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STATE OF MICHIGAN

COURT OF APPEALS

JOYS MALCOLM KING, JR.,

Plaintiff-Appellant,

v

MEMBERSELECT INSURANCE COMPANY,

Defendant-Appellee

and

JOHN DOE, MICHIGAN ASSIGNED CLAIMS PLAN, and MICHIGAN AUTOMOBILE INSURANCE PLACEMENT FACILITY,

Defendants.

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No. 375797
Wayne Circuit Court
LC No. 22-013145-NI

Before: ACKERMAN, P.J., and BAZZI and LIEVENSE, JJ.

LIEVENSE, J. (*dissenting*).

Before oral argument, we ordered the parties to file supplemental briefs addressing whether this Court had jurisdiction considering its recent holding in *Stanley v Farmers Ins Exch*, ___ Mich App ___, ___; ___ NW3d ___ (2026) (Docket No. 374881); slip op at 2, that "where a party agrees to a final dismissal with the same opposing party and fails to reserve appellate rights, the stipulated dismissal extinguishes any claim of appeal from earlier rulings involving that party." Because I believe *Stanley* is distinguishable and does not require us to dismiss this case for lack of jurisdiction, and I would address the merits of this appeal, I dissent.

I. JURISDICTION AND *STANLEY*

For context relevant to jurisdiction, and as the majority summarizes, plaintiff's complaint included five counts: a third-party negligence count against John Doe, the unknown hit-and-run driver (Count 1); third-party UM and UIM counts against MemberSelect for damages permitted under the policy (Counts 2 and 3); a first-party count for PIP benefits against MemberSelect (Count 4); and a first-party count for PIP benefits against the MAIPF in the event plaintiff was ineligible

for benefits from MemberSelect (Count 5). The trial court first granted partial summary disposition and dismissed Counts 2 and 3 against MemberSelect in a nonfinal order. Later, after resolving the PIP claims, plaintiff, MemberSelect, and the MAIPF stipulated to dismiss Counts 4 and 5.[1]

The plaintiff in *Stanley* filed a first-party one count complaint for PIP benefits against Auto-Owners Insurance Company and the MAIPF. *Id*. at ___; slip op at 1. Auto-Owners denied liability, and Farmers Insurance Exchange was assigned as the servicing insurer for the assigned-claims plan and assumed defense of the case. *Id*. at ___; slip op at 1-2. After the trial court dismissed Auto-Owners from the case, Farmers moved for partial summary disposition, arguing that the plaintiff could not recover money for certain medical bills because plaintiff had assigned her rights to be paid for those bills to the medical provider. *Id*. at ___; slip op at 2. Following a hearing, the trial court agreed with Farmers and granted partial summary disposition, ruling the plaintiff could not pursue claims to recover money for those medical bills. *Id.* The plaintiff and Farmers later agreed to a stipulated order dismissing the plaintiff's complaint for PIP benefits with prejudice pursuant to an agreement to submit the matter to binding arbitration. *Id.* Because the plaintiff did not include a reservation of rights to appeal the earlier order granting partial summary disposition to Farmers for those specific medical bills, this Court held plaintiff was not an aggrieved party within the meaning of MCR 7.203(A)(1), and that it lacked jurisdiction over the appeal. *Id*. at ___; slip op at 3.

In its supplemental brief in this case, MemberSelect argues that *Stanley* bars plaintiff's appeal because it is not an aggrieved party. Plaintiff disagrees, arguing in the alternative that: (1) *Stanley* was wrongly decided; (2) *Stanley* is distinguishable because here the prior order addressed two distinct counts separate from the count dismissed in the stipulated order; and (3) even if this Court lacks jurisdiction, it should exercise its discretion and consider the merits of the case as if on leave to appeal or remand the case to the trial court to consider other relief.

I agree that *Stanley* is distinguishable. While *Stanley* contains broad language regarding the impact of a stipulated dismissal order involving the same parties that does not reserve appellate rights, the complaint in that case only included one count, for PIP benefits, and the earlier grant of partial summary disposition pertained to specific claims for money to cover certain medical expenses as part of the PIP benefits that had been assigned to a medical provider, not dismissal of any counts. Thus, *Stanley* held the plaintiff was no longer "aggrieved" and we lacked jurisdiction when the subsequent stipulated order dismissed the one count on which the plaintiff had sought and was denied coverage for the specific medical bills, and did not reserve appellate rights. Important to the analysis in *Stanley* was that the plaintiff was not "aggrieved" by "an order to which that party had consented." *Stanley*, ___ Mich App ___, slip op at 2.

Here, on the other hand, plaintiff had not consented to the earlier nonfinal order granting partial summary disposition dismissing Counts 2 and 3 for UM and UIM benefits. And Counts 2 and 3 were third party claims brought in part because the motorist was unidentified, and those counts sought relief distinct from the PIP benefits sought in Counts 4 and 5 that plaintiff later agreed to dismiss in the stipulated order. There is a difference between an earlier order that

[1] It is not clear whether the trial court ever addressed Count 1.

dismisses entire counts like in this case, and the earlier order in *Stanley* that precluded recovery for certain medical bills sought in the single-count[2] complaint that the plaintiff then agreed to dismiss in the subsequent stipulated order without reserving appeal rights.

Thus, while plaintiff settled Count 5 for PIP benefits with MAIPF and later agreed to dismiss that count, that settlement did not include potential recoverable damages in plaintiff's third-party claims against the unknown motorist (Count 1) or against MemberSelect for UM or UIM coverage, where MemberSelect stood in the shoes of the tortfeasor, the unknown driver who committed the hit-and-run (Counts 2 and 3). No one thought plaintiff was giving up his right to appeal the dismissal of his third-party UM or UIM counts when he agreed to dismiss his PIP counts. I would therefore conclude that plaintiff is an aggrieved party under MCR 7.203(A)(1) and that we have jurisdiction, and address the merits of this case.

II. MERITS ANALYSIS

As to the merits, the trial court dismissed plaintiff's UM and UIM counts against MemberSelect after finding that plaintiff had not fulfilled MemberSelect's policy requirement that plaintiff make a written report to local law enforcement to make such a claim. Considering the merits requires more details as to the facts of the case.

A. RELEVANT FACTUAL BACKGROUND

When plaintiff was struck by a hit-and-run driver on June 11, 2022, no one witnessed the accident, but a bystander saw plaintiff laying injured on the ground and called 911. For unknown reasons the Detroit Police Department did not respond. Instead, the Detroit Fire Department was dispatched to the scene at around 11:00 p.m. to treat plaintiff, who "couldn't or wouldn't explain what happened." The DFD report also detailed that the bystander recognized plaintiff as "someone

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[2] Part of the problem applying *Stanley* is its use of the term "claims" and whether that necessarily means the same as "counts," when the two words do not mean the same thing but are sometimes used interchangeably. *Compare* the definition of "Claim" and "Count" in Black's Law Dictionary: CLAIM, *Black's Law Dictionary* (12th ed) ("1. A statement that something yet to be proved is true. 2. The assertion of an existing right; any right to payment or to an equitable remedy, even if contingent or provisional. 3. A demand for money, property, or a legal remedy to which one asserts a right; esp., the part of a complaint in a civil action specifying what relief the plaintiff asks for."); COUNT, *Black's Law Dictionary* (12th ed) ("In a complaint or similar pleading, the statement of a distinct claim.").

The majority says that the stipulated dismissal order in *Stanley* "broadly dismiss[ed] the plaintiff's remaining *claims* against the defendant with prejudice." (emphasis added). But *Stanley* involved a one-*count* complaint for PIP benefits, and so the *claims* for certain medical expenses that were the subject of the earlier partial summary disposition order were part of the same *count* that the plaintiff subsequently agreed to dismiss without reserving appellate rights. Here, counts 2 and 3 were separate counts from those dismissed by the final stipulated order.

Another problem applying *Stanley* may be what words are enough to preserve appellate rights and what words are not. That problem is not at issue here, however.

who normally hangs out in the area." The report went on to list the following injuries: "Pt has 2in deep laceration on left forehead, and abrasions that look like road rash on left thigh. Abrasions on left forearm. Pt complained of hurting all over. 10/10. No other specific complaints."

Plaintiff was transferred by ambulance to the emergency department at Beaumont Hospital in Dearborn, where he underwent surgery for a fractured pelvis. His medical records stated "[b]ased on injuries sustained, it is most likely the patient was struck by a car." After his discharge from the hospital and rehabilitation facility, plaintiff did not have any additional known contact with the police about the hit-and-run accident.

As mentioned by the majority, MemberSelect moved for partial summary disposition under MCR 2.116(C)(8) and (C)(10) as to plaintiffs UM and UIM motorist counts (Counts 2 and 3), arguing plaintiff was not entitled to UM or UIM coverage under MemberSelect's policy because plaintiff failed to make a "written report" of the hit-and-run accident to "local law enforcement" within 24 hours or "as soon as it is reasonably possible."

After holding oral argument on the motion, the trial court allowed the parties to file supplemental briefs on whether plaintiff complied with the "written report" to "local law enforcement" provision of the policy, and they did so. At another hearing, counsel for MemberSelect conceded and the trial court agreed that the purpose of the provision was to prevent insurance fraud. The trial court ultimately issued an order granting MemberSelect's motion for summary disposition for "reasons stated on the record," and dismissed Counts 2 and 3 against MemberSelect with prejudice. The reasons stated on the record were:

> I understand arguments on both sides, I do. I understand why the defense wants to make sure that the provisions outlined in the terms of the insurance coverage are followed, but I also look at the intent of it. And the intent really is to make certain that somebody isn't trying to claim benefits under an . . . underinsured motor vehicle coverage when there is no proof that an accident even occurred by a hit and run driver.
>
> * * *
>
> Well the Court in this case will find that the Defendant does not satisfy that burden under a (C)(8) standard because there is a question. The report that was filed by EMS. It was not technically under the Detroit Police Department, but EMS is an arm. That call was made from 911 and apparently, according to this report before this Court, there is, you know, the 911 operator operates through the city of Detroit. It's dispatched through the city of Detroit. Okay. They're law enforcement. The concern that . . . the Defendant has is the notice provision so that there's not fraud, because that's a valid concern.
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> With respect to (C)(10), a motion brought under MCR 2.116(C)(10) . . . And here's what bothers or troubles this Court. . . . [A]nd I agree with the Plaintiff. Plaintiff sustained serious injuries warranting a surgery. After the surgery, he spent some time in the hospital. After the hospital stay, spent some

time for the rehab. So obviously the Plaintiff could not comply with the 24-hour period.

But that policy also indicates that when it's . . . reasonable to do so. Obviously, somebody who's just suffered some injuries as a result of a motor vehicle accident might be in a hospital setting, as is the case here. However, this case has been going on for two years. There should have been a police report made. It should have been filed and it wasn't.

And while I appreciate the position the Plaintiff's in, it's not up to this Court to do the job of the Plaintiff and it's not also up to this Court to usurp the very plain language of the [policy] and interpret it by finding that the EMS report satisfies that requirement.

So there is no genuine issue of material fact for the trier of fact . . . to decide. There wasn't a police report filed, and I'm not persuaded by the Supplemental Briefs that that changes anything.

So the Court's gonna go ahead and grant the Partial Motion For Summary Disposition.

A few months after the trial court dismissed Counts 2 and 3, plaintiff settled his first-party counts for PIP benefits against MAIPF (Count 5). On May 5, 2025, upon stipulation of the parties, the trial court dismissed "[p]laintiff's claims against [d]efendants Memberselect [] and [MAIPF]" with prejudice, presumably referring to Counts 4-5, the only remaining counts against those defendants. This final order closed the case and plaintiff appealed, challenging the trial court's earlier decision to dismiss Counts 2 and 3 and arguing that the trial court erred in granting MemberSelect's motion for summary disposition under MCR 2.116(C)(10) when it held the 911 call and DFD report were insufficient to satisfy MemberSelect's policy requirements. I agree and would reverse and remand for further proceedings.

B. STANDARD OF REVIEW

Although MemberSelect moved for summary disposition under MCR 2.116(C)(8), the trial court allowed the parties to file supplemental responses to MemberSelect's motion, it considered the exhibits attached to those briefs in making a decision, and it decided MemberSelect's motion under MCR 2.116(C)(10). See *Jawad A Shah, MD, PC v State Farm Mut Auto Ins Co*, 324 Mich App 182, 206-207; 920 NW2d 148 (2018). A motion under MCR 2.116(C)(10) tests the factual sufficiency of a claim. *El-Khalil v Oakwood Healthcare, Inc*, 504 Mich 152; 934 NW2d 665 (2019). "In evaluating a motion for summary disposition brought under this subsection, a trial court considers affidavits, pleadings, depositions, admissions, and other evidence submitted by the parties, in the light most favorable to the party opposing the motion. *Maiden v Rozwood*, 461 Mich 109, 120; 597 NW2d 817 (1999). "Where the proffered evidence fails to establish a genuine issue regarding any material fact, the moving party is entitled to judgment as a matter of law." *Id*. "A question of fact exists when reasonable minds could differ as to the conclusions to be drawn from the evidence." *Dextrom v Wexford Co*, 287 Mich App 406, 415-416; 789 NW2d 211 (2010). This Court reviews the grant or denial of summary disposition de novo. *Id*. at 118.

C. ANALYSIS

"Insurance policies are interpreted in accordance with the principles of contract interpretation." *Auto-Owners Ins Co v Martin*, 284 Mich App 427, 433; 773 NW2d 29 (2009). "[W]hether contract language is ambiguous is a question of law that we review de novo." *Klapp v United Ins Group Agency, Inc*, 468 Mich 459, 463; 663 NW2d 447 (2003). Similarly, "the proper interpretation of a contract is also a question of law that we review de novo." *Id*.

This Court's "main goal in interpreting a contract is to honor the parties' intent." *Davis v LaFontaine Motors, Inc*, 271 Mich App 68, 73; 719 NW2d (2006). "Courts must discern the parties' intent from the words used in the contract and must enforce an unambiguous contract according to its plain terms." *Id*. "A contract is to be construed in favor of the insured only when an ambiguity exists." *Smejkal v Beck*, 351 Mich App 274, 279; 35 NW3d 649. "If a relevant term is undefined, this does not make the policy ambiguous, and the fact that dictionaries define words differently will not create an ambiguity." *Id*. Rather, "[a]n insurance contract is ambiguous when its provisions are capable of conflicting interpretations." *Farm Bureau Mut Ins Co of Michigan v Nikkel*, 460 Mich 558, 566; 596 NW2d 915 (1999). Because UM and UIM coverage is not required by the no-fault act, MCL 500.3105, "interpretation of the policy dictates under what circumstances those benefits will be awarded." *Rohlman v Hawkeye-Security Ins Co*, 442 Mich 520, 524-525; 502 NW2d 310 (1993).

I begin with the relevant language in MemberSelect's policy that details what the insured must do in case of an accident or loss:

> 2. A person claiming Personal Injury Protection under Part II or Uninsured and Underinsured Motorists Bodily Injury Coverage under Part III must promptly:
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> * * *
>
> e) under Part III – Uninsured and Underinsured Motorists Bodily Injury Coverage:
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> 1) make a written report of a hit-and-run accident within 24 hours to local law enforcement;
>
> 2) allow us to inspect the car occupied by the insured person; and
>
> 3) file with us within 30 days written notice of the hit-and-run accident.
>
> 4) if it is shown that it is not reasonably possible to give such notice within the prescribed time as described in 1) and 3) above, notice must be given as soon as it is reasonably possible.

Plaintiff argues the term "local law enforcement" is undefined by the contract and is therefore ambiguous, and that, even if this Court were to disagree, the supplied DFD report and 911 call at least demonstrate "substantial compliance" with the terms of the contract, citing the substantial compliance doctrine. See *Rodgers v JP Morgan Chase Bank NA*, 315 Mich App 301, 310; 319 NW2d 381 (2016) ("if a good-faith attempt to perform does not precisely meet the terms

of an agreement or statutory requirements, the performance will still be considered complete if the essential purpose is accomplished."). MemberSelect argues the contract is unambiguous and therefore not open to judicial construction. And, because plaintiff undisputedly did not make a written report to the police, and because "law enforcement agency," as defined by statutes and caselaw, does not include 911 operators or EMS personnel, MemberSelect argues the DFD report and 911 call were insufficient to satisfy the policy's requirements.

I agree with MemberSelect that the contract is unambiguous, but I would hold that plaintiff's statements to the DFD, which resulted in the written DFD report, are sufficient to meet the policy requirements. The parties do not dispute that, because plaintiff was injured, it was not plaintiff's fault that the Detroit Police Department or some other police agency did not arrive at the scene in response to the 911 call, nor do they dispute that because of his injuries plaintiff could not have gone to a police station to make a written report within 24 hours of the hit-and-run accident. And since plaintiff did not go to a police station later, there is no need to decide the meaning of the alternative contract provision of giving notice "as soon as it is reasonably possible."

As to the "make a written report" requirement, the policy does not specify whether the claimant must be the one to write the report, whether it must be handwritten or typed, or whether it must include a written statement from the claimant. These open questions do not mean the language is ambiguous. Who "writes" the report does not matter—the common understanding of "make a written report" is that the person must somehow communicate with someone, and that communication results in a written report. MemberSelect generally agreed at oral argument.

Similarly, the "to local law enforcement" contract provision needs to be applied to determine whether plaintiff complied with it. Here, what happened satisfied the policy requirements. A bystander saw plaintiff injured on the ground and called 911 and the fire department responded. Although, according to the report, plaintiff "couldn't or wouldn't explain what happened," he at least communicated to someone presumably in uniform, to the best of his ability, that he "hurt all over." Plaintiff's communication at the scene resulted in a written report by DFD of a hit-and-run accident. The report was generated the same day as the accident and included a statement from a bystander.

In these circumstances and given the policy provision's purpose is to prevent fraud, the DFD report is a more credible confirmation that a hit-and-run accident happened than if plaintiff had gone to the Detroit Police Department after being released from a medical facility a few days or weeks later.

Neither party has cited a case that has decided this exact question. MemberSelect cites *Hall v Auto Club Ins Ass'n*, unpublished per curiam opinion of the Court of Appeals, issued April 22, 2025 (Docket No. 369422), pp 1-2. *Hall* involved identical policy language, and this Court reversed the trial court's denial of the insurer's motion for summary disposition where the plaintiff failed to make a written report to law enforcement within 24 hours of a hit-and-run accident. In *Hall*, the plaintiff allegedly called the police after the hit-and-run accident, but no one responded to the scene and the plaintiff eventually left. *Hall*, unpub op at 1-2.

But unlike here where we have a report, the plaintiff in *Hall*, unpub op at 2, never reported what happened to anyone leading to a written report. And, notably, MemberSelect does not argue

that the information in the DFD report is insufficient to meet the purpose of the "make a written report" provision, as was the case in *Hall* where no writing existed. Nor does MemberSelect suggest the DFD report is fraudulent such that it is invalid. MemberSelect even acknowledged at oral argument that had the report containing the same information come from the Detroit Police Department, it potentially would satisfy MemberSelect's policy.

MemberSelect argues the definitions of "law enforcement agency" and "law enforcement officer" in Michigan statutes do not include a firefighter or fire department, so a fire department cannot be considered "local law enforcement" under the contract.[3] MemberSelect ignores, however, that MCL 750.411a(4) of the Michigan Penal Code equally criminalizes making false reports of medical emergencies to police departments, fire departments, and other first responders:

> A person shall not intentionally make or intentionally cause to be made a false report of a medical or other emergency to a peace officer, police agency of this state or of a local unit of government, firefighter or fire department of this state or a local unit of government of this state, 9-1-1 operator, medical first responder, or any governmental employee or contractor or employee of a contractor who is authorized to receive reports of medical or other emergencies.

The fact that our state punishes these false statements equally means that the DFD report satisfies the text and purpose of the policy provision at issue.

I believe there is no genuine dispute that the DFD report met the requirement of a written report to local law enforcement, and I would reverse the order granting MemberSelect's motion for partial summary disposition dismissing Counts 2 and 3 and remand for further proceedings on those claims.

/s/ Andrew J. Lievense

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[3] See the Commission on Law Enforcement Standards Act, MCL 28.602. MemberSelect also identifies *People v Lucas*, unpublished per curiam opinion of the Court of Appeals, issued December 23, 2025 (Docket No. 372439), which states that statements made to EMS were insufficient to fall within the scope of MCL 768.27c(1)(e) of statements made to "law enforcement officer[s]." MCL 768.27c, however, concerns the circumstances where hearsay statements made by a declarant may be admissible in domestic violence cases, and the statute's use of "law enforcement *officer*" is different from the contract's use of "local law enforcement."