Agents E&O Standard of Care Project

Alabama Survey

To gain a deeper understanding of the differing agent duties and standard of care by state, the Big "I" Professional Liability Program and Swiss Re Corporate Solutions surveyed their panel counsel attorneys. Each attorney was asked to draft a brief synopsis outlining the agents' standard of care in their state. They were also asked to identify and include a short summary of the landmark cases. In addition, many of the summaries include sample case studies emphasizing how legal duties and issues with standard of care effected the outcome. Finally, recent trends in errors in the state may also be included.

This risk management information is a value-added service of the Big "I" Professional Liability Program and Swiss Re Corporate Solutions. For more risk management information and tools visit www.iiaba.net/EOHappens. On the specific topic of agents' standard of care check out this article from the Hassett Law firm, our E&O seminar module, and this risk management webinar.

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May 30, 2014

VIA EMAIL
John Nesbitt
SwissRe
John_nesbitt@swissre.com

Dear John:

I appreciate providing me the opportunity to prepare information regarding the standard of care for insurance agents in the state of Alabama. I am enclosing a memorandum setting forth recent case law on these issues. I think this memorandum briefly sets out the duties of an insurance agent under the current state of law in Alabama. If you feel as though it needs more detail or if you need any more information please let me know and I will be happy to supplement this.

In the correspondence regarding this project you also requested information on case studies and areas where I think the greatest amount of exposure exists for agents in Alabama.

There are two areas where I see the most exposure against insurance agents in Alabama. The first area revolves around purchasing general liability insurance for entities providing "professional services" and not explaining that errors and omission coverage also needs to be purchased to protect the insured for their business operations. I have seen these claims arise in two common areas: (1) land appraisers and building inspectors and (2) home builders. These entities are required to purchase liability insurance by the state of Alabama to hold their business license. However, the state only requires them to purchase general liability insurance. General liability policies are not going to provide coverage for "professional services" such as an appraisal or inspection nor will they provide coverage for a contractor's "work product" or "completed work."

I currently have one case involving a home inspector where the general liability coverage did not provide coverage for his errors in inspecting a home and failing to discover termite damage. The general liability carrier denied coverage and the inspector sued the agent for failing to get him the proper coverage. Although the agent says he told the inspector he needed errors and omission coverage and the inspector declined, there is no documentation of this exchange in the file. Of course the inspector denies he was told to purchase errors and omissions. The argument by plaintiff is that the agent is essentially selling a worthless policy.

I have had numerous cases where agents wrote general liability policies for home builders and coverage was denied for construction defects. In one ongoing case, the home builder was sued for defects in the construction of the house. The homeowner ultimately obtained a $600,000 arbitration award against the home builder for the faulty construction. The general liability carrier for the home builder denied coverage based upon the work product exclusions. The home builder then sued the insurance agent alleging the agent did not provide him the proper insurance coverage. The agent insists there was no insurance available that would provide coverage for the claim but there is no documentation showing the insured was told of the limitations of the general liability policy. Fortunately, the policy was delivered and under Alabama law the insured is deemed to be on notice of the pertinent exclusions. In this instance it is easy to argue the home builder was sold a policy that provided little, if any coverage.

The insurance company's denial of the homebuilders claim under his general liability policy is currently before the Supreme Court of Alabama. The Supreme Court initially reversed the trial court's order finding coverage under the general liability policy. An application for rehearing on the reversal of summary judgment has been filed. The matter is still pending. There have been numerous amicus briefs filed by the Home Builders and General Contractors Association for the state of Alabama on this issue. The issue has garnered a great deal of interest in Alabama as to coverages available to contractors. If this issue is overturned and coverage found it would greatly limit the potential exposure for insurance agents. If it is upheld insurance agents need to be made aware that they should inform contractors that general liability policies will not cover their work. Agents need to have something signed by the contractor indicating this has been explained to them. They will need to explore possibilities of obtaining additional coverage if it exists.

The second area causing the most exposure deals with the issuance of certificates of insurance. Certificates of insurance are issued on a daily basis with very little oversight and they can lead to a great deal of liability exposure. The certificates are often issued when construction entities are going on different jobs. Often times insureds will request that the general contractor or owner be given additional insured status. I am finding cases where the agents will indicate that a certificate holder is an additional insured without going through the insurance company to get an additional insured endorsement issued. Most agents seem to assume there is a blanket additional insured endorsement on all policies. However, most non-standard companies do not have such an endorsement and require additional underwriting and a new endorsement. The agents also only send the first page of the Accord form and don't send the second page which contains language limiting the applicability of the certificate and informing all entities listed that an endorsement to the policy is required for additional insured status.

The additional insured status has come up multiple times and companies will always deny the additional insured status if an endorsement is not issued. I have found agents that have been sued for failing to get an additional insured endorsement yet are still operating the same way and indicating on certificates that people are additional insured without going through the proper underwriting processes.

Other times I find that certificates of insurance are issued without confirming coverage and sometimes have even been issued prior to coverage being put in place so contractors could get on a job. These are all violations of the insurance statutes in the state of Alabama. A certificate of insurance should never be issued absent proof that a policy is actually in place and coverage bound. However, when dealing with these construction entities they often times wait to the last second to request the insurance coverage and certificates and are always in a hurry to get on the job.

With Alabama now being a reasonable reliance state the usual fraud and misrepresentation claims in procuring insurance are not arising as often because an insured is deemed to be on notice of the content of a policy. Therefore, the old claims of "the agent told me it would be covered" no longer are viable if policy language says otherwise. I do think the agents in Alabama and probably throughout the country need much more intensive continuing education on the two areas I have discussed as they seem to be the primary areas of potential exposure.

Again I appreciate you allowing me handle this assignment. If you need any additional information please call.

Sincerely,

/s/ Daniel S. Wolter

Daniel S. Wolter
DSW/csl

INSURANCE AGENT'S STANDARD OF CARE IN ALABAMA

Procurement

In Highlands Underwriters Ins. Co. v. Elegante, Inns, Inc., 361 So.2d 1060 (Ala. 1978), the Alabama Supreme Court wrote:

> The law in regard to the duty that insurance agents or brokers owe to their principals, the insureds, is stated as follows:
>
> > '. . . when an insurance agent or broker, with a view to compensation, undertakes to procure insurance for a client, and unjustifiably or negligently fails to do so, he becomes liable for any damage resulting therefrom. (See annotation at 29 A.L.R. 171)' Timmerman Ins. Agency, Inc. v. Miller, 229 So2d 475, 477 (1969).
>
> Once the parties have come to an agreement on the procurement of insurance, the agent or broker must exercise reasonable skill, care, and diligence in effecting coverage. Crump v. Geer Brothers, Inc., 336 So.2d 1091 (Ala. 1976); Waldon v. Commercial Bank, 281 So.2d 279 (Ala. Civ. App. 1973). When the agent or broker has failed in the duty he assumes, the principal may sue either for *breach of the contract* or, in tort, for breach of the duty imposed on the agent or broker. Waldon v. Commercial Bank, *supra*." (Emphasis added.)

361 So.2d at 1065.

In Kanellis v. Pacific Indemnity Co., 917 So.2d 149 (Ala. Civ. App. 2005), the Court of Civil Appeals set forth the elements for asserting a negligent-procurement claim against an agent:

> Like any negligence claim, a claim in tort alleging a negligent failure of an insurance agent to fulfill a voluntary undertaking to procure insurance ... requires demonstration of the classic elements of a negligence theory, i.e., '(1) duty, (2) breach of duty, (3) proximate cause, and (4) injury.' Albert v. Hsu, 602 So.2d 895, 897 (Ala. 1992). Under Alabama law, however, contributory negligence is a complete defense[1] to a claim based on negligence. Mitchell v. Torrence Cablevision USA, Inc., 806 So.2d 1254, 1257 (Ala. Civ. App. 2000).

Id. at 155.

Insured's Duty to Read – Contributory Negligence

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[1] See discussion *infra* and Footnote 2.

Alabama Courts have applied a new standard placing an important duty upon the insured, which can act as a complete defense to any negligent or contractual failure to procure claim. In Nance v. Southerland, 79 So.3d 612 (Ala. Civ. App. 2010), the Alabama Court of Civil Appeals considered Plaintiff's claim against the insurer and agent for uninsured motorist and med pay benefits were disallowed where Plaintiff was found to have signed a rejection of these coverages on her written application. Plaintiff argued that the agent had verbally stated these coverages would be included, but as Plaintiff was able to read and understand the English language, she was deemed, as a matter of law[2], to have assented to its terms despite her testimony that she did not read it. Id. at 619-20.

The Court of Civil Appeals further stated that an agent's duty to inform a customer of the various coverages is primarily a matter of law. Id. at 620. However, Plaintiff failed to cite any legal authority in support of her argument that the agent had a duty and as a consequence, the argument was deemed waived. Id.

Special Relationship (Fiduciary)

At present there do not appear to be any State Court decisions imposing a heightened or fiduciary duty upon an insurance agent when procuring insurance products for his/her clients. Alabama Courts seem to leave the door open to the possibility, and one Federal District agreed that such a relationship did exist under particular circumstances. In Express Oil Change, LLC v. Anb Ins. Servs., 933 F.Supp.2d 1313 (N.D. Ala. 2013), the Northern District of Alabama found a fiduciary relationship existed between the insured and agent. Citing Alabama law, the Federal Court reasoned:

> Although insurance agents and brokers are generally not regarded as fiduciaries under Alabama law, the Alabama Supreme Court has recently defined a fiduciary or confidential relationship as follows:
>
> > A confidential relationship is one in which one person occupies toward another such a position of adviser or counselor as reasonably to inspire confidence that he will act in good faith for the other's interests, or when one person has gained the confidence of another and purports to act or advise with the other's interest in mind; where trust and confidence are reposed by one person in another who, as a result, gains

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[2] Known as the "duty to read defense". Id. at 621. *See also* Foremost Ins. Co. v. Parham, 693 So.2d 409 (Ala. 1997) adopting the "reasonable reliance" standard of review:

> a "trial court can enter a judgment as a matter of law in a fraud case where the undisputed evidence indicates that the party or parties claiming fraud in a particular transaction were fully capable of reading and understanding their documents, but nonetheless made a deliberate decision to ignore written contract terms."

Foremost at 693 So.2d at 421.

an influence or superiority over the other . . .

Id. at 1352, *citing* DGB, LLC v. Hinds, 55 So.3d 318 (Ala. 2010)(internal citations omitted).

As for Alabama State Court decisions, the door for imposing a heightened duty is certainly open. In Guinn v. American Integrity Ins. Co., 568 So.2d 760 (Ala. 1990), the Supreme Court of Alabama considered a claim by an insured against two agents alleging fraud and breach of fiduciary duty in the sale of Medicare supplemental insurance. Plaintiff paid premiums on two policies that the agents allegedly represented would provide her greater coverage than the policies she already had. Id. at 762. Plaintiff then unsuccessfully tried to cancel these policies before she received them, and later consulted another insurance agent to review the new policies against the old, and discovered that they did not provide additional coverage, but were just more expensive. Id. After testimony by one of the insurers that the new policies indeed failed to provide her more coverage than her original ones, the Supreme Court found that a scintilla[3] of evidence existed to establish a claim of fraud. Id. However, the Court found that Plaintiff failed to establish facts whereupon the agents could be liable for breach of fiduciary duty. Id. at 764. Plaintiff had argued that she had told the agents that she was not knowledgeable about insurance policies, and that she would have to rely on the agents to tell her what she needed in order to get the coverage she desired. Id. at 761-62. Plaintiff also argued that her advanced age (88), lack of mental strength, lack of knowledge of insurance matters and the agents' superior knowledge of insurance products warranted imposition of a fiduciary duty. Id. at 764. Nevertheless, the Court was unwilling to impose a specialized duty upon the agents stating that this did not arise to the level of creating a fiduciary duty. Id.

More recently, in Maloof v. John Hancock Life Ins. Co., 60 So.3d 263 (Ala. 2010) the Supreme Court of Alabama appeared to leave the door open for a "breach of fiduciary duty" claim against an agent, citing the rationale of Guinn. However, the Supreme Court refused to apply this heightened duty to the either the insurer or the agent due to Plaintiff's testimony tending to show that his relationship with Plaintiff (although long standing) was nothing outside the typical salesperson-customer relationship. Id. at 274. In refusing to apply a heightened duty, the Court also considered the fact that Plaintiff, "[was] a well-educated professional and an experienced investor," and agreed with the trial Court that there was, "no evidence that would justify the imposition of a fiduciary duty owed to [Plaintiff] by [the insurer and agent] and that summary judgment was accordingly proper." Id.

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[3] Review of summary judgment considered under the old "scintilla rule". This standard of evidence was abolished by Ala. Code §12-21-12, requiring that the non-movant must present "substantial evidence" to overcome a MSJ. *See generally* Crutcher v. Williams, 12 So.3d 631, 632 (Ala. 2008); Waddell & Reed, Inc. v. United Investors Life Ins. Co., 875 So.2d 1143, 1152 (Ala. 2003).

16 of 20 DOCUMENTS

Lucile Guinn v. American Integrity Insurance Company, et al

No. 89-470

Supreme Court of Alabama

568 So. 2d 760*; *1990 Ala. LEXIS 716

September 7, 1990

SUBSEQUENT HISTORY: [**1] Released for Publication October 18, 1990.

PRIOR HISTORY: Appeal from Covington Circuit Court; No. CV-87-28; William H. Baldwin.

DISPOSITION: AFFIRMED IN PART, REVERSED IN PART, AND REMANDED.

COUNSEL: Clark Carpenter of Wooten, Thornton, Carpenter, O'Brien & Lazenby, Talladega, Alabama.

Mark E. Fuller of Cassady, Fuller & Marsh, Enterprise, Alabama.

JUDGES: Almon, Justice, Hornsby, C.J., and Maddox, Adams, and Steagall, JJ., concur.

OPINION BY: ALMON

OPINION

[*761] This is an appeal from a summary judgment entered in favor of defendants Guy Martin, Roger McCollough, Southern Insurance Service, American Integrity Insurance Company ("American Integrity"), Providers Fidelity Life Insurance Company ("Providers Fidelity"), and Senior Citizens Group Insurance Trust of America, [1] and against the plaintiff, Lucile Guinn, on her fraud claims. Guinn also appeals from the dismissal of her claims alleging a violation of *Ala. Code 1975, § 27-12-6*, a breach of fiduciary duty, and negligence and wantonness, as well as from the denial of a discovery motion.

1 Guinn's original complaint named three other defendants. However, the plaintiff and those defendants reached a settlement and those defendants were voluntarily dismissed.

[**2] Martin and McCollough, who did business as Southern Insurance Service, were general agents for American Integrity and Providers Fidelity. They visited Guinn at her home in an attempt to sell her medicare supplement insurance. Guinn was receptive to Martin and McCollough, but informed them that she already had coverage. Guinn had approximately five months of coverage remaining before a renewal premium of $ 594 was due, and had served all of the required waiting periods under those policies. Guinn, who was 88 years old at the time, informed Martin and McCollough that she was especially interested in obtaining the best nursing home coverage she could. However, she alleges that she emphasized that she did not want to be over-insured. Guinn also alleges that she told the agents that she was not knowledgeable about insurance policies and the different kinds of benefits they provided, and would rely on them to tell her what [*762] she needed to do to get the coverage that she desired.

Although the evidence is in dispute on this point, it appears that either Martin or McCollough reviewed the policies that Guinn had in force at the time and then offered her a "package" that was comprised of an American [**3] Integrity policy and a Providers Fidelity policy. Guinn said that the agents told her that the nursing home benefits available under that package were superior to those available under her existing coverage. They advised her to buy their package and allow her other policies to lapse. The agents also told Guinn that she would be able to cancel the American Integrity policy within 10 days of its effective date, and the Providers Fidelity pol-

icy within 30 days of its effective date, if she was not satisfied with them. Guinn agreed to make the purchase and gave the agents a single check for the initial premiums of $ 808.70 for the American Integrity policy and $ 107.50 for the Providers Fidelity policy, a total of $ 916.20.

Soon after she made that purchase, but before she received her policies, Guinn made three unsuccessful attempts to cancel the policies. She later consulted another insurance agent, who reviewed her old and new policies and told her that her new policies did not provide better coverage than did her old policies, but were just more expensive. Soon after receiving that agent's opinion, Guinn filed a complaint alleging, inter alia, that Martin and McCollough had made fraudulent [**4] misrepresentations of material facts concerning the relative merits of her earlier policies and the policies they sold her. It is from the trial court's disposition of the various claims in that complaint that this appeal arises.

Fraud Claims

Guinn appeals the summary judgment in favor of the defendants on her numerous claims of fraud. The trial judge entered that judgment in favor of Providers Fidelity because he was of the opinion that Guinn was not aware of the fact that she was issued a policy by that defendant. Judgment was entered in favor of the other defendants because the trial court held that Guinn had not shown any damage as a result of Martin and McCollough's alleged misrepresentations.

When reviewing a summary judgment, this Court must review all of the evidence that was before the trial court and must review it in a light that is most favorable to the non-movant. *Turner v. Systems Fuel, Inc., 475 So. 2d 539 (Ala. 1985)*. If a case was filed on or before June 11, 1987, the effective date of the "substantial evidence rule" and our review reveals the existence of a scintilla of evidence in support of each of the elements of the plaintiff's claim, the summary judgment [**5] must be reversed. *Ala. Code 1975, § 12-21-12*; *Folmar v. Montgomery Fair Co., 293 Ala. 686, 309 So. 2d 818 (1975)*. Except, of course, in the case of a summary judgment for the defendant based on uncontroverted proof of a defense.

The elements of fraud are: (1) a misrepresentation (2) of a material fact (3) that was relied upon by the plaintiff (4) who was damaged as a proximate result of that misrepresentation. *Earnest v. Pritchett-Moore, Inc., 401 So. 2d 752, 754 (Ala. 1981)*. In her complaint and deposition Guinn alleged that Martin and McCollough made a number of misrepresentations to her regarding the benefits that would be available under the package that they sold her, as well as the necessity of buying both of the policies in that package. Martin and McCollough argue that Guinn had other reasons for buying those policies from them, most notably the increased customer service that was available from their now defunct agency, Southern Insurance Service. However, both Martin and McCollough conceded in their depositions that the coverage provided by the American Integrity policy was at best equal to, and in some respects was inferior to, the coverage Guinn already had. The [**6] American Integrity policy had an initial premium of $ 808.70. Both agents agreed that it was only the Providers Fidelity policy, with an initial premium of $ 107.50, that provided the enhanced nursing home coverage that Guinn desired. Martin and McCollough also agreed that there was no reason that they [*763] could not have sold only the Providers Fidelity policy to Guinn.

Additional testimony was provided by Marvin Watkins, Providers Fidelity's agency director. Watkins stated that the American Integrity policy did not provide Guinn with any coverage that she did not already have and that it was not in her best interests to replace her existing coverage by buying both of the policies offered to her by Martin and McCollough. Watkins also stated that a person who told Guinn that such a purchase would be in her best financial interests would not be telling her the truth.

After reviewing the evidence, this Court concludes that there was a scintilla of evidence that Martin and McCollough misrepresented to Guinn the necessity of buying the American Integrity policy. The testimony of those two agents, standing alone, indicates that that policy simply replaced, at a cost of $ 808.70, coverage that [**7] Guinn already had and that had all of its waiting periods served. Such misrepresentations, if made, would involve a material fact and would appear to have been relied upon by Guinn to her detriment.

This Court does not agree with the trial court's conclusion that there was no evidence indicating that Guinn was aware that she was buying a policy from Providers Fidelity at the time she made the purchase. Both agents testified that the benefits available under that policy were explained to Guinn, and that the application form that she signed bore a Providers Fidelity logo. The moment in time that is relevant to fraud claims is that moment at which the plaintiff, in reliance on the defendants' representations, took the action that later proved to be detrimental. *Connell v. State Farm Mutual Auto. Ins. Co., 482 So. 2d 1165, 1167 (Ala. 1985)*. Although Guinn may have appeared somewhat confused, during her deposition, regarding whether she had purchased a policy from Providers Fidelity, that confusion is not relevant to the issue of reliance, because it took place years after the transaction occurred.

In addition, this Court does not agree that Guinn did not present a scintilla of evidence [**8] that she was damaged by the agents' alleged misrepresentations. If, in fact, Guinn's purchase of the American Integrity policy was needless, then it is clear that she parted with over $ 800 and received absolutely no advantage. This Court also rejects the defendants' argument that, possible misrepresentations notwithstanding, Guinn suffered no damage because she did not file a claim during the period that she was insured by American Integrity and Providers Fidelity. This is not an action for breach of contract, and that argument ignores the hardship that would be experienced by any person after needlessly spending over $ 800.

Dismissed Claims

Guinn's original complaint included 19 counts, and the defendants filed motions to dismiss for failure to state a claim. *Rule 12(b)(6), Ala. R. Civ. P.* The trial court entered an order dismissing the counts "claiming damages for breach of a fiduciary relationship and . . . for a violation of *[§] 27-12-1 of the Code of Alabama 1975* et seq.," but denying the motions to dismiss "as to the claim [sic] for damages for misrepresentation or legal fraud." The order concluded by stating that the motions to dismiss were denied as to the fraud "claim" [**9] but were "granted as to all other claims in the complaint."

Guinn later filed an amended complaint, consisting of 11 counts that were numbered "Three A," "Four A," etc.; these counts were refined versions of Counts Three, Four, etc., of the original complaint. The trial court also dismissed the amended complaint, issuing the following order:

"The Court having duly considered the amended complaint is of the opinion that the amended complaint attempts to state a private cause of action for the Defendants' breach of a statutorily imposed duty; for a breach of a fiduciary relationship by the Defendants; and for negligence and wantonness on the part of the corporate Defendants in hiring sales agents; but the Court is of the opinion that these allegations merely add to the [*764] claim for fraud previously allowed and that the allegations state no cause of action against any of the Defendants; it is therefore ORDERED, ADJUDGED and DECREED that except as to the claim for legal fraud all other claims attempting [sic] to be stated by the Plaintiff are hereby dismissed."

Without sifting through the claims individually, we shall address the arguments regarding the dismissal as they are presented.

[**10] Guinn alleged in several counts that Martin and McCullough made false representations and comparisons regarding her existing policies and the policies that they wanted to sell her, thus violating *Ala. Code 1975, § 27-12-6*. That statute prohibits the practice of "twisting," that is, the use of misrepresentations or incomplete or inaccurate comparisons of policies in attempts to induce policyholders to exchange or convert existing policies. The defendants contend that *§ 27-12-6* does not create a private right of action and that the dismissal of the claim based on that section was correct. Under the holdings of this Court in *HealthAmerica v. Menton, 551 So. 2d 235, 243 (Ala. 1989)*, cert. denied, *493 U.S. 1093, 110 S. Ct. 1166, 107 L. Ed. 2d 1069 (1990)*; *Tribble v. Provident Life & Acc. Ins. Co., 534 So. 2d 1096 (Ala. 1988)*; and *Jarrard v. Nationwide Mutual Ins. Co., 495 So. 2d 584 (Ala. 1986)*, Guinn's allegations of a violation of *§ 27-12-6* supported her claims of fraud, and to that extent those allegations should be given proper consideration on remand. It does not appear that any of those counts stated a statutory claim for relief that is different in any material respect from [**11] a fraud claim, so we see no basis for holding the trial court in error in dismissing those counts.

Guinn's breach of fiduciary duty claim was premised on her allegation that her reposal of trust in Martin and McCollough to advise her on what policies she should purchase, coupled with their acceptance of that trust, created a fiduciary relationship. She argues that her reliance, along with her advanced age, lack of mental strength, lack of knowledge of insurance matters, and the agents' superior knowledge concerning insurance, constituted special circumstances that warranted the imposition of a fiduciary duty on Martin and McCollough.

This Court has held that an insurance agent may be the agent of the insured, the insurer, or both. *Washington National Ins. Co. v. Strickland, 491 So. 2d 872, 874-75 (Ala. 1985)*. However, an insurance agent is generally not considered to be an agent of the insured until a contract of insurance has been entered into. *Strickland, supra*; *Highlands Underwriters Ins. Co. v. Elegante Inns, Inc., 361 So. 2d 1060 (Ala. 1978)*. Until such a contractual relationship has been established, the parties remain in the relationship of salesperson and prospective [**12] customer. The salesperson and his principal may be liable for damages if he misrepresents material facts in an attempt to induce the prospective customer to enter into the contract, *Harrell v. Dodson, 398 So. 2d 272 (Ala. 1981)*; *Ala. Code 1975, § 6-5-101* through -104. However, that potential liability does not indicate the existence of a fiduciary relationship.

In addition, the existence of a duty is a question of law for the trial court. *Berkel & Co. Contractors v. Providence Hospital, 454 So. 2d 496 (Ala. 1984)*; *Hand v. Butts, 289 Ala. 653, 270 So. 2d 789 (1972)*. Because Guinn failed to present evidence of a relationship between herself and Martin and McCollough that gave rise

to a fiduciary duty, the court did not err in dismissing the claim based on an alleged fiduciary duty.

Guinn also appeals the dismissal of her claims alleging negligence and wantonness against the defendant insurance companies. Those claims alleged that the companies failed to use due care in selecting, training, and monitoring their agents, and thus made the alleged wrongful acts of Martin and McCollough more likely to occur. However, title 27 of the Alabama Code of 1975 regulates some aspects [**13] of the insurance industry, including the licensing and conduct of insurance agents. Guinn does not allege that the defendant companies [*765] violated the guidelines set out in that chapter in selecting, training, or monitoring their agents. Therefore, this Court concludes that, in regard to their selection, training, and monitoring of agents, there was no evidence that the companies violated the standard of care mandated by the legislature, and we affirm the trial court's dismissal of Guinn's negligence and wantonness claims.

For the reasons stated, this Court holds that in support of each element of her fraud claims Guinn presented sufficient evidence to defeat the defendants' motion for summary judgment. Therefore, as to the fraud claims the summary judgment is reversed. Because this Court is reversing as to the fraud claims, the issue raised by Guinn regarding the trial court's denial of her discovery motion will not be addressed. In other respects the judgment is affirmed.

EXPRESS OIL CHANGE, LLC, Plaintiff, v. ANB INSURANCE SERVICES, INC., et al., Defendants.

CV-10-BE-0263-KOB

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ALABAMA, SOUTHERN DIVISION

933 F. Supp. 2d 1313*; *2013 U.S. Dist. LEXIS 43288*; *56 Employee Benefits Cas. (BNA) 2654

March 27, 2013, Decided
March 27, 2013, Filed

COUNSEL: [**1] For Express Oil Change, LLC, Express Oil Change Group Health Care Plan, Plaintiffs: David H Marsh, Michael K Beard, LEAD ATTORNEYS, MARSH RICKARD & BRYAN PC, Birmingham, AL.

For Willis of Alabama, Inc., Petitioner: E Britton Monroe, LLOYD, GRAY, WHITEHEAD & MONROE PC, Birmingham, AL; Rachel V Barlotta, BAKER DONELSON BEARMAN CALDWELL & BERKOWITZ PC, Birmingham, AL.

For ANB Insurance Services, Inc., S.S. Nesbitt & Company, Alan L Wood, Defendants: John P Scott, Jr, Michael T Scivley, LEAD ATTORNEYS, W Drake Blackmon, STARNES DAVIS FLORIE LLP, Birmingham, AL.

For Blue Cross Blue Shield of Alabama, Defendant, Counter Claimant: Grace Robinson Murphy, LEAD ATTORNEY, Edward A Hosp, MAYNARD COOPER & GALE PC, Birmingham, AL; Katherine L Soppet, MAYNARD COOPER & GALE, Birmingham, AL.

For Express Oil Change, LLC, Counter Defendant: David H Marsh, Michael K Beard, LEAD ATTORNEYS, MARSH RICKARD & BRYAN PC, Birmingham, AL.

JUDGES: KARON OWEN BOWDRE, UNITED STATES DISTRICT JUDGE.

OPINION BY: KARON OWEN BOWDRE

OPINION

[*1317] **MEMORANDUM OPINION**

This controversy arises from Plaintiff Express Oil's attempt to create a self-funded health benefits plan for its employees while eliminating any uninsured risk for itself by procuring stop-loss insurance. [**2] Express Oil employed and relied on Defendants ANB Insurance and Alan Wood to help it transition from a fully-insured to a self-funded health plan, design a suitable self-funded plan, and procure appropriate stop-loss insurance. Express Oil purchased a self-funded plan from Defendant Blue Cross, and Blue Cross administered the plan, which became effective in 2003. Express Oil allegedly believed that the self-funded plan had a $1 million dollar comprehensive lifetime maximum for each covered member and thus procured stop-loss insurance covering any member's claims that exceeded $75,000 up to the $1,000,000 dollar comprehensive lifetime maximum.

The genesis of this specific dispute is the birth of twins by one of Express Oil's employees. One of the twins was born with very serious medical issues and quickly amassed costly medical bills under Express Oil's self-funded plan. During the early years of the child's life, Express Oil paid over $2.8 million dollars in claims on the child. During the 2007-2008 policy year, Express Oil exhausted its $1,000,000 lifetime maximum stop-loss reimbursement benefits. Under the self-funded plan's definition of "lifetime maxmimum," however, many of the [**3] claims incurred by the child were not subject to the self-funded plan's lifetime maximum, and Express Oil remained liable for the claims that exceeded the $1

million ceiling of the stop-loss insurance policy. Express Oil was exposed to this liability as a result of the misinterpretation of the self-funded plan's definition of "lifetime maximum" and its subsequent procurement of stop-loss insurance that did not fully cover it from the liabilities from which it had intended to protect itself. In the instant lawsuit, Express Oil seeks to hold at least one of the Defendants liable for this costly gap in coverage.

This unusual ERISA case comes before the court on Defendants ANB Insurance Services and Alan L. Wood's Motion for Partial Summary Judgment (doc. 88); Defendant Nesbitt & Co.'s Motion for Summary Judgment (doc. 90); Defendant Blue Cross and Blue Shield of Alabama's Motion for Partial Summary Judgment (doc. 92); and Defendant Blue Cross and Blue Shield of Alabama's Motion to Strike (doc. 113). The parties have fully briefed ANB and Wood's Motion for Partial Summary Judgment and Blue Cross's Motion for Partial Summary Judgment. Plaintiffs Express Oil Change, LLC, and the Express Oil [**4] Change Group Health Care Plan (collectively "Express Oil") did not file a response to Nesbitt's Motion for Summary Judgment. The court has considered the parties' submissions and applicable law, and for the reasons explained below, concludes that Blue Cross's Motion to Strike is due to be granted in part and denied in part; Nesbitt's Motion for Summary Judgment is due to be granted in its entirety; Blue Cross's Motion for Partial Summary Judgment is due to be granted in its entirety; and ANB and Wood's Motion for Partial Summary Judgment is due to be granted as to Count VII for negligent procurement of insurance but due to be denied on Count XII for breach of fiduciary duty.

[*1318] I. PROCEDURAL HISTORY AND COUNTS ALLEGED IN THE AMENDED AND RECAST COMPLAINT

Express Oil Change, LLC filed this lawsuit on November 10, 2008 in the Circuit Court for Jefferson County, Alabama, against ANB Insurance Services, Inc.; S.S. Nesbitt & Co.; and Alan L. Wood. (Doc. 1-1, at 22). On November 6, 2009, Express Oil Change amended the complaint and added Blue Cross and Unimerica Insurance Company as Defendants. Blue Cross removed the case to this court on February 3, 2010, based on this court's federal question [**5] jurisdiction over ERISA claims (doc. 1), and on March 24, 2010, Blue Cross filed a breach of contract counterclaim against Express Oil (doc. 15). On April 20, 2010, Express Oil Change, with the leave of court, filed an "Amended and Recast Complaint" (doc. 24) which added the Express Oil Change Group Health Care Plan as a Plaintiff and added several new claims. On February 16, 2011, Unimerica Insurance Company filed a motion for summary judgment (doc. 43), to which Express Oil elected not to file a responsive brief. The court granted Unimerica's motion for summary judgment and dismissed Unimerica with prejudice on April 20, 2011 (doc. 63), leaving Nesbitt, Blue Cross, ANB, and Wood as the remaining defendants.

The Amended and Recast Complaint alleges sixteen different counts. Counts I, II, III, IV, V, & VI are alleged against Blue Cross; counts VII, VIII, XI, & XII are alleged against Wood, ANB, and Nesbitt; counts IX & X are alleged against Wood only; and counts XIII & XIV are alleged against ANB and Nesbitt only. Counts XV & XVI are no longer in the case because they were alleged only against Unimerica, which this court dismissed, as stated above. (Doc. 63).

A. Counts alleged against [**6] *Blue Cross and by Blue Cross*

The Amended and Recast Complaint alleges the following counts against Blue Cross: Count I--breach of duty as an ERISA fiduciary; Count II --breach of contract; Count III-- breach of the implied covenant of good faith and fair dealing; Count IV-- negligent or wanton failure to properly design the plan; Count V--negligent or wanton failure to properly administer, handle, process, and pay claims under the plan; and Count VI--fraudulent suppression. In its answer, Blue Cross asserts a breach of contract counterclaim against Express Oil, which is not addressed in this opinion.

B. Counts alleged against Wood, ANB, and Nesbitt

The Amended and Recast Complaint alleges the following counts against Wood, ANB, and Nesbitt: Count VII--negligent or wanton failure to procure sufficient stop-loss insurance for Express Oil; Count VIII--breach of an express or implied contract with Express Oil to provide expertise and guidance regarding Express Oil's self-funded plan; Count XI--fraudulent suppression; and Count XII--breach of fiduciary duties.

C. Counts alleged against Wood only

The Amended and Recast Complaint alleges the following counts against Wood: Count IX--negligent or wanton breach [**7] of contract; and Count X --fraud.

D. Counts alleged against ANB and Nesbitt only

The Amended and Recast Complaint alleges the following counts against ANB and S.S. Nesbitt: Count XIII --negligent or wanton failure to properly investigate, hire, train, supervise, and retain Wood; [*1319] and Count XIV--vicarious liability for the wrongful conduct of Wood.

II. STATEMENT OF FACTS[1]

1 The court accepts this statement of facts, taken in the light most favorable to the plaintiff, for summary judgment purposes only. *See Davis v. Williams, 451 F.3d 759, 763 (11th Cir. 2006)* ("Even though the facts, as accepted at the summary judgment stage of the proceedings, may not be the actual facts of the case, our analysis for purposes of summary judgment must begin with a description of the facts in the light most favorable to the plaintiff.") (citations omitted).

A. Background

Before 2003, Express Oil had a fully-insured health plan for its employees. In 2002, Express Oil contemplated changing to a self-funded plan, also known as a self-insured plan. Under a self-funded plan, an employer provides health benefits to its employees out of its own funds, in contrast to a fully-insured plan in which an employer pays fixed [**8] premiums to an insurance carrier, which in turn pays the health benefits of the employees. Self-funding has a number of benefits, among them increased flexibility in designing a health care plan and a potential reduction in cost.

That potential reduction in cost, however, is counterbalanced by an increase in risk resulting from unpredictable or catastrophic claims, which may be devastating to a smaller employer that may not have the financial resources to meet those obligations. To protect against these catastrophic claims, most self-funded employers purchase "stop-loss insurance." Stop-loss insurance is a separate contract between the employer and a stop-loss insurance carrier where the insurance company agrees to reimburse the employer for claims that exceed a certain level. Many of these stop-loss contracts, however, also provide for a ceiling on the amount of reimbursement an employer may receive. In addition to procuring stop-loss insurance, many self-funded employers also contract out the administration of their employees' claims to a third-party administrator.

Blue Cross supplied Express Oil with the self-funded plan that Express Oil ultimately used in administering health benefits [**9] to its employees. The plan limited the amount of benefits that Express Oil covered members could receive, a term known as the "lifetime maximum." A "covered member" is any Express Oil employee who subscribes to the plan and any eligible dependents. Def. Blue Cross Ex. 4, 2007 SPD, at 44. Under the lifetime maximum, Express Oil employees were eligible for up to $1,000,000 in lifetime benefits for every covered member; however, as defined under the plan, this cap applied only to *some* services, such as out-of-network services, or services not provided by a hospital, physician, or provider with which any Blue Cross and/ or Blue Shield plan has a Preferred Provider Organization ("PPO") contract for the furnishing of health care services. The plan did not set any limitation on the benefits a member could receive for in-network services, or services provided by a hospital, physician or provider with which any Blue Cross and/or Blue Shield plan has a PPO contract.

Express Oil, however, apparently understood that the plan would provide a *comprehensive* lifetime maximum of $1,000,000 for *all* services to its members, an understanding that factored into the way Express Oil procured stop-loss insurance. [**10] Because Express Oil believed that it would only be exposed to $1,000,000 in claims for any one covered member, it procured stop-loss insurance with a specific deductible of $75,000 per covered member per year and a $1,000,000 per covered member lifetime maximum reimbursement. Thus, under its stop-loss insurance contract, Express Oil [*1320] would pay up to $75,000 per covered member per year for its members' claims; if any one member's claims exceeded $75,000, then the stop-loss carrier would reimburse Express Oil that amount, but only up to $1,000,000 over the life of the member.

Express Oil did not realize that this self-funding plan and stop-loss insurance arrangement left a gap where Express Oil could be exposed to unlimited liability if a covered member used over $1,000,000 of in-network services. This gap became starkly visible when an Express Oil employee's wife, a covered member, gave birth prematurely to twins, also covered members, incurring catastrophic claims that, over several years, significantly exceeded the $1,000,000 ceiling on Express Oil's stop-loss insurance.

This gap in risk exposure--and who is at fault for its existence--underlies this lawsuit. Express Oil alleges that four [**11] different entities or individuals are liable: ANB Insurance Agency, the agency that assisted Express Oil in moving to a self-funded plan and helped it procure stop-loss insurance; Alan Wood, an ANB employee and the agent who assisted Express Oil with its self-funded plan and stop-loss insurance; S.S. Nesbitt, the insurance agency that acquired ANB's assets in 2007 and that hired Wood after the acquisition; and Blue Cross Blue Shield, which provided Express Oil with and administered its self-funded plan.

B. Express Oil's transition to a self-funded plan

Before 2003, Ricky Brooks, the Chief Executive Officer of Express Oil, developed a personal relationship with Richard Pardue, an insurance broker who worked at ANB Insurance in 2003. Brooks and Pardue established a relationship and routinely saw each other socially. Their relationship before 2003 extended into the business

realm as well, as Pardue and Brooks invested money together in a new Express Oil store in Tarrant, Alabama. Before 2003, Pardue also served as Express Oil's agent for its property and casualty insurance and its worker's compensation coverage. In November 2001, Pardue left HRH, an insurance agency, to run and develop [**12] Alabama National Bank's insurance operation, ANB Insurance Services.

In 2002, Ronnie Hill, a self-employed insurance agent, made an unsolicited phone call to Greg Glover, Express Oil's Chief Financial Officer, Secretary, and Treasurer, to talk with Glover about the concept of a self-funded insurance plan. According to Glover, Hill discussed a concept which involved "more risk than a fully insured plan," but that "might save some money over time." Depo. Gregory Glover 83:15-83:17 (Oct. 7, 2009) (Depo. Glover I). Hill suggested to Glover that Express Oil contact Blue Cross about the administrative services that Blue Cross could provide to a self-funded plan.

Glover contacted Blue Cross in 2002, asking about the fees associated with a self-funded plan and requesting a report. In response, Blue Cross provided a claims experience report and a rate for administering the self-funded plan. At that time, Express Oil decided not to switch to a self-funded plan, however, because United Healthcare had given Express Oil a quote for a fully-insured plan that was less expensive than Express Oil's then fully-insured plan with Blue Cross, and also because the subject of the self-funded plan "just seemed [**13] so complex and no longer worthy of [Glover]'s time." Depo. Glover I 94:13-94:14.

In 2003, Express Oil contacted ANB Insurance (now operating as Nesbitt and Co.). Greg Glover and Ricky Brooks met with ANB employees Richard Pardue and Alan Wood to discuss transitioning from a [*1321] fully-insured health plan to a self-insured plan. Glover testified in deposition that "[Wood] was presented as the benefits expert at the agency and was experienced in the concept [of the self-funded plan]." Depo. Glover I 120:12-120:15. Glover's observation accords with Pardue's own testimony that Wood was the ANB employee with expertise in the area of stop-loss insurance regarding self-funded plans.

According to Glover, the 2003 meeting "eventually resulted in a self-funded plan for Express Oil Change where ANB was the agent on the stop-loss and from our perspective was our consultant on the overall issue." Depo. Glover I 120:18-120:21. Glover asked Wood for help with the plan design, and Glover understood that Wood was helping Express Oil form a self-funded plan. After Glover and Brooks decided to go with a self-funded plan, Wood and Glover began communicating with Blue Cross about options for a self-funded insurance [**14] plan, although Glover never had a face-to-face meeting with anyone at Blue Cross. Glover understood that Blue Cross offered various plan options and gave a lot of flexibility in designing the plans, based in part on his experience with Blue Cross when it fully-insured Express Oil.

At some point during June or July 2003, Glover requested that Blue Cross provide him a summary of what Blue Cross could set up as a self-funded plan. Blue Cross supplied Express Oil with two examples of self-funded plans in July 2003. In addition to the Blue Cross-supplied plans, Wood also provided Glover with more generalized examples of self-funded plans in response to Glover's request for "help and advice just in general to plan design issues." Depo. Glover I 146:21-146:23. In Glover's communication with Blue Cross he corresponded with Stephanie Talbot, a marketing representative at Blue Cross, about how he wanted to design Express Oil's self-funded plan, and discussed issues such as co-pays for doctor's visits and prescription card co-pays or deductibles.

1. The Plan Benefits Comparison Chart

The plan comparison that Blue Cross provided in July 2003 was a chart comparing the "Personal Choice Benefits" and [**15] the "BlueCard PPO" plans. The chart indicated, for both plans, that the "Lifetime Maximum" was $1,000,000 per person. The definition of the lifetime maximum in this chart did not limit the lifetime maximum to certain services nor did it state that the lifetime maximum was comprehensive.

Although Glover could not specifically recall which of the proposed Blue Cross plans Express Oil ultimately used, he believed they used the "BlueCard PPO" plan. Glover testified that in his discussions with both Blue Cross and Wood, he never discussed specifics of the plan as it related to the lifetime maximum.

2. The 2003 Summary Plan Description, updated annually

Before the self-funded plan went into effect on October 1, 2003, Blue Cross provided Glover with a document, the Summary Plan Description ("SPD"), that summarized the benefits the plan would make available to Express Oil employees. Although Glover could not specifically recall whether the document he received was the 2003 SPD, Glover understood the document he did receive reflected the terms of Express Oil's plan that were to apply to the employees. The 2003 SPD included a definition of the "Lifetime Maximum," which was the same definition included [**16] in Express Oil's previ-

ous fully-insured plan with Blue Cross. The 2003 SPD defined the Lifetime Maximum as

> $1,000,000 lifetime maximum for each covered member; **applies only to** Other Covered Services, Non-PPO Outpatient [*1322] Hospital Services, Non-PPO Physician Services, Mental Health and Substance Abuse Physician Services unless otherwise stated.

Ex. 3, 2003 SPD at 6 (emphasis added). Because the lifetime maximum is defined to apply only to certain services, any service not enumerated in that definition has no limitation on the lifetime amount that a covered member can incur. Thus, under Express Oil's plan, as summarized in the SPD, no lifetime maximum applied to benefits for services that were provided through the Blue Cross network--PPO services--and that were not "Other Covered Services."

Some of the "Other Covered Services" were defined in a separate table in the 2003 SPD. The table also includes a footnote stating that "[m]ost other covered services are paid at 80% of the Allowed Amount after the calendar year deductible is met." Def. Blue Cross Ex. 3, 2003 SPD at 7. The 2003 SPD later enumerates a full list of "Other Covered Services." Number 15 in that list says "Physician's Covered Services. [**17] Surgery includes preoperative and postoperative care, reduction of fractures and endoscopic procedures, maternity deliveries and heart catherization." Def. Blue Cross Ex. 3 at 22.

From 2003 to 2008, Express Oil renewed its self-funded plan with Blue Cross, and each year around October Blue Cross issued a new SPD. Each year Blue Cross accompanied the updates with a letter informing Glover that it was printing the annual SPD. Blue Cross produced letters from 2004 to 2007 where Glover indicated on the letter that the SPDs were "Approved as Written" and signed the letter.

The record reflects that no meaningful differences existed between these SPDs until 2007. In 2006, Blue Cross issued an SPD in the middle of the plan's year, although Glover could not recall why nor could he recall any changes that occurred in the plan. Although Blue Cross issued the 2006 SPD mid-year, the 2006 SPD appears identical to the 2003 SPD. In 2007, Blue Cross issued a more substantial update to its SPD, although Blue Cross claimed that the changes were all in formatting.

3. The Benefits Summary

In addition to the 2003 SPD, Blue Cross also provided Express Oil with a Benefits Summary. The Benefits Summary, created [**18] on August 11, 2003, and revised on September 15, 2003, also provided the same definition of the lifetime maximum as in the 2003 SPD. Glover testified in deposition that he recalled receiving the Benefits Summary, but that he did not know whether it was provided to him before the plan went into effect on October 1, 2003.

4. Glover executes the document making the self-funded plan effective and the Administrative Services Agreement

On September 26, 2003, Glover signed Blue Cross's plan description document, which indicated that the plan would become effective on October 1, 2003. The plan description document did not include a detailed definition of the lifetime maximum, instead stating under subheading "F. Major Medical Benefits" that Express Oil's plan provided a $1,000,000 maximum lifetime benefit. Def. Ex. 11 to Depo. Glover I at 4. Glover had the opportunity to read the document before he signed it, although he could not recall in his deposition whether he had read the document. Glover testified that changes were made to the plan over time, including at time periods other than renewal, and that benefits were added to the plan at his request.

On December 11, 2003, Glover also executed [**19] an Administrative Services Agreement ("ASA") with Blue Cross setting out each parties' obligations and responsibilities with respect to the self-funded Express Oil plan. The 2003 ASA defined [*1323] Blue Cross as the "Claims Administrator" and Express Oil as the "Plan Sponsor" and "Plan Administrator," and provided that Blue Cross, as Claims Administrator, "shall administer the benefits provided by the Plan . . . subject to all of the terms and conditions of the Plan . . . ." Ex. 1, 2003 ASA at 1. The 2003 ASA also included a "hold harmless" provision, which provided in relevant part that Blue Cross's execution of the ASA "shall not be deemed as the assumption by the Claims Administrator of any responsibility other than the provision of Administrative Services only as specified [in the ASA]." Ex. 1, 2003 ASA at 4.

C. Express Oil's procurement of stop-loss insurance

Express Oil's only discussions about stop-loss insurance during the first year of the self-funded plan's existence were with Wood. Glover did not discuss stop-loss proposals with anybody at Blue Cross during 2003 or 2004. Express Oil, with Wood as its agent, first procured "Specific Excess Loss Insurance" from Monumental Life Insurance [**20] Company, effective beginning October 1, 2003. Under the stop-loss policy with Monumental, Express Oil received coverage of up to

$1,000,000 per covered person with a specific deductible per covered person of up to $75,000. Thus, under this stop-loss policy, Express Oil paid a premium for each covered member in exchange for reimbursement by Monumental for any covered member's claims that exceeded $75,000. Glover testified that his belief that the plan had a *comprehensive* lifetime maximum per covered member of $1,000,000 factored into the decision to procure stop-loss insurance that only covered up to $1,000,000.

Beginning in 2004, Express Oil obtained proposals for stop-loss insurance each year from other agents, in addition to ANB Insurance and Wood, before it purchased stop-loss insurance. Notwithstanding the additional proposals, Express Oil decided to renew its stop-loss coverage with Monumental for 2004 with the same $75,000 specific deductible and the same coverage.

D. Blue Cross sends Express Oil stop-loss insurance proposals in 2005

In 2005, Blue Cross provided Express Oil with a stop-loss proposal from Companion Life Insurance Company. Glover forwarded the proposal to Wood but [**21] did not look at it himself. Companion Life's stop-loss proposal suggested coverage of $2,000,000, an amount that Glover admitted in deposition would not have been necessary if the plan benefits were capped at $1,000,000 for all services. To the extent Glover discussed stop-loss proposals with the Blue Cross marketing representatives, he testified that he had "very limited discussions" with them because they were "clearly uncomfortable in [that] arena." Depo. Greg Glover 75:18-75:20 (Aug. 5, 2011) ("Depo. Glover II"). Ultimately, Express Oil renewed its stop-loss coverage in 2005 with Monumental, which at some point became Unimerica, with the same $75,000 specific deductible and $1,000,000 lifetime maximum reimbursement per covered member.

E. The Inception of the Q claim

In May 2006, the wife of one of Express Oil's employees, "Mr. Q," had twins that were born prematurely. One of the twins was born with a serious medical condition, and the child's health conditions resulted in substantial medical claims totaling $378,047.00 for the plan and policy year October 1, 2005 - September 30, 2006 (the court shall refer to this claim, and others incurred by Mr. Q, as the "Q claim"). After Express [**22] Oil exhausted the $75,000 deductible, it received $303,047.00 in stop-loss insurance reimbursement benefits under its stop-loss insurance policy with Unimerica [*1324] for the Q claim Express Oil paid in that plan and policy year.

F. Express Oil's Stop-Loss Coverage in 2006, and the continuing accrual of the Q claim

In September 2006, Express Oil renewed its stop-loss coverage and accepted Unimerica's proposal for $1,000,000 in lifetime benefits per covered member. Because the stop-loss insurance issued for a self-funded group plan in Alabama is obtained on an annual basis and subject to underwriting review each year, any covered member with medical claims that continue over several years may be "lasered," *i.e.*, excluded from insurance coverage or subject to a higher deductible for each subsequent policy year. Thus, when Express Oil renewed its stop-loss coverage with Unimerica after the first year the Q claim accrued, Unimerica lasered the Q claim by increasing the specific deductible for the Q child to $195,000 for that year.

Blue Cross also provided Express Oil with another stop-loss proposal from Companion Life in 2006. That proposal indicated that it was based on Express Oil's current plan [**23] using the Blue Cross network. Blue Cross also provided Express Oil a stop-loss proposal from Lloyds of London in 2006, which required a $350,000 specific annual deductible for the Q claim. Glover could not recall discussing either of the 2006 proposals with anybody at Blue Cross, and ultimately renewed the stop-loss coverage with Unimerica.

Throughout the October 1, 2006 - September 30, 2007 policy year, the Q claim continued to accrue, and Express Oil paid medical claims of $850,972.62 through its plan for the Q child. After exhaustion of the required deductible amount, Unimerica provided $627,003.22 in stop-loss reimbursement benefits.

G. Express Oil's Stop-Loss Coverage in 2007, the 2007 updates to the SPD and ASA

In 2007, Express Oil renewed its stop-loss insurance with Unimerica, accepting a proposal that provided for $1,000,000 in lifetime benefits per covered member, with an increase in the Q child's specific annual deductible to $225,000. During the October 1, 2007 - September 30, 2008 policy year, Express Oil paid medical claims in excess of $1.5 million for the Q child. Under the stop-loss policy, Unimerica only provided $69,948.78 in stop-loss reimbursement benefits to Express [**24] Oil because it had exhausted its $1,000,000 lifetime maximum stop-loss reimbursement benefits for the Q claim. Because much of the Q claim resulted from medical services not subject to the Express Oil plan's lifetime maximum, Express Oil remained liable for much of the Q child's claims that exceeded the $1,000,000 ceiling in Unimerica's stop-loss insurance policy.

On November 17, 2007, Glover wrote to a Blue Cross employee, Mark McLaughlin, explaining that

Glover had been informed that the Q claim had hit the $1,000,000 mark, which would end the stop-loss carrier's liability. Glover asked whether Express Oil's plan indeed had a $1,000,000 lifetime maximum and whether that maximum would affect Blue Cross's payments on the Q claim. Mr. McLaughlin responded by quoting the pre-2007 SPDs' definition of the lifetime maximum, explaining that the maximum did not apply to PPO services provided by a PPO provider. Glover states that this e-mail was the first time he learned that Express Oil's plan did not have a comprehensive lifetime maximum.

In 2007, Blue Cross also issued a new SPD that appeared different from the 2006 SPD. Mary Bell, an employee with Blue Cross's Customer Benefits Administration, [**25] [*1325] explained that Blue Cross, in connection with a software upgrade, reformatted its "template" plan documents. According to Blue Cross, the changes were intended to make the SPD more user-friendly by putting all the relevant information on a topic in one place. Some of the language in the plan also changed, although an operations manager in Blue Cross's Claims Department, Jeremy Dennis, testified that the changes were not substantive. Specifically, Dennis testified that the SPD did not introduce any changes into how the lifetime maximum was calculated, what services were applicable to the lifetime maximum, and the 365 day inpatient hospital limit.

Although Dennis testified that the 2007 SPD did not change how the lifetime maximum was calculated, the language about the lifetime maximum did change. Before 2007, the lifetime maximum was defined as a $1,000,000 maximum benefit that applied only to certain services. *See supra* Part I.B.2. In the 2007 update, the SPD defined the lifetime maximum in two separate parts of the document. First, under the heading "COST SHARING," the 2007 SPD stated that the lifetime maximum was $1,000,000. 2007 SPD at 8.

Later under the "Lifetime Maximum" subheading, [**26] the 2007 SPD stated:

> The lifetime maximum benefit for each covered member under the plan is specified in the table above. The lifetime maximum is the maximum amount each covered member is eligible to receive for applicable covered services in his or her lifetime. Lifetime maximum amounts are accumulated from claim payment amounts under the plan and prior or subsequent plans or contracts issued to your group by us.
>
> The lifetime maximum generally applies to services or supplies that are subject to the calendar year deductible. It may also apply to certain other services and supplies, depending upon specifications from your group.
>
> The following are some examples that generally apply to the lifetime maximum:
>
> o Certain other covered services and supplies;
>
> o Out-of-network outpatient hospital services (except treatment of accidental injury rendered within 72 hours);
>
> o Out-of-network physician services

2007 SPD at 9.

When Blue Cross issued the reformatted SPD, its Customer Benefit Administration sent each group a letter along with the SPDs for approval. In the letter to Express Oil, dated December 11, 2007, Blue Cross stated:

> We remind you that you are the "plan administrator" and "plan sponsor" under [**27] ERISA . . . and/or the terms of your plan. Among other things, this imposes upon your group the sole legal responsibility to . . . (iii) ascertain that the booklet accurately and fully describes the benefits that you intend for us to provide or administer. . . . Nothing in our agreements with you and no actions taken by us are intended to delegate any of these responsibilities under the plan or applicable law to us.
>
> . . . .
>
> Your acceptance of our provision of benefits under the plan to your employees and their dependents constitutes your group's acceptance of the terms of this letter and an affirmative direction to us to administer benefits as provided for herein.

Def. Blue Cross Ex. 12 at 2. Kathy Palmer, Express Oil's Director of Payroll, signed this letter on January 9, 2008.

Blue Cross also updated its ASA in 2007. The 2007 ASA stated that the Claims Administrator, Blue Cross, would "exercise the discretionary fiduciary authority to [*1326] process and adjudicate claims under the Plan." Def. Blue Cross Ex. 2 at 3. The 2007 ASA further explained that this discretionary fiduciary authority "encompasses all determinations and findings necessary to process and adjudicate claims, such as the discretionary [**28] authority to construe and apply the Plan . . . ."

Def. Blue Cross Ex. 2 at 3. The 2007 ASA included a section titled "Stop-Loss Insurance," specifically providing that the "Employer is responsible for selecting and maintaining in force, if desired, suitable stop-loss insurance coverage." Def. Blue Cross Ex. 2 at 5. The 2007 ASA also provided that the "Claims Administrator is entitled to rely on instructions, communications, or directions from the Employer concerning Plan design . . . and other areas of Plan administration for which the employer is responsible." Def. Blue Cross Ex. 2 at 9.

H. Blue Cross's administration and payment of claims

During the relevant time period, Jeremy Dennis was the operations manager for claims administration in the group account area at Blue Cross. Dennis testified that Blue Cross administers claims based on the SPD, and that the internal systems are coded based on the SPD to determine what benefits applied to each group. Dennis also testified that the SPD in its entirety demonstrated what services were covered under "Other Covered Services," as that term is referenced in the definition of the lifetime maximum. Specifically, Dennis emphasized that the footnote [**29] under the table of "Other Covered Services" that stated that "Most Other Covered Services are paid at 80% of the Allowed Amount after the calendar year deductible is met" brought within the scope of "Other Covered Services" any service listed in the SPD that is paid at 80%. 2006 SPD at 7.

I. The Q claim audit and Blue Cross's credit to Express Oil

Between May 2006 and October 2008, the total paid claims for the Q claim exceeded $2,800,000. Although Glover testified that he "would not pretend to be able to see a problem with how [Blue Cross] adjudicated the [Q] claim," his new agent, Wade Bice, advised him to hire somebody to audit the Q claim. On Bice's advice, Express Oil retained Northshore International Insurance Services as consultants and auditors to evaluate how Blue Cross administered the plan to determine if Blue Cross had overpaid the Q claim under Express Oil's plan.

Northshore consultants Adria Garneau and Tammy Burns evaluated Blue Cross's handling of the Q claim and prepared two reports. The first report, dated August 3, 2009, was based on the 2006 SPD and Blue Cross business records. The supplemental report, dated August 28, 2009, incorporated the 2007 SPD.

In the August [**30] 3, 2009 report, Northshore determined that Blue Cross paid a total $2,854,928.14 in Q claims. Of this sum, Northshore determined that Blue Cross had paid $1,277,699.09 for services subject to the $1,000,000 lifetime maximum; Northshore, thus, concluded that Blue Cross had overpaid the Q claim by $277,669.09. Blue Cross alleges that this report, however, did not apply all the terms of the plan, and Garneau qualified the report as being formed on the basis of an incomplete ability to determine which physician services were in-network or out-of-network. While the report did exclude hospital stays less than 365 days from the calculation of the lifetime maximum, it included in-network physician services, which, according to Blue Cross, were not subject to the lifetime maximum. Northshore decided to include in-network physician services based on its interpretation of [*1327] the 2006 SPD's definition of the lifetime maximum. Specifically, Northshore concluded that the definition of lifetime maximum in the 2006 SPD stated that it applied only to certain services, including "Other Covered Services," and, in turn, that the SPD's section on "Other Covered Services" included "Physician's covered services." [**31] Garneau could not recall applying the 2007 SPD when calculating the overpayment in the August 3, 2009 report.

Northshore revised its overpayment calculation in the August 28, 2009 report, concluding that Blue Cross had paid only $84,584.10 over the $1,000,000 lifetime maximum for the Q claim. Garneau stated that to the best of her recollection, the difference between the August 3 and August 28 reports was the application of the 2007 SPD. Thus, the August 28, 2009 report excluded all physician services, both in- and out-of-network, after October 1, 2007 from the lifetime maximum, but still included in-network physician services before October 1, 2007, based on Northshore's opinion that the 2006 SPD did not clearly outline which covered services would apply to the $1,000,000 lifetime maximum. Northshore, thus, calculated the overpayment by applying all pre-2007 physician services toward the lifetime maximum, except for inpatient hospital services that exceeded the 365-day inpatient hospital limit. Because Blue Cross asserts that in-network physician services should not have counted towards the lifetime maximum, it states that Northshore's overpayment calculation would be reduced even [**32] further if these services were excluded from the lifetime maximum.

In early 2009, Blue Cross determined that it had overpaid the Q claim subject to the $1,000,000 cap, and gave Express Oil a return credit for approximately $110,000. Dennis, Blue Cross's operations manager, testified in deposition that the overpayment had resulted from a reporting error.

J. Termination of the Plan

In October, 2008, Express Oil elected to terminate its self-funded plan and return to a fully-insured plan. Blue Cross did not offer to insure Express Oil under a fully-funded plan, and Express Oil terminated its self-insured plan with Blue Cross.

K. Nesbitt acquires the assets of ANB Insurance

In May 2007, Nesbitt acquired the assets of ANB Insurance under an Asset Purchase Agreement. Section 3.2 of the Asset Purchase Agreement provided that Nesbitt would not assume any of the liabilities of ANB Insurance arising out of any events occurring before the Effective Time for acquisition in May 2007, except as expressly included in the Asset Purchase Agreement. ("Asset Purchase Agreement," Doc. 89-1, at 11). Nesbitt also hired Wood in May 2007, after it acquired the assets of ANB Insurance. Before it purchased the assets [**33] of ANB in May 2007, Nesbitt was not at all involved with selling insurance or providing any services to Express Oil.

L. Alleged roles of the parties in designing Express Oil's plan and procuring stop-loss insurance

1. Responsibility for designing or advising on the lifetime maximum

One of the central disputes in this case surrounds the lifetime maximum and whether Blue Cross was responsible for advising and explaining the operation of the lifetime maximum in the plan to Express Oil. The definition of Blue Cross's lifetime maximum, as it existed from 2003 to 2007, is present in two different documents about which Glover was questioned in his deposition: the 2003 SPD and the Benefits Summary. Blue Cross also provided Express Oil with two different documents [*1328] that did not provide the definition of lifetime maximum limiting it to "other covered services" and out-of-network services, but instead only stated that the lifetime maximum was $1,000,000: the plan benefits comparison chart Talbot provided to Glover in July 2003 and the application to establish a new group plan signed by Glover in September 2003.

T. Wayne Bowling, Express Oil's expert witness and a vice president at the insurance brokerage [**34] firm Willis of Alabama, submitted an expert report stating that he became aware, as early as 1999, "that the standard Blue Cross Blue Shield of Alabama PPO plan design had a feature that was different and unique from other carriers and [third-party administrators]." Expert Rpt. Wayne Bowling at 2. This "different and unique" feature was the lifetime maximum that did *not* apply to all covered charges, unlike most plans up until the mid-2000s "that included a $1,000,000 lifetime maximum for ALL covered charges." Expert Rpt. Wayne Bowling at 2. Thomas Yeary, Blue Cross's expert witness and an insurance broker with forty years experience, also acknowledged that Blue Cross had a unique plan, explaining that "Blue Cross contracts have always contained an unusual lifetime maximum provision," and that "[k]nowledgeable employee benefits brokers are aware of this unique feature of the Blue Cross Contract." Expert Rpt. Thomas Yeary at 2.

Some of the witnesses also acknowledged that Blue Cross customers--specifically CFOs or other management personnel responsible for an employer's self-funded plan--could reasonably misunderstand Blue Cross's lifetime maximum provision, believing it to be a comprehensive [**35] limitation. Bowling testified that although "an average intelligent person that reads [the provision on lifetime maximum benefits] could understand it," his experience was that most people did not understand it. Depo. Wayne Bowling 175:3-175:6. Bowling also stated that, "The majority of the employers that I met with were not aware that this lifetime limit did not apply to all charges . . . . In my experience, I found that without their broker, agent or consultant pointing it out to them; [*sic*] it is unlikely that the average Employee Benefit manager, Human Resource director or Chief Financial Officer would be aware of this benefit." Expert Rpt. Wayne Bowling at 2-3. Similarly, Mark McLaughlin, who worked as both a marketing representative and a service representative for Blue Cross, testified that he sometimes dealt with customers who would not comprehend that the lifetime maximum applied only to certain services, instead believing that it was a comprehensive limit. Express Oil's executives fell into the category of those who did not understand the lifetime maximum, as both Glover and Brooks stated that they believed that the plan had a $1,000,000 comprehensive lifetime maximum for [**36] all services when the plan became effective.

Bowling also testified that Blue Cross had no responsibility to advise an employer on how the lifetime maximum applied to certain services if Blue Cross did not supply lifetime coverage. He stated in his expert report that "[i]f the employer chooses to self insure the entire risk, it is the role of the broker or consultant to inform them of that risk."

Express Oil, however, cites to evidence that Express Oil argues shows that Blue Cross's normal practice was to explain the limited $1,000,000 lifetime maximum to customers. Bill Kerley, an Assistant District Manager at Blue Cross, testified that Blue Cross would normally undertake to go over the lifetime maximum with customers at initial sales presentations, where Blue Cross would cover the benefits of the self-funded plan in detail. In response to [*1329] this evidence, Blue Cross emphasizes that Kerley's testimony applied to initial sales presentations, which Blue Cross did not do with Express Oil in this case. Blue Cross also cites to the testimony of Clay Steed, a marketing service representative at Blue Cross at the time Express Oil switched to a self-funded plan, who testified that he would not [**37] proactively

bring up the lifetime maximum when Blue Cross "already had the business." Depo. Clay Steed 123:12-13.

Express Oil also cites to the testimony of Thomas Byrd, ANB's expert witness and a founder of a third-party administrator firm that specializes in self-funded ERISA programs; Byrd stated that Blue Cross's SPDs made it very difficult to identify which services fell within the scope of "Other Covered Services" that applied towards the lifetime maximum. Mary Bell, a Blue Cross employee in Customer Benefits Administration, explained why Blue Cross could not offer an exhaustive definition of the lifetime maximum in its plan documents. Specifically, she stated that because Blue Cross could not know how it would process a claim until it received the claim, Blue Cross could not list everything that would go towards the lifetime maximum.

2. Responsibility for plan design and cost

Blue Cross cites to Express Oil's expert, Bowling, who stated that Express Oil's broker, ANB, had the responsibility of knowing Express Oil's objectives regarding plan design and cost and helping Express Oil make decisions regarding the plan. Bowling further stated that the broker's role also includes advising [**38] the client of the risk of the non-comprehensive lifetime maximum and offering coverage or a way to mitigate risk by redesigning the plan.

III. MOTION TO STRIKE

When Blue Cross filed its reply brief, it contemporaneously filed a motion to strike Glover's affidavit (Pl. Ex. 36) and a portion of Garneau's affidavit (Pl. Ex. 51) that Express Oil submitted with its opposition brief. Blue Cross argues that the statements it moves to strike are either contradictory or inconsistent with these witnesses' prior sworn deposition testimony.

A. Standard of Review

The Eleventh Circuit has held that "a party cannot give 'clear answers to unambiguous questions' in deposition and thereafter raise an issue of material fact in a contradictory affidavit that fails to explain the contradiction." *Rollins v. TechSouth, 833 F.2d 1525, 1530 (11th Cir. 1987)*. When a party does so, "the court may disregard the affidavit as a sham." *Id.* The Eleventh Circuit clarified that courts are to "apply this rule sparingly because of the harsh effect this rule may have on a party's case," because allowing "every failure of memory or variation in a witness' testimony to be regarded as a sham would require far too much from lay [**39] witnesses and would deprive the [jury] the traditional opportunity to determine which point in time and with which words the affiant was stating the truth." *Id.* To disregard an affidavit, the court must find "some inherent inconsistency" between the deposition testimony and the affidavit. *Id.*

B. Discussion

1. Greg Glover

Blue Cross focuses on two paragraphs of the affidavit of Greg Glover, Express Oil's Chief Financial Officer, as inconsistent with his deposition testimony. In paragraph three of his affidavit, Glover states that Blue Cross provided him with a "benefit comparison" chart, which did not explain Blue Cross's lifetime maximum. [*1330] He further states in this paragraph that "[t]his was the document that I reviewed and used to compare the benefits we had under our existing United Healthcare plan." Aff. Gregory Glover ¶ 3. In the next paragraph, Glover states that "[w]hile Express [Oil] was considering moving to a self-funded plan, I do not believe I ever had a discussion with anyone at Blue Cross about the $1,000,000 lifetime maximum per member or saw any document that explained how the $1,000,000 maximum per member actually worked." Aff. Gregory Glover ¶ 4. As the court reads Blue [**40] Cross's motion to strike, it interprets Glover's affidavit as stating that he did not receive any documents before the plan went into effect that explained the lifetime maximum.

Blue Cross asserts Glover's deposition testimony contradicts these statements; in his deposition testimony, Glover speaks in more uncertain terms about the documents he relied upon. For example, in his deposition Glover authenticated an application he signed to establish a new group plan. Blue Cross also cites to portions of Glover's deposition where he testified that he may have received other documents, such as the 2003 SPD or the Benefits Summary, that explained that the lifetime maximum was limited, and not comprehensive. In his first deposition, Glover testified that he recalled receiving a booklet from Blue Cross in the fall of 2003 and that he recalled receiving a document similar to the 2003 SPD before Express Oil's plan became effective. More significantly, Glover testified that although he could not remember when he looked at the provisions relating to the lifetime maximum, he recalled reviewing the provisions of the lifetime maximum some time before the plan became effective. Depo. Glover I 191:12-192:12. [**41] Later in his deposition, Glover also equivocated on what documents he received from Blue Cross, testifying that he was unable to say whether he received the 2003 SPD and that he could not emphatically state that the benefits comparison was the only document he read before the plan became effective.

Upon review of Glover's deposition testimony and affidavit, the court disagrees that his affidavit is inher-

ently inconsistent with his testimony, largely because the court interprets Glover's affidavit differently than Blue Cross does. The court reads paragraph three of Glover's affidavit as stating that the primary document upon which he relied in *comparing* the proposed benefits of Blue Cross's plans to United Healthcare's was the benefits comparison chart. The court does not read this statement to mean that the only document Glover received or read was the benefits comparison chart.

Similarly, the court reads paragraph four more narrowly than Blue Cross. Glover states in that paragraph that he did not *believe* he ever saw a document that explained how the $1,000,000 lifetime maximum actually worked while Express Oil was *considering* moving to a self-funded plan. As the court reads this statement, [**42] Glover's affidavit does not preclude that Express Oil received the SPD or Benefits Summary after Express Oil *decided* to create its self-funded plan, or that Glover received documents containing, but not necessarily fully explaining, the definition of the lifetime maximum, even if he does not *believe* that he did. [2] Under this interpretation, even Glover's admission that he read the language regarding the definition [*1331] of lifetime maximum contained in the SPD or Benefits Summary before October 1, 2003 is not inconsistent with his affidavit, because Glover could have read that language after Express Oil decided to create the self-funded plan--*i.e.*, after it moved beyond the point of considering its self-funded plan to executing the plan.

> 2 Even if Mr. Glover did receive documents containing the definition of the lifetime maximum, those documents presumably did not fully explain how the lifetime maximum worked. As Blue Cross employee Mary Bell testified, Blue Cross could not offer an exhaustive explanation of the lifetime maximum in its plan documents. *See supra* part I. L.1.

Thus, the court concludes that the affidavit contains enough qualifying language as to render it benign, such that it does [**43] not create any new genuine issues of material fact that Blue Cross seems to fear. Ultimately, the court reads Glover's affidavit as stating less than what both Blue Cross and Express Oil interpret it to mean, and, accordingly, DENIES Blue Cross's motion to strike Glover's affidavit. In doing so, the court emphasizes that it does not read the affidavit as creating a genuine dispute of material fact that Glover did not receive any plan documents containing the description of the lifetime maximum. That Glover may not have recalled reviewing the documents does not negate his testimony that Express Oil received at least some document detailing the plan benefits, including the lifetime maximum, before October 1, 2003, even if Glover did not read or comprehend the document. Moreover, Glover's testimony does not negate that the 2003 SPD and the Benefits Summary contain the definition of lifetime maximum at issue in this case, even if Glover *believes* that he did not see such a document.

2. Adria Garneau

Blue Cross moves to strike two paragraphs of the affidavit of Northshore consultant Adria Garneau. In paragraph five of Garneau's affidavit, she summarizes her conversations with Blue Cross, after [**44] Northshore submitted one of its reports, regarding what services were subject to the lifetime maximum. Garneau states that "[Blue Cross's] explanations were not always consistent" and that in her telephone conferences with Blue Cross, "[Blue Cross] took the position, rather emphatically, that Express [Oil's] 2007 SPD had been changed to provide that in-network physician charges were not subject to the lifetime maximum." Aff. Adria Garneau ¶ 5. In paragraph seven of Garneau's affidavit, she states her understanding that Blue Cross was taking the position that the scope of services subject to the lifetime maximum did not change between the 2006 and 2007 SPDs. She then states that if she accurately understood Blue Cross's position, "it is certainly a reversal of the position [Blue Cross] took in [Northshore's] discussion with [Blue Cross] representatives in 2009." Aff. Adria Garneau ¶ 7.

Blue Cross cites to Garneau's deposition in which she testified that Blue Cross consistently asserted to her that in-network physician services should not count towards the lifetime maximum. *See* Depo. Adria Garneau 81:9-81:13 ("Q: . . . Blue Cross has always contended that in-network physician services [**45] should not count toward the lifetime maximum, correct? A: That's what they said, yes."); Depo. Adria Garneau 83:6-83:13 (Q: "[Blue Cross has] been consistent stating that out-of-network physician services do count towards the lifetime max, correct? A: Correct."). Blue Cross also cites to a portion of Garneau's deposition where she testifies that Blue Cross told her the 2007 SPD was issued to clarify, and not change, the 2006 SPD.

In response to Blue Cross's argument, Express Oil argues that Blue Cross misunderstands Garneau's affidavit. Express Oil asserts that when Garneau refers to "services" in paragraph five, she is not referring to inconsistencies in Blue Cross's application of in-network physician services [*1332] to the lifetime maximum, but to inconsistencies generally in what services counted as "Other Covered Services" applicable to the lifetime maximum--*i.e.*, services apart from physician services. Express Oil asserts that paragraph seven's reference to the "reversal of Blue Cross's position" is not directed towards inconsistencies in Blue Cross's position on whether in-network physician services apply towards the

lifetime maximum, but instead to inconsistencies between the language [**46] of the 2006 and 2007 SPDs. Express Oil further argues that even if Garneau's affidavit was inconsistent with her deposition testimony, the inconsistency does not rise to the level of making her affidavit, or portions of it, a "sham affidavit."

The court concludes that, unlike Blue Cross's interpretation of Glover's affidavit, Blue Cross's interpretation of Garneau's affidavit is mostly accurate. The court agrees with Express Oil that Garneau's statement that "[Blue Cross's] explanations [regarding services subject to the lifetime maximum] were not always consistent" could be read to mean that Blue Cross provided inconsistent explanations for what services applied to the lifetime maximum. Accordingly, the court DENIES Blue Cross's motion to strike that statement in paragraph five. But the court cannot read Garneau's subsequent statement in paragraph five that "[Blue Cross] took the position [in telephone conferences with Northshore], rather emphatically, that Express [Oil's] 2007 SPD had been changed to provide that in-network physician charges were not subject to the lifetime maximum. . . ., " to mean anything other than that Blue Cross changed its position on whether in-network physician [**47] services could apply to the lifetime maximum. Garneau gave a clear answer to an unambiguous question in her deposition, and now flatly contradicts that answer in her affidavit. Accordingly, the court GRANTS Blue Cross's motion to strike the referenced excerpt in her affidavit, the fifth sentence of paragraph five. The court STRIKES this sentence, and will not consider it when reviewing the underlying motions for summary judgment.

In replying to Express Oil on paragraph seven, Blue Cross concedes that it *did* change some language between the 2006 and 2007 SPD, but maintains that the changes were intended to clarify the SPDs, and not substantively change the scope of services applied to the lifetime maximum as paragraph seven of Garneau's affidavit implies. The court agrees with Blue Cross's interpretation of this paragraph, despite Express Oil's efforts to paint Garneau's statement as referring to changes between the 2006 and 2007 SPD, as opposed to substantive changes in Blue Cross's position on whether in-network physician services applied to the lifetime maximum. Because the second sentence of paragraph seven of Garneau's affidavit also contradicts the clear answers she gave to unambiguous [**48] questions in her deposition, the court also GRANTS Blue Cross's motion to strike the second sentence of paragraph seven. The court STRIKES this sentence and will not consider it when reviewing the underlying motions for summary judgment.

IV. STANDARD OF REVIEW

Summary judgment is an integral part of the Federal Rules of Civil Procedure. Summary judgment allows a trial court to decide cases when no genuine issues of material fact are present and the moving party is entitled to judgment as a matter of law. *See Fed. R. Civ. P. 56.* When a district court reviews a motion for summary judgment, it must determine two things: (1) whether any genuine issues of material fact exist; and if not, (2) whether the moving party is entitled to judgment as a matter of law. *Fed. R. Civ. P. 56(c).*

The moving party "always bears the initial responsibility of informing the district court of the basis for its motion, and identifying [*1333] those portions of 'the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any,' which it believes demonstrate the absence of a genuine issue of material fact." *Celotex Corp. v. Catrett, 477 U.S. 317, 323, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986)* (quoting *Fed. R. Civ. P. 56*). [**49] The moving party can meet this burden by offering evidence showing no dispute of material fact or by showing that the non-moving party's evidence fails to prove an essential element of its case on which it bears the ultimate burden of proof. *Celotex, 477 U.S. at 322-23. Rule 56*, however, does not require "that the moving party support its motion with affidavits or other similar materials *negating* the opponent's claim." *Id.*

Once the moving party meets its burden of showing the district court that no genuine issues of material fact exist, the burden then shifts to the non-moving party "to demonstrate that there is indeed a material issue of fact that precludes summary judgment." *Clark v. Coats & Clark, Inc., 929 F.2d 604, 608 (11th Cir. 1991).* Disagreement between the parties is not significant unless the disagreement presents a "genuine issue of material fact." *Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 251-52, 106 S. Ct. 2505, 91 L. Ed. 2d 202 (1986).* In responding to a motion for summary judgment, the non-moving party "must do more than simply show that there is some metaphysical doubt as to the material fact." *Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 586, 106 S. Ct. 1348, 89 L. Ed. 2d 538 (1986).* The non-moving party must [**50] "go beyond the pleadings and by [its] own affidavits, or by the 'depositions, answers to interrogatories, and admissions on file,' designate 'specific facts showing that there is a *genuine issue for trial.*'" *Celotex, 477 U.S. at 324* (quoting *Fed. R. Civ. P. 56(e)*) (emphasis added); *see also* Advisory Committee Note to 1963 Amendment of *Fed. R. Civ. P. 56(e)* ("The very mission of summary judgment procedure is to pierce the pleadings and to assess the proof in order to see whether there is a genuine need for trial."). The moving party need not present evidence in a form admissible at trial; "however, he may not merely rest on [the]

pleadings." *Celotex, 477 U.S. at 324.* If the evidence is "merely colorable, or is not significantly probative, summary judgment may be granted." *Anderson, 477 U.S. at 249-50* (citations omitted).

In reviewing the evidence submitted, the court must "view the evidence presented through the prism of the substantive evidentiary burden," to determine whether the nonmoving party presented sufficient evidence on which a jury could reasonably find for the nonmoving party. *Anderson, 477 U.S. at 254*; *Cottle v. Storer Commc'n, Inc., 849 F.2d 570, 575 (11th Cir. 1988).* The [**51] court must refrain from weighing the evidence and making credibility determinations, because these decisions fall to the province of the jury. *See Anderson, 477 U.S. at 255*; *Stewart v. Booker T. Washington Ins. Co., 232 F.3d 844, 848 (11th Cir. 2000)*; *Graham v. State Farm Mut. Ins. Co., 193 F.3d 1274, 1282 (11th Cir. 1999).* "Even if a district court 'believes that the evidence presented by one side is of doubtful veracity, it is not proper to grant summary judgment on the basis of credibility choices.'" *Feliciano v. City of Miami Beach, 707 F.3d 1244, 2013 WL 425445, *16 (11th Cir. Feb. 5, 2013)* (citing *Miller v. Harget, 458 F.3d 1251, 1256 (11th Cir. 2006)).* The court should not disregard self-serving statements made in sworn testimony simply because they are self-serving at the summary judgment stage, and if the self-serving statements create a genuine issue of material fact, the court should deny summary judgment on that basis. *707 F.3d 1244, [WL] *18.*

[*1334] Furthermore, all evidence and inferences drawn from the underlying facts must be viewed in the light most favorable to the non-moving party. *Graham, 193 F.3d at 1282.* The nonmoving party "need not be given the benefit of every inference but only of [**52] every reasonable inference." *Id.* The evidence of the non-moving party "is to be believed and all justifiable inferences are to be drawn in [its] favor." *Anderson, 477 U.S. at 255.* After both parties have addressed the motion for summary judgment, the court must grant the motion *if* no genuine issues of material fact exist *and if* the moving party is entitled to judgment as a matter of law. *Fed. R. Civ. P. 56.*

V. DISCUSSION

A. All claims against Nesbitt are due to be dismissed

Nesbitt raises two arguments in its unopposed motion for summary judgment. First, Nesbitt argues that its Asset Purchase Agreement with ANB bars claims based on ANB's alleged actions or omissions before May 2007. Second, Nesbitt argues that Express Oil cannot prove that Nesbitt is liable for any alleged acts or omissions after May 2007. The court agrees, and Express Oil's failure to respond to Nesbitt's motion while responding to all other pending motions reveals that Express Oil also does not place much confidence in its claims against Nesbitt.

1. The Asset Purchase Agreement bars all claims based on actions or omissions before May 2007

Although Blue Cross removed the case based on federal question jurisdiction--that [**53] ERISA preempted Express Oil's state law claims against Blue Cross at the time of removal--Express Oil only asserts state law claims against Nesbitt. Nesbitt argues that as the purchasing corporation in an Asset Purchase Agreement, it is not liable for the debts of the selling corporation under Alabama law.

Alabama law provides that when a corporation purchases the assets of another corporation, the purchasing corporation generally is not liable, in contrast to a merger where a successor corporation remains liable for its predecessors' liabilities. *Matrix-Churchill v. Springsteen, 461 So. 2d 782, 786 (Ala. 1984).* Four exceptions exist to this rule: (1) an express agreement exists for the purchasing corporation to assume the liabilities of the selling corporation; (2) the transaction is a *de facto* merger or consolidation of the two companies; (3) the transaction is a fraudulent attempt to escape liability; or (4) the purchasing corporation is a mere continuation of the selling corporation. *Matrix-Churchill, 461 So. 2d at 786.*

Express Oil has not presented any evidence that any of the four exceptions exist in this case. Although the Asset Purchase Agreement provided that Nesbitt would assume [**54] some of ANB's liabilities, none of the categories of liabilities assumed encompasses Express Oil's claims against ANB. Moreover, Express Oil has neither pointed to any evidence, nor indeed even responded to Nesbitt's brief, showing that Nesbitt's purchase of ANB's assets is a *de facto* merger or a fraudulent attempt to escape liability. Accordingly, the court concludes that Nesbitt did not acquire any liabilities ANB may have incurred toward Express Oil before May 2007.

2. Express Oil has not shown that Nesbitt was responsible for any of the alleged conduct giving rise to the claims after May 2007

Express Oil has not produced evidence that any action taken or not taken by Nesbitt after May 2007 gave rise to any of Express Oil's claims in this action. Express Oil obtained the stop-loss insurance from ANB prior to May 2007 and complains [*1335] of ANB and Wood's actions in procuring and explaining that insurance policy in 2003, well before Nesbitt acquired ANB. In the Asset Purchase Agreement, Nesbitt does not assume any liabilities or obligations of ANB that arose from "any event or circumstance occurring or existing

prior to the Effective Time." (Doc .89-1 , at 11). Express Oil, therefore, has [**55] not shown that Nesbitt was responsible for any actions or omissions that gave rise to the claims in this case after May 2007, and the court will GRANT judgment in favor of Nesbitt on all of Express Oil's claims against Nesbitt and DISMISS Nesbitt from this case WITH PREJUDICE.

B. All Claims Against Blue Cross are due to be Dismissed

Blue Cross argues that the six alleged causes of action asserted against it should be dismissed for various reasons. First, Blue Cross argues that ERISA preempts three of Express Oil's claims: breach of contact, breach of the covenant of good faith and fair dealing, and negligent/wanton plan administration. Alternatively, Blue Cross argues that Alabama law does not recognize a claim for either breach of the implied covenant of good faith and fair dealing or for negligent/wanton plan administration. Second, Blue Cross argues that it did not breach any fiduciary duty to Express Oil because it had no duty to design the plan and because its administration of the plan was consistent with the SPDs or, at a minimum, constituted a reasonable interpretation of the plan's terms. Third Blue Cross argues that Express Oil's negligent and wanton design claim and its fraudulent [**56] suppression claim are both barred by the statute of limitations, or alternatively, fail on the merits.

In response to Blue Cross's motion for summary judgment, Express Oil conceded that summary judgment is due to be granted as to Count III, breach of the implied covenant of good faith and fair dealing, and Count V, negligent or wanton administration and payment of claims. Accordingly, the court GRANTS Blue Cross's motion for summary judgment on Counts III & V. The court addresses the remaining counts below: Count I for breach of fiduciary duty as an ERISA fiduciary; Count II for breach of contract; Count IV for negligent or wanton failure to properly design the plan; and Count VI for fraudulent suppression.

1. Is Count II for breach of contract preempted by ERISA?

ERISA's preemption clause, § 514(a), provides that ERISA "supersede[s] any and all State laws insofar as they . . . relate to any employee benefit plan . . . ." *29 U.S.C. § 1144(a).* "[T]he express pre-emption provisions of ERISA are deliberately expansive, and designed to establish pension plan regulation as exclusively a federal concern." *Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 46, 107 S. Ct. 1549, 95 L. Ed. 2d 39 (1987)* (internal quotation omitted); *see* [**57] *also id.* (analyzing legislative history of ERISA and quoting a representative who described the "reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans" as ERISA's "crowning achievement") (alterations in original).

Blue Cross argues that § 514(a) preempts Count II of Express Oil's Amended and Recast Complaint. Count II alleges that "Defendant Blue Cross breached the Agreement that Blue Cross entered into with Express Oil and the Plan." The Amended and Recast Complaint does not state with any specificity which contract was breached, much less any specific provision that gives rise to the damages Express Oil seeks. In its motion for summary judgment, Blue Cross states that the alleged agreement is the ASA, and Express Oil, in its opposition, does not [*1336] indicate that it intended to assert breach of any other contract.

The ASAs set forth the parties' obligations and responsibilities regarding the plan. The 2003 ASA provided that Blue Cross would "administer the benefits provided by the Plan . . . subject to all of the terms and conditions of the Plan . . . ." Def. Blue Cross Ex. 1 at 1. The 2007 ASA provided that Blue Cross would "exercise the [**58] discretionary fiduciary authority to process and adjudicate claims under the Plan." Def. Blue Cross Ex. 2 at 3. The ASAs, thus, indicate that Blue Cross's fundamental responsibility under the ASAs was to administer the plan according to the terms of the plan.

Express Oil's breach of contract claim appears to relate directly to its health benefits plan. Express Oil alleges that Blue Cross misapplied the plan and overpaid the Q claim, an allegation Express Oil bolsters with the reports from Northshore's audit. The success of Express Oil's claim turns on whether Blue Cross properly applied the terms of Express Oil's plan, and not on whether it committed some misconduct apart from the plan in its dealings with Express Oil. Thus, Express Oil's breach of contract claim appears to be preempted by *§ 514(a) of ERISA* because it "relate[s] to [an] employee benefit plan . . . . " *29 U.S.C. 1144(a).*

Another district court in the Eleventh Circuit has arrived at a similar conclusion. In *AutoNation, Inc. v. United Healthcare Ins. Co.*, AutoNation, an employer with a self-funded plan, executed an administrative services agreement with United Healthcare under which United agreed to administer AutoNation's [**59] plan for three years. *423 F. Supp. 2d 1265, 1267 (S.D. Fla. 2006).* After AutoNation's plan experienced a substantial increase in cost, AutoNation hired an auditor to investigate United's performance under the plan. The auditor concluded that United failed to deliver the value or services that it promised to deliver, and AutoNation sued United alleging, among other claims, breach of contract. *Id. at 1267-68.* The district court, after discussing relevant cases finding both preemption and no preemption,

held that no question existed "that the state law claims 'relate[d] to' the ERISA Plan" and were thus preempted by ERISA. *Id. at 1271.*

Express Oil apparently recognizes the close factual similarity between these cases, as it does not attempt to distinguish the facts of this case from *AutoNation*, but instead argues that *AutoNation* does not bind this court. Express Oil also asserts that "strong arguments exist to justify carving this claim out of ERISA and treating it as a state law claim." Pl. Opp. Br. at 31. Express Oil relies on the case of *W. E. Aubuchon Co. v. BeneFirst, LLC, 661 F. Supp. 2d 37 (D. Mass. 2009)* for these arguments. As with *AutoNation, Aubuchon* also involved a dispute [**60] between an employer and plan administrator, where the employer alleged that the plan administrator had made processing errors that added millions of dollars in additional costs to the plan. *Aubuchon, 661 F. Supp. 2d at 39.* The district court in *Aubuchon* held that the employer's breach of contract claim was not preempted because the employer was challenging provisions of the contract that did not relate to or implicate ERISA--such as the requirement that the plan administrator maintain certain records. *Id. at 47.* Express Oil argues that claims by plans against third party administrators are distinct from claims asserted by participants or beneficiaries because the former category of claims are merely business disputes that do not necessarily affect the relationship between ERISA participants and fiduciaries.

To bolster its argument that the relationship between Blue Cross and Express [*1337] Oil is "nothing more than a garden variety business dispute," Express Oil also cites to a provision in the ASA concerning the resolution of audit claims that provides that the parties are to "allocate errors [in making claim payments] among themselves, based on the relative degree of fault of each party." [**61] 2007 ASA at 9. Express Oil asserts that "[Blue Cross's] use of the fault based concepts suggests that the disputes should be governed by state common law." Pl. Opp. Br. at 33.

Neither the *Aubuchon* case nor the presence of the provision on resolving audit disputes, however, persuades this court that Express Oil's breach of contract claim does not "relate" to an ERISA plan. In fact, the district court in *Aubuchon* clearly distinguished the nature of the breach of contract claims in its case--breach of contract for failure to meet certain performance standards in the contract--from breach of contract for *paying claims incorrectly.* As the court noted, "Whether a particular claim was, or was not, paid in accordance with the terms of the Plan might require the Court in some circumstances to interpret the Plan to adjudicate the dispute. If such an interpretation were required, it might be that the claim is preempted . . . . But that is not the case here." *Aubuchon, 661 F. Supp. 2d at 48* (internal citation omitted). Because Express Oil has not sued for the breach of contractual provisions that would solely govern the relationship between *it* and Blue Cross, but instead has sued for breach of contract [**62] alleging that Blue Cross paid too much in claims to ERISA plan beneficiaries under the plan, the court finds *Aubuchon* inapplicable.

This case falls into that category distinct from the *Aubuchon* claim--here, the claimed breach arises from Blue Cross incorrectly paying claims. To determine whether Blue Cross incorrectly paid claims, the court will have to interpret the plan. As the *Aubuchon* court foretold, the question of whether a claim was paid in accordance with the terms of the plan "might require" the court to interpret the plan, and thus be preempted. *Aubuchon, 661 F. Supp. 2d at 48*

Similarly, the contractual provision on audit disputes has little bearing in this case. Express Oil is not suing to enforce the audit dispute provision or seeking damages for its breach; if it were, perhaps it would have a stronger argument that its breach of contract claim is a "garden variety business dispute" that does not relate to an ERISA plan. But where, as here, Express Oil alleges that Blue Cross breached the ASAs by overpaying claims under the terms of the plan, the court concludes that the breach of contract claim "relates to" Express Oil's employee benefit plan, and is, thus, preempted by ERISA [**63] and is due to be dismissed.

Accordingly, the court GRANTS Blue Cross's motion for summary judgment as to Count II, breach of contract, because that claim is preempted by ERISA.

2. Can Express Oil maintain its negligent and wanton design claim against Blue Cross?

In Count IV of the Amended and Recast Complaint, Express Oil alleges that Blue Cross undertook to design the plan, that Blue Cross negligently or wantonly failed to properly design the plan, and that as a proximate consequence of Blue Cross's conduct, Express Oil and the plan suffered economic losses.

Blue Cross asserts that the statute of limitations bars Express Oil's negligent and wanton design claim. *Alabama Code § 6-2-38* provides a two-year statute of limitations for claims alleging liability for negligence. *See Ala. Code § 6-2-38(l)* ("All actions for any injury to the person or rights of another not arising from contract [*1338] and not specifically enumerated in this section must be brought within two years."). "Under Alabama law, the statute of limitations begins to run when the cause of action 'accrues,' which occurs 'as soon as the party in whose favor it rises is entitled to maintain a cause of action thereon,' even if the 'full [**64] amount of damages' is not apparent at the time the legal injury

occurs." *Russell Petroleum Corp. v. Environ Prod., Inc., 333 F. Supp. 2d 1228, 1232 (M.D. Ala. 2004)* (citing *Spain v. Brown & Williamson Tobacco Corp., 872 So. 2d 101, 114 (Ala. 2003))*. Alabama courts have also held that the "discovery rule" that tolls the statute of limitations for fraud claims does *not* apply to actions based upon allegations of negligent or wanton misconduct. *R.R. Sanders v. Peoples Bank & Trust Co., 817 So. 2d 683, 686 (Ala. 2001)* (citing *Ala. Code § 6-2-3*). Thus, Blue Cross argues that *§ 6-2-38* bars Express Oil's claim for negligent plan design. In support of this argument, Blue Cross cites to *Booker v. United American Ins. Co., 700 So. 2d 1333 (Ala. 1997)*, and *Henson v. Celtic Life Ins. Co., 621 So. 2d 1268 (Ala. 1993)*.

In *Booker*, the plaintiffs, a married couple, met with an employee working for an insurance agent on May 15, 1991, and asked for a major medical insurance policy. *Booker, 700 So. 2d at 1335*. The employee indicated to the plaintiffs that he could provide them an ideal policy through United American, and the plaintiffs, relying on the employee's representation, signed the application for [**65] the policy and started paying premiums. In actuality, the policy was not a major medical policy, but only a hospitalization policy. After the plaintiffs received the hospitalization policy, they unsuccessfully attempted to contact somebody at the agent's office to have the policy explained. In April 1993, one of the plaintiffs was hospitalized and incurred $49,000 in medical bills, only $14,000 of which the hospitalization policy covered. Four months later, the Bookers filed suit, including a claim against United American for negligent or wanton supervision of the insurance agent, and for the agent's own negligent or wanton behavior. The Court stated that "It is well settled that a negligence cause of action accrues when the plaintiff can first maintain the action, regardless of whether the full amount of damage is apparent at the time of the first injury." *Id. at 1340*. The Court also cited *Henson v. Celtic Life Ins. Co.* for the rule that a "plaintiff's completion of an application for a health insurance policy start[s] the running of the two-year limitations period for a negligence action" because *§ 6-2-38* does not contain a discovery rule. *Id.* (citing *Henson v. Celtic Life Ins. Co., 621 So. 2d at 1273*). [**66] The Alabama Supreme Court affirmed the dismissal of the negligence and wantonness claims based on *Henson* and *§ 6-2-38* because the claims accrued in May 1991 when the Bookers signed the application and wrote the check for the policy, and the Bookers did not bring suit until August 1993, more than two years after the accrual of their claims. *Booker, 700 So. 2d at 1340*.

The court finds little distinction between the analyses in *Booker* and *Henson* and this case. Although the Alabama Supreme Court provides little analysis in these cases, the court agrees with the principle underlying the opinions: the injury occurred at the moment the plaintiffs entered into an insurance plan that did not contain the protection or coverage that the plaintiff thought it did. Because the injury occurred at that time, the negligence cause of action also accrued at that time, and the court will apply this principle to this case. Even though the plaintiffs in both *Booker* and *Henson* were individuals, and not a small business with a sophisticated CFO, and even though the plaintiffs did not realize their policies were deficient until more than two years after they received them, the courts held their claims barred [**67] [*1339] by the statute of limitations, relying on the absence of a discovery rule in *§ 6-2-38*. *See Booker, 700 So. 2d at 1339-40*; *Henson, 621 So. 2d at 1274*. In this case, Express Oil did not realize that its policy was allegedly deficient until more than four years after it switched to the self-funded plan Blue Cross offered, and did not add Blue Cross as a defendant until 2009, six years after it contracted with Blue Cross as a plan administrator.

Express Oil responds to *Booker* and *Henson* by citing two cases and attempting to distinguish *Booker*. The first of the cited cases, *Collins v. Scenic Homes, Inc., 38 So. 3d 28 (Ala. 2009)*, involved claims by residents of an apartment building that was designed by an unlicensed architect in 1982 caught fire in 2004. The residents asserted negligence and wantonness claims against the defendants, alleging that the defendants had failed to construct and maintain a reasonably safe apartment building with adequate safeguards against a fire. The Alabama Supreme Court held that the residents' claims were not barred by the twenty-year statute of repose, explaining that the statute of repose did not begin to apply until the residents had the right to sue after [**68] the fire occurred. *Id. at 35*. The Court arrived at this conclusion by relying on previous case law stating that "where the act complained of does not itself constitute legal injury at the time, but the plaintiff's injury comes only as a result of, and in furtherance and subsequent development of, the act of the defendant, the cause of action 'accrues' . . . . 'when, and only when, the damages are sustained.'" *Id.* (citing *Smith v. Medtronic, Inc., 607 So. 2d 156, 159 (Ala. 1992))*.

Express Oil also cites to *Williamson v. Indianapolis Life Ins. Co., 741 So. 2d 1057 (Ala. 1999)*, a "vanishing premiums" case, in arguing that it had no legal injury until the Q claim exceeded $1,000,000. In *Williamson*, the plaintiff had purchased life insurance policies based on an insurance agent's representation that the plaintiff would only have to pay a large premium for ten years, after which the policies "would go into 'auto pilot' and the premiums would vanish . . . ." *Id. at 1060*. These "vanishing premium" policies were based on the under-

lying theory that the value of the policies would generate enough income to pay premiums beyond ten years such that the policy would sustain itself. Whether the policies [**69] could sustain themselves, however, was based on a variety of factors, and left open the possibility that the insured might have to pay out-of-pocket premiums after ten years. The plaintiff sued before the expiration of the ten-year period when he realized that he would probably have to pay additional premiums after the ten years, and provided evidence that the insurance company knew that "vanishing premium" policies were not viable when it sold the plaintiff his policies. The insurer moved for summary judgment, arguing that the plaintiff could not sue unless and until the insurer actually asked him to pay for out-of-pocket premiums. *Williamson, 741 So. 2d at 1060.*

On rehearing, the Alabama Supreme Court held that the plaintiff had suffered no discernible injury when he filed his action and, therefore, was precluded from suing the insurer. *Williamson, 741 So. 2d at 1061.* The Court noted that, in several other cases, the Court had held that plaintiffs who had not suffered harm, loss, or injury had no claim to adjudicate, even if their alleged injury was based on possible future harm. *See id. at 1060-61*; *see also Ford Motor Co. v. Rice, 726 So. 2d 626, 631 (Ala. 1998)* (holding that an [**70] owner of a sport-utility vehicle could not maintain a lawsuit alleging fraudulent suppression based solely on the risk that her vehicle *might* roll over because of an alleged defect); *Pfizer, Inc. v. Farsian, 682 So. 2d 405, 406, 408 (Ala. 1996)* (holding that a [*1340] plaintiff who received a manufactured heart valve could not recover damages based on speculation that the valve *might* fail, even when that speculation was supported by evidence of valve failures and even when evidence existed that the valve's failure rate was higher than that represented by the defendant). Applying the rationale of those cases, the Court determined that the plaintiff with the vanishing premium policy had no claim until he suffered actual harm, loss, or injury, which the Court held would not occur until the premiums did not "vanish" as promised. *Williamson, 741 So. 2d at 1061.*

Express Oil argues that when the facts of this case are viewed through the prism of *Collins* and *Williamson*, its claim for negligence is not barred by the statute of limitations. Under the holding of *Collins*, a party does not have a cause of action until a legal injury occurs: Express Oil asserts that its claims against Blue Cross are analogous [**71] to the "vanishing premium" policies in *Williamson* where the Alabama Supreme Court found the plaintiff did not yet have a legal injury. Express Oil, thus, argues that "[n]o cause of action arose until the contingency occurred and Express [Oil] was required to pay out more than what was covered by the stop loss coverage." Pl. Opp. Br. to Def. Blue Cross. Mot. S.J. at 18. Express Oil attempts to distinguish *Booker* by explaining that "[u]nlike *Booker*, there is no claim here that Express [Oil] was induced to pay for a policy it did not receive." Pl. Opp. Br. to Def. Blue Cross Mot. S.J. at 18.

The court does not find Express Oil's arguments persuasive because Express Oil has not explained why it does not have a legal injury that is distinct from those of the plaintiffs in the *Booker* and *Henson* cases. The plaintiffs in both *Booker* and *Henson* alleged that an insurance company or its agent negligently sold them a policy that failed to provide the coverage the defendants or their agents had allegedly promised. These claims strongly resemble Express Oil's negligent design claim, where it alleges that Blue Cross, by failing to advise Express Oil on its limited definition of the lifetime maximum, [**72] negligently provided Express Oil with a self-funded plan that failed to perform as Express Oil thought it would and instead exposed it to greater risk. In holding that the plaintiffs in *Booker* and *Henson* were barred by the statute of limitations, the Alabama Supreme Court implicitly determined in both cases that a legal injury occurred at the moment the defendants issued a policy because the plaintiffs were exposed to a risk they thought they were protected against at that moment. Express Oil has only conclusorily stated that no cause of action occurred at that point, but has not explained why Blue Cross's alleged actions in 2003 did not constitute a legal injury when providing a policy that did not provide the expected coverage constituted injury for the plaintiffs in *Booker* and *Henson.*

Assuming Blue Cross indeed owed a duty to design the plan Express Oil wanted and then breached that duty, the legal injury alleged in Express Oil's negligent plan design claim occurred when Express Oil began using the BlueCard PPO plan as its own self-funded plan in 2003. In reviewing *Williamson*, this court finds the vanishing premium policy cases distinguishable from the facts involving Express Oil's [**73] plan and also finds that the Alabama Supreme Court has held that a legal injury can exist between an insured and an insurer at the moment the policy goes into effect.

To arrive at its holding that vanishing premium policies do not give rise to a cause of action, the Court in *Williamson* distinguished the facts of its case from *Boswell v. Liberty National Life Ins. Co.,* [*1341] *643 So. 2d 580 (Ala. 1994).* In *Boswell*, the plaintiffs alleged fraud claims that arose from switching their cancer insurance policy, even though they had not filed any claims under the cancer insurance policy at the time of suit. The plaintiffs in *Boswell* alleged that an insurance agent induced them to switch a cancer insurance policy for a policy that cost more but offered less coverage, contrary to the agent's representation that they would

have increased coverage and additional benefits under the new policy. *Id.* The Court held that even though the plaintiffs had not yet filed a claim under the policy, they still had a legal injury upon which they could sue, explaining that "even if the insured files no claim, the loss of what the insured paid for constitutes legal damage or a legal injury." *Id. at 582*. As the Court [**74] aptly stated, "The insurer cannot be allowed to profit from its fraud simply because the insured is 'lucky' enough never to have to use the coverage." *Id.*

The court acknowledges that the count in this case is not for fraud, but, nevertheless, finds the logic from *Boswell* applicable to these facts. Express Oil thought it was contracting with Blue Cross to design a plan that had a comprehensive lifetime maximum, and paid Blue Cross a fee to design that plan. Assuming *arguendo* that Blue Cross had a duty to assist Express Oil in the design of the plan and engage in a comprehensive review with Express Oil of what the plan contained, then Blue Cross failed to meet its duty to Express Oil at the moment that the plan went into effect. Whether Express Oil's alleged injury resulted from negligent or fraudulent conduct does not change the fact that the legal injury occurred when Express Oil did not receive the plan for which it thought it had bargained and that it was paying Blue Cross a fee to design. Thus, the court concludes that Express Oil's legal injury occurred in October 2003, when the Express Oil plan took effect and Blue Cross began administering it. Because Express Oil filed suit against [**75] Blue Cross more than two years later, the statute of limitations bars this claim for negligence.

The court now addresses the new duties beyond those involved in plan design that Express Oil appears to have raised for the first time in its responsive brief to Blue Cross's motion for summary judgment. In its responsive brief, Express Oil alleges that Blue Cross had a duty to (a) explain to Express Oil how the lifetime maximum operated and point out its scope and limitations when Express Oil adopted the plan, a duty established from custom and practice; and (b) explain to Express Oil the limited scope of its lifetime maximum and why Express Oil should accept Blue Cross's stop-loss insurance proposals, a duty established by Blue Cross's undertaking to provide stop-loss quotes. Express Oil also includes arguments relating to negligent undertaking--a claim that it never included in its Amended and Recast Complaint--but gives little in the way of explanation as to what "voluntary undertaking" Blue Cross performed in its role as Express Oil's third party administrator.

These alleged duties do not appear to fall within the scope of the claim alleged in Express Oil's Amended and Recast Complaint [**76] for negligent or wanton *plan design*. The court agrees with Blue Cross's assertion in its reply brief that "[Express Oil] should be precluded from 'amending' their claims at this stage of the litigation.'" Def. Blue Cross Reply Br. at 18 n. 28. Express Oil initially filed this lawsuit in November, 2008, and twice amended its complaint, with the *second amendment* occurring in this court in April, 2010. The original Scheduling Order issued in this case further provided Express Oil until October 4, 2010 to amend its pleadings. Although Express Oil did not have the [*1342] depositions of the expert witnesses or Blue Cross employees at the time the deadline for amending pleadings elapsed, it had Glover's extensive deposition from October, 2009, and ample time to amend its complaint and pursue new theories or to petition the court for leave to amend if later discovery warranted amendment. Therefore, the court will not consider any new negligence claims to the extent Express Oil has sought to argue them in its responsive brief, and has only considered Express Oil's claim that Blue Cross negligently *designed* the plan in considering Blue Cross's statute of limitations argument--an alleged action that [**77] occurred and gave rise to legal injury in 2003.

Blue Cross also argues that Express Oil's wantonness claims are barred by the two-year statutory period. [3] However, upon review of the parties' briefs, the court agrees with Blue Cross that Express Oil "appears to have abandoned its claims for wantonness as it cites no case law or specific facts to support those claims," Def. Blue Cross Reply Br. at 17, particularly when Blue Cross cited *Capstone Building Corp.* in discussing the statute of limitations for wantonness claims in its initial brief. As the Eleventh Circuit has explained, "the onus is upon the parties to formulate arguments; grounds alleged in the complaint but not relied upon in summary judgment are deemed abandoned." *Solutia Inc. v. McWane, Inc., 672 F.3d 1230, 1239, 393 U.S. App. D.C. 290 (11th Cir. 2012)* (quoting *Resolution Trust Corp. v. Dunmar Corp., 43 F.3d 587, 598 (11th Cir. 1995))*. Accordingly, the court GRANTS Blue Cross's motion for summary judgment as to Count IV for negligent plan design because it is barred by the applicable statute of limitations and for wanton plan design because Express Oil has abandoned its wantonness claim.

> 3 To support this argument, Blue Cross cites *Ex Parte Capstone Building Corp., 96 So. 3d 77, 79 (Ala. 2012)* [**78] ("We hereby . . . confirm that claims of wantonness are subject to the two-year statute of limitations found in *Ala. Code 1975, § 6-2-38(l)*."). The Alabama Supreme Court, however, clarified that its holding would only apply prospectively. *See id. at 93* ("[W]e adhere to our conclusion that it would be unjust to announce a decision that applied retroactively so as to immediately cut off the right to bring suit upon any claim that had accrued more than two

> years prior to our original decision and that would not provide a reasonable transition to the rule announced then and affirmed today."). Before the decision in *Capstone Building Corporation*, "a tort claim based on allegations of wanton misconduct was subject to the six-year statute of limitations found in *Ala. Code 1975, § 6-2-34(1)* . . . ." *Id. at 79* (citing *McKenzie v. Killian, 887 So. 2d 861 (Ala. 2004)).* Under *Capstone Building Corp.*, Express Oil appears to be able to maintain its claims for wantonness.

3. Can Express Oil maintain its fraudulent suppression claim against Blue Cross?

In Count VI of the Amended and Recast Complaint, Express Oil alleges a fraudulent suppression claim against Blue Cross based on Blue Cross's alleged [**79] failure to disclose material facts. Blue Cross moves for summary judgment on the fraudulent suppression claim on multiple grounds, arguing that the statute of limitations bars the fraud claim and alternatively that it did disclose all material facts to Express Oil. In its opposition brief, Express Oil does not appear to have responded to Blue Cross's arguments directed to its fraudulent suppression claim, and therefore, that claim is abandoned. *See Coal. for the Abolition of Marijuana Prohibition v. City of Atlanta, 219 F.3d 1301, 1326 (11th Cir. 2000)* (finding that a party's failure to brief and argue an issue before the district court is grounds for declaring it abandoned).

The court need not engage in extensive analysis on why Express Oil cannot maintain its fraudulent suppression claim. The Alabama Supreme Court has clearly and [*1343] consistently stated that a plaintiff who receives documents in connection with an allegedly fraudulent transaction has the duty to read those documents and investigate facts that should provoke inquiry. *See Amer-Us Life Ins. Co. v. Smith, 5 So. 3d 1200, 1208-09 (Ala. 2008)* (summarizing and discussing three prior Alabama Supreme Court cases affirming summary [**80] judgment in favor of defendant insurance companies when the plaintiff possessed documents that contradicted an insurance agent's alleged misrepresentations). Specifically as to the claim of fraudulent suppression, "[i]f one receives from a defendant documents that put him on notice of the very facts alleged to have been suppressed, then that defendant cannot have suppressed those facts." *Liberty Natl. Life Ins. Co. v. Ingram, 887 So. 2d 222, 229 (Ala. 2004)* (quoting *Richardson v. Liberty Natl. Life Ins. Co., 750 So. 2d 575, 578 (Ala. Civ. App. 1999)).*

Similarly, Express Oil also has received several documents from Blue Cross that discuss the limited lifetime maximum, specifically the 2003 SPD, the Benefits Summary, and the subsequent SPDs, for which Glover signed a letter indicating that they were "Approved as Written." Although Glover testified that he did not read some of the larger documents that Blue Cross provided regarding Express Oil's plan, his ignorance as to the contents of those documents does not negate the fact that (a) he received the documents, and (b) they contained a definition of the lifetime maximum that applied the lifetime maximum to some--but not all--services. The [**81] Alabama Supreme Court enforces the duty to read documents and investigate inconsistencies without regard to education and business sophistication; the seemingly bright-line rule should apply to a company of over three hundred employees with a college-educated CFO. Accordingly, this court GRANTS Blue Cross's motion for summary judgment as to Count VI for fraudulent suppression.

4. Did Blue Cross breach its fiduciary duty?

In Count I of its Amended and Recast Complaint, Express Oil alleges that Blue Cross is an ERISA fiduciary; that Blue Cross owed a duty to act in accordance with the prudent person principle and in accordance with the documents and instruments governing the plan; and that Blue Cross violated its fiduciary duty based on a number of actions Express Oil alleges Blue Cross took. In its responsive brief opposing Blue Cross's Motion for Partial Summary Judgment, Express Oil casts Blue Cross's alleged breach of fiduciary duty only in the context of overpayment of claims under Express Oil's plan. *See* Pl. Resp. Br. to Def. Blue Cross Mot. S.J. at 16 ("Count One claims that, after the Plan was instituted, [Blue Cross] as an ERISA fiduciary violated various fiduciary duties, including [**82] claims-processing errors that resulted in overpayments and improper payments."); *id.* at 30-31 ("[Express Oil] contends that [Blue Cross] is liable on the overpayment claim, either under Count One, the breach of fiduciary duty claim, or alternatively, on the state law breach of contract claim in Count Two."). In its reply in support of its Motion for Partial Summary Judgment, Blue Cross acknowledges that "it owed a fiduciary duty to administer claims pursuant to the Plan documents." Def. Blue Cross Reply Br. at 26.

Express Oil specifically argues that Blue Cross breached its fiduciary duty by excluding in-network physician services from the Q claim's lifetime maximum. According to Express Oil, the correct interpretation of the arguably ambiguous SPDs is that *all* physician services apply towards the lifetime maximum. Under this interpretation, [*1344] the Q claim would have reached the lifetime maximum sooner, and Express Oil's plan would not have had to pay as much in benefits for that claim. The interpretation Express Oil advances is the same position that the Northshore auditors took in their

August 3, 2008 report, although Express Oil appears to argue alternatively that the court should adopt [**83] the Northshore auditors' conclusion in the August 28, 2008 report. *See* Pl. Br. Opp. Def. Blue Cross Mot. S.J. at 41 ("The only uncertainty is whether [Blue Cross's decision] was wrong to the tune of $277,000 or $84,000.").

Under ERISA, a fiduciary is an entity "with respect to a plan to the extent . . . [it] exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets [or] . . . has any discretionary authority or discretionary responsibility in the administration of such plan." *29 U.S.C. § 1002(21)(A)*. ERISA defines the fiduciary's duties in *29 U.S.C. § 1104*. According to this section, the fiduciary must discharge its duties under the plan "*solely* in the interest of the participants and beneficiaries and . . . for the exclusive purpose[] of providing benefits to participants and beneficiaries." *29 U.S.C. § 1104(a)(1)(A)* (emphasis added). ERISA further requires the fiduciary to discharge its duties "with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would [**84] use in the conduct of an enterprise of a like character and with like aims." *29 U.S.C. § 1104(a)(1)(B)*. ERISA also requires the fiduciary to discharge its duties "in accordance with the documents and instruments governing the plan" to the extent those documents and instruments are compliant with ERISA. *29 U.S.C. § 1104(a)(1)(D)*.

In addition, ERISA has a section addressing liability for breach of fiduciary duty. *See 29 U.S.C. § 1109*. Under this section, a fiduciary that breaches its duties "shall be personally liable to make good to such plan any losses to the plan resulting from each such breach," along with disgorgement of profits and other equitable relief. *29 U.S.C. § 1109*. ERISA's section on civil enforcement allows a "participant, beneficiary or fiduciary" to bring an action for appropriate relief under *§ 1109*, *see 29 U.S.C. § 1132(a)(2)*, and to "enjoin any act or practice which violates any provision of [ERISA] or the terms of the plan, or . . . to obtain other equitable relief . . . to enforce any provisions of [ERISA] or the terms of the plan." *29 U.S.C. § 1132(a)(3)*.

Express Oil asserts in its Amended and Recast Complaint that *it* is a fiduciary that has standing to bring suit [**85] under *§ 1132(a)(2)* and *(a)(3)*, and Blue Cross does not contest this assertion. The Eleventh Circuit has explained, however, that *§ 1132(a)(3)* acts as a "'catchall' provision, providing relief only for injuries not otherwise adequately provided for by ERISA." *Katz v. Comprehensive Plan of Group Ins., 197 F.3d 1084, 1084-85 (11th Cir. 2004)* (affirming a district court's interpretation of *§ 1132(a)(3)*) (citing *Katz v. ALLTEL Corp., 985 F. Supp. 1157, 1161 (N.D. Ga. 1997)*). The court must evaluate Express Oil's *§ 1132(a)(2)* and *(a)(3)* claims within the unusual context of an employer claiming that a claims administrator breached its duties under ERISA by paying more in benefits than it should have.

i. The Standard Applied in Reviewing Blue Cross's interpretation of the plan

Express Oil, through the statutory provisions of ERISA, asserts that Blue Cross violated its fiduciary duties by failing to meet the prudent person standard [*1345] and by failing to discharge its duties in accordance with the documents and instruments governing the plan. In this case, the two alleged violations seem to be one and the same, as the factual root of Express Oil's claim is that Blue Cross allegedly misinterpreted [**86] Express Oil's plan by attributing too much of the Q claim towards services that did not count towards the lifetime maximum. Throughout its responsive brief, Express Oil has not alleged that Blue Cross did not act as a prudent person in executing its duties as a claims administrator, but instead that Blue Cross incorrectly interpreted the ambiguous plan it supplied to Express Oil and caused more to be paid to a beneficiary in benefits than the plan allowed.

This allegation provides an interesting twist, as Express Oil's claim is the opposite of the usual ERISA claim brought by a beneficiary under *§ 1132(a)(1)* to recover benefits due under a plan. Under the current case law in the Eleventh Circuit, an ERISA claims administrator's decision to deny benefits is analyzed under a six-step process that reviews a benefits decision under a *de novo* standard if the administrator does not have discretion in reviewing claims, and an arbitrary and capricious standard if the administrator is vested with discretion to review the claims. *See Blankenship v. Metro. Life Ins. Co., 644 F.3d 1350, 1355 (11th Cir. 2011)*. Neither party has cited to authority that squarely addresses the inverse situation, which [**87] is what Express Oil alleges here--a claim under *§ 1132(a)(2)* that a claims administrator has breached its fiduciary duties by paying more in benefits than it should.

Other courts in the Eleventh Circuit have applied the "stricter" "statutorily-mandated 'prudence' standard" to claims brought by self-funded employers under *§ 1132(a)(2)*. *See AutoNation, 423 F. Supp. 2d at 1272*; *Baker Cty. Med. Servs., Inc. v. Brown, 2005 U.S. Dist. LEXIS 43482, at *16-17 (M.D. Fla. Aug. 24, 2005)*. Upon review of these cases, the court determines that the prudent person standard does not apply to review of these claims because the claims that Express Oil alleges are distinct from those in *AutoNation* and *Baker County Medical Services* and are more akin to the denial of ben-

efits claims to which the arbitrary and capricious standard applies.

In *Baker County Medical Services*, the plaintiff was a self-funded employer whose reinsurance carrier became insolvent and was unable to reimburse the employer for certain claims its employees incurred. *2005 U.S. Dist. LEXIS 43482, at *9-10*. The third party administrator had delayed in submitting one of those claims to the reinsurance carrier because it attempted to obtain [**88] a discount on the claim and had initially applied a fifty percent reduction to the claim, which it later determined was applied in error. After the third party administrator was unable to obtain a discount and had reversed its decision on the penalty, it submitted the claim to the reinsurance carrier for reimbursement; however, by the time the reinsurance carrier received the claim, it had already experienced severe financial difficulties and had suspended all reimbursements. *2005 U.S. Dist. LEXIS 43482 at *6-9*. Consequently, the plaintiff was not able to obtain reimbursements for the claim, and sued the third party administrator alleging that it had breached its fiduciary duty by attempting to obtain discounts it should have known were unavailable and by incorrectly applying the reduction to the claim; the plaintiff further alleged that the delay caused by this breach prevented it from receiving reimbursement from the reinsurance carrier. *2005 U.S. Dist. LEXIS 43482 at *11*. The court in *Baker* [*1346] *County Medical Services* concluded that the prudent person standard applied in reviewing the third party administrator's actions; because the prudent person standard "essentially tests the reasonableness of [the third party administrator]'s [**89] conduct," the evidence the plaintiff had presented created a genuine issue of material fact. *See Baker Cty. Med. Servs., 2005 U.S. Dist. LEXIS 43482, at *21*.

AutoNation involved a similar set of facts as in *Baker County Medical Services*. Although the plaintiffs in *AutoNation* did not allege the same errors as in *Baker County Medical Services*, they alleged generally, based on the report of an auditor, that the third party administrator failed to "deliver the value, level of review, or services contemplated and paid-for" and continued to disregard its obligations even after it was made aware of flaws in its administration of claims. The plaintiffs' claims included failure to detect excessive overpayments and payments of benefits to terminated employees. *AutoNation, 423 F. Supp. 2d at 1268*. The court in *AutoNation*, in considering a motion to dismiss, denied the motion as to the plaintiffs' breach of fiduciary duty claim, relying on the district court's opinion in *Baker County Medical Services* and its recognition that processing errors could provide a basis for a claim under ERISA's "prudence" standard." *Id. at 1272* (concluding that the plaintiffs could state a claim that the third party [**90] administrator's improper administration violated ERISA's prudence standard).

Unlike *Baker County Medical Services* or *AutoNation*, however, Express Oil's arguments regarding its ERISA breach of fiduciary duty claim are *not* based on alleged deficiencies in the *processing* of the Q claim, but on the parties' disagreement over the proper interpretation of the BlueCard PPO plan that Express Oil was operating under when it incurred the Q claim. Moreover, Express Oil is not asserting that Blue Cross's administration of the plan was generally flawed, but that Blue Cross's interpretation of one *individual* claim is erroneous and not in accordance with the 2006 and 2007 SPDs. Were Express Oil to have argued that Blue Cross's overpayment resulted from more issues with Blue Cross's *administration* of the plan, such as an error in reporting the proper amount of all claims, then Express Oil's claim for breach of fiduciary duty would have been more akin to the claims alleged in *Baker County Medical Services* and *AutoNation* and the court would have applied the prudent person standard. But because Express Oil's claim for breach of fiduciary duty is based on its argument that Blue Cross misinterpreted the [**91] plan in counting services towards the lifetime maximum, the court concludes a different standard applies.

In *Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989)*, the Supreme Court explained that "ERISA abounds with the language and terminology of trust law" and that "[t]rust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers." *Id. at 110-11*. Under *Firestone*, "a trustee may be given power to construe disputed or doubtful terms, and in such circumstances the trustee's interpretation will not be disturbed if reasonable." *Id. at 111*. The Court held that, " [A] denial of benefits challenged under *§ 1132(a)(1)(B)* is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Id. at 115*.

The court finds no reason not to apply *Firestone's* trust principles to Express [*1347] Oil's particular breach of fiduciary duty claim, especially when the validity of Express Oil's overpayment claim turns on the same plan interpretation as an Express Oil employee's claim for a denial of benefits. *See Firestone, 498 U.S. at 115* [**92] ("[T]he validity of a claim to benefits under an ERISA plan is likely to turn on the interpretation of the terms in the plan at issue."). In fact, were Blue Cross to have denied benefits to Mr. Q, explaining that he had reached the lifetime maximum, Mr. Q could have at least alleged a suit under *§ 1132(a)(1)*. Express Oil's claim appears to be the flip side of that coin, and, thus, reviewable under the "arbitrary and capricious standard" if

Blue Cross were vested with discretion in reviewing claims.

Express Oil argues, however, that Blue Cross's administration of the Q claim should be reviewed *de novo*. Under *Firestone, de novo* review applies unless the benefit plan gives an administrator discretionary authority to construe the terms of the plan. *Firestone, 498 U.S. at 115*. The court reviewed both the 2003 ASA and 2007 ASA, and while it found a specific grant of discretionary fiduciary authority to review claims in the 2007 ASA, it could not find any such grant in the 2003 ASA. *See* 2007 ASA at 3 ("[Blue Cross] will exercise the discretionary fiduciary authority to process and adjudicate claims under the plan."). Because courts are to apply the *de novo* standard of review "[w]hen a plan [**93] is silent or ambiguous as to an [a]dministrator's discretionary authority," the court, thus, reviews challenges to Blue Cross's interpretation of the 2003-2006 SPDs *de novo. See Kirwan v. Marriott Corp., 10 F.3d 784, 789 (11th Cir. 1994)*. But because the 2007 SPD expressly vested with Blue Cross discretionary fiduciary authority to review claims, the court will review Blue Cross's administration of Express Oil's plan for the 2007-2008 policy year, when the plan paid in excess of $1.5 million for the Q claim, under the arbitrary and capricious standard.

ii. Blue Cross's interpretation of the 2003-2006 SPDs was not de novo wrong

Express Oil essentially argues that Blue Cross's interpretation of the 2003-2006 SPDs is *de novo* wrong because those SPDs are ambiguous and the Northshore auditors arrived at a different interpretation. The court agrees that the SPDs are not a model of clarity. The definition of "lifetime maximum" in the 2003-2006 SPDs states that the lifetime maximum "applies only to Other Covered Services" and "Non-PPO Physician Services." Immediately below the definition of the lifetime maximum is a table enumerating a non-exhaustive list of "Other Covered Services," with a [**94] footnote referring the reader to a later "Other Covered Services" section and explaining that "[m]ost Other Covered Services are paid at 80% of the Allowed Amount after the calendar year deductible is met." While the table listing "Other Covered Services" does *not* include physicians' services, the subsection on "Other Covered Services" referenced in the footnote to the table lists "Physician's Covered Services." The explanation following "Physician's Covered Services" states that "[s]urgery requires preoperative and postoperative care, reduction of fractures and endoscopic procedures, maternity deliveries and heart catheterization." Thus, the definition of lifetime maximum, which relies upon multiple internal cross-references, hardly paints a clear picture of what services apply to the lifetime maximum.

The difficulty in interpreting the plan raises the question of whether Blue Cross's interpretation is *de novo* wrong *if* the plan is ambiguous. Express Oil argues that the court should interpret ambiguities [*1348] in its favor, citing to Eleventh Circuit law that holds that "application of the rule of contra proferentem is appropriate in resolving ambiguities in insurance contracts regulated [**95] by ERISA." *Lee v. Blue Cross/Blue Shield, 10 F.3d 1547, 1551 (11th Cir. 1994)* (citing *Heasley v. Belden & Blake Corp., 2 F.3d 1249 (3d Cir. 1993))*. The court, however, questions the applicability of the *contra proferentem* rule to this case because the application of *contra proferentem* is intended to protect the *beneficiary*, which in this case would be Mr. Q. As the Eleventh Circuit explained, "[The reasoning behind the *contra proferentem* rule] is especially convincing where, as here, an *insured employee* seeks contractual benefits under ERISA, a statute designed to protect the interests of such employees." *Heasley, 2 F.3d at 1257* (emphasis added). If this court were to interpret the 2006-2007 SPDs to resolve ambiguities in favor of Express Oil, it would be doing so at the expense of the insured employee. Thus, applying the *contra proferentem* rule to claims challenging overpayment as opposed to a denial of payments to employees puts Blue Cross in between a rock and a hard place and creates an inherent conflict in Blue Cross's administration of Express Oil's plan. Given that ERISA was intended to protect the interests of employees, the court concludes that the *contra proferentem* rule [**96] should not be available to a self-funded employer if its application adversely affects the rights of a covered employee.

Moreover, even if Express Oil could receive the benefit of the *contra proferentem* rule, the rule only applies if the court determines the SPD is ambiguous. *See Homes of Legend, Inc., v. McCollough, 776 So. 2d 741, 746 (Ala. 2000)* ("[I]f all other rules of contract construction fail to resolve the ambiguity, then, under the rule of *contra proferentem*, any ambiguity must be construed against the drafter of the contract.") (emphasis in original). Closer scrutiny of the 2003-2006 SPDs reveals that the perceived ambiguity is not so blatant as Express Oil asserts, even if the SPDs are not a model of clarity. The definition of the lifetime maximum states that it applies only to "Other Covered Services" and "*Non-PPO Physician Services*," among other enumerated services. The inclusion of "Non-PPO Physician Services" in the list of services that applies towards the lifetime maximum would be rendered meaningless if the court construed the term "Other Covered Services" to include *all* physician services. In fact, the list of services enumerated under "Other Covered Services" does [**97] not even reference unqualified "Physician Services," but includes the term "Physician's *Covered* Services." The court reads that term, with the qualifier "Covered"--which is not in-

cluded in the term "Non-PPO Physician Services"--to naturally mean that a *subset* of Physician Services are included in the definition of "Other Covered Services." Although the court is at a loss to explain exactly what that subset of services actually includes, it cannot accept Express Oil's and Northshore's interpretation of the SPDs upon a more technical reading of the SPD.

Accordingly, the court concludes that Blue Cross's interpretation of the 2003-2006 SPDs was not *de novo* wrong, particularly when rejecting the *contra proferentem* rule intended to protect the employees covered by the plan. [4]

> 4 The court also is not persuaded by Express Oil's attempts to paint Blue Cross's conduct during the audit as "arbitrary." Whether Blue Cross was slow to respond to Express Oil and Northshore's requests for records or did not produce consistent and accurate records does not affect whether Blue Cross breached a fiduciary duty by misinterpreting the SPDs, but is an issue that relates to Blue Cross's duty of care to administer [**98] the plan as adjudged under the prudent person standard. Express Oil did not advance this argument in its brief, however, and the court thus declines to consider it.

[*1349] *iii. Blue Cross's interpretation of the 2007 SPD was not arbitrary and capricious*

Because the 2007 SPD specifically vested Blue Cross with the discretionary fiduciary authority to review claims, the court will review Blue Cross's administration of Express Oil's plan for the 2007-2008 policy year under the arbitrary and capricious standard. "Under the arbitrary and capricious standard of review, the plan administrator's decision to deny benefits must be upheld so long as there is a 'reasonable basis' for the decision." *Oliver v. Coca Cola Co., 497 F.3d 1181, vacated in part on petition for reh'g, 506 F.3d 1316 (11th Cir. 2007).* Although the 2003 SPD defines the lifetime maximum in general terms, the 2007 SPD's definition of lifetime maximum specifically includes out-of-network physician services as applying toward the lifetime maximum. *See* 2007 ASA at 9 ("The lifetime maximum generally applies to services or supplies that are subject to the calendar year deductible . . . . The following are some examples that generally apply [**99] to the lifetime maximum: . . . Out-of-network physician services."). That Blue Cross had a reasonable basis for interpreting the 2007 SPD to exclude in-network physician services from the lifetime benefit is supported by Northshore's modification to its audit report, which it re-issued on August 28, 2012, to incorporate the 2007 SPD and exclude in-network physician services during the 2007-2008 policy year from the calculation of the lifetime maximum.

Express Oil argues at length that the 2007 SPD is unintelligible and that one "would have to be a mind reader" to figure out the 2007 SPD. Pl. Opp. Br. to Def. Blue Cross Mot. S.J. at 39. Despite offering these subjective observations of the 2007 SPD, Express Oil does not offer any authority stating that Blue Cross breached a fiduciary duty by drafting and administering claims under an allegedly ambiguous plan document, particularly when the 2007 ASA placed upon Express Oil the duty to "ascertain that the [2007 SPD] accurately and fully describes the benefits that the Employer intends the Claims Administrator to provide or Administer." 2007 ASA at 2; *see also* 2007 ASA at 5 ("[As a Plan Sponsor] the Employer exercises non-fiduciary discretion [**100] concerning the design of the Plan."). Moreover, as explained in the preceding section, to the extent the court would apply *contra proferentem*, it would construe ambiguities in favor of the insured employee.

Accordingly, the court concludes that Blue Cross's interpretation of the 2007 SPD was not arbitrary and capricious.

iv. Conclusion on Express Oil's claim against Blue Cross for Breach of Fiduciary Duty

The court finds that the particular breach of fiduciary duty alleged by Express Oil under *§ 1132(a)(2)* for overpayment of benefits should be reviewed under the same arbitrary and capricious standard enunciated by the Supreme Court in *Firestone* and applied by the Eleventh Circuit for denial of benefits claims under *§ 1132(a)(1)*. Under this standard, the court concludes that Blue Cross did not breach a fiduciary standard based on its interpretation of the SPDs in administering the Q claim. Accordingly, the court GRANTS Blue Cross's motion for summary judgment as to Count I for breach of fiduciary duty.

5. Conclusion on Blue Cross's motion for summary judgment

Blue Cross has shown that no genuine issues of material fact exist that would preclude it from summary judgment on all [*1350] claims Express [**101] Oil alleged against Blue Cross in the Amended and Recast Complaint. Accordingly, the court GRANTS Blue Cross's Partial Motion for Summary Judgment in its entirety and GRANTS JUDGMENT in favor of Blue Cross and against Express Oil. Blue Cross remains in the case because of its breach of contract counterclaim against Express Oil.

C. Claims Against ANB and Wood

Unlike Blue Cross, ANB and Wood only move for partial summary judgment on two of the counts alleged against them in the Amended and Recast Complaint. Specifically, ANB and Wood move for summary judgment on Count VII for negligent procurement of insurance, arguing that Express Oil cannot prove that it could have procured stop-loss insurance that would have covered the Q claim. ANB and Wood also move for summary judgment on Count XII for breach of fiduciary duty, asserting that insurance brokers or agents are generally not regarded as fiduciaries unless they have a special relationship of trust and confidence with a plaintiff, and arguing that no such relationship exists in this case.

1. Did ANB and Wood negligently procure insurance?

Express Oil claims that ANB and Wood's failure to procure appropriate stop-loss coverage was negligent. [**102] [5] ANB and Wood assert that they are entitled to summary judgment on this count because Express Oil cannot establish that ANB and Wood could have procured additional coverage under the stop-loss policy or an entirely different stop-loss policy to protect Express Oil from the costs it incurred on the Q claim.

5 Express Oil has abandoned its wantonness claim. (Doc. 105, at 12).

"[T]o prevail on a claim of negligent procurement, the plaintiff must prove that the coverage obtained was not the coverage requested." *Sudduth v. Equitable Life Assur. Soc'y, 2007 U.S. Dist. LEXIS 63174, at *18 (S.D. Ala. 2007)* (citing *Kanellis v. Pacific Indemnity Co., 917 So. 2d 149, 155 (Ala. Civ. App. 2005))*. "Like any negligence claim, a claim in tort alleging a negligent failure of an insurance agent to fulfill a voluntary undertaking to procure insurance, . . . requires demonstration of the classic elements of a negligence theory, i.e., '(1) duty, (2) breach of duty, (3) proximate cause, and (4) injury.'" *Kanellis, 917 So. 2d at 155* (citing *Albert v. Hsu, 602 So. 2d 895, 897 (Ala. 1992))*.

An insurer has no duty to procure insurance that he "could not *actually* obtain." *Hawk v. Roger Watts Ins. Agency, 989 So. 2d 584, 591 (Ala. Civ. App. 2008)*. [**103] In *Hawk*, the court ruled that the insurer had no duty to procure insurance coverage for after-market modifications on an automobile because "no other agent could have procured [coverage] for him." *Id.* Similarly, in this case Express Oil has not produced evidence that ANB and Wood could have procured stop-loss insurance that would have prevented the damages that Express Oil now claims.

During the first two coverage years, Express Oil was reimbursed under the stop-loss policy on the Q claim, but in the third policy year, Express Oil incurred claims in excess of the policy's $1,000,000 ceiling. During the first two policy years, Express Oil did not assert a claim for negligent procurement of insurance because it suffered no recoverable damage. [6] In the [*1351] third policy year, Express Oil claims damages because it did not have sufficient stop-loss coverage to be reimbursed for all the payments it made on the Q claims after the exhaustion of the required deductible.

6 During the first two policy years, Express Oil may have had a claim that it could have asserted for negligent failure to procure the coverage and protection it thought it was receiving under the plan, but it did not assert it presumably [**104] because it had not yet suffered any monetary damages as a result of the gap in coverage between the lifetime maximum and the stop-loss policy.

The stop-loss coverage provided under Express Oil's policy procured by ANB and Wood and any other policy that they could have procured for Express Oil, no matter the coverage amount, would have been subject to review by its underwriting department each policy year. Therefore, any insurer could have "lasered" the Q claim or excluded coverage for the Q claim by the third policy year, the year in which Express Oil incurred its losses at issue. Thus, Express Oil cannot now claim that ANB and Wood definitively *could* have but did not obtain a specific stop-loss policy that would have covered the Q claims in the third policy year. [7]

7 ANB and Wood correctly point out in their Reply brief that courts differ regarding whether they classify a plaintiff's failure to establish the availability of insurance coverage as a lack of duty, breach, causation, or damages. Regardless of how it is characterized, in *Hawk*, [**105] the Alabama Court of Civil Appeals required that the plaintiff produce evidence that the insurance coverage sought was in fact available in the market.

The testimonies of Wayne Bowling, Express Oil's expert, and Richard Yeary, Blue Cross's expert, support the assertion that obtaining different or additional stop-loss insurance would not necessarily have covered all of the Q claims. (Docs. 89-18, 19, 20, 21, 22). In fact, Unimerica did exclude coverage for any Q claims in October 2008 when underwriting Express Oil's new $2,000,000 stop-loss policy. (Doc. 89-23, at 42). Express Oil has presented no evidence that "but for" ANB and Wood's alleged negligence in procurement of the $1,000,000 stop-loss policy, Express Oil would not have suffered the damages it now claims. Because Express Oil's expert could only testify as to whether different or

additional stop-loss insurance *might* have decreased Express Oil's out of pocket expenses on the Q claim, Express Oil has not produced sufficient evidence that ANB and Wood's failure to provide different or additional coverage caused the damages at issue in this case.

Because Express Oil fails to produce any evidence of causation, it cannot present a [**106] prima facie case of negligent procurement of insurance. Thus, the court will GRANT summary judgment in favor of Wood and ANB on Count VII and DISMISS WITH PREJUDICE Count VII of Express Oil's Amended and Recast Complaint.

2. Did ANB and Wood breach their fiduciary duty?

ANB and Wood argue that Express Oil's breach of fiduciary duty claim fails as a matter of law because no fiduciary relationship existed between the parties. Although insurance agents and brokers are generally not regarded as fiduciaries under Alabama law, the Alabama Supreme Court has recently defined a fiduciary or confidential relationship as follows:

> A confidential relationship is one in which one person occupies toward another such a position of adviser or counselor as reasonably to inspire confidence that he will act in good faith for the other's interests, or when one person has gained the confidence of another and purports to act or advise with the other's interest in mind; where trust and confidence are reposed by one person in another who, as a result, gains an influence or superiority over the other . . .

DGB, LLC v. Hinds, 55 So. 3d 218 (Ala. 2010) (internal citations omitted). This [*1352] court recognizes that this [**107] kind of fiduciary relationship existed between Express Oil and ANB and Wood. Express Oil executives Brooks and Glover trusted Pardue and thus ANB and Wood, ANB's employee benefits salesperson, to counsel and advise Express Oil about the procurement of a self-funded health plan and stop-loss insurance to cover its liability under the self-funded plan. Additionally, before Express Oil even considered a self-funded health plan, Pardue served as Express Oil's agent for its property insurance, casualty insurance, and worker's compensation coverage. (Doc. 107-22, at 12-13). ANB and Wood do not dispute that a close advisory relationship existed between the parties, and they recognize that ANB wanted its agents to act as "trusted advisors" as opposed to merely insurance salesmen. *Id.* at 78-79.

Wood and ANB argue that this case is similar to *Maloof v. John Hancock Life Ins. Co., 60 So. 3d 263 (Ala. 2010)*. In that case, the Supreme Court of Alabama affirmed the grant of summary judgment to an insurance agent on a claim of breach of fiduciary duty because no fiduciary relationship existed between the insured and the agent. That case is distinguishable from this one because the insureds' testimony [**108] in *Maloof* proved that they "certainly did not view their relationship with [the insurance agent,] though cordial and long-standing, as anything special or outside the typical salesperson-customer relationship." *Id. at 274*. By contrast, in this case, Express Oil has demonstrated that its executives placed trust and confidence in ANB and Wood in developing a self-funded health plan and in procuring the appropriate stop-loss insurance to protect Express Oil under the self-funded plan. This type of relationship where ANB and Wood inspired confidence in Express Oil that they would act in good faith for its interests goes beyond that of a mere insurance agent/customer relationship like in *Maloof*.

Express Oil has produced evidence that ANB and Wood breached their fiduciary duty by failing to adequately explain to Express Oil how the stop-loss coverage interfaced with Blue Cross's unusual lifetime maximum in its self-funded plan and how Express Oil could cap its total liability with a comprehensive lifetime maximum offered by Blue Cross. Express Oil has also presented evidence that ANB and Wood's breach caused it the damages at issue in this action. ANB and Wood do not raise any arguments regarding [**109] the breach, causation, or damages elements of the breach of fiduciary duty claim in their Motion for Partial Summary Judge or their Reply.

Express Oil has produced evidence sufficient to show a fiduciary relationship existed between ANB and Wood and Express Oil and resulting damages that were caused as a breach of that relationship. Thus, the court will DENY ANB and Wood's motion for summary judgment on Count XII for breach of fiduciary duty.

VI. CONCLUSION

For the reasons more fully stated above, the court will GRANT IN PART and DENY IN PART Blue Cross's Motion to Strike. The court will GRANT IN ITS ENTIRETY Nesbitt's Motion for Summary Judgment; ENTER JUDGMENT in favor of Nesbitt and against Express Oil on Counts VII, VIII, XI, XII, XIII, and XIV; and DISMISS Nesbitt as a party to this action WITH PREJUDICE. The court will GRANT IN ITS ENTIRETY Blue Cross's Motion for Partial Summary Judgment and ENTER JUDGMENT in favor Blue Cross and against Express Oil on Counts I, II, III, IV, V, and VI. [8] The [*1353] court will GRANT ANB and Wood's

Motion for Partial Summary Judgment on Count VII but DENY ANB and Wood's Motion for Partial Summary Judgment on Count XI. Counts VIII, IX, X, XI, and XII against [**110] Wood remain before the court; Counts VIII, XI, XII, XIII, and XIV against ANB remain before the court; and Blue Cross's counterclaim against Express Oil remains before the court. The court will enter an order simultaneously to that effect.

8 The court grants summary judgment for Blue Cross on all of the claims Express Oil asserts against Blue Cross but does not address the breach of contract counterclaim Blue Cross has asserted against Express Oil.

DONE and ORDERED this 27th day of March, 2013.

/s/ Karon Owen Bowdre

KARON OWEN BOWDRE

UNITED STATES DISTRICT JUDGE

Harriet Maloof and John A. Maloof, Jr. v. John Hancock Life Insurance Company and Parker A. Glasgow

1090684

SUPREME COURT OF ALABAMA

60 So. 3d 263*; *2010 Ala. LEXIS 196

September 30, 2010, Released

SUBSEQUENT HISTORY: As Amended August 24, 2011.

Released for Publication March 31, 2011.

PRIOR HISTORY: [**1]

Appeal from Jefferson Circuit Court. (CV-08-900797). G. William Noble, Trial Judge.

DISPOSITION: AFFIRMED.

COUNSEL: For Appellants: Leah O. Taylor, Rhonda P. Chambers, Taylor & Taylor, Birmingham.

For Parker A. Glasgow, Appellee: Bruce F. Rogers, Charles K. Hamilton, Bainbridge, Mims, Rogers & Smith, LLP, Birmingham.

For John Hancock Life Insurance, Company (U.S.A.), Appellee: Emily Sides Bonds, Timothy M. Davis, Jones, Walker, Waechter, Poitevent, Carrére & Denégre, LLP, Birmingham.

JUDGES: STUART, Justice. Lyons, Smith, Bolin, Parker, Murdock, and Shaw, JJ., concur. Woodall, J., concurs in the result. Cobb, C.J., dissents.

OPINION BY: STUART

OPINION

[*265] STUART, Justice.

Harriet Maloof and John A. Maloof, Jr., sued John Hancock Life Insurance Company ("John Hancock") and Parker A. Glasgow, an independent insurance agent, in the Jefferson Circuit Court, alleging fraudulent misrepresentation, suppression. breach of contract, negligent and/or wanton failure to procure insurance, and breach of fiduciary duties arising out of Glasgow's sale of two universal life-insurance policies to the Maloofs in 1989 and 1992. The trial court entered a summary judgment in favor of John Hancock and Glasgow on all the claims, and the Maloofs appeal as to all the claims except the breach-of-contract claim. We affirm.

I.

John Maloof first became acquainted with Glasgow in approximately 1969 when they met at the University of Alabama at Birmingham Hospital where John worked as a cardiologist; Glasgow sold insurance to other physicians at the hospital. Over the next two decades, John purchased at least two life-insurance policies from Glasgow, as well as disability [**2] insurance. In 1989, after consulting with Glasgow, John elected to replace five existing life-insurance policies providing approximately $ 275,000 of coverage with two new policies issued by Manulife Financial. [1] When questioned by Glasgow's attorney during his deposition, John explained that the object of these transactions was to provide funds to pay the estate taxes that would be due upon John's death:

> "The reason that these policies were even being discussed was because we were talking about estate planning and we got into a discussion of -- of estate taxes and things like that. The entire reason for even considering these policies was to fund estate tax planning. Parker was kind enough to make me an appointment with [Birmingham attorney] Kirby Sevier,

> who's an estate planner, and arranged it, and we went over there together. The whole purpose of the policies was to take care of estate planning. That was the reason for the policies."

John also testified that Glasgow assured him that taking out these policies was in his and Harriet's best financial interests. One of the policies purchased by John in 1989 was a $ 500,000 universal-life policy; the other policy was a renewable and convertible [**3] $ 500,000 term-life policy with an initial term of three years. In 1992, John purchased another $ 500,000 of life insurance from Manulife through Glasgow; this coverage was another universal-life policy with a face value of $ 250,000 and a $ 250,000 term rider. John stated in his deposition that this policy was also purchased as an estate-planning move to provide liquidity for any estate taxes due upon his death and that Glasgow again represented that it was in John's best financial interests to purchase the policy. All the policies named Harriet as the beneficiary.

> 1 Manulife Financial acquired John Hancock in approximately 2004 and now conducts most of its business in the United States as John Hancock.

During the next several years, the Maloofs received quarterly bills for each of the three insurance polices and paid them as they came due. The quarterly payment for the 1989 universal-life policy was [*266] $ 1,275.25, the quarterly payment for the 1992 universal-life policy was $ 1,418.14, and the quarterly payment for the 1989 term-life policy was initially $ 493, but increased to $ 1,028 in 1992 and to $ 1,633 in 1995. In 1998, the Maloofs elected not to renew the term-life policy and it [**4] was canceled. Thereafter, the Maloofs continued to pay the quarterly bills for the two universal-life policies without incident until 2007.

On January 4, 2007, the Maloofs made what would ultimately be their last quarterly payment of $ 1,418.14 on the 1992 universal-life policy, and on February 12, 2007, the Maloofs made what would ultimately be their last quarterly payment of $ 1,275.25 on the 1989 universal-life policy. The Maloofs subsequently received a notice from John Hancock dated February 13, 2007, notifying them that an additional premium payment of $ 5,265.12 was required by April 15, 2007, in order to continue the 1992 universal-life policy until July 13, 2007; otherwise, the notice informed them, the 1992 universal-life policy would terminate on April 15. They later received another notice from John Hancock, dated May 29, 2007, informing them that an additional premium payment of $ 7,573.15 was required by July 29, 2007, in order to continue the 1989 universal-life policy until November 29, 2007; otherwise, this notice informed them, that policy would terminate on July 29. After receiving these notices, John contacted Glasgow, who had retired in 2000, to inquire why his [**5] policies would be terminating, even though he had timely paid the premiums on the policies for approximately 18 years. John states that Glasgow told him that he would investigate the matter, and it appears that Glasgow did subsequently contact John Hancock; however, John states that Glasgow ultimately told him that there was nothing Glasgow could do. At his deposition, John testified that he decided not to pay the additional premiums requested by John Hancock to keep his policies in effect because doing so would essentially be "just throwing money away." The Maloofs subsequently received notice from John Hancock that the 1992 universal-life policy was terminated on April 15, 2007, and that the 1989 universal-life policy was terminated on July 29, 2007.

On March 13, 2008, the Maloofs sued John Hancock and Glasgow in the Jefferson Circuit Court, alleging fraudulent misrepresentation, suppression, breach of contract, negligent and/or wanton failure to procure insurance, and breach of fiduciary duties arising out of their purchase of the universal-life policies in 1989 and 1992. The gravamen of their complaint was that Glasgow had misrepresented to them that purchasing those insurance policies [**6] was in their best financial interests and that the policies would provide benefits that would be available to pay any estate taxes due upon John's death when, in fact, based upon the projected insurance and interest rates at the time of sale, those policies would likely lapse when John was approximately 78 years old unless the Maloofs at some point substantially increased the amount of the premiums they paid. On April 16, 2008, John Hancock moved the trial court to stay all proceedings pending a ruling from the United States District Court for the Southern District of California on whether the Maloofs' action was barred by the settlement of a class action overseen by that court in 1998 in which allegedly deceptive sales practices used by Manulife between 1982 and 1993 were challenged; Glasgow subsequently joined in that motion. On June 19, 2008, the trial court entered a limited stay during which some preliminary discovery could still be conducted; however, that stay was lifted in its entirety effective November 19, 2008, after the United States District Court for [*267] the Southern District of California held that the Maloofs' claims were not covered by the settlement of the previous class [**7] action except to the extent that the Maloofs alleged that the contract charges on their life-insurance policies had been misrepresented.

On December 29, 2008, the trial court set an initial trial date of September 21, 2009; that trial date was later continued until February 1, 2010. On October 22, 2009,

Glasgow and John Hancock filed their first formal answers to the Maloofs' complaint. On November 2, 2009, the Maloofs moved to strike those answers, arguing that they were untimely under *Rule 12(a), Ala. R. Civ. P.*, which requires defendants to "serve an answer within 30 days after the service of the summons and complaint." Accordingly, the Maloofs argued, John Hancock and Glasgow's answers were filed over 550 days late. On December 7, 2009, the trial court denied the Maloofs' motion. The Maloofs then petitioned this Court for a writ of mandamus directing the trial court to strike John Hancock's and Glasgow's answers as untimely; however, on January 22, 2010, this Court denied that petition, without an opinion (No. 1090375).

On November 24, 2009, Glasgow moved the trial court to enter a summary judgment in his favor on all counts, and, on November 25, 2009, John Hancock did the same. [**8] The Maloofs filed responses opposing the motions, but, on January 5, 2010, the trial court entered an order granting the motions of John Hancock and Glasgow and entering a summary judgment in their favor. On February 10, 2010, the Maloofs filed their notice of appeal to this Court.

II.

The Maloofs first make the general argument that the summary judgment entered by the trial court was erroneous because, they say, it was based at least partly upon affirmative defenses asserted by John Hancock and Glasgow; however, the Maloofs argue, those defenses had been effectively waived because John Hancock and Glasgow did not assert them until they filed their untimely answers more than 550 days after the answers were due. See *Baldwin County Elec. Membership Corp. v. City of Fairhope, 999 So. 2d 448, 461 (Ala. 2008)* (stating that the appellant had waived affirmative defenses first asserted in an untimely pleading). However, in both their motion to strike John Hancock's and Glasgow's answers and their brief filed with this Court, the Maloofs fail to address the significance of the stay entered by the trial court on June 19, 2008; rather, they argue only that [*268] the answers were late because they were [**9] not filed within 30 days after the summonses and complaints were served. In fact, the order entered by the trial court on June 19, 2008, granting a limited stay states that "either party shall file an appropriate d[i]sposit[i]ve pleading to the court" when the United States District Court for the Southern District of California ruled on John Hancock's motion asserting that the Maloofs' claims were part of a 1998 class action presided over by that court, thus indicating that the defendants' obligations to file merits-related pleadings or motions were in abeyance during the duration of the stay. Accordingly, John Hancock's and Glasgow's answers were not late merely because, as the Maloofs argue, they were not filed by the 31st day after the summonses and complaints were served. Instead, the relevant issue would instead be whether the answers were late because they were not filed for almost a year after the stay was lifted on November 19, 2008. However, this is not an issue that was raised by the Maloofs in either the trial court or in their brief filed with this Court. They instead have argued exclusively that the answers were late because they were not filed within 30 days after the [**10] summonses and complaints were served. This Court will not consider an argument not raised in the trial court or in the appellate briefs; accordingly, there is no basis on which to hold that the trial court erred in failing to grant the Maloofs' motion to strike John Hancock's and Glasgow's answers. See *Yellow Dog Dev., LLC v. Bibb County, 871 So. 2d 39, 41 (Ala. 2003)* ("[T]his Court will not 'reverse a trial court's judgment based on arguments not presented to the trial court or based on arguments not made to this [C]ourt. '" (quoting *Brown v. Wal-Mart Stores, Inc., 864 So. 2d 1100, 1104 (Ala. Civ. App. 2002)))*.

III.

We next consider the Maloofs' arguments that the trial court erred by entering a summary judgment in favor of John Hancock and Glasgow on the Maloofs' fraudulent-misrepresentation and suppression claims, their negligent-and/or wanton-failure-to-procure-insurance claim, and their breach-of-fiduciary-duties claim; the Maloofs do not challenge the judgment entered on their breach-of-contract claim. We review these arguments pursuant to the following standard of review.

> "This Court's review of a summary judgment is de novo. *Williams v. State Farm Mut. Auto. Ins. Co., 886 So. 2d 72, 74 (Ala. 2003).* [**11] We apply the same standard of review as the trial court applied. Specifically, we must determine whether the movant has made a prima facie showing that no genuine issue of material fact exists and that the movant is entitled to a judgment as a matter of law. *Rule 56(c), Ala. R. Civ. P.*; *Blue Cross & Blue Shield of Alabama v. Hodurski, 899 So. 2d 949, 952-53 (Ala. 2004).* In making such a determination, we must review the evidence in the light most favorable to the nonmovant. *Wilson v. Brown, 496 So. 2d 756, 758 (Ala. 1986).* Once the movant makes a prima facie showing that there is no genuine issue of material fact, the burden then shifts to the nonmovant to produce 'substantial evidence' as to the exist-

> ence of a genuine issue of material fact. *Bass v. SouthTrust Bank of Baldwin County, 538 So. 2d 794, 797-98 (Ala. 1989)*; *Ala. Code 1975, § 12-21-12*."

Dow v. Alabama Democratic Party, 897 So. 2d 1035, 1038-39 (Ala. 2004).

The Maloofs' fraudulent-misrepresentation and suppression claims were premised on the allegation that Glasgow misrepresented to the Maloofs that the universal-life policies were in their best financial interests and that they would provide funds that would be available [**12] to pay the estate taxes due upon John's death, while at the same time suppressing from them the facts that the policies were actually not in their best interests and that benefits from those policies would not be available to pay estate taxes due upon John's death if he lived beyond approximately age 78. To merit consideration by a jury, both of these claims require some evidence of reasonable reliance, that is, that the Maloofs reasonably relied upon the alleged false representations, *Boswell v. Liberty Nat'l Life Ins. Co., 643 So. 2d 580, 581 (Ala. 1994)*, or that they reasonably relied "on the state of affairs as it appeared in the absence of the suppressed information." *Houston County Health Care Auth. v. Williams, 961 So. 2d 795, 814 (Ala. 2006)*. In its order granting John Hancock's and Glasgow's motions for a summary judgment, the trial court explained its conclusion that evidence of reasonable reliance was lacking:

> "Counts one and two of [the Maloofs'] complaint allege fraud and suppression, and the undisputed facts of this case [*269] place it squarely within the facts and holding of the Alabama Supreme Court's recent decision in *AmerUS Life Insurance Co. v. Smith, 5 So. 3d 1200 (Ala. 2008)*. [**13] As in this case, *AmerUS* involved a plaintiff insured filing suit for substantially similar claims of fraudulent misrepresentation and suppression against his insurer and independent insurance agent. The similarities between the cases are striking insofar as: (1) both *AmerUS* and this case arise from the sale of universal life policies; (2) both *AmerUS* and this case involve misrepresentations as to the advisability of plaintiffs' purchase of the universal life policies; the replacement of life insurance policies owned by the plaintiffs, the amount of premiums to be paid, and the length of time in which those premiums would carry the policies; (3) in both *AmerUS* and this case, the universal life policies were sold by independent insurance agents who were appointed to sell the products of the insurance company and who sold a substantial amount of business through the insurance company; (4) in both *AmerUS* and this case, the universal life policies issued by the insurance company called for the payment of 'planned premiums'; (5) in both *AmerUS* and this case, the universal life policies advised the plaintiffs to read their policy carefully; (6) in both *AmerUS* and this case, the universal [**14] life policies provided the plaintiffs with a 'free-look' provision; (7) in both *AmerUS* and this case, the universal life policies were self-described as 'Flexible Premium Adjustable Life Policies'; (8) in both *AmerUS* and this case, the universal life policies contained statements disclosing that the policies would lapse if sufficient premiums were not paid to keep the policies in force; (9) in both *AmerUS* and this case, plaintiffs were provided documents both at the time of issuance of the policies and afterwards, including annual statements, showing the performance of the policies based upon assumed interest rates and indicating policy lapses, all of which contradicted the alleged misrepresentations made by the insurance agent; and (10) in both *AmerUS* and this case, it was communicated to the plaintiffs that additional premiums beyond the planned premium would be required to sustain the policies. In *AmerUS*, the communication was verbal; here, the communication occurred in two separate letters in 1992 and 1997 written by the insurance agent and received and kept by the [Maloofs]. Based upon the holding in *AmerUS* and its overwhelming application to the present case, this court finds, [**15] as a matter of law, that [the Maloofs] cannot establish the necessary element of reasonable reliance in order to sustain their fraud and suppression claims. For these same reasons, [the Maloofs] were likewise put on notice of the alleged fraud more than two years prior to the commencement to this action, and, therefore, these claims are barred by the applicable statute of limitations.
>
> "Additional grounds bar some of the misrepresentations claimed by [the

> Maloofs]. The statement allegedly made to plaintiff John Maloof as to what was in his best financial interests is a statement of opinion and not a statement of a material fact. Moreover, the statement that the policies would be available to pay estate taxes was not false because the universal life policies would have been available for such purposes if sufficient premiums had been paid.
>
> "Other grounds likewise mandate dismissal of [the Maloofs'] suppression claims as [the Maloofs] have failed to offer substantial evidence to establish a duty to disclose by the defendants, and [*270] the court finds that there was no special relationship between the insurance agent and the [Maloofs]. As to [the Maloofs'] claims regarding suppression of the policies' [**16] contractual charges, [the Maloofs] agree that such claims are barred by the order entered earlier by the United States District Court for the Southern District of California and filed in this case."

In their briefs to this Court, John Hancock and Glasgow reiterate the rationale of the trial court, while the Maloofs attempt to distinguish *AmerUS Life Insurance Co. v. Smith, 5 So. 3d 1200 (Ala. 2008)*, arguing that the facts in this case are substantially different from the facts there and that reasonable reliance is a question for the jury. For the reasons that follow, we disagree.

Regardless of any oral misrepresentations that Glasgow may have made to convince the Maloofs to apply for new life-insurance policies, it is undisputed that the Maloofs had 20 days to review both the 1989 and 1992 universal-life policies after they received the policies and that they could cancel the policies at any time within that 20-day "free-look" period and receive a full refund of any premiums paid. Page three of both the 1989 and 1992 policies clearly states that "[t]his policy provides life insurance coverage for the lifetime of the life insured if sufficient premiums are paid. *Premium payments in addition* [**17] *to the planned premium may need to be made to keep this policy and coverage in force.*" (Emphasis added.) When questioned by Glasgow's attorney about this language when he was deposed, John acknowledged that he understood its plain meaning:

> "Q: What does that mean please, sir?
>
> "A: It means you may have to pay more to keep the policy in force.
>
> "Q: All right. And you have no trouble understanding that language?
>
> "A: I understand it.
>
> "Q: Okay. And so you would have understood back in [19]89, when you got this policy, that you may be required to make additional premium payments in the future, is that right?
>
> "A: Yes."

Moreover, within the 20-day free-look period the Maloofs had to review the 1989 and 1992 universal-life policies after receiving them, they also received a document produced by John Hancock labeled "Statement of Policy Cost and Benefit Information" for each policy. This document summarized the contract and surrender charges associated with the policy, as well as the expected life of the policy based on the premiums paid and interest rates and mortality rates applied. The document received in conjunction with the 1989 universal-life policy stated that the policy would lapse in approximately [**18] 4 years based on guaranteed interest rates and mortality rates, while the policy would lapse in approximately 18 years based on the current interest rates and mortality rates. The document received in conjunction with the 1992 universal-life policy stated that the policy would lapse in approximately 4 years based on guaranteed interest rates and mortality rates, while the policy would lapse in approximately 16 years based on the current interest rates and mortality rates. Both documents also contained the following disclaimer:

> "The projected results of your insurance program may change significantly with variations in interest rates; mortality rates (risk charges); and the frequency, timing and amounts of premium payments. The projected values using 'current rates' are not guaranteed and the values with guaranteed rates are the [*271] minimum that you will receive upon the surrender of the policy.
>
> "Read your policy very carefully. In addition, there are other factors which could affect the projected values."

John acknowledged in his deposition that the language of this disclaimer was "perfectly clear." [2]

> 2 John Hancock and Glasgow submitted additional evidence indicating that, over the approximately [**19] 18-year period between the time

they purchased the first universal-life policy in 1989 and the time John testified that he realized his policy was in danger of lapsing in 2007, the Maloofs were sent other letters and documents indicating that the universal-life policies could lapse before John died.

In *AmerUS*, this Court stated:

> "In light of the language of the documents surrounding the insureds' purchase of the life-insurance policies at issue in this case and the conflict between [the insurance agent's] alleged misrepresentations and the documents presented to [the plaintiff], it cannot be said that [the plaintiff] *reasonably* relied on [the insurance agent's] representations. As this Court stated in *Torres [v. State Farm Fire & Cas. Co., 438 So. 2d 757 (Ala. 1983)]*: '[T]he right of reliance comes with a concomitant duty on the part of the plaintiffs to exercise some measure of precaution to safeguard their interests.' *438 So. 2d at 759*. The insureds here took no precautions to safeguard their interests. If nothing else, the language in the policies and the cost-benefit statement should have provoked inquiry or a simple investigation of the facts by [the plaintiff]. Instead, based upon [**20] the record before us, we must conclude that [the plaintiff] 'blindly trust[ed]' [the insurance agent] and 'close[d] [his] eyes where ordinary diligence require[d] [him] to see.' *Munroe v. Pritchett, 16 Ala. 785, 789 (1849)*. ... We conclude that no reasonable person could read the policies and the cost-benefit statement and not be put on inquiry as to the existence of inconsistencies, thereby making reliance on [the insurance agent's] representations unreasonable as a matter of law. Because the insureds failed to present substantial evidence indicating that [the plaintiff's] reliance on [the insurance agent's] representations was reasonable, [the life insurance company] is entitled to a JML."

5 So. 3d at 1215-16. We agree with the trial court that our holding in *AmerUS* controls here. The Maloofs argue that this case is different from *AmerUS* because the alleged misrepresentations were different; however, that fact is ultimately immaterial. The relevant inquiry is the same in both *AmerUS* and this case: whether it was reasonable for the insured to rely on an insurance agent's representations about an insurance policy when those representations are contradicted by language in the insurance [**21] policy itself. This Court has repeatedly stated that it is not, not only in *AmerUS*, but also in *Baker v. Metropolitan Life Insurance Co., 907 So. 2d 419 (Ala. 2005)*; *Liberty National Life Insurance Co. v. Ingram, 887 So. 2d 222 (Ala. 2004)*; and *Alfa Life Insurance Corp. v. Green, 881 So. 2d 987 (Ala. 2003)*.

The Maloofs claim that Glasgow misrepresented to them that the universal-life policies they purchased were in their best interests and that they would provide funds that would be available to pay the estate taxes due upon John's death, while at the same time suppressing from them the facts that the policies were actually not in their best interests and that benefits from those policies would not be available to pay estate taxes due upon John's death if he lived beyond approximately age 78. However, the Maloofs could not have reasonably [*272] relied on the alleged misrepresentations concerning the availability of benefits from those policies to pay estate taxes due upon John's death in light of the clear language of the insurance policies. Moreover, with regard to Glasgow's alleged misrepresentation that the purchase of the 1989 and 1992 universal-life policies was in the Maloofs' best financial [**22] interests, we agree with the trial court that this was merely a statement of an opinion, not of a material fact. See *State Farm Fire & Cas. Co. v. Slade, 747 So. 2d 293, 322-23 (Ala. 1999)* (holding that insurance agent's statements that the purchased insurance policy was "the Cadillac of all insurance" and "the very best" amounted to mere puffery that could not reasonably be relied upon in light of the insured's level of education and degree of sophistication). Accordingly, the trial court did not err by entering a summary judgment in favor of John Hancock and Glasgow on the Maloofs' fraud claims.

The Maloofs have also argued that the trial court erred by entering a summary judgment in favor of John Hancock and Glasgow on their claim alleging that John Hancock and Glasgow negligently and/or wantonly failed to procure insurance for them. We have stated that "'when an insurance agent or broker, with a view to compensation, undertakes to procure insurance for a client, and unjustifiably or negligently fails to do so, he becomes liable for any damages resulting therefrom.'" *Crump v. Geer Bros., 336 So. 2d 1091, 1093 (Ala. 1976)* (quoting *Timmerman Ins. Agency, Inc. v. Miller, 285 Ala. 82, 85, 229 So. 2d 475, 477 (1969)*). [**23] The Maloofs allege that Glasgow agreed to procure life-insurance policies for them that would provide benefits available to pay estate taxes due upon John's death; however, they argue, they now have no such life-insurance policies.

The undisputed facts indicate that Glasgow did in fact procure two universal life-insurance policies for the Maloofs and that, had the Maloofs continued to pay sufficient premiums on those policies, they would have remained in effect and the benefits of those policies would have been available for any purpose after John died. John Hancock did not spontaneously act to cancel the policies in 2007, nor did Glasgow take any action leading to their cancellation; rather, the Maloofs elected not to pay the increased premiums required to keep the policies in effect. There is no doubt that they made that decision with full knowledge of the fact that the failure to pay the increased premiums would lead to the cancellation of the policies. Thus, the undisputed facts indicate that Glasgow in fact fulfilled the Maloofs' request to procure life-insurance policies that would provide funds that could be used to pay estate taxes upon John's death, and those policies were [**24] canceled only after the Maloofs failed to pay the required premiums. John Hancock and Glasgow cannot be held liable for the negligent or wanton failure to procure insurance based on the Maloofs' failure to pay the required premiums; accordingly, the summary judgment was properly entered on this count.

The Maloofs' final argument is that the trial court erred by entering a summary judgment in favor of John Hancock and Glasgow on the Maloofs' claim that John Hancock and Glasgow breached certain duties owed to them because of their alleged fiduciary relationship with Glasgow, namely, the duty to disclose material facts related to the insurance policies and the duty to act in the Maloofs' best interests. This Court discussed this claim in a similar context in *Guinn v. American Integrity Insurance Co., 568 So. 2d 760, 764 (Ala. 1990)*, where we stated:

> [*273] "[The plaintiff's] breach of fiduciary duty claim was premised on her allegation that her reposal of trust in [the defendant insurance agents] to advise her on what policies she should purchase, coupled with their acceptance of that trust, created a fiduciary relationship. She argues that her reliance, along with her advanced age, lack of mental [**25] strength, lack of knowledge of insurance matters, and the agents' superior knowledge concerning insurance, constituted special circumstances that warranted the imposition of a fiduciary duty on [the agents].
>
> "This Court has held that an insurance agent may be the agent of the insured, the insurer, or both. *Washington National Ins. Co. v. Strickland, 491 So. 2d 872, 874-75 (Ala. 1985)*. However, an insurance agent is generally not considered to be an agent of the insured until a contract of insurance has been entered into. *Strickland, supra*; *Highlands Underwriters Ins. Co. v. Elegante Inns, Inc., 361 So. 2d 1060 (Ala. 1978)*. Until such a contractual relationship has been established, the parties remain in the relationship of salesperson and prospective customer. The salesperson and his principal may be liable for damages if he misrepresents material facts in an attempt to induce the prospective customer to enter into the contract, *Harrell v. Dodson, 398 So. 2d 272 (Ala. 1981)*; *Ala. Code 1975, § 6-5-101 through 6-5-104*. However, that potential liability does not indicate the existence of a fiduciary relationship.
>
> "In addition, the existence of a duty is a question of law for the trial court. [**26] *Berkel & Co. Contractors v. Providence Hospital, 454 So. 2d 496 (Ala. 1984)*; *Hand v. Butts, 289 Ala. 653, 270 So. 2d 789 (1972)*. Because [the plaintiff] failed to present evidence of a relationship between herself and [the defendant agents] that gave rise to a fiduciary duty, the court did not err in dismissing the claim based on an alleged fiduciary duty."

For the reasons that follow, we similarly conclude in this case that there was insufficient evidence of a relationship between the parties that would give rise to fiduciary duties.

The Maloofs summarize their argument that they had a special relationship with Glasgow that gave rise to fiduciary duties as follows in their brief to this Court:

> "For many years, [the Maloofs] entrusted their financial affairs and estate planning needs to Glasgow. His relationship with [the Maloofs] was far more confidential and complex than that of a mere insurance salesman. Glasgow indicated to the [Maloofs] that he was their 'financial planner.' Glasgow not only sold insurance products to the [Maloofs], but guided and advised [them] regarding important financial and estate planning affairs and decisions. He made insurance, financial and estate planning [**27] recommendations

> to the Maloofs. He referred them to a lawyer and made the appointment with the lawyer. He even went with the Maloofs to meet with the lawyer. He witnessed their wills. Their relationship far surpasses that of merely a 'salesperson and prospective customer' and does indeed give rise to a fiduciary duty. *[Guinn, 568 So. 2d] at 764.* Glasgow's relationship with [the Maloofs] is precisely the type that gives rise to a fiduciary duty."

Maloofs' brief, pp. 59-60. However, the Maloofs' general contention that they had a trusting and confidential relationship with Glasgow is belied by the testimony John gave in his deposition regarding that relationship, where he made the following statements:

> [*274] "Every insurance agent I've ever known has had a lot of recommendations and a lot of promises and wants to sell me something and wants to get money and Parker [Glasgow] is no exception. So, I'm certain that when I talked to him he told me whatever was favorable that he wanted me to hear, and that's the way it is. That's -- that's the way it was. And Parker called. I would see him. I wouldn't see him every time, but -- because I knew that he wanted to sell me something. So, even though I liked [**28] him I'm not stupid and I knew he wanted to sell me something and I didn't want to just buy something for no reason. So, I'm sure he explained to me whatever it was he thought that I should know or that I ought to know to make me buy the policy."
>
> "[T]here was a consistent record of trying to sell me policies, and for that reason there was a lot less credibility between me and Mr. Glasgow than there might have been otherwise."
>
> "My perception was that he wanted to sell me policies for whatever reason rather than the correct reason. "
>
> "He was forever trying to sell me policies. Every time I saw him he had one idea after another selling -- do this, do that, trade this in, do that. All he wanted to do was sell me policies and make a commission."
>
> "I always considered whatever [Glasgow] said. I took everything with a grain of salt."

This testimony indicates that the Maloofs certainly did not view their relationship with Glasgow, though cordial and longstanding, as anything special or outside the typical salesperson-customer relationship. Combined with the facts in the record indicating that John is a well-educated professional and an experienced investor, we agree with the conclusion of the trial [**29] court that there was "no evidence that would justify the imposition of a fiduciary duty owed to [the Maloofs] by [John Hancock and Glasgow]" and that the summary judgment was accordingly proper.

IV.

The Maloofs sued John Hancock and Glasgow, alleging fraudulent misrepresentation, suppression, breach of contract, negligent and/or wanton failure to procure insurance, and breach of fiduciary duties arising out of Glasgow's sale of certain life-insurance policies to the Maloofs in 1989 and 1992. After the trial court entered a summary judgment in favor of John Hancock and Glasgow on all the claims asserted by the Maloofs, the Maloofs appealed. Because no genuine issue of material fact exists, we affirm the judgment of the trial court.

AFFIRMED.

Lyons, Smith, Bolin, Parker, Murdock, and Shaw, JJ., concur.

Woodall, J., concurs in the result.

Cobb, C.J., dissents.

DISSENT BY: COBB

DISSENT

COBB, Chief Justice (dissenting).

I respectfully dissent. I believe that, in affirming the summary judgment in this case, the majority improperly substitutes itself for the trier of fact. Since *Foremost Insurance Co. v. Parham, 693 So. 2d 409 (Ala. 1997)*, the test for when an aggrieved person is charged with discovering fraud has been [**30] "reasonable reliance."

> "[T]he trial court can enter a judgment as a matter of law in a fraud case where the *undisputed* evidence indicates that the party or parties claiming fraud in a [*275] particular transaction were fully capable of reading and understanding their documents, but nonetheless made a

> deliberate decision to ignore written contract terms."

693 So. 2d at 421 (emphasis added).

The standard of appellate review of a summary judgment requires that we view the evidence most favorably in favor of the nonmovants, John A. Maloof, Jr., and Harriet Maloof, *Wilma Corp. v. Fleming Foods of Alabama, Inc., 613 So. 2d 359 (Ala. 1993)*; *Hanners v. Balfour Guthrie, Inc., 564 So. 2d 412, 413 (Ala. 1990)*. I emphasize that neither the trial court nor this Court is in the business of weighing the facts at the summary-judgment stage. That is, we should consider only whether the evidence offered in support of the summary-judgment motion is "evidence of such weight and quality that fair-minded persons in the exercise of impartial judgment can reasonably infer the existence of the fact sought to be proved." *West v. Founders Life Assurance Co. Of Florida, 547 So. 2d 870, 871 (Ala. 1989)*. Moreover, the nature [**31] of the misrepresentations constituting the fraud and suppression asserted by the Maloofs in this case is of particular note. Specifically, Parker Glasgow, an agent for John Hancock Insurance Company, represented that the policies would be in the Maloofs' best financial interests and that the policies would supply benefits at John's death of approximately $ 1,000,000. Although the policies and documents delivered to the Maloofs indicated that they *might* be subject to additional premium payments, representations by Glasgow indicated that the policies would become self-sustaining, and his October 30, 1992, letter to the Maloofs indicated that

> "*[the policy] is building up cash value and this cash value will help to keep the premiums level at a later date.* It may be necessary to pay more into this policy in order for it to be maintained at the full death benefit level of $ 500,000 past age 74 according to current interest rates. I went over this with you in a letter February 7, 1990. However, the insurance amount could be reduced at some later date and that would have the effect of extending the policy for a longer period of time. For example, you could stop paying the premium at age 65, [**32] reduce the death benefit and, thereby, extend the coverage into your 80's."

(Emphasis supplied.)

Whether the policy language suggesting that additional premiums *might* be required negates a claim of fraud in light of this letter and the evidence concerning Glasgow's representations is a genuine issue of material fact that precludes a summary judgment. The trier of fact could reasonably infer that Glasgow's representations and letter do suggest that the policies will generate income sufficient to pay extra premium requirements so that the policies will remain in force in spite of any increased premium.

There is no evidence in this case suggesting that at the time John Maloof executed these policies he was informed, or should have reasonably been able to discover, that greatly increased premiums, premiums approaching the actual value of the policies, would be *absolutely necessary* in order to sustain the policies. Rather, the policies and the accompanying documentation note that "[t]he projected results of your insurance program may change significantly with variations in interest rates; mortality rates (risk charges); and the frequency, timing and amounts of premium payments." Whether policy [**33] results may be "significantly" better or worse than expected was left to the speculation of the policyholder. In this case, of course, Glasgow's speculation for John Maloof was that the policy would [*276] generate such income that premium payments might be reduced or eliminated. However, the evidence presented by the Maloofs' expert, Dr. David Lange, makes clear that these policies were so significantly underfunded that John Hancock knew at the time it issued the policies that significant additional payments would almost certainly be necessary. When asked about the language in Glasgow's letter that premium payments "may be" required, Dr. Lange stated:

> "But [Glasgow is] an insurance sales person who sold this policy and ran the illustration and would certainly be aware of the Statement of Policy Cost and Benefit Information and be aware the interest rates had declined.
>
> "In fact, the -- that this policy by '92, and since he had run a large number of illustrations in these various documents, he had to know from the beginning it wasn't going to make it. It was going to make it to seventy-four or thereabouts. And since interest rates were coming down, was unlikely to do so. I'm amazed, absolutely [**34] amazed that he would use the phrase: 'it may be necessary.'"

Further, when questioned about Glasgow's representation that the policy period could be extended by a reduction in the death benefit, Dr. Lange stated, "It's actually a complete falsity."

A reasonable person could understand from this evidence that it was readily apparent to John Hancock and to Glasgow that the policies were so underfunded at the time they were issued that they would fail in the purpose intended for the Maloofs. Moreover, an insurance expert like Dr. Lange, trained in the mathematics of insurance policies, could also uncover this fact. However, when questioned about a layman's ability to understand the policies, Dr. Lange stated:

> "The difficulty I have with that is because of the calculations involved in there, that I'm not sure someone, even if they read it, would appreciate the mathematics involved."

Thus, there is a genuine issue of material fact in this case as to whether the various documents supplied by John Hancock, including the policies and the annual statements and updates, disclosed facts from which a layman like John Maloof could discern that the policies were so underfunded that they could *never* [**35] serve his estate-planning purposes. Further, none of those documents directly contradict Glasgow's representations that the policies would generate income that would significantly defray additional premium costs or that the policies could be extended at the same premium costs by reducing death benefits. None of the documents supplied to the Maloofs before the policies were canceled makes clear that huge increases in premium payments will absolutely be required in order to maintain the policies. In fact, the Maloofs became aware of the fraud and suppression asserted in their claims only when they received notice that the policies were being canceled unless the Maloofs paid substantial additional premiums. Further, this cancellation was to take place in spite of the fact that the Maloofs had timely paid all premiums required on the policies during the 18 years since the first policy was purchased.

In addition to my concern that the summary judgment incorrectly holds that there is no genuine issue of fact as to whether the Maloofs could have relied on the misrepresentations by Glasgow in this case, the above recitation of facts highlights the ambiguities in the instant policies, particularly [**36] from a layman's perspective. Although the analysis of this issue does not involve a breach-of-contract claim, the majority's conclusion that the policies [*277] and the documentation from John Hancock are clear about the effect, or lack of effect, of these policies certainly flies in the face of the rule that ambiguities in an insurance contract are to be construed against the drafter of the contract. *Twin City Fire Ins. Co. v. Alfa Mut. Ins. Co., 817 So. 2d 687, 695 (Ala. 2001)*. See also *Life Ins. Co. of Georgia v. Miller, 292 Ala. 525, 296 So.2d 900 (1974)*.

Although the trial court relied on *AmerUS Life Insurance Co. v. Smith, 5 So. 3d 1200 (Ala. 2008)*, I believe that there are significant differences between the facts in this case and those in that case. In *AmerUS*, the plaintiff admitted that he did not read his policies, and the information supplied in the policy information directly contradicted the representations of the insurance agent. Thus, the Court concluded that the plaintiff's reliance on the agent's representations could not, as a matter of law, be reasonable. This is not the case here. In this case, without the knowledge of an insurance expert, it is not clear that the representations [**37] that the policies would generate income that would significantly defray premium costs are inconsistent with the language in the policies that "[t]he projected results of your insurance program may change significantly ...." Nor is it clear from the policies and subsequent documentation that the policies were so underfunded as to be, in the words of Dr. Lange, "DOA." [3] In fact, Dr. Lange indicated that a layman could not easily comprehend the financial-outcome implications of the policies. Further, the increased premiums required to sustain the policy in *AmerUS* were approximately $ 25,000; in this case the amount of premiums necessary to extend John Maloof's million-dollar coverage until age 90 exceeded $ 1,036,000.

3 DOA is an acronym for "dead on arrival."

Moreover, the financial and business relationship between the plaintiff and the agent in *AmerUS* was not nearly as significant as the relationship between John Maloof and Parker Glasgow in this case. As I noted in my dissent in *AmerUS Life Insurance Co. v. Smith, 5 So. 3d at 1217*, the reasonable-reliance standard adopted by the Court in *Foremost Insurance Co. v. Parham, 693 So. 2d 409 (Ala. 1997)*, which imputes to a signatory the knowledge [**38] of the contents of a contract, is subject to certain exceptions. *Potter v. First Real Estate Co., 844 So. 2d 540 (Ala. 2002)*.

> "'The instant case does not come within the rule of *Southern Building & Loan Ass'n v. Dinsmore, 225 Ala. 550, 144 So. 21 (1932)*, that the law imputes no knowledge of a contract's contents to a party who signs the contract without having read or having knowledge of its contents, if that party is lulled into a feeling

> of security because of a misrepresentation of the contents of the contract and because of special circumstances, relationships, or disability of the party relating to the contract's execution. See also *Arkel Land Co. v. Cagle, 445 So. 2d 858 (Ala. 1983)*; *Rose v. Lewis, 157 Ala. 521, 48 So. 105 (1908)*."'

AmerUS, 5 So. 3d at 1217 (Cobb, C.J., dissenting) (quoting *Holman v. Joe Steele Realty, Inc., 485 So. 2d 1142, 1144 (Ala. 1986)*). As we recognized in *Potter, supra*, a special relationship between the contract signatory, here John Maloof, and the sales agent, here Parker Glasgow, can constitute an exception to the imputation of knowledge required by the reasonable-reliance standard. In *Potter*, the relationship was between the plaintiffs, a young married [**39] couple, and their real-estate agent, who misrepresented to them that the property that they sought to purchase was not located in a flood plain. Although that relationship was entirely contractual, the Court [*278] determined that the nature of that relationship, in which the real-estate agent asserted that she represented the plaintiff buyers as much as she represented the seller, was such that there was a question for the trier of fact as to whether the buyers had notice of a survey showing that the property was located in a flood plain. Here, there is evidence in the record that could support the inference that John Maloof thought of Glasgow as just another insurance salesman. However, there is also evidence in this record indicating otherwise, and we must view all the evidence most favorably to the Maloofs, including John Maloof's testimony that he relied on Glasgow, *Wilma Corp., supra.* Under this standard, we consider only whether there is also evidence from which the jury could conclude that Glasgow had a special relationship with John Maloof that supported John Maloof's reliance on Glasgow's assurance because the jury, as trier of fact, would be free to disregard other statements by [**40] John Maloof supporting a different inference.

In fact, the record shows that Glasgow had been John Maloof's exclusive insurance agent for some 20 years before the transactions at issue in this case and that he also served as John Maloof's "financial planner." Further, John Maloof received reports, at least annually, from Glasgow concerning his financial interests and the effect of his insurance on his estate planning; Glasgow also participated in estate-planning meetings between John Maloof and his lawyer, and he contributed to those meetings by representing that the policies were valid additional assets of John Maloof's estate. As I noted in my dissent in *AmerUS*, the significance of a relationship of this type is entirely distinct from a single transaction between an insurance agent and a client; the relationship in this case is more of a special relationship than the "special relationship" based on a single transaction that this Court recognized in *Potter*. If the law in *Potter* concerning what constitutes a special relationship is no longer to be recognized, then *Potter* should be overruled. Accordingly, I believe that the question of Glasgow's special relationship with John Maloof [**41] presents at least a question of fact as to whether John Maloof could have reasonably relied on Glasgow's representations under the facts of this case.

Thus, I disagree that the difference in nature of the misrepresentations in this case and those in *AmerUS* are ultimately immaterial -- in this case, unlike in *AmerUS*, there is a question of fact as to whether the policies and subsequent documents supplied to the Maloofs could reasonably be understood by one who did not have specialized knowledge of the mathematics underlying the policies; it is certainly not apparent that the cost of keeping the policies would come to exceed the actual value of the policies in less than 20 years. The record also shows that Glasgow's representations as to the performance of the policies was not directly contradicted by the policies and other documentation, and there is at least a question of fact as to whether Glasgow was in such a special relationship with John Maloof that the Maloofs' reliance on the misrepresentations was reasonable under the circumstances. The question of reasonable reliance in this case is a question of fact to be decided by the trier of fact; reasonable reliance is not a standard [**42] that should be used to shield those who make false representations that they know, or should know, are untrue from the damage caused by their lies. The summary judgment in this case should be reversed. Therefore, I dissent.

Kenneth Nance and Pamela Nance v. Mike Southerland, Southerland Insurance Company, Windsor Insurance Company, and Infinity Insurance Company

2080746

COURT OF CIVIL APPEALS OF ALABAMA

79 So. 3d 612*; *2010 Ala. Civ. App. LEXIS 33

January 29, 2010, Released

SUBSEQUENT HISTORY: Released for Publication February 3, 2012.
Rehearing denied by *Nance v. Southerland, 2010 Ala. Civ. App. LEXIS 1043 (Ala. Civ. App., Mar. 12, 2010)*

PRIOR HISTORY: [**1]
Appeal from Madison Circuit Court. (CV-05-934). Karen K. Hall, Trial Judte.

DISPOSITION: AFFIRMED.

COUNSEL: For Appellants: Phillip A. Gibson, Huntsville.

For Southerland Insurance Company, Mike Southerland, Appellees: Robert V. Wood, Jr., Nicole L. Schroer, Wilmer & Lee, P.A., Huntsville.

For Windsor Insurance Company, Infinity Insurance Company, Appellees: C. Peter Bolvig, Hall, Conerly & Bolvig, P.C., Birmingham.

JUDGES: MOORE, Judge. Pittman, Bryan, and Thomas, JJ., concur. Thompson, P.J., concurs in the result, without writing.

OPINION BY: MOORE

OPINION

[*614] MOORE, Judge.

Kenneth Nance and Pamela Nance appeal from summary judgments entered by the Madison Circuit Court in favor of Mike Southerland, Southerland Insurance Company, Windsor Insurance Company, and Infinity Insurance Company (hereinafter sometimes referred to collectively as "the defendants").

Facts

The relevant evidence submitted by the parties in support of or in opposition to the motions for a summary judgment shows the following. In 2003, the Nances decided to procure new automobile-insurance coverage. Kenneth testified that he and Pamela discussed the matter and agreed that Pamela would obtain the insurance through Southerland Insurance Company ("Southerland"). [1] Kenneth testified that he and Pamela had previously discussed that they needed to make sure they obtained uninsured-motorist coverage of between $ 25,000 and $ 50,000 and medical-payments coverage. Kenneth stated that he had specifically instructed Pamela, before she went to Southerland's office, to get insurance in both their names.

1 In his deposition, [**2] Mike Southerland testified that the correct legal name of the business is S.I., Inc.; however, the pleadings were never amended to reflect that designation.

On May 14, 2003, Pamela met with Mike Southerland and informed him that she was seeking automobile insurance on behalf of herself and Kenneth. Pamela testified that, during the meeting, she requested that Mike obtain an automobile-insurance policy designating both herself and Kenneth as named insureds and providing "full coverage"; however, Pamela did not specifically request uninsured-motorist coverage. Pamela testified that Mike agreed to her requests and that he then proceeded to fill out an application for an automo-

bile-insurance policy. According to Pamela, as part of the application process, she told Mike all she could remember regarding her and Kenneth's driving histories, some of which was negative. Pamela testified that she then signed some documents, but she did not remember what documents or how many [*615] documents she signed. She also testified that Mike quoted her a premium price but that she did not pay anything at that time.

Pamela testified that she left Southerland's office and returned 30 or 40 minutes later, followed [**3] by Kenneth. According to Pamela, at that time, Kenneth provided Mike information regarding Kenneth's personal identification numbers as well as the motor-vehicle identification numbers of the two automobiles to be insured. Pamela testified that both she and Kenneth reiterated to Mike that they wanted full coverage in both their names. Pamela testified that Kenneth had inquired of Mike whether full coverage included uninsured-motorist and medical-payments coverage. Pamela testified that Mike had responded that those coverages would be included. Pamela testified that Mike had told them that Kenneth did not need to sign anything.

Pamela stated that the Nances tendered to Mike a check for approximately $ 136, which was intended as the premium for "full coverage." Pamela did not recall Mike informing her that the premium she was paying may be subject to increase based on a review of the Nances' driving records. Kenneth testified that Pamela left to go to school immediately after they gave Mike the check. Pamela testified that Mike did not provide her any documents to take with her regarding automobile insurance. Kenneth testified that Mike provided him with temporary proof-of-insurance cards [**4] and a receipt for the premium payment. Kenneth testified that Mike then told him a policy would be mailed to the Nances. Mike testified that he had no specific recollection of his meetings with Pamela and Kenneth.

The application Mike completed sought automobile-insurance coverage from Windsor Insurance Company ("Windsor"). [2] The application, entitled "Windsor Auto Alabama Private Passenger Automobile Application," consists of two pages. The first page identifies "Pamela Nance" as the only applicant and contains space for information on past moving violations and traffic accidents, which is blank. Under a section entitled "COVERAGE INFORMATION," the application lists "Uninsured Motorists" and "Medical Payments" and provides various options. An "X" is marked in the boxes entitled "Reject" under both categories. The application indicates that the policy would be in effect for 6 months and that the total premium would be $ 547, with a 25% down payment of $ 136.75 payable immediately, followed by 4 equal quarterly payments of 18.75% of the total premium.

2 Windsor Insurance Company had merged with Infinity Insurance Company, but the policy in this case was issued under the name of Windsor [**5] Insurance Company.

The second page consists of, among other things, a section entitled in bold print "UNINSURED MOTORISTS COVERAGE-ALL APPLICANTS MUST SIGN FORM IF UM IS REJECTED." Immediately beneath that language, the application states:

> "I elect to REJECT protection against Uninsured Motorists as provided in the applicable statutes which permit me to reject insurance against loss caused by uninsured motorists. The undersigned (and each of them) do(es) hereby reject such Insurance coverage, and it is hereby understood and agreed: that such coverage will not be afforded any person by this policy; that this rejection of Uninsured Motorists Coverage applies with respect to all vehicles now insured under the policy as well as any vehicle which may be covered by the policy in the future regardless of whether or not [*616] it is owned by the insured on the date of execution of this rejection instrument.
>
> "MUST BE SIGNED. Applicant(s) signature(s): "

Pamela signed and dated that section.

The second page of the application further provided, in pertinent part:

> "I understand [Windsor] will investigate my application for insurance. I authorize [Windsor]: ... to request driving records or motor vehicle reports [**6] ('MVR') for every driver listed herein.... I understand the purpose will be to collect information to rate and underwrite my policy. ... If data in a ... MVR warrants a premium increase, I agree to pay any additional premium.
>
> "All available coverages were explained to me. I knowingly made the selections indicated herein. Any portion of the application filled out by an agent or broker is expressly acknowledged to have been done at my request. I understand that I am entitled to receive a copy of this application at the time of application. ..."

Pamela signed and dated the application just below that language.

In his deposition, Kenneth denied ever seeing the application. In her deposition, Pamela testified that she did not recall seeing the application, but she indicated that she must have seen it because she had signed it. Pamela, a school teacher, stated that she was "pretty much" an educated person capable of reading and understanding the English language. After reviewing the first page of the application, Pamela testified that, without further explanation, she could not have understood that she was rejecting uninsured-motorist and medical-payments coverage. Upon reviewing the second page of [**7] the application, Pamela testified that she understood that the application indicated she was rejecting uninsured-motorist coverage. However, Pamela testified that she did not read the language rejecting uninsured-motorist coverage before signing the application. Pamela testified that she had assumed and had trusted that she was getting the coverage she requested so she had signed the application without reading it. Pamela denied that anyone had prevented her from reading the application.

On May 14, 2003, based on the information contained in the application, Windsor generated an automobile-insurance policy for the Nances ("the policy"). The declarations page for that policy listed "Pamala Nance" as the "named insured." The declarations page did not list any coverage for uninsured-motorist insurance or medical-payments insurance. Vanessa Bray, a Windsor employee, testified that the policy, including the declarations page, should have been mailed to the Nances so they could verify that they had obtained the coverage they requested. Mike testified that, if the Nances had reviewed the policy, they could have contacted him if they perceived any problems. The Nances testified that they never [**8] received a copy of the policy.

As part of the process of generating the policy, Windsor conducted a driving-record check on the Nances, which revealed some negative information that had not been disclosed in the application. Based on that new information, Windsor increased the premium for the policy by $ 205, which rendered the $ 136.75 down payment made by the Nances insufficient. Windsor drafted an "Important Notice to the Insured" and a "Special Notice" advising Pamela of the increase in the premium and the information upon which that increase had been based. Bray testified that those notices should have been sent to Pamela as part of the policy.

[*617] On May 16, 2003, Windsor drafted a document entitled "Notice of Cancellation of Family Auto Policy" ("the notice of cancellation"). That document, which was directed to Pamela at the address stated in the application, with a copy to Southerland as Pamela's agent, stated, in pertinent part:

> "YOU ARE HEREBY NOTIFIED IN ACCORDANCE WITH THE TERMS AND CONDITIONS OF THE ABOVE MENTIONED POLICY THAT YOUR INSURANCE WILL CEASE WITHOUT FURTHER NOTICE AT AND FROM THE HOUR AND DATE MENTIONED ABOVE (12:01 AM 5/28/03) DUE TO NONPAYMENT OF PREMIUM.
>
> "REASON [**9] FOR CANCELLATION - NOT ENOUGH DOWNPAYMENT RECEIVED FOR POLICY PREMIUM: DEFICIENT BY $ 51.25
>
> "TO PREVENT THE CANCELLATION OF YOUR POLICY, YOUR PAYMENT MUST BE POSTMARKED ON OR BEFORE 05/27/03. YOUR POLICY WILL NOT BE REINSTATED IF YOUR PAYMENT OF THE FULL AMOUNT SHOWN AS PAST DUE ON THIS NOTICE IS NOT POSTMARKED BY 05/27/03.
>
> "AMOUNT PAST DUE - $ 51.25 WHICH WAS DUE ON 05/14/03"

(Capitalization in original.)

Windsor placed into evidence two internal certificates of mailing, a federal certificate of mailing, [3] and the affidavit of Kendra Slagle, a "litigation specialist," all of which were intended to prove that Windsor had mailed the notice of cancellation to Pamela on May 17, 2003. Bray testified that a copy of the notice of cancellation also should have been mailed to Southerland. Mike testified on behalf of Southerland that he did not receive a copy of the notice of cancellation but that he did receive another notice from Windsor, presumably the "Important Notice to the Insured," indicating that the Nances owed an additional premium. Mike stated that he placed that notice in his file and that he did not take any steps to ensure that the Nances were aware of the premium deficiency or of [**10] the impending cancellation of their automobile-insurance policy. The Nances deny that they ever received the notice of cancellation from Windsor or any other notice of the premium deficiency. The Nances

did not pay the additional premium, and Windsor canceled the policy as of May 28, 2003, without providing further notice to Southerland or the Nances.

> 3 A federal certificate of mailing is "a service offered by the United States Postal Service. Upon payment of an additional fee, domestic customers can get a certificate evidencing the mailing of a specific piece of mail on a specific day." *Sisson v. State Farm Fire & Cas. Co., 824 So. 2d 708, 709 n.1 (Ala. 2001)*. A federal certificate of mailing "serves as proof that the United States Postal Service received and sent a particular piece of mail." *Echavarria v. National Grange Mut. Ins. Co., 275 Conn. 408, 415, 880 A.2d 882, 886 (2005)*.

On June 21, 2003, Kenneth received injuries in a two-car accident, allegedly due to the negligence of Christopher Cummings, the operator of the other automobile. Several days after the accident, Kenneth telephoned Mike to make a claim under the Windsor policy, only to be informed that the Nances had no insurance [**11] coverage. Kenneth testified that Mike never explained why the Nances did not have coverage, but Mike testified that he vaguely recalled telling Kenneth that the policy had been canceled due to nonpayment of the additional premium. The Nances stated in their affidavits that they had settled their claim against Cummings [*618] for $ 25,000, the limits of his automobile-liability coverage; however, the Nances maintained that their damages exceeded $ 25,000 and that those excess damages would have been covered under the medical-payments and uninsured-motorist coverages they had requested.

The Nances filed an eight-count complaint against the defendants that, as amended, basically alleged that the defendants had negligently, wantonly, and fraudulently failed to procure and provide for them the insurance they had requested and that the defendants had negligently, wantonly, and fraudulently failed to inform them of the premium deficiency and of the status of their automobile-insurance coverage. The Nances alleged that Windsor and/or Infinity Insurance Company ("Infinity"), which had merged with Windsor (*see supra* note 2), had breached the insurance contract, had failed to pay the Nances uninsured-motorist [**12] benefits, and had committed bad faith. The Nances also claimed that Windsor and/or Infinity and Southerland had negligently or wantonly hired, trained, or supervised their agents and employees as to how to advise insureds and provide coverage and that Windsor and/or Infinity was vicariously liable for the actions of those persons causing the Nances' damages. Pamela additionally claimed loss of consortium.

On January 4, 2007, Windsor and Infinity moved for a summary judgment on all counts asserted in the amended complaint. On January 9, 2007, Mike and Southerland moved for a summary judgment on all counts asserted in the amended complaint. On February 27, 2007, the Nances filed a response opposing the summary-judgment motions. To their response, the Nances attached their affidavits, in which they stated, among other things, that, had they received the declarations page of the policy, they would have taken steps to assure that they obtained medical-payments and uninsured-motorist coverage and that, had they received notice of the premium deficiency and the notice of cancellation, they would have cured the deficiency in order to keep the policy in force.

On February 28, 2007, the Nances [**13] filed a motion to strike the defendants' evidence purporting to prove that Windsor mailed the notice of cancellation. In their response to the summary-judgment motions, the Nances argued that, without that evidence, the defendants had not proven an effective cancellation of the policy. On March 1, 2007, Mike and Southerland filed a brief in opposition to the Nances' motion to strike, which Windsor and Infinity later joined.

On March 12, 2007, without expressly ruling on the Nances' motion to strike, and without specifying its reasons, the trial court entered an order granting the summary-judgment motions on all counts asserted in the Nances' amended complaint except the negligence claim against Mike and Southerland. On June 30, 2008, Mike and Southerland renewed their motion for a summary judgment on the remaining negligence count, submitting, among other evidence, portions of the deposition of the Nances' expert witness, Lynn Hare Phillips. [4] On September 23, 2008, the Nances responded to the renewed summary-judgment motion and filed a motion to strike the portions of the deposition of Phillips upon which Mike and Southerland relied. On December 23, 2008, the trial court entered a [**14] summary judgment as to the remaining negligence count against Mike and [*619] Southerland, again without specifying its reasons and without expressly ruling on the Nances' motion to strike. The Nances timely appealed to the Alabama Supreme Court; that court transferred the appeal to this court on May 20, 2009, pursuant to *Ala. Code 1975, § 12-2-7(6)*.

> 4 The Nances tendered Phillips, an attorney, as an expert regarding the standard of care required of an insurance agent and the breaches of that standard of care by Mike and Southerland.

Issues

On appeal, the Nances primarily argue that the trial court erred in entering summary judgments for the de-

fendants on their negligence, wantonness, fraud, breach-of-contract, uninsured-motorist, and respondeat superior claims. [5] The Nances also argue that the trial court erred in denying their motions to strike. We need not decide the second issue, because, without considering the evidence the Nances moved to strike, we hold that the trial court properly entered the summary judgments for the defendants.

> 5 The Nances make no argument that the trial court erred in entering summary judgments as to their bad-faith, loss-of-consortium, and negligent and wanton hiring, [**15] training, and supervision claims. Therefore, we will not discuss those claims further.

Standard of Review

"The standard of review applicable to a summary judgment is the same as the standard for granting the motion." *McClendon v. Mountain Top Indoor Flea Market, Inc., 601 So. 2d 957, 958 (Ala. 1992).*

> "A summary judgment is proper when there is no genuine issue of material fact and the moving party is entitled to a judgment as a matter of law. *Rule 56(c)(3), Ala. R. Civ. P.* The burden is on the moving party to make a prima facie showing that there is no genuine issue of material fact and that it is entitled to a judgment as a matter of law. In determining whether the movant has carried that burden, the court is to view the evidence in a light most favorable to the nonmoving party and to draw all reasonable inferences in favor of that party. To defeat a properly supported summary judgment motion, the nonmoving party must present 'substantial evidence' creating a genuine issue of material fact -- 'evidence of such weight and quality that fair-minded persons in the exercise of impartial judgment can reasonably infer the existence of the fact sought to be proved.' *Ala. Code 1975, 12-21-12*; [**16] *West v. Founders Life Assurance Co. of Florida, 547 So. 2d 870, 871 (Ala. 1989).*"

Capital Alliance Ins. Co. v. Thorough-Clean, Inc., 639 So. 2d 1349, 1350 (Ala. 1994). Questions of law are reviewed de novo. *Alabama Republican Party v. McGinley, 893 So. 2d 337, 342 (Ala. 2004).*

Analysis

The Rejection-of-Insurance Issue

The defendants argue that they are entitled to a summary judgment because, they say, Pamela indisputably rejected medical-payments and uninsured-motorist coverage. The defendants presented evidence indicating that Pamela signed the application rejecting medical-payments coverage on the first page and rejecting uninsured-motorist coverage on both pages. Pamela admitted that she signed the application, which unambiguously rejects both coverages, but she stated that she did not read the application before signing it. However, a party capable of reading and understanding English given the opportunity to review an insurance application cannot avoid the legal consequences of signing that document, indicating his or her assent to its terms, on the basis that he or she did not read it. *See Kanellis v. Pacific Indem. Co., 917 So. 2d 149, 155 (Ala. Civ. APP. 2005); Syx v. Midfield Volkswagen, Inc., 518 So. 2d 94 (Ala. 1987).* [**17] *See also* Harold Weston, Annotation, [*620] *Insured's Duty to Read Insurance Policy as Affirmative Defense in Claims Against Insurance Agents and Brokers*, 8 A.L.R.6th 549, § 27 (2005) . Hence, Pamela is bound by her assent to the terms of the application, including her rejection of medical-payments and uninsured-motorist coverage.

The Nances submit that Pamela should not be bound because, they say, Mike negligently or wantonly breached a duty to adequately explain uninsured-motorist and medical-payments coverage to Pamela so that she could make an informed decision before rejecting those coverages. The Nances' sole "argument" on this point consists of one sentence in their statement of facts in which they recite that Phillips, their expert witness, opined that Mike "should have explained to the Nances what uninsured/underinsured motorist coverage was at the time they were purchasing their insurance" and two clauses in the argument portion of their brief stating, respectively, that Mike negligently and recklessly failed to explain the different coverages to the Nances. The Nances do not cite a single Alabama case or statute recognizing the duty of an insurance agent to advise an applicant of [**18] the scope of rejected coverage or any case that would indicate that such a duty exists under circumstances similar to those existing in this case.

The question whether Mike owed a duty to inform the Nances of the various coverages Pamela rejected primarily would be one of law. [6] *See, e.g., Meyer v. Norgaard, 160 Wis. 2d 794, 467 N.W.2d 141 (Wis. Ct. App. 1991).* Under *Rule 28, Ala. R. App. P.*, a party has a duty to cite appropriate legal authority to demonstrate that the trial court erred. """[I]t is not the function of [an appellate court] to do a party's legal research or to make and address legal arguments for a party based on undelineated

general propositions not supported by sufficient authority or argument."'" *Ex parte Borden, [Ms. 1050042, Aug, 17, 2007] 60 So. 3d 940, 943, 2007 Ala. LEXIS 164, *9 (Ala. 2007)* (quoting *Butler v. Town of Argo, 871 So. 2d 1, 20 (Ala. 2003)*, quoting in turn *Dykes v. Lane Trucking, Inc., 652 So. 2d 248, 251 (Ala. 1994)*). When the appellant fails to cite any legal authority in support of an argument, this court will consider that argument waived as if it had not been made at all. *See Ex parte Borden, supra.* Hence, we do not address the issue whether Pamela's rejection of medical-payments [**19] and uninsured-motorist coverage should be considered invalid due to Mike and Southerland's alleged failure to fully advise her of the scope of those coverages.

> 6 Other jurisdictions are split on this issue based primarily on whether the duties of an insurance agent to advise an applicant regarding coverages arise under common law or statutory provisions. *See*, William H. Danne, Jr., Annotation, *Construction of Statutory Provision Governing Rejection or Waiver of Uninsured Motorist Coverage*, 55 A.L.R.3d 216, § 4 (1974) ("Where the statute permitting an insured to 'reject' otherwise mandatory uninsured motorist coverage is silent upon the matter, different opinions have been expressed as to whether a particular insured's refusal of such coverage, if otherwise sufficient as a statutory rejection, is rendered ineffective by the insurer's failure to have explained the nature of uninsured motorist protection to him.").

The Nances secondly argue that Pamela's rejection of uninsured-motorist coverage should not apply to Kenneth because, they say, he would have been a named insured on the policy but for Mike's negligent, wanton, and fraudulent conduct. Under *Ala. Code 1975, § 32-7-23* (a,, only [**20] a "named insured shall have the right to reject [uninsured-motorist] coverage"" When only one spouse is the named insured, his or her valid rejection of uninsured-motorist coverage binds the other insured spouse. *See Progressive Specialty* [*621] *Ins. Co. v. Naramore, 950 So. 2d 1138, 1142 (Ala. 2006)*; *Progressive Specialty Ins. Co. v. Green, 934 So. 2d 364, 366 (Ala. 2006)*. On the other hand, when both spouses are named insureds, the rejection of uninsured-motorist coverage by one spouse does not affect the rights of the other spouse to those benefits. *See State Farm Mut. Auto. Ins. Co. v. Martin, 292 Ala. 103, 289 So. 2d 606 (1974)*; *Nationwide Ins. Co. v. Nicholas, 868 So. 2d 457 (Ala Civ. App. 2003)*. Alabama law has never considered the issue whether a spouse merely intended to be a named insured must sign the uninsured-motorist waiver, but *§ 32-7-23(a)* unambiguously applies only to actual "named insureds," so Pamela's rejection does bind Kenneth.

In the application, Mike designated Pamela as the lone applicant and the lone signatory in regard to the rejection of uninsured-motorist coverage. The Nances do not dispute that Pamela signed the application disclosing that she would be the lone [**21] "named insured." In *Progressive Specialty Insurance Co. v. Gore, 1 So. 3d 996 (Ala. 2008)*, the supreme court held that a wife could not sign a rejection of uninsured-motorist coverage on behalf of her husband when the application disclosed that only the husband would be a named insured. In this case, the undisputed facts present the exact opposite situation, and yield the exact opposite result -- Pamela's decision to be labeled the lone "named insured" authorized her to reject uninsured-motorist coverage on behalf of Kenneth. In light of Pamela's signing the application unambiguously indicating that she would be the only "named insured," neither Mike and Southerland nor Windsor and Infinity can be liable for failing to designate Kenneth as a "named insured" under the legal theories advanced by the Nances. *See Kanellis, 917 So. 2d at 154* (holding that insureds' failure to read policy disclosing that agent had not procured depreciation coverage they had requested precluded agent's liability under negligence theory); *Syx, supra* (holding that insured who failed to read insurance application, which clearly disclosed that insurance would not provide "full coverage," could not maintain fraud [**22] action because insured could not have reasonably relied on oral statement that policy would provide "full coverage" made by automobile seller's representative).

The Nances maintain that they contracted with, and otherwise expected, Mike and Southerland to procure for them medical-payments and uninsured-motorist coverage. *See Montz v. Mead & Charles, Inc., 557 So. 2d 1, 4 (Ala. 1987)* (describing duty of insurance agent to use reasonable skill and care in procuring insurance requested by insurance applicant). However, the application unambiguously discloses that Mike and Southerland did not request such coverage from Windsor. *See Syx, supra.* Any expectations the Nances might have had regarding the coverages Mike would obtain would be unreasonable as a matter of law under those circumstances. *See Banks v. SCI Alabama Funeral Servs., Inc., 801 So. 2d 20 (Ala. Civ. App. 2001)*; *Mitchell Nissan, Inc. v. Foster, 775 So. 2d 138, 140 (Ala. 2000)*. Under the factual circumstances presented in this case, the Nances' expectations do not create any genuine issue of material fact regarding the validity of Pamela's rejection of uninsured-motorist coverage.

Based on the duty-to-read defense, Mike and [**23] Southerland cannot be liable for negligently, wantonly, or fraudulently failing to designate Kenneth as a named insured or for negligently, wantonly, or fraudulently failing to procure medical-payments and uninsured-motorist coverage for the Nances. Because the

Nances validly rejected coverage, Windsor and Infinity cannot be liable for breach of contract or for [*622] failing to pay the Nances uninsured-motorist benefits.

The Failure-to-Notify Issue

The Nances next maintain that, although Pamela rejected medical-payments and uninsured-motorist coverage, the defendants negligently, wantonly, and fraudulently deprived them of the right to acquire that coverage later. The Nances first maintain that Windsor had a duty to send them the policy, including the declarations page, which would have revealed to them that Kenneth had not been designated as a named insured and that they had not obtained medical-payments and uninsured-motorist coverage. In their motion for a summary judgment, Windsor and Infinity argued that Windsor owed no duty to the Nances other than those duties arising out of their contractual relationship, which only existed for a brief period. However, during that time, according to [**24] Bray, one of the duties Windsor voluntarily undertook was the duty to deliver a copy of the policy, with the declarations page, to the Nances, which Windsor failed to do according to the undisputed evidence in the record. [7] "[A] party 'who volunteers to act, though under no duty to do so, is . . . charged with the duty of acting with due care.'" *Berkel & Co. Contractors, Inc. v. Providence Hosp., 454 So. 2d 496, 503 (Ala. 1984)* (quoting *Dailey v. City of Birmingham, 378 So. 2d 728, 729 (Ala. 1979))*.

> 7 In their reply brief, the Nances argue, for the first time, that Windsor had a duty under *Ala. Code 1975, § 27-14-19(a)*, to deliver the policy and that Windsor's failure to do so estopped Windsor from denying medical-payments or uninsured-motorist coverage, citing *Brown Machine Works & Supply Co. v. Insurance Co. of North America, 659 So. 2d 51, 61 (Ala. 1995)*. We hereby grant Windsor and Infinity's motion to strike that argument, which raises an issue not raised in the trial court and which cannot be raised for the first time in a reply brief. *See McGough v. G & A, Inc., 999 So. 2d 898, 905 n.3 (Ala. Civ.App. 2007)* ("Ordinarily, we do not consider *issues* raised for the first time in a [**25] reply brief.").

At the trial-court level, Windsor and Infinity did not specifically argue that they were entitled to a judgment as a matter of law on the claim that Windsor had negligently failed to send the Nances a copy of the policy. Nevertheless, Windsor and Infinity argued in the trial court generally that all the claims asserted by the Nances failed as a matter of law because the claims are "patently inconsistent with the written terms of the application." As applied to the Nances' claim that Windsor failed to deliver the policy, we agree with that argument. The failure to deliver a policy of insurance is actionable only when the insured is prejudiced thereby. *See Akpan v. Farmers Ins. Exch., Inc., 961 So. 2d 865, 871 (Ala. Civ. APP. 2007)* . Prejudice obviously may occur when an insured has no actual or constructive knowledge of a limitation on, or exclusion from, coverage until delivery of the policy, *see Ex parte Clarke, 728 So. 2d 135 (Ala. 1998)*; however, when the policy merely conforms to the limitations set out in the insurance application, of which the insured is charged with knowledge, the insured cannot claim any prejudice from a failure of the insurer to deliver the [**26] policy. *See generally Danforth v. Government Employees Ins. Co., 282 Ga. App. 421, 426, 638 S.E.2d 852, 858 (2006)* ("'When an insurance company fails to mail or deliver the insurance policy to the insured within a reasonable amount of time after its issuance, the insurance company may still rely on exclusions contained in the policy *of which the insured otherwise had notice*.'" (quoting, with modifications, *Williams v. Fallaize Ins. Agency, 220 Ga. App. 411, 414, 469 S.E.2d 752, 756 (1996))*); *Kozlik v. Gulf Ins. Co., 2003 WI App 251, 268 Wis. 2d 491, 503, 673 N.W.2d 343, 349 (Wis. Ct. App. 2003)* ("We therefore hold that an [*623] insurer may not deny coverage based on limitations or exclusions in a policy, even if clearly stated, *where the insured was not otherwise informed of such provisions*." (emphasis added)).

The Nances maintain that, had they received the policy, they would have realized only then that they had not obtained medical-payments and uninsured-motorist coverage and that they would have taken steps to cure those omissions. However, as a matter of law, the Nances already were aware from the contents of the application that they had not requested those coverages. *See Locklear Dodge City, Inc. v. Kimbrell, 703 So. 2d 303, 306 (Ala. 1997)* [**27] ("[T]his Court has held that a person who signs a contract is on notice of the terms therein and is bound thereby even if he or she fails to read the document." (citing *Power Equip. Co. v. First Alabama Bank, 585 So. 2d 1291 (Ala. 1991))*). They cannot claim in retrospect, after they have sustained a loss presumably within the scope of medical-payments and uninsured-motorist coverage, that they would have taken some action to secure that coverage based on the information in the declarations page when they had not taken that action already based on their knowledge of the information contained in the application. *See W.G. Yates & Sons Constr. Co. v. Zurich American Ins. Co.*, 2008 U.S. Dist. LEXIS 1816 (Civil Action No. 06-0803-WS-B, Jan. 8, 2008) (S.D. Ala. 2008) (not reported in F. Supp. 2d) (finding insured's argument that it would have obtained replacement insurance had it received policy to be unavailing when insured was already generally aware of type of policy exclusion at issue).

The Nances next argue that the defendants did not notify them of the premium deficiency and of the impending cancellation of the policy for nonpayment of premium. At her deposition, Bray produced the "Important Notice to the Insured" [**28] and a "Special Notice" describing the increase in the premium and the information upon which that increase had been based. Bray testified that those notices should have been sent to Pamela as part of the policy. However, Windsor and Infinity presented no evidence indicating that Windsor had, in fact, mailed those notices. Mike testified that he received a premium-deficiency notice, presumably one or both of those documents, but that he did not contact the Nances to ensure they knew they owed an additional premium. The Nances denied that they received any documents from Windsor, including the premium-deficiency notices. The evidence appears undisputed that the Nances did not receive the notices of the premium deficiency.

Whether the evidence sufficiently demonstrates that the Nances received the notice of cancellation depends on application of a particular statute, *Ala. Code 1975, § 27-23-25*, which provides:

> "Proof of mailing of notice of cancellation or of reasons for cancellation to the named insured at the address shown in the policy shall be sufficient proof of notice."

Pursuant to that statute, if the insurer provides clear and convincing evidence of a definite and specific character [**29] that it mailed a notice of cancellation of a policy of automobile-liability insurance, then that evidence sufficiently proves the insured received notice of the cancellation. *See Ex parte Alfa Mut. Gen. Ins. Co., 742 So. 2d 182, 185 (Ala. 1999)*. The parties dispute whether the defendants presented admissible and clear and convincing evidence indicating that Windsor mailed the notice of cancellation in compliance with *§ 27-23-25*; solely for the purposes of this opinion, we will assume that the defendants did not. Hence, it is not necessary to rule on the Nances' motions to strike, both of which are directed toward evidence regarding [*624] the mailing of the notice of cancellation and its effectiveness to notify the Nances of the cancellation of the policy.

The Nances contend that Windsor owed them a duty to properly notify them of the premium deficiency and impending cancellation of their policy and that, under the specific circumstances of the case, Mike owed them a duty once he received the notice of deficiency to advise them of that notice and its effect on the status of their policy. [8] Assuming, without deciding, the truth of those assertions, we conclude, as matter of law, that any breach [**30] of those duties did not proximately cause the damage of which the Nances complain.

> 8 Again, the Nances have not cited any legal authority for the proposition that their insurance agent owed them a duty to notify them of a premium deficiency or of an impending cancellation of their policy. *See Rule 28, Ala. R. APP. P.* We do not decide that question because we affirm the summary judgment in favor of Mike and Southerland on different grounds.

The proximate cause of an injury is "'the direct and immediate, efficient cause of the injury.'" *Mobile City Lines, Inc. v. Proctor, 272 Ala. 217, 224, 130 So. 2d 388, 394 (1961)* (quoting *Western Railway of Alabama v. Mutch, 97 Ala. 194, 196, 11 So. 894, 895 (1892))*. Proximate cause is defined as "an act or omission that in a natural and continuous sequence, unbroken by any new and independent causes, produces the injury and without which the injury would not have occurred." *Byrd v. Commercial Credit Corp., 675 So. 2d 392, 393 (Ala. 1996)*.

> "[G]enerally proximate cause is a question to be determined by the trier of the fact. Even so, the question of proximate cause may be decided by a summary judgment if "'there is a total lack of evidence from which [**31] the fact-finder may reasonably infer a direct causal relation between the culpable conduct and the resulting injury.'" *Green v. Alabama Power Co., 597 So. 2d 1325, 1328 (Ala. 1992)* (quoting *Davison v. Mobile Infirmary, 456 So. 2d 14, 24 (Ala. 1984))*; *see also Cooley v. Gulf Bank, Inc., 773 So. 2d 1039, 1044 (Ala. Civ. App. 1999)* (Crawley, J., concurring in part and dissenting in part)."

Gooden v. City of Talladega, 966 So. 2d 232, 239-40 (Ala. 2007) . In this case, the Nances testified that, had they been notified of the premium deficiency and of the impending cancellation of their automobile-insurance policy, they would have paid the premium in order to keep the policy in force. However, that payment would not have increased the coverage to include medical-payments and uninsured-motorist coverage for which the Nances did not contract. Hence, the omission of which the Nances complain -- the failure to notify them of the premium deficiency and impending cancellation of the policy for that reason -- did not produce the injury at issue -- lack of medical-payments and uninsured-motorist coverage.

Thus, we hold that the trial court properly entered summary judgments on the various claims [**32] arising out of the failure of the defendants to provide to the Nances the policy, the premium-deficiency notices, and the notice of cancellation.

Conclusion

We conclude that the trial court did not err in entering the summary judgments for the defendants. The evidence shows without dispute that Pamela signed an application for automobile insurance rejecting medical-payments and uninsured-motorist coverage. As a result, the Nances obtained a policy of automobile insurance that did not contain those coverages. Any alleged subsequent omission by the defendants did not affect the scope of the coverage [*625] obtained and did not proximately cause the Nances to forgo the procurement of the additional insurance they claim they wanted. Regardless of the theory of liability advanced, the defendants are entitled to a judgment as a matter of law.

AFFIRMED.

Pittman, Bryan, and Thomas, JJ., concur.

Thompson, P.J., concurs in the result, without writing.