that particular provision "was limited to the Medical Payment, Comprehensive and Collision Coverage claims and did not extend to the Liability Protection portion of the policy." (Brief of Appellee, pp. 4 and 9).

Yet elsewhere in his Brief plaintiff Kincaid states that the provisions of § 3901-01-54 of

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<sup>1</sup> See also page 9 of the Court of Appeals Opinion.

<sup>2</sup> Plaintiff's belated fiduciary duty argument is clearly flawed. In an ordinary insurer-insured relationship, the insurer does not owe a fiduciary duty to the insured. *See Schwartz v. Stewart Title Guar. Co.* (Cuyahoga 1999), 134 Ohio App. 3d 601, 616 ("Ohio law does not impose upon an insurer a fiduciary duty with respect to the analysis of claims, absent evidence that the insured placed special trust or confidence in the insurer"). Instead, standard contract law applies, and the insurer's duty is simply the duty of good faith that arises in every insurance contract. In any event, neither the duty of good faith nor even a fiduciary or "quasi fiduciary" duty would require an insurer to reimburse an insured for alleged expenses of which it never received notice.

the Ohio Administrative Code are germane to this case since “plaintiff qualifies as a ‘first party claimant’” within the meaning of that section (Brief of Appellee, pp. 18 and 23). Significantly, however, plaintiff fails to mention paragraph (G)(1) of § 3901-1-54, which paragraph specifically states, as a “**general standard for settlement of claims,**” that an insurer “shall within twenty-one days of the receipt of properly executed proof(s) of loss decide whether to accept or deny such claims.” (Paragraph (C)(1) of § 3901-1-54, in turn, defines “proof of loss” as a “document from the claimant that provides sufficient information from which the insurer can determine the existence and the amount of the claim.”) In other words, regardless of whether the proof of loss provision contained in the Erie policy is applicable to this situation or not, Plaintiff would have this Court ignore the fact that, under the Ohio Administrative Code, an insurance company has **no obligation** to pay a “first party claim” until **after** it receives a document that enables it to “determine the existence and the amount of the claim.” These provisions of the Ohio Administrative Code – which are discussed in detail at pages 10-11 of the amicus brief of the Ohio Association of Civil Trial Attorneys – therefore contradict plaintiff’s position that he has standing to sue defendant Erie for breach of contract (and for bad faith) without ever having presented such a document to Erie.

**D. THE INTERPRETATION OF THE POLICY URGED BY DEFENDANT ERIE AND BY THE AMICI DOES NOT DEPRIVE POLICYHOLDERS OF ANY RIGHT THEY HAVE TO OBTAIN REIMBURSEMENT OF CERTAIN EXPENSES**

Plaintiff Kincaid also suggests that, given the absence of any express language in the liability protection section of the policy with respect to “notice,” it would be unreasonable to interpret the policy as requiring such notice since that would have the effect of “deny[ing] reimbursement to every insured save for those few who are somehow

privity to this unwritten law.” (Brief of Appellee, p. 21) This assertion is not only illogical, but also contrary to human experience. Any insured understands, as a matter of course, that he or she cannot expect to be reimbursed under an insurance policy for incurred expenses unless and until he or she gives the insurer notice, in some manner, that he or she has actually incurred such expenses.

**E. PLAINTIFF IGNORES RELEVANT CASE LAW**

Plaintiff Kincaid also fails to mention several relevant cases when, at pp. 15-16 of his Brief, he purports to discuss the “available case law.” For example, plaintiff totally ignores the case of *Cochran v. State Farm Mut. Auto. Ins. Co.* (Ga. Super. Ct., August 13, 2003), 2003 WL 25485811, even though that case is discussed in the Merit Brief filed by defendant Erie and in three of the amici briefs. Plaintiff’s avoidance of the *Cochran* case is telling, since that case involves the exact same “additional benefit” provision, and the exact same issues, that are present in the instant case. The holding that plaintiff thereby avoids mentioning is, of course, right on point: namely, that the defendant insurance company did not breach the insurance contract because “plaintiff did not make a request for payment or present any documentation supporting his claim for reimbursement” before filing suit. In the Georgia Court’s view, the insurance company’s duty to reimburse “presupposes a request or demand for payment by plaintiff.”

Conversely, while scrupulously ignoring *Cochran*, plaintiff Kincaid repeatedly cites the decisions in *Johnson v. Geico Gen. Ins. Co.* (S.D. Fla. Nov. 3, 2008), Case No. 08-80740, 2008 W.L. 4793616 (S.D. Fla.), *Kavouras v. Allstate Ins. Co.* (N.D. Ohio Dec. 1, 2008), Case No. 1:08-cv-571, 2008 U.S. Dist. LEXIS 108404, and *Gallo v. Westfield Natl. Ins. Co.* (Cuyahoga March 12, 2009), Case No. 91893, 2009-Ohio-1094. However, none of these cases say anything about the issue that is involved in this case,

*i.e.*, whether an insured has standing to sue for breach of contract when he or she never presented a claim to the insurance company. Rather, in each of these cases, the courts denied a Rule 12(b)(6) motion to dismiss because the plaintiff had affirmatively alleged that he or she had performed “all conditions precedent.” The courts concluded that that allegation was sufficient to defeat a Rule 12(b)(6) motion. The instant case, however, involves a motion for judgment on the pleadings brought under Rule 12(C), which takes into account all pleadings, including the answer filed by the defendant. In the instant case, that answer expressly (and repeatedly) denied that plaintiff Kincaid ever made any request for express reimbursement, and plaintiff’s complaint made no allegation to the contrary. Moreover, as pointed out by amicus curiae Ohio Insurance Institute, when defending against a Rule 12(C) motion a plaintiff cannot rely on legal conclusions (such as “plaintiff complied with all terms of the policy”) and must “allege sufficient underlying facts that relate to and support the alleged claim,” quoting from *Clemens v. Katz* (Lucas March 29, 2009), Case No. L-08-1274, 2009 Ohio App. LEXIS 1232 at P7. (Brief of Ohio Insurance Institute, pp. 11-12).

Plaintiff also ignores *McGinn v. State Farm Mutual Auto Insurance Co.* (2004) 268 Neb. 843, 689 N.W.2d 802, cited by the Ohio Insurance Institute. This was a class action ostensibly brought under the medical payments coverage of an automobile insurance policy, seeking recovery for medical treatments that the plaintiff (and other class members) had received as a result of automobile accidents. The principal causes of action were for breach of contract and breach of the covenant of good faith and fair dealing. However, it developed that plaintiff McGinn “had not filed a claim under the medical payments coverage provision of his policy and, therefore, had no claim denied

by State Farm.” (689 N.W.2d at 805) The trial court therefore sustained State Farm’s demurrer, and the Nebraska Supreme Court affirmed that dismissal, because, contrary to the conclusory allegations of his complaint, “McGinn has not alleged a breach of his contract of insurance, and this ‘cause of action’ as well as the remaining dependent ‘causes of action’ are not suitable for judicial resolution.”

**F. PLAINTIFF’S ATTEMPT TO AVOID THE STANDING ISSUE**

Plaintiff also attempts to brush aside the arguments made by amici and by defendant Erie that to have standing to sue, a plaintiff must present an issue that is ripe for judicial resolution, and that there is no actual dispute in cases of this kind until a request for payment has been made by the purported obligee. See *Café Miami v. Domestic Rental*, 2006-Ohio-6596, ¶ 12 (8<sup>th</sup> Dist.) and *Telxon Corp. v. Smart Media of Delaware, Inc.*, 2005-Ohio-4931, ¶ 53 (11<sup>th</sup> Dist.), both of which cases cited Restatement of the Law 2d, Contracts (1981), Section 238, for the proposition that, for the “plaintiff to place the defendant in breach, the plaintiff must tender performance of his obligation and demand performance by the defendant of the reciprocal obligation.” In the *Telxon* case the Eleventh District concluded (in ¶ 54):

From a reasonableness standpoint, this may be the most troubling aspect of this whole case – that [plaintiff] never demanded that [defendant] perform this alleged promise. Therefore, [plaintiff’s] claim is legally insufficient. . .

According to plaintiff Kincaid, the position taken by defendant Erie and by the amici is “nonsensical.” (Brief of Appellee, p. 31), since it would mean that in “order to possess standing to sue for a debt due upon a note, a creditor would first have to present notice and proof to the debtor and wait for a rejection before the dispute was ‘ripe’.” (*Ibid.*) Promissory notes, however, are usually payable at a definite time or on

demand (see R.C. 1303.03(A)(2)), and it has long been established in Ohio that “if a note is payable on demand after the date of maturity, actual demand is not necessary before action may be commenced on it.” *Marion Insurance Agency, Inc. v. Fahey Banking Co.*, 61 Ohio App.3d 9, 12 (3<sup>rd</sup> Dist. 1988). That, however, is not the situation in insurance cases such as this. In insurance cases such as this, the “debtor,” – *i.e.*, the insurance company – does not have in its possession a promissory note or other document indicating that a particular insured has a claim against it. To the contrary, the purported “debtor” has no knowledge of any such claim. The law therefore requires the obligee to give some kind of notice to the alleged obligor before filing suit.

#### **CONCLUSION**

Progressive amici curiae respectfully urge this Court to reverse the judgment of the Court of Appeals.

Respectfully submitted,

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**CERTIFICATE OF SERVICE**

The undersigned hereby certifies that a copy of the foregoing Reply Brief of Amici Curiae Progressive Preferred Insurance Company, Progressive Direct Insurance Company, Progressive Casualty Insurance Company, and Progressive Specialty Insurance Company in Support of Appellant was served via regular United States mail on this 21<sup>st</sup> day of June, 2010, on the following:

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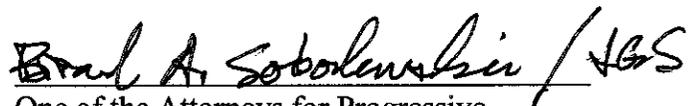
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