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Client Alert: Pride and Prejudiced – When to Report Insurance Claims

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A condominium association in Florida is required by law to "use its best efforts to obtain and maintain adequate property insurance to protect the association, the association property, the common elements, and the condominium property, which must be insured by the association pursuant to this subsection." §718.111(11), F.S. While condominium associations are required to use their best efforts to *obtain* adequate insurance, there is no such requirement to actually *use* said insurance, despite the intention of the legislature in having enacted Section 718.111(11).[1]

It is surprising how many condominium associations opt not to report insurance claims, typically in fear of raising their insurance premiums, a very real concern in Florida over the past few years. However, property insurers do not increase premiums based solely upon the number of claims a single insured reports. Rather, insurance companies consider several factors, including the number of claims reported in a geographical area, whether the property is located in an area more prone to natural disasters, and the age of the property. While it is possible for your premiums to increase solely as a result of reporting multiple claims, you would have to report an unusually high number of claims in a short period of time.[2]

Conversely, if a condominium association fails to report a claim, it could consign itself to footing the bill for a repair potentially costing tens of thousands of dollars—especially with inflation over the past few years.[3] Further, if the repair is shoddily done and causes more damage, the association will have a far more difficult time securing insurance coverage than it would had it reported the initial claim in the first place.

So then how many hours, days, weeks or months does an association have to report a property insurance claim? Unfortunately, there is no set deadline. Florida courts have, however, weighed in on when an insured should report a claim. *LoBello v. State Farm Florida Ins. Co.,* 152 So.3d 595 (Fla. 2d DCA 2014) was a seminal case in Florida on the issue of when an insured should report a claim. In *LoBello*, the insured sued State Farm for denying his sinkhole claim, but State Farm argued LoBello did not report the damage until four (4) years after they noticed it, which diminished State Farm's ability to fully investigate the loss. The trial court granted summary judgment in favor of LoBello. State Farm appealed, and the Second District Court of Appeal reversed, finding that an issue of fact remained as to whether LoBello's notice was timely. The court explained whether a claim was timely reported could be determined by considering when a "reasonable person" would otherwise report an insurance claim:

> An event must be of sufficient consequence to trigger an insured's duty to provide notice. Notice is necessary when there has been an occurrence that should lead a reasonable and prudent person to believe that a claim for damages would arise. The duty to provide notice arises when a reasonable person, viewing all available facts and information, would conclude that an award implicating the policy is likely.

Id. (internal quotations omitted)

Under common law, a "reasonable person" is a hypothetical person used as a legal standard to determine whether someone acted with the degree of attention, knowledge, intelligence, and judgment that society requires of its members. "The reasonable person acts sensibly, does things without serious delay, and takes proper but not excessive precautions." REASONABLE PERSON, *Black's Law Dictionary* (11th ed. 2019)

Although the law grants discretion to the person or entity reporting the insurance claim to determine whether the damage is "of sufficient consequence to trigger a…duty to provide notice," it is always best to simply report the damage, regardless of whether it seems small, or that its repair will not exceed the applicable deductible. For example, in *1500 Coral Towers Condominium Ass'n, Inc. v. Citizens Property Ins. Corp.,* 112 So.3d 541 (Fla. 3d DCA 2013), the association allegedly sustained damage from Hurricane Wilma in October of 2005. However, the association did not believe the damage would exceed its deductible, so it did not file an insurance claim and instead moved forward with repairs. Four years later, after it realized the cost to repair was higher than originally anticipated, the association decided to file an insurance claim.

Citizens denied the claim because (1) it had been four years since the occurrence, and (2) the association had already completed several repairs, thereby altering the property from its original damaged condition. Citizens moved for summary judgment on a prejudice defense, and the trial court granted its motion. The association appealed, but the Third District Court of Appeal agreed with Citizens and found the association's excuse for not reporting the claim (that the repairs would not exceed its deductible) did not sufficiently rebut the presumption of prejudice against Citizens the association had caused by waiting four years to report the claim. *See also, Ideal Mut. Ins. Co. v. Waldrep,* 400 So.2d 782 (Fla. 3d DCA 1981) (Holding that not knowing the full extent of the damage is not an excuse to delay reporting a claim).

We believe it is always good practice to report property damage to your insurance carrier as soon as you discover damage, even if it looks inconsequential, you do not believe it will be covered, or you want to investigate the damage more to determine its scope. Report the claim first.

Similarly, associations should not do anything to alter the condition of the damaged property before the insurance adjuster has the opportunity to inspect, unless it is to protect the property from further damage, such as installing a temporary tarp, shutting water off, or hiring a water mitigation company to dry out any moisture to avoid mold growth. If you must have water mitigation done, it is imperative you take multiple photographs and/or videos of the damage *before* any work is done. The water mitigation company should also take photographs and prepare a report, which must be provided to the insurance company. Sometimes, it is helpful to think of damaged property as a crime scene. There is a reason law enforcement and forensic personnel place caution tape around crime scenes: they want to preserve the condition of the scene as much as possible in order to extract as much evidence as possible.

It is the same for insurance. Property insurance policies offer coverage only for certain causes of loss; usually for wind damage, fire damage, or sudden and accidental water damage. That means the insurance company has to determine what caused the damage in order to reach a determination as to whether the damage is covered under the insurance policy. For example, if a pipe suddenly bursts, causing water damage to a unit,

the water damage would be covered. However, if a pipe leaks over the course of months or years, the damage it causes likely would not be covered. Therefore, if the association removes all of the water-damaged building material before the insurance company inspects, the insurance company cannot independently verify whether the leak was sudden and accidental or long term and may therefore deny the claim. Was there rot or mold or multiple ring stains on the cabinets or baseboards, or was the water damage new? These are questions the insurance company must be able to answer in order to determine whether the damage is covered.

Below is a step-by-step process for the insurance claim process:

1. Discovery of the damage.
2. Report the damage directly to your insurance company or confirm that your agent is reporting the claim. An insurance representative will provide you with a claim number and typically with the name of your adjuster.
3. The adjuster will reach out (typically within 24-48 hours) to schedule a time to inspect the damage.
4. The adjuster will usually take pictures of the damage and ask questions about the timeline. Sometimes the adjuster will request what is called a "recorded statement," which is simply a recorded interview where the adjuster will ask questions about the damage. If the insurance company does not believe it has sufficient information, it may request addition information, including:
    a. Examination under oath (similar to a deposition, but conducted outside of litigation); or
    b. Sworn proof of loss (a statement attesting to the amount insured is seeking in damages)
    c. You will want counsel to attend the examination or review the sworn proof of loss.
5. The adjuster will take his or her findings back to the insurance company, which will then determine whether the damage is covered.
6. Once the insurance company makes its determination, it will issue a coverage letter either (1) granting full coverage; (2) granting partial coverage; or (3) denying coverage.

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[1] The purpose of Section 718.111.(11) is "to protect the safety, health, and welfare of the people of the State of Florida and to ensure consistency in the provision of insurance coverage to condominiums and their unit owners."

[2] Megna, Michelle, *Why did my homeowners insurance go up?*, insurance.com (Updated on June 22, 2023), Why did my homeowners insurance go up? | Insurance.com; Elizabeth Rivelli, *Does your homeowners insurance go up after a claim?*, Bankrate (April 18, 2023), Does your homeowners insurance go up after a claim? | Bankrate

[3] Inflation affects the price of raw building materials. For example, the price of sheathing increased in 2021, resulting in the exponential increase in the cost to replace a roof.

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