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STATE OF MICHIGAN
IN THE SUPREME COURT

JAWAD A. SHAH, M.D., P.C.
INTEGRATED HOSPITAL SPECIALISTS, PS, INSIGHT ANESTHESIA, PLLC, and STERLING ANESTHESIA, PLLC

Plaintiffs/Appellees,

V

STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY,

Defendant/Appellant.

Supreme Court Case No.: 157951

Court of Appeals Case No. 340370

Genesee County Circuit Court
Case No. 17-108637-NF

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PLAINTIFFS/APPELLANTS' SUPPLEMENTAL APPENDIX

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EXHIBIT A

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF GENESEE

JAWAD A. SHAH, MD, PC,
INTEGRATED HOSPITAL SPECIALISTS, PC,
INSIGHT ANESTHESIA PLLC and
STERLING ANESTHESIA, PLLC,
(George Hensley),

Plaintiff,

v

STATE FARM MUTUAL AUTOMOBILE
INSURANCE COMPANY,

Defendant.

File No.: 17-108637-NF

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DEFENDANT STATE FARM'S MOTION FOR SUMMARY DISPOSITION OF PROVIDER NO-FAULT CLAIM UNDER MCR 2.116(C)(8)

NOW COMES the Defendant, State Farm Mutual Automobile Insurance Company ("State Farm"), by and through its attorneys, Hackney Grover PLC, and moves this Court pursuant to MCR 2.116(C)(8) to dismiss Plaintiffs' Jawad A. Shah, MD, P.C., Integrated Hospital Specialists, PC., Insight Anesthesia, PLLC and Sterling Anesthesia, PLLC, ("Plaintiffs") claim for personal injury protection benefits under the no-fault act. In support of this motion, State Farm states as follows:

1. On February 24, 2017, Plaintiffs filed this action against State Farm

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asserting a single claim for personal injury protection benefits under the no-fault act. Specifically, Plaintiffs seek to recover the cost of medical services that it provided to George Hensley, a State Farm insured, to treat injuries that he allegedly suffered in an automobile accident that occurred on November 30, 2014.

2. Plaintiffs have failed to state a claim upon which relief may be granted. On May 25, 2017, the Michigan Supreme Court conducted a "thorough review of the no-fault scheme" and held that it does "not grant healthcare providers a statutory cause of action against insurers to recover the costs of providing products, services, and accommodations to an injured person." *Covenant Medical Center, Inc. v. State Farm Mutual Automobile Ins. Co.*, 2017 WL 2303337 (Mich. May 25, 2017) (attached as Exhibit A). The Michigan Supreme Court found that the no-fault statute "contains no language that can be reasonably understood as creating a right for a healthcare provider to directly sue a no-fault insurer" and thus held with unmistakable clarity: "A healthcare provider possesses no statutory cause of action under the no-fault act against a no-fault insurer for recovery of PIP benefits." *Id.*

3. Plaintiffs' no-fault claim in this lawsuit stands in direct contravention of the Michigan Supreme Court's decision in *Covenant*. Accordingly, it must be dismissed.

4. The grounds for this motion are stated more fully in the accompanying brief, which is expressly incorporated herein.

WHEREFORE, Defendant State Farm respectfully requests that this Court grant its motion and enter an order dismissing with prejudice the single claim for personal injury protection benefits asserted by Plaintiffs under the no-fault act.

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HACKNEY GROVER PLC
Attorneys for Defendant

Dated: July 17, 2017

By: _____

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***

BRIEF IN SUPPORT OF DEFENDANT STATE FARM'S MOTION FOR SUMMARY DISPOSITION OF PROVIDER NO-FAULT CLAIM UNDER MCR 2.116(C)(8)

Introduction

This is a no-fault case filed by Plaintiffs, healthcare providers, against Defendant State Farm Insurance Automobile Insurance Company ("State Farm"). Plaintiffs seek to recover the cost of certain medical services that it rendered to George Hensley, one of State Farm's insured, for injuries that he allegedly suffered in an automobile accident on November 30, 2014. Although this lawsuit was unremarkable at the time it was filed as the Michigan Court of Appeals has been permitting healthcare providers to assert direct claims against no-fault insurers for years, the Michigan Supreme Court has now put a stop to that practice. On May 25, 2017, after close examination of the full text of the no-fault act, it issued a decision expressly and unequivocally holding that there is no statutory basis to permit a medical provider to sue an insurer for personal injury protection benefits to recover the costs of treatment rendered to an insured. Plaintiffs'

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no-fault claim stands in direct violation of that basic principle. Accordingly, it must be dismissed.

Statement of Facts

Plaintiffs claim that they are owed $82,070.00, for services provided to George Hensley, and claim that no payments have been made on George Hensley's account. These services were provided after the November 30, 2014 motor vehicle accident. The services provided by Plaintiffs to George Hensley include physician examinations, consultations, and surgeries.

These services were provided by Plaintiffs to George Hensley due to his diagnoses of cervical and lumbar radiculopathy, cervicalgia, and low back pain. The medical care provider who treated Mr. Hensley at Plaintiffs' facilities was Dr. Jawad Shah.

As evidenced by Plaintiffs' Complaint, Plaintiffs are seeking reimbursement for the services provided to Mr. Hensley pursuant to the Michigan No-Fault Act, specifically MCL 500.3101, MCL 500.3105 and MCL 500.3107(1)(a). In fact, the only cause of action in Plaintiffs' Complaint is for no-fault allowable expenses. (See Plaintiff's Complaint, attached as Exhibit B).

Standard of Review

MCR 2.116(C)(8) directs a trial court to enter summary disposition against a plaintiff who "has failed to state a claim on which relief can be granted." A motion under this rule "is well taken if it is clear from the pleadings alone that the claim does not state a legal basis for recovery." *Wilson v Acacia Park Cemetery Assoc*, 162 Mich App 638, 642 (1987). When confronted with a motion under MCR 2.116(C)(8), a court must

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accept all of the factual allegations supporting the claim as true. *See ETT Ambulance Service Corp v Rockford Ambulance, Inc*, 204 Mich 392, 395 (1994). That presumption of truth, however, does not extend to conclusory statements. "[T]he mere statement of a pleader's conclusions, unsupported by allegations of fact, will not suffice to state a cause of action." *Id.*

Argument

The legal basis for State Farm's summary disposition motion is straightforward. Michigan law no longer permits healthcare providers to assert claims against insurers under the no-fault act for treatment rendered to individuals injured in automobile accidents. On May 25, 2017, the Michigan Supreme Court conducted a "thorough review of the no-fault scheme" and held that it does "not grant healthcare providers a statutory cause of action against insurers to recover the costs of providing products, services, and accommodations to an injured person." *Covenant Medical Center, Inc. v. State Farm Mutual Automobile Ins. Co.*, 2017 WL 2303337 (Mich. May 25, 2017). The Michigan Supreme Court found that the no-fault statute "contains no language that can be reasonably understood as creating a right for a healthcare provider to directly sue a no-fault insurer" and thus held with unmistakable clarity: "A healthcare provider possesses no statutory cause of action under the no-fault act against a no-fault insurer for recovery of PIP benefits." *Id.*

This case falls squarely within the prohibition announced by the Michigan Supreme Court in *Covenant*. Plaintiffs have asserted a single cause of action under the no-fault act seeking to recover the cost of medical treatment that it rendered to State

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Farm's insured in connection with his alleged injuries. The statute does not permit such a direct provider claim. Only an insured may assert a no-fault claim against his/her insurer to recover personal injury protection benefits that are allegedly due and owing. Plaintiffs have failed to state a cognizable cause of action, and its claim against State Farm must therefore be dismissed.

Conclusion

For the reasons stated, Defendant State Farm respectfully requests that this Honorable Court grant its motion for summary disposition and enter an order dismissing with prejudice the single claim for personal injury protection benefits asserted by Plaintiffs, under the no-fault act.

HACKNEY GROVER PLC
Attorneys for Defendant

Dated: July 17, 2017

By: _____
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CERTIFICATION OF SERVICE

Hillary Fidler certifies that on July 16, 2017 she served a copy of Defendant State Farm's Motion for Summary Disposition for Provider No-Fault Claim Under MCR 2.116(C)(8) and Brief in Support of Motion on the above attorneys of record by mailing same to them at their addresses of record via first class mail with postage prepaid thereupon.

_____
Hillary Fidler

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2017 WL 2303337
Only the Westlaw citation is currently available.
Supreme Court of Michigan.

COVENANT MEDICAL CENTER, INC., Plaintiff–Appellee,
v.
STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, Defendant–Appellant.

Docket No. 152758
|
Calendar No. 5
|
Argued December 7, 2016
|
Decided May 25, 2017

Synopsis

Background: Healthcare provider brought action against patient's automobile insurer to recover personal protection insurance (PIP) benefits, after patient settled his suit against insurer and released insurer from liability. The Circuit Court, Saginaw County, Robert L. Kaczmarek, J., granted insurer's motion for summary disposition. Provider appealed. The Court of Appeals, 313 Mich.App. 50, 880 N.W.2d 294, reversed and remanded. Insurer's application for leave to appeal was granted.

[Holding:] As a matter of first impression, the Supreme Court, Zahra, J., held that a healthcare provider possesses no statutory cause of action against an insurer for recovery of PIP benefits, overruling *LaMothe v. Auto Club Ins. Ass'n*, 214 Mich.App. 577, 543 N.W.2d 42, *Munson Med. Ctr v. Auto Club Ins. Ass'n*, 218 Mich.App. 375, 554 N.W.2d 49, *Lakeland Neurocare Ctrs. v. State Farm Mut. Auto. Ins. Co* , 250 Mich.App. 35, 645 N.W.2d 59, *Regents of the Univ. of Mich. v. State Farm Mut. Ins. Co.*, 250 Mich.App. 719, 650 N.W.2d 129, *Mich. Head & Spine Institute, P.C. v State Farm Mut Auto. Ins. Co.*, 299 Mich.App. 442, 830 N.W.2d 781, *Moody v. Home Owners Ins. Co.*, 304 Mich.App. 415, 849 N.W.2d 31, *Wyoming Chiropractic Health Clinic, PC v. Auto-Owners Ins. Co.*, 308 Mich.App. 389, 864 N W.2d 598.

Judgment of the Court of Appeals reversed and remanded.

Bernstein, J., filed dissenting opinion.

West Headnotes (17)

[1] **Appeal and Error**
Cases Triable in Appellate Court

A court's decision to grant summary disposition based on the entry of judgment, dismissal, or release is reviewed de novo. Mich. Ct. R. 2.116(C)(7).

Cases that cite this headnote

[2] **Appeal and Error**
Cases Triable in Appellate Court

Questions of statutory interpretation are reviewed de novo.

Cases that cite this headnote

[3] **Statutes**
Language

The role of a court in interpreting statutory language is to ascertain the legislative intent that may reasonably be inferred from the words in a statute.

Cases that cite this headnote

[4] **Statutes**
Language and intent, will, purpose, or policy

The focus of a court's statutory analysis must be the statute's express language, which offers the most reliable evidence of the Legislature's intent.

Cases that cite this headnote

[5] **Statutes**
Giving effect to statute or language; construction as written

When the statutory language is clear and unambiguous, judicial construction is not

permitted and the statute is enforced as written.

Cases that cite this headnote

[6] **Constitutional Law**
Judicial 'reading into' or 'out of' statutory language

A court may read nothing into an unambiguous statute that is not within the manifest intent of the Legislature as derived from the words of the statute itself.

Cases that cite this headnote

[7] **Insurance**
no-Fault Insurance

A healthcare provider possesses no statutory cause of action against a no-fault insurer for recovery of personal protection insurance (PIP) benefits; overruling *LaMothe v. Auto Club Ins. Ass'n*, 214 Mich.App. 577, 543 N.W.2d 42, *Munson Med. Ctr. v. Auto Club Ins. Ass'n*, 218 Mich.App. 375, 554 N.W.2d 49, *Lakeland Neurocare Ctrs. v. State Farm Mut. Auto. Ins. Co.*, 250 Mich.App. 35, 645 N.W.2d 59, *Regents of the Univ. of Mich. v. State Farm Mut. Ins. Co.*, 250 Mich.App. 719, 650 N.W.2d 129, *Mich. Head & Spine Institute, P.C. v. State Farm Mut. Auto. Ins. Co.*, 299 Mich.App. 442, 830 N.W.2d 781, *Moody v. Home Owners Ins. Co.*, 304 Mich.App. 415, 849 N.W.2d 31, *Wyoming Chiropractic Health Clinic, PC v. Auto-Owners Ins. Co.*, 308 Mich.App. 389, 864 N.W.2d 598, Mich. Comp. Laws Ann. §§ 500.3105, 500.3107, 500.3112, 500.3114, 500.3115, 500.3145(1), 500.3148, 500.3157, 500.3158(2).

Cases that cite this headnote

[8] **Courts**
Highest appellate court

Although the Supreme Court is not in any way bound by the opinions of the Court of Appeals, the Supreme Court nevertheless treads cautiously in considering whether to reject a long line of caselaw developed by the intermediate appellate court.

Cases that cite this headnote

[9] **Courts**
Highest appellate court

The longevity of a line of Court of Appeals caselaw will not deter the Supreme Court from intervening when that caselaw clearly misinterprets the statutory scheme at issue.

Cases that cite this headnote

[10] **Statutes**
Liberal or strict construction

It is imperative that the Supreme Court aims to conform the caselaw to the text of the applicable statutes to ensure that those to whom the law applies may look to those statutes for a clear understanding of the law.

Cases that cite this headnote

[11] **Insurance**
no-Fault Insurance

Charges for healthcare services rendered are not "incurred" by a healthcare provider, in the context of the no-fault act, because a provider is not subject to charges for the products, services, and accommodations it delivers to others. Mich. Comp. Laws Ann. § 500.3107(1)(a).

Cases that cite this headnote

[12] **Insurance**
no-Fault Insurance

Healthcare providers do not become "liable" for allowable expenses, in the context of the no-fault act; rather, charges for healthcare are incurred by others, most commonly patients, and those patients are the ones who become liable for payment of those charges. Mich. Comp. Laws Ann. § 500.3107(1)(a).

Cases that cite this headnote

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[13] **Insurance**
no-Fault Insurance

No-fault act provision that addresses to whom personal protection insurance (PIP) benefits are payable allows for the common practice of no-fault insurers directly paying healthcare providers, but its text does not require direct payment of healthcare providers. Mich. Comp. Laws Ann. § 500.3112.

Cases that cite this headnote

[14] **Statutes**
Conjunctive and disjunctive words

The Legislature's use of the disjunctive word "or" in a statute indicates an alternative or choice between two things.

Cases that cite this headnote

[15] **Insurance**
no-Fault Insurance

According to the no-fault act provision that addresses to whom personal protection insurance (PIP) benefits are payable, PIP benefits, which are paid by the insurer, may, can, or must be paid either to the injured person or for the benefit of the injured person; in the case of the injured person's death, PIP benefits may, can, or must be paid either to the decedent's dependents or for the benefit of those dependents. Mich. Comp. Laws Ann. § 500.3112.

Cases that cite this headnote

[16] **Insurance**
no-Fault Insurance

"Person" in the no-fault act's priority provision for personal protection insurance (PIP) benefits, cannot mean a healthcare provider because providers are not named in the PIP insurance policy and do not sustain accidental bodily injuries. Mich. Comp. Laws Ann. § 500.3114(1).

Cases that cite this headnote

[17] **Health**
Contracts for services

Insurance
no-Fault Insurance

A healthcare provider that furnishes healthcare services to a person for injuries sustained in a motor vehicle accident may seek payment from the injured person for the provider's reasonable charges, rather than the no-fault insurer.

Cases that cite this headnote

BEFORE THE ENTIRE BENCH (except Wilder, J.)

OPINION

Zahra, J.

This case presents the significant question of whether a healthcare provider possesses a statutory cause of action against a no-fault insurer to recover personal protection insurance benefits for allowable expenses incurred by an insured under the no-fault act, MCL 500.3101 *et seq.* Relying on several of its previous decisions, the Court of Appeals concluded that it is "well settled that a medical provider has independent standing to bring a claim against an insurer for the payment of no-fault benefits."[1] The insurer sought leave to appeal in this Court, and we granted the application to consider in part that conclusion, which this Court has never addressed.[2]

A thorough review of the statutory no-fault scheme reveals no support for an independent action by a healthcare provider against a no-fault insurer. In arguing that healthcare providers may directly sue no-fault insurers, plaintiff primarily relies on MCL 500.3112, which provides, in pertinent part, that "[p]ersonal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his death, to or for the benefit of his dependents." While this provision undoubtedly allows no-fault insurers to directly pay healthcare providers for the benefit of an injured person, its terms do not grant healthcare providers a statutory cause of action against insurers to recover the costs of

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providing products, services, and accommodations to an injured person. Rather, MCL 500.3112 permits a no-fault insurer to discharge its liability to an injured person by paying a healthcare provider directly, on the injured person's behalf. And further, no other provision of the no-fault act can reasonably be construed as bestowing on a healthcare provider a statutory right to directly sue no-fault insurers for recovery of no-fault benefits. We therefore hold that healthcare providers do not possess a statutory cause of action against no-fault insurers for recovery of personal protection insurance benefits under the no-fault act. The Court of Appeals caselaw concluding to the contrary is overruled to the extent that it is inconsistent with this holding. We reverse the judgment of the Court of Appeals in this case and remand the case to the Saginaw Circuit Court for entry of an order granting summary disposition to defendant.

I. FACTS AND PROCEDURAL HISTORY

*3 On June 20, 2011, Jack Stockford was injured in a motor vehicle accident. His no-fault insurer was defendant, State Farm Mutual Automobile Insurance Company. Stockford was treated on at least three occasions by plaintiff, Covenant Medical Center, a healthcare provider. Plaintiff sent defendant bills on July 3, August 2, and October 9, 2012, for medical services it provided to Stockford. It is undisputed that defendant received the bills, which totaled $43,484.80. Defendant denied coverage on or about November 15, 2012, and refused to pay the bills.

On June 4, 2012, Stockford filed suit against defendant for no-fault benefits, including personal protection insurance (PIP) benefits.[3] Stockford settled his case with defendant on April 2, 2013, for $59,000. In connection with the settlement, Stockford executed a broad release, which encompassed all allowable no-fault expenses, including medical bills, and "any and all past and present claims incurred through January 10, 2013[.]"

Plaintiff brought the instant suit against defendant on April 25, 2013, seeking payment of its billed expenses.[4] Plaintiff asserted that it learned of the settlement and release when defendant answered its complaint in May 2013. In September 2013, defendant moved for summary disposition under MCR 2.116(C)(7) (dismissal due to release) and MCR 2.116(C)(8) (failure to state a claim). Defendant maintained that plaintiff's claim for benefits was derivative of Stockford's claim, which was extinguished by the release. Therefore, defendant argued, plaintiff no longer possessed a claim against it.

In an opinion dated May 15, 2014, the circuit court granted summary disposition to defendant pursuant to MCR 2.116(C)(7). The court agreed with defendant that Stockford's release was dispositive, holding that any claim plaintiff may have had against Stockford's insurer was "dependent on the insurer being obligated to pay benefits to the provider on behalf of its insured" and that the "release end[ed] the insurer's obligation to pay benefits to or on behalf of its insured under its contract of insurance."

Plaintiff appealed by right in the Court of Appeals. In a published per curiam opinion, the panel reversed the circuit court's decision, concluding that defendant's liability to plaintiff could not be discharged by defendant's settlement with Stockford because defendant had received written notice of plaintiff's claim before the settlement, presumably from the bills that plaintiff mailed to defendant.[5] The panel opined that, in this situation, the settlement could not constitute a "good faith" payment covering the noticed third-party claim for purposes of MCL 500.3112. The panel reasoned in part:

> [W]hile a provider's right to payment from the insurer is created by the right of the insured to benefits, an insured's agreement to release the insurer in exchange for a settlement does not release the insurer with respect to the provider's noticed claims unless the insurer complies with MCL 500.3112.[6]

According to the panel, in order to discharge liability under these circumstances, MCL 500.3112 "requires that the insurer apply to the circuit court for an appropriate order directing how the no-fault benefits should be allocated."[7] The Court of Appeals therefore reversed the circuit court's order granting summary disposition in favor of defendant and remanded the case for further proceedings.

*4 Defendant applied for leave to appeal in this Court. As previously mentioned, this Court granted leave to consider in part "whether a healthcare provider has an

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independent or derivative claim against a no-fault insurer for no-fault benefits[.]" [8]

II. STANDARD OF REVIEW AND RULES OF STATUTORY INTERPRETATION

[1] The circuit court granted summary disposition under MCR 2.116(C)(7), which applies when "[e]ntry of judgment, dismissal of the action, or other relief is appropriate because of release...." This Court reviews de novo a court's decision to grant summary disposition. [9]

[2] [3] [4] [5] [6] This Court also reviews de novo questions of statutory interpretation. [10] The role of this Court in interpreting statutory language is to "ascertain the legislative intent that may reasonably be inferred from the words in a statute." [11] "The focus of our analysis must be the statute's express language, which offers the most reliable evidence of the Legislature's intent." [12] When the statutory language is clear and unambiguous, judicial construction is not permitted and the statute is enforced as written. [13] "[A] court may read nothing into an unambiguous statute that is not within the manifest intent of the Legislature as derived from the words of the statute itself." [14]

III. ANALYSIS

[7] The Court of Appeals concluded that the release executed between Stockford and defendant did not release defendant from liability regarding plaintiff's claim. This conclusion was premised on the notion that a healthcare provider who provides services to a person injured in a motor vehicle accident possesses its *own* statutory claim against the injured person's no-fault insurer to compel payment for services rendered on behalf of the insured. The Court of Appeals panel in the instant case did not critically dissect the pertinent statutory provisions of the no-fault act to find support for this premise but instead followed previous decisions of the Court of Appeals, which it was bound to do. [15] Plaintiff urges us to likewise follow the long line of cases from the Court of Appeals recognizing that a healthcare provider may sue a no-fault insurer to recover PIP benefits under the no-fault act. We decline plaintiff's invitation, relying instead on the language of the no-fault act to conclude that a healthcare provider possesses no statutory cause of action against a no-fault insurer for recovery of PIP benefits.

A. COURT OF APPEALS CASELAW

[8] [9] [10] The foundation of any opinion interpreting a statutory provision is the parsing of the words of the pertinent act or statute under review. This case is no exception. Nonetheless, we are presented with decades of Court of Appeals caselaw concluding that a healthcare provider may assert a direct cause of action against a no-fault insurer to recover no-fault benefits. Although this Court is not in any way bound by the opinions of the Court of Appeals, we nevertheless tread cautiously in considering whether to reject a long line of caselaw developed by our intermediate appellate court. That being said, the longevity of a line of Court of Appeals caselaw will not deter this Court from intervening when that caselaw clearly misinterprets the statutory scheme at issue. Correcting erroneous interpretations of statutes furthers the rule of law by conforming the caselaw of this state to the language of the law as enacted by the representatives of the people. And it is imperative that this Court aim to conform our caselaw to the text of the applicable statutes to ensure that those to whom the law applies may look to those statutes for a clear understanding of the law. [16] We therefore begin our analysis with a brief discussion of how this issue developed in the Court of Appeals.

*5 There are three cases on which the Court of Appeals has frequently relied when concluding that a healthcare provider may directly sue a no-fault insurer. The first is *LaMothe v. Auto Club Ins. Ass'n*, [17] in which the panel opined that it could "anticipate that health care services providers, as practical litigants, would bypass the insured and directly sue, pursuant to third-party beneficiary theories, the entity with prospects identical to their own for engendering jury sympathy—the insurer." Significantly, the *LaMothe* parties did not litigate whether the no-fault act permits such a direct cause of action because the insurer had agreed via contractual provision "to fully defend and indemnify the insured from liability...." [18]

The following year, in *Munson Med. Ctr. v. Auto Club Ins. Ass'n*, [19] the Court of Appeals stated that

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the defendant insurer's "obligation to pay" and the plaintiff healthcare provider's "right to be paid for the injureds' no-fault medical expenses arise pursuant to MCL 500.3105, 500.3107, and 500.3157...." But there was no indication that this "right" was in dispute; the central issue in the case concerned the meaning of "customary charges." Moreover, while the panel cited particular statutory provisions, it did not parse the language of those provisions or provide any meaningful analysis to support the implication that a healthcare provider possesses a direct cause of action against a no-fault insurer for PIP benefits.

Also frequently cited for the proposition that a healthcare provider may directly sue a no-fault insurer is *Lakeland Neurocare Ctrs. v. State Farm Mut. Auto. Ins. Co.*[20] But as in *LaMothe*, the issue was neither presented nor decided in *Lakeland* because the defendant insurer in *Lakeland* "did not dispute that plaintiff had the legal right to commence this action for payment of medical services rendered to defendant's insured."[21] Instead, the litigated issue was whether the provider could recover penalty interest under MCL 500.3142 and attorney fees under MCL 500.3148.[22]

None of these cases decided whether healthcare providers possess a statutory cause of action against no-fault insurers. Despite this, subsequent panels of the Court of Appeals have, in published and unpublished cases alike, consistently relied on one or more of the cases just discussed as if they had decided the issue, generally failing to engage in any statutory analysis of their own to ground a healthcare provider's cause of action in the text of the no-fault act. This is aptly illustrated by the cases cited by the Court of Appeals in the instant case for the proposition that "it is ... well settled that a medical provider has independent standing to bring a claim against an insurer for the payment of no-fault benefits."[23] Like *LaMothe*, *Munson*, and *Lakeland*, none of the cases cited by the Court of Appeals provides any textual analysis of the no-fault act to support this proposition.[24]

*6 In sum, the Court of Appeals' decision in this case was premised on the notion that a healthcare provider possesses a statutory cause of action against a no-fault insurer for payment of no-fault benefits. The panel gleaned this notion not from the text of the no-fault act, but from previous decisions of the Court of Appeals that are likewise devoid of the statutory analysis necessary to support that premise. We find this caselaw unconvincing, and unlike the Court of Appeals panel, we are not bound by the conclusion that a healthcare provider possesses a right to bring a direct cause of action against a no-fault insurer to recover PIP benefits under the no-fault act. We instead rely on the language of the no-fault act itself to answer the question presented in this case.

B. STATUTORY ANALYSIS

It bears repeating that completely absent from the analysis in the Court of Appeals cases discussed earlier is a meaningful explanation of what language in the no-fault act creates a cause of action for healthcare providers against insurers. And indeed, the no-fault act does not, in any provision, explicitly confer on healthcare providers a direct cause of action against insurers. In fact, only two sections of the act, MCL 500.3157 and MCL 500.3158, even mention healthcare providers. MCL 500.3157 states:

> A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance.

MCL 500.3158(2) states:

> A physician, hospital, clinic or other medical institution providing, before or after an accidental bodily injury upon which a claim for personal protection insurance benefits is based, any product, service or accommodation in relation to that or any other injury,

> or in relation to a condition claimed to be connected with that or any other injury, if requested to do so by the insurer against whom the claim has been made, (a) shall furnish forthwith a written report of the history, condition, treatment and dates and costs of treatment of the injured person and (b) shall produce forthwith and permit inspection and copying of its records regarding the history, condition, treatment and dates and costs of treatment.

The former provision, MCL 500.3157, merely sets forth a limitation on the charges that may be assessed by a healthcare provider for treatment of an injured person. That a provider has the right to charge a reasonable amount for its products, services, or accommodations in no way obligates an insurance carrier to directly reimburse the provider for those charges. The latter provision, MCL 500.3158(2), simply requires that a healthcare provider make the injured person's medical records and certain treatment information available to the insurer. Neither of these provisions, by their express terms or by implication, confers on a healthcare provider a right to sue a no-fault insurer for reimbursement of the amounts it charged for treatment. Therefore, any such statutory right must be found in the sections of the no-fault act that do not explicitly refer to healthcare providers.

Plaintiff urges us to find support for a healthcare provider's direct cause of action in MCL 500.3105 and MCL 500.3107. MCL 500.3105(1) makes a no-fault insurer liable for the payment of PIP benefits. MCL 500.3105(1) states that "[u]nder personal protection insurance an insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, subject to the provisions of this chapter." MCL 500.3107 provides that "personal protection insurance benefits are payable for" certain costs, including "[a]llowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation," MCL 500.3107(1)(a), and "[w]ork loss consisting of loss of income from work," MCL 500.3107(1)(b). According to plaintiff, because benefits are payable for "reasonable charges" under MCL 500.3107(1)(a), including charges incurred for services rendered by healthcare providers under MCL 500.3157, the no-fault insurer must directly pay the provider's reasonable charges.

*7 [11] [12] MCL 500.3105 and MCL 500.3107, when taken together, provide that an insurer is liable to pay benefits for certain listed costs. Yet these provisions do nothing more than define the scope and nature of the requisite coverage. They do not identify to whom the insurer is liable or who has the right to assert a claim for benefits. Further, the language of MCL 500.3107(1)(a), which pertains to allowable expenses like those at issue here, is not amenable to an interpretation that would allow a healthcare provider to sue an insurer for reimbursement. MCL 500.3107(1)(a) provides that benefits are "payable" for "[a]llowable expenses consisting of all reasonable charges *incurred*...." In the context of the no-fault act, this Court has defined "incur" as " '[t]o become liable or subject to, [especially] because of one's own actions.' "[25] Charges for healthcare services rendered are not "incurred" by a healthcare provider because a provider is not subject to charges for the products, services, and accommodations it delivers to others. Nor do providers become "liable" for allowable expenses. Rather, charges for healthcare are incurred by others, most commonly patients, and those patients are the ones who become liable for payment of those charges. Therefore, because a healthcare provider does not incur reasonable charges and is not liable for allowable expenses, plaintiff's argument that MCL 500.3107(1)(a) permits a provider to directly sue an insurer for reimbursement is not persuasive.[26] Moreover, plaintiff's interpretation of MCL 500.3107(1)(a) improperly requires the Court to read into MCL 500.3107(1)(a) a meaning that the Legislature did not manifest through the words of MCL 500.3107(1)(a) itself.[27]

[13] Plaintiff, like previous panels of the Court of Appeals,[28] largely relies on MCL 500.3112 in support of its argument that healthcare providers possess a direct cause of action against no-fault insurers. That provision states in full:

> Personal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his death, to or for the benefit of his dependents. Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person

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> who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person. If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:
>
> (a) To the dependents of the injured person, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor.
>
> (b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse. [MCL 500.3112.]

While this section, which addresses to whom PIP benefits are payable, undoubtedly allows for the common practice of no-fault insurers directly paying healthcare providers, its text does not require direct payment of healthcare providers or give providers any right to directly sue a no-fault insurer, as will be evidenced through a sentence-by-sentence examination of the provision.

[14] [15] The first sentence, which provides that PIP benefits "are payable to or for the benefit of an injured person or, in the case of his death, to or for the benefit of his dependents," addresses both allowable expenses and survivor's loss and sets forth the groups of persons to whom an insurer may direct payment to discharge its liability to the insured. The Legislature's use of the disjunctive word "or" indicates "an alternative or choice between two things."[29] The word immediately preceding the disjunctive options is "payable," which is defined by the *Merriam–Webster's Collegiate Dictionary* to mean "that may, can, or must be paid."[30] Therefore, according to the first sentence of MCL 500.3112, PIP benefits, which are paid by the insurer, "may, can, or must be paid" either (1) to the injured person *or* (2) for the benefit of the injured person. In the case of the injured person's death, PIP benefits "may, can, or must be paid" either (1) to the decedent's dependents *or* (2) for the benefit of those dependents. This sentence does nothing more than allow a no-fault insurer to satisfy its obligation to the insured by paying the injured person directly or by paying a party providing PIP services on the injured person's behalf. That a third party may *receive* payment directly from an insurer for PIP benefits does not mean that the third party has a statutory *entitlement* to that method of payment.

*8 Plaintiff urges us to find, like previous Court of Appeals panels have, a provider cause of action in MCL 500.3112's phrase, "for the benefit of the injured person." This language, however, does not state that benefits are payable "to the provider," or otherwise indicate that a provider itself has an entitlement to benefits. To the contrary, it expressly leaves that entitlement with the injured person and merely recognizes that one who does not have a direct cause of action against a no-fault insurer may be paid directly by the insurer, but only in order to benefit the injured person. Simply stated, nothing in the first sentence is properly construed as bestowing a statutory cause of action on the injured person's healthcare provider.

The second sentence of MCL 500.3112 reads:

> Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person.

This sentence allows a no-fault insurer to discharge its liability through payment to or for the benefit of a person it believes is entitled to benefits, as long as the payment is made in good faith and the insurer has not been previously "notified in writing of the claim of some other person." Plaintiff argues that healthcare providers qualify as "some other person" for purposes of this sentence. Even if this were so, plaintiff still has not demonstrated a legal right of action against a no-fault insurer. The phrase "claim of some other person" does not itself confer on any person a "claim"[31] or "right" to recover benefits. Rather, it presupposes that "some other person" otherwise possesses a claim for PIP benefits against the insurer.[32] Significantly, plaintiff is unable to demonstrate

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that the no-fault act elsewhere confers on a healthcare provider a right to claim benefits from a no-fault insurer.

The third sentence of MCL 500.3112 reads, "If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit court for an appropriate order." This sentence merely provides a procedure for resolving doubts about which persons are entitled to benefits; it does not itself confer a right or entitlement on any person, including a healthcare provider, to sue a no-fault insurer.[33] And the sentence's reference to "apportionment" cannot logically pertain to allowable expenses like the reasonable charges incurred for healthcare services, because an injured person owes the provider, and is entitled to PIP benefits for, the entirety of those allowable expenses under MCL 500.3107(1)(a), not an apportioned amount.[34]

*9 Finally, the fourth sentence provides, "The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate." And the fifth sentence addresses the payment of dependent and survivor benefits in the absence of a court order. These sentences contain no language that can be reasonably understood as creating a right for a healthcare provider to directly sue a no-fault insurer. As in the third sentence, the reference to "apportionment" in the fourth sentence is inapplicable in the context of charges for services rendered by a healthcare provider. Similarly, the fourth sentence's call for the court to take into account "the relationship of the payees to the injured person" is inapt in the context of a healthcare provider's bill for services rendered. If the injured person qualifies for benefits, the insurer is liable under MCL 500.3107(1)(a) to pay "all reasonable charges incurred" by the injured person; no further inquiry into the "relationship" between the injured person and the provider is relevant.[35] And the fifth sentence on its face pertains only to payment to dependents and survivors. Therefore, the fourth and fifth sentences clearly do not create a statutory cause of action for healthcare providers.

While plaintiff primarily cites MCL 500.3112 as establishing a healthcare-provider cause of action under the no-fault act, there is nothing in the language of this provision that can reasonably be interpreted as vesting a healthcare provider with a right to demand reimbursement from a no-fault insurer for services the provider rendered to an insured. Although this provision allows insurers to pay a provider of no-fault services directly "for the benefit of" the insured, it does not establish a concomitant claim enforceable by an insured's benefactors.[36] Plaintiff has not pointed to any other provision in the no-fault act that bestows on healthcare providers a right to directly sue a no-fault insurer.[37]

*10 [16] Two textual clues found elsewhere in the no-fault act support the conclusion that a healthcare provider does not possess a statutory cause of action against a no-fault insurer. The priority statutes, MCL 500.3114 and MCL 500.3115, define against whom an individual may make a claim for benefits. The default rule for priority is found in MCL 500.3114(1), which states, in part, that "a personal protection insurance policy ... applies to accidental bodily injury to the person named in the policy, the person's spouse, and a relative of either domiciled in the same household...." "Person" in this instance cannot mean a healthcare provider because providers are not named in the PIP insurance policy and quite simply do not sustain accidental bodily injuries. MCL 500.3114(2) states that "[a] person suffering accidental bodily injury ... shall receive the [PIP] benefits to which the person is entitled from the insurer of the motor vehicle," and MCL 500.3114(4), (5), and (6) prioritize the order in which "a person suffering accidental bodily injury arising from a motor vehicle accident ... shall claim personal protection insurance benefits from [multiple] insurers [.]" MCL 500.3115(1) similarly sets forth the insurer priority for "a person suffering accidental bodily injury while not an occupant of a motor vehicle," and it provides that those persons "shall claim [PIP] benefits" in the order provided in MCL 500.3115(1). In both of these provisions, the Legislature specifically contemplates that the entitlement or claim belongs to the person who has "sustained accidental bodily injury," and the statutory language goes into great detail regarding the priority of insurers for claims by a person suffering such injury. Notably lacking from these entitlement provisions is any arguable reference to or contemplation of a healthcare provider's entitlement to benefits under the no-fault act.[38]

[17] In sum, a review of the plain language of the no-fault act reveals no support for plaintiff's argument that a

healthcare provider possesses a statutory cause of action against a no-fault insurer.[39] This conclusion does not mean that a healthcare provider is without recourse; a provider that furnishes healthcare services to a person for injuries sustained in a motor vehicle accident may seek payment from the injured person for the provider's reasonable charges.[40] However, a provider simply has no statutory cause of action of its own to directly sue a no-fault insurer. Accordingly, we overrule all Court of Appeals caselaw inconsistent with this conclusion.

IV. APPLICATION

*11 Given our conclusion that healthcare providers possess no statutory cause of action under the no-fault act, it is unnecessary to consider the substance of the Court of Appeals' opinion. Because a healthcare provider possesses no statutory right to sue a no-fault insurer, we need not examine whether a release executed between an insured and an insurer releases an insurer's liability for a healthcare provider's "claim." Further, the release executed in this case between Stockford and defendant does not appear to extinguish Stockford's liability to plaintiff. And nothing in this opinion would bar plaintiff from seeking reimbursement of the amount due it directly from Stockford, the person to whom services were provided.[41]

V. CONCLUSION

The Court of Appeals' opinion in this case is premised on the notion that an injured person's healthcare provider has an independent statutory right to bring an action against a no-fault insurer for payment of no-fault benefits. This premise is unfounded and not supported by the text of the no-fault act. A healthcare provider possesses no statutory cause of action under the no-fault act against a no-fault insurer for recovery of PIP benefits. Plaintiff therefore has no statutory entitlement to proceed with its action against defendant. Accordingly, we reverse the judgment of the Court of Appeals and remand this case to the Saginaw Circuit Court for entry of an order granting summary disposition to defendant.

Stephen J. Markman, Bridget M. McCormack, David F. Viviano, Joan L. Larsen

Bernstein, J. (dissenting).

I respectfully disagree with the majority's conclusion that healthcare providers do not possess a cause of action under Michigan's no-fault act, MCL 500.3101 *et seq.*, to recover personal protection insurance (PIP) benefits from a no-fault insurer for services provided to an insured. I believe that MCL 500.3112 establishes that an independent action may be brought by a healthcare provider against a no-fault insurer and that the majority's contrary construction is not supported by the plain language of the statute. Accordingly, I would affirm the judgment of the Court of Appeals.

I. FACTS AND PROCEDURAL HISTORY

Jack Stockford, who held no-fault insurance through defendant, State Farm Mutual Automobile Insurance Company, was injured in a motor vehicle accident on June 20, 2011. Plaintiff, Covenant Medical Center, Inc., provided medical services to Stockford on multiple occasions in the following months. Plaintiff sent defendant bills for these services totaling $43,484.80 on July 3, 2012, August 2, 2012, and October 9, 2012. Defendant sent plaintiff a written denial of payment on November 15, 2012.

Meanwhile, apparently unbeknownst to plaintiff, Stockford had filed suit against defendant on June 4, 2012, seeking PIP benefits for expenses arising out of the June 20 accident. Stockford entered into an agreement with defendant on April 2, 2013, by which defendant consented to pay Stockford $59,000 in exchange for a full and final release "regarding all past and present claims incurred through January 10, 2013, for what are commonly referred to as first party benefits or personal injury protection benefits...." As part of this broad release, Stockford agreed to indemnify defendant against claims made by any providers. Plaintiff was specifically named in this portion of the release agreement.

Plaintiff did not learn of the release until it filed suit against defendant on April 25, 2013. Defendant was granted summary disposition pursuant to MCR 2.116(C)

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(7) under the theory that Stockford's release barred plaintiff's claim. The Court of Appeals reversed in a published per curiam opinion, concluding that defendant's settlement agreement with Stockford had not been a "good faith" payment that could discharge its liability to plaintiff under MCL 500.3112. *Covenant Med. Ctr., Inc. v. State Farm Mut. Auto. Ins. Co.*, 313 Mich.App. 50, 880 N.W.2d 294 (2015).

II. ANALYSIS

***12** I agree with the majority that none of the caselaw relied on by the Court of Appeals directly addressed the question of whether healthcare providers have an independent cause of action for PIP benefits under the no-fault act. However, this does not necessarily mean that the Court of Appeals' longstanding interpretation of the no-fault act was inconsistent with the plain language of the statute. While no provision of the no-fault act confers a direct cause of action specific to healthcare providers, the plain language of MCL 500.3112 suggests that such a cause exists. Furthermore, although no provision of the no-fault act explicitly states that a healthcare provider may have a claim for PIP benefits, healthcare providers are no different in this regard from any other would-be claimant under the no-fault act, including injured people themselves.

No provision of the no-fault act expressly defines "claimant." However, provisions such as MCL 500.3112 contemplate who may *receive* PIP benefits under the no-fault act, and the ability to receive benefits is necessary in order to claim them. Absent any specific statement establishing who may bring a claim for PIP benefits, we must consider the plain language of MCL 500.3112, which provides:

> Personal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his death, to or for the benefit of his dependents. Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person. If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:
>
> (a) To the dependents of the injured person, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor.
>
> (b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse.

The first sentence of MCL 500.3112 suggests that healthcare providers have a claim for PIP benefits. It provides that PIP benefits "are payable to or for the benefit of an injured person or, in the case of his death, to or for the benefit of his dependents." MCL 500.3112. As the majority notes, this plainly means that insurers may pay benefits directly to healthcare providers, because such a payment would be "for the benefit of" the injured person or the injured person's dependents. *Id.* The majority clearly believes that an injured person is entitled to bring an action to recover these benefits, hanging its hat on the "shall claim" language of MCL 500.3114 and MCL 500.3115. But this language no more establishes an entitlement to make a legal claim than does the "payable to or for the benefit of" language of MCL 500.3112.

In the absence of any express entitlement provision in MCL 500.3112, the majority insists that MCL 500.3114 and MCL 500.3115 function as entitlement provisions for injured persons. However, as the majority admits, these are priority statutes that govern the order of priority among insurers rather than explicitly defining who may be a claimant under the no-fault act. The majority asserts that these two provisions are entitlement provisions because they include language to the effect that an injured person " 'shall claim [PIP] benefits,' " *ante* at 22 (alteration in original), but this interpretation ignores the context in which that language appears. The "shall claim" language appears in MCL 500.3114(4) and (5) and MCL 500.3115(1). In each of those provisions, the "shall claim" language is part of the longer phrase "shall claim [PIP] benefits from insurers in the following order of priority," immediately followed by a list of the insurers that may be

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required to pay benefits. MCL 500.3114(4) and (5); MCL 500.3115(1). The mandate of these statutes is not to define who must *receive* benefits, but who must *pay* them.

*13 Indeed, MCL 500.3114 and MCL 500.3115 cannot possibly define the bounds of who can bring an action for PIP benefits. The majority's reliance on *Belcher v. Aetna Cas. & Surety Co.*, 409 Mich. 231, 251–252, 293 N.W.2d 594 (1980), for the proposition that MCL 500.3114 and MCL 500.3115 are entitlement provisions that exclude the possibility of a provider claim is inapt. Although the *Belcher* Court referred to MCL 500.3114 and MCL 500.3115 as entitlement provisions in some sense, it rejected the notion that these two sections of the no-fault act constituted the be-all and end-all of potential PIP benefit claimants, remarking that neither provision gave survivors an express right to claim benefits even though survivors' benefits are clearly recognized in MCL 500.3108 and MCL 500.3112. *Belcher*, 409 Mich. at 254–255, 293 N.W.2d 594.

The *Belcher* Court was right. A finding that MCL 500.3114 and MCL 500.3115 are the only statutes in the no-fault act that establish an entitlement to a legal claim would render nugatory the language in MCL 500.3112 that permits payment of benefits to dependents and to other parties for the benefit of the injured person (a group of recipients that the majority concedes would include healthcare providers). See *ante* at 15. Such a reading would run counter to the rule of statutory interpretation barring us from interpreting statutes in a manner that would render any portion of a statute surplusage or nugatory. *Wyandotte Electrical Supply Co. v. Electrical Tech Sys., Inc.*, 499 Mich. 127, 140, 881 N.W.2d 95 (2016). Therefore, I cannot interpret MCL 500.3114 and MCL 500.3115 as the only provisions in the no-fault act that establish an entitlement to a legal claim for PIP benefits.

Nor can I conclude that MCL 500.3112 supports the notion that injured persons have a cause of action for PIP benefits but healthcare providers do not. MCL 500.3112 makes PIP benefits "payable"—that is, benefits "that may, can, or must be paid"[1]—to either the injured person *or* to someone else for that person's benefit, e.g., a healthcare provider. The statute does not treat these options differently. It is inconsistent to conclude that healthcare providers do not have an entitlement to PIP benefits while an injured person does. Healthcare providers cannot be barred from seeking to enforce their right to payment under this provision.[2]

The remainder of MCL 500.3112 does not undercut the conclusion that providers have an entitlement to a legal claim for PIP benefits. Indeed, the remainder of this provision does not discuss entitlement to benefits, but rather delineates procedures to be followed when there is some dispute among claimants to benefits. The second sentence of MCL 500.3112 explains that a good-faith payment of PIP benefits discharges an insurer's liability unless the insurer has received written notice of "the claim of some other person." The third sentence allows an insurer, claimant, or other interested party to seek a court order determining the proper person to receive benefits or the proper apportionment of benefits. The fourth permits a court to designate payees or apportion benefits as it considers appropriate, while the remainder of the provision directs an insurer's payment of benefits in the absence of a court order.

*14 The majority suggests that these aspects of MCL 500.3112 are inconsistent with the notion that the no-fault act establishes a healthcare provider's entitlement to a legal claim, but this is simply not the case. Although the directives in MCL 500.3112 do not in themselves entitle healthcare providers to benefits, they do not derogate the entitlement to make a legal claim alluded to in the first sentence of MCL 500.3112. The majority suggests that the bulk of MCL 500.3112 cuts against the notion of a provider claim and must be limited to dependent and survivor benefits, but this is not true. For example, contrary to the majority's assertion, the reference to apportionment in the third sentence is not limited in this fashion. "Apportionment" as used in that sentence could certainly apply to expenses incurred for healthcare services if, for example, an injured person received treatment from multiple providers resulting in PIP-qualifying charges. Nor do the fourth and fifth sentences suggest that the entirety of MCL 500.3112 is limited to dependent and survivor benefits. These sentences instead provide purely discretionary rubrics a trial court may follow when issuing an order. These sentences do not prevent the distribution of benefits to a healthcare provider.

In sum, the no-fault act does not expressly grant healthcare providers the right to directly sue insurers for PIP benefits. But it does not expressly grant that right to any party, not even an insured party injured in a motor

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vehicle accident. If we are to require an express statutory provision in order to create a cause of action, and no such provision appears in the no-fault act, it would follow that no party could ever bring suit to compel an insurer to pay PIP benefits. But it simply cannot be that the Legislature created a statutory scheme for the distribution of PIP benefits that no party could ever recover if an insurer denied coverage. MCL 500.3112 permits payment of PIP benefits to either an injured person or to a healthcare provider because direct payment to the provider would be for the benefit of the injured person. To hold that only an injured person is entitled to enforce this right to payment renders surplusage the possibility of payment to a third party like a healthcare provider. To avoid such an interpretation of the language of the no-fault act, healthcare providers must have a claim for PIP benefits.

III. APPLICATION

Because the no-fault act gives healthcare providers a claim for PIP benefits, I believe that the Court of Appeals reached the correct result in this case. In theory, an agreement like the one between Stockford and defendant could extinguish an insurer's liability for PIP benefits arising out of a particular accident. However, the second sentence of MCL 500.3112 provides:

> Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person.

As the Court of Appeals found, the release executed by Stockford and defendant was not in good faith. Defendant had been made aware of plaintiff's claim through the bills plaintiff transmitted to it. However, defendant entered into the settlement with Stockford and sought to permanently foreclose plaintiff's claim for PIP benefits without informing plaintiff.[3] The Court of Appeals' conclusion that the settlement with Stockford did not constitute a good-faith payment was eminently reasonable, as was the Court's concomitant conclusion that the payment did not discharge defendant's liability as contemplated by the second sentence of MCL 500.3112.

IV. CONCLUSION

I disagree with the majority's conclusion that the no-fault act does not give healthcare providers the right to bring an action against a no-fault insurer for PIP benefits. That reading renders nugatory the first sentence of MCL 500.3112, which permits payment of PIP benefits to healthcare providers. Because I believe that healthcare providers like plaintiff are entitled to enforce the receipt of payment due and that the Court of Appeals correctly concluded that defendant's liability for PIP benefits under MCL 500.3112 was not discharged, I would affirm the judgment of the Court of Appeals.

WILDER, J., did not participate in the disposition of this matter.

All Citations

--- N.W.2d ----, 2017 WL 2303337

Footnotes

1 See *Covenant Med. Ctr., Inc. v. State Farm Mut. Auto. Ins. Co.*, 313 Mich.App. 50, 54, 880 N.W.2d 294 (2015), and cases cited therein.

2 *Covenant Med. Ctr., Inc. v. State Farm Mut. Auto. Ins. Co.*, 499 Mich. 941, 879 N.W.2d 262 (2016).

3 No-fault benefits are broader than PIP benefits. For instance, no-fault benefits include, *inter alia*, property-protection benefits and work-loss benefits. See *Turner v. Auto Club Ins. Ass'n*, 448 Mich. 22, 30, 528 N.W.2d 681 (1995). The instant case concerns healthcare providers and, in turn, only PIP benefits.

4 Though initially filed in the Kent Circuit Court, the case was transferred to the Saginaw Circuit Court in July 2013.

5 *Covenant*, 313 Mich.App. at 53, 880 N.W.2d 294.

6 *Covenant*, 313 Mich.App. at 54, 880 N.W.2d 294.

7 *Id.* at 53, 880 N.W.2d 294.

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8 *Covenant*, 499 Mich. 941, 879 N.W.2d 262.

9 *Horace v. Pontiac*, 456 Mich. 744, 749, 575 N.W.2d 762 (1998).

10 *Hannay v. Dep't of Transp.*, 497 Mich. 45, 57, 860 N.W.2d 67 (2014).

11 *People v. Couzens*, 480 Mich. 240, 249, 747 N.W.2d 849 (2008).

12 *Badeen v. PAR, Inc.*, 496 Mich. 75, 81, 853 N.W.2d 303 (2014).

13 *People v. Gardner*, 482 Mich. 41, 50, 753 N.W.2d 78 (2008).

14 *Roberts v. Mecosta Co. Gen. Hosp.*, 466 Mich. 57, 63, 642 N.W.2d 663 (2002).

15 MCR 7.215(J)(1) ("A panel of the Court of Appeals must follow the rule of law established by a prior published decision of the Court of Appeals issued on or after November 1, 1990, that has not been reversed or modified by the Supreme Court, or by a special panel of the Court of Appeals as provided in this rule.").

16 *Robinson v. Detroit*, 462 Mich. 439, 467, 613 N.W.2d 307 (2000) (stating that "it is to the words of the statute itself that a citizen first looks for guidance in directing his actions," because "the essence of the rule of law" is "to know in advance what the rules of society are").

17 *LaMothe v. Auto Club Ins. Ass'n*, 214 Mich.App. 577, 586, 543 N.W.2d 42 (1995).

18 *Id.* at 583, 543 N.W.2d 42. The Court of Appeals quoted a letter that the insurer sent the insured's attorney, which stated in part that "[i]f any of the medical providers bring a claim against [the insured], [the insurer] will defend and indemnify him. In fact, [the insurer] will waive any technical defects and allow the provider to sue the [insurer] directly so that [the insured] won't even have to be a party to the litigation." *Id.* at 583 n.4, 543 N.W.2d 42.

19 *Munson Med. Ctr. v. Auto Club Ins. Ass'n*, 218 Mich.App. 375, 381, 554 N.W.2d 49 (1996).

20 *Lakeland Neurocare Ctrs. v. State Farm Mut. Auto. Ins. Co.*, 250 Mich.App. 35, 645 N.W.2d 59 (2002).

21 *Id.* at 37, 645 N.W.2d 59.

22 *Id.* at 44, 645 N.W.2d 59.

23 *Covenant*, 313 Mich.App. at 54, 880 N.W.2d 294, citing *Wyoming Chiropractic Health Clinic, PC v. Auto-Owners Ins. Co.*, 308 Mich.App. 389, 396–397, 864 N.W.2d 598 (2014); *Moody v. Home Owners Ins. Co.*, 304 Mich.App. 415, 440, 849 N.W.2d 31 (2014), rev'd sub nom on other grounds by *Hodge v. State Farm Mut. Auto. Ins. Co.*, 499 Mich. 211, 884 N.W.2d 238 (2016); *Mich. Head & Spine Institute, P.C. v. State Farm Mut. Auto. Ins. Co.*, 299 Mich.App. 442, 448 n. 1, 830 N.W.2d 781 (2013); *Lakeland Neurocare*, 250 Mich.App. at 42–43, 645 N.W.2d 59; *Regents of the Univ. of Mich. v. State Farm Mut. Ins. Co.*, 250 Mich.App. 719, 733, 650 N.W.2d 129 (2002).

24 The panel in the instant case cited *Wyoming Chiropractic*, 308 Mich.App. at 396–397, 864 N.W.2d 598, in which the Court of Appeals did not itself analyze any section of the no-fault act to conclude that the no-fault act established a cause of action for healthcare providers. Instead, the panel in *Wyoming Chiropractic* relied on prior cases leading back to *Munson* and *Lakeland* as already having established this premise as "fact." The instant panel also cited *Moody*, 304 Mich.App. 415, 849 N.W.2d 31, and *Regents of the Univ. of Mich.*, 250 Mich.App. 719, 650 N.W.2d 129, both of which stated in a cursory manner that healthcare providers possess a claim or cause of action against no-fault insurers without citing any statutes or otherwise substantively addressing the issue. In *Moody*, the Court of Appeals recognized, without analyzing, that a provider could "bring an independent cause of action against a no-fault insurer," but that the provider's claim was "completely derivative of and dependent on" the claim of the patient insured. *Moody*, 304 Mich.App. at 440, 849 N.W.2d 31. In *Regents of the Univ. of Mich.*, the panel concluded that while the claims of the medical providers were "derivative claims, they also ha[d] direct claims for personal protection insurance benefits." *Regents of the Univ. of Mich.*, 250 Mich.App. at 733, 650 N.W.2d 129, citing *Munson*, 218 Mich.App. 375, 554 N.W.2d 49, and *LaMothe*, 214 Mich.App. at 585–588, 543 N.W.2d 42. This language in *Regents of the Univ. of Mich.* appears in a passage discussing whether MCL 600.5821(4) or MCL 500.3145(1) governs the statute of limitations applicable when a political subdivision of the state is the plaintiff in a no-fault action; the opinion did not itself analyze the issue of a provider's right to directly sue a no-fault insurer. The only other case cited by the Court of Appeals is *Mich. Head & Spine Institute*, 299 Mich.App. at 448 n. 1, 830 N.W.2d 781, but the panel in that case merely referred to the phrase "for the benefit of" in MCL 500.3112 and added "which this Court has recognized creates an independent cause of action for healthcare providers." The Court cited only *Lakeland*, without providing any statutory analysis of its own.

25 *Proudfoot v. State Farm Mut. Ins. Co.*, 469 Mich. 476, 484, 673 N.W.2d 739 (2003), quoting *Webster's II New College Dictionary* (2001) (alterations in original).

26 Plaintiff also points to the word "payable" in MCL 500.3107 to argue that no-fault benefits are to be paid to a healthcare provider for all reasonable charges for medical treatment. But MCL 500.3107 is silent regarding to whom the benefits are

payable. Plaintiff does not explain how this provision vests a provider with rights against an insurer or otherwise indicates that benefits are payable to a provider.

27 See *Roberts*, 466 Mich. at 63, 642 N.W.2d 663.

28 See, e.g., *Chiropractors Rehab. Group, P.C. v. State Farm Mut. Auto. Ins. Co.*, 313 Mich.App. 113, 881 N.W.2d 120 (2015); *Wyoming Chiropractic*, 308 Mich.App. 389, 864 N.W.2d 598.

29 See *People v. Kowalski*, 489 Mich. 488, 499 n. 11, 803 N.W.2d 200 (2011) (" 'Or' is ... a disjunctive [term], used to indicate a disunion, a separation, an alternative.") (quotation marks and citation omitted; alteration in original).

30 *Merriam–Webster's Collegiate Dictionary* (11th ed.). "Payable" is not defined in the no-fault act. We therefore presume that the Legislature intended for the word to have its common and ordinary meaning. MCL 8.3a. To assist in determining the ordinary meaning of relevant words, this Court may consult a dictionary. *Klooster v. Charlevoix*, 488 Mich. 289, 304, 795 N.W.2d 578 (2011).

31 Because the no-fault act does not define "claim," we may consult a dictionary definition. *Klooster*, 488 Mich. at 304, 795 N.W.2d 578. The relevant dictionary definitions of "claim" include "a demand for something due or believed to be due" and "a right to something." *Merriam–Webster's Collegiate Dictionary* (11th ed.). Therefore, to have a "claim" under the no-fault act, a provider must have a right to payment of PIP benefits from a no-fault insurer.

32 We need not decide precisely to whom this sentence applies in order to conclude that it does not confer on a healthcare provider the right to sue for payment of benefits. It seems, however, that this sentence is likely applicable primarily to dependents and survivors given that the end of the statute pertains to the allocation of benefits to those groups of persons.

33 Plaintiff argues that a healthcare provider qualifies as a "person" for purposes of the third sentence of MCL 500.3112 given that the Insurance Code, in MCL 500.114, defines the word "person" to include corporate entities, like healthcare providers. But this Court long ago recognized that, given its inconsistent use throughout the no-fault act, "the term 'person' must be construed in the exact context in which it is used to ascertain its precise meaning." *Belcher v. Aetna Cas. and Surety Co.*, 409 Mich. 231, 258, 293 N.W.2d 594 (1980). Plaintiff has not explained why "person," in the context of the third sentence of MCL 500.3112, refers to a corporate entity like a healthcare provider. In any event, even if a healthcare provider were a "person" for purposes of this sentence, the sentence itself, as discussed, does not purport to create or confer any rights with respect to the "persons" covered by its doubt-resolution procedure.

34 See *Douglas v. Allstate Ins. Co.*, 492 Mich. 241, 257, 821 N.W.2d 472 (2012) (noting that MCL 500.3107(1) allows "unlimited lifetime benefits" for allowable expenses). In contrast, apportionment of benefits is necessary when the allowable benefits are finite in amount, as is the case with survivor's loss benefits. See MCL 500.3108(1).

Again, we need not decide precisely to whom this sentence pertains in order to conclude that it does not confer on a healthcare provider the right to sue for payment of benefits. Nonetheless, we note that it would seem to primarily pertain to dependent and survivor benefits. There are several scenarios in which there could be doubt regarding the proper dependent or survivor to receive benefits. For example, under MCL 500.3110(1), doubt could emerge about whether a surviving spouse or a minor child is a proper person to receive benefits if it were unclear whether they were living in the same house as the victim. Doubt could also emerge under MCL 500.3110(2) regarding the proper apportionment of benefits because "the extent of [one's] dependency shall be determined in accordance with the facts as they exist at the time of death." Similarly, doubt could emerge under MCL 500.3110(3) because this subsection conditions "dependent" status on particular factual inquiries. In those circumstances, a hearing might be necessary for the circuit court to "designate the payees and make an equitable apportionment" of benefits. MCL 500.3112.

35 In contrast, the relationship between a payee and an injured person is relevant when survivor and dependent benefits are at issue. Certain individuals are conclusively presumed to be dependents under MCL 500.3110(1) but when one of those conclusive relationships is not at issue, "questions of dependency and the extent of dependency shall be determined in accordance with the facts as they exist at the time of death" under MCL 500.3110(2), which may require an inquiry into the parties' relationship.

36 The dissent asserts that this conclusion "renders surplusage the possibility of payment to a third party like a healthcare provider." This is not so. By permitting insurers to directly pay healthcare providers on the injured person's behalf, MCL 500.3112 allows the insurer to eliminate the insured as a conduit in the payment process, relieving the insured from having to redirect to the healthcare provider payment received from the insurer. It is not surplusage for the statute to expressly permit an insurer to directly pay its insured's healthcare bills in order to discharge its obligation to its insured. The fact that the statute grants that permission does not create a right in the providers to sue the insurer for payment.

37 Other provisions cited by plaintiff in support of its argument that healthcare providers have a direct claim of their own are MCL 500.3145(1) and MCL 500.3148.

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MCL 500.3145(1), the no-fault statute of limitations provision, provides that "[a]n action for recovery of personal protection insurance benefits payable under this chapter for accidental bodily injury may not be commenced later than 1 year after the date of the accident causing the injury...." Plaintiff argues that this provision does not only permit the injured person to bring a lawsuit, but that it plainly allows a timely lawsuit for recovery of PIP benefits "payable under this chapter" and that under MCL 500.3107, MCL 500.3157, and MCL 500.3112, allowable expenses are payable to healthcare providers. Consequently, plaintiff contends that MCL 500.3145(1) contemplates that providers will bring lawsuits to recover benefits. According to plaintiff, the third sentence of MCL 500.3145(1) confirms this interpretation by stating that "the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced." Under plaintiff's interpretation, the Legislature's use of the word "claimant," instead of "injured person," demonstrates that other persons, like providers, may bring lawsuits to recover PIP benefits. MCL 500.3148, which pertains to attorney fees, states in part that "[a]n attorney is entitled to a reasonable fee for advising and representing a claimant in an action for personal or property protection insurance benefits which are overdue." MCL 500.3148(1). Plaintiff similarly argues that the statute's reference to "claimant" rather than "injured person" indicates that healthcare providers have the right to bring an independent lawsuit for payment of PIP benefits. Plaintiff's reliance on the references to "claimant" rather than "injured person" in MCL 500.3145(1) and MCL 500.3148 is helpful to plaintiff's argument only if healthcare providers are proper claimants under the no-fault act. The provisions cited by plaintiff do not establish that providers possess a claim under the act. Because MCL 500.3145(1) and MCL 500.3148 do not create rights to PIP benefits that do not otherwise exist, plaintiff's reliance on these provisions is misplaced.

38 This conclusion is consistent with *Belcher*, 409 Mich. at 236, 293 N.W.2d 594, in which this Court considered whether "no-fault insurance benefits [are] to be paid to the surviving dependent(s) of a deceased uninsured motorist[.]" (Quotation marks and citation omitted.) In analyzing this issue, this Court opined that the no-fault act "operates to compensate only a limited class of persons for economic losses sustained as a result of motor vehicle accidents. Under personal protection insurance, benefits are made payable only to injured persons or surviving dependents of the injured person." *Id.* at 243–244, 293 N.W.2d 594. The Court further described MCL 500.3114 and MCL 500.3115 as the no-fault act's only entitlement provisions "in the sense that they are the only sections where persons are given the right to claim personal protection insurance benefits from a specific insurer." *Id.* at 252, 293 N.W.2d 594. *Belcher* is not directly applicable in this case because it did not examine whether a healthcare provider possesses a cause of action under the no-fault act. Contrary to the dissent's assertion, we do not rely on *Belcher* to exclude the possibility of a provider claim, nor do we contend that an injured person's cause of action under the no-fault act derives entirely from MCL 500.3114 and MCL 500.3115. Instead, we simply note that *Belcher*'s holding is consistent with our independent conclusion that healthcare providers possess no statutory cause of action because, just like the remainder of the no-fault act, neither MCL 500.3114 nor MCL 500.3115 contemplate that a healthcare provider may directly claim recovery for the cost of providing PIP benefits.

Moreover, in *Belcher* this Court concluded that, while the text of the entitlement provisions gives only injured persons the right to assert a claim for benefits against a no-fault insurer, the Legislature clearly intended that surviving dependents recover certain losses in the event that the injured person dies, as evidenced by the provision of benefits for survivors in MCL 500.3108 and MCL 500.3112. *Id.* at 254–255, 293 N.W.2d 594. To effectuate the intent made explicit in the statutory language, the Court inferred from the language of MCL 500.3114 and MCL 500.3115 that when an injured person is given the right to recover benefits from a specific insurer, the surviving dependents have the same right of recovery for their losses. *Id.* at 255, 293 N.W.2d 594. Contrary to the dissent's belief, no similar statutory basis exists for recognizing this type of claim on the part of an injured person's healthcare provider. We will not infer a cause of action for healthcare providers when the language of the no-fault act indicates no such desire on the part of the Legislature.

39 We conclude today only that a healthcare provider possesses no statutory right to sue a no-fault insurer. While defendant argues that a provider likewise possesses no contractual right to sue a no-fault insurer given that healthcare providers are incidental rather than intended beneficiaries of a contract between the insured and the insurer, this Court declines to make such a blanket assertion. That determination rests on the specific terms of the contract between the relevant parties. See *Schmalfeldt v. N. Pointe Ins. Co.*, 469 Mich. 422, 428, 670 N.W.2d 651 (2003) ("A person is a third-party beneficiary of a contract only when *that contract* establishes that a promisor has undertaken a promise 'directly' to or for that person.") (citations omitted; emphasis added). This Court need not consider whether plaintiff possesses a contractual right to sue defendant in the instant case because plaintiff did not allege any contractual basis for relief in its complaint.

40 See *Miller v. Citizens Ins. Co.*, 490 Mich. 905, 804 N.W.2d 740 (2011). Moreover, our conclusion today is not intended to alter an insured's ability to assign his or her right to past or presently due benefits to a healthcare provider. See MCL

500.3143; *Professional Rehab Assoc. v. State Farm Mut. Auto. Ins. Co.*, 228 Mich.App. 167, 172, 577 N.W.2d 909 (1998) (noting that only the assignment of future benefits is prohibited by MCL 500.3143).

41 See *Miller*, 490 Mich. at 904, 804 N.W.2d 740.

1 *Merriam–Webster's Collegiate Dictionary* (11th ed.).

2 To the extent that the majority argues that healthcare providers are not entitled to benefits because they do not "incur" charges within the meaning of MCL 500.3107(1)(a), it is incorrect. Healthcare providers clearly become liable for expenses arising out of the treatment of injured persons, expenses that include, among other things, human labor (and associated wages and salaries) and the cost of medical equipment and its operation.

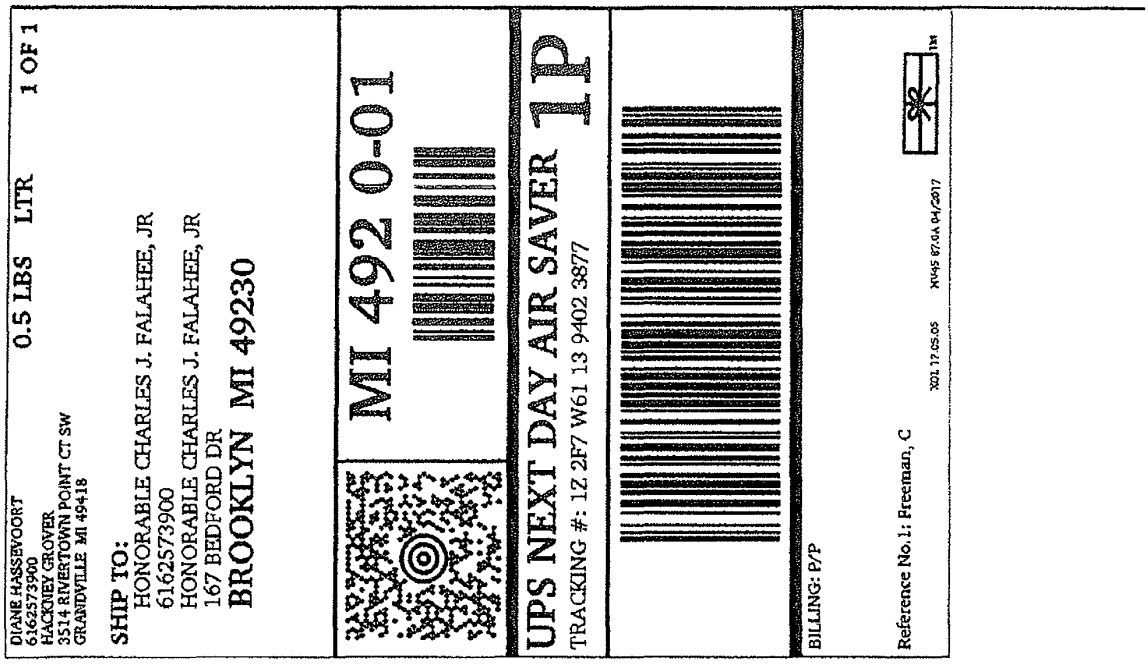
3 It is, of course, interesting that in this settlement agreement defendant demanded indemnification against provider claims that it now insists cannot exist under the no-fault act.

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Approved, SCAO

Original - Court
1st copy - Defendant

2nd copy - Plaintiff
3rd copy - Return

STATE OF MICHIGAN JUDICIAL DISTRICT 7th JUDICIAL CIRCUIT COUNTY PROBATE	SUMMONS AND COMPLAINT	CASE NO. 17 - 106637 - NF

Court address
900 S. Saginaw Street, #204, Flint, MI 48502

JUDITH A. FULLERTON P-20455 Court telephone no.
(810) 257-3220

Plaintiff's name(s), address(es), and telephone no(s).	v	Defendant's name(s), address(es), and telephone no(s).
JAWAD A. SHAH, MD, PC, INTEGRATED HOSPITAL SPECIALISTS, PC, INSIGHT ANESTHESIA, PLLC AND STERLING ANESTHESIA, PLLC (GEORGE HENSLEY)		STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY
Plaintiff's attorney, bar no., address, and telephone no. DAVID KLEIN (P76332) ELIA & PONTO, PLLC 25800 Northwestern Highway, Suite 850 Southfield, MI 48075 (248) 595-8579		

SUMMONS **NOTICE TO THE DEFENDANT**: In the name of the people of the State of Michigan you are notified:

1. You are being sued.
2. **YOU HAVE 21 DAYS** after receiving this summons to **file a written answer with the court** and serve a copy on the other party **or take other lawful action with the court** (28 days if you were served by mail or you were served outside this state). (MCR 2.111[C])
3. If you do not answer or take other action within the time allowed, judgment may be entered against you for the relief demanded in the complaint.

Issued	This summons expires	Court clerk
FEB 24 2017	MAY 26 2017	Stephanie Davis

This summons is invalid unless served on or before its expiration date. This document must be sealed by the seal of the court.

COMPLAINT ***Instruction: The following is information that is required to be in the caption of every complaint and is to be completed by the plaintiff. Actual allegations and the claim for relief must be stated on additional complaint pages and attached to this form.***

☐ This is a business case in which all or part of the action includes a business or commercial dispute under MCL 600.8035.

Family Division Cases

☐ There is no other pending or resolved action within the jurisdiction of the family division of circuit court involving the family or family members of the parties.

☐ An action within the jurisdiction of the family division of the circuit court involving the family or family members of the parties has been previously filed in _____ Court.

The action ☐ remains ☐ is no longer pending. The docket number and the judge assigned to the action are:

Docket no.	Judge	Bar no.

General Civil Cases

☐ There is no other pending or resolved civil action arising out of the same transaction or occurrence as alleged in the complaint.

☑ A civil action between these parties or other parties arising out of the transaction or occurrence alleged in the complaint has been previously filed in Genesee County Circuit Court.

The action ☑ remains ☐ is no longer pending. The docket number and the judge assigned to the action are:

Docket no.	Judge	Bar no.
16-106945-NF	Judith A. Fullerton	

VENUE

Plaintiff(s) residence (include city, township, or village)	Defendant(s) residence (include city, township, or village)
City of Flint, County of Genesee	City of Flint, County of Genesee
Place where action arose or business conducted City of Flint, County of Genesee	

02/22/2017
Date

Signature of attorney/plaintiff

If you require special accommodations to use the court because of a disability or if you require a foreign language interpreter to help you fully participate in court proceedings, please contact the court immediately to make arrangements.

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF GENESEE

17-108637-NF

JAWAD A. SHAH, MD, PC,
INTEGRATED HOSPITAL SPECIALISTS, PC,
INSIGHT ANESTHESIA, PLLC AND
STERLING ANESTHESIA, PLLC
(GEORGE HENSLEY),

Plaintiffs,

vs.

STATE FARM MUTUAL AUTOMOBILE
INSURANCE COMPANY,

Defendant.

CASE NO. 17 -NF
HON. JUDITH A. FULLERTON
P-39488

A TRUE COPY
GENESEE COUNTY CLERK

DAVID KLEIN (P76332)
ELIA & PONTO, PLLC
Attorneys for Plaintiffs
25800 Northwestern Highway, Suite 850
Southfield, MI 48075
(248) 595-8579 / Fax: (248) 595-8729
dklein@eliaandponto.com

There was a previous action against STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY arising out of the same transaction or occurrence as alleged in this Complaint before the Honorable Judith A. Fullerton in the Genesee County Circuit Court, Case No. 16-106945-NF, which is currently pending.

David Klein, Attorney for Plaintiffs

COMPLAINT

NOW COMES Plaintiffs, JAWAD A. SHAH, MD, PC, INTEGRATED HOSPITAL SPECIALISTS, PC, INSIGHT ANESTHESIA, PLLC and STERLING ANESTHESIA, PLLC, (hereafter referred to as "Plaintiffs"), by and through their attorneys, ELIA & PONTO, PLLC, and

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for their Complaint against Defendant, STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, a foreign insurer, (hereafter referred to as "Defendant"), states as follows:

JURISDICTION AND VENUE

1. That Plaintiffs are Michigan corporations licensed to conduct business under the laws of the State of Michigan, and at all times pertinent herein have their principal business location in the County of Genesee, State of Michigan.

2. That Defendant, STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, upon information and belief has been at all times pertinent hereto a foreign insurer conducting business in the State of Michigan, including the County of Genesee.

3. Venue is proper pursuant to MCLA 600.1621, and jurisdiction is proper for the reason that the amount in controversy is more than Twenty-Five Thousand ($25,000.00) Dollars, exclusive of costs and attorneys' fees.

COMMON FACTUAL ALLEGATIONS

4. At all times pertinent hereto, Plaintiffs are in the business of providing medical and related health care services in the State of Michigan.

5. On or about November 30, 2014, GEORGE HENSLEY, suffered accidental bodily injuries arising out of a motor vehicle accident entitling him to No-Fault benefits within the meaning of the Michigan No-Fault Act, MCL 500.3101 *et seq*.

6. STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY is the No-Fault insurer responsible for paying personal injury protection benefits applicable to the injuries GEORGE HENSLEY sustained in the accident, either by way of contract, a copy of which is in Defendant's possession, or by way of statute.

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7. Upon information and belief, at the time of the accident, GEORGE HENSLEY was a policyholder or individual covered under the insurance policy premiums paid of an automobile insurance policy, and thus, an insured of the Defendant.

8. Defendant was promptly notified of the accident, the injuries sustained by GEORGE HENSLEY and the need for medically related care and services for said injuries.

9. A claim number was assigned by the Defendant to the insured's claim for personal injury protection benefits.

10. That from March 10, 2016 through the present time, and possibly in the future, GEORGE HENSLEY has received medical services occasioned by the above-referenced automobile accident from the Plaintiffs.

11. The services Plaintiffs provided were reasonable and necessary for GEORGE HENSLEY's care, recovery or rehabilitation arising from the injuries sustained in the motor vehicle accident.

12. Plaintiffs submitted claims to the Defendant for payment for the services provided to GEORGE HENSLEY which may not include services post the date of the Complaint.

13. A statement of the services provided by Plaintiffs currently totaling in the amount of **$82,070.00** is attached hereto as **Exhibit 1.**

14. Defendant failed, refused and otherwise denied Plaintiffs' claim for payment for the services provided to GEORGE HENSLEY in violation of its statutory and contractual obligations to provide No-Fault benefits.

BREACH OF CONTRACT

15. Plaintiffs restate and reallege all prior paragraphs as though fully stated herein.

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16. Plaintiffs submitted reasonable proof of their entire claim to the Defendant and Defendant failed or refused to pay such claim within 30 days of receipt.

17. Defendant's failure to pay Plaintiffs' personal protection benefits constitutes a material breach of contract.

18. As a direct and proximate cause of Defendant's breach of contract, Plaintiffs have been damaged.

WHEREAS, Plaintiffs, JAWAD A. SHAH, MD, PC, JAWAD A. SHAH, MD, PC, INTEGRATED HOSPITAL SPECIALISTS, PC, INSIGHT ANESTHESIA, PLLC and STERLING ANESTHESIA, PLLC, respectfully request the following relief:

A. Hold that Plaintiffs are medical providers who rendered services for the benefit of GEORGE HENSLEY and are entitled to a direct cause of action for payment of those services under MCLA 500.3112 for personal protection benefits totaling the amount of $82,070.00;

B. Find that Plaintiffs submitted reasonable proof of their entire claim to the Defendant and Defendant failed to pay such claim within 30 days of receipt as required by MCLA 500.3142, therefore rendering such payments overdue and subject to interest under Section 3142 and attorney fees under Section 3148;

C. Award Plaintiffs a judgment against Defendant in the amount of $82,070.00, plus interest on overdue payments in the amount of 12% per annum in accordance with Section 3142, and reasonable attorney fees in addition to the judgment as required by Section 3148;

D. Award Plaintiffs a judgment against Defendant for those services rendered post the date of complaint and are supported by the evidence submitted at trial;

E. Award all costs of this action;

F. Award prejudgment and post judgment interest;

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G. Award such other relief this Court deems just and reasonable.

DECLARATORY JUDGMENT

19. Plaintiffs restate and reallege all prior paragraphs as thought fully stated herein.

20. An actual controversy exists between Plaintiffs and Defendant with respect to rights to payment under the insured's insurance policy and the amount of personal protection benefits owed thereunder.

21. Pursuant to MCR 2.605(1) this Honorable Court may declare the rights and other legal relations of the interested party seeking a declaratory judgment, whether or not other relief could be sought for or granted.

WHEREFORE, Plaintiffs, JAWAD A. SHAH, MD, PC, JAWAD A. SHAH, MD, PC, INTEGRATED HOSPITAL SPECIALISTS, PC, INSIGHT ANESTHESIA, PLLC and STERLING ANESTHESIA, PLLC, bring this action for declaratory judgment to determine the rights of Plaintiffs with respect to receiving payment for medical services provided. After this Court determines that Defendant owes Plaintiffs for said services provided, order Defendant to pay Plaintiffs directly.

RELIEF REQUESTED

WHEREFORE, Plaintiffs, JAWAD A. SHAH, MD, PC, JAWAD A. SHAH, MD, PC, INTEGRATED HOSPITAL SPECIALISTS, PC, INSIGHT ANESTHESIA, PLLC and STERLING ANESTHESIA, PLLC, demand judgment in the total amount of $82,070.00 plus interest and overdue payments in the amount of 12% per annum until paid, MCL 500.3142, judgment interest in the amount allowable by law, and attorney fees pursuant to Michigan's No-Fault Act, MCL 500.3148, none of which are a sum certain at this time or could be made a sum certain by computation at this time.

Respectfully submitted,

ELIA & PONTO, PLLC

By: _____

David Klein (P76332)
Attorney for Plaintiffs
25800 Northwestern Hwy., Suite 850
Southfield, MI 48075
(248) 595-8579 / Fax: (248) 595-8729
dklein@eliaandponto.com

Dated: February 22, 2017

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EXHIBIT 1

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Billing

Jawad A. Shah M.D. P.C. • Insight Pain Management Center
Insight Imaging • Insight Radiologists P.C. • INSIGHT HEALTH & FITNESS CENTER
• INSIGHT HEALING CENTER
•Insight Physical Therapy & Neuro-Rehab Center
• Insight Chiropractic center
4800 S. Saginaw St. • SUITE 1805 Flint, mi 48507-2669 • Tel: (810) 275-9108 • Fax: (810) 213-0263

Name:	HENSLEY, GEORGE
Account No:	23083

Claim No	Date	Description	Charges	Payments	Adjust	WithHeld	Pt Bal	Ins Bal
221695	2/2/2017	Charges (Pr:JAS Fac: CLINIC IHS)	$ 200.00				$ -	$ 200.00
220265	1/26/2017	Charges (Pr:MJP Fac: MRI)	$ 3,965.00				$ -	$ 3,965.00
198346	9/30/2016	Charges (Pr:JAS Fac: CLINIC IHS)	$ 200.00				$ -	$ 200.00
	10/31/2016	STATE FARM AUTO INSURANCE		$ -	$ -	$ -		
180323	6/15/2016	Charges (Pr:AP Fac: PGIHS)	$ 32,620.00				$ -	$ 32,620.00
	7/25/2016	STATE FARM AUTO INSURANCE		$ -	$ -	$ -		
185419	6/15/2016	Charges (Pr:CLR Fac: PGSA)	$ 7,950.00				$ -	$ 7,950.00
180324	6/15/2016	Charges (Pr:JAS Fac: PGIHS)	$ 32,620.00				$ -	$ 32,620.00
	7/25/2016	STATE FARM AUTO INSURANCE		$ -	$ -	$ -		
166063	3/29/2016	Charges (Pr:JAS Fac: CLINIC)	$ 290.00				$ -	$ 290.00
	6/2/2016	STATE FARM AUTO INSURANCE		$ -	$ -	$ -		
163973	3/14/2016	Charges (Pr:MJP Fac: MRI)	$ 4,025.00				$ -	$ 4,025.00
	4/11/2016	STATE FARM AUTO INSURANCE		$ -	$ -	$ -		
163465	3/10/2016	Charges (Pr:JAS Fac: CLINIC)	$ 200.00				$ -	$ 200.00
	4/20/2016	STATE FARM AUTO INSURANCE		$ -	$ -	$ -		
		Total	$82,070.00	$0.00	$0.00	$0.00	$0.00	$82,070.00

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EXHIBIT B

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF GENESEE

JAWAD A. SHAH, MD, PC,
INTEGRATED HOSPITAL SPECIALISTS, PC,
INSIGHT ANESTHESIA, PLLC AND
STERLING ANESTHESIA, PLLC
(GEORGE HENSLEY),

Plaintiffs,

vs.

STATE FARM MUTUAL AUTOMOBILE
INSURANCE COMPANY,

Defendant.

CASE NO. 17-108637-NF
HON. JUDITH A. FULLERTON

/

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/

PLAINTIFFS' RESPONSE TO DEFENDANT'S MOTION FOR SUMMARY DISPOSITION

NOW COMES Plaintiffs, JAWAD A. SHAH, MD, PC, INTEGRATED HOSPITAL SPECIALISTS, PC, INSIGHT ANESTHESIA, PLLC AND STERLING ANESTHESIA, PLLC, by and through their attorneys, ELIA & PONTO, PLLC, and in response to defendant's motion for summary disposition states:

1. Plaintiffs admit.
2. Plaintiff denies, a motion for leave to amend has been filed.
3. Plaintiff denies.

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4. Plaintiff neither admits nor denies but leaves defendant to their proofs.

WHEREFORE, Plaintiffs, JAWAD A. SHAH, MD, PC, INTEGRATED HOSPITAL SPECIALISTS, PC, INSIGHT ANESTHESIA, PLLC AND STERLING ANESTHESIA, PLLC respectfully request this Honorable Court to deny defendant's motion for summary disposition and grant plaintiffs' motion for leave to amend.

Respectfully submitted,

ELIA & PONTO, PLLC

By: _____

David Klein (P76332)
Attorney for Plaintiffs
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Dated: August 7, 2017

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF GENESEE

JAWAD A. SHAH, MD, PC,
INTEGRATED HOSPITAL SPECIALISTS, PC,
INSIGHT ANESTHESIA, PLLC AND
STERLING ANESTHESIA, PLLC
(GEORGE HENSLEY),

Plaintiffs,

vs.

STATE FARM MUTUAL AUTOMOBILE
INSURANCE COMPANY,

Defendant.

CASE NO. 17-108637-NF
HON. JUDITH A. FULLERTON

/

DAVID KLEIN (P76332)
ELIA & PONTO, PLLC
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25800 Northwestern Highway, Suite 850
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/

BRIEF IN OPPOSITION OF DEFENDANT'S MOTION FOR SUMMARY DISPOSITION UNDER MCR 2.116(C)(8)

NOW COMES Plaintiffs, JAWAD A. SHAH, MD, PC, INTEGRATED HOSPITAL SPECIALISTS, PC, INSIGHT ANESTHESIA, PLLC AND STERLING ANESTHESIA, PLLC, by and through their attorneys, ELIA & PONTO, PLLC, and for their Brief in opposition of defendant's motion for summary disposition, hereby relies on the facts stated below, the facts as set forth in their motion for leave to amend, MCR 2.118(A)(2); MCR 2.118(E); *Covenant Medical Center, Inc. v. State Farm Mut. Auto. Ins. Co.*, 2017 Mich. LEXIS 971, 2017 WL 2303337 (Mich. May 25, 2017); *Professional Rehab Associates v. State Farm Mutual Auto. Ins. Co.*, 228 Mich

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App 167, 172; 577 NW2d 909 (1998); *Midura v. Lincoln Consolidated Schools,* 111 Mich App 558, 563; 314 Nw2d 691 (1981); *Mcalla v. Ellis* 129 Mich App 452, 457; 341 NW2d 525 (1983); *Meyer v. Hubbell,* 117 Mich App 699, 705-706; 324 NW2d 139 (1982), *Rubino v. Sterling Heights* 94 Mich App 494, 499-500; 290 NW2d 43 (1979); *Messer v. Floyd Rice Ford, Inc.* 91 Mich App 644, 649-650, 649-650; 284 NW2d 139 (1979); *Labar v. Cooper* 376 Mich. 401, 405; 137 N.W.2d 136 (1965); *Grist v. Upjohn Company* 1 Mich App 72; 134 N.W.2d 358 (1965); the below brief in support, and the exhibits attached hereto.

STATEMENT OF FACTS

That Plaintiffs' complaint was originally filed on February 24, 2017 for medical services provided by Plaintiffs to GEORGE HENSLEY, arising from a Motor Vehicle Accident (MVA) which occurred on or about November 30, 2014. That the *Covenant* decision (properly cited in the attached motion) was decided on **May 25, 2017**. That on July 11, 2017 patient, GEORGE HENSLEY, assigned his rights to Plaintiffs, for pursuit of payment, for his No-Fault Benefits for the treatment and care rendered by Plaintiffs (See attached **EXHIBIT 1**). That plaintiff has filed a motion for leave to amend with the court in light of the *Covenant* decision which would rectify any issue of standing raised by the defendant in this instance.

STANDARD OF REVIEW

Defendant has filed a motion for summary disposition under MCR 2.116(C)(8) which allows for a court to enter summary disposition against a plaintiff who "has failed to state a claim on which relief can be granted. A motion under this rule "is well taken if it is clear from the pleadings alone that the claim does not state a legal basis for recovery." *Wilson v. Acacia Park Cemetery Assoc*, 162 Mich App 638, 642 (1987). When confronted with a motion under MCR

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2.116(C)(8), a court must accept all of the factual allegations supporting the claim as true. *ETT Ambulance Service Corp v. Rockford Ambulance, Inc.*, 204 Mich 392, 395 (1994).

MCR 2.118(A)(2) states in pertinence, "Except as provided in subrule (A)(1) a party may amend a pleading only by leave of the court or by written consent of the adverse party. Leave shall be freely given when justice so requires." This court rule was further examined in the holding of *Welke v. Kuzilla*, 140 Mich. App 658; 365 N.W.2d 205 (1985), for which the court held that the decision to allow an amendment of the complaint is within the discretion of the trial court **(EXHIBIT 2)**. The court went on to hold, however that

> "This discretion is not unlimited. This language [that "leave shall be freely given when justice so requires"] imposes a limitation on the discretion of the court necessitating a finding that justice would not be served by an amendment to pleadings. The allowance of an amendment is not an act of grace, but a right of a litigant who can show that an amendment will not work an injustice on the opposing party" *Id.* at 207 quoting *Midura v. Lincoln Consolidated Schools,* 111 Mich App 558, 563; 314 Nw2d 691 (1981); *Mcalla v. Ellis* 129 Mich App 452, 457; 341 NW2d 525 (1983).

The court went further in this holding, reaffirming the decision in *Meyer v. Hubbell,* 117 Mich App 699, 705-706; 324 NW2d 139 (1982), "Such a motion should be granted absent undue delay, bad faith, a dilatory motive or when an amendment would be futile." They further affirmed once again that, "Mere lateness in moving to amend is an insufficient reason to deny the motion, absent unfair prejudice to the opposing party" *Rubino v. Sterling Heights* 94 Mich App 494, 499-500; 290 NW2d 43 (1979).

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LAW AND ANALYSIS

I. THAT PLAINTIFFS HAVE PROMPTLY FILED A MOTION FOR LEAVE TO AMEND IN LIGHT OF THE COVENANT DECISION AND NO UNDUE DELAY, BAD FAITH OR PREJUDICE CAN BE ALLEGED BY THE DEFENDANT.

The decision in *Welke v. Kulka* to allow amendment of the complaint (to add a malpractice claim) late in the procedural proceedings, clearly shows that extreme leniency should be granted by the court in parties' requests to amend complaints. While discussion regarding insufficient opportunity to obtain discovery was debated by the court, it was held that only in the most extreme circumstances where trial was imminent and prior discovery completed in the case would not contribute to discovery on the claim sought to be added by the amendment, should motions to amend the complaint be denied *Messer v. Floyd Rice Ford, Inc.* 91 Mich App 644, 649-650, 649-650; 284 NW2d 139 (1979). This is clearly not the case in this factual circumstance, the previous discovery conducted would allow defendant sufficient information in order to prepare a defense. Furthermore, the amended portion of the complaint will add an assignment of rights count, which will simply support the previously alleged breach of contract allegations submitted in the Plaintiffs' original complaint. Plaintiffs have promptly filed their motion in light of the recent *Covenant* decision as well as obtaining an assignment of rights from patient, GEORGE HENSLEY. Defendant is able to conduct discovery as to the requested amended portion of the complaint and cannot raise any issue of undue delay, bad faith, or prejudice, and therefore the court should grant Plaintiffs' request.

II. THE MOMENT THE ASSIGNMENT OF RIGHTS WAS OBTAINED, PLAINTIFFS ORIGINALLY FILED NO-FAULT CLAIM WAS VIABLE.

Plaintiffs at the time they filed this complaint on February 24, 2017, in accordance with the relevant and applicable case law had an independent right of action to bring against Defendant

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for breach of contract. Following the holding of *Covenant* (as more thoroughly explained in intervening plaintiff's motion to amend), it was determined statutorily that medical providers had no right of direct cause of action (as was previously upheld by the Court of Appeals), however this did not affect the providers ability to obtain the rights of patients through assignment. Which as detailed in plaintiffs' motion to amend which is set for hearing the same day as this disposition hearing, said assignment was obtained from the patient in this case. While plaintiffs filed this motion to amend their complaint in order to clarify the previous allegations, it is plaintiffs' contention that the original No-Fault claim which was filed in this matter, was applicable the moment that the patient's assignment was obtained. The patient by assigning his rights to the medical providers, has provided a basis to support the previous claim of damages arising from the MVA, for medical treatment rendered (now that the independent statutory right for direct action has been extinguished by the Supreme Court), which is the basis of plaintiffs' claims against Defendant.

Plaintiffs in this instance have filed a motion to amend, due to the uncertainty that exists in the court system following *Covenant*, and to ensure that there was no claim of undue delay or prejudice to the Defendant, for plaintiff not properly pleading their complaint. While Defendant may claim there is a lack of standing in this matter, defendant relies on ten plus years of Appellate case law which upheld plaintiff's position, and at the time of plaintiff's original complaint, plaintiff maintained standing to file the lawsuit. Furthermore, it is plaintiffs' contention that the assignment supports the originally filed No-Fault claim, and the amendment is for clarification of previous plead allegations. Plaintiffs' motion to amend, should be freely granted as no prejudice or undue delay has occurred.

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III. IF GEORGE HENSLEY IS NOT A NAMED INSURED THE NON TRANSFER LANGUAGE IS NOT APPLICABLE PURSUANT TO *SHELTON V. AUTO-OWNERS INS. CO.*

If this honorable court does interpret the contractual provisions contained within Defendant's policy to prevent assignment, Defendant must show that GEORGE HENSLEY is a named insured and therefore is privy to the contractual exclusions contained within the policy. In the appellate court's recent decision in *Shelton v. Auto-Owners Ins. Co., 2017* Mich. App. LEXIS 242 (Mich. Ct. App. Feb. 14, 2017), it was held that exclusionary provisions in insurance companies no-fault policies do not apply to parties for whom have not contracted with said insurer (See attached case law, **EXHIBIT 3**). In the factual circumstances before the court in *Shelton*, the party whom had filed the complaint against Auto Owners Insurance Company was not the person to whom the no-fault policy was issued, but rather a passenger in the insured vehicle for which the action was brought statutorily in accordance with the priority chain. The court held that the *Bahri* fraud exclusion which was being raised by the Defendant, was therefore not applicable to Shelton, as he "was not a party to, nor an insured under, the policy" *Id.* at 3. Plaintiffs in this instance are not aware of whether GEORGE HENSLEY is a named insured or not to Defendant's contract. However, it is clear in the recent holding of *Shelton* that if he is not named within the policy, the contractual exclusion does not apply, and Defendant's claim of anti-assignment is not applicable.

IV. THE EXCLUSIONARY LANGUAGE WITHIN THE POLICY IS NOT ENFORCEABLE AS IT IS AGAINST PUBLIC POLICY IN ACCORDANCE WITH BINDING CASE LAW

The exclusionary language within the Defendant policy, if viewed by this court as prohibiting assignment of the benefits under the policy, should be voidable when viewed in the context of the standing case law in Michigan. While Defendant is correct, that Michigan law recognizes the

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validity of contractual provisions against assignment of contract, (see the holding of *Employers Mutual Liab Ins Co v Mich Mut Auto Ins Co*, 101 Mich App 697, 702, 300 NW2d 682 (1980), where an assignment in violation of an anti-assignment clause voided coverage under the policy), this holding was only as to **an assignment that had occurred prior to the loss**. However, it was specifically held by the Supreme Court in *Roger Williams Ins Co v Carrignton*, 43 Mich 252, 5 NW 303 (1880), that an anti-assignment clause in an insurance contract is not enforceable **where the assignment occurs after the loss**, as the claim under the policy is viewed no differently than any other assignment of an accrued cause of action. In the factual circumstances of *Roger Williams* an action was brought by an assignee of a policy of insurance for damage sustained in a fire to horses and livery property. The insurance policy maintained anti-assignment language which voided the policy if assigned. The insurance policy was assigned to Carrington, following the occurrence of the fire, and the court held that,

> "The assignment having been made after the loss did not require consent of the company. The provision of the policy forfeiting it for an assignment without the company's consent is invalid, so far as it applies to the transfer of an **accrued cause of action**. It is the absolute right of every person - secured in this State by statute - to assign such claims, and such a right cannot be thus prevented. It cannot concern the debtor, and it is against public policy" *Id.* at 304.
> (See attached case law, **EXHIBIT 4)**

This holding was further interpreted by the United States District Court for the Western District of Michigan in *Action Auto Stores, Inc v United Capitol Ins Co*, 845 F Supp 417, 423 (WD Mich 1993) (**EXHIBIT 5**). In their holding the Federal Court interpreted Michigan Law regarding anti-assignment provisions. Specifically they stated,

> "Plaintiff also cites Section 792 of Volume 43 of *American Jurisprudence*, Second Edition, for the proposition that such general stipulations prohibiting assignment without the insurer's consent apply only to assignments before loss and not against assignment after loss. The cited paragraph notes that **a provision against assignment after loss is null and void as inconsistent with the covenant of**

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> **indemnity and contrary to public policy**. 43 Am. Jur. 2d Insurance Section 792 (1982)....Because the clause at issue is itself ambiguous and because there is strong public policy in favor of assignment of such contract rights, the **court holds that paragraph F of the "Common Policy Conditions" prohibits only transfer and assignment of a right prior to loss and does not prohibit assignment of an accrued cause of action**. Plaintiff's motion for summary disposition is granted to the extent that it asks that the court find that the defense of assignment of the insurance policy does not bar coverage." *Id.* at 422-423.

In *Wonsey v Life Ins Co of N Am*, 32 F Supp 2d 939 (1998), the court referred to the "modern trend" regarding contractual prohibitions on assignments and noted:

> "As the latest Restatement makes clear, the modern trend with respect to **contractual prohibitions on assignments is to interpret these clauses narrowly, as barring only the delegation of duties, and not necessarily as precluding the assignment of rights from assignor to assignee**. The rationale behind these cases is derived from the implicit recognition that the obligor, the party obligated to perform, would not suffer any harm by a mere assignment of payments under a contract. Harm to obligor would result, however, in cases involving personal services contracts or other situations where the duties owed to the parties may change depending on the identity of the assignee. *Id.* at 943.

In *Marion v. Vaughn*, 12 Mich. App 453, 463 (1968), the court held that, "there is considerable body of authority favoring the view that a matured debt is freely assignable even though a restriction literally provides otherwise..." Additionally, this case, cited the relevant and prevailing case law of *Roger Williams Ins Co v Carrington*, stating that, "Provisions prohibiting assignment of rights under insurance policies have been held not to prevent assignment of the insured's claim against the insurer after the loss." *Id.* at 463.

Viewed in the context of the applicable case law in *Roger Williams Ins Co v Carrington*, and the Federal Court support that anti-assignment clauses are not applicable in circumstances where an assignment is obtained following a loss, it is clear that the anti-assignment language is voidable against public policy as written in the defendant's policy. It is clear that the loss, in the present circumstances occurred on November 30, 2014 when GEORGE HENSLEY was involved

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in a motor vehicle accident for which injuries were sustained. As a result of said loss, medical treatment was (and may continue to be) rendered by plaintiffs for which bills have been submitted to the Defendant. Mr. Hensley on July 11, 2017, following the loss, and the accrual of medical benefits, assigned his rights for payment of the medical treatment rendered by plaintiffs. It is clear that he assigned an accrued cause of action (unpaid bills for medical services rendered) following an actual loss, and will continue to do so in the future. Given this fact pattern, it stands to reason that the applicable case law, thereby would void the anti-assignment language contained within the Defendant's policy provision, and as such the assignment of rights to pursue this action should qualify the plaintiff to amend their complaint.

V. PLAINTIFFS SOUGHT AMENDMENT TO THEIR COMPLAINT SHOULD RELATE BACK TO THE ORIGINAL DATE OF FILING IN THIS INSTANCE.

Defendant may argue that if allowed, intervening plaintiff's amended complaint would be considered a supplemental pleading and therefore would be barred by the statute of limitations. As noted in MCR 2.118(D) Relation Back of Amendment: "An amendment that adds a claim or defense relates back to the date of the original pleading if the claim or defense asserted arose out of the conduct, transaction or occurrence set forth, or attempted to be set forth, in the original pleading." The Supreme court discussed in *Labar v. Cooper* 376 Mich. 401, 405; 137 N.W.2d 136 (1965); when interpreting GCR 118.1 and 118.4 (which were adopted almost verbatim as MCR 2.118(A)(1)&(2) and MCR 2.118(D) respectively) the purpose of the relation back amendment:

> "GCR 1963, 118 is an adoption of Federal Rule 15. The purpose of its adoption is stated by Honigman and Hawkins, 1 Michigan Court Rules Annotated, page 416: "The relationship between the original pleading and a proposed amendment becomes important when the date of filing the amendment raises a question of limitations. The doctrine of "relation back" was devised by the courts to associate the amended matter with the date of the original pleading, so that it would not be barred by the statute of limitations."

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It was discussed in further detail,

> Sub rule 118.4 [which is now MCR 2.118(D)] is intended to introduce a more liberal and workable test, borrowed from the Federal Rules...The test is no longer conceptual but rather functional. **The amendment relates back to the date of the original pleading and, therefore, is not barred by limitations, whenever the claim or defense asserted in the amendment arose out of the conduct, transaction or occurrence set forth or attempted to be set forth in the original pleading.** ***It is thus beside the point that the amendment introduces new facts, a new theory, or even a different cause of action, so long as it springs from the same transactional setting as that pleaded originally.*** The new test satisfies the basic policy of the statute of limitations, because the transactional base of the claim must still be pleaded before the statute runs, thereby giving defendant notice within the statutory period that he must be prepared to defend against all claims for relief arising out of that transaction." (See attached case law, **EXHIBIT 6**).

The circumstances clearly point in this instance to allowing the amendment of the complaint to relate back to the original amendment. In this case, plaintiffs are supporting their right of action from the previously alleged breach of No-fault Act claim that arose from injuries sustained in the MVA on November 30, 2014 (**the transaction or occurrence for which gave rise to this lawsuit being said MVA). Distinguishable from the facts in *Grist v. Upjohn Company* 1 Mich App 72; 134 N.W.2d 358 (1965), where the court held that claims of additional instances of slander [separate transactions or occurrences from the original claim of slander] were considered "supplemental pleadings" and therefore did not relate back to the original date of filing (See attached case law, **EXHIBIT 7**), in this factual circumstance, there is no new transaction or occurrence (additional MVA). The amended complaint seeks to support the previously filed No-Fault claim, and therefore should be related back to the original date of filing in this instance.

VI. PLAINTIFFS HEREIN RELY ON AND ADOPT THE ARGUMENTS CONTAINED IN THE HONORABLE NANCI GRANT OF THE 6TH CIRCUIT COURT OF THE COUNTY OF OAKLAND WRITTEN OPINION AS TO THE VALIDITY OF ASSIGNMENTS

Plaintiff further attaches and adopts the arguments contained within the order and opinion written by the Honorable Nanci Grant of the 6th Circuit County of Oakland as persuasive

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precedence, as she was faced with the identical issue as arises in this situation (See attached opinion **EXHIBIT 8**).

WHEREFORE, Plaintiffs respectfully request this Honorable Court denying defendant's motion for summary disposition and allowing Plaintiffs to Amend Their Complaint as assignments were obtained in accordance with the Supreme Court decision in *Covenant*

Respectfully submitted,

ELIA & PONTO, PLLC

By: _____

David Klein (P76332)
Attorney for Plaintiffs
25800 Northwestern Hwy., Suite 850
Southfield, MI 48075
(248) 595-8579 / Fax: (248) 595-8729
dklein@eliaandponto.com

Dated: August 7, 2017

PROOF OF SERVICE

The undersigned certifies that a copy of the foregoing instrument was served upon all parties to the above cause to each of the attorneys of record herein at their respective addresses disclosed on the pleadings on August 8 2017 by U.S. Mail.

Debra Gatto

Debra Gatto

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EXHIBIT 1

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MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF RIGHTS FORM

I, George K. Hensley, ("Assignor"), hereby assign to **(Jawad A Shah MD PC)**
(Print Patient's Name)

("Assignee") all rights, privileges and remedies to payment for health care services, products or accommodations ("Services") provided by Assignee to Assignor to which Assignor is or may be entitled under MCL 500.3101, *et seq*, the No Fault Act. This Assignment is for the right to payment of Assignee's charges, only, and not for the right to payment of any other No Fault insurance benefits.

The Assignment as set forth above is for all services already provided to Assignor by Assignee prior to or at the time of Assignor's execution of this agreement. Specifically, this Assignment **does not** include an Assignment of any future No Fault benefits.

Assignor hereby certifies that Assignor has incurred charges for services provided by Assignee for which the rights, privileges and remedies for payment are hereby assigned.

Assignor hereby certifies its understanding that while Assignee may, pursuant to this Assignment, pursue payment from a person or entity other than Assignor, this agreement may be revoked by Assignee upon a determination by it, or if a determination is made pursuant to judicial or quasi-judicial proceedings, that Assignor lacks Michigan No Fault ("PIP" or "Personal Injury Protection") coverage or that the services subject to this Assignment are not payable pursuant to any such coverage for any reason under MCL 500.3101, *et seq*, The No Fault Act, any applicable policy of insurance, and/or due to any actions or conduct of Assignor.

As consideration for the Assignment hereby granted, Assignor accepts Assignee's assumption of the burden and/or cost of pursuit of payment from any person or entity from whom payment for the above referenced services is or might be owed under MCL 500.3101, *et seq*, The No Fault Act. This Assignment is not revocable by Assignor so long as Assignee's performance as described in this paragraph is underway.

Assignor understands that should Assignor contract with or retain his/her own counsel to seek his/her own No Fault benefits, that counsel shall have no right to pursue payment of these assigned benefits nor shall counsel be entitled to any payment of an attorney fee from the services provided by Assignee.

Assignor and Assignee agree that in the event any terms or provisions of this agreement are declared invalid or unenforceable by any Court or Federal or State Government Agency having jurisdiction over the subject matter of this agreement, the remaining terms and provisions that are not affected thereby shall remain in full force and effect.

George K. Hensley
(Print Name of Patient or Legal Guardian)

George K. Hensley
(Signature of Patient or Legal Guardian)

7-11-17
(Date of Signature)

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MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF RIGHTS FORM

I, GEORGE L. HENSLEY ("Assignor"), hereby assign to **(Integrated Hospital**
(Print Patient's Name)
Specialists PC)

("Assignee") all rights, privileges and remedies to payment for health care services, products or accommodations ("Services") provided by Assignee to Assignor to which Assignor is or may be entitled under MCL 500.3101, *et seq*, the No Fault Act. This Assignment is for the right to payment of Assignee's charges, only, and not for the right to payment of any other No Fault insurance benefits.

The Assignment as set forth above is for all services already provided to Assignor by Assignee prior to or at the time of Assignor's execution of this agreement. Specifically, this Assignment **does not** include an Assignment of any future No Fault benefits.

Assignor hereby certifies that Assignor has incurred charges for services provided by Assignee for which the rights, privileges and remedies for payment are hereby assigned.

Assignor hereby certifies its understanding that while Assignee may, pursuant to this Assignment, pursue payment from a person or entity other than Assignor, this agreement may be revoked by Assignee upon a determination by it, or if a determination is made pursuant to judicial or quasi-judicial proceedings, that Assignor lacks Michigan No Fault ("PIP" or "Personal Injury Protection") coverage or that the services subject to this Assignment are not payable pursuant to any such coverage for any reason under MCL 500.3101, *et seq*, The No Fault Act, any applicable policy of insurance, and/or due to any actions or conduct of Assignor.

As consideration for the Assignment hereby granted, Assignor accepts Assignee's assumption of the burden and/or cost of pursuit of payment from any person or entity from whom payment for the above referenced services is or might be owed under MCL 500.3101, *et seq*, The No Fault Act. This Assignment is not revocable by Assignor so long as Assignee's performance as described in this paragraph is underway.

Assignor understands that should Assignor contract with or retain his/her own counsel to seek his/her own No Fault benefits, that counsel shall have no right to pursue payment of these assigned benefits nor shall counsel be entitled to any payment of an attorney fee from the services provided by Assignee.

Assignor and Assignee agree that in the event any terms or provisions of this agreement are declared invalid or unenforceable by any Court or Federal or State Government Agency having jurisdiction over the subject matter of this agreement, the remaining terms and provisions that are not affected thereby shall remain in full force and effect.

GEORGE L. HENSLEY
(Print Name of Patient or Legal Guardian)

George L. Hensley
(Signature of Patient or Legal Guardian)

7-11-17
(Date of Signature)

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MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF RIGHTS FORM

I, George L. Hensley, ("Assignor"), hereby assign to **(Insight Radiologists PC)**
(Print Patient's Name)

("Assignee") all rights, privileges and remedies to payment for health care services, products or accommodations ("Services") provided by Assignee to Assignor to which Assignor is or may be entitled under MCL 500.3101, *et seq*, the No Fault Act. This Assignment is for the right to payment of Assignee's charges, only, and not for the right to payment of any other No Fault insurance benefits.

The Assignment as set forth above is for all services already provided to Assignor by Assignee prior to or at the time of Assignor's execution of this agreement. Specifically, this Assignment **does not** include an Assignment of any future No Fault benefits.

Assignor hereby certifies that Assignor has incurred charges for services provided by Assignee for which the rights, privileges and remedies for payment are hereby assigned.

Assignor hereby certifies its understanding that while Assignee may, pursuant to this Assignment, pursue payment from a person or entity other than Assignor, this agreement may be revoked by Assignee upon a determination by it, or if a determination is made pursuant to judicial or quasi-judicial proceedings, that Assignor lacks Michigan No Fault ("PIP" or "Personal Injury Protection") coverage or that the services subject to this Assignment are not payable pursuant to any such coverage for any reason under MCL 500.3101, *et seq*, The No Fault Act, any applicable policy of insurance, and/or due to any actions or conduct of Assignor.

As consideration for the Assignment hereby granted, Assignor accepts Assignee's assumption of the burden and/or cost of pursuit of payment from any person or entity from whom payment for the above referenced services is or might be owed under MCL 500.3101, *et seq*, The No Fault Act. This Assignment is not revocable by Assignor so long as Assignee's performance as described in this paragraph is underway.

Assignor understands that should Assignor contract with or retain his/her own counsel to seek his/her own No Fault benefits, that counsel shall have no right to pursue payment of these assigned benefits nor shall counsel be entitled to any payment of an attorney fee from the services provided by Assignee.

Assignor and Assignee agree that in the event any terms or provisions of this agreement are declared invalid or unenforceable by any Court or Federal or State Government Agency having jurisdiction over the subject matter of this agreement, the remaining terms and provisions that are not affected thereby shall remain in full force and effect.

George L. Hensley
(Print Name of Patient or Legal Guardian)

George L. Hensley
(Signature of Patient or Legal Guardian)

7-11-17
(Date of Signature)

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MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF RIGHTS FORM

I, George L. Hensley ("Assignor"), hereby assign to **(Precision Surgical Associates)**
(Print Patient's Name)

("Assignee") all rights, privileges and remedies to payment for health care services, products or accommodations ("Services") provided by Assignee to Assignor to which Assignor is or may be entitled under MCL 500.3101, *et seq*, the No Fault Act. This Assignment is for the right to payment of Assignee's charges, only, and not for the right to payment of any other No Fault insurance benefits.

The Assignment as set forth above is for all services already provided to Assignor by Assignee prior to or at the time of Assignor's execution of this agreement. Specifically, this Assignment **does not** include an Assignment of any future No Fault benefits.

Assignor hereby certifies that Assignor has incurred charges for services provided by Assignee for which the rights, privileges and remedies for payment are hereby assigned.

Assignor hereby certifies its understanding that while Assignee may, pursuant to this Assignment, pursue payment from a person or entity other than Assignor, this agreement may be revoked by Assignee upon a determination by it, or if a determination is made pursuant to judicial or quasi-judicial proceedings, that Assignor lacks Michigan No Fault ("PIP" or "Personal Injury Protection") coverage or that the services subject to this Assignment are not payable pursuant to any such coverage for any reason under MCL 500.3101, *et seq*, The No Fault Act, any applicable policy of insurance, and/or due to any actions or conduct of Assignor.

As consideration for the Assignment hereby granted, Assignor accepts Assignee's assumption of the burden and/or cost of pursuit of payment from any person or entity from whom payment for the above referenced services is or might be owed under MCL 500.3101, *et seq*, The No Fault Act. This Assignment is not revocable by Assignor so long as Assignee's performance as described in this paragraph is underway.

Assignor understands that should Assignor contract with or retain his/her own counsel to seek his/her own No Fault benefits, that counsel shall have no right to pursue payment of these assigned benefits nor shall counsel be entitled to any payment of an attorney fee from the services provided by Assignee.

Assignor and Assignee agree that in the event any terms or provisions of this agreement are declared invalid or unenforceable by any Court or Federal or State Government Agency having jurisdiction over the subject matter of this agreement, the remaining terms and provisions that are not affected thereby shall remain in full force and effect.

George L. Hensley
(Print Name of Patient or Legal Guardian)

George L. Hensley
(Signature of Patient or Legal Guardian)

7-16-19
(Date of Signature)

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EXHIBIT 2

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Questioned
As of: June 1, 2017 5:26 PM Z

Welke v. Kuzilla

Court of Appeals of Michigan

November 13, 1984, Submitted ; February 6, 1985, Decided

Docket No. 75515

Reporter
140 Mich. App. 658 *; 365 N.W.2d 205 **; 1985 Mich. App. LEXIS 2454 ***

ROBERT J. WELKE, personal Representative of the Estate of JUDITH L. WELKE, Deceased, Plaintiff-Appellant, v. SHARLYN MARGARET KUZILLA, a/k/a SHARLYN MARGARET LYONS, and BRADFORD G. CAPPER, D.O., Defendants-Appellees

Subsequent History: Later proceeding at *Welke v. Kuzilla, 144 Mich. App. 245, 375 N.W.2d 403, 1985 Mich. App. LEXIS 2808 (1985)*

Leave to appeal denied by *Welke v. Kuzilla, 424 Mich. 861, 1985 Mich. LEXIS 1962 (1985)*

Disposition: [***1] Affirmed.

Core Terms

discovery, trial court, malpractice, amend, patient, medical malpractice, decedent, motion to amend, denial of motion, psychiatrist, malpractice action, physician-patient, malpractice claim, circumstances, foreseeable, special relationship, endangered, motion for leave, opposing party, no duty, identifiable, requires, argues, futile, insure, plaintiff's claim, reasonable care, instant case, preparation, deposition

Case Summary

Procedural Posture
Plaintiff husband appealed an order of the trial court (Michigan), which denied plaintiff's motion for leave to amend his wrongful death compliant against defendant driver after plaintiff's wife was killed in an auto accident with defendant, to add a medical malpractice count against defendant doctor who was treating defendant driver with medication. Plaintiff contended that lack of time for discovery was an invalid reason for the denial.

Overview
Plaintiff husband filed a wrongful death action against defendant driver after plaintiff's wife was killed in an automobile accident with defendant. Defendant doctor owned the car that defendant driver was operating, and plaintiff later filed a motion for leave to amend the compliant to add a medical malpractice count against defendant doctor because he was treating defendant driver with medication at the time of the accident and failed to prevent her from driving. The trial court made arrangements for plaintiff to file a separate complaint against defendant doctor, which plaintiff did, and denied the motion to consolidate the actions because there was not sufficient time left to conduct discovery. Plaintiff appealed and contended that the trial court abused its discretion and that the little time left for discovery was not a sufficient reason for denial. The court affirmed and held that the trial court did not abuse its discretion because adding a medical malpractice count was adding an entirely different theory and defendant would not have time to prepare. Since plaintiff was able to file a separate malpractice action, neither party was prejudiced.

Jacob Bryant

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Outcome

The court affirmed an order which denied plaintiff husband's motion for leave to amend his wrongful death complaint against defendant driver after plaintiff's wife was killed in an auto accident with defendant, to add a medical malpractice action count against defendant doctor who was treating driver with medication because additional time consuming discovery would have been necessary and plaintiff was able to file a separate action.

LexisNexis® Headnotes

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Leave of Court

Governments > Courts > Judges

HN1[] GCR 1963, 118.1, permits a party to amend its pleading by leave of court which shall be freely given when justice so requires. While the decision to grant or deny leave is within the discretion of the trial court, the decision will not be reversed absent an abuse of discretion. This discretion is not unlimited. This language that leave shall be freely given when justice so requires imposes a limitation on the discretion of the court necessitating a finding that justice would not be served by an amendment to pleadings. The allowance of an amendment is not an act of grace, but a right of a litigant who can show that an amendment will not work an injustice on the opposing party.

Counsel: *Chambers, Steiner, Mazur, Ornstein & Amlin, P.C.* (by *Courtney E. Morgan, Jr.*, and *Angela J. Nicita*), for plaintiff.

Highland & Currier, P.C. (by *John N. Highland*), for Bradford G. Capper, D.O.

Judges: H. Hood, P.J., and S. J. Bronson and R. L. Tahvonen, * JJ. R. L. Tahvonen, J., concurred. Bronson, J. *(dissenting)*.

Opinion by: HOOD

Opinion

[*662] [206]** Plaintiff appeals as of right from the trial court's order denying his motion for leave to amend his complaint to add a medical malpractice count against defendant Dr. Bradford G. Capper.

[*663] On October 13, 1981, plaintiff filed this wrongful death action against defendant Sharlyn Kuzilla alleging that she negligently caused the death of plaintiff's decedent and wife Judith Welke in an automobile crash occurring September 11, 1981. Defendant Dr. Capper owned the automobile driven by defendant Kuzilla. On August 30, 1983, plaintiff filed a motion for leave to amend to add several new tort theories and allegations of damages including a medical malpractice count against Dr. Capper.

In his proposed amended complaint **[***2]** regarding the medical malpractice count, plaintiff alleged that Dr. Capper was defendant Kuzilla's treating physician prior to the accident. As such, Dr. Capper allegedly had a duty to protect the public and, in particular, plaintiff's decedent from any imminent foreseeable danger posed by defendant Kuzilla. Dr. Capper allegedly breached this duty by prescribing many controlled substances to defendant Kuzilla without warning her of the drugs' effects on her driving ability and by allowing her to drive his motor vehicle while she was under the influence of the drugs.

* Circuit judge, sitting on the Court of Appeals by assignment.

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On September 9, 1983, the trial court heard arguments regarding the motion to amend the complaint limited to adding only the medical malpractice count because the period of limitations on that action was about to run. Defendant's argument that amending to add a medical malpractice count a few months short of the discovery cut-off date (WCCR 301.3[c]) and so soon before mediation and trial would prejudice defendant convinced the court to deny the motion. Nevertheless, the trial court did not deny the motion to amend the complaint to add the medical malpractice count until it ascertained that plaintiff could still [***3] timely file a separate medical malpractice action against Dr. [*664] Capper. The trial court made arrangements for plaintiff to file the complaint on the date of hearing despite the fact that the clerk's office was officially closed. Plaintiff did file the separate action on September 9, 1983.

In a subsequent order, the trial court granted plaintiff's remaining motion for leave to amend the complaint. However, the trial court denied plaintiff's motion to consolidate the medical malpractice action with this case. On March 15, 1984, the trial court ordered defendant's motion for summary judgment in the medical malpractice action granted stating that plaintiff failed to state a claim, GCR 1963, 117.2(1), because this state does not recognize a third-party cause of action based upon a physician-patient relationship. Plaintiff also filed a separate claim of appeal from that order. (Docket No. 77810).

Plaintiff argues in this appeal that the trial court abused its discretion by denying his motion for leave to amend the complaint to add a medical malpractice count. Plaintiff argues that the little time left for discovery was not a sufficient reason alone to find the necessary [***4] prejudice to defendant to deny the motion. Plaintiff argues that defendant was already fully aware of the facts underlying the action.

Defendant argues that the trial court did not abuse its discretion because adding a medical malpractice claim would require Dr. Capper's medical malpractice insurer to become involved and, most certainly, new counsel. Trial would have to be delayed to allow additional discovery, particularly deposition of expert witnesses. The original complaint did not act as notice to Dr. Capper's malpractice carrier that it would need to prepare a defense despite the commonality of underlying facts. Defendant also argues, even though the trial [*665] court did not decide the motion for this reason, that plaintiff's amendment would have been futile.

HN1[↑] GCR 1963, 118.1 permits a party to amend its pleading by leave of court which "shall be freely given when justice so requires". While the decision to grant or [**207] deny leave is within the discretion of the trial court, the decision will not be reversed absent an abuse of discretion. *McCalla v Ellis, 129 Mich App 452, 457; 341 NW2d 525 (1983)*. This discretion is not unlimited.

"'This language [that [***5] "leave shall be freely given when justice so requires"] imposes a limitation on the discretion of the court necessitating a finding that justice would not be served by an amendment to pleadings. The allowance of an amendment is not an act of grace, but a right of a litigant who can show that an amendment will not work an injustice on the opposing party.' *Midura v Lincoln Consolidated Schools, 111 Mich App 558, 563; 314 NW2d 691 (1981)*." *McCalla, supra, p 457*.

Such a motion should be granted absent undue delay, bad faith, a dilatory motive or when an amendment would be futile. *Meyer v Hubbell, 117 Mich App 699, 705-706; 324 NW2d 139 (1982)*. Mere lateness in moving to amend is an insufficient reason to deny the motion, absent unfair prejudice to the opposing party. *Rubino v Sterling Heights, 94 Mich App 494, 499-500; 290 NW2d 43 (1979)*.

In this case, the trial court was faced with an uncomfortable dilemma. Although plaintiff's motion to amend came late in the proceedings, a few months of discovery time was still available to defendant. However, the trial court recognized that adding a medical malpractice count was adding an entirely different theory of which defendant [***6] would not previously have had notice and, therefore, time to prepare. Defendant's medical malpractice [*666] insurer would need to be notified and new counsel would probably be retained. Discovery would undoubtedly need to be extended by order. Even though plaintiff stated that he was willing to agree to an extension of discovery, the trial court could not guarantee that the Chief Judge of the Wayne County Circuit Court would grant such an extension. See WCCR 301.3(g)(1).

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We find that because prejudice to defendant was possible, the trial court did not abuse its discretion by denying the motion for leave to amend to add the medical malpractice count. Nevertheless, we do so *only* given the special circumstances of this case, *i.e.*, that the trial court compromised the interests of both parties by denying the motion but facilitated plaintiff's filing of the medical malpractice action in a timely manner. By ruling in this manner, the trial court furthered the spirit of GCR 1963, 118.1, not by granting the motion for leave to amend, but by helping plaintiff preserve the cause of action he desired to add to the complaint. Thus, neither plaintiff nor defendant were ultimately [***7] prejudiced.

Because we affirm on the grounds given by the trial court, we need not address defendant's argument that, alternatively, the trial court could have denied plaintiff's motion because his medical malpractice claim would have been futile. We do, however, refer defendant to this Court's recent decision in *Duvall v Goldin, 139 Mich App 342, 362 NW2d 275 (1984)*.

Affirmed.

Dissent by: BRONSON

Dissent

Bronson, J. *(dissenting)*.

Plaintiff appeals from an order denying his motion for leave to amend his complaint to add a claim of medical malpractice [*667] against the defendant doctor. The majority holds that, due to possible prejudice to defendant, the motion to amend was properly denied. I cannot agree with the majority's determination, and, therefore, I respectfully dissent for the reasons stated herein.

On October 13, 1981, plaintiff, Robert J. Welke, filed this action as the personal representative of his wife's estate. The initial complaint alleged that the decedent, Judith Welke, was killed due to injuries sustained when a vehicle owned by defendant Bradford Capper, D.O., and driven by defendant Sharlyn Kuzilla crossed the center line resulting in a head-on collision [***8] with the vehicle operated by the decedent. Defendant Kuzilla is not a party to this appeal.

[**208] On November 5, 1982, a substitution of attorneys was filed and plaintiff's current counsel made their appearance. On December 1, 1982, the first deposition was taken in this matter, that of the defendant driver.

On January 26, 1983, the deposition of defendant Dr. Capper was partially taken, but has not yet been completed. On May 11, 1983, the deposition of the investigating police officer was taken. The husband of the defendant driver was deposed on June 30, 1983.

During the course of these discovery depositions there was testimony that defendant Dr. Capper had prescribed several drugs for defendant Kuzilla over a period of several months prior to the fatal accident. These drugs included pain pills, muscle relaxants, diet pills and Valium.

There was also testimony that on the evening prior to the accident in question, defendant Dr. Capper injected defendant Kuzilla with some substance and perhaps dispensed other drugs to her.

On August 30, 1983, plaintiff filed a motion for [*668] leave to amend his complaint. In his proposed amended complaint, plaintiff sought to [***9] add a malpractice claim against Dr. Capper. The proposed amended complaint alleged that defendant Capper breached the standard of care for his profession by prescribing controlled substances for other than lawful medical purposes, by failing to warn his patient of the dangers of operating a vehicle while under the influence of controlled substances, by allowing his patient, defendant Kuzilla, to operate a motor vehicle when he knew that she was under the influence of controlled substances, and by placing his patient in a position which threatened the health and safety of the public.

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Oral argument on plaintiff's motion was heard on September 9, 1983, before the Honorable Paul S. Teranes of the Wayne County Circuit Court. Judge Teranes was sitting as a substitute because the judge who had been assigned to the case for pretrial matters was unavailable. Plaintiff's motion to amend was denied because the lower court felt that the amendment was sought too late. Discovery was to be cut off on December 13, 1983, and the court felt that this would not permit sufficient time for defendant Capper to conduct discovery on the malpractice claim.

When his motion to amend was denied, plaintiff [***10] filed a new action against defendant Capper on September 9, 1983. This second complaint included a malpractice claim. On September 27, 1983, plaintiff filed a motion to consolidate the September, 1983, action with the instant case. This motion was denied without prejudice on November 18, 1983. Defendant then filed a motion for summary judgment in the September, 1983, action arguing that plaintiff's malpractice action failed to state a claim upon which relief could be granted. Defendant's motion was granted in March, 1984. In [*669] December, 1983, defendant Kuzilla filed a separate malpractice action against defendant Capper, seeking, *inter alia*, damages for emotional distress caused her by the death of Mrs. Welke, and blaming the fatal crash on the fact that Dr. Capper gave her illicit substances causing her to lose control of the vehicle. The instant appeal, however, involves only Judge Teranes' denial of plaintiff's motion to amend his original complaint to include a count of malpractice against Dr. Capper.

I

Plaintiff contends that the trial court abused its discretion in denying his motion to amend his complaint. The decision to grant or deny an amendment is [***11] one within the discretion of the trial court. *Rubino v Sterling Heights, 94 Mich App 494; 290 NW2d 43 (1979)*; *McCalla v Ellis, 129 Mich App 452; 341 NW2d 525 (1983)*. Due to the mandate of GCR 1963, 118.1, however, the trial judge's discretion to grant or deny leave to amend pleadings is not unlimited. *Ben P Fyke & Sons v Gunter Co, 390 Mich 649, 656-657; 213 NW2d 134 (1973)*; *Rubino, supra, p 499*; *Midura v Lincoln Consolidated Schools, 111 Mich App 558, 562-563; 314 NW2d 691 [**209] (1981)*; *McCalla, supra, p 457*. As this Court explained in *Midura, supra, pp 562-563*:

"The discretion invested in trial judges under the standard 'leave shall be freely given when justice so requires' is not boundless. This language imposes a limitation on the discretion of the court necessitating a finding that justice would not be served by an amendment to pleadings. The allowance of an amendment is not an act of grace, but a right of a litigant who can show that an amendment will not work an injustice on the opposing party. *Fyke & Sons, supra, 659*."

Absent some specific finding of injustice to the [*670] opposing party, amendment should be granted as [***12] a matter of right.

In *Fyke & Sons, supra*, the Michigan Supreme Court indicated several factors which should be examined by a judge in determining whether an injustice would result if amendment was granted. *Id., p 656*. In *Fyke*, the Court made clear that a delay in seeking amendment, without a finding of bad faith or actual prejudice caused by delay, will not justify denial of a motion to amend. *Id., pp 663-664*.

The trial court in this case denied plaintiff's motion to amend because it believed that plaintiff sought to amend his complaint "too late". The judge was concerned that the defendant doctor would have insufficient time to complete necessary discovery on the malpractice claim within the three months remaining prior to the cut-off date for discovery. From the record, this appears to have been the trial court's only reason for denying the motion to amend.

The fact that there is little time left for discovery is not sufficient reason in and of itself to deny amendment. This is particularly true where it is possible to extend discovery. *Rubino, supra, p 500*.

"Mere lateness in moving to amend is an insufficient reason to deny the motion, absent unfair [***13] prejudice to the opposing party. *Spartan Asphalt Paving Co v Grand Ledge Mobile Home Park, 71 Mich App 177, 247 NW2d 589 (1976)*. In the instant case, defendant is not prejudiced by the addition to the complaint of the counts of nuisance and breach of contract. Discovery is not precluded merely because a pretrial conference has occurred.

Jacob Bryant

GCR 1963, 301.7 permits the court to order subsequent discovery 'on written notice for good cause shown'. Nor does sufficient prejudice exist because the added counts involve complex legal and factual issues." Id., p 500.

[*671] Plaintiff's counsel agreed to an extension of the discovery period to permit defendant Capper the opportunity to do any necessary discovery and obtain any necessary expert witnesses, thereby eliminating any possible prejudice to defendant resulting from the amendment. Further, at the time of the hearing on plaintiff's motion to amend, there were still seven months remaining before trial.

While this Court has upheld the denial of a motion to amend on the ground that there is insufficient opportunity for the opposing party to obtain discovery, it has done so only under the extreme circumstances where trial [***14] is imminent and prior discovery completed in the case will contribute nothing to discovery on the claim sought to be added by amendment. Messer v Floyd Rice Ford, Inc, 91 Mich App 644, 649-650; 284 NW2d 139 (1979), rev'd on other grounds 407 Mich 962; 288 NW2d 352 (1980). Such is not true of the case at bar. The trial court failed to make any inquiry into the discovery which had been conducted in the case. However, the factual circumstances which have been the subject of discovery thus far are the same factual circumstances which underlie the proposed malpractice claim.

The result of the trial court's decision to deny amendment is that plaintiff filed a second action, thus placing two cases on the court's docket involving substantially the same factual circumstances. An additional set of discovery proceedings, mediation [**210] and trial were added to the trial court's already crowded docket when discovery in the original action could have simply been extended to accommodate the new claim.

In the absence of any actual prejudice to defendant, the trial court must allow plaintiff leave to amend his complaint. I would therefore instruct [*672] the trial court to [***15] allow the amendment, extending the time of discovery to accommodate the amendment and eliminate any possible prejudice to defendant. Rubino, supra.

II

Defendant contends that, even absent prejudice, the motion to amend was properly denied because amendment would have been futile. Futility is a recognized reason to deny leave to amend only if the complaint is "legally insufficient on its face". Fyke & Sons, supra, p 660. Defendant alleges that a cause of action in malpractice cannot exist in the case at bar because there is no physician-patient relationship between the plaintiff's decedent and defendant doctor. Defendant argues that, in the absence of a doctor-patient relationship, there was no duty owed to plaintiff's decedent and such an action will not lie. While it is undisputed that plaintiff's decedent and Dr. Capper were not in a direct patient-physician relationship, neither is it disputed that Dr. Capper and Sharlyn Kuzilla did have such a relationship.

In a negligence action, whether for medical malpractice or any other personal injury action based upon negligence, the question of whether a duty exists is one of law for the court's resolution. Elbert v Saginaw [***16], 363 Mich 463; 109 NW2d 879 (1961); 57 Am Jur 2d, Negligence, § 34, p 381.

"Duty" comprehends whether the defendant is under any obligation to the plaintiff to avoid negligent conduct. It does not include, where there is an obligation, the nature of the obligation and the standard of care. Moning v Alfono, 400 Mich 425, 437; 254 NW2d 759 (1977).

"It is better to reserve 'duty' for the problem of the [*673] relation between individuals which imposes upon one a legal obligation for the benefit of the other, and to deal with particular conduct in terms of a legal standard of what is required to meet the obligation. In other words, 'duty' is a question of whether the defendant is under any obligation for the benefit of the particular plaintiff; and in negligence cases, the duty is always the same, to conform to the legal standard of reasonable conduct in the light of the apparent risk. What the defendant must do, or must not do, is a question of the standard of conduct required to satisfy the duty. The distinction is one of convenience only, and it must be remembered that the two are correlative, and one cannot exist without the other." Prosser, Torts (4th ed), § 53, [***17] p 324.

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Generally, there is no duty to control the conduct of a third person to prevent him or her from causing harm to another absent a special relationship between the actor and the third person which imposes a duty upon the actor to control the third person's conduct. 2 Restatement Torts, 2d, § 315(a), p 122; Davis v Lhim, 124 Mich App 291, 299; 335 NW2d 481 (1983).

In the effort to resolve the question of whether the defendant doctor owed a duty of care to plaintiff's decedent, we are guided by decisions of this state and decisions from other jurisdictions which have considered the issue of liability to a third party. Courts in Michigan have recognized under a variety of factual circumstances that a third party may have a claim grounded in negligence against a defendant based upon the defendant's relationship with another party. See, *e.g.*, Moning, supra (manufacturer, wholesaler, and retailer of manufactured product owe a legal obligation of due care to a bystander affected by the use of the product); Clark v Dalman, 379 Mich 251; 150 NW2d 755 (1967) (general contractor owed a duty in general not to endanger employees of the subcontractor or inspectors or anyone [***18] else lawfully on the project [*674] site); Davis, supra (psychiatrist owes a duty of reasonable care to persons who are readily identifiable as [**211] foreseeably endangered by his patient); Romeo v Van Otterloo, 117 Mich App 333; 323 NW2d 693 (1982) (employer may owe duty to third party to supervise the activity of his employee); Duvall v Goldin, 139 Mich App 342; 362 NW2d 275 (1984) (doctor owed duty of reasonable care to protect the driving public where doctor's negligence in diagnosis or treatment of patient contributes to plaintiff's injuries). *Contra*, see, Friedman v Dozorc, 412 Mich 1; 312 NW2d 585 (1981) (attorney owes no duty of care to an adverse party in litigation).

In Davis, supra, p 305, relying on Tarasoff v Regents of University of California, 17 Cal 3d 425; 131 Cal Rptr 14; 551 P2d 334 (1976), this Court held that a psychiatrist does owe a professional duty of care to those who could foreseeably be injured by his patient.

"[When] a psychiatrist determines or, pursuant to the standard of care of his profession, should determine that his patient poses a serious danger of violence to a readily identifiable person, the psychiatrist [***19] has a duty to use reasonable care to protect that individual against such danger."

This Court's imposition of a duty on psychiatrists in Davis, supra, was based upon the physician-patient relationship and general tort law principles.

"Under the common law, no one owes any duty to protect an individual who is endangered by a third person *unless* he has *some special relationship* with either the dangerous person or the potential victim. Tarasoff, supra, p 435. See, *e.g.*, American States Ins Co v Albin, 116 Mich App 201, 206; 324 NW2d 574 (1982). [*675] *The California court found that a psychiatrist has such a 'special relationship' to his patient.* Consequently, the court held that, under certain circumstances, a psychiatrist owes a duty to use reasonable care to protect persons endangered by his patient.

"Michigan case law supports the *Tarasoff* holding. 'Duty' is one of six elements of an action for negligence. Moning v Alfono, 400 Mich 425, 437; 254 NW2d 759 (1977). Moreover, 'in negligence cases, the duty is always the same, to conform to the legal standard of reasonable conduct in light of the apparent risk'. Prosser, Torts (4th ed), § 53, [***20] p 324, cited in Moning v Alfono, supra, p 437." Davis, supra, pp 299-300. (Emphasis added.)

Although *Tarasoff* did not expressly limit the scope of duty to identifiable victims, *Davis* stated that the duty of the psychiatrist is limited to only those persons readily identifiable as foreseeably endangered. *Davis*, p 303. The Court noted that, under Michigan law, once a duty is imposed, that duty is owed to any person within the scope of foreseeable risk. In the case of a psychiatrist's duty to persons endangered by his or her patient, however, the Court held that a narrower scope of duty was required for reasons of public policy. Id., p 304.

In *Duvall*, this Court recently extended *Davis* to uphold a negligence claim against a physician based upon allegations similar to those presented in the instant case. The Court reasoned that while *Davis* was factually limited to readily identifiable persons, *Davis* does not preclude recognizing a "special relationship" between the doctor and

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patient, and therefore the imposition of a duty in a broader context. See, 2 Restatement Torts, 2d, § 315, p 122. The Court, therefore, held that:

"[Defendant] [***21] did in fact have a special relationship with his patient, the so-called 'dangerous person', which [*676] we believe is sufficient to place this case within the exception to the common-law rule that no one has a duty to protect an individual who is endangered by the conduct of another. Where the actor stands in a special relationship with *either* the third-party victim or the person causing the injury, a duty of reasonable care may arise." Duvall, supra, [**212] pp 350-351. (Emphasis in original.)

Implicit in *Duvall* is a recognition that *Davis* fashioned an exception to the general foreseeability rule in holding that a psychiatrist only has a duty to readily identifiable persons threatened by his or her patient.

Duvall is in accord with the opinions of courts in other jurisdictions which have examined this issue. Davis v Mangelsdorf, 138 Ariz 207; 673 P2d 951 (Ariz App, 1983); Gooden v Tips, 651 SW2d 364 (Tex App, 1983); Wharton Transport Corp v Bridges, 606 SW2d 521 (Tenn, 1980); Watkins v United States, 589 F2d 214 (CA 5, 1979); Freese v Lemmon, 210 NW2d 576 (Iowa, 1973); Kaiser v Suburban Transportation System, 65 Wash 2d [***22] 461; 398 P2d 14 (1965).

I would hold, therefore, that defendant Dr. Capper owed a duty to plaintiff's decedent, an innocent driver within the scope of foreseeable risk, by virtue of his special relationship with Sharlyn Kuzilla.

III

Having found that defendant owed a duty to plaintiff's decedent, it is necessary to return to defendant's original argument that a doctor owes no duty and that an action for malpractice cannot stand in the absence of a physician-patient relationship. In Duvall, supra, p 358, the Court circumvented this issue by finding that plaintiff's action was not founded upon medical malpractice. The [*677] Court did, however, find a duty based upon general principles of negligence law. Of the cases from other jurisdictions which have addressed this issue, only two courts addressed the duty issue directly. Gooden v Tips, supra; Davis v Mangelsdorf, supra. The remaining courts dealt with this issue in terms of foreseeability of the injury and proximate causation, Watkins v United States, supra, or merely assumed the existence of a duty owed. Wharton Transport Corp v Bridges, supra; Kaiser v Suburban Transportation System, supra; Freese v Lemmon, [***23] supra. Although each court recognized, either explicitly or implicitly, that the doctor owed a duty to the plaintiff, no court to my knowledge has directly addressed the issue of whether a case such as the one at bar may sound in malpractice in the absence of a direct physician-patient relationship between the defendant doctor and the plaintiff's decedent. I would hold that, for reasons of logical consistency and public policy, plaintiff's claim is properly considered as one sounding in medical malpractice.

To hold, as defendant urges, that plaintiff's proposed amendment is futile because it alleges malpractice as opposed to negligence, would be to elevate form over substance. In order for plaintiff to prove his claim against defendant, whether under negligence or malpractice, it is necessary for plaintiff to demonstrate: 1) the existence of a physician-patient relationship between defendant doctor and the third person who was a cause-in-fact of plaintiff's injury; 2) the breach of the applicable standard of care required by the doctor in the treatment of his or her patient. The applicable standard of care requires the physician to exercise that degree of skill, care and diligence [***24] exercised by members of the same profession, practicing in the same or a similar locality, in light of the present [*678] state of medical science. Kambas v St Joseph's Mercy Hospital of Detroit, Michigan, 389 Mich 249, 254-255; 205 NW2d 431 (1973). Duvall, supra, pp 350-352; Kaiser, supra, p 464; Watkins, supra, p 217; Gooden, *surpa*, pp 369-370; see generally, Wharton Transport Corp, supra, pp 526-527; Freese, supra p 579. In Michigan, the testimony of experts is required to establish that a doctor has breached the standard of care required. Marchlewicz v Stanton, 50 Mich App 344, 347; 213 NW2d 317 (1973); and 3) that the negligent treatment of the patient was a proximate cause of plaintiff's injury. Duvall, supra, p 352; Gooden, supra, pp 369-370; Watkins, supra, p 219.

[**213] It is clear that a prerequisite to plaintiff's claim is the proving of malpractice in the doctor's treatment of his or her patient. Without demonstrating malpractice in the doctor-patient relationship, plaintiff will not be able to show

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proximate causation. Thus, although plaintiff's decedent and the defendant doctor are not in a direct doctor-patient [***25] relationship, the necessity of plaintiff's proving that the doctor's malpractice was a proximate cause of plaintiff's decedent's injury requires us to treat plaintiff's claim as one sounding in malpractice.

Defendant relies on Rogers v Horvath, 65 Mich App 644; 237 NW2d 595 (1975), in arguing that there is no duty owed to plaintiff's decedent in the absence of a patient-physician relationship. In *Rogers*, plaintiff was examined by the defendant doctor in preparation for the doctor's testimony before a workers' compensation referee. Subsequent to the examination, the doctor testified that plaintiff was not injured and was a malingerer. This Court upheld the dismissal of plaintiff's malpractice claim, holding:

[*679] "The examination of plaintiff was performed on behalf of her employer in preparation for testifying before the workmen's compensation referee, and it was not performed for the plaintiff's benefit to diagnose or treat an ailment. The trial court was correct in ruling that plaintiff had no cause of action for malpractice.

"The term 'malpractice' denotes a breach of the duty owed by one in rendering professional services to a person who has contracted for [***26] such services; in physician-malpractice cases, the duty owed by the physician arises from the physician-patient relationship. No such relationship existed in the case at bar. Defendant was employed by General Motors to examine one of its employees in preparation for a workmen's compensation hearing. Plaintiff did not employ the defendant, nor did she seek or receive medical advice or treatment. Under such circumstances, the defendant did not owe plaintiff any duty arising from a physician-patient relationship. This is not to say that a physician who examines a person for reasons other than diagnosis or treatment and for the benefit of some one other than the examinee owes no duty of due care to that person. Rather, we hold that the physician in such a case does not owe such a duty of care as will subject him to liability for malpractice." (Footnotes omitted.) Rogers, supra, pp 646-647.

Of critical importance to our holding in *Rogers* was our finding that plaintiff's claim did not rest upon a patient-physician relationship, either directly or, as in the instant case, derivatively and as a prerequisite to plaintiff's claim. Unlike *Rogers*, however, the instant case [***27] requires a finding of malpractice in a direct physician-patient relationship between the defendant doctor and the injured patient.

Of further importance to my holding are the policy concerns regarding the imposition of liability on doctors in a case such as the one at bar. As stated in Duvall, supra, we do not intend to make physicians highway accident insurers. I do believe, [*680] however, that liability is properly imposed where a doctor's malpractice is the proximate cause of a plaintiff's injuries. An important consideration in the willingness of courts to impose malpractice liability on doctors is the ability of the defendants to pass on to the general public, through malpractice insurance and individual billings, the inevitable damages resulting from their activities, or at least to distribute them over a relatively large group. See, Prosser, *Palsgraf Revisited*, 52 Mich L Rev 1, 30-32 (1953). In the typical malpractice action, the doctor is able to insure against the risk of liability through the required malpractice insurance. By characterizing the instant action as one in malpractice, the risk of liability now imposed upon the defendant is already insured [***28] against through his malpractice insurance in effect. It would be anomalous to impose liability on a doctor for injuries arising out of his treatment of a patient, and to require the doctor to insure against this risk of liability separately [**214] and distinctly from the risk imposed under traditional malpractice actions.

I would reverse the trial court's denial of plaintiff's motion to amend and instruct the court to extend the time of discovery to accommodate the amendment and eliminate any possible prejudice to defendant.

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EXHIBIT 3

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Shelton v. Auto-Owners Ins. Co.

Court of Appeals of Michigan

February 14, 2017, Decided

No. 328473

Reporter
2017 Mich. App. LEXIS 242 *; 2017 WL 603591

TYANN SHELTON, Plaintiff-Appellee, and DWAYNE WILLIAMS, Plaintiff, and MICHIGAN CRNAS STAFFING, LLC, Intervening Plaintiff, v AUTO-OWNERS INSURANCE COMPANY, Defendant-Appellant.

Notice: THIS OPINION IS UNCORRECTED AND SUBJECT TO REVISION BEFORE PUBLICATION IN THE MICHIGAN COURT OF APPEALS REPORTS.

Prior History: [*1] Wayne Circuit Court. LC No. 13-010612-NF.

Shelton v. Auto-Owners Ins. Co., 2015 Mich. App. LEXIS 2533 (Mich. Ct. App., Dec. 21, 2015)

Core Terms

insurer, benefits, no-fault, fraudulent, services, replacement, photographs, insurance policy, trial court, occurrence, coverage, summary disposition, question of fact, claimant, applies, argues, investigative report, deposition, lifting, spouse, shirt

Case Summary

Overview
HOLDINGS: [1]-The exclusionary provision in the insurer's no-fault policy did not apply to the passenger and could not operate to bar her claim; [2]-The appellate court found that the photographs and investigator's reports were insufficient to establish beyond a question of fact that the passenger committed fraud despite the testimony, medical reports, and affidavits that supported the passenger's claim of injury and need for medical care and assistance; [3]-The types of inconsistencies found with the passenger's statements were not sufficient to establish the elements of fraud beyond a question of fact; [4]-The wrongful conduct doctrine did not apply.

Outcome
Judgment affirmed.

LexisNexis® Headnotes

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

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HN1[] Personal injury protection benefits are mandated by statute under the no-fault act, MCL 500.3105, and, therefore, the statute is the rule book for deciding the issues involved in questions regarding awarding those benefits. On the other hand, the insurance policy itself is the contract between the insurer and the insured.

Governments > Legislation > Interpretation

HN2[] The primary rule of statutory construction is that, where the statutory language is clear and unambiguous, the statute must be applied as written. Additionally, the primary task in construing a statute is to discern and give effect to the intent of the Legislature. A court must give effect to every word, phrase, and clause and avoid a construction that would render any part of the statute surplusage or nugatory.

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

HN3[] Under Subsection 1 of the no-fault priority statute, a personal protection insurance policy applies to the person named in the policy, the person's spouse, and a relative of either domiciled in the same household, MCL 500.3114(1).

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

HN4[] MCL 500.3114(4) does not state that the owner or operator's insurance policy "applies" to the passenger's claim for benefits, and its text, unlike that of Subsection (1), omits any mention of a personal protection insurance policy, instead providing that the injured person is to claim personal protection insurance benefits from insurers, beginning with the insurer of the owner or registrant of the vehicle occupied.

Insurance Law > Claim, Contract & Practice Issues > Policy Cancellation, Denial & Nonrenewal > Material Misrepresentations

Insurance Law > Remedies > Costs & Attorney Fees > Unreasonable & Vexatious Actions

HN5[] As always, if an insurer concludes that a claim is fraudulent, it may deny the claim. Should the claimant then file suit, the burden is on the claimant to prove that he is entitled to his claimed benefits, a burden that is highly unlikely to be met if the factfinder concludes that the claim is fraudulent. And insurers can obtain attorney fees for having to litigate any claims that are determined to be fraudulent. MCL 500.3148.

Insurance Law > Claim, Contract & Practice Issues > Policy Interpretation > Exclusions

Insurance Law > ... > Procedure > Evidence & Trial > Burdens of Proof

Insurance Law > Claim, Contract & Practice Issues > Policy Cancellation, Denial & Nonrenewal > Material Misrepresentations

HN6[] Reliance on an exclusionary clause in an insurance policy is an affirmative defense and so defendant has the burden of proof. An insurance company has the burden to prove that one of the policy's exclusions applies. Thus, to obtain summary disposition the insurer must show that there is no question of material fact as to any of the elements of its affirmative defense. The elements, as set forth in Bahri, are as follows: To void a policy because the insured has wilfully misrepresented a material fact, an insurer must show that (1) the misrepresentation was material, (2) that it was false, (3) that the insured knew that it was false at the time it was made or that it was made recklessly, without any knowledge of its truth, and (4) that the insured made the material misrepresentation with the

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intention that the insurer would act upon it. A statement is material if it is reasonably relevant to the insurer's investigation of a claim.

Civil Procedure > Appeals > Standards of Review > De Novo Review

Civil Procedure > Appeals > Summary Judgment Review > Standards of Review

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Genuine Disputes

HN7[] The appellate court reviews de novo motions for summary disposition under *MCR 2.116(C)(10)*. In doing so, it is required to view the affidavits, pleadings, depositions, admissions, and other documentary evidence in the light most favorable to the nonmovant. Similarly, all reasonable inferences must be drawn in favor of the nonmovant. Summary disposition is only appropriate under *MCR 2.116(C)(10)* when there is no genuine issue with respect to any material fact and the moving party is entitled to judgment as a matter of law. A genuine issue of material fact exists when the record, giving the benefit of reasonable doubt to the opposing party, leaves open an issue upon which reasonable minds could differ.

Civil Procedure > Appeals > Appellate Briefs

HN8[] Reply briefs must be confined to rebuttal, and a party may not raise new or additional arguments in its reply brief.

Torts > ... > Elements > Causation > Causation in Fact

HN9[] The wrongful conduct rule applies to activities or behavior that occur prior to, and are causative of, the injury.

Counsel: For TYANN SHELTON, Plaintiff-Appellee: STEVEN A. HICKS.

For DWAYNE WILLIAMS, Plaintiff: TIMOTHY P. LUXON.

For AUTO-OWNERS INSURANCE COMPANY, Defendant-Appellant: CHRISTOPHER P. ENDRES.

Judges: Before: K. F. KELLY, P.J., and GLEICHER and SHAPIRO, JJ. K. F. KELLY, P.J. (concurring).

Opinion by: Douglas B. Shapiro

Opinion

SHAPIRO, J.

In this No-Fault personal injury protection (PIP) case, defendant sought summary disposition based upon a fraud exclusion clause in its policy. Defendant asserted that plaintiff made fraudulent statements concerning her need for replacement services and so was excluded by the policy from all PIP benefits. The trial court granted summary

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disposition as to replacement services, a ruling from which plaintiff has not appealed.[1] The trial court denied the motion as to payment for medical services and from that ruling, defendant appeals by leave granted.[2] We affirm.

Shelton alleges she was injured in a single-car collision on January 22, 2013. The vehicle was owned and operated by Timothy Williams; Shelton was a passenger. She sought PIP benefits from defendant because she did not own a vehicle nor reside with a relative who did. [*2] Thus, defendant, as Williams's insurer, was to provide her with those PIP benefits to which she was entitled under the No-Fault Act. MCL 500.3114(4)(a). Plaintiff claimed PIP benefits that included medical expenses and replacement services for household chores, beginning in January 2013.[3] Defendant denied the claim and plaintiff brought suit.

Defendant moved for summary disposition asserting that plaintiff was not entitled to PIP benefits under an exclusionary clause in the policy reading:

> We will not cover any person seeking coverage under this policy who has made fraudulent statements or engaged in fraudulent conduct with respect to procurement of this policy or to any **OCCURRENCE** for which coverage is sought.

Defendant argues that this policy exclusion applies to plaintiff despite the fact that she is not a policyholder, and that the evidence demonstrates beyond a question of fact that plaintiff engaged in fraud as defined in the policy. Defendant relies largely on Bahri v IDS Prop Cas Ins Co, 308 Mich App 420, 423-426; 864 NW2d 609 (2014), in which we held that a fraud provision in an insurance contract could bar a claim for PIP benefits when the policyholder filed a claim for replacement services for a date prior to the subject accident. However, both the law and the facts [*3] of this case differ substantially from those that existed in Bahri.

The law governing application of the policy exclusion in *Bahri* is not applicable in this case. In *Bahri*, the provision applied to the plaintiff in that case because "defendant issued [the subject] no-fault automobile policy to [the] plaintiff." Bahri, 308 Mich App at 421. In this case, however, plaintiff was not a party to, nor an insured under, the policy; she was injured while a passenger and because neither she nor her spouse or resident relative had a no-fault policy, defendant was required to pay her benefits pursuant to statute, not pursuant to a contractual agreement.

The Michigan Supreme Court stated in Rohlmanv Hawkeye Security, 442 Mich 520, 524-525; 502 NW2d 310 (1993), that

> HN1[↑] "PIP benefits are mandated by statute under the no-fault act, MCL 500.3105; MSA 24.13105, and, therefore, the statute is the 'rule book' for deciding the issues involved in questions regarding awarding those

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[1] The record does not make clear the basis for the dismissal of the replacement services claim. Defendant asserts that the trial court's decision implies that the court made a finding of fraud, and plaintiff argues the decision was based on a lack of proofs for the replacement services claim. Defendant refers us to the trial courts remark during the hearing that she "[doesn't] like people misrepresenting the truth." However, the court also stated that after a review of the plaintiff's deposition she could not conclude that plaintiff lied. And in making its ruling, the trial court did not cite or discuss the elements of fraud, make findings regarding those elements, or even use the word "fraud." Neither party asked the court to clarify its ruling or to make a finding of fraud. Because the dismissal of the replacement services claim has not been appealed we need not address it further.

[2] Shelton v. Auto-Owners Ins. Co., unpublished order of the Court of Appeals, entered December 21, 2015 (Docket No. 328473), 2015 Mich. App. LEXIS 2533.

[3] Before the trial court, defendant also argued that plaintiff fraudulently misrepresented her preaccident history by failing to disclose that she made a PIP claim following a 2005 accident. The trial court rejected the argument regarding the prior auto accident noting that plaintiff's statement about the 2005 accident could have simply been a mistake or a failure of memory and that "it really becomes an issue for the jury to decide whether or not she's credible." Defendant has not argued on appeal that the trial court erred in its ruling as to the 2005 claim. Moreover, the materials submitted by defendant with its brief on appeal relevant to the 2005 claim are not in the lower court record and were stricken, with consent, at oral argument.

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> benefits. On the other hand, the insurance policy itself . . . is the contract between the insurer and the insured . . . ."

The Supreme Court adhered to this principle in *Harris v Auto Club Ins Ass'n, 494 Mich 462, 471-472; 835 NW2d 356 (2013)*, a case involving a motorcycle-automobile collision, *MCL 500.3114(5)(a)*, using language paralleling the language used in *MCL 500.3114(4)(a)*, provided that if the injured motorcyclist, his spouse or a resident [*4] relative did not have a no-fault policy then his no-fault benefits would be paid by the insurer of the owner or registrant of the automobile. In *Harris*, the Court stated that plaintiff could not take advantage of the uncoordinated medical benefit provision in the policy because his claim did not flow from the subject policy, but "solely by statute." *Harris, 494 Mich at 472* The Court held that:

> [The plaintiff] is not claiming benefits under a no-fault insurance policy that he or anyone else procured. [He] is neither a third-party beneficiary nor a subrogee of the no-fault policy issued to the person that struck him and thus he [was] not eligible to receive benefits under that policy. Rather, [the plaintiff's] right to PIP benefits arises solely by statute. [*Id.*]

Defendant's argument is directly contrary to the grounds for the holdings in both *Rohlman* and *Harris*. Here, as in those cases, plaintiff's no-fault benefits are governed "solely by statute." Thus, the exclusionary provision in defendant's no-fault policy does not apply to plaintiff and cannot operate to bar plaintiff's claim.

This is also consistent with the text of the relevant statutes. *HN2*[↑] "The primary rule of statutory construction is that, where the [*5] statutory language is clear and unambiguous, the statute must be applied as written." *Cruz v State Farm Mut Auto Ins Co, 466 Mich 588, 594; 648 NW2d 591 (2002)*. Additionally, the "primary task in construing a statute is to discern and give effect to the intent of the Legislature." *Farmers Ins Exch v Farm Bureau Gen Ins Co, 272 Mich App 106, 111; 724 NW2d 485 (2006)* (citation and quotations omitted). "[A] court must give effect to every word, phrase, and clause and avoid a construction that would render any part of the statute surplusage or nugatory." *Id.*

HN3[↑] Under Subsection 1 of the no-fault priority statute, "a personal protection insurance policy . . . *applies* to the person named in the policy, the person's spouse, and a relative of either domiciled in the same household." *MCL 500.3114(1)* (emphasis added). Plaintiff is not an individual named in defendant's policy, a person named in the policy's spouse, or a relative of either the person named in defendant's policy or his spouse. Therefore, pursuant to the statute, defendant's policy does not "apply" to plaintiff. Rather, plaintiff received no-fault benefits pursuant to Subsection 4, which reads:

> Except as provided in *subsections (1) to (3)*, a person suffering accidental bodily injury arising from a motor vehicle accident while an occupant of a motor vehicle shall claim personal protection insurance benefits from insurers in [*6] the following order of priority:
> (a) The insurer of the owner or registrant of the vehicle occupied.
>
> (b) The insurer of the operator of the vehicle occupied. [*MCL 500.3114(4)*.]

HN4[↑] *Subsection (4)* does not state that the owner or operator's insurance policy "applies" to the passenger's claim for benefits, and its text, unlike that of *Subsection (1)*, omits any mention of a personal protection insurance *policy*, instead providing that the injured person is to "claim personal protection insurance benefits from insurers," beginning with "[t]he insurer of the owner or registrant of the vehicle occupied." *MCL 500.3114(4)(a)*.

Defendant argues that as a matter of public policy we should depart from the statute because if we do not, no-fault insurers will lose the ability to deny fraudulent no-fault claims. This argument is meritless.*HN5*[↑] As always, if an insurer concludes that a claim is fraudulent, it may deny the claim.[4] Should the claimant then file suit, the burden is

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[4] This Court has long held that insurers should be afforded an opportunity to review claims for lack of coverage, excessiveness, and fraud. *Advocacy Org for Patients & Providers v Auto Club Ins Ass'n, 257 Mich App 365, 378; 670 NW2d 569 (2003)*.

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on the claimant to prove that he is entitled to his claimed benefits, a burden that is highly unlikely to be met if the factfinder concludes that the claim is fraudulent.[5] And insurers can obtain attorney fees for having to litigate any claims that are determined to be fraudulent. MCL 500.3148.

This case also presents [*7] very different facts than did *Bahri*.[6] In *Bahri*, the insurer presented unrebutted evidence (a) that plaintiff claimed replacement services benefits for three weeks *before the auto accident even occurred*; and (b) that over a period of seven weeks she repeatedly engaged in a wide range of chores on the days for which she claimed that someone else did them for her. 308 Mich App at 425-426. In this case, it is clear that a questions of fact exist as to whether plaintiff made material misrepresentations and, if so, whether they were made with the intent to defraud defendant.

HN6[↑] Reliance on an exclusionary clause in an insurance policy is an affirmative defense and so defendant has the burden of proof. An "insurance company has the burden to prove that one of the policy's exclusions applies." Auto Owners Ins Co v Seils, 310 Mich App 132, 146; 871 NW2d 530 (2015). Thus, to obtain summary disposition the insurer must show that there is no question of material fact as to any of the elements of its affirmative defense. The elements, as set forth [*8] in *Bahri*, are as follows:

> "To void a policy because the insured has wilfully misrepresented a material fact, an insurer must show that (1) the misrepresentation was material, (2) that it was false, (3) that the insured knew that it was false at the time it was made or that it was made recklessly, without any knowledge of its truth, and (4) that the insured made the material misrepresentation with the intention that the insurer would act upon it. A statement is material if it is reasonably relevant to the insurer's investigation of a claim. [Mina v Gen Star Indemnity Co, 218 Mich App 678, 686; 555 NW2d 1 (1996), rev'd in part on other grounds *455 Mich. 866, 568 N.W.2d 80 (1997)* (citation omitted).]" [Bahri, 308 Mich App at 424-25.]

HN7[↑] We review de novo motions for summary disposition under *MCR 2.116(C)(10)*. Dressel v Ameribank, 468 Mich 557, 561; 664 NW2d 151 (2003). In doing so, we are required to view the affidavits, pleadings, depositions, admissions, and other documentary evidence in the light most favorable to the nonmovant. Liparoto Constr, Inc v

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[5] MCL 500.3107(1), subsections (a), (b) and (c), respectively require plaintiff to prove: that the medical expenses were "reasonable charges incurred for reasonably necessary [medical care]," that the costs for replacement services were "reasonably incurred in obtaining ordinary and necessary services," and that plaintiff has lost "income from work [he or she] would have performed during the first 3 years from the date of the accident if he or she would not have been injured."

[6] We note that the policy language in the instant case differs significantly from that in Bahri, 308 Mich App at 424-425. In *Bahri*, the exclusion read: "We do not provide coverage for any insured who has made fraudulent statements or engaged in fraudulent conduct in connection with any accident or loss for which coverage is sought under this policy." Id. at 423-424. The exclusion in this case states:

> We will not cover any person seeking coverage under this policy who has made fraudulent statements or engaged in fraudulent conduct *with respect to procurement of this policy or to any* **OCCURRENCE** for which coverage is sought. [Emphasis added.]

Defendant has not provided us with the policy definition of "occurrence," but in all cases dealing with the term, it has been defined as the accident or event during which the injury occurs. See, e.g. Frankenmuth Mut Ins Co v Masters, 460 Mich 105, 112-113; 595 NW2d 832 (1999) (stating that the applicable insurance policy defined the term "occurrence" as "an accident, . . . which occurs during the policy period"), Group Ins Co v Czopek, 440 Mich 590, 597-598; 489 NW2d 444 (1992) (stating that the term "occurrence" was defined in the policy as "an accident, . . . which results, during the policy term, in bodily injury or property damage."), and Mich Basic Prop Ins Ass'n v Wesarovich, 214 Mich App 319, 327-328; 542 NW2d 367 (1995) (finding that the definition of "occurrence" in the policy included an accident that resulted in personal injury during the policy period). Defendant has not alleged any fraud "with respect to the procurement of the policy" nor with respect to the "occurrence." The claimed fraud was in the reporting of services later provided, an event not referenced in the provision. However, as the issue was not considered below we decline to rule on this basis. Mich Ed Ass'n v Secretary of State, 280 Mich App 477, 488; 761 NW2d 234 (2008), aff'd 489 Mich 194; 801 N.W.2d 35 (2011); People v Byrne, 199 Mich App 674, 677; 502 NW2d 386 (1993).

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Gen Shale Brick, Inc, 284 Mich App 25, 29; 772 NW2d 801 (2009). Similarly, all reasonable inferences must be drawn in favor of the nonmovant. Dextrom v Wexford Co, 287 Mich App 406, 415; 789 NW2d 211, lv den 488 Mich. 853, 787 N.W.2d 508 (2010). Summary disposition is only appropriate under MCR 2.116(C)(10) when there is no genuine issue with respect to any material fact and the moving party is entitled to judgment as a matter of law. Maiden v Rozwood, 461 Mich 109, 120; 597 NW2d 817 (1999). "A genuine issue of material fact exists when the record, giving the benefit of reasonable doubt to [*9] the opposing party, leaves open an issue upon which reasonable minds could differ." West v GMC, 469 Mich 177, 183; 665 NW2d 468 (2003).

In support of its motion, defendant relied on an investigator's reports and some photographs counsel represents were taken by the investigator on June 1.[7] Defendant argues that the photographs and investigator's reports are sufficient to establish beyond a question of fact that defendant committed fraud despite the testimony, medical reports, and affidavits that support plaintiff's claim of injury and need for medical care and assistance. We disagree. First, many of the photographs are so blurred and distant that it is impossible to determine who is being photographed and what they are doing. Second, the descriptions in defendant's brief are at times inconsistent with the investigator's reports. For example, defendant's brief states that on June 1 plaintiff "is observed outstretching both of her arms above her head to lift and pass a child." However, the investigator's report dated June 1, 2013 states that the "claimant" being observed is "Timothy Williams," not plaintiff, and all of the report's references to "the claimant" use the pronoun "he." The only person that the report identifies as being "observed [*10] lifting the toddler" is Williams.[8] The only women referred to in that report are two "female subject[s]" neither of whom are identified in the report as plaintiff despite the fact that plaintiff had been watched by this investigator on two prior occasions. Moreover, the only photographs submitted by defendant are dated June 1, 2013, the date that the report does not identify plaintiff as being present.

Defendant also argues that plaintiff fraudulently claimed assistance with doing laundry on June 1, because the investigator's report states that on that date he saw plaintiff wringing out a shirt while on the front lawn of her home.[9] A single instance of a single shirt being wrung out does not demonstrate beyond question that plaintiff can operate a washer or dryer, carry loads of laundry or the like. Nor does it conclusively demonstrate an intent to defraud. Similarly, the fact that plaintiff was seen walking without a visible brace[10] and was observed to bend on two occasions does not establish beyond a question of fact that she has defrauded defendant.[11] By contrast, as noted above, the insurer in *Bahri [*11]* presented uncontested evidence (a) that plaintiff claimed replacement services benefits for three weeks before the auto accident even occurred; and (b) that over a period of seven weeks she repeatedly engaged in a wide range of chores on the days for which she claimed that someone else did them for her. 308 Mich App at 425-426. While such repeated activities are sufficient to establish the elements of fraud

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[7] While not raised in the briefing, based on the record before us it appears that many of the documents on which defendant relies including the three surveillance reports and the photographs, do not meet the evidentiary requirements of ***MCR 2.116(G)(6)*** and should not have been considered. That rule provides that "affidavits, depositions, admissions and documentary evidence offered in support of or in opposition to a motion based on ***subrule (C)(1)-(7)*** or ***(10)*** *shall only be considered to the extent that the content or substance would be admissible as evidence.*" (emphasis added). The relied upon reports appear to be hearsay. Their ostensible author did not testify and has not provided an affidavit that the statements in his reports are true and that he will so testify at trial. The same is true of the photographs on which defendant relies.

[8] The report states, "The claimant is also observed lifting the toddler and shaking him as he is playing with the toddler."

[9] In fact, the report is equivocal as to this fact, stating that plaintiff "*appears* to be wringing it out." (emphasis added). And there is no reference to any photographs or videotape to confirm even this self-serving statement.

[10] Plaintiff testified that she is able to walk. She also testified that she always wore a back brace but stated that sometimes she wore it under her clothing and sometimes over.

[11] Defendant's brief refers us to a passage in plaintiff's deposition that is not in the record in support of its position. On that page plaintiff states that she "normally" wears a back brace and that if wearing a loose fitting shirt she wears it under her shirt. Defendant also refers us to one of the June 1, 2013 photos in which a woman is seen carrying what appears to be a small plastic bag (contents unknown) and argues this was inconsistent with her deposition testimony. However, plaintiff testified that she could walk to nearby stores and that she could lift a bag containing five regular size cans of vegetables.

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beyond a question of fact, a single episode of wringing out a shirt does not; nor do isolated examples of an injured person participating in simple physical actions such as bending, modest lifting, or other basic physical movements that they testify are painful or difficult. These types of inconsistencies with a claimant's statements are not sufficient to establish any of the elements of fraud beyond a question of fact.

Defendant raises an alternative argument in its reply brief, claiming that plaintiff's no fault claim is barred by the wrongful-conduct rule. However, HN8[↑] "[r]eply briefs must be confined to rebuttal, and a party may not raise new or additional arguments in its reply brief." *Kinder Morgan Michigan, LLC v City of Jackson, 277 Mich App 159, 174; 744 NW2d 184 (2007)*, citing *MCR 7.212(G)*. Accordingly, we need not reach the issue. However, were we to do so, we would reject the argument. HN9[↑] The wrongful [*12] conduct rule applies to activities or behavior that occur prior to, and are causative of, the injury.[12] See *Cervantes v Farm Bureau Gen Ins Co, 272 Mich App 410, 417; 726 NW2d 73 (2006)* (stating that "the wrongful conduct rule only applies if a plaintiff's wrongful conduct is a proximate cause of his injuries") and see *Orzel v Scott Drug Co, 449 Mich 550, 558; 537 NW2d 208 (1995)* ("[The plaintiff's] injury must have been suffered while and as a proximate result of committing an illegal act.") (internal quotations and citations omitted). Defendant makes no such claim here.

Affirmed. We do not retain jurisdiction.

/s/ Douglas B. Shapiro

/s/ Elizabeth L. Gleicher

Concur by: Kirsten Frank Kelly

Concur

K. F. KELLY, P.J. (*concurring*).

I concur in the result only.

/s/ Kirsten Frank Kelly

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[12] Defendant's brief provides no citation to cases applying the wrongful conduct rule as it seeks to do. And when asked at oral argument for supporting caselaw, defendant could provide none.

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EXHIBIT 4

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Roger Williams Ins. Co. v. Carrington

Supreme Court of Michigan

April 7, 1880, Submitted ; April 14, 1880, Decided

No Number in Original

Reporter
43 Mich. 252 *; 5 N.W. 303 **; 1880 Mich. LEXIS 776 ***

The Roger Williams Insurance Company v. Mark Carrington.

Prior History: [***1] Error to St. Clair. Submitted April 7. Decided April 14.

Disposition: The judgment must be affirmed with costs.

Core Terms

insured, premium, removal

Case Summary

Procedural Posture
Defendant insurer appealed from a judgment of the Circuit Court for the County of St. Clair (Michigan), which was entered in favor of plaintiff assignee of the insured in an action seeking recovery for property which was destroyed by fire.

Overview
The insured had obtained an insurance policy over his livery stable stock which was destroyed by fire. He assigned the interest therein to an assignee who commenced an action against the insurer upon the insurer's denial that there was a policy in effect. At the time of the fire, the horses, carriages, and other livery property had been in another stable, where the business had been moved to. The assignment had not been consented to by the insurer, however, it had occurred after the fire and accordingly, no consent was required. The insurer contended that although there was originally a policy, it had been cancelled due to non-payment of the premium which fact it contended was told to the insurance agent. However, the court held that the agent was one for the insurer and not for the insured. Additionally, the factual determinations on that issue, as well as whether the agent made the arrangements with the insurer for the movement of the insured property, were properly considered by the jury and they were supported by sufficient evidence.

Outcome
The court affirmed the judgment of the trial court in favor of the assignee of the insured.

LexisNexis® Headnotes

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43 Mich. 252, *252; 5 N.W. 303, **303; 1880 Mich. LEXIS 776, ***1

Contracts Law > Standards of Performance > Assignments > General Overview

Criminal Law & Procedure > Sentencing > Forfeitures > Proceedings

Insurance Law > Liability & Performance Standards > Bad Faith & Extracontractual Liability > Assignment of Claims

HN1[] It is the absolute right of every person--secured in Michigan by statute--to assign insurance claims, and such a right cannot be thus prevented. It cannot concern the debtor, and it is against public policy.

Contracts Law > Contract Modifications > General Overview

Contracts Law > Procedural Matters > Statute of Frauds > General Overview

Insurance Law > Contract Formation > Oral Contracts

Insurance Law > ... > Policy Interpretation > Parol Evidence > General Overview

HN2[] There is no rule of law which, in cases outside of the Statute of Frauds, prevents written contracts from being changed by parol, or which requires insurance contracts to be in writing.

Headnotes/Syllabus

Headnotes

Insurance -- Assignment of policy after loss -- Parol change in policy.

The right to assign an accrued cause of action is statutory in Michigan and cannot be defeated.

A clause in an insurance policy providing for its forfeiture if assigned without the company's consent, cannot in Michigan prevent its assignment after the loss.

The finding of a jury cannot be disturbed if there was evidence to justify it, unless the jury were allowed to find under improper directions.

Insurance policies are not required by law to be in writing, and outside of the statute of frauds there is no rule of law which prevents written contracts from being changed by parol.

Syllabus

Action on insurance policy. Defendant brings error.

Counsel: Whipple & Voorhies for plaintiff in error.

O'Brien J. Atkinson and Elliott G. Stevenson for defendant in error. An insurance policy can be changed or enlarged by parol, *Seaman v. O'Hara 29 Mich. 66*; Kennebec Co. v. Augusta Ins. Co. 6 Gray 209; *First Baptist Church v. Brooklyn Ins. Co. 19 N.Y. 305*.

Judges: Campbell, J. The other Justices concurred.

Opinion by: Campbell

Jacob Bryant

Opinion

[***2] [*253] [**303] Action was brought in the circuit court for the county of St. Clair by Carrington as assignee of a policy of insurance originally issued by plaintiff in error to Angeline James on a livery stable stock in Port Huron. The policy bore date October 16, 1876, and was assigned after the property insured was burned up. The fire which destroyed the property was in September, 1877. The policy was by its terms made payable to Carrington as his interest should appear. It was thus arranged to secure a debt due him from Mrs. James and secured.

At the time of the fire the horses and carriages and other livery property destroyed were in a livery stable at Lexington, to which place the business had been removed in November, 1876, and one of the questions presented related to the effect of this removal.

The company after the loss repudiated any liability on the ground that no such policy was in force.

There is some difficulty in applying the assignments of error in this case, but perhaps they present sufficiently the more important issues.

Proof of loss was made in final shape about three months after the fire. It was not objected to for delay, [*254] but for want of any insurance. [***3] There was evidence bearing very plainly on difficulties of proof caused by this dispute as to the existence of the policy, and we do not think there was anything which, as matter of law, made the delay sufficient for a forfeiture. [**304] The assignment having been made after the loss, did not require consent of the company. The provision of the policy forfeiting it for an assignment without the company's consent is invalid, so far as it applies to the transfer of an accrued cause of action. *HN1*[↑] It is the absolute right of every person--secured in this State by statute--to assign such claims, and such a right cannot be thus prevented. It cannot concern the debtor, and it is against public policy.

Two principal questions arose on the trial, *first*, whether the policy was originally valid and continued uncanceled; and *second*, whether the removal to Lexington put an end to its force if otherwise in existence.

The original execution of the policy was admitted, but it was claimed to have been canceled for non-payment of premium. It is not claimed that notice of cancellation was given to the insured, and the verdict negatives it. But it is claimed that Linnaeus Noble, the insurance agent who [***4] issued the policy, was acting in the capacity of agent for Mrs. James, and that the company by notifying him sufficiently notified her.

Upon most of the leading facts Noble's testimony is contradicted, and it was a question of fact for the jury what transactions really occurred throughout.

There was a conflict as to the precise relations of the parties concerning the obtaining of this particular policy, and how far Noble acted for Mrs. James concerning it. There was evidence of a particular bargain made about it. There was evidence that the premium was actually paid by a note, which was taken up after renewal. There was evidence that the company drew for and obtained the amount of this premium from Noble, and while he testifies it was afterwards made up to him, he does not [*255] show how or why, and he does not show that the payment to the company was after the pretended cancellation, which was for non-payment of premium.

Upon all of these questions the jury have found in favor of the insured, and there was evidence to justify the finding. Unless they were allowed to do this under improper directions their finding cannot be disturbed.

The charges asked, which called for instructions [***5] that Noble was agent for Mrs. James, were all too broad. Upon the testimony it cannot properly be said that there was anything more than an open question of fact. The court could not be asked to charge either that he was her agent or that a partial detail of facts would make him such, when there were other facts explaining them, besides many contradicting them. The charges [**305] asked were not so drawn as to leave the jury any discretion upon matters of dispute. And we are strongly inclined to think that there was no testimony which fairly tended to show that in this particular transaction Noble could have been found

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by the jury to have acted for any material purpose as agent for any but the company, whatever may have been his position in regard to other transactions.

Upon the question of assent to the transfer of the insured property to Lexington there is also some conflict of testimony. There was positive testimony that before the removal the agent was notified of the desire to remove it, and that it would not be removed until provision was made to keep it protected by the insurance, and that Noble told James, the husband and agent of the insured, before the removal that the proper steps [***6] had been taken. There was also evidence, which though objected to was clearly relevant, that shortly before the loss Noble was written to for the purpose of having the policy renewed when it should run out, and answered promising to attend to it. There was also other evidence on the same subject. The agent's own books showed a memorandum purporting to be a new insurance for a year from the [*256] time of the removal, covering the property at Lexington, but claimed it was a mere memorandum of a proposed insurance that was never made. Upon all these facts the jury certainly had a right to believe the agent had done what James said he had, and that there had been an absolute representation of insurance and an agreement to that effect. The policy contained an express authority in the insured to surrender the policy and get back a part of the premium, and no return of premium was pretended to have been made, while the jury must have found it had all been paid.

The objection that such change in the policy was void unless in writing, is disposed of by our own previous decisions. *HN2*[↑] There is no rule of law which, in cases outside of the Statute of Frauds, prevents written contracts from [***7] being changed by parol, or which requires insurance contracts to be in writing. The subject was fully considered in *Westchester Fire Ins. Co. v. Earle 33 Mich. 143*, where the cases are cited and commented on. We think there is no difficulty in the way of the contract relied on.

Some question arose whether a certain stallion was properly included among the stock. There was testimony that except at certain seasons he was used as a livery horse, and we think he was properly so found by the jury. [**306] We do not discover anything in the record indicating that any action has been had of which plaintiff in error can complain.

The judgment must be affirmed with costs.

The other Justices concurred.

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EXHIBIT 5

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Action Auto Stores v. United Capitol Ins. Co.

United States District Court for the Western District of Michigan, Southern Division

February 8, 1993, Decided ; February 8, 1993, Filed

File No. 5:91-CV-32

Reporter
845 F. Supp. 417 *; 1993 U.S. Dist. LEXIS 4464 **

ACTION AUTO STORES, INC., a Michigan corporation, Plaintiff, v. UNITED CAPITOL INSURANCE COMPANY, Garnishee-defendant, and OSCAR W. LARSON COMPANY, a Michigan corporation, Defendant.

Core Terms

Garnishee, insured, summary judgment motion, insurance policy, coverage, pollutants, settlement agreement, exclusions, argues, court finds, summary judgment, operations, settlement, damages, parties, garnishment, defenses, relieve, contends, property damage, containment, products, asserts, install, invalid, removal, notice, disclosure statement, insurance company, real property

Case Summary

Procedural Posture
Plaintiff judgment creditor sought summary judgment to allow it to receive proceeds from an insurance contract between its judgment debtor and defendant garnishee, the insurer of judgment debtor. Defendant sought judgment stating it was not indebted to the judgment debtor and should not be subject to garnishment.

Overview
Plaintiff judgment creditor sought to garnish proceeds under an insurance policy issued by defendant garnishee after plaintiff and the judgment debtor settled some of plaintiff's claims and a verdict was rendered in plaintiff's favor on the remaining claims. Defendant alleged it was not indebted to judgment debtor and should not be subject to garnishment. Both parties filed motions for summary judgment. The court denied the motions for summary judgment insofar as a question of fact existed as to whether the cooperation clause of the insurance policy was violated by judgment debtor's alleged refusal to cooperate and prepare a defense of the underlying suit. It further found that defendant did not waive the defense that a policy exclusion prevented coverage for damage done to land and that the issue should be more fully addressed by the parties. The court requested defendant to reassess its position regarding several of its defenses and declined to address the issue of coverage as it was improperly raised in a responsive pleading. Plaintiff's motion was granted to the extent that it sought a declaration that the balance of defendant's defenses were invalid.

Outcome
The court denied defendant garnishee's motion for summary judgment and granted plaintiff judgment creditor's motion in part and denied it in par. Summary judgment was not proper when a question of fact existed as to whether judgment debtor violated the cooperation clause of the insurance policy and the issue of coverage needed to be more fully addressed.

LexisNexis® Headnotes

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Civil Procedure > ... > Summary Judgment > Evidentiary Considerations > Scintilla Rule

Civil Procedure > Judgments > Summary Judgment > Evidentiary Considerations

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > General Overview

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Appropriateness

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Genuine Disputes

HN1[] Summary judgment is appropriate only where no genuine issue of fact remains to be decided so that the moving party is entitled to judgment as a matter of law. There is no material issue of fact for trial unless, in viewing the evidence in favor of the nonmoving party, a reasonable factfinder could return a verdict for that party. If the evidence is merely colorable or is not significantly probative, summary judgment may be granted.

Civil Procedure > ... > Summary Judgment > Burdens of Proof > General Overview

Civil Procedure > ... > Summary Judgment > Burdens of Proof > Nonmovant Persuasion & Proof

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > General Overview

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Appropriateness

HN2[] The party moving for summary judgment bears the initial responsibility of informing the court of the basis of its motion and identifying those portions of the record which demonstrate the absence of a material issue of fact. Once this has been done, the nonmoving party must come forward with specific facts showing that there is a material issue of fact on an issue that the nonmoving party will bear the burden of proof at trial. Fed. R. Civ. P. 56(e). If, after adequate discovery, the party bearing the burden of proof fails to make a showing sufficient to establish an essential element of his claim, summary judgment is appropriate.

Civil Procedure > Preliminary Considerations > Federal & State Interrelationships > General Overview

Civil Procedure > ... > Federal & State Interrelationships > Choice of Law > General Overview

Civil Procedure > Preliminary Considerations > Federal & State Interrelationships > Erie Doctrine

HN3[] A federal court sitting in diversity must apply the law of the state in which it sits, including that state's choice of law principles.

Insurance Law > ... > Obligations of Parties > Policyholders > Duty to Cooperate

HN4[] The insurer must show that the insured's lack of compliance materially injured its ability to contest the merits of the claims.

Contracts Law > Defenses > Ambiguities & Mistakes > General Overview

Insurance Law > ... > Policy Interpretation > Ambiguous Terms > General Overview

Insurance Law > ... > Policy Interpretation > Ambiguous Terms > Construction Against Insurers

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Insurance Law > Claim, Contract & Practice Issues > Policy Interpretation > Exclusions

Insurance Law > Claim, Contract & Practice Issues > Policy Interpretation > Ordinary & Usual Meanings

Insurance Law > Claim, Contract & Practice Issues > Policy Interpretation > Plain Language

HN5[] An ambiguous contract provision must be construed against the insurer and in favor of the insured and exclusionary clauses in insurance policies are to be strictly construed against the insurer. If the meaning of terms used in the contract are clear and unambiguous, however, their terms are to be taken and understood in their plain, ordinary, and popular sense.

Counsel: [**1] For ACTION AUTO STORES, INC. plaintiff: L. David Lawson, Winegarden, Shedd, Haley, Lindholm, et al, 501 Citizens Bank Bldg., Flint, MI 48502, Genesee, (313) 767-3600.

For UNITED CAPITOL INSURANCE COMPANY, a foreign corporation garnishee: Constantine N. Kallas, Leonard A. Henk, Kathlyn M. Rasmussen, Kallas & Henk, PC, 1471 Woodward Ave., Suite 200, Bloomfield Hills, MI 48302, Oakland, (313) 335-5450.

Judges: GIBSON

Opinion by: BENJAMIN F. GIBSON

Opinion

[*418] Hon. Benjamin F. Gibson

OPINION

Pending before the Court are cross-motions for summary judgment. The issue before the Court is whether garnishee-defendant United Capitol Insurance Company [*419] ("garnishee") is obligated under an insurance contract to pay garnishee-plaintiff Action Auto Company ("plaintiff") funds that plaintiff was awarded in a lawsuit it brought against defendant Oscar W. Larson Company. Plaintiff contends that garnishee has a contractual obligation to pay the sum. Garnishee asserts that a settlement agreement between defendant and plaintiff negates any duty it may have had to pay, and it further argues that various exclusions contained in the insurance policy preclude its obligation to pay. [1] Finally, garnishee argues that "known risk" [**2] and "loss in progress" doctrines bar coverage.

I.

Defendant was employed by plaintiff and Sun Oil Company to install gasoline containment systems at three Action Auto locations. In 1988, defendant filed various actions in state court for money it claimed plaintiff owed it for the work it had done. Plaintiff counterclaimed for breach of express and implied warranties, alleging that defendant had negligently installed the systems. Plaintiff also alleged that defendant failed to remove contaminated soil from some of the locations. The actions were consolidated.

Garnishee agreed to defend defendant in the action but reserved the right to contest coverage, at least for some claims. [2] Plaintiff and defendant entered a partial settlement prior to trial. [**3] Garnishee was not a party to this

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[1] Larson has filed no motions in this action. The dispute is essentially between Action and United Capitol. As discussed in the Court's Opinion and Order of January 13, 1992, Larson's interests are aligned with Action's, thus creating complete diversity of parties.

[2] Two reservation of rights letters were sent to defendant. The first letter, dated October 3, 1989, cited section F(2) of the "absolute pollution exclusion" clause of the policy. The October 3 letter also stated that "United Capitol Insurance Company does not waive any other defenses is (sic) may have under the Policy including the late notification of the loss." The second letter, dated March 26, 1990, cites other exclusions at issue in this lawsuit.

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settlement, and it apparently had no knowledge of the agreement until after it was made. [3] According to the settlement, defendant dismissed its claims with prejudice. In return, plaintiff dismissed same of its claims and agreed not to execute on or enforce a judgment against any of defendant's assets except on those arising out of insurance policies or contracts. Defendant apparently stopped contesting some claims and a default was entered in the amount of $ 2,197,000.00. Plaintiff's other claims were tried in state court where a jury rendered a verdict of two million dollars against defendant.

[**4] Plaintiff filed a writ of garnishment in the Ingham County Circuit Court against garnishee. Garnishee filed a garnishee disclosure statement in which it alleged that it was not indebted to defendant and that it should not be subject to garnishment. Garnishee argued that no underlying debt existed since the settlement agreement released defendant from liability, and it also argued that various provisions in the insurance policy prevented garnishment. On May 15, 1991, garnishee removed the case to this Court. Plaintiff moved to remand, but in an Opinion and Order dated January 13, 1992, this Court determined that it had subject matter jurisdiction over the action and that remand was improper. Cross-motions for summary judgment were subsequently filed.

II.

HN1[↑] Summary judgment is appropriate only where no genuine issue of fact remains to be decided so that the moving party is entitled to judgment as a matter of law. Atlas Concrete Pipe, Ins. v. Roger J. Au & Son, Ins. (In re Atlas Concrete Pipe, Inc.), 668 F.2d 905, 908 (6th Cir. 1982). There is no material issue of fast for trial unless, in viewing the evidence in favor of the nonmoving party, a reasonable [**5] fact finder could return a verdict for that party. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 249, 91 L. Ed. 2d 202, 106 S. Ct. 2505 (1986). "If the evidence is merely colorable or is not significantly [*420] probative, summary judgment may be granted." Anderson, 477 U.S. at 249 (citations omitted).

HN2[↑] The party moving for summary judgment bears the initial responsibility of informing the court of the basis of its motion and identifying those portions of the record which demonstrate the absence of a material issue of fact. Celotex Corp. v. Catrett, 477 U.S. 317, 323, 91 L. Ed. 2d 265, 106 S. Ct. 2548 (1986). Once this has been done, the nonmoving party must come forward with specific facts showing that there is a material issue of fact on an issue which the nonmoving party will bear the burden of proof at trial. Fed. R. Civ. P. 56(e); Celotex, 477 U.S. at 322-24. If after adequate discovery the party bearing the burden of proof fails to make a showing sufficient to establish an essential element of his claim, summary judgment is appropriate. *Id.*

III.

Garnishee's motion for summary judgment asks this Court to find that it [**6] has no obligation to pay damages either because the insurance policy prohibits liability in situations in which a settlement agreement is executed without the insurer's consent or because exclusions contained in the policy prohibit liability for the kind of damage at issue in this litigation. Plaintiff has made a separate motion for summary judgment in which it asks that various defenses to garnishment be declared legally insufficient.

The Court notes that while the parties have submitted several briefs apiece, the number of issues in contention has made it impossible for any one issue to be extensively briefed. While this Opinion is dispositive of some issues, it requires that others be briefed more fully and resubmitted for the Court's consideration.

IV.

Garnishee argues that because a settlement agreement was entered between plaintiff and defendant, defendant was not legally obligated to pay the judgment, negating garnishee's obligation under the insurance policy. In

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[3] This is implied by garnishee though not overtly stated. The settlement agreement itself states that defendant "through its counsel, disclosed its intent to enter into, and provided the draft dated May 1, 1990 of, (sic) this Agreement to any and all actual or potential insurers of claims against it . . . ." Settlement Agreement, Garnishee's Motion for Summary Judgment, Exhibit 3, at 5, P C.

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addition, garnishee contends that entering the agreement without its consent was a violation of the insurance contract releasing it from any obligation to pay.

A.

Garnishee argues that because plaintiff agreed [**7] to collect its judgment only from insurance proceeds instead of other assets of defendant, defendant is not legally obligated to pay any damages. Garnishee concludes that because the insurance agreement *only* covers casts the insured must pay, the fact that defendant has avoided incurring a legal obligation relieves it of its duty.

This case is governed by Michigan law. [4] The Michigan case most closely on point is *Alyas v. Gillard, 180 Mich. App. 154, 446 N.W.2d 610 (1989)*. In this case, the Michigan Court of Appeals held that a consent judgment compelling a plaintiff to collect only from defendant's insurer did not relieve defendant from "any and all liability" and thus relieve the insurer from its contractual obligation to pay the claim. Garnishee claims that this case is distinguishable, however, because the insurer involved in *Alyas* refused to defend the insured.

[**8] The *Alyas* court first reasoned that the settlement agreement did not release defendant from liability but that, instead, it merely limited the assets plaintiff could recover to insurance proceeds. Using this line of reasoning, plaintiff argues that the agreement in the instant case did not relieve defendant of liability but merely created a separate contract in which plaintiff agreed not to execute judgment against certain assets. According to plaintiff, while defendant may sue for breach of contract if plaintiff fails to abide by this clause, the contract does not relieve defendant of liability.

The *Alyas* court, however, gave other reasons for its decision. The court discussed [*421] *Sargent v. Johnson,* [5] an Eighth Circuit case which held that an insurer had no obligation to pay insurance when an insured entered a settlement agreement which relieved the insured from any obligation and placed all obligation on the insurer. The *Alyas* court noted that the case before it was distinguishable because *Sargent* concerned the bad faith of the insured while the case before it concerned the bad faith of the insurer. This reasoning indicates that the enforceability of settlement [**9] agreements turns on an examination of whether or not the parties have acted in good faith or bad faith.

After closely reading the case, the Court interprets *Alyas* to be based primarily on the first rationale discussed by the court. The Court finds that the case turns on the fact that the settlement agreement was not a release from liability but a separate contract limiting the assets which could be collected. The court finds that *Sargent* does not apply Michigan law and that *Alyas* should be followed. The Court therefore grants plaintiff's motion for summary judgment to the extent that it asks the Court to declare this defense insufficient.

B.

Garnishee also claims that no coverage exists because various provisions in the insurance policy preclude coverage in situations in which the insured reaches a settlement without the insurer's consent. Garnishee claims that the settlement agreement [**10] was executed in violation of § 4, P 2(c), (d) and § *4 P 3* of the Insurance Policy. These paragraphs read as follows:

2. Duties in the Event of Occurrence, Claim or Suit.

. . . .

c. You and any other involved insured must

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[4] *HN3*[↑] A federal court sitting in diversity must apply the law of the state in which it sits, including that state's choice of law principles. *Klaxon Co. v. Stentor Electric Mfg. Co., 313 U.S. 487, 85 L. Ed. 1477, 61 S. Ct. 1020 (1941)*. This Court is confident that the Michigan court would apply Michigan law to resolve this case. The parties have also assumed that Michigan law applies.

[5] *Sargent v. Johnson, 551 F.2d 221 (8th Cir. 1977)*. The case applied Minnesota law.

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(1) Immediately send us copies of any demands, notices, summonses or legal papers received in connection with the claim or "suit";
(2) Authorize us to obtain records and other information;
(3) Cooperate with us in the investigation, settlement or defense of the claim or "suit" and
(4) Assist us, upon our request, in the enforcement of any right against any person or organization which may be liable to the insured because of injury or damage to which this insurance may also apply.

d. No insured will, except at their own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent.

3. Legal Action Against Us.

No person or organization has a right under this Coverage Part:

a. To join us as a party or otherwise bring us into a "suit" asking for damages from an insured; or

b. To sue us on this Coverage Part unless all of its terms have been [**11] fully complied with.

A person or organization may sue us to recover on an agreed settlement or on a final judgment against an insured obtained after an actual trial. . . . An agreed settlement means a settlement and release of liability signed by us, the insured and the claimant or the claimant's legal representative.

Insurance Policy, Garnishee's Motion for Summary Judgment, Exhibit 1, § *4 P 2*(c), (d) and § *4 P 3*.

The Court finds that there was no violation of paragraphs 2(d) or 3 of the Insurance Policy and that there is a question of fact as to whether there was a violation of paragraph 2(c). Paragraph 2(d) was clearly not violated because it requires only that the insured not voluntarily make a payment, assume any legal obligation, or incur expense without the consent of the insurer. Defendant did *not* assume a legal obligation to pay any damages to plaintiff through the settlement agreement. The agreement *relieved* defendant of same liability and directed plaintiff as to the assets that could be collected *in the event* defendant was later found to be liable. The agreement did not compel [*422] defendant or [**12] garnishee to make any payment or incur any expense nor did it obligate defendant or garnishee to pay the plaintiff anything. Therefore, it did not violate section 2(d) of the insurance policy. [6]

Garnishee states that under paragraph 3, it can only be sued to recover on "an agreed upon settlement" or a "final judgment." Because an agreed upon settlement is defined as one in which the insurer participates, garnishee argues that the insured cannot recover based upon the settlement. The Court agrees with garnishee's logic, and if the settlement agreement were the basis of the obligation, this paragraph would prevent coverage. A final judgment of a court, however, not the settlement agreement, forms the basis of the judgment that garnishee is being asked to pay. The provision, therefore, does not prohibit garnishee's liability.

There is a question of fact as to whether paragraph 2(c)(3) was violated. This provision requires that [**13] the insured cooperate with the insurer in defending a claim. Garnishee argues that after entering the settlement agreement defendant lost all incentive to help garnishee prepare a defense and that defendant's refusal to cooperate relieves it of liability. Garnishee has presented no proof, however, of defendant's lack of cooperation. Furthermore, under Michigan law, *HN4*[↑] the insurer must show that the insured's lack of compliance materially injured its ability to contest the merits of the claims. *Anderson v. Kemper Insurance Co., 128 Mich. App. 249, 253-54, 340 N.W.2d 87, 90 (1983)*. The question of prejudice is one of fact which is best left far resolution by a jury. Because a question of fact exists as to whether the cooperation clause was violated, the Court denies both plaintiff's and defendant's motion for summary judgment on this issue.

C.

Garnishee maintains that the settlement agreement violates paragraph E of the "Common Policy Conditions" section of the insurance policy. According to garnishee, the settlement agreement constituted the assignment of the insurance policy which is expressly forbidden by paragraph E of the document. [**14] Paragraph E refers to

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[6] This factor also distinguishes the case from the case authority cited by plaintiff.

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premiums, and the Court sees nothing in the section prohibiting assignment or transfer of the policy. Paragraph F of the "Common Policy Conditions" document does prohibit the transfer of rights and duties under the policy without the insurer's written consent except in the case of death of an individual named insured. [7]

Garnishee relies on *Employers Mutual v. Michigan Mutual, 101 Mich. App. 697, 300 N.W.2d 682 (1980)*, for the proposition that the assignment of a right in violation of an anti-assignment clause in an insurance policy voids coverage. Plaintiff points out, however, that *Employers* is distinguishable from the instant case because in *Employers* [**15] the insured property was transferred prior to the loss the insurance covered. The case is also distinguishable because the policy's prohibition was far more clear and unambiguous than that contained in the instant policy. The policy in *Employers* specifically stated that the insurance "shall be void" in case either the policy or the insured interest is "sold, assigned, transferred or pledged without the previous consent in writing of the company." The clause at issue in this case does not contain language making the insurance void [8] nor does it specifically mention assignment.

Plaintiff also cites Section 792 of Volume 43 of *American Jurisprudence*, Second Edition, for the proposition that such general stipulations prohibiting assignment without the insurer's consent apply only to assignments before loss and not against assignment after loss. The cited paragraph notes that a provision against [**16] assignment after loss is null [*423] and void as inconsistent with the covenant of indemnity and contrary to public policy. *43 Am. Jur. 2d Insurance § 792* (1982). *See also Roger Williams Insurance Company v. Carrington, 43 Mich. 252, 5 N.W. 303 (1880)* (invalidating a provision which required forfeiture of a policy for post-lost assignment without consent of the insurer.)

Because the clause at issue is itself ambiguous and because there is a strong public policy in favor of assignment of such contract rights, the court holds that paragraph F of the "Common Policy Conditions" prohibits only transfer and assignment of a right prior to loss and does not prohibit assignment of an accrued cause of action. Plaintiff's motion for summary judgment is granted to the extent that it asks that the court find that the defense of assignment of the insurance policy does not bar coverage.

V.

Garnishee asserts several arguments as to why various exclusions contained in its policy prohibit garnishment. The Court discusses each in turn. When interpreting the insurance policy at issue, the Court bears in mind that Michigan courts have held "(1) that *HN5*[↑] an ambiguous contract provision [**17] must be construed against the insurer and in favor of the insured, and (2) that exclusionary clauses in insurance policies are to be strictly construed against the insurer" *Farm Bureau Mutual Ins. Co. v. Stark, 437 Mich. 175, 181, 468 N.W.2d 498, 501 (1991)*. If the meaning of terms used in the contract are clear and unambiguous, however, their terms are "to be taken and understood in their plain, ordinary, and popular sense." *Id.* (internal citations omitted).

A.

Garnishee claims that it is released from liability through an "absolute pollution exclusion" endorsement which was contained in all three policies it issued to defendant. That exclusion reads as follows:

F. This insurance does not apply to:
(1) "bodily injury" or "property damage" arising out of the actual, alleged or threatened discharge, dispersal, release or escape of pollutants;
(a) at or from premises you own, rent or occupy;
(b) at or from any site or location used by or for you or others for the handling, storage, disposal, processing or treatment of waste material;

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[7] In addition to the arguments discussed below, plaintiff maintains that no assignment was made in the settlement agreement because the agreement merely promises that an assignment will be made at a future time. Plaintiff argues that such a promise is distinguishable from an assignment itself.

[8] The document does state that "All Coverage Parts included in this policy are subject to the following conditions."

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(c) which are at any time transported, handled, stored, treated, disposed of, or [**18] processed as waste by or for you or any person or organization for whom you may be legally responsible; or
(d) at or from any site or location on which you or any contractors or subcontractors working directly or indirectly on your behalf are performing operations
(i) to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize pollutants
(ii) if the pollutants are brought on or to the site or location by or for you,

The word "pollutants" as used herein means any solid, liquid, gaseous or thermal irritants or contaminants, including smoke, vapor, soot, fumes, acids, biological elements and agents, and visual esthetics, the presence of any or all which (sic) adversely affects human health or welfare, unfavorably alters ecological balances of importance to human life, adversely affects other species of importance to mankind, or degrades the vitality of the environment for esthetic, cultural, and/or historical purposes.

The word "waste material" as used herein means materials which are intended to be or have been recycled, reconditioned or reclaimed.

Insurance Policy, Garnishee's Motion for Summary Judgment, Exhibit 1, UC-253(9-87) § F.

Garnishee appears [**19] to rely on sections F(1)(d)(i) and F(2) of the exclusion agreement. The Court finds that section F(2) is clearly inapplicable because there is no evidence that the government ever directed defendant [*424] to take any action whatsoever with regard to the pollutants. [9]

Plaintiff argues that section F(1)(d)(i) does not apply because the issue before the jury in the state suit involved only damages arising from leaks or discharges of fuel from equipment on which Larson performed defective work and that the jury [**20] was told not to award damages based upon the cleanup of contamination which was on the sites prior to the contract. [10] [**21] Plaintiff maintains that any claims against defendant based upon improper cleanup were dismissed prior to the trial and are not the subject of the present garnishment action. Plaintiff asserts that the work at issue in the state action was unrelated to testing and cleanup of pollutants and does not fall within the scope of F(1)(d)(i). Plaintiff supports this position by quoting the instructions given to the jury. *Oscar W. Larson v. Action Auto Stores, Inc.*, 88-61169-CK, Trial Transcript at 92-93 (Ingham County Cir. Ct. June 7, 1990). While garnishee provides evidence that defendant's cleanup efforts were mentioned at trial, it sets forth no evidence showing that the jury considered any claims for testing, cleaning up, monitoring, etc., of pollutants. The Court thus cannot grant garnishee's motion for summary judgment based upon this exclusion. [11] Plaintiff's motion for summary judgment, however, is granted to the extent that it asks the Court to find this defense to garnishment to be invalid.

B.

Garnishee maintains that exclusion 2(j)(5) negates its duty to pay. Plaintiff claims that garnishee is estopped from asserting this defense because it was not mentioned until its second "reservation of rights" letter. Plaintiff relies primarily upon *Meirthew v. Last, 376 Mich. 33, 135 N.W.2d 353 (1965)*. *Meirthew* held that an insurer could not rely on a general reservation of rights letter to claim that it had no duty to pay after it had defended the insured in an action. *Meirthew* is distinguishable [**22] from the case *sub judice* because the insurance company did not give

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[9] Garnishee notes that if the government *had* ordered defendant to clean the pollutants, it would not have to pay for such costs. Garnishee argues that plaintiff is seeking to get reimbursement for costs for which it is liable as an owner under the same statutes, therefore it should not have to pay the costs. The Court finds such an argument unpersuasive as the language of the contract limits the application of section F(2) to situations in which the *insured* is ordered to conduct cleanup by the government.

[10] Garnishee has filed a separate summary judgment motion in which it claims that this same pollution exclusion policy applies to exclude money awarded to plaintiff through the default judgment entered against defendant in state court. Plaintiff's time for responding to this motion has not yet expired, so the Court does not address it at this time.

[11] Garnishee may be attempting to argue that because Larson was hired to install equipment to "contain gasoline," *(see* Garnishee's Brief in Support of its Motion for Summary Judgment at 17), it was performing operations relating to containment of pollution. The court, however, agrees with plaintiff's analysis that the gasoline was not a pollutant nor was it considered a pollutant while it was in the container. The primary purpose for installing the system was to promote consumer use of gasoline, not to remedy a pollution problem.

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notice of the particular exclusion it intended to rely upon until garnishment proceedings. In this case, garnishee gave a detailed notice stating that it intended to rely on provision 2(j)(5) two months in advance of trial. There is no evidence that garnishee knew that it would rely on this exclusion earlier or that it delayed in informing defendant of its intent. In addition, eight months before trial it provided a general reservation of rights letter which at least put defendant on notice that the insurer might contest coverage. There is no evidence that defendant suffered prejudice from garnishee's actions. The Court therefore holds that the defense was not waived.

Plaintiff asserts that exclusion 2(j)(5) should not apply by its own terms as defendant was not performing operations *on* the real property that was damaged. Exclusion 2(j)(5) states:

2. This insurance does not apply to:

. . . .

j. "Property damage" to:

. . . .

[*425] (5) That particular part of real property on which you or any contractors or subcontractors working directly or indirectly on your behalf are performing operations, if the [**23] "property damage" arises out of those operations;

Insurance Policy, Garnishee's Brief in Support of its Motion for Summary Judgment, Exhibit 1, § *1 P 2*(j)(5).

Plaintiff claims that Larson was only performing operations "on" dispensers, pipes, and related products. It argues that the exclusion was designed to cover damages to such items which may constitute fixtures, and therefore real property, when installed on real property. Plaintiff claims that the exclusion is not meant to refer to the surrounding property which was polluted.

Garnishee claims that Larson performed operations on the polluted property in question by physically digging the real property to install the gasoline containment equipment. Garnishee argues that the narrow reading of the clause suggested by plaintiff renders the clause nonsensical as other exclusions in the contract already exclude damage done to the insured's product and materials.

The Court does not read the exclusion provision as narrowly as plaintiff, and it holds that the exclusion prevents coverage for damage done to land or other property that defendant physically worked on. However, the facts presented do not [**24] reveal whether all of the property damage at issue was done to such land. The Court finds that this issue should be more fully addressed by the parties. [12] Specifically, the parties should inform the Court of what property was found to be polluted in the state action and of the type of work performed "on" such property. At this time, both plaintiff's and garnishee's motions for summary judgment must be denied.

C.

Garnishee contends that exclusion 2(m) also precludes its duty to provide coverage That exclusion reads:

2. The insurance does not apply to:

. . . .

m. property damage to "impaired property" or property that has not been physically injured, arising out of:

(1) A defect, deficiency, inadequacy or dangerous condition in "your product" or "your work"; or

(2) A delay or failure [**25] by you or anyone acting on your behalf to perform a contract or agreement in accordance with its terms.

This exclusion does not apply to the loss of use of other property arising out of sudden and accidental physical injury to "your product" or "your work" after it has been put to its intended use.

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[12] Plaintiff also asserts that the exclusion does not apply because it is limited to damage which occurs at the time work is being performed. The Court holds that this issue should also be re-briefed by the parties.

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Insurance Policy, Garnishee's Brief in Support of its Motion for Summary Judgment, Exhibit 1, § 1 P 2(m).

Impaired property is defined as follows:

5. "Impaired property" means tangible property, other than "your product" or "your work," that cannot be used or is less useful because:

a. It incorporates "your product" or "your work" that is known or thought to be defective, deficient, inadequate or dangerous; or

b. You have failed to fulfill the terms of a contract or agreement;

if such property can be restored to use by:

a. The repair, replacement, adjustment or removal of "your product" or "your work"; or

b. Your fulfilling the terms of the contract or agreement,

Insurance Policy, Garnishee's Brief in Support of its Motion for Summary Judgment, Exhibit 1, § 5 P 5.

Plaintiff argues that this [**26] exclusion is inapplicable because the property at issue cannot be restored to use by repair, replacement, adjustment, or removal of the containment [*426] system. [13] Garnishee relies upon *Reliance Insurance Co. v. Mogavero* [14] in which the federal court for the District of Maryland found that a similar exclusion prohibited coverage for property damage caused by defective construction work performed by the insured. While the allegation against the insured in *Mogavero* was similarly for breach of contract and breach of warranty, the exclusion in that case was not identical to the one at issue here. Significantly, it did not limit the exclusion to impaired property defined as property that can be restored to use by the repair, replacement, adjustment, or removal of the insured's product or work or the insured's fulfilling the terms of the contract or agreement. Therefore, the Court declines to adopt the *Mogavero* court's holding.

[**27] The Court finds that no evidence has been presented that any damage done to property surrounding the containment system can be remedied by the repair, replacement, or adjustment of defendant's work product. Furthermore, such a result is illogical as any pollution done to surrounding property could not possibly be remedied or rectified by the removal of the defective work product. Garnishee's motion for summary judgment must therefore be denied on this issue. Plaintiff's motion is granted to the extent that it asks that the Court hold this defense to be invalid.

D.

Garnishee also contends that the exclusionary provision contained in section 2(n) precludes coverage. Section 2(n) states:

2. This insurance does not apply to:

. . . .

n. Damages claimed for any loss, cost or expense incurred by you or others for the loss of use, withdrawal, recall, inspection, repair, replacement, adjustment, removal or disposal of:

(1) "Your product";

(2) "Your work"; or

(3) "Impaired property";

if such product, work, or property is withdrawn or recalled from the market or from use by any person or organization because of a known or suspected defect, deficiency, inadequacy or dangerous [**28] condition in it.

Insurance Policy, Garnishee's Brief in Support of its Motion for Summary Judgment, Exhibit 1, § 1 P 2(n).

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[13] None of the subsequent briefs filed by garnishee address this exclusion.

[14] *Reliance Insurance Co. v. Mogavero, 640 F. Supp. 84 (D. Md. 1986)*.

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Garnishee contends that this provision applies because polluted property had to be removed because of a defect in said property caused by defendant's product. Plaintiff responds that paragraph 2(n) applies only to products, work, or property that is taken out of the market or out of use because of withdrawal or recall. Plaintiff maintains that the exclusion is referred to as the "sistership" exclusion because it arises from the recall of a group of airplanes when one of its "sister" ships evidenced a structural defect.

Plaintiff cites Honeycomb Systems, Inc. v. Admiral Insurance Company, 567 F. Supp. 1400, 1406-07 (D. Me. 1983). In *Honeycomb*, the District of Maine cites multiple district cases and an insurance treatise to conclude that a similar provision was designed "to limit the insurer's exposure in cases where, because of the actual failure of the insured's product, similar products are withdrawn from use to prevent the failure of those other products, which have not yet failed." Id. at 1406. [**29] It concluded that the rationale behind the exclusion was to prevent the insurer from being saddled with the cost of preventing other failures. *Id.*

The Court finds that plaintiff's reading of the exclusion is more logical than garnishee's. In addition to relying on the analysis done in the *Honeycomb* case, the Court notes that the language of the exclusion itself does not support garnishee's reading of the clause. The exclusion refers to "withdrawal from the market or from use." This language does not encompass the removal of polluted earth from the work site. Garnishee's motion for summary judgment cannot be granted based upon this exclusion. Plaintiff's motion for summary judgment is granted to the extent [*427] that it asks this Court to find the defense to be invalid.

E.

Plaintiff's motion for summary judgment asks that this Court find invalid several other defenses based upon specific exclusions in the policy. These defenses were raised by garnishee in its original garnishee disclosure statement. Specifically, plaintiff asks that the Court find invalid:

(1) the defense that United Capitol has no liability under its policies for "products completed operations hazard" [**30] (plaintiff's Motion for Summary Judgment at P C);
(2) the defense that coverage is barred by exclusion 2(g) of the Policy (plaintiff's Motion for Summary Judgment at P H);
(3) the defense that coverage is barred by exclusion 2(l) (Plaintiff's Motion for Summary Judgment at P I;
(4) the defense that coverage is barred by exclusion 2(b) (plaintiff's Motion for Summary Judgment at P K);
(5) the defense that there is no coverage due to late notice or lack of notice (plaintiff's Motion for Summary Judgment at P L); and
(6) the defense that there is no coverage under exclusion J(1) or J(6) of the insurance policy (Plaintiff's Motion for Summary Judgment at P B). [15]

Garnishee's reply to plaintiff's summary judgment [**31] motion does not respond to plaintiff's arguments about these exclusions. [16] While plaintiff has addressed each of the exclusions, they were not extensively briefed. After reading plaintiff's arguments and examining the exclusions of the policy on which they are based, the Court denies the motions based upon insufficient briefing. This is not a decision on the merits, and either party may submit a renewed summary judgment based upon these exclusions if the motion is accompanied by a more detailed brief.

Because garnishee has not used these exclusions as a basis for its own summary judgment motion and because it has not responded to the arguments plaintiff's summary judgment motion raises [**32] about the exclusions, the Court questions whether garnishee itself wishes to continue to rely upon these defenses. Garnishee is urged to

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[15] Paragraph B of plaintiff's motion for summary judgment refers to exclusion J of the insurance policy. The Court has addressed exclusion J(5) of the Policy and found that the issue should be further briefed by the parties. The Court did not address exclusions J(1) or J(6) in its Opinion.

[16] Garnishee does address the "products complete operations hazard" clause in its reply brief. Garnishee states that any coverage plaintiff had under this section is negated by the Absolute Pollution Exclusion Endorsement. Garnishee should reconsider its position in light of the Court's decision with regard to that exclusion.

reassess it position regarding these defenses and, if it no longer wishes to rely upon them, it is urged to inform the Court through stipulation or motion that it will withdraw any defense based upon such exclusions.

VI.

In its brief in response to plaintiff's motion for summary judgment, garnishee contends that there is no coverage under the insurance policies at issue because of the "loss in progress" doctrine and the "known risk" doctrine. Plaintiff argues that because its motion for summary judgment sought dismissal of certain defenses plead by garnishee, it is inappropriate at this time for garnishee to raise the question of coverage. Plaintiff argues that, at the very least, it should be allowed more time and space to fully brief the issues. The Court determines that while this argument may well be the appropriate subject of a summary judgment motion brought by garnishee, it is not properly raised in a responsive brief. [17] The Court therefore declines to address the issue at this time. The Court makes clear that this is not a decision [**33] on the merits, and, as the issue may well be dispositive to the case, it allows garnishee time to [*428] file another summary judgment motion addressing the issue.

VII.

Garnishee's motion for summary judgment requests that this Court find that it has no obligation to pay the judgment entered against defendant because such payment is prohibited because defendant entered a settlement agreement with plaintiff or because various exclusions in the insurance policy prohibit coverage. For the reasons stated above, garnishee's motion must be denied. Also for the reasons stated above, plaintiff's motion is granted in part and denied in part.

BENJAMIN F. GIBSON

U.S. DISTRICT JUDGE

DATED: February 8, 1993

ORDER

At a session of the [**34] Court held in and for said District and Division, in the City of Grand Rapids, Michigan, this 8th day of February, 1993.

PRESENT: HON. BENJAMIN F. GIBSON, U.S. DISTRICT JUDGE

In accordance with the Opinion dated February 8, 1993,

IT IS HEREBY ORDERED that garnishee United Capitol Insurance Company's motion for summary judgment (pleading no. 33) is HEREBY DENIED.

IT IS FURTHER ORDERED that plaintiff Action Auto Stores' motion for summary judgment (pleading no. 35) is hereby GRANTED IN PART and DENIED IN PART.

IT IS FURTHER ORDERED that the parties shall have thirty (30) days to file renewed motions for summary judgment briefing the issues that the Court has indicated in its Opinion should be addressed.

IT IS FURTHER ORDERED that the times for filing responsive pleadings shall be governed by Rule 29 of the Western District of Michigan's Local Court Rules.

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[17] Plaintiff also contends that the issue is improperly raised because the defense was not contained in garnishee's garnishee disclosure statement. Garnishee has since filed a motion to amend the garnishee disclosure statement, and the Court determines that said motion should be granted.

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IT IS FURTHER ORDERED that garnishee United Capitol Insurance Company's motion (pleading no. 45) to file an amended garnishee disclosure statement adding the defenses based upon the "Loss in Progress" and "Known Risk Doctrines" is GRANTED.

IT IS SO ORDERED,

BENJAMIN F. GIBSON

U.S. DISTRICT JUDGE

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EXHIBIT 6

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Labar v. Cooper

Supreme Court of Michigan

June 10, 1965, Submitted ; October 4, 1965, Decided

Docket Nos. 50,884, 50,885

Reporter
376 Mich. 401 *; 137 N.W.2d 136 **; 1965 Mich. LEXIS 232 ***

LaBAR v. COOPER

Prior History: [***1] Appeal from Van Buren; Anderson (David J.), J.

Disposition: Reversed and remanded.

Core Terms

amend, original pleading, limitations, cases, arm, court rule, shot, trial judge, set forth, cause of action, occurrence, deceased, injected, motions, upper

Case Summary

Procedural Posture
Appellants, patient and her husband, sought review of a judgment from the trial court (Michigan) which denied their motion to amend the pleadings of their complaint in order to charge respondent doctor with general negligence.

Overview
The patient was injured when she was administered an intermuscular shot in the upper arm, which allegedly damaged her radial nerve. The patient and her husband sued the doctor for medical malpractice. They brought a motion to amend their complaint, primarily to charge the doctor with general acts of negligence in sending the patient to the hospital when he knew the standard of care employed by the nurses was faulty and that the shots were administered by them in a dangerous place. The trial court denied the motions. On appeal the court held that the amendment was not barred by the running of the statute of limitations because the new charge arose out of the conduct, transaction, or occurrence alleged in the original pleading. The court was unable to ascertain whether the trial judge exercised his discretion properly in denying the motion and remanded the case for further disposition, stating that the exercise of discretion should be supported by specific findings.

Outcome
The court ruled against the doctor and remanded the patient and husband's motion to amend the pleadings of their medical malpractice case to the trial court.

LexisNexis® Headnotes

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376 Mich. 401, *401; 137 N.W.2d 136, **136; 1965 Mich. LEXIS 232, ***1

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Leave of Court

Civil Procedure > Pleading & Practice > Pleadings > General Overview

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

HN1[] **Amendment of Pleadings, Leave of Court**

Mich. Gen. Ct. R. 118.1 read as follows: 1 Amendments. A party may amend his pleading once as a matter of course at any time before or within 15 days after a responsive pleading is served or, if the pleading is one to which no responsive pleading is required and the action has not been placed upon the trial calendar, he may amend it at any time before or within 15 days after it is served. Otherwise, a party may amend his pleading only by leave of court or by written consent of the adverse party. Leave shall be freely given when justice so requires. All amendments shall be filed in writing, dated, and numbered consecutively. Unless otherwise indicated therein, an amended pleading shall supersede the former pleading.

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Relation Back

HN2[] **Amendment of Pleadings, Relation Back**

Mich. Gen. Ct. R. 118.4 reads: 4 Relation Back of Amendments. Except for the purpose of demanding a trial by jury under sub-rule 508.2, the amendment relates back to the date of the original pleading whenever the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading.

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Relation Back

Governments > Legislation > Statute of Limitations > Time Limitations

Civil Procedure > Pleading & Practice > Pleadings > General Overview

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

Governments > Legislation > Statute of Limitations > General Overview

HN3[] **Amendment of Pleadings, Relation Back**

The relationship between the original pleading and a proposed amendment becomes important when the date of filing the amendment raises a question of limitations. The doctrine of relation back was devised by the courts to associate the amended matter with the date of the original pleading, so that it would not be barred by the statute of limitations. But some restrictions had to be placed upon the doctrine, or claims clearly barred could be resurrected by pleading them in an amendment to an unrelated claim which was not barred. Previous Michigan cases had set this restriction in terms of whether the amended matter involved a new cause of action.

Civil Procedure > ... > Affirmative Defenses > Statute of Limitations > Borrowing Statutes

Governments > Legislation > Statute of Limitations > General Overview

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Relation Back

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HN4[] **Statute of Limitations, Borrowing Statutes**
Mich. Gen. Ct. R. 118.4 is intended to introduce a more liberal and workable test, borrowed from the federal rules. The test is no longer conceptual, but rather functional. The amendment relates back to the date of the original pleading and, therefore, is not barred by limitations, whenever the claim or defense asserted in the amendment arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading. It is thus beside the point that the amendment introduces new facts, a new theory, or even a different cause of action, so long as it springs from the same transactional setting as that pleaded originally. The new test satisfies the basic policy of the statute of limitations, because the transactional base of the claim must still be pleaded before the statute runs, thereby giving defendant notice within the statutory period that he must be prepared to defend against all claims for relief arising out of that transaction.

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

HN5[] **Pleadings, Amendment of Pleadings**
Federal courts uniformly hold that amendments, which conform to *Fed. R. Civ. P. 15*, should be decided on their merits, not on technicalities.

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

HN6[] **Pleadings, Amendment of Pleadings**
An amendment which arises out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading is permitted under Mich. Gen. Ct. R. 118.4. The test, therefore, is no longer whether an amendment states a new cause of action, but is whether it arises out of the conduct, transaction, or occurrence alleged in the original pleading sought to be amended.

Headnotes/Syllabus

Headnotes

1. Pleading -- Amendment.

An amendment of a pleading relates back to the date of the original pleading whenever the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading, since the opposite party has been made aware of the claim sought to be enforced (GCR 1963, 118.1, 118.4).

2. Same -- Amendments.

Amendments to pleadings should be decided on their merits, not on technicalities (GCR 1963, 118.1, 118.4).

3. Courts -- Court Rules -- Amendment of Pleadings.

The new court rules apply to amendments sought to be made following the effective date of the rules, to pleadings filed before the effective date (GCR 1963, 14, 118.1, 118.4).

4. Pleading -- Amendment -- Malpractice.

Denial of amendments to plaintiffs' complaints in actions arising out of defendants' alleged malpractice *held,* improper, where they were based on the same transaction, and gave no occasion for claim of surprise, but merely

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sharpened the precise issue in order that defendants might know the legal theories upon which [***2] plaintiffs were proceeding (GCR 1963, 118.1, 118.4).

5. Same -- Amendment.

Amendments to pleadings shall be freely given when justice so requires (CLS 1961, § 600.2301; GCR 1963, 118).

6. Same -- Amendment -- Remand -- Discretion of Court.

Orders denying plaintiffs the right to amend their complaints in actions arising from defendants' alleged malpractice in injuring radial nerve in plaintiff wife's arm are reversed and case remanded with direction that if the amendments are again denied, such exercise of discretion be supported by specific findings as to reasons for such denial (GCR 1963, 118).

Syllabus

Declaration by Henry LaBar against Joseph E. Cooper and Kathleen Deja for alleged malpractice in the injection of plaintiff's wife's arm. Similar action by Lois LaBar. Plaintiffs' motions to amend declarations denied. Plaintiffs appeal.

Counsel: *Doyle, James & Dark*, for plaintiffs.

Howard & Howard (*William J. Howard*, of counsel), for defendants.

Judges: Adams, J. T. M. Kavanagh, C. J., and Dethmers, Kelly, Black, Souris, Smith, and O'Hara, JJ., concurred.

Opinion by: ADAMS

Opinion

[*402] [**137] These are husband and wife companion cases for alleged medical malpractice. [***3] The claim of injury to Mrs. LaBar arises out of an intermuscular shot which was administered July 30, 1960, [*403] in the upper arm, allegedly damaging the radial nerve.

Suits were begun March 27, 1962. Pretrial was completed January 17, 1963. The cases were ready at the November, 1963, term. Plaintiffs requested adjournment to the January, 1964, term which was granted upon stipulation.

The deposition of defendant Joseph E. Cooper was taken on May 16 and May 27, 1963. He testified:

> "Q. And Doctor, when you mention shots being given in the upper arm, where is the acceptable place in the upper arm for administering intermuscular shots?
>
> "A. Personally acceptable or medically acceptable?
>
> "Q. Medically acceptable.
>
> "A. Medically acceptable is usually in the upper half of the arm; mostly it is recommended if it must be given in or near the tip of the deltoid muscle. I personally do not adhere to this and haven't for many years. My training was to give intermuscular shot in the glutaneous area since it is much less apt to cause pain and discomfort and there's remote or slight chance of any nerve injury."

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He could not remember giving any orders as to [***4] where Mrs. LaBar was to receive the shot. Prior to when she was given it, he had expressed himself, time and again, to the nursing staff about the proper place for administering such a shot.

> "The reason for my mentioning it was that even in the doctors' offices in the area, this is, the upper arm is the popular spot to receive injections and having observed many many sore arms and lumps as the result of injections in this area and having been taught, where I was schooled, that this was not the proper or the best place to give them, I frequently expressed my opinion as I was taught [*404] and for the reason I've seen many sore arms, I could see no reason for it when the injection could go equally as well in the buttocks."

Before the doctor's deposition was taken, the plaintiffs' allegations of malpractice had consisted primarily of a charge that defendants negligently injected or caused to be injected a needle in Mrs. LaBar's arm which damaged the left radial nerve, causing nerve palsy and ensuing injuries.

Two weeks before the January, 1964, term was to begin, and some six months after Dr. Cooper was deposed, plaintiffs' attorneys moved to amend the declarations, primarily [***5] to charge Dr. Cooper with general [**138] acts of negligence in sending Mrs. LaBar to the hospital when he knew the standard of care employed by the nurses was faulty and that shots were administered by them in a dangerous place. The trial judge denied the motions and this Court granted leave to appeal.

I.

The trial judge stated:

> "Prior to filing the motions the statute of limitations, both as to malpractice and ordinary negligence, had run. Prior to the effective date of GCR 1963, the motion would have been denied, because of the running of the statute." [1]

HN1[] Michigan General Court Rules 118.1 and 118.4 read as follows:

> ".1 Amendments. A party may amend his pleading once as a matter of course at any time before or within 15 days after a responsive pleading is served or, if the pleading is one to which no responsive pleading is required and the action has not [*405] been placed upon the trial calendar, he [***6] may amend it at any time before or within 15 days after it is served. Otherwise, a party may amend his pleading only by leave of court or by written consent of the adverse party. *Leave shall be freely given when justice so requires.* All amendments shall be filed in writing, dated, and numbered consecutively. Unless otherwise indicated therein, an amended pleading shall supersede the former pleading." (Emphasis supplied.)
>
> HN2[] ".4 Relation Back of Amendments. Except for the purpose of demanding a trial by jury under sub-rule 508.2, the amendment relates back to the date of the original pleading *whenever the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading."* (Emphasis supplied.)

GCR 1963, 118 is an adoption of Federal Rule 15. The purpose of its adoption is stated by Honigman and Hawkins, 1 Michigan Court Rules Annotated, page 416:

> HN3[] "The relationship between the original pleading and a proposed amendment becomes important when the date of filing the amendment raises a question of limitations. The doctrine of 'relation back' was devised by the courts [***7] to associate the amended matter with the date of the original pleading, so that it would not be barred by the statute of limitations. But some restrictions had to be placed upon the doctrine, or claims clearly barred could be resurrected by pleading them in an amendment to an unrelated claim which was not barred. Previous Michigan cases had set this restriction in terms of whether the amended matter involved a new cause of action.

[1] CLS 1961, § 600.5805(3) (Stat Ann 1962 Rev § 27A.5805[3]). -- Reporter.

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HN4[↑] "Sub-rule 118.4 is intended to introduce a more liberal and workable test, borrowed from the Federal rules. See committee comment (5), *supra*. The test is no longer conceptual, but rather functional. [*406] The amendment relates back to the date of the original pleading and, therefore, is not barred by limitations, whenever the claim or defense asserted in the amendment arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading. *It is thus beside the point that the amendment introduces new facts, a new theory, or even a different cause of action, so long as it springs from the same transactional setting as that pleaded originally.* The new test satisfies the basic policy of the statute [***8] of limitations, because the transactional base of the claim must still be pleaded before the statute runs, thereby giving defendant notice within the statutory [**139] period that he must be prepared to defend against all claims for relief arising out of that transaction." (Emphasis supplied.)

Defendants place great stress upon their substantive rights by virtue of the statute of limitations, asserting that the Supreme Court lacks the power to change by court rule the substantive law. Mr. Justice Black, speaking for the United States Supreme Court, in the case of *Tiller v. Atlantic Coast Line Railroad Company (1945), 323 U.S. 574, 581 (65 S Ct 421, 89* L ed 465) said:

"The original complaint in this case alleged a failure to provide a proper lookout for deceased, to give him proper warning of the approach of the train, to keep the head car properly lighted, to warn the deceased of an unprecedented and unexpected change in manner of shifting cars. The amended complaint charged the failure to have the locomotive properly lighted. Both of them related to the same general conduct, transaction and occurrence which involved the death of the deceased. There was therefore [***9] *no departure. The cause of action now, as it was in the beginning, is the same -- it is a suit to recover damages for the wrongful death of the deceased.* 'The effect of the amendment [*407] here was to facilitate a fair trial of the existing issues between plaintiff and defendant.' *Maty v. Grasselli Co., 303 U.S. 197, 201 (58 S Ct 507, 82* L ed 745). *There is no reason to apply a statute of limitations when, as here, the respondent has had notice from the beginning that petitioner was trying to enforce a claim against it because of the events leading up to the death of the deceased* in the respondent's yard." (Emphasis supplied.)

We adopt the above reasoning of the United States Supreme Court.

HN5[↑] Federal courts uniformly hold that amendments, which conform to *FRCP 15*, should be decided on their merits, not on technicalities. *Copeland Motor Co. v. General Motors Corp. (CA 5), 199 F2d 566, 567, 568*; *Cooper v. American Employers' Insurance Company (CA 6), 296 F2d 303, 306*. For a recent application of this rule, see *Link Aviation, Inc., v. Downs (1963), 117 App DC 40, 42 (325 F2d 613, 615)*, and the cases cited therein. See, also, the [***10] discussion in *United States v. Memphis Cotton Oil Co., 288 U.S. 62, 67-69 (53 S Ct 278, 77* L ed 619); 3 *Moore's Federal Practice, § 15.02[1]*, p 814; 1A Barron and Holtzoff, § 442, p 712.

Under prior decisions, before adoption of the General Court Rules of 1963, we have generally followed the rule that an amendment which states a new cause of action is barred. *Gorman v. Newaygo Circuit Judge, 27 Mich 138, 140*; *Michigan Central R. Co. v. Kalamazoo Circuit Judge, 35 Mich 227*; *Nugent v. Kent Circuit Judge, 93 Mich 462, 463*; *Wingert v. Wayne Circuit Judge, 101 Mich 395, 397*; *Bockoff v. Curtis, 241 Mich 553, 558*; *O'Rourke v. Deffenbaugh, 280 Mich 407, 414, 415*; *Talbot v. Stoller, 366 Mich 296, 301*. However, in adopting new court rules it was our intention to depart from some of the strictures of the old rule and to permit HN6[↑] an amendment which arises "out of the conduct, [*408] transaction, or occurrence set forth or attempted to be set forth in the original pleading." GCR 1963, 118.4. The test, therefore, is no longer whether an amendment states a new cause of action, but is whether it arises out of the conduct, transaction, [***11] or occurrence alleged in the original pleading sought to be amended. From the effective date of the new court rules, [2] the old rule cited in the cases immediately above was meant no longer to be followed. Accordingly, the new court rules govern in this case.

[**140] II.

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[2] See GCR 1963, 14. -- Reporter.

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If the amendments were not barred by the running of the statute of limitations, there remains the question of exercise of discretion by the trial judge. Defendants also opposed the motions on the ground that the cases had been pretried, placed on the calendar, and adjourned over one term at the request of the plaintiffs.

The trial judge stated:

> "Granting of the motions would require the allowance of additional time to defendants to answer, require further discovery depositions subjecting defendants to further expense in attending or participating or to peril of nonattendance, and the possibility of further delay through requests for further pretrial conference. The transaction occurred nearly 4 **[***12]** years ago. The case should be heard and disposed of before time dims further the memories of witnesses."

There is nothing in the record before us to support the judge's statement that further discovery depositions would be required. No such claim was made by counsel for either of the parties. It would appear that all medical witnesses had been deposed. Further **[*409]** pretrial would at best be summary and could be disposed of quickly. There can be no claim of surprise. The testimony upon which plaintiffs' new theory is based comes from defendant Cooper's own mouth. The amendments were based upon the same transaction as the original declaration. They merely sharpened the precise issue of malpractice or negligence in order that defendants might know the legal theories upon which plaintiffs were proceeding. From the record before us, no reason appears why the amendments could not have been allowed and the cases tried as scheduled.

It should always be borne in mind that GCR 1963, 118 provides that leave to amend shall be freely given when justice so requires, and that RJA § 2301 (CLS 1961, § 600.2301 [Stat Ann 1962 Rev § 27A.2301]) provides for amendment either in **[***13]** form or substance for the furtherance of justice.

While the conclusions upon which the trial judge based his exercise of discretion are before us, his findings are not. Consequently, we are unable to say whether he exercised his discretion properly. The cases are remanded to the trial judge for further disposition in the light of this opinion. In the event the motions are denied, such exercise of discretion should be supported by specific findings as to reasons for the same.

Reversed and remanded. Costs to appellants.

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EXHIBIT 7

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Grist v. Upjohn Co.

Court of Appeals of Michigan

January 18, 1965, Submitted Division Three ; April 19, 1965, Decided

Docket No. 238

Reporter
1 Mich. App. 72 *; 134 N.W.2d 358 **; 1965 Mich. App. LEXIS 185 ***

GRIST v. THE UPJOHN COMPANY

Subsequent History: [***1] Leave to Appeal Denied by Supreme Court July 1, 1965.

Prior History: Appeal from Kalamazoo; Fox (Raymond W.), J.

Disposition: Affirmed.

Core Terms

slander, amend, amended declaration, trial court, supplemental pleading, employees, statute of limitations, original declaration, cause of action, declaration, libel, original pleading, allegations, supplied, supplemental declaration, set forth, counts

Case Summary

Procedural Posture
Plaintiff employee sought review of the judgment of a trial court in Kalamazoo County (Michigan), which held that the employee's amended pleadings in her slander claim against defendants, employer and employees, was an amended declaration, and ordered the striking of certain statements in the pleading.

Overview
Originally, the employee filed a five count declaration, and in the first four counts, separately sued the employees for slander. In the fifth count, the employee alleged that the employees and the employer conspired together to use the claimed slanderous statements to destroy the employee's "good name." After several proceedings, the employer's motion to dismiss was granted, and the employee filed an amended pleading. The employee appealed from the judgment granting the employer's motion to strike portions of the amended pleading and for a more definite statement. On appeal, the court affirmed the judgment of the trial court. The court found that the employee's supplemental leading was properly treated as an amended declaration, because the employee did not obtain leave of the trial court to file a supplemental pleading. Therefore, the employee filed the pleading subject to the objections of the employer. The court found that the trial court properly granted the employer's motion for a more definite statement in order to eliminate the claimed slanderous acts that were not a proper basis for relief.

Outcome
The court affirmed the judgment of the trial court, which held that the employee's amended pleadings in her slander claim against the employer was an amended declaration, and ordered the striking of certain statements in the pleading.

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LexisNexis® Headnotes

Governments > Legislation > Statute of Limitations > Time Limitations

Torts > Intentional Torts > Defamation > Libel

Torts > ... > Defamation > Defenses > Statute of Limitations

Torts > Intentional Torts > Defamation > Slander

Torts > Procedural Matters > Statute of Limitations > General Overview

HN1[] **Statute of Limitations, Time Limitations**
The statutory provisions concerning limitation of personal actions provide in part: 5. Actions founded upon libel or slander shall be brought within one year from the time the cause of action accrues and not afterwards. Mich. Comp. Laws § 609.13 (1956); Mich. Stat. Ann § 27.605 (1959 Cum Supp.).

Civil Procedure > ... > Affirmative Defenses > Statute of Limitations > Revival

Governments > Legislation > Statute of Limitations > Extensions & Revivals

Torts > Intentional Torts > Defamation > General Overview

Governments > Legislation > Statute of Limitations > General Overview

Torts > ... > Defamation > Defenses > Statute of Limitations

Torts > Intentional Torts > Defamation > Libel

Torts > Intentional Torts > Defamation > Slander

Torts > Procedural Matters > Statute of Limitations > General Overview

HN2[] **Statute of Limitations, Revival**
The right of action accrues from the time of publication. The time within which an action for libel or slander must be commenced is usually fixed by statute, and there can be no legal trial of such an action while a plea by defendant of the statute of limitations remains unanswered and undisposed. The general rule is that the statute begins to run from the time when the defamation is published, even though the person defamed has no knowledge thereof until some time afterward; and this, it has been intimated, even though plaintiff's ignorance may be due to fraud on the part of defendant. Admissions or repetitions. When a right of action for slander has been once barred by the statute of limitations, it cannot be revived by an admission of defendant that he did utter the slanderous words, nor can the running of the statute be prevented by repetitions of the slander, although of course a separate action will lie for any repetition within the statutory time.

Governments > Legislation > Statute of Limitations > Time Limitations

Torts > Procedural Matters > Statute of Limitations > General Overview

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Governments > Legislation > Statute of Limitations > General Overview

Torts > ... > Defamation > Defenses > Statute of Limitations

Torts > Intentional Torts > Defamation > Slander

HN3[] **Statute of Limitations, Time Limitations**
Each act of slander is the basis for a separate action, but all such separate acts of slander may be joined in one declaration provided the statute of limitations has not run.

Governments > Legislation > Statute of Limitations > General Overview

Torts > Intentional Torts > Defamation > Libel

Torts > ... > Defamation > Defenses > Statute of Limitations

HN4[] **Legislation, Statute of Limitations**
With respect to so-called "black list" reports wherein an employer states his reasons for discharging a former employee, the view has been taken that if such a writing is exhibited to a third person at some time within the applicable limitation period prior to a commencement of a libel suit based on alleged defamatory matter appearing in the writing, there is a new and independent publication against which limitations then commence to run and the action may consequently be maintained, even though it appears that the statement was originally exhibited to some third person at a time which antedates the statutory period.

Civil Procedure > Pleading & Practice > Pleadings > Rule Application & Interpretation

Governments > Legislation > Statute of Limitations > Time Limitations

Torts > ... > Defamation > Defenses > Statute of Limitations

Governments > Legislation > Statute of Limitations > General Overview

Torts > Intentional Torts > Defamation > Slander

Torts > Procedural Matters > Statute of Limitations > General Overview

HN5[] **Pleadings, Rule Application & Interpretation**
Each act of slander constitutes a separate cause of action and the statute of limitations commences to run from the date of each such utterance. Separate acts of slander may be joined in the same pleading provided they all occur within the statutory period.

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Relation Back

Criminal Law & Procedure > ... > Warrantless Searches > Consent to Search > Sufficiency & Voluntariness

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Leave of Court

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Civil Procedure > Pleading & Practice > Pleadings > Supplemental Pleadings

HN6[] **Amendment of Pleadings, Relation Back**

Amended and supplemental pleadings are governed by Mich. Gen. Ct. R. 118.1, 118.4, and 118.5 (1963): 1 A party may amend his pleading once as a matter of course at any time before or within 15 days after a responsive pleading is served or, if the pleading is one to which no responsive pleading is required and the action has not been placed upon the trial calendar, he may amend it at any time before or within 15 days after it is served. Otherwise, a party may amend his pleading only by leave of court or by written consent of the adverse party. Leave shall be freely given when justice so requires. All amendments shall be filed in writing, dated, and numbered consecutively. Unless otherwise indicated therein, an amended pleading shall supersede the former pleading. 4 Except for the purpose of demanding a trial by jury under Mich. Gen. Ct. R. 508.2, the amendment relates back to the date of the original pleading whenever the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading.

Civil Procedure > Pleading & Practice > Pleadings > Supplemental Pleadings

HN7[] **Pleadings, Supplemental Pleadings**

Amended and supplemental pleadings are governed by Mich. Gen. Ct. R. 118.1, 118.4, and 118.5 (1963):Upon motion of a party the court may, upon reasonable notice and upon such terms as are just, permit him to serve a supplemental pleading to set forth any transactions or occurrences or events which have happened since the date of the pleading sought to be supplemented, whether or not the original pleading is defective in its statement of a claim for relief or defense. If the court deems it advisable that the adverse party plead thereto, it shall so order, specifying the time therefor.

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Relation Back

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

Civil Procedure > Pleading & Practice > Pleadings > Supplemental Pleadings

HN8[] **Amendment of Pleadings, Relation Back**

Mich. Gen. Ct. R. 118.4 (1963), permits the amendment to relate back to the date of the original pleading. However, there is no provision for relating back as to supplemental pleadings, Mich. Gen. Ct. R. 118.5 (1963). (6) Any transactions or occurrences arising after the original pleading may be set forth by supplemental pleading under this subsection. To preclude any hard and fast distinction between amended and supplemental pleadings, this subsection includes the proposed amendment to the federal rule which authorizes supplemental pleading whether or not the original pleading is defective. Thus a supplemental pleading which does present a valid statement of claim will allow the action to proceed, even if the original pleading remains defective for lack of amendment. Because there is no provision for relation back, a supplemental pleading based upon new facts must be filed before the statutory period of limitations has expired.

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Leave of Court

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

Civil Procedure > Pleading & Practice > Pleadings > Supplemental Pleadings

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HN9[] **Amendment of Pleadings, Leave of Court**

Under Mich. Ct. R. 72, § 1 (a) (1945), provides that the Supreme Court may exercise any or all of the procedures of amendment of the trial court.

Headnotes/Syllabus

Headnotes

1. Libel and Slander -- Limitation of Actions.

An action for libel or slander must be brought within 1 year from the time the cause of action accrues and not afterwards (CLS 1956, § 609.13).

2. Same -- Accrual of Cause of Action.

An action for libel or slander accrues from the time of publication (CLS 1956, § 609.13).

3. Same -- Limitation of Actions -- Trial on Merits.

There can be no legal trial on the merits of an action for libel or slander after a plea of the statute of limitations is interposed until after disposition of such plea (CLS 1956, § 609.13).

4. Same -- Limitation of Actions -- Admission.

A right of action for libel or slander cannot be revived by an admission of defendant after the statute of limitations has barred the action that he did utter the defamatory matter (CLS 1956, § 609.13).

5. Same -- Limitation of Actions -- Repetition.

The running of the statute of limitations as to a slander cannot be prevented by repetitions of the slander, although a separate action will lie for any repetition within the statutory time (CLS 1956, [***2] § 609.13).

6. Same -- Limitation of Actions -- Separate Acts.

Each slander is the basis for a separate action, but all such separate acts may be joined in 1 declaration provided the statute of limitations has not run (CLS 1956, § 609.13).

7. Same -- Limitation of Actions -- Separate Acts.

Separate acts of slander may be joined in the same pleading provided they all occur within the period before being barred by the statute of limitations (CLS 1956, § 609.13).

8. Pleading -- Amendment -- Leave of Court.

An amendment to a pleading following 15 days after a responsive pleading has been served may be made only by leave of court or by written consent of the adverse party (GCR 1963, 118.1).

9. Same -- Amendment.

An amendment of a pleading relates back to the date of the original pleading whenever the claim asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading (GCR 1963, 118.4).

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10. Same -- Supplemental Pleading.

A supplemental pleading may be permitted in order to set forth any transactions or occurrences or events which have happened since the date of the pleading sought to be supplemented, [***3] upon motion of the party who gives reasonable notice thereof and upon such terms as the court may impose (GCR 1963, 118.5).

11. Same -- Supplemental -- Relation Back.

The court rules do not provide for the relating back of a supplemental pleading to the date of the original pleading as is permitted to amendment of a pleading (GCR 1963, 118.4, 118.5).

12. Same -- Supplemental Pleading -- Limitation of Actions.

A supplemental pleading based upon new facts must be filed before the statutory period of limitations has expired (CLS 1956, § 609.13; GCR 1963, 118.5).

13. Same -- Amendment -- Libel and Slander Action.

Authorization by the Supreme Court to amend pleading, subject to the objections of defendant, accorded plaintiff in libel and slander action, did not accord her the right to file a supplemental pleading, hence, the pleading adopted pursuant to the authorization given must be treated as an amended declaration, subject to the objections of the defendant (GCR 1963, 118.4, 118.5).

14. Same -- Amendment -- Objections.

Supreme Court's authorization to plaintiff to amend her pleading, subject to objections of defendant, did not effectuate an estoppel upon defendant from objecting [***4] to plaintiff's pleading on the ground that it alleged subsequent matters for which leave of court had to be obtained, since the same source for authority to make the amendment also gave defendant the right to object to any matters contained in such amendment (Court Rule No 72, § 1 [a] [1945]).

15. Same -- Amendment -- More Definite Statement -- Limitation of Actions.

Amended declaration in libel and slander action was properly limited to acts of slander to which the pleaded statute of limitations could not be used as a bar, hence, it was not improper on the part of the court to require a more definite statement as to claimed acts of slander in order to advise defendant if the same were subject to the statute of limitations, subsequent acts being barred by such statute (CLS 1956, § 609.13; GCR 1963, 118.4, 118.5).

16. Costs -- Third Appeal -- Assessment.

Costs are awarded to defendant on third appeal by plaintiff, in action for libel and slander, where trial court's determination on defendant's motion for a more definite statement, to strike portions of amended declaration, and for accelerated judgment is affirmed and the cause remanded for further proceedings, but assessment [***5] of costs is to await determination on the merits.

Syllabus

Declaration by Arletta T. Grist against The Upjohn Company, a Michigan corporation, and others for alleged slander. From order granting motion to strike certain portion of declaration and to dismiss as to defendant corporation, plaintiff appeals.

Counsel: *Thomas S. Stearns* and *Hoffman, McDonald & Hoffman* (*Leo W. Hoffman*, of counsel), for plaintiff.

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Robert H. Hosick, Robert C. Carson, Murray D. Welch, Jr., Gerard Thomas, and *E. Raymond Stanhope* (*Ford, Kriekard & Brown*, of counsel), for defendant Upjohn Company.

Judges: Holbrook, J. Fitzgerald, P. J., and Burns, J., concurred.

Opinion by: HOLBROOK

Opinion

[*75] **[**359]** This is the third appeal [1] to be considered concerning the proceedings originally brought by Arletta T. Grist, plaintiff and appellant, against The Upjohn Company, a Michigan corporation, defendant and appellee, for alleged slander. The suit was commenced by summons being issued on December 5, 1957, with declaration being filed February 17, 1958.

[*6]** Plaintiff, Arletta T. Grist, claimed continuous employment with the defendant, Upjohn Company, from September 15, 1938, until April 5, 1957, upon which date she was dismissed.

Plaintiff employed a five count declaration, and in the first four counts, separately sued defendant's employees for slander. The fifth count alleged defendant employees together with defendant, Upjohn Company (The Upjohn Company being the fifth defendant) conspired together to employ the claimed slanderous statements of the defendant's employees for the purpose of "destroying plaintiff's good name".

Defendant Upjohn, being a corporation, moved to strike and for dismissal in its favor, assigning as the reason that the declaration contained no allegation that the alleged slanderous statements had been authorized or ratified by it. The trial court granted defendant Upjohn's motion relying on the rule of *Robertson v. New York Life [**360] Insurance Company (1945), 312 Mich 92*.

The order granting defendant Upjohn's motion was dated July 15, 1959. On August 7, 1959, plaintiff filed a "motion for rehearing" and an alternative motion for "leave to amend as to The Upjohn **[*76]** Company". On **[***7]** January 6, 1960, the trial court denied such last mentioned motion, basing its decision upon the *Robertson Case*, and ruling further that the proposed amendment offered after "the statute of limitations had now run," introduced a new, statute-barred cause. From the order granting defendant Upjohn's motion to dismiss, and from such order denying plaintiff's motion, plaintiff appealed to the Supreme Court.

This appeal was considered in the case of *Grist v. The Upjohn Company (1961), 362 Mich 470*, and on p 472, of said opinion the Court stated:

> "The motion to dismiss was granted on authority of applicable law as same stood when that motion and the subsequent motion were decided against plaintiff's pleaded right of action. However, after plaintiff's appendix and both briefs on appeal were filed here, the rule of *Robertson* -- on which Judge Fox properly relied -- was overruled by *Poledna v. Bendix Aviation Corp., 360 Mich 129, 140*. In these circumstances fairness suggests remand, rather than reversal, in order that the trial judge may reconsider in *Poledna's* light defendant Upjohn's motion to dismiss."

Thereafter, plaintiff filed a motion to amend together **[***8]** with the proposed amended declaration on May 19, 1961. On May 23, 1961, the action against the individual defendants (employees of defendant) was dismissed by stipulation. The trial court postponed the hearing, on plaintiff's motion "to amend" until after the court's decision on the defendant's "motion to dismiss". The trial court then took defendant's original motion to dismiss under advisement. On August 4, 1961, opinion granting defendant's original motion was filed. The trial court held that "even in *Poledna's* light," plaintiff did not state a cause of action because she "fails to allege that the slanderous

[1] For prior appeals see *362 Mich 470* and *368 Mich 578*. -- Reporter.

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remarks were made in the discharge [*77] of the duty of the employees or in relation to a matter about which their duty permitted or required them to act".

Order granting motion to dismiss was filed August 14, 1961. Hearing on plaintiff's motion for leave to amend was held on August 31, 1961. On the same day, plaintiff took an appeal from the trial judge's order granting the defendant's motion to dismiss. On November 29, 1961, the trial judge ruled that because the plaintiff had appealed, the circuit court lacked jurisdiction to consider motion to amend.

[***9] This appeal was considered in the case of Grist v. The Upjohn Company (1962), 368 Mich 578, wherein Mr. Justice Adams stated on pp 581-585:

"The first question to be considered is whether or not the plaintiff's original declaration states a cause of action against Upjohn. Count 5 of plaintiff's original declaration alleges:

"'Defendant Margery White was employed in the personnel department of the defendant Upjohn Company and it was a part of her duties as such employee to consider the work and conduct of plaintiff and other women employees, to inform her superiors thereof and to handle matters pertaining thereto, and to the discharges of any woman employee, including inquiries regarding previous employees.' * * *

"Count 1 alleges that defendant White falsely stated to various persons that the plaintiff was a poor worker, was guilty of a great deal of absenteeism and that she sold or delivered eggs on company time. It is alleged that when plaintiff applied for work with other companies an inquiry was made about plaintiff to defendant [**361] White, defendant White falsely stated that plaintiff was discharged because she had an unsatisfactory attendance record and [***10] poor performance record. Counts 2, 3, and 4 allege that the other individual defendants made the [*78] same false statements about plaintiff, resulting in her being unable to obtain employment in the Kalamazoo area.

"Are these allegations sufficient to come under the rule of *Poledna?* It is as follows (pp 139, 140):

"'A corporation may be held liable for slander uttered by an agent while in the discharge of his duty as agent and in relation to the matter about which his duty as agent permits or requires him to act in the same way and to the same extent as an individual could be held liable for the same slander.'

"The allegations of count 5 of plaintiff's declaration in effect allege that each of the individual defendants was an employee of Upjohn, was in some sort of supervisory capacity over plaintiff and was responsible for assessing the work and performance of plaintiff. It is then alleged that for the purpose of destroying plaintiff's good name and reputation, and preventing her from obtaining employment or damaging her in her attempts to obtain employment, they made false assessments of her work performances, causing her discharge, and that defendant White directly [***11] and in her capacity as an employee of Upjohn made representations to other possible employers that prevented plaintiff from securing employment. There has been alleged a direct causal connection by the agents of Upjohn acting in discharge of their duties as such agents or employees with the damage to plaintiff. It was therefore erroneous of the trial court to grant the defendant's motion to dismiss.

"As to the 2 attempts which were made by plaintiff to amend, it will be recalled that the first of these was made prior to the first appeal to this Court. * * *

"Plaintiff alleges therein that the slanderous statements of Upjohn's employees were 'expressly' authorized or 'ratified' by Upjohn. Express authorization or ratification was not alleged in the original declaration. The evidence necessary to support the original declaration and that to support [*79] the amended declaration would not be the same. 'The amendment represented a change in plaintiff's theory and amounted to introducing a new cause of action'. Cook v. Wolverine Stockyards Co., 344 Mich 207, 210. The trial court did not abuse its discretion in denying plaintiff's motion to amend.

"Finally, what is [***12] the present status of the second attempt to amend the declaration which was noticed for hearing on August 31, 1961, the same day the court heard the defendant's motion to dismiss? * * * The trial court lost jurisdiction to rule on the motion to amend when the second appeal was taken to this Court. However, in view of the ruling of this Court at this time, *plaintiff may now, if she chooses, amend as a matter of right, subject, of course, to objection to the contents of the amendment by defendant.*

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"Remanded. Costs to plaintiff." (Emphasis supplied.)

The proceedings were again returned to the trial court for further action. Plaintiff elected, pursuant to the order of the Supreme Court by notice filed in the trial court on February 18, 1963, "to stand upon her *amended declaration* heretofore filed herein May 19, 1961". (Emphasis supplied.)

Thereafter, defendant, The Upjohn Company, filed on March 6, 1963, a motion for **[**362]** more definite statement, to strike portions of amended declaration and for accelerated judgment.

The trial judge, Honorable Raymond W. Fox, circuit judge, ruled on said motion and granted the motion to strike portions of the amended declaration **[***13]** in part, denied the motion for accelerated judgment and granted the motion for more definite statement.

The order of the court in accordance with the opinion was filed November 7, 1963. In said order, the trial court held that plaintiff's amended pleading of May 19, 1961, was an *amended declaration* **[*80]** and ordered the striking of all allegations alleging slanderous statements and acts of interference with plaintiff's employment occurring after the date of filing of the original declaration, and required plaintiff to allege specifically, instead of generally, slanderous statements and acts of interference with plaintiff's employment as to persons performing such acts, and time when such statements and acts occurred. From this order the plaintiff and appellant has appealed to this Court claiming: (1) The court erred in holding and ruling that plaintiff's pleading was an amended declaration, instead of an amended and supplemental declaration; (2) defendant waived its objection, and is estopped now from objecting to plaintiff's pleading on the ground that it alleged subsequent matters and it was necessary to obtain leave of court; (3) regardless of whether plaintiff's amendment **[***14]** be considered an amended declaration, a supplemental declaration, or an amended and supplemental declaration, it properly pleaded plaintiff's case; (4) plaintiff's pleading was not defective for uncertainty.

This Court deems it imperative to consider the law concerning libel and slander insofar as limitation of actions are concerned in dealing with the objections of the plaintiff to the trial court's order of November 7, 1963.

HN1[↑] The statutory provisions concerning limitation of personal actions provide in part:

"5. Actions founded upon libel or slander shall be brought within 1 year from the time the cause of action accrues and not afterwards." CLS 1956, § 609.13 (Stat Ann 1959 Cum Supp § 27.605). [2]

The general rule concerning limitation of actions is found in 37 CJ, Libel and Slander, § 314, p 17:

[*81] *HN2*[↑] "The right of action accrues from the time of publication. The time within **[***15]** which an action for libel or slander must be commenced is usually fixed by statute, and there can be no legal trial of such an action while a plea by defendant of the statute of limitations remains unanswered and undisposed of. The general rule is that the statute begins to run from the time when the defamation is published, even though the person defamed has no knowledge thereof until some time afterward; and this, it has been intimated, even though plaintiff's ignorance may be due to fraud on the part of defendant. * * *

"Admissions or repetitions. When a right of action for slander has been once barred by the statute of limitations, it cannot be revived by an admission of defendant that he did utter the slanderous words, *nor can the running of the statute be prevented by repetitions of the slander,* although of course a separate action will lie for any repetition within the statutory time." (Emphasis supplied.)

Plaintiff in her amended declaration of May 19, 1961, alleged numerous acts of slander by the defendant; some specifically, many generally, and others of a continuing **[**363]** nature. Defendant does not object to any of the separate acts of alleged slander **[***16]** but does object to any allegations concerning slander occurring subsequent to the date of the filing of the first declaration, February 17, 1958.

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[2] For current provisions, see PA 1961, No 236, § 5805 (CLS 1961, § 600.5805 [Stat Ann 1962 Rev § 27A.5805]).

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Michigan follows the general rule as recited in 37 CJ, *supra*, that HN3[↑] each act of slander is the basis for a separate action, but that all such separate acts of slander may be joined in one declaration provided the statute of limitations has not run. See *Randall v. Wayne Circuit Judge (1893), 96 Mich 284*.

The rule concerning publication of libel for purposes of statute of limitations is further set forth in *1 ALR2d 384, 392, 399*:

> "§ 4 * * * *Age-Herald Pub. Co. v. Waterman (1914), 188 Ala 272 (66 So 16*, Ann Cas 1916E, 900), **[*82]** where the libel sued on was set up in one count of the complaint as having appeared in defendant's newspaper and, more than a year after the date of such publication, other counts were added which alleged publication of the same libel in newspapers in other cities at the inducement of the defendant. Although the additional counts had been eliminated at the trial on plaintiff's request, the court took occasion to observe that such counts, setting up republications in other papers, stated **[***17]** different causes of action from that alleged in the original complaint, and pointed out that since they were filed more than one year after the original publication, the rule that an amendment of a complaint which sets up a new cause of action rather than restates the original cause of action in different language is not allowable after expiration of limitations on the original cause of action applied. * * *
>
> "§ 9 -- 'Black list' reports. As to statement with reference to discharge from private employment as actionable per se, see annotation in 66 ALR 1499.
>
> HN4[↑] *"With respect to so-called 'black list' reports wherein an employer states his reasons for discharging a former employee, the view has been taken that if such a writing is exhibited to a third person at some time within the applicable limitation period prior to a commencement of a libel suit based on alleged defamatory matter appearing in the writing, there is a new and independent publication against which limitations then commence to run and the action may consequently be maintained, even though it appears that the statement was originally exhibited to some third person at a time which antedates the statutory period."* **[***18]** (Emphasis supplied.)

It appears without question that HN5[↑] each act of slander constitutes a separate cause of action and the statute of limitations commences to run from the date of each such utterance. Separate acts of slander may be joined in the same pleading provided they all occur within the statutory period.

[*83] The plaintiff and appellant has urged that in four particulars the trial judge erred in his opinion concerning the amended declaration filed May 19, 1961. Plaintiff claims that the court should have considered such pleading as an amended *and* supplemental declaration. Plaintiff advances in effect that the same should be classified as neither fish nor fowl, but both. There may be instances in the law that justify such a conclusion, but is this one of them?

HN6[↑] Amended and supplemental pleadings are governed by GCR 1963, 118.1, 118.4, 118.5:

> ".1 Amendments. A party may amend his pleading once as a matter of course at any time before or within 15 days after a responsive pleading is served or, if the pleading is one to which no responsive pleading is required and the action has not been **[**364]** placed upon the trial calendar, he may amend it at any time **[***19]** before or within 15 days after it is served. Otherwise, a party may amend his pleading only by leave of court or by written consent of the adverse party. Leave shall be freely given when justice so requires. All amendments shall be filed in writing, dated, and numbered consecutively. Unless otherwise indicated therein, an amended pleading shall supersede the former pleading. * * *
>
> ".4 Relation Back of Amendments. Except for the purpose of demanding a trial by jury under sub-rule 508.2, *the amendment relates back to the date of the original pleading whenever the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading.*
>
> HN7[↑] ".5 Supplemental Pleadings. *Upon motion of a party the court may, upon reasonable notice and upon such terms as are just, permit him to serve a supplemental pleading to set forth any transactions or*

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occurrences or events which have happened since the date of the pleading sought to be supplemented, [*84] whether or not the original pleading is defective in its statement of a claim for relief or defense. If the court deems it advisable that [***20] the adverse party plead thereto, it shall so order, specifying the time therefor." (Emphasis supplied.)

The right of the plaintiff to file an amended declaration would be predicated upon the court rule, *supra,* and by reason of the ruling in the case of Grist v. The Upjohn Company (1962), 368 Mich 578, wherein the Court said on pp 584, 585:

"However, in view of the ruling of this Court at this time, plaintiff may now, if she chooses, amend as a matter of right, subject, of course to objection to the contents of the amendment by defendant." (Emphasis supplied.)

The Supreme Court, as above stated, permitted plaintiff to *amend* her declaration. This she elected to do by adopting the amended declaration filed May 19, 1961.

HN8[] GCR 1963, 118.4, permits the amendment to relate back to the date of the original pleading. However, there is no provision for relating back as to supplemental pleadings, GCR 1963, 118.5. In 1 Michigan Court Rules Annotated, by Honigman and Hawkins (2d ed), p 409, we find committee notes:

"(6) Supplemental Pleadings. Any transactions or occurrences arising after the original pleading may be set forth by supplemental pleading under [***21] this subsection. To preclude any hard and fast distinction between amended and supplemental pleadings, this subsection includes the proposed amendment to the federal rule which authorizes supplemental pleading whether or not the original pleading is defective. Thus a supplemental pleading which does present a valid statement of claim will allow the action to proceed, even if the original pleading remains defective for lack of amendment.

[*85] *"Because there is no provision for relation back, a supplemental pleading based upon new facts must be filed before the statutory period of limitations has expired."* (Emphasis supplied.)

The dismissal of the plaintiff by defendant took place April 5, 1957; the original declaration for slander brought by plaintiff against defendant was filed February 17, 1958, and the amended pleading was filed May 19, 1961, alleging, among other things, the original claimed slanderous acts, and in addition slanderous acts occurring subsequent to the filing of the original declaration. Inasmuch as each slanderous act is a basis for an action and the statute of limitations runs from the date of each such act, we have a condition wherein the pleading [***22] [**365] of May 19, 1961, cannot be a supplemental pleading, without eliminating all claimed acts of slander occurring more than one year prior to the last mentioned date.

In any event, the provisions in the GCR, *supra,* for filing of supplemental pleadings requires an order of the court allowing the same. HN9[] Under Court Rule No 72, § 1 (a) (1945), in effect at the time of the last appeal to the Supreme Court, provided that the Supreme Court may exercise any or all of the procedures of amendment of the trial court. This the Court did not do, but only allowed plaintiff to amend if she so desired, subject to objections of defendant. Inasmuch as the plaintiff did not obtain leave of the trial court to file a supplemental pleading, the pleading of May 19, 1961, in all events must be treated as an amended declaration.

The second error claimed by plaintiff is "defendant waived its objection and is estopped now from objecting to plaintiff's pleading on the ground that it alleged subsequent matters and it was necessary to obtain leave of court". This Court cannot agree with plaintiff. There is no estoppel applicable for the reason [*86] that plaintiff's election to stand on [***23] the May 19, 1961, pleading, was predicated upon the authority of the Supreme Court which also gave to defendant the right to object to any matters contained in such amendment.

The third error claimed by plaintiff is "regardless of whether plaintiff's amendment be considered an amended declaration, a supplemental declaration, or an amended and supplemental declaration, it properly pleaded plaintiff's case". The Court can agree with this statement subject to the qualifications that subsequent alleged acts of slander claimed against the defendant after the filing of the original declaration, February 17, 1958, are improper by reason of the statute of limitations. The subsequent acts of slander cannot be charged as a cause for damages. Further,

the requirement of a more definite statement as to such claimed acts of slander was necessary so that defendant might be advised if same could be subject to objections, particularly, the statute of limitations.

The fourth and last alleged error claimed by plaintiff is "plaintiff's pleading was not defective for uncertainty". The Court has dealt with this claim of the plaintiff in this opinion. It would appear that the main reason for this **[***24]** requirement was to eliminate the claimed slanderous acts which were not a proper basis for relief.

The history of this case indicates that on occasion courts of justice may move slowly but also surely, best illustrated by the quotation: "Though the mills of God grind slowly, yet they grind exceeding small; Though with patience He stands waiting, with exactness grinds He all". [3]

The first appeal provided plaintiff with a right of action not then available to her under her pleadings **[*87]** because of the ruling in the *Robertson Case*. The second appeal clarified the proper application of the *Poledna Case*. This third appeal, will permit, we hope, the plaintiff and the defendant both to have a trial upon the merits without further delay.

The trial court properly disposed of all the matters brought by defendant's motion "for more definite statement, to strike portions of amended declaration **[***25]** and for accelerated judgment". Affirmed and remanded for further proceedings. Costs to defendant, assessment of same to await determination on the merits.

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[3] Friedrich von Logau, 1604-1655, Retribution (Translation by Henry W. Longfellow [Cambridge ed], p 616).

Jacob Bryant

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EXHIBIT 8

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STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

SHEILA R. GRANDISON,

Plaintiff,

and

Case Number **2016-152313-NF**
Honorable Nanci J. Grant

SUPERIOR DIAGNOSTICS, INC., and
MENDELSON ORTHOPEDICS, P.C.

Intervening Plaintiffs,

-v-

FARM BUREAU GENERAL INSURANCE
COMPANY OF MICHIGAN, a Michigan
Insurance Company,

Defendant,

ORDER AND OPINION

At a session of said Court, held in the Courthouse in the City of Pontiac, County of Oakland, State of Michigan on 10th day of July, 2017.

PRESENT: HONORABLE NANCI J. GRANT, CHIEF JUDGE

The matters are before the Court on Defendant Farm Bureau General Insurance Company's motions for summary disposition regarding Intervening Plaintiff Superior Diagnostics, Inc. and Intervening Plaintiff Mendelson Orthopedics, PC's intervening

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complaints.[1] Also before the Court are Intervening Plaintiffs' motions for leave to amend the intervening complaints and Farm Bureau's "Emergency Motion for Second Adjournment of Trial Date." After oral arguments were held on June 28, 2017, the Court took the matters under advisement. The Court now rules as follows:

This matter arises from Plaintiff Sheila Grandison being involved in a motor vehicle accident. She filed suit against Farm Bureau, seeking first-party benefits. Superior Diagnostics and Mendelson Orthopedics were permitted to file intervening complaints in this action in relation to medical services they provided to Plaintiff.

With respect to Farm Bureau's motions for summary disposition on the intervening complaints, it argues that the claims should be "stricken" pursuant to *Covenant Medical Center v State Farm*, __ Mich __, issued May 25, 2017 (Docket No. 152758), slip op at 22-24, which held that healthcare providers do not have a statutory cause of action against a no-fault insurer for the payment of no-fault benefits.

In response, Intervening Plaintiffs argue that Plaintiff assigned them her rights to obtain payment for the services that they provided to her. They correctly argue that the Supreme Court in *Covenant* stated in a footnote that its "conclusion . . . is not intended to alter an insured's ability to assign his or her right to past or presently due benefits to a healthcare provider." *Covenant*, slip op at 24 n 40.

In a reply brief, however, Farm Bureau correctly argues that the plain language of the insurance contract prohibited Plaintiff from assigning rights or duties under the policy without its written consent. See *Harbor Park Market Inc v Gronda*, 277 Mich App 126, 130 (2007) (contracts are interpreted according to their plain meaning). According to Farm Bureau, it is undisputed that it never gave Plaintiff consent to assign rights under the insurance contract to Intervening Plaintiffs, therefore establishing that the assignments are invalid. Intervening

[1] Although Farm Bureau's motions were labeled motions in limine, the parties acknowledged at oral arguments that they treated the motions as motions for summary disposition and that the notice requirements outlined in the relevant court rules have been followed. Accordingly, this Court will treat the instant motions as motions for summary disposition, despite the manner in which Farm Bureau labeled them.

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Plaintiffs anticipated Farm Bureau's argument. In their response brief, they argue that the anti-assignment clause cannot be invoked post-loss. This Court agrees.

"Although, as a general rule, courts must provide competent parties the utmost liberty to engage in contractual relations, a contract is valid only if it involves a proper subject matter. A proposed contract is concerned with a proper subject matter only if the contract performance requirements are not *contrary to public policy.*" *Morris & Doherty v Lockwood*, 259 Mich App 38, 54 (2003) (citations and quotations omitted; emphasis in original).

While all legitimate causes of action are generally assignable, *Grand Traverse Convention & Visitor's Bureau v Park Place Motor Inn, Inc*, 176 Mich App 445, 448 (1998), Michigan law also recognizes the validity of contractual provisions against assignment of contracts, including insurance policies, see *Employers Mut Liab Ins Co v Mich Mut Auto Ins Co,* 101 Mich App 697, 702 (1980). An anti-assignment clause will not be enforced, however, where a loss occurs before the assignment, because in that situation the assignment of the claim under the policy is viewed no differently than any other assignment of an accrued cause of action. *Action Auto Stores, Inc v United Capitol Ins Co*, 845 F Supp 417, 423 (WD Mich 1993), citing *Roger Williams Insurance Co v Carrington,* 43 Mich 252, 254 (1880). More specifically, the Court in *Roger Williams Insurance Co,* 43 Mich at 254, observed the following:

> The assignment having been made after the loss did not require consent of the company. The provision of the policy forfeiting it for an assignment without the company's consent is invalid, so far as it applies to the transfer of an accrued cause of action. It is the absolute right of every person—secured in this state by statute—to assign such claims, and such a right cannot be thus prevented. It cannot concern the debtor, and it is against public policy.

Thus, the rule stated in *Roger Williams Insurance* recognizes a distinction between pre-loss assignments and post-loss assignments.

The majority of Courts in other jurisdictions follow the rule that clauses in insurance policies prohibiting assignments do not prevent an assignment after the loss has occurred, although sometimes for different reasons than that stated in *Roger Williams Insurance*. See e.g., *Millard Gutter Company v Farm Bureau Property & Casualty Insurance Company*, 295 Neb

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419, 427 (Neb 2016) ("The majority of courts follow the rule that clauses in insurance policies prohibiting assignments do not prevent an assignment after the loss has occurred."); *Gopher Oil Co v American Hardware Mut Ins Co*, 588 NW2d 756, 763-764 (Minn App 1999) (observing that "[t]he great majority of courts follow this distinction between risk and loss and allow an insured to assign a loss" despite a standard consent-to-assignment clause and commenting that doing otherwise would provide "an insurer . . . the windfall of not having to insure an occurrence that it received premiums for covering"); *Wehr Constructors v Assurance Co of Am*, 384 SW3d 680, 682 (Ky 2012) ("the majority rule holds that an anti-assignment clause such as the one we examine is unenforceable once an insured occurrence takes place"); *Fluor Corp v Superior Ct*, 61 Cal 4th 1175, 1213-1215 (Cal 2015).

The rationale for such a distinction has been explained as follows by a treatise on contract law:

> Antiassignment clauses in insurance policies are strictly enforced against attempted transfers of the policy itself before a loss has occurred, because this type of assignment involves a transfer of the contractual relationship and, in most cases, would materially increase the risk to the insurer. Policy provisions that require the company's consent for an assignment of rights are generally enforceable only before a loss occurs, however. As a general principle, a clause restricting assignment does not in any way limit the policyholder's power to make an assignment of the rights under the policy—consisting of the right to receive the proceeds of the policy—after a loss has occurred. The reasoning here is that once a loss occurs, an assignment of the policyholder's rights regarding that loss in no way materially increases the risk to the insurer. After a loss occurs, the indemnity policy is no longer an executory contract of insurance. It is now a vested claim against the insurer and can be freely assigned or sold like any other chose in action or piece of property. [17 Richard A. Lord, A Treatise on the Law of Contracts by Samuel Williston, § 49:119 (4th ed. 2015).]

The Court agrees with this reasoning. It properly focuses upon the policy supporting anti-assignment clauses: ensuring that the insurer is not subjected to a risk it did not agree to

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insure. Here, Farm Bureau does not explain or rationalize why it inserted the anti-assignment clause in its policy or why it should be enforced after a loss occurs. There is no indication in the record as to how Farm Bureau would face an increased risk or any other adverse consequence as a result of the post-loss assignment. In this Court's opinion, when the event giving rise to the insurer's liability occurs, the reason for enforcing an anti-assignment clause disappears because the insurer's liability becomes fixed, and its risk is no longer dependent upon the unique characteristics of the insured.

Further, as argued by Intervening Plaintiffs, the No-Fault Act only prohibits assignment of a right to benefits payable in the future. MCL 500.3143 ("An agreement for assignment of a right to benefits payable in the future is void."). This was discussed extensively in *Professional Rehab Assoc v State Farm Mut Auto Ins Co*, 228 Mich App 167, 172 (1998), and the *Covenant* majority cited both MCL 500.3143 and *Professional Rehab Assoc*, see *Covenant*, slip op at 24 n 40. Thus, Plaintiff had an assignable interest so long as she was not assigning rights concerning future benefits.

When reviewing both of the assignments, it is clear that Plaintiff only assigned Intervening Plaintiffs rights with respect to past due and presently due benefits. Because Plaintiff made valid assignments to Intervening Plaintiffs, Farm Bureau's motions for summary disposition are denied. Based on this holding, it is not necessary for this Court to decide whether the Supreme Court's holding in *Covenant* is retroactive. See *B P 7 v Bureau of State Lottery*, 231 Mich App 356, 359 (1998) (holding that Courts will not generally not decide moot issues).

Turning to Intervening Plaintiffs' motions for leave to amend, a motion to amend ordinarily should be granted, unless one of the following particularized reasons exists:

> [1] undue delay, [2] bad faith or dilatory motive on the part of the movant, [3] repeated failure to cure deficiencies by amendments previously allowed, [4] undue prejudice to the opposing party by virtue of allowance of the amendment, [and 5] futility. . . . [*Sands Appliance Servs Inc v Wilson*, 463 Mich 231, 239 (2000) (alternation in original), citing *Ben P Fyke & Sons v Gunter Co*, 390 Mich 649, 656 (1973).]

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The Court agrees with Intervening Plaintiffs that, after applying the above listed factors, there is no reason to deny the motions for leave to amend. Although Farm Bureau alleges that it would be prejudiced, it does not provide any meaningful analysis to support this. As argued by Mendelson Orthopedics, Intervening Plaintiffs have been litigating the substantive merits of this case with Farm Bureau for nearly one year. By allowing amendment, this Court is merely allowing Intervening Plaintiffs to exchange one theory of standing for another based on a change in the law that occurred mid-litigation.

As such, Intervening Plaintiffs' motions for leave to amend their intervening complaints are granted. Intervening Plaintiffs must file the amended pleadings within seven (7) days of the date of this order.

In so holding, the Court notes that Farm Bureau argues that, even if Intervening Plaintiffs are permitted to amend or supplement their complaints, part of their claims will be barred under MCL 500.3145. To support this, Farm Bureau argues that any alteration to the complaints would amount to supplemental pleadings and that there is no relation back provision for a supplemental pleading.

MCR 2.118 addresses amendment and supplemental pleadings, and MCR 2.118(D) states in relevant part that "[a]n amendment that adds a claim or defense relates back to the date of the original pleading if the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth, or attempted to be set forth, in the original pleading." Here, Intervening Plaintiffs merely seek to add additional facts concerning standing to the original cause of action and are not relying on conduct or a transaction or occurrence different from the one involved in the original action. Accordingly, the Court rejects Farm Bureau's arguments that part of Intervening Plaintiffs' claims will be barred under MCL 500.3145. See *Miller v Chapman Contracting*, 477 Mich 102, 105-107 (2007). See also Wright and Miller's Federal Practice and Procedure, Civil § 1508.

Finally, Farm Bureau's "Emergency Motion for Second Adjournment of Trial Date" is denied because the Court is not persuaded that it is entitled to the relief it seeks. Trial will commence at 8:30 a.m. on Tuesday, July 18, 2017.

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In sum, Farm Bureau's motions for summary disposition on the Intervening Plaintiffs' claims are denied. Intervening Plaintiffs' motions for leave to amend are granted, and they must file the amended pleadings within seven (7) days of the date of this order. Farm Bureau's second motion for adjournment of trial is denied.

IT IS SO ORDERED.

NANCI J. GRANT, Chief Judge

PROOF OF SERVICE

I certify that a copy of the above instrument was served upon the attorneys/parties of record in the above case via the United States Postal Service at the addresses above on 7/10/17.

/s/ Brenda Beiter
Judicial Assistant to the Hon. Nanci J. Grant

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EXHIBIT C

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF GENESEE

JAWAD A. SHAH, MD, PC,
INTEGRATED HOSPITAL SPECIALISTS, PC,
INSIGHT ANESTHESIA, PLLC AND
STERLING ANESTHESIA, PLLC
(GEORGE HENSLEY),

Plaintiffs,

vs.

STATE FARM MUTUAL AUTOMOBILE
INSURANCE COMPANY,

Defendant.

CASE NO. 17-108637-NF
HON. JUDITH A. FULLERTON

/

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/

PLAINTIFFS' MOTION FOR LEAVE TO AMEND THEIR COMPLAINT

NOW COMES Plaintiffs, JAWAD A. SHAH, MD, PC, INTEGRATED HOSPITAL SPECIALISTS, PC, INSIGHT ANESTHESIA, PLLC AND STERLING ANESTHESIA, PLLC, by and through their attorneys, ELIA & PONTO, PLLC, and in support of their Motion to Amend Their Complaint, states as follows:

1. That Plaintiffs, JAWAD A. SHAH, MD, PC, INTEGRATED HOSPITAL SPECIALISTS, PC, INSIGHT ANESTHESIA, PLLC AND STERLING ANESTHESIA, PLLC's complaint in this matter was filed on February 24, 2017 for medical services provided by Plaintiffs

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to GEORGE HENSLEY, arising from a Motor Vehicle Accident (MVA) which occurred on or about November 30, 2014.

2. That as a result of the recent decision in *Covenant Medical Center, Inc. v. State Farm Mut. Auto. Ins. Co.*, 2017 Mich. LEXIS 971, 2017 WL 2303337 (Mich. May 25, 2017), that it has been held that "... a provider simply has **no statutory cause of action** of its own to directly sue a no-fault insurer." (See attached case law, **EXHIBIT 1**).

3. However, the Supreme Court made it extremely clear in **footnote #40** in their opinion that, "Moreover, to our conclusion today is not intended to alter an insured's ability to assign his or her right to past or presently due benefits to a healthcare provider" *Id.* at 26.

4. Furthermore as stated in *Professional Rehab Associates v. State Farm Mutual Auto. Ins. Co.*, 228 Mich App 167, 172; 577 NW2d 909 (1998), the court held that assignment of benefits by patients to medical providers, for past and present benefits, does not violate MCL 500.3143 (See attached case law **EXHIBIT 2**, underlined *Id.* at 174).

5. As a result of the recent decision, Plaintiffs obtained (and will continue to obtain) an assignment of rights for past and present due benefits from GEORGE HENSLEY (See attached assignments, **EXHIBIT 3**).

6. That as a result of the recent decision in *Covenant v. State Farm Mut. Auto. Ins. Co.*, it has become necessary for Plaintiff to amend their pleadings under MCR 2.118(A), to properly include an assignment of rights provision.

7. That MCR 2.118(A)(2) states that "...a party may amend a pleading only by leave of the court or by written consent of the adverse party. Leave **shall be freely given when justice so requires.**"

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8. Given the sudden and seemingly retroactive holding of *Covenant,* medical providers have been left with only two options to ensure payment of their medical bills (1) to petition the court to allow amendment of the complaint after obtaining an assignment of rights from the patient (2) to sue the patient directly for the recovery of the benefits.

9. That it is clear that justice so requires the amendment of this complaint, as there was no undue delay or bad faith in the request for this amendment and the Defendant will suffer no undue hardship or prejudice with said amendment of the complaint, as it simply supports the previously plead allegations in the original complaint.

WHEREFORE, Plaintiffs, JAWAD A. SHAH, MD, PC, INTEGRATED HOSPITAL SPECIALISTS, PC, INSIGHT ANESTHESIA, PLLC AND STERLING ANESTHESIA, PLLC respectfully request this Honorable Court to enter an Order pursuant to MCR 2.118(A)(2) allowing Plaintiffs to Amend Their Complaint and relating said amendment back to the original date of filing.

Respectfully submitted,

ELIA & PONTO, PLLC

By: _____

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Dated: August 7, 2017

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF GENESEE

JAWAD A. SHAH, MD, PC,
INTEGRATED HOSPITAL SPECIALISTS, PC,
INSIGHT ANESTHESIA, PLLC AND
STERLING ANESTHESIA, PLLC
(GEORGE HENSLEY),

Plaintiffs,

vs.

STATE FARM MUTUAL AUTOMOBILE
INSURANCE COMPANY,

Defendant.

CASE NO. 17-108637-NF
HON. JUDITH A. FULLERTON

A TRUE COPY
GENESEE COUNTY CLERK

/

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/

BRIEF IN SUPPORT OF PLAINTIFFS' MOTION FOR LEAVE TO AMEND THEIR COMPLAINT

NOW COMES Plaintiffs, JAWAD A. SHAH, MD, PC, INTEGRATED HOSPITAL SPECIALISTS, PC, INSIGHT ANESTHESIA, PLLC AND STERLING ANESTHESIA, PLLC, by and through their attorneys, ELIA & PONTO, PLLC, and for their Brief in Support of Plaintiffs' Motion to Amend Their Complaint, hereby relies on the facts stated above in their motion, MCR 2.118(A)(2); MCR 2.118(E); *Covenant Medical Center, Inc. v. State Farm Mut. Auto. Ins. Co.*, 2017 Mich. LEXIS 971, 2017 WL 2303337 (Mich. May 25, 2017); *Professional Rehab Associates v. State Farm Mutual Auto. Ins. Co.*, 228 Mich App 167, 172; 577 NW2d 909 (1998); *Midura v.*

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Lincoln Consolidated Schools, 111 Mich App 558, 563; 314 Nw2d 691 (1981); *Mcalla v. Ellis* 129 Mich App 452, 457; 341 NW2d 525 (1983); *Meyer v. Hubbell,* 117 Mich App 699, 705-706; 324 NW2d 139 (1982), *Rubino v. Sterling Heights* 94 Mich App 494, 499-500; 290 NW2d 43 (1979); *Messer v. Floyd Rice Ford, Inc.* 91 Mich App 644, 649-650, 649-650; 284 NW2d 139 (1979); *Labar v. Cooper* 376 Mich. 401, 405; 137 N.W.2d 136 (1965); *Grist v. Upjohn Company* 1 Mich App 72; 134 N.W.2d 358 (1965); the below brief in support, and the exhibits attached hereto.

STATEMENT OF FACTS

That Plaintiffs' complaint was filed on February 24, 2017 for medical services provided by Plaintiffs to GEORGE HENSLEY, arising from a Motor Vehicle Accident (MVA) which occurred on or about November 30, 2014. That the *Covenant* decision (properly cited in the attached motion) was decided on **May 25, 2017**. That on July 11, 2017 patient, GEORGE HENSLEY, assigned his rights to Plaintiffs, for pursuit of payment, for his No-Fault Benefits for the treatment and care rendered by Plaintiffs (See attached **EXHIBIT 3**).

STANDARD OF REVIEW

MCR 2.118(A)(2) states in pertinence, "Except as provided in subrule (A)(1) a party may amend a pleading only by leave of the court or by written consent of the adverse party. Leave shall be freely given when justice so requires." This court rule was further examined in the holding of *Welke v. Kuzilla*, 140 Mich. App 658; 365 N.W.2d 205 (1985), for which the court held that the decision to allow an amendment of the complaint is within the discretion of the trial court **(EXHIBIT 4)**. The court went on to hold, however that

> "This discretion is not unlimited. This language [that "leave shall be freely given when justice so requires"] imposes a limitation on the discretion of the court necessitating a

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finding that justice would not be served by an amendment to pleadings. The allowance of an amendment is not an act of grace, but a right of a litigant who can show that an amendment will not work an injustice on the opposing party" *Id.* at 207 quoting *Midura v. Lincoln Consolidated Schools,* 111 Mich App 558, 563; 314 Nw2d 691 (1981); *Mcalla v. Ellis* 129 Mich App 452, 457; 341 NW2d 525 (1983).

The court went further in this holding, reaffirming the decision in *Meyer v. Hubbell,* 117 Mich App 699, 705-706; 324 NW2d 139 (1982), "Such a motion should be granted absent undue delay, bad faith, a dilatory motive or when an amendment would be futile." They further affirmed once again that, "Mere lateness in moving to amend is an insufficient reason to deny the motion, absent unfair prejudice to the opposing party" *Rubino v. Sterling Heights* 94 Mich App 494, 499-500; 290 NW2d 43 (1979).

LAW AND ANALYSIS

I. THAT PLAINTIFFS HAVE PROMPTLY FILED A MOTION FOR LEAVE TO AMEND IN LIGHT OF THE COVENANT DECISION AND NO UNDUE DELAY, BAD FAITH OR PREJUDICE CAN BE ALLEGED BY THE DEFENDANT.

The decision in *Welke v. Kulka* to allow amendment of the complaint (to add a malpractice claim) late in the procedural proceedings, clearly shows that extreme leniency should be granted by the court in parties' requests to amend complaints. While discussion regarding insufficient opportunity to obtain discovery was debated by the court, it was held that only in the most extreme circumstances where trial was imminent and prior discovery completed in the case would not contribute to discovery on the claim sought to be added by the amendment, should motions to amend the complaint be denied *Messer v. Floyd Rice Ford, Inc.* 91 Mich App 644, 649-650, 649-650; 284 NW2d 139 (1979). This is clearly not the case in this factual circumstance, the previous

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discovery conducted would allow defendant sufficient information in order to prepare a defense. Furthermore, the amended portion of the complaint will add an assignment of rights count, which will simply support the previously alleged breach of contract allegations submitted in the Plaintiffs' original complaint. Plaintiffs have promptly filed this motion in light of the recent *Covenant* decision as well as obtaining an assignment of rights from patient, GEORGE HENSLEY. Defendant is able to conduct discovery as to the requested amended portion of the complaint and cannot raise any issue of undue delay, bad faith, or prejudice, and therefore the court should grant Plaintiffs' request.

ARGUMENTS AGAINST FUTILITY OF MOTION TO AMEND BASED ON ANTI-ASSIGNMENT CLAUSE

It is anticipated that defendant in their response to plaintiff's motion to amend will raise several claims against assignment, and the futility of amendment, and as such plaintiffs include the below arguments to further support their motion to amend the complaint.

I. THE MOMENT THE ASSIGNMENT OF RIGHTS WAS OBTAINED, PLAINTIFFS ORIGINALLY FILED NO-FAULT CLAIM WAS VIABLE.

Plaintiffs at the time they filed this complaint on February 24, 2017, in accordance with the relevant and applicable case law had an independent right of action to bring against Defendant for breach of contract. Following the holding of *Covenant* (as more thoroughly explained in intervening plaintiff's motion to amend), it was determined statutorily that medical providers had no right of direct cause of action (as was previously upheld by the Court of Appeals), however this did not affect the providers ability to obtain the rights of patients through assignment. Which as detailed in plaintiffs' motion to amend, said assignment was obtained from the patient in this case. While plaintiffs filed this motion to amend their complaint in order to clarify the previous allegations, it is plaintiffs' contention that the original No-Fault claim which was filed in this

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matter, was applicable the moment that the patient's assignment was obtained. The patient by assigning his rights to the medical providers, has provided a basis to support the previous claim of damages arising from the MVA, for medical treatment rendered (now that the independent statutory right for direct action has been extinguished by the Supreme Court), which is the basis of plaintiffs' claims against Defendant.

Plaintiffs in this instance have filed a motion to amend, due to the uncertainty that exists in the court system following *Covenant*, and to ensure that there was no claim of undue delay or prejudice to the Defendant, for plaintiff not properly pleading their complaint. While Defendant may claim there is a lack of standing in this matter, defendant relies on ten plus years of Appellate case law which upheld plaintiff's position, and at the time of plaintiff's original complaint, plaitniff maintained standing to file the lawsuit. Furthermore, it is plaintiffs' contention that the assignment supports the originally filed No-Fault claim, and the amendment is for clarification of previous plead allegations. Plaintiffs' motion to amend, should be freely granted as no prejudice or undue delay has occurred.

II. IF GEORGE HENSLEY IS NOT A NAMED INSURED THE NON TRANSFER LANGUAGE IS NOT APPLICABLE PURSUANT TO *SHELTON V. AUTO-OWNERS INS. CO.*

If this honorable court does interpret the contractual provisions contained within Defendant's policy to prevent assignment, Defendant must show that GEORGE HENSLEY is a named insured and therefore is privy to the contractual exclusions contained within the policy. In the appellate court's recent decision in *Shelton v. Auto-Owners Ins. Co., 2017* Mich. App. LEXIS 242 (Mich. Ct. App. Feb. 14, 2017), it was held that exclusionary provisions in insurance companies no-fault policies do not apply to parties for whom have not contracted with said insurer (See attached case law, **EXHIBIT 5**). In the factual circumstances before the court in *Shelton*, the party whom had

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filed the complaint against Auto Owners Insurance Company was not the person to whom the no-fault policy was issued, but rather a passenger in the insured vehicle for which the action was brought statutorily in accordance with the priority chain. The court held that the *Bahri* fraud exclusion which was being raised by the Defendant, was therefore not applicable to Shelton, as he "was not a party to, nor an insured under, the policy" *Id.* at 3. Plaintiffs in this instance are not aware of whether GEORGE HENSLEY is a named insured or not to Defendant's contract. However, it is clear in the recent holding of *Shelton* that if he is not named within the policy, the contractual exclusion does not apply, and Defendant's claim of anti-assignment is not applicable.

III. THE EXCLUSIONARY LANGUAGE WITHIN THE POLICY IS NOT ENFORCEABLE AS IT IS AGAINST PUBLIC POLICY IN ACCORDANCE WITH BINDING CASE LAW

The exclusionary language within the Defendant policy, if viewed by this court as prohibiting assignment of the benefits under the policy, should be voidable when viewed in the context of the standing case law in Michigan. While Defendant is correct, that Michigan law recognizes the validity of contractual provisions against assignment of contract, (see the holding of *Employers Mutual Liab Ins Co v Mich Mut Auto Ins Co*, 101 Mich App 697, 702, 300 NW2d 682 (1980), where an assignment in violation of an anti-assignment clause voided coverage under the policy), this holding was only as to **an assignment that had occurred prior to the loss**. However, it was specifically held by the Supreme Court in *Roger Williams Ins Co v Carrignton*, 43 Mich 252, 5 NW 303 (1880), that an anti-assignment clause in an insurance contract is not enforceable **where the assignment occurs after the loss**, as the claim under the policy is viewed no differently than any other assignment of an accrued cause of action. In the factual circumstances of *Roger Williams* an action was brought by an assignee of a policy of insurance for damage sustained in a fire to horses and livery property. The insurance policy maintained anti-assignment language which

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voided the policy if assigned. The insurance policy was assigned to Carrington, following the occurrence of the fire, and the court held that,

> "The assignment having been made after the loss did not require consent of the company. The provision of the policy forfeiting it for an assignment without the company's consent is invalid, so far as it applies to the transfer of an **accrued cause of action**. It is the absolute right of every person - secured in this State by statute - to assign such claims, and such a right cannot be thus prevented. It cannot concern the debtor, and it is against public policy" *Id.* at 304.
> (See attached case law, **EXHIBIT 6**)

This holding was further interpreted by the United States District Court for the Western District of Michigan in *Action Auto Stores, Inc v United Capitol Ins Co*, 845 F Supp 417, 423 (WD Mich 1993) (**EXHIBIT 7**). In their holding the Federal Court interpreted Michigan Law regarding anti-assignment provisions. Specifically they stated,

> "Plaintiff also cites Section 792 of Volume 43 of *American Jurisprudence*, Second Edition, for the proposition that such general stipulations prohibiting assignment without the insurer's consent apply only to assignments before loss and not against assignment after loss. The cited paragraph notes that **a provision against assignment after loss is null and void as inconsistent with the covenant of indemnity and contrary to public policy**. 43 Am. Jur. 2d Insurance Section 792 (1982)....Because the clause at issue is itself ambiguous and because there is strong public policy in favor of assignment of such contract rights, the **court holds that paragraph F of the "Common Policy Conditions" prohibits only transfer and assignment of a right prior to loss and does not prohibit assignment of an accrued cause of action.** Plaintiff's motion for summary disposition is granted to the extent that it asks that the court find that the defense of assignment of the insurance policy does not bar coverage." *Id.* at 422-423.

In *Wonsey v Life Ins Co of N Am*, 32 F Supp 2d 939 (1998), the court referred to the "modern trend" regarding contractual prohibitions on assignments and noted:

> "As the latest Restatement makes clear, the modern trend with respect to **contractual prohibitions on assignments is to interpret these clauses narrowly, as barring only the delegation of duties, and not necessarily as precluding the assignment of rights from assignor to assignee**. The rationale behind these cases is derived from the implicit recognition that the obligor, the party obligated to perform, would not suffer any harm by a mere assignment of payments under a

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> contract. Harm to obligor would result, however, in cases involving personal services contracts or other situations where the duties owed to the parties may change depending on the identity of the assignee. *Id.* at 943.

In *Marion v. Vaughn*, 12 Mich. App 453, 463 (1968), the court held that, "there is considerable body of authority favoring the view that a matured debt is freely assignable even though a restriction literally provides otherwise…" Additionally, this case, cited the relevant and prevailing case law of *Roger Williams Ins Co v Carrington*, stating that, "Provisions prohibiting assignment of rights under insurance policies have been held not to prevent assignment of the insured's claim against the insurer after the loss." *Id.* at 463.

Viewed in the context of the applicable case law in *Roger Williams Ins Co v Carrington*, and the Federal Court support that anti-assignment clauses are not applicable in circumstances where an assignment is obtained following a loss, it is clear that the anti-assignment language is voidable against public policy as written in the defendant's policy. It is clear that the loss, in the present circumstances occurred on November 30, 2014 when GEORGE HENSLEY was involved in a motor vehicle accident for which injuries were sustained. As a result of said loss, medical treatment was (and may continue to be) rendered by plaintiffs for which bills have been submitted to the Defendant. Mr. Hensley on July 11, 2017, following the loss, and the accrual of medical benefits, assigned his rights for payment of the medical treatment rendered by plaintiffs. It is clear that he assigned an accrued cause of action (unpaid bills for medical services rendered) following an actual loss, and will continue to do so in the future. Given this fact pattern, it stands to reason that the applicable case law, thereby would void the anti-assignment language contained within the Defendant's policy provision, and as such the assignment of rights to pursue this action should qualify the plaintiff to amend their complaint.

IV. PLAINTIFFS SOUGHT AMENDMENT TO THEIR COMPLAINT SHOULD RELATE BACK TO THE ORIGINAL DATE OF FILING IN THIS INSTANCE.

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Defendant may argue that if allowed, intervening plaintiff's amended complaint would be considered a supplemental pleading and therefore would be barred by the statute of limitations. As noted in MCR 2.118(D) Relation Back of Amendment: "An amendment that adds a claim or defense relates back to the date of the original pleading if the claim or defense asserted arose out of the conduct, transaction or occurrence set forth, or attempted to be set forth, in the original pleading." The Supreme court discussed in *Labar v. Cooper* 376 Mich. 401, 405; 137 N.W.2d 136 (1965); when interpreting GCR 118.1 and 118.4 (which were adopted almost verbatim as MCR 2.118(A)(1)&(2) and MCR 2.118(D) respectively) the purpose of the relation back amendment:

> "GCR 1963, 118 is an adoption of Federal Rule 15. The purpose of its adoption is stated by Honigman and Hawkins, 1 Michigan Court Rules Annotated, page 416: "The relationship between the original pleading and a proposed amendment becomes important when the date of filing the amendment raises a question of limitations. The doctrine of "relation back" was devised by the courts to associate the amended matter with the date of the original pleading, so that it would not be barred by the statute of limitations."

It was discussed in further detail,

> Sub rule 118.4 [which is now MCR 2.118(D)] is intended to introduce a more liberal and workable test, borrowed from the Federal Rules…The test is no longer conceptual but rather functional. **The amendment relates back to the date of the original pleading and, therefore, is not barred by limitations, whenever the claim or defense asserted in the amendment arose out of the conduct, transaction or occurrence set forth or attempted to be set forth in the original pleading.** ***It is thus beside the point that the amendment introduces new facts, a new theory, or even a different cause of action, so long as it springs from the same transactional setting as that pleaded originally.*** The new test satisfies the basic policy of the statute of limitations, because the transactional base of the claim must still be pleaded before the statute runs, thereby giving defendant notice within the statutory period that he must be prepared to defend against all claims for relief arising out of that transaction." (See attached case law, **EXHIBIT 8**).

The circumstances clearly point in this instance to allowing the amendment of the complaint to relate back to the original amendment. In this case, plaintiffs are supporting their right of action from the previously alleged breach of No-fault Act claim that arose from injuries

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sustained in the MVA on November 30, 2014 (**the transaction or occurrence for which gave rise to this lawsuit being said MVA). Distinguishable from the facts in *Grist v. Upjohn Company* 1 Mich App 72; 134 N.W.2d 358 (1965), where the court held that claims of additional instances of slander [separate transactions or occurrences from the original claim of slander] were considered "supplemental pleadings" and therefore did not relate back to the original date of filing (See attached case law, **EXHIBIT 9**), in this factual circumstance, there is no new transaction or occurrence (additional MVA). The amended complaint seeks to support the previously filed No-Fault claim, and therefore should be related back to the original date of filing in this instance.

Plaintiff further attaches and adopts the arguments contained within the order and opinion written by the Honorable Nanci Grant of the 6th Circuit County of Oakland as persuasive precedence, as she was faced with the identical issue as arises in this situation (See attached opinion **EXHIBIT 10**).

WHEREFORE, Plaintiffs respectfully request this Honorable Court to enter an Order pursuant to MCR 2.118(A)(2) allowing Plaintiffs to Amend Their Complaint and relating said amendment back to the original date of filing.

Respectfully submitted,

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By: _____

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Dated: August 7, 2017

PROOF OF SERVICE

The undersigned certifies that a copy of the foregoing instrument was served upon all parties to the above cause to each of the attorneys of record herein at their respective addresses disclosed on the pleadings on August 8, 2017 by U.S. Mail.

Debra Gatto

Debra Gatto

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EXHIBIT 1

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Covenant Med. Ctr., Inc. v. State Farm Mut. Auto. Ins. Co.

Supreme Court of Michigan

December 7, 2016, Argued; May 25, 2017, Decided; May 25, 2017, Filed

No. 152758

Reporter
2017 Mich. LEXIS 971 *; 2017 WL 2303337

COVENANT MEDICAL CENTER, INC., Plaintiff-Appellee, v STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, Defendant-Appellant.

Prior History: Covenant Medical Center, Inc., brought suit in the Saginaw Circuit Court against State Farm Mutual Automobile Insurance Company to recover payment under the no-fault act, MCL 500.3101 et seq., for medical services it provided to State Farm's insured, Jack Stockford, following an automobile accident in which Stockford was injured. Covenant sent bills totaling $43,484.80 to State Farm for healthcare services it provided to Stockford. State Farm denied payment on November 15, 2012. In the meantime, Stockford had filed suit against State Farm for no-fault benefits, including personal protection insurance (PIP) benefits. Without Covenant's knowledge, Stockford and State Farm settled Stockford's claim for $59,000 shortly before Covenant initiated its action against State Farm. As part of the settlement, Stockford released State Farm from liability for all allowable no-fault expenses and any claims accrued through January 10, 2013. State Farm moved for summary disposition under MCR 2.116(C)(7) (dismissal due to release) and MCR 2.116(C)(8) (failure to state a claim). The court, Robert L. Kaczmarek, J., granted State Farm's motion under MCR 2.116(C)(7), explaining that Covenant's claim was dependent on State Farm's obligation to pay no-fault benefits to [*2] Stockford, an obligation that was extinguished by the settlement between Stockford and State Farm. Covenant appealed by right in the Court of Appeals, and in a published per curiam opinion, the Court of Appeals, M. J. KELLY, P.J., and MURRAY and SHAPIRO, JJ., reversed the circuit court's decision. 313 Mich App 50, 880 N.W.2d 294 (2015). According to the Court, the settlement with Stockford did not discharge State Farm's liability to Covenant because State Farm had notice of Covenant's claim for no-fault benefits for the benefit of Stockford. Because State Farm had notice of Covenant's claim, State Farm's settlement with Stockford was not a good-faith payment of no-fault benefits it owed. The Court of Appeals concluded that the circumstances of this case were addressed in MCL 500.3112, which required State Farm to seek a court order directing the proper allocation of benefits when, in addition to a first-party claim for benefits, there was also a third-party claim for payment of no-fault benefits. The Supreme Court granted State Farm's application for leave to appeal. *499 Mich 941, 879 N.W.2d 262 (2016)* [*1].

Covenant Med. Ctr., Inc. v. State Farm Mut. Auto. Ins. Co., 313 Mich. App. 50, 880 N.W.2d 294, 2015 Mich. App. LEXIS 2006 (Oct. 22, 2015)

Core Terms

insurer, no-fault, benefits, healthcare provider, provider, injured person, sentence, protection of persons, entitlement, insurance benefits, provisions, expenses, possesses, claimant, services, statutory cause of action, cause of action, survivor, charges, circuit court, statutes, caselaw, cases, accidental bodily injury, settlement, payees, reasonable charge, direct cause, apportionment, healthcare

Case Summary

Jacob Bryant

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Overview

HOLDINGS: [1]-While MCL 500.3112 undoubtedly allowed no-fault insurers to directly pay healthcare providers for the benefit of an injured person, its terms did not grant healthcare providers a statutory cause of action against insurers to recover the costs of providing products, services, and accommodations to an injured person; [2]-The statute permitted a no-fault insurer to discharge its liability to an injured person by paying a healthcare provider directly, on the injured person's behalf; [3]-No other provision of the no-fault act could reasonably be construed as bestowing on a healthcare provider a statutory right to directly sue no-fault insurers for recovery of no-fault benefits; [4]-The hospital did not possess a statutory cause of action against the insurer for recover of personal protection insurance benefits under the no-fault act.

Outcome
Judgment reversed and remanded.

LexisNexis® Headnotes

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN1[] MCL 500.3112 provides, in part, that personal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his death, to or for the benefit of his dependents. While this provision undoubtedly allows no-fault insurers to directly pay healthcare providers for the benefit of an injured person, its terms do not grant healthcare providers a statutory cause of action against insurers to recover the costs of providing products, services, and accommodations to an injured person. Rather, MCL 500.3112 permits a no-fault insurer to discharge its liability to an injured person by paying a healthcare provider directly, on the injured person's behalf. And further, no other provision of the no-fault act can reasonably be construed as bestowing on a healthcare provider a statutory right to directly sue no-fault insurers for recovery of no-fault benefits. Healthcare providers do not possess a statutory cause of action against no-fault insurers for recovery of personal protection insurance benefits under the no-fault act.

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Appropriateness

Civil Procedure > Appeals > Standards of Review > De Novo Review

Civil Procedure > Appeals > Summary Judgment Review > Standards of Review

HN2[] MCR 2.116(C)(7) applies when entry of judgment, dismissal of the action, or other relief is appropriate because of release. The Michigan Supreme Court reviews de novo a court's decision to grant summary disposition.

Civil Procedure > Appeals > Standards of Review > De Novo Review

Governments > Legislation > Interpretation

HN3[] The Michigan Supreme Court also reviews de novo questions of statutory interpretation. The role of the supreme court in interpreting statutory language is to ascertain the legislative intent that may reasonably be inferred from the words in a statute. The focus of our analysis must be the statute's express language, which offers the most reliable evidence of the Legislature's intent. When the statutory language is clear and unambiguous, judicial

construction is not permitted and the statute is enforced as written. A court may read nothing into an unambiguous statute that is not within the manifest intent of the Legislature as derived from the words of the statute itself.

Governments > Legislation > Interpretation

HN4 The foundation of any opinion interpreting a statutory provision is the parsing of the words of the pertinent act or statute under review.

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN5 The no-fault act does not, in any provision, explicitly confer on healthcare providers a direct cause of action against insurers. In fact, only two sections of the act, MCL 500.3157 and MCL 500.3158, even mention healthcare providers. MCL 500.3157 states: A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance.

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN6 MCL 500.3158(2) states: A physician, hospital, clinic or other medical institution providing, before or after an accidental bodily injury upon which a claim for personal protection insurance benefits is based, any product, service or accommodation in relation to that or any other injury, or in relation to a condition claimed to be connected with that or any other injury, if requested to do so by the insurer against whom the claim has been made, (a) shall furnish forthwith a written report of the history, condition, treatment and dates and costs of treatment of the injured person and (b) shall produce forthwith and permit inspection and copying of its records regarding the history, condition, treatment and dates and costs of treatment.

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN7 MCL 500.3157 merely sets forth a limitation on the charges that may be assessed by a healthcare provider for treatment of an injured person. That a provider has the right to charge a reasonable amount for its products, services, or accommodations in no way obligates an insurance carrier to directly reimburse the provider for those charges. The latter provision, MCL 500.3158(2), simply requires that a healthcare provider make the injured person's medical records and certain treatment information available to the insurer. Neither of these provisions, by their express terms or by implication, confers on a healthcare provider a right to sue a no-fault insurer for reimbursement of the amounts it charged for treatment. Therefore, any such statutory right must be found in the sections of the no-fault act that do not explicitly refer to healthcare providers.

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN8 MCL 500.3105(1) makes a no-fault insurer liable for the payment of PIP benefits. MCL 500.3105(1) states that under personal protection insurance an insurer is liable to pay benefits for accidental bodily injury arising out of

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the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, subject to the provisions of this chapter. MCL 500.3107 provides that personal protection insurance benefits are payable for certain costs, including allowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation, MCL 500.3107(1)(a), and work loss consisting of loss of income from work, MCL 500.3107(1)(b).

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN9[] MCL 500.3105 and MCL 500.3107, when taken together, provide that an insurer is liable to pay benefits for certain listed costs. Yet these provisions do nothing more than define the scope and nature of the requisite coverage. They do not identify to whom the insurer is liable or who has the right to assert a claim for benefits. Further, the language of MCL 500.3107(1)(a), which pertains to allowable expenses, is not amenable to an interpretation that would allow a healthcare provider to sue an insurer for reimbursement. MCL 500.3107(1)(a) provides that benefits are "payable" for allowable expenses consisting of all reasonable charges incurred. In the context of the no-fault act, the Texas Supreme Court has defined "incur" as to become liable or subject to, especially because of one's own actions. Charges for healthcare services rendered are not "incurred" by a healthcare provider because a provider is not subject to charges for the products, services, and accommodations it delivers to others. Nor do providers become "liable" for allowable expenses. Rather, charges for healthcare are incurred by others, most commonly patients, and those patients are the ones who become liable for payment of those charges.

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN10[] While MCL 500.3112, which addresses to whom PIP benefits are payable, undoubtedly allows for the common practice of no-fault insurers directly paying healthcare providers, its text does not require direct payment of healthcare providers or give providers any right to directly sue a no-fault insurer, as will be evidenced through a sentence-by-sentence examination of the provision.

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN11[] The first sentence of MCL 500.3112, which provides that PIP benefits are payable to or for the benefit of an injured person or, in the case of his death, to or for the benefit of his dependents, addresses both allowable expenses and survivor's loss and sets forth the groups of persons to whom an insurer may direct payment to discharge its liability to the insured. The Legislature's use of the disjunctive word "or" indicates an alternative or choice between two things. The word immediately preceding the disjunctive options is "payable," which is defined to mean that may, can, or must be paid. Therefore, according to the first sentence of MCL 500.3112, PIP benefits, which are paid by the insurer, may, can, or must be paid either (1) to the injured person or (2) for the benefit of the injured person. In the case of the injured person's death, PIP benefits may, can, or must be paid either (1) to the decedent's dependents or (2) for the benefit of those dependents. This sentence does nothing more than allow a no-fault insurer to satisfy its obligation to the insured by paying the injured person directly or by paying a party providing PIP services on the injured person's behalf. That a third party may receive payment directly from an insurer for PIP benefits does not mean that the third party has a statutory entitlement to that method of payment.

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

Jacob Bryant

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HN12[] MCL 500.3112's phrase, "for the benefit of the injured person," does not state that benefits are payable "to the provider," or otherwise indicate that a provider itself has an entitlement to benefits. To the contrary, it expressly leaves that entitlement with the injured person and merely recognizes that one who does not have a direct cause of action against a no-fault insurer may be paid directly by the insurer, but only in order to benefit the injured person. Simply stated, nothing in the first sentence is properly construed as bestowing a statutory cause of action on the injured person's healthcare provider.

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN13[] The second sentence of MCL 500.3112 reads: Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person. This sentence allows a no-fault insurer to discharge its liability through payment to or for the benefit of a person it believes is entitled to benefits, as long as the payment is made in good faith and the insurer has not been previously notified in writing of the claim of some other person. The phrase "claim of some other person" does not itself confer on any person a "claim" or "right" to recover benefits. Rather, it presupposes that "some other person" otherwise possesses a claim for PIP benefits against the insurer.

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN14[] The third sentence of MCL 500.3112 reads, If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit court for an appropriate order. This sentence merely provides a procedure for resolving doubts about which persons are entitled to benefits; it does not itself confer a right or entitlement on any person, including a healthcare provider, to sue a no-fault insurer. And the sentence's reference to "apportionment" cannot logically pertain to allowable expenses like the reasonable charges incurred for healthcare services, because an injured person owes the provider, and is entitled to PIP benefits for, the entirety of those allowable expenses under MCL 500.3107(1)(a), not an apportioned amount.

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN15[] The fourth sentence of MCL 500.3107(1)(a) provides, The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. And the fifth sentence addresses the payment of dependent and survivor benefits in the absence of a court order. These sentences contain no language that can be reasonably understood as creating a right for a healthcare provider to directly sue a no-fault insurer. As in the third sentence, the reference to "apportionment" in the fourth sentence is inapplicable in the context of charges for services rendered by a healthcare provider. Similarly, the fourth sentence's call for the court to take into account "the relationship of the payees to the injured person" is inapt in the context of a healthcare provider's bill for services rendered. If the injured person qualifies for benefits, the insurer is liable under MCL 500.3107(1)(a) to pay "all reasonable charges incurred" by the injured person; no further inquiry into the "relationship" between the injured person and the provider is relevant. And the fifth sentence on its face pertains only to payment to dependents and survivors. Therefore, the fourth and fifth sentences clearly do not create a statutory cause of action for healthcare providers.

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

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HN16[] There is nothing in the language of MCL 500.3112 that can reasonably be interpreted as vesting a healthcare provider with a right to demand reimbursement from a no-fault insurer for services the provider rendered to an insured. Although this provision allows insurers to pay a provider of no-fault services directly "for the benefit of" the insured, it does not establish a concomitant claim enforceable by an insured's benefactors.

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN17[] The priority statutes, MCL 500.3114 and MCL 500.3115, define against whom an individual may make a claim for benefits. The default rule for priority is found in MCL 500.3114(1), which states, in part, that a personal protection insurance policy applies to accidental bodily injury to the person named in the policy, the person's spouse, and a relative of either domiciled in the same household. "Person" in this instance cannot mean a healthcare provider because providers are not named in the PIP insurance policy and quite simply do not sustain accidental bodily injuries. MCL 500.3114(2) states that a person suffering accidental bodily injury shall receive the PIP benefits to which the person is entitled from the insurer of the motor vehicle, and MCL 500.3114(4), (5), and (6) prioritize the order in which a person suffering accidental bodily injury arising from a motor vehicle accident shall claim personal protection insurance benefits from multiple insurers.

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN18[] MCL 500.3115(1) sets forth the insurer priority for a person suffering accidental bodily injury while not an occupant of a motor vehicle, and it provides that those persons shall claim PIP benefits in the order provided in MCL 500.3115(1). In both MCL 500.3114 and 500.3115, the Legislature specifically contemplates that the entitlement or claim belongs to the person who has sustained accidental bodily injury, and the statutory language goes into great detail regarding the priority of insurers for claims by a person suffering such injury. Notably lacking from these entitlement provisions is any arguable reference to or contemplation of a healthcare provider's entitlement to benefits under the no-fault act.

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > Medical Benefits

HN19[] A review of the plain language of the no-fault act reveals no support for plaintiff's argument that a healthcare provider possesses a statutory cause of action against a no-fault insurer. This conclusion does not mean that a healthcare provider is without recourse; a provider that furnishes healthcare services to a person for injuries sustained in a motor vehicle accident may seek payment from the injured person for the provider's reasonable charges. However, a provider simply has no statutory cause of action of its own to directly sue a no-fault insurer.

Judges: Chief Justice: Stephen J. Markman. Justices: Brian K. Zahra, Bridget M. McCormack, David F. Viviano, Richard H. Bernstein, Joan L. Larsen, Kurtis T. Wilder. BERNSTEIN, [*3] J. (dissenting). WILDER, J., did not participate in the disposition of this matter.

Opinion by: Brian K. Zahra

Opinion

BEFORE THE ENTIRE BENCH (except WILDER, J.)

ZAHRA, J.

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This case presents the significant question of whether a healthcare provider possesses a statutory cause of action against a no-fault insurer to recover personal protection insurance benefits for allowable expenses incurred by an insured under the no-fault act, MCL 500.3101 et seq. Relying on several of its previous decisions, the Court of Appeals concluded that it is "well settled that a medical provider has independent standing to bring a claim against an insurer for the payment of no-fault benefits."[1] The insurer sought leave to appeal in this Court, and we granted the application to consider in part that conclusion, which this Court has never addressed.[2]

A thorough review of the statutory no-fault scheme reveals no support for an independent action by a healthcare provider against a no-fault insurer. In arguing that healthcare providers may directly sue no-fault insurers, plaintiff primarily relies on HN1[↑] MCL 500.3112, which provides, in pertinent part, that "[p]ersonal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his death, [*4] to or for the benefit of his dependents." While this provision undoubtedly allows no-fault insurers to directly pay healthcare providers for the benefit of an injured person, its terms do not grant healthcare providers a statutory cause of action against insurers to recover the costs of providing products, services, and accommodations to an injured person. Rather, MCL 500.3112 permits a no-fault insurer to discharge its liability to an injured person by paying a healthcare provider directly, on the injured person's behalf. And further, no other provision of the no-fault act can reasonably be construed as bestowing on a healthcare provider a statutory right to directly sue no-fault insurers for recovery of no-fault benefits. We therefore hold that healthcare providers do not possess a statutory cause of action against no-fault insurers for recovery of personal protection insurance benefits under the no-fault act. The Court of Appeals caselaw concluding to the contrary is overruled to the extent that it is inconsistent with this holding. We reverse the judgment of the Court of Appeals in this case and remand the case to the Saginaw Circuit Court for entry of an order granting summary disposition [*5] to defendant.

I. FACTS AND PROCEDURAL HISTORY

On June 20, 2011, Jack Stockford was injured in a motor vehicle accident. His no-fault insurer was defendant, State Farm Mutual Automobile Insurance Company. Stockford was treated on at least three occasions by plaintiff, Covenant Medical Center, a healthcare provider. Plaintiff sent defendant bills on July 3, August 2, and October 9, 2012, for medical services it provided to Stockford. It is undisputed that defendant received the bills, which totaled $43,484.80. Defendant denied coverage on or about November 15, 2012, and refused to pay the bills.

On June 4, 2012, Stockford filed suit against defendant for no-fault benefits, including personal protection insurance (PIP) benefits.[3] Stockford settled his case with defendant on April 2, 2013, for $59,000. In connection with the settlement, Stockford executed a broad release, which encompassed all allowable no-fault expenses, including medical bills, and "any and all past and present claims incurred through January 10, 2013[.]"

Plaintiff brought the instant suit against defendant on April 25, 2013, seeking payment of its billed expenses.[4] Plaintiff asserted that it learned of the settlement [*6] and release when defendant answered its complaint in May 2013. In September 2013, defendant moved for summary disposition under MCR 2.116(C)(7) (dismissal due to release) and MCR 2.116(C)(8) (failure to state a claim). Defendant maintained that plaintiff's claim for benefits was derivative of Stockford's claim, which was extinguished by the release. Therefore, defendant argued, plaintiff no longer possessed a claim against it.

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[1] See Covenant Med Ctr, Inc v State Farm Mut Auto Ins Co, 313 Mich App 50, 54, 880 NW2d 294 (2015), and cases cited therein.

[2] ***Covenant Med Ctr, Inc v State Farm Mut Auto Ins Co, 499 Mich 941; 879 N.W.2d 262 (2016)***.

[3] No-fault benefits are broader than PIP benefits. For instance, no-fault benefits include, *inter alia*, property-protection benefits and work-loss benefits. See Turner v Auto Club Ins Ass'n, 448 Mich 22, 30, 528 NW2d 681 (1995). The instant case concerns healthcare providers and, in turn, only PIP benefits.

[4] Though initially filed in the Kent Circuit Court, the case was transferred to the Saginaw Circuit Court in July 2013.

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In an opinion dated May 15, 2014, the circuit court granted summary disposition to defendant pursuant to MCR 2.116(C)(7). The court agreed with defendant that Stockford's release was dispositive, holding that any claim plaintiff may have had against Stockford's insurer was "dependent on the insurer being obligated to pay benefits to the provider on behalf of its insured" and that the "release end[ed] the insurer's obligation to pay benefits to or on behalf of its insured under its contract of insurance."

Plaintiff appealed by right in the Court of Appeals. In a published per curiam opinion, the panel reversed the circuit court's decision, concluding that defendant's liability to plaintiff could not be discharged by defendant's settlement with Stockford because defendant had received written notice of plaintiff's [*7] claim before the settlement, presumably from the bills that plaintiff mailed to defendant.[5] The panel opined that, in this situation, the settlement could not constitute a "good faith" payment covering the noticed third-party claim for purposes of MCL 500.3112. The panel reasoned in part:

> [W]hile a provider's right to payment from the insurer is created by the right of the insured to benefits, an insured's agreement to release the insurer in exchange for a settlement does not release the insurer with respect to the provider's noticed claims unless the insurer complies with MCL 500.3112.[6]

According to the panel, in order to discharge liability under these circumstances, MCL 500.3112 "requires that the insurer apply to the circuit court for an appropriate order directing how the no-fault benefits should be allocated."[7] The Court of Appeals therefore reversed the circuit court's order granting summary disposition in favor of defendant and remanded the case for further proceedings.

Defendant applied for leave to appeal in this Court. As previously mentioned, this Court granted leave to consider in part "whether a healthcare provider has an independent or derivative claim against a no-fault insurer for no-fault benefits[.]"[8]

II. STANDARD [*8] OF REVIEW AND RULES OF STATUTORY INTERPRETATION

The circuit court granted summary disposition under HN2[] MCR 2.116(C)(7), which applies when "[e]ntry of judgment, dismissal of the action, or other relief is appropriate because of release . . . ." This Court reviews de novo a court's decision to grant summary disposition.[9]

HN3[] This Court also reviews de novo questions of statutory interpretation.[10] The role of this Court in interpreting statutory language is to "ascertain the legislative intent that may reasonably be inferred from the words in a statute."[11] "The focus of our analysis must be the statute's express language, which offers the most reliable evidence of the Legislature's intent."[12] When the statutory language is clear and unambiguous, judicial construction

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[5] Covenant, 313 Mich App at 53.

[6] Covenant, 313 Mich App at 54.

[7] Id. at 53.

[8] **Covenant, 499 Mich 941; 879 N.W.2d 262.**

[9] Horace v Pontiac, 456 Mich 744, 749; 575 NW2d 762 (1998).

[10] Hannay v Dep't of Transp, 497 Mich 45, 57; 860 NW2d 67 (2014).

[11] People v Couzens, 480 Mich 240, 249; 747 NW2d 849 (2008).

[12] Badeen v PAR, Inc, 496 Mich 75, 81; 853 NW2d 303 (2014).

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is not permitted and the statute is enforced as written.[13] "[A] court may read nothing into an unambiguous statute that is not within the manifest intent of the Legislature as derived from the words of the statute itself."[14]

III. ANALYSIS

The Court of Appeals concluded that the release executed between Stockford and defendant did not release defendant from liability regarding plaintiff's claim. This conclusion was premised on the notion that a healthcare provider [*9] who provides services to a person injured in a motor vehicle accident possesses its *own* statutory claim against the injured person's no-fault insurer to compel payment for services rendered on behalf of the insured. The Court of Appeals panel in the instant case did not critically dissect the pertinent statutory provisions of the no-fault act to find support for this premise but instead followed previous decisions of the Court of Appeals, which it was bound to do.[15] Plaintiff urges us to likewise follow the long line of cases from the Court of Appeals recognizing that a healthcare provider may sue a no-fault insurer to recover PIP benefits under the no-fault act. We decline plaintiff's invitation, relying instead on the language of the no-fault act to conclude that a healthcare provider possesses no statutory cause of action against a no-fault insurer for recovery of PIP benefits.

A. COURT OF APPEALS CASELAW

HN4[] The foundation of any opinion interpreting a statutory provision is the parsing of the words of the pertinent act or statute under review. This case is no exception. Nonetheless, we are presented with decades of Court of Appeals caselaw concluding that a healthcare provider may assert [*10] a direct cause of action against a no-fault insurer to recover no-fault benefits. Although this Court is not in any way bound by the opinions of the Court of Appeals, we nevertheless tread cautiously in considering whether to reject a long line of caselaw developed by our intermediate appellate court. That being said, the longevity of a line of Court of Appeals caselaw will not deter this Court from intervening when that caselaw clearly misinterprets the statutory scheme at issue. Correcting erroneous interpretations of statutes furthers the rule of law by conforming the caselaw of this state to the language of the law as enacted by the representatives of the people. And it is imperative that this Court aim to conform our caselaw to the text of the applicable statutes to ensure that those to whom the law applies may look to those statutes for a clear understanding of the law.[16] We therefore begin our analysis with a brief discussion of how this issue developed in the Court of Appeals.

There are three cases on which the Court of Appeals has frequently relied when concluding that a healthcare provider may directly sue a no-fault insurer. The first is *LaMothe v Auto Club Ins Ass'n*,[17] in which [*11] the panel opined that it could "anticipate that health care services providers, as practical litigants, would bypass the insured and directly sue, pursuant to third-party beneficiary theories, the entity with prospects identical to their own for engendering jury sympathy—the insurer." Significantly, the *LaMothe* parties did not litigate whether the no-fault act

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[13] *People v Gardner, 482 Mich 41, 50; 753 NW2d 78 (2008)*.

[14] *Roberts v Mecosta Co Gen Hosp, 466 Mich 57, 63; 642 NW2d 663 (2002)*.

[15] *MCR 7.215(J)(1)* ("A panel of the Court of Appeals must follow the rule of law established by a prior published decision of the Court of Appeals issued on or after November 1, 1990, that has not been reversed or modified by the Supreme Court, or by a special panel of the Court of Appeals as provided in this rule.").

[16] *Robinson v Detroit, 462 Mich 439, 467; 613 NW2d 307 (2000)* (stating that "it is to the words of the statute itself that a citizen first looks for guidance in directing his actions," because "the essence of the rule of law" is "to know in advance what the rules of society are").

[17] *LaMothe v Auto Club Ins Ass'n, 214 Mich App 577, 586; 543 NW2d 42 (1995)*.

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permits such a direct cause of action because the insurer had agreed via contractual provision "to fully defend and indemnify the insured from liability . . . ."[18]

The following year, in *Munson Med Ctr v Auto Club Ins Ass'n*,[19] the Court of Appeals stated that the defendant insurer's "obligation to pay" and the plaintiff healthcare provider's "right to be paid for the injureds' no-fault medical expenses arise pursuant to MCL 500.3105, 500.3107, and 500.3157 . . . ." But there was no indication that this "right" was in dispute; the central issue in the case concerned the meaning of "customary charges." Moreover, while the panel cited particular statutory provisions, it did not parse the language of those provisions or provide any meaningful analysis to support the implication that a healthcare provider possesses a direct cause of action against a no-fault insurer **[*12]** for PIP benefits.

Also frequently cited for the proposition that a healthcare provider may directly sue a no-fault insurer is *Lakeland Neurocare Ctrs v State Farm Mut Auto Ins Co*.[20] But as in *LaMothe*, the issue was neither presented nor decided in *Lakeland* because the defendant insurer in *Lakeland* "did not dispute that plaintiff had the legal right to commence this action for payment of medical services rendered to defendant's insured."[21] Instead, the litigated issue was whether the provider could recover penalty interest under MCL 500.3142 and attorney fees under MCL 500.3148.[22]

None of these cases decided whether healthcare providers possess a statutory cause of action against no-fault insurers. Despite this, subsequent panels of the Court of Appeals have, in published and unpublished cases alike, consistently relied on one or more of the cases just discussed as if they had decided the issue, generally failing to engage in any statutory analysis of their own to ground a healthcare provider's cause of action in the text of the no-fault act. This is aptly illustrated by the cases cited by the Court of Appeals in the instant case for the proposition that "it is . . . well settled that a medical provider has independent **[*13]** standing to bring a claim against an insurer for the payment of no-fault benefits."[23] Like *LaMothe*, *Munson*, and *Lakeland*, none of the cases cited by the Court of Appeals provides any textual analysis of the no-fault act to support this proposition.[24]

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[18] *Id. at 583*. The Court of Appeals quoted a letter that the insurer sent the insured's attorney, which stated in part that "[i]f any of the medical providers bring a claim against [the insured], [the insurer] will defend and indemnify him. In fact, [the insurer] will waive any technical defects and allow the provider to sue the [insurer] directly so that [the insured] won't even have to be a party to the litigation." *Id. at 583 n 4*.

[19] *Munson Med Ctr v Auto Club Ins Ass'n, 218 Mich App 375, 381; 554 NW2d 49 (1996)*.

[20] *Lakeland Neurocare Ctrs v State Farm Mut Auto Ins Co, 250 Mich App 35; 645 NW2d 59 (2002)*.

[21] *Id. at 37*.

[22] *Id. at 44*.

[23] *Covenant, 313 Mich App at 54*, citing *Wyoming Chiropractic Health Clinic, PC v Auto-Owners Ins Co, 308 Mich App 389, 396-397; 864 NW2d 598 (2014)*; *Moody v Home Owners Ins Co, 304 Mich App 415, 440; 849 NW2d 31 (2014)*, rev'd sub nom on other grounds by *Hodge v State Farm Mut Auto Ins Co, 499 Mich 211; 884 NW2d 238 (2016)*; *Mich Head & Spine Institute, PC v State Farm Mut Auto Ins Co, 299 Mich App 442, 448 n 1; 830 NW2d 781 (2013)*; *Lakeland Neurocare, 250 Mich App at 42-43*; *Regents of the Univ of Mich v State Farm Mut Ins Co, 250 Mich App 719, 733; 650 NW2d 129 (2002)*.

[24] The panel in the instant case cited *Wyoming Chiropractic, 308 Mich App at 396-397*, in which the Court of Appeals did not itself analyze any section of the no-fault act to conclude that the no-fault act established a cause of action for healthcare providers. Instead, the panel in *Wyoming Chiropractic* relied on prior cases leading back to *Munson* and *Lakeland* as already having established this premise as "fact." The instant panel also cited *Moody, 304 Mich App 415; 849 N.W.2d 31*, and *Regents of the Univ of Mich, 250 Mich App 719; 650 N.W.2d 129*, both of which stated in a cursory manner that healthcare providers possess a claim or cause of action against no-fault insurers without citing any statutes or otherwise substantively addressing the issue. In *Moody*, the Court of Appeals recognized, without analyzing, that a provider could "bring an independent cause of action against a no-fault insurer," but that the provider's claim was "completely derivative of and dependent on" the claim of the patient insured. *Moody, 304 Mich App at 440*. In *Regents of the Univ of Mich*, the panel concluded that while the claims of the medical

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In sum, the Court of Appeals' decision in this case was premised on the notion that a healthcare provider possesses a statutory cause of action against a no-fault insurer for payment of no-fault benefits. The panel gleaned this notion not from the text of the no-fault act, but from previous decisions of the Court of Appeals that are likewise devoid of the statutory analysis necessary to support that premise. We find this caselaw unconvincing, and unlike the Court of Appeals panel, we are not bound by the conclusion that a healthcare provider possesses a right to bring a direct cause of action against a no-fault insurer to recover PIP benefits under the no-fault act. We instead rely on the language of the no-fault act itself to answer the question presented in this case.

B. STATUTORY ANALYSIS

It bears repeating that completely absent from the analysis **[*14]** in the Court of Appeals cases discussed earlier is a meaningful explanation of what language in the no-fault act creates a cause of action for healthcare providers against insurers. And indeed, *HN5*[] the no-fault act does not, in any provision, explicitly confer on healthcare providers a direct cause of action against insurers. In fact, only two sections of the act, *MCL 500.3157* and *MCL 500.3158*, even mention healthcare providers. *MCL 500.3157* states:

> A physician, hospital, clinic or other person or institution lawfully rendering treatment to an injured person for an accidental bodily injury covered by personal protection insurance, and a person or institution providing rehabilitative occupational training following the injury, may charge a reasonable amount for the products, services and accommodations rendered. The charge shall not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance.

HN6[] *MCL 500.3158(2)* states:

> A physician, hospital, clinic or other medical institution providing, before or after an accidental bodily injury upon which a claim for personal protection insurance benefits is based, any product, service or accommodation in relation to that or **[*15]** any other injury, or in relation to a condition claimed to be connected with that or any other injury, if requested to do so by the insurer against whom the claim has been made, (a) shall furnish forthwith a written report of the history, condition, treatment and dates and costs of treatment of the injured person and (b) shall produce forthwith and permit inspection and copying of its records regarding the history, condition, treatment and dates and costs of treatment.

The former provision, *HN7*[] *MCL 500.3157*, merely sets forth a limitation on the charges that may be assessed by a healthcare provider for treatment of an injured person. That a provider has the right to charge a reasonable amount for its products, services, or accommodations in no way obligates an insurance carrier to directly reimburse the provider for those charges. The latter provision, *MCL 500.3158(2)*, simply requires that a healthcare provider make the injured person's medical records and certain treatment information available to the insurer. Neither of these provisions, by their express terms or by implication, confers on a healthcare provider a right to sue a no-fault insurer for reimbursement of the amounts it charged for treatment. Therefore, **[*16]** any such statutory right must be found in the sections of the no-fault act that do not explicitly refer to healthcare providers.

Plaintiff urges us to find support for a healthcare provider's direct cause of action in *MCL 500.3105* and *MCL 500.3107*. *HN8*[] *MCL 500.3105(1)* makes a no-fault insurer liable for the payment of PIP benefits. *MCL 500.3105(1)* states that "[u]nder personal protection insurance an insurer is liable to pay benefits for accidental bodily injury arising out of the ownership, operation, maintenance or use of a motor vehicle as a motor vehicle, subject to the provisions of this chapter." *MCL 500.3107* provides that "personal protection insurance benefits are

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providers were "derivative claims, they also ha[d] direct claims for personal protection insurance benefits." *Regents of the Univ of Mich, 250 Mich App at 733*, citing *Munson, 218 Mich App 375, 554 N.W.2d 49*, and *LaMothe, 214 Mich App at 585-586*. This language in *Regents of the Univ of Mich* appears in a passage discussing whether *MCL 600.5821(4)* or *MCL 500.3145(1)* governs the statute of limitations applicable when a political subdivision of the state is the plaintiff in a no-fault action; the opinion did not itself analyze the issue of a provider's right to directly sue a no-fault insurer. The only other case cited by the Court of Appeals is *Mich Head & Spine Institute, 299 Mich App at 448 n 1*, but the panel in that case merely referred to the phrase "for the benefit of" in *MCL 500.3112* and added "which this Court has recognized creates an independent cause of action for healthcare providers." The Court cited only *Lakeland*, without providing any statutory analysis of its own.

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payable for" certain costs, including "[a]llowable expenses consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's care, recovery, or rehabilitation," MCL 500.3107(1)(a), and "[w]ork loss consisting of loss of income from work," MCL 500.3107(1)(b). According to plaintiff, because benefits are payable for "reasonable charges" under MCL 500.3107(1)(a), including charges incurred for services rendered by healthcare providers under MCL 500.3157, the no-fault insurer must directly pay the provider's reasonable charges.

HN9[] MCL 500.3105 and MCL 500.3107, when taken together, provide that an insurer is liable to pay benefits for certain [*17] listed costs. Yet these provisions do nothing more than define the scope and nature of the requisite coverage. They do not identify to whom the insurer is liable or who has the right to assert a claim for benefits. Further, the language of MCL 500.3107(1)(a), which pertains to allowable expenses like those at issue here, is not amenable to an interpretation that would allow a healthcare provider to sue an insurer for reimbursement. MCL 500.3107(1)(a) provides that benefits are "payable" for "[a]llowable expenses consisting of all reasonable charges *incurred* . . . ." In the context of the no-fault act, this Court has defined "incur" as "'[t]o become liable or subject to, [especially] because of one's own actions.'"[25] Charges for healthcare services rendered are not "incurred" by a healthcare provider because a provider is not subject to charges for the products, services, and accommodations it delivers to others. Nor do providers become "liable" for allowable expenses. Rather, charges for healthcare are incurred by others, most commonly patients, and those patients are the ones who become liable for payment of those charges. Therefore, because a healthcare provider does not incur reasonable charges and is not liable for allowable expenses, [*18] plaintiff's argument that MCL 500.3107(1)(a) permits a provider to directly sue an insurer for reimbursement is not persuasive.[26] Moreover, plaintiff's interpretation of MCL 500.3107(1)(a) improperly requires the Court to read into MCL 500.3107(1)(a) a meaning that the Legislature did not manifest through the words of MCL 500.3107(1)(a) itself.[27]

Plaintiff, like previous panels of the Court of Appeals,[28] largely relies on MCL 500.3112 in support of its argument that healthcare providers possess a direct cause of action against no-fault insurers. That provision states in full:

> Personal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his death, to or for the benefit of his dependents. Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person. If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit [*19] court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:
> (a) To the dependents of the injured person, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor.

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[25] Proudfoot v State Farm Mut Ins Co, 469 Mich 476, 484; 673 NW2d 739 (2003), quoting *Webster's II New College Dictionary* (2001) (alterations in original).

[26] Plaintiff also points to the word "payable" in MCL 500.3107 to argue that no-fault benefits are to be paid to a healthcare provider for all reasonable charges for medical treatment. But MCL 500.3107 is silent regarding to whom the benefits are payable. Plaintiff does not explain how this provision vests a provider with rights against an insurer or otherwise indicates that benefits are payable to a provider.

[27] See Roberts, 466 Mich at 63.

[28] See, e.g., Chiropractors Rehab Group, PC v State Farm Mut Auto Ins Co, 313 Mich App 113; 881 NW2d 120 (2015); Wyoming Chiropractic, 308 Mich App 389; 864 N.W.2d 598.

(b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse. [MCL 500.3112.]

HN10[] While this section, which addresses to whom PIP benefits are payable, undoubtedly allows for the common practice of no-fault insurers directly paying healthcare providers, its text does not require direct payment of healthcare providers or give providers any right to directly sue a no-fault insurer, as will be evidenced through a sentence-by-sentence examination of the provision.

HN11[] The first sentence, which provides that PIP benefits "are payable to or for the benefit of an injured person or, in the case of his death, to or for the benefit of his dependents," addresses both allowable expenses and survivor's **[*20]** loss and sets forth the groups of persons to whom an insurer may direct payment to discharge its liability to the insured. The Legislature's use of the disjunctive word "or" indicates "an alternative or choice between two things."[29] The word immediately preceding the disjunctive options is "payable," which is defined by the *Merriam-Webster's Collegiate Dictionary* to mean "that may, can, or must be paid."[30] Therefore, according to the first sentence of MCL 500.3112, PIP benefits, which are paid by the insurer, "may, can, or must be paid" either (1) to the injured person *or* (2) for the benefit of the injured person. In the case of the injured person's death, PIP benefits "may, can, or must be paid" either (1) to the decedent's dependents *or* (2) for the benefit of those dependents. This sentence does nothing more than allow a no-fault insurer to satisfy its obligation to the insured by paying the injured person directly or by paying a party providing PIP services on the injured person's behalf. That a third party may *receive* payment directly from an insurer for PIP benefits does not mean that the third party has a statutory *entitlement* to that method of payment.

Plaintiff urges us to find, like previous Court of Appeals panels have, a provider cause of action in HN12[] MCL 500.3112's phrase, "for the benefit of the injured person." This language, however, does not state that benefits are payable "to the provider," or otherwise indicate that a provider itself has an entitlement to benefits. To the contrary, it expressly leaves that entitlement with the injured person and merely recognizes that one who does not have a direct cause of action against a no-fault insurer may be paid directly by the insurer, but only in order to benefit the injured person. Simply stated, nothing in the first sentence is properly construed as bestowing a statutory cause of action on the injured person's healthcare provider.

HN13[] The second sentence of MCL 500.3112 reads:

> Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person.

This sentence allows a no-fault insurer to discharge its liability through payment to or for the benefit of a person it believes is entitled **[*22]** to benefits, as long as the payment is made in good faith and the insurer has not been previously "notified in writing of the claim of some other person." Plaintiff argues that healthcare providers qualify as "some other person" for purposes of this sentence. Even if this were so, plaintiff still has not demonstrated a legal right of action against a no-fault insurer. The phrase "claim of some other person" does not itself confer on any person a "claim"[31] or "right" to recover benefits. Rather, it presupposes that "some other person" otherwise

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[29] See *People v Kowalski*, 489 Mich 488, 499 n 11, 803 NW2d 200 (2011) ("'Or' is . . . a disjunctive [term], used to indicate a disunion, a separation, an alternative.") (quotation marks and citation omitted; alteration in original).

[30] *Merriam-Webster's Collegiate Dictionary* **[*21]** (11th ed). "Payable" is not defined in the no-fault act. We therefore presume that the Legislature intended for the word to have its common and ordinary meaning. MCL 8.3a. To assist in determining the ordinary meaning of relevant words, this Court may consult a dictionary. *Klooster v Charlevoix*, 488 Mich 289, 304; 795 NW2d 578 (2011).

[31] Because the no-fault act does not define "claim," we may consult a dictionary definition. *Klooster*, 488 Mich at 304. The relevant dictionary definitions of "claim" include "a demand for something due or believed to be due" and "a right to something."

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possesses a claim for PIP benefits against the insurer.[32] Significantly, plaintiff is unable to demonstrate that the no-fault act elsewhere confers on a healthcare provider a right to claim benefits from a no-fault insurer.

HN14[] The third sentence of MCL 500.3112 reads, "If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit court for an appropriate order." This sentence merely provides a procedure for resolving doubts about which persons are entitled to benefits; it does [*23] not itself confer a right or entitlement on any person, including a healthcare provider, to sue a no-fault insurer.[33] And the sentence's reference to "apportionment" cannot logically pertain to allowable expenses like the reasonable charges incurred for healthcare services, because an injured person owes the provider, and is entitled to PIP benefits for, the entirety of those allowable expenses under MCL 500.3107(1)(a), not an apportioned amount.[34]

Finally, HN15[] the fourth sentence provides, "The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate." And the fifth sentence addresses the payment of dependent and survivor benefits in the absence of a court order. These sentences contain no language that can be reasonably understood as creating a right for a healthcare provider to directly sue a no-fault insurer. As in the third sentence, the reference to "apportionment" in the fourth sentence is inapplicable in the context of charges for services rendered by a healthcare provider. Similarly, the fourth sentence's call for the court to take into account "the relationship of [*24] the payees to the injured person" is inapt in the context of a healthcare provider's bill for services rendered. If the injured person qualifies for benefits, the insurer is liable under MCL 500.3107(1)(a) to pay "all reasonable charges incurred" by the injured person; no further inquiry into the "relationship" between the injured person and the provider

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Merriam-Webster's Collegiate Dictionary (11th ed). Therefore, to have a "claim" under the no-fault act, a provider must have a right to payment of PIP benefits from a no-fault insurer.

[32] We need not decide precisely to whom this sentence applies in order to conclude that it does not confer on a healthcare provider the right to sue for payment of benefits. It seems, however, that this sentence is likely applicable primarily to dependents and survivors given that the end of the statute pertains to the allocation of benefits to those groups of persons.

[33] Plaintiff argues that a healthcare provider qualifies as a "person" for purposes of the third sentence of MCL 500.3112 given that the Insurance Code, in MCL 500.114, defines the word "person" to include corporate entities, like healthcare providers. But this Court long ago recognized that, given its inconsistent use throughout the no-fault act, "the term 'person' must be construed in the exact context in which it is used to ascertain its precise meaning." Belcher v Aetna Cas and Surety Co, 409 Mich 231, 258, 293 NW2d 594 (1980). Plaintiff has not explained why "person," in the context of the third sentence of MCL 500.3112, refers to a corporate entity like a healthcare provider. In any event, even if a healthcare provider were a "person" for purposes of this sentence, the sentence itself, as discussed, does not purport to create or confer any rights with respect to the "persons" covered by its doubt-resolution procedure.

[34] See Douglas v Allstate Ins Co, 492 Mich 241, 257; 821 NW2d 472 (2012) (noting that MCL 500.3107(1) allows "unlimited lifetime benefits" for allowable expenses). In contrast, apportionment of benefits is necessary when the allowable benefits are finite in amount, as is the case with survivor's loss benefits. See MCL 500.3108(1).

Again, we need not decide precisely to whom this sentence pertains in order to conclude that it does not confer on a healthcare provider the right to sue for payment of benefits. Nonetheless, we note that it would seem to primarily pertain to dependent and survivor benefits. There are several scenarios in which there could be doubt regarding the proper dependent or survivor to receive benefits. For example, under MCL 500.3110(1), doubt could emerge about whether a surviving spouse or a minor child is a proper person to receive benefits if it were unclear whether they were living in the same house as the victim. Doubt could also emerge under MCL 500.3110(2) regarding the proper apportionment of benefits because "the extent of [one's] dependency shall be determined in accordance with the facts as they exist at the time of death." Similarly, doubt could emerge under MCL 500.3110(3) because this subsection conditions "dependent" status on particular factual inquiries. In those circumstances, a hearing might be necessary for the circuit court to "designate the payees and make an equitable apportionment" of benefits. MCL 500.3112.

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is relevant.[35] And the fifth sentence on its face pertains only to payment to dependents and survivors. Therefore, the fourth and fifth sentences clearly do not create a statutory cause of action for healthcare providers.

While plaintiff primarily cites MCL 500.3112 as establishing a healthcare-provider cause of action under the no-fault act, HN16[] there is nothing in the language of this provision that can reasonably be interpreted as vesting a healthcare provider with a right to demand reimbursement from a no-fault insurer for services the provider rendered to an insured. Although this provision allows insurers to pay a provider of no-fault services directly "for the benefit of" the insured, it does not establish a concomitant claim enforceable by an insured's benefactors.[36] Plaintiff has not pointed to any other provision in the no-fault act that bestows on healthcare [*25] providers a right to directly sue a no-fault insurer.[37]

Two textual clues found elsewhere in the no-fault act support the conclusion that a healthcare provider does not possess a statutory cause of action against a no-fault insurer. HN17[] The priority statutes, MCL 500.3114 and MCL 500.3115, define against whom an individual may make a claim for benefits. The default rule for priority is found in MCL 500.3114(1), which states, in part, that "a personal protection insurance policy . . . applies to accidental bodily injury to the person named in the policy, the person's spouse, and a relative of either domiciled in the same household . . . ." "Person" in this instance cannot mean a healthcare provider because providers are not

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[35] In contrast, the relationship between a payee and an injured person is relevant when survivor and dependent benefits are at issue. Certain individuals are conclusively presumed to be dependents under MCL 500.3110(1) but when one of those conclusive relationships is not at issue, "questions of dependency and the extent of dependency shall be determined in accordance with the facts as they exist at the time of death" under MCL 500.3110(2), which may require an inquiry into the parties' relationship.

[36] The dissent asserts that this conclusion "renders surplusage the possibility of payment to a third party like a healthcare provider." This is not so. By permitting insurers to directly pay healthcare providers on the injured person's behalf, MCL 500.3112 allows the insurer to eliminate the insured as a conduit in the payment process, relieving the insured from having to redirect to the healthcare provider payment received from the insurer. It is not surplusage for the statute to expressly permit an insurer to directly pay its insured's healthcare bills in order to discharge its obligation to its insured. The fact that the statute grants that permission does not create a right in the providers to sue the insurer for payment.

[37] Other provisions cited by plaintiff in support of its argument that healthcare providers have a direct claim of their own are MCL 500.3145(1) and MCL 500.3148.

MCL 500.3145(1), the no-fault statute of limitations provision, provides that "[a]n action for recovery of personal protection insurance benefits payable under this chapter for accidental bodily injury may not be commenced later than 1 year after the date of the accident causing the injury . . . ." Plaintiff argues that this provision does not only permit the injured person to bring a lawsuit, but that it plainly allows a timely lawsuit for recovery of PIP benefits "payable under this chapter" and that under MCL 500.3107, MCL 500.3157, and MCL 500.3112, allowable expenses are payable to healthcare providers. Consequently, plaintiff contends that MCL 500.3145(1) contemplates that providers will bring lawsuits to recover benefits. According to plaintiff, the third sentence of MCL 500.3145(1) confirms this interpretation by stating that "the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced." Under plaintiff's interpretation, the Legislature's use of the word "claimant," instead of "injured person," demonstrates that other persons, like providers, may bring lawsuits to recover PIP benefits.

MCL 500.3148, which pertains to attorney fees, states in part that "[a]n attorney is entitled to a reasonable fee for advising and representing a claimant in an action for personal or property protection insurance benefits which are overdue." MCL 500.3148(1). Plaintiff similarly argues that the statute's reference to "claimant" rather than "injured person" indicates that healthcare providers have the right to bring an independent lawsuit for payment of PIP benefits.

Plaintiff's reliance on the references to "claimant" rather than "injured person" in MCL 500.3145(1) and MCL 500.3148 is helpful to plaintiff's argument only if healthcare providers are proper claimants under the no-fault act. The provisions cited by plaintiff do not establish that providers possess a claim under the act. Because MCL 500.3145(1) and MCL 500.3148 do not create rights to PIP benefits that do not otherwise exist, plaintiff's reliance on these provisions is misplaced.

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named in the PIP insurance policy and quite simply do not sustain accidental bodily injuries. MCL 500.3114(2) states that "[a] person suffering accidental bodily injury . . . shall receive the [PIP] benefits to which the person is entitled from the insurer of the motor vehicle," and MCL 500.3114(4), (5), and (6) prioritize the order in which "a person suffering accidental bodily injury arising from a motor vehicle accident . . . shall claim personal protection insurance benefits from [multiple] insurers[.]" HN18[] MCL 500.3115(1) similarly sets forth the insurer priority [*26] for "a person suffering accidental bodily injury while not an occupant of a motor vehicle," and it provides that those persons "shall claim [PIP] benefits" in the order provided in MCL 500.3115(1). In both of these provisions, the Legislature specifically contemplates that the entitlement or claim belongs to the person who has "sustained accidental bodily injury," and the statutory language goes into great detail regarding the priority of insurers for claims by a person suffering such injury. Notably lacking from these entitlement provisions is any arguable reference to or contemplation of a healthcare provider's entitlement to benefits under the no-fault act.[38]

In sum, HN19[] a review of the plain language of the no-fault act reveals no support for plaintiff's argument that a healthcare provider possesses a statutory cause of action against a no-fault insurer.[39] This conclusion does not mean that a healthcare provider is without recourse; a provider that furnishes healthcare services to a person for injuries sustained in a motor vehicle accident may seek payment from the injured person for the provider's reasonable charges.[40] However, a provider simply has no statutory cause of action [*27] of its own to directly sue a no-fault insurer. Accordingly, we overrule all Court of Appeals caselaw inconsistent with this conclusion.

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[38] This conclusion is consistent with Belcher, 409 Mich at 236, in which this Court considered whether "no-fault insurance benefits [are] to be paid to the surviving dependent(s) of a deceased uninsured motorist[.]" (Quotation marks and citation omitted.) In analyzing this issue, this Court opined that the no-fault act "operates to compensate only a limited class of persons for economic losses sustained as a result of motor vehicle accidents. Under personal protection insurance, benefits are made payable only to injured persons or surviving dependents of the injured person." Id. at 243-244. The Court further described MCL 500.3114 and MCL 500.3115 as the no-fault act's only entitlement provisions "in the sense that they are the only sections where persons are given the right to claim personal protection insurance benefits from a specific insurer." Id. at 252. *Belcher* is not directly applicable in this case because it did not examine whether a healthcare provider possesses a cause of action under the no-fault act. Contrary to the dissent's assertion, we do not rely on *Belcher* to exclude the possibility of a provider claim, nor do we contend that an injured person's cause of action under the no-fault act derives entirely from MCL 500.3114 and MCL 500.3115. Instead, we simply note that *Belcher*'s holding is consistent with our independent conclusion that healthcare providers possess no statutory cause of action because, just like the remainder of the no-fault act, neither MCL 500.3114 nor MCL 500.3115 contemplate that a healthcare provider may directly claim recovery for the cost of providing PIP benefits.

Moreover, in *Belcher* this Court concluded that, while the text of the entitlement provisions gives only injured persons the right to assert a claim for benefits against a no-fault insurer, the Legislature clearly intended that surviving dependents recover certain losses in the event that the injured person dies, as evidenced by the provision of benefits for survivors in MCL 500.3108 and MCL 500.3112. Id. at 254-255. To effectuate the intent made explicit in the statutory language, the Court inferred from the language of MCL 500.3114 and MCL 500.3115 that when an injured person is given the right to recover benefits from a specific insurer, the surviving dependents have the same right of recovery for their losses. Id. at 255. Contrary to the dissent's belief, no similar statutory basis exists for recognizing this type of claim on the part of an injured person's healthcare provider. We will not infer a cause of action for healthcare providers when the language of the no-fault act indicates no such desire on the part of the Legislature.

[39] We conclude today only that a healthcare provider possesses no statutory right to sue a no-fault insurer. While defendant argues that a provider likewise possesses no contractual right to sue a no-fault insurer given that healthcare providers are incidental rather than intended beneficiaries of a contract between the insured and the insurer, this Court declines to make such a blanket assertion. That determination rests on the specific terms of the contract between the relevant parties. See Schmalfeldt v N Pointe Ins Co, 469 Mich 422, 428; 670 NW2d 651 (2003) ("A person is a third-party beneficiary of a contract only when *that contract* establishes that a promisor has undertaken a promise 'directly' to or for that person.") (citations omitted; emphasis added). This Court need not consider whether plaintiff possesses a contractual right to sue defendant in the instant case because plaintiff did not allege any contractual basis for relief in its complaint.

[40] See Miller v Citizens Ins Co, 490 Mich 904, 804 N.W.2d 740 (2011). Moreover, our conclusion today is not intended to alter an insured's ability to assign his or her right to past or presently due benefits to a healthcare provider. See MCL 500.3143;

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IV. APPLICATION

Given our conclusion that healthcare providers possess no statutory cause of action under the no-fault act, it is unnecessary to consider the substance of the Court of Appeals' opinion. Because a healthcare provider possesses no statutory right to sue a no-fault insurer, we need not examine whether a release executed between an insured and an insurer releases an insurer's liability for a healthcare provider's "claim." Further, the release executed in this case between Stockford and defendant does not appear to extinguish Stockford's liability to plaintiff. And nothing in this opinion would bar plaintiff from seeking reimbursement of the amount due it directly from Stockford, the person to whom services were provided.[41]

V. CONCLUSION

The Court of Appeals' opinion in this case is premised on the notion that an injured person's healthcare provider has an independent statutory right to bring an action against a no-fault insurer for payment of no-fault benefits. This premise is unfounded and not supported by the text of the no-fault [*28] act. A healthcare provider possesses no statutory cause of action under the no-fault act against a no-fault insurer for recovery of PIP benefits. Plaintiff therefore has no statutory entitlement to proceed with its action against defendant. Accordingly, we reverse the judgment of the Court of Appeals and remand this case to the Saginaw Circuit Court for entry of an order granting summary disposition to defendant.

Brian K. Zahra

Stephen J. Markman

Bridget M. McCormack

David F. Viviano

Joan L. Larsen

Dissent by: Richard H. Bernstein

Dissent

BERNSTEIN, J. (*dissenting*).

I respectfully disagree with the majority's conclusion that healthcare providers do not possess a cause of action under Michigan's no-fault act, *MCL 500.3101 et seq.*, to recover personal protection insurance (PIP) benefits from a no-fault insurer for services provided to an insured. I believe that *MCL 500.3112* establishes that an independent action may be brought by a healthcare provider against a no-fault insurer and that the majority's contrary construction is not supported by the plain language of the statute. Accordingly, I would affirm the judgment of the Court of Appeals.

I. FACTS AND PROCEDURAL HISTORY

Jack Stockford, who held no-fault insurance through defendant, State Farm [*29] Mutual Automobile Insurance Company, was injured in a motor vehicle accident on June 20, 2011. Plaintiff, Covenant Medical Center, Inc., provided medical services to Stockford on multiple occasions in the following months. Plaintiff sent defendant bills for these services totaling $43,484.80 on July 3, 2012, August 2, 2012, and October 9, 2012. Defendant sent plaintiff a written denial of payment on November 15, 2012.

Professional Rehab. Assocs. v State Farm Mut. Auto. Ins. Co., 228 Mich App 167, 172; 577 NW2d 909 (1998) (noting that only the assignment of future benefits is prohibited by *MCL 500.3143*).

[41] See *Miller, 490 Mich at 904*.

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Meanwhile, apparently unbeknownst to plaintiff, Stockford had filed suit against defendant on June 4, 2012, seeking PIP benefits for expenses arising out of the June 20 accident. Stockford entered into an agreement with defendant on April 2, 2013, by which defendant consented to pay Stockford $59,000 in exchange for a full and final release "regarding all past and present claims incurred through January 10, 2013, for what are commonly referred to as first party benefits or personal injury protection benefits . . . ." As part of this broad release, Stockford agreed to indemnify defendant against claims made by any providers. Plaintiff was specifically named in this portion of the release agreement.

Plaintiff did not learn of the release until it filed suit against defendant [*30] on April 25, 2013. Defendant was granted summary disposition pursuant to MCR 2.116(C)(7) under the theory that Stockford's release barred plaintiff's claim. The Court of Appeals reversed in a published per curiam opinion, concluding that defendant's settlement agreement with Stockford had not been a "good faith" payment that could discharge its liability to plaintiff under MCL 500.3112. Covenant Med Ctr, Inc v State Farm Mut Auto Ins Co, 313 Mich App 50; 880 NW2d 294 (2015).

II. ANALYSIS

I agree with the majority that none of the caselaw relied on by the Court of Appeals directly addressed the question of whether healthcare providers have an independent cause of action for PIP benefits under the no-fault act. However, this does not necessarily mean that the Court of Appeals' longstanding interpretation of the no-fault act was inconsistent with the plain language of the statute. While no provision of the no-fault act confers a direct cause of action specific to healthcare providers, the plain language of MCL 500.3112 suggests that such a cause exists. Furthermore, although no provision of the no-fault act explicitly states that a healthcare provider may have a claim for PIP benefits, healthcare providers are no different in this regard from any other would-be claimant under the no-fault act, including injured [*31] people themselves.

No provision of the no-fault act expressly defines "claimant." However, provisions such as MCL 500.3112 contemplate who may *receive* PIP benefits under the no-fault act, and the ability to receive benefits is necessary in order to claim them. Absent any specific statement establishing who may bring a claim for PIP benefits, we must consider the plain language of MCL 500.3112, which provides:

> Personal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his death, to or for the benefit of his dependents. Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person. If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship [*32] of the payees to the injured person and other factors as the court considers appropriate. In the absence of a court order directing otherwise the insurer may pay:
> (a) To the dependents of the injured person, the personal protection insurance benefits accrued before his death without appointment of an administrator or executor.
> (b) To the surviving spouse, the personal protection insurance benefits due any dependent children living with the spouse.

The first sentence of MCL 500.3112 suggests that healthcare providers have a claim for PIP benefits. It provides that PIP benefits "are payable to or for the benefit of an injured person or, in the case of his death, to or for the benefit of his dependents." MCL 500.3112. As the majority notes, this plainly means that insurers may pay benefits directly to healthcare providers, because such a payment would be "for the benefit of" the injured person or the injured person's dependents. *Id.* The majority clearly believes that an injured person is entitled to bring an action to recover these benefits, hanging its hat on the "shall claim" language of MCL 500.3114 and MCL 500.3115. But this language no more establishes an entitlement to make a legal claim than does the "payable to or for the benefit [*33] of" language of MCL 500.3112.

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In the absence of any express entitlement provision in MCL 500.3112, the majority insists that MCL 500.3114 and MCL 500.3115 function as entitlement provisions for injured persons. However, as the majority admits, these are priority statutes that govern the order of priority among insurers rather than explicitly defining who may be a claimant under the no-fault act. The majority asserts that these two provisions are entitlement provisions because they include language to the effect that an injured person "'shall claim [PIP] benefits,'" *ante* at 22 (alteration in original), but this interpretation ignores the context in which that language appears. The "shall claim" language appears in MCL 500.3114(4) and (5) and MCL 500.3115(1). In each of those provisions, the "shall claim" language is part of the longer phrase "shall claim [PIP] benefits from insurers in the following order of priority," immediately followed by a list of the insurers that may be required to pay benefits. MCL 500.3114(4) and (5); MCL 500.3115(1). The mandate of these statutes is not to define who must *receive* benefits, but who must *pay* them.

Indeed, MCL 500.3114 and MCL 500.3115 cannot possibly define the bounds of who can bring an action for PIP benefits. The majority's reliance on Belcher v Aetna Cas & Surety Co, 409 Mich 231, 251-252; 293 NW2d 594 (1980), for the proposition that MCL 500.3114 and MCL 500.3115 are entitlement **[*34]** provisions that exclude the possibility of a provider claim is inapt. Although the *Belcher* Court referred to MCL 500.3114 and MCL 500.3115 as entitlement provisions in some sense, it rejected the notion that these two sections of the no-fault act constituted the be-all and end-all of potential PIP benefit claimants, remarking that neither provision gave survivors an express right to claim benefits even though survivors' benefits are clearly recognized in MCL 500.3108 and MCL 500.3112. Belcher, 409 Mich at 254-255.

The *Belcher* Court was right. A finding that MCL 500.3114 and MCL 500.3115 are the only statutes in the no-fault act that establish an entitlement to a legal claim would render nugatory the language in MCL 500.3112 that permits payment of benefits to dependents and to other parties for the benefit of the injured person (a group of recipients that the majority concedes would include healthcare providers). See *ante* at 15. Such a reading would run counter to the rule of statutory interpretation barring us from interpreting statutes in a manner that would render any portion of a statute surplusage or nugatory. Wyandotte Electrical Supply Co v Electrical Tech Sys, Inc, 499 Mich 127, 140; 881 NW2d 95 (2016). Therefore, I cannot interpret MCL 500.3114 and MCL 500.3115 as the only provisions in the no-fault act that establish an entitlement to a legal claim for PIP benefits.

Nor can I conclude that MCL 500.3112 supports the **[*35]** notion that injured persons have a cause of action for PIP benefits but healthcare providers do not. MCL 500.3112 makes PIP benefits "payable"—that is, benefits "that may, can, or must be paid"[1]—to either the injured person *or* to someone else for that person's benefit, e.g., a healthcare provider. The statute does not treat these options differently. It is inconsistent to conclude that healthcare providers do not have an entitlement to PIP benefits while an injured person does. Healthcare providers cannot be barred from seeking to enforce their right to payment under this provision.[2]

The remainder of MCL 500.3112 does not undercut the conclusion that providers have an entitlement to a legal claim for PIP benefits. Indeed, the remainder of this provision does not discuss entitlement to benefits, but rather delineates procedures to be followed when there is some dispute among claimants to benefits. The second sentence of MCL 500.3112 explains that a good-faith payment of PIP benefits discharges an insurer's liability unless the insurer has received written notice of "the claim of some other person." The third sentence allows an insurer, claimant, or other interested party to seek a court **[*36]** order determining the proper person to receive benefits or the proper apportionment of benefits. The fourth permits a court to designate payees or apportion benefits as it considers appropriate, while the remainder of the provision directs an insurer's payment of benefits in the absence of a court order.

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[1] *Merriam-Webster's Collegiate Dictionary* (11th ed).

[2] To the extent that the majority argues that healthcare providers are not entitled to benefits because they do not "incur" charges within the meaning of MCL 500.3107(1)(a), it is incorrect. Healthcare providers clearly become liable for expenses arising out of the treatment of injured persons, expenses that include, among other things, human labor (and associated wages and salaries) and the cost of medical equipment and its operation.

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The majority suggests that these aspects of MCL 500.3112 are inconsistent with the notion that the no-fault act establishes a healthcare provider's entitlement to a legal claim, but this is simply not the case. Although the directives in MCL 500.3112 do not in themselves entitle healthcare providers to benefits, they do not derogate the entitlement to make a legal claim alluded to in the first sentence of MCL 500.3112. The majority suggests that the bulk of MCL 500.3112 cuts against the notion of a provider claim and must be limited to dependent and survivor benefits, but this is not true. For example, contrary to the majority's assertion, the reference to apportionment in the third sentence is not limited in this fashion. "Apportionment" as used in that sentence could certainly apply to expenses incurred for healthcare services if, for example, an injured person received treatment from multiple providers resulting in PIP-qualifying [*37] charges. Nor do the fourth and fifth sentences suggest that the entirety of MCL 500.3112 is limited to dependent and survivor benefits. These sentences instead provide purely discretionary rubrics a trial court may follow when issuing an order. These sentences do not prevent the distribution of benefits to a healthcare provider.

In sum, the no-fault act does not expressly grant healthcare providers the right to directly sue insurers for PIP benefits. But it does not expressly grant that right to any party, not even an insured party injured in a motor vehicle accident. If we are to require an express statutory provision in order to create a cause of action, and no such provision appears in the no-fault act, it would follow that no party could ever bring suit to compel an insurer to pay PIP benefits. But it simply cannot be that the Legislature created a statutory scheme for the distribution of PIP benefits that no party could ever recover if an insurer denied coverage. MCL 500.3112 permits payment of PIP benefits to either an injured person or to a healthcare provider because direct payment to the provider would be for the benefit of the injured person. To hold that only an injured person is entitled to enforce [*38] this right to payment renders surplusage the possibility of payment to a third party like a healthcare provider. To avoid such an interpretation of the language of the no-fault act, healthcare providers must have a claim for PIP benefits.

III. APPLICATION

Because the no-fault act gives healthcare providers a claim for PIP benefits, I believe that the Court of Appeals reached the correct result in this case. In theory, an agreement like the one between Stockford and defendant could extinguish an insurer's liability for PIP benefits arising out of a particular accident. However, the second sentence of MCL 500.3112 provides: plaintiff.[3] The Court of Appeals' conclusion that the settlement with Stockford did not constitute a good-faith payment was eminently reasonable, as was the Court's concomitant conclusion that the payment did not discharge defendant's liability as contemplated by the second sentence of MCL 500.3112.

> Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other [*39] person.

As the Court of Appeals found, the release executed by Stockford and defendant was not in good faith. Defendant had been made aware of plaintiff's claim through the bills plaintiff transmitted to it. However, defendant entered into the settlement with Stockford and sought to permanently foreclose plaintiff's claim for PIP benefits without informing

IV. CONCLUSION

I disagree with the majority's conclusion that the no-fault act does not give healthcare providers the right to bring an action against a no-fault insurer for PIP benefits. That reading renders nugatory the first sentence of MCL 500.3112, which permits payment of PIP benefits to healthcare providers. Because I believe that healthcare providers like plaintiff are entitled to enforce the receipt of payment due and that the Court of Appeals correctly concluded that defendant's liability for PIP benefits under MCL 500.3112 was not discharged, I would affirm the judgment of the Court of Appeals.

Richard H. Bernstein

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[3] It is, of course, interesting that in this settlement agreement defendant demanded indemnification against provider claims that it now insists cannot exist under the no-fault act.

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WILDER, J., did not participate in the disposition of this matter.

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EXHIBIT 2

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Professional Rehabilitation Assocs. v. State Farm Mut. Auto. Ins. Co.

Court of Appeals of Michigan

October 7, 1997, Submitted ; February 20, 1998, Decided

No. 195938

Reporter
228 Mich. App. 167 *; 577 N.W.2d 909 **; 1998 Mich. App. LEXIS 52 ***

PROFESSIONAL REHABILITATION ASSOCIATES, as Assignee of CLIFFORD LAY, Plaintiff-Appellant, v STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, Defendant-Appellee.

Prior History: [***1] LC No. 94-DA6199-AV. Oakland Circuit Court.

Disposition: Reversed and Remanded.

Core Terms

benefits, district court, no-fault, summary disposition, guardian, insanity, appointment, services, assign, saving, circuit court, one year, past due, insurer, insurance benefits, provides, rights, void, protection of persons, disability

Case Summary

Procedural Posture
Plaintiff assignee appealed the order of the Oakland Circuit Court (Michigan) that affirmed a district court order granting summary disposition to defendant insurer in the assignee's cause of action for past due medical and rehabilitation benefits under an insurance policy assigned to the assignee by an injured man's guardian. The case had sustained several appeals and rejections before the state supreme court remanded it as on leave granted.

Overview

A wife was appointed her husband's guardian and subsequently assigned the husband's insurance rights to benefits to the assignee after the insurer denied four claims for services. The district court's initial grant of summary judgment, based on the statutory limitations period, was affirmed; however, the circuit court based its affirmance on its ruling that the assignment was void as a matter of law. On remand, the court reversed the circuit court's affirmance of summary judgment granted by the district court and remanded the case. In so doing, the court held, adversely to the district and circuit courts, that Mich. Comp. Laws § 500.3143 (Mich. Stat. Ann. 24.13143) proscribed an assignment of rights to benefits payable in the future and did not prohibit past due benefits. To the extent, therefore, that the instant assignment gave the assignee the rights to past due benefits, the court ruled it was valid. Further, the court held that the statute of limitations was tolled by the husband's incompetency, pursuant to Mich. Comp. Laws § 600.5851 (Mich. Stat. Ann. 27A.5851), until one year after that disability was removed and not one year after the guardian was appointed.

Outcome
The court reversed the circuit court's order affirming the district court's order granting summary judgment to the insurer and remanded the case to the district court.

Jacob Bryant

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LexisNexis® Headnotes

Civil Procedure > Appeals > Summary Judgment Review > General Overview

Civil Procedure > Appeals > Summary Judgment Review > Standards of Review

Civil Procedure > ... > Summary Judgment > Motions for Summary Judgment > General Overview

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > General Overview

Civil Procedure > Appeals > Standards of Review > De Novo Review

HN1[] The appellate court reviews grants of summary disposition de novo as a question of law. A motion for summary disposition tests the factual support for a claim to determine whether it can be resolved on an issue of law. Giving the benefit of reasonable doubt to the nonmovant, the court must determine whether a record might be developed that would result in an issue upon which reasonable minds could differ. All inferences are to be drawn in favor of the nonmoving party. Thus, before judgment may be granted, the court must be satisfied that it is impossible for the claim asserted to be supported by the evidence at trial because of some deficiency that cannot be overcome.

Civil Procedure > Appeals > Standards of Review > De Novo Review

Governments > Legislation > Interpretation

HN2[] Statutory interpretation is a question of law also subject to review de novo on appeal. The primary goal of statutory interpretation is to ascertain and give effect to the intent of the legislature in enacting a provision. Statutory language should be construed reasonably, keeping in mind the purpose of the statute. The first criterion in determining intent is the specific language of the statute. If the statutory language is clear and unambiguous, judicial construction is neither required nor permitted and courts must apply the statute as written. However, if reasonable minds can differ regarding the meaning of a statute, judicial construction is appropriate.

Contracts Law > ... > Negotiable Instruments > Enforcement > Overdue Instruments

Insurance Law > ... > Motor Vehicle Insurance > Coverage > General Overview

Insurance Law > ... > Coverage > No Fault Coverage > General Overview

HN3[] An insurer is liable to pay personal protection insurance benefits for accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle, subject to the provisions of the no-fault act. *Mich. Comp. Laws § 500.3105(1)* (Mich. Stat. Ann. § 24.13105(1)). The act itself further notes that statutory benefits are payable as loss accrues, *Mich. Comp. Laws § 500.3142(1)* (Mich. Stat. Ann. § 24.13142(1)), and that benefits are overdue if not paid within 30 days after an insurer receives reasonable proof of the fact and of the amount of loss sustained. *Mich. Comp. Laws § 500.3142(2)* (Mich. Stat. Ann. § 24.13142(2)).

Contracts Law > Standards of Performance > Assignments > General Overview

Insurance Law > Liability & Performance Standards > Bad Faith & Extracontractual Liability > Assignment of Claims

Insurance Law > ... > Coverage > No Fault Coverage > General Overview

Jacob Bryant

HN4[] Mich. Comp. Laws § 500.3143 (Mich. Stat. Ann. § 24.13143) provides in full: An agreement for assignment of a right to benefits payable in the future is void. Under the plain language of the statute, a right to benefits payable in the future is distinguishable from a right to past due or presently due benefits.

Contracts Law > Contract Conditions & Provisions > General Overview

Contracts Law > Contract Interpretation > Severability

Business & Corporate Compliance > ... > Contracts Law > Types of Contracts > Divisible Contracts

Insurance Law > Claim, Contract & Practice Issues > Policy Interpretation > General Overview

HN5[] The failure of a distinct part of a contract does not void valid, severable provisions. The primary consideration in determining whether a contractual provision is severable is the intent of the parties.

Governments > Legislation > Statute of Limitations > General Overview

Governments > Legislation > Statute of Limitations > Time Limitations

Insurance Law > Liability & Performance Standards > Notice to Insurers > General Overview

Insurance Law > ... > Coverage > No Fault Coverage > General Overview

HN6[] The no-fault statute of limitations, Mich. Comp. Laws § 500.3145 (Mich. Stat. Ann. 24.13145), provides in pertinent part: (1) An action for recovery of personal protection insurance benefits payable under this chapter for accidental bodily injury may not be commenced later than 1 year after the date of the accident causing the injury unless written notice of injury as provided herein has been given to the insurer within 1 year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury. If the notice has been given or a payment has been made, the action may be commenced at any time within 1 year after the most recent allowable expense, work loss or survivor's loss has been incurred. However, the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced.

Governments > Legislation > Statute of Limitations > General Overview

Governments > Legislation > Statute of Limitations > Tolling

Insurance Law > ... > Coverage > No Fault Coverage > General Overview

HN7[] The general saving provision of the Revised Judicature Act applies to all causes of action created by Michigan statutes even when the statute creating the right contains its own limitation period. The saving provision applies to actions for the recovery of personal protection insurance benefits under the no-fault act.

Governments > Legislation > Statute of Limitations > Time Limitations

Governments > Legislation > Statute of Limitations > Tolling

HN8[] Mich. Comp. Laws § 600.5851 (Mich. Stat. Ann. § 27A.5851) provides in pertinent part: (1) Except as otherwise provided in subsections (7) and (8), if the person first entitled to make an entry or bring an action under this act is under 18 years of age or insane at the time the claim accrues, the person or those claiming under the person shall have 1 year after the disability is removed through death or otherwise, to make the entry or bring the

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action although the period of limitations has run. This section does not lessen the time provided for in section 5852.(2) The term insane as employed in this chapter means a condition of mental derangement such as to prevent the sufferer from comprehending rights he or she is otherwise bound to know and is not dependent on whether or not the person has been judicially declared to be insane.

Estate, Gift & Trust Law > Estate Administration > Conservators & Guardians > General Overview

Governments > Legislation > Statute of Limitations > General Overview

Governments > Legislation > Statute of Limitations > Time Limitations

Governments > Legislation > Statute of Limitations > Tolling

HN9[] The appointment of a guardian for a mentally incompetent person is not a removal of the disability under *Mich. Comp. Laws § 600.5851(1)* (Mich. Stat. Ann. § 27A.5851(1)). Periods of limitation, therefore, do not begin to run against insane persons upon such appointment. The disability saving provision provides that an individual mentally incompetent at the time a cause of action accrues may file the claim before the applicable limitation period runs after the disability is removed. The period does not begin to run with the appointment of a guardian on behalf of a mentally incompetent person.

Business & Corporate Compliance > ... > Negotiable Instruments > Types of Parties > Assignees & Assignors

Business & Corporate Compliance > ... > Types of Commercial Transactions > Negotiable Instruments > Transfer of Negotiable Instruments

Insurance Law > Liability & Performance Standards > Bad Faith & Extracontractual Liability > Assignment of Claims

HN10[] An assignee stands in the shoes of the assignor and acquires the same rights as the assignor possessed.

Counsel: Law Offices of Wayne J. Miller; P. C. (by Gloria Perez), for the plaintiff. Bingham Farms.

Romain, Donofrio, Kuck & Egerer, P. C. (by Melanie T. Frazier), for the defendant. Southfield.

Judges: Before: Jansen, P.J., and Doctoroff and Gage, JJ.

Opinion by: HILDA R. GAGE

Opinion

[911]** **[*168]** GAGE, J.

This case is before this Court on remand from our Supreme Court for consideration as on leave granted. *Professional Rehabilitation Ass'n v State Farm Mut Automobile Ins Co, 452 Mich. 857, 550 N.W.2d 794 (1996).* Plaintiff appeals an order issued by the circuit court that affirmed a district court order granting summary disposition to defendant. We reverse.

Defendant's insured, Clifford Lay, was injured in an automobile accident in October 1980. Within one year of the accident, Cherrie Lay was appointed her husband's guardian. Plaintiff provided extensive medical and rehabilitation services to Clifford. Defendant paid for some, but not all, of the services plaintiff provided. In a letter dated May 27, 1992, defendant denied payment for services plaintiff provided to Clifford on July 11, 1991, August 5, 1991, September 16, 1991, and **[***2]** December 31, 1991. On June 25, 1993, Cherrie Lay assigned Clifford's rights

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under the insurance [*169] policy to plaintiff. Plaintiff filed suit in the district court on May 12, 1994, seeking to recover the balance due on plaintiff's account for the four unpaid 1991 service dates.

Defendant moved for summary disposition pursuant to MCR 2.116(C)(10), alleging that the Suit was barred by the no-fault act's one-year statute of limitations, MCL 500.3145; MSA 24.13145. Plaintiff defended on the basis of the insanity saving provision of the Revised Judicature Act (RJA), MCL 600.5851; MSA 27A.5851, arguing that it tolled the one-year-back provision. Plaintiff further contended that whether Clifford Lay had suffered a condition of mental derangement such that the insanity saving provision applied was a question of fact making summary disposition inappropriate. The district court granted defendant's motion and dismissed the claim. The court held that the one-year statute of limitations applied because Clifford's guardian was obligated to bring a lawsuit under the act within one year of her appointment. Plaintiff filed a motion for reconsideration, which was denied by the district court without elaboration, [***3] following a brief discussion on the record clarifying that plaintiff had, in fact, filed suit within one year of its receipt of the assignment.

Plaintiff then filed a claim of appeal with the circuit court, which affirmed the dismissal of plaintiff's claim on the separate ground that no assignment of no-fault benefits is permitted under MCL 500.3143; MSA 24.13143, an argument that had been raised by defendant in its response to plaintiff's district court motion for reconsideration. The circuit court disagreed with plaintiff's argument that assignment of past due or presently due benefits, as distinguished [*170] from future benefits, was allowed and held that the assignment to plaintiff was void as a matter of law and that dismissal of plaintiff's claim had therefore been proper.

Next, plaintiff filed an application for leave to appeal to this Court, which this Court denied for lack of merit. Plaintiff's subsequent motion for rehearing was also denied, Plaintiff then filed an application for leave to appeal to the Supreme Court. In lieu of granting leave to appeal, the Supreme Court remanded the matter to this Court "as on leave granted for it to consider whether the circuit court's opinion [***4] that the assignment is void under MCL 500.3143; MSA [**912] 24.13143, and whether the district court's opinion that the tolling provision for insanity was inapplicable because the injured person had a guardian, are clearly erroneous."

On remand, plaintiff first argues that the circuit court erred in holding that an assignment of past-due no-fault benefits violates MCL 500.3143; MSA 24.13143. We agree.

HN1[] This Court reviews grants of summary disposition de novo as a question of law. Smith v Globe Life Ins Co, 223 Mich. App. 264, 270; 565 N.W.2d 877 (1997). A motion for summary disposition tests the factual support for a claim to determine whether it can be resolved on an issue of law. Id. at 272. Giving the benefit of reasonable doubt to the nonmovant, the court must determine whether a record might be developed that would result in an issue upon which reasonable minds could differ. *Id.* All inferences are to be drawn in favor of the nonmoving party. *Id.* Thus, before [*171] judgment may be granted, the court must be satisfied that it is impossible for the claim asserted to be supported by the evidence at trial because of some deficiency that cannot be overcome. *Id.*

HN2[] Statutory interpretation [***5] is a question of law also subject to review de novo on appeal. USAA Ins Co v Houston General Ins Co, 220 Mich. App. 386, 389; 559 N.W.2d 98 (1996).

> The primary goal of statutory interpretation is to ascertain and give effect to the intent of the Legislature in enacting a provision. Statutory language should be construed reasonably, keeping in mind the purpose of the statute. The first criterion in determining intent is the specific language of the statute. *If the statutory language is clear and unambiguous, judicial construction is neither required nor permitted and courts must apply the statute as written.* However, if reasonable minds can differ regarding the meaning of a statute, judicial construction is appropriate. [Id. at 389-390 (emphasis added; citations omitted).]

The no-fault insurance act, MCL 500.3101 et seq.; MSA 24.13101 *et seq.*, "was offered as an innovative social and legal response to the long payment delays, inequitable payment structure, and high legal costs inherent in the tort (or 'fault') liability system. The goal of the no-fault insurance system was to provide victims of motor vehicle accidents assured, adequate, and prompt reparation [***6] for certain economic losses." Shavers v Attorney General, 402 Mich. 554, 578-579; 267 N.W.2d 72 (1978). HN3[] An insurer is liable to pay personal protection

insurance benefits for accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle, subject to the provisions of the no-fault act. MCL 500.3105(1); MSA 24.13105(1). The act itself further [*172] notes that statutory benefits "are payable as loss accrues," MCL 500.3142(1); MSA 24.13142(1), and that benefits "are overdue if not paid within 30 days after an insurer receives reasonable proof of the fact and of the amount of loss sustained." MCL 500.3142(2); MSA 24.13142(2).

The statute at issue, HN4[↑] MCL 500.3143; MSA 24.13143, provides in full: "An agreement for assignment of a right to benefits payable in the future is void. "We believe that this statutory language is "clear and unambiguous." USAA Ins Co, supra at 389. Under the plain language of the statute, "a right to benefits payable in the future" is distinguishable from a right to past due or presently due benefits. Keeping in mind our duty to discern and effectuate the intent of the Legislature, we believe that if the [***7] Legislature had intended to prohibit the assignment of all rights, it would not have included the word "future" in the language of the statute. The Legislature is presumed to have intended the meaning that a statute plainly expresses. *Institute in Basic Life Principles; Inc v Watersmeet Twp (After Remand, 217 Mich. App. 7, 12; 551 N.W.2d 199 (1996)*.

Having found that the statute serves only to ban the assignment of benefits payable in the future and not those that are past due or presently due, we must determine whether [**913] the assignment in question purports to assign only past due and presently due benefits or whether it purports to assign future benefits as well. We could locate only one published opinion that interprets this provision in terms of an assignment to a medical provider, and that is the opinion cited by the circuit court in support of its dismissal of plaintiff's claim. In Aetna Casualty & Surety Co v Starkey, [*173] 116 Mich. App. 640; 323 N.W.2d 325 (1982), the parent of an injured child assigned to a hospital no-fault insurance benefits due from an insurer. Although plaintiff argues that the assignment in *Aetna* was executed before the provision of any services [***8] and by its terms applied to future benefits, the opinion does not make this point clear. This Court described the language of the assignment as purporting to assign "any insurance benefits from Aetna which would become due and payable," id. at 642, or as "any benefits which would become payable." Id. at 646. By its own language, the *Aetna* assignment dealt with benefits that "would become" payable, and this Court held that this prior assignment of personal protection benefits to a medical provider was void under MCL 500.3143; MSA 24.13143. However, this Court did not hold that any assignment of benefits, including those past due or presently due would be invalid.

The assignment in the present case provided for

> all of Clifford Lay's rights to be reimbursed or to have counseling services expenses paid by State Farm Mutual Automobile Insurance Company and any other insurer or self-insurer for services provided by Professional Rehabilitation Associates in connection with injuries to Clifford Lay arising out of an automobile accident.

We find the language of the assignment somewhat ambiguous. On the one hand, the assignment states "all of Clifford Lay's rights," [***9] which connotes both past and future benefits. On the other hand, it refers to "services provided" in the past tense. To the extent that the assignment can be read as assigning future benefits, that part of the assignment is void as a matter of law. MCL 500.3143; MSA 24.13143. This holding does not abrogate the entire assignment, however. HN5[↑] [*174] The failure of a distinct part of a contract does not void valid, severable provisions. Samuel D Begola Services, Inc v Wild Bros, 210 Mich. App. 636, 641; 534 N.W.2d 217 (1995). The primary consideration in determining whether a contractual provision is severable is the intent of the parties. *Id.*

In the present case, the assignment was made only after defendant had denied coverage for four specific service dates. Moreover, plaintiff sought recovery only for the specific service dates already denied by defendant. We conclude that the parties intended to assign Clifford Lay's right to recover payment for these past-due benefits. To the extent that the parties purported to assign Clifford Lay's right to recover payment for those past service dates and therefore past due or presently due benefits, MCL 500.3143; MSA 24.13143 does not invalidate [***10] the assignment. The circuit court therefore erred in affirming the district court's grant of summary disposition to defendant on the ground that the assignment of benefits to plaintiff was invalid.

II

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Plaintiff also argues that the district court erred in holding that the insanity saving provision of MCL 600.5851; MSA 27A.5851 was inapplicable because Clifford Lay had a court-appointed guardian who was obligated to file a lawsuit under the no-fault act within one year of her assignment. We agree.

HN6[] The no-fault statute of limitations, MCL 500.3145; MSA 24.13145, provides in pertinent part:

> (1) An action for recovery of personal protection insurance benefits payable under this chapter for accidental bodily injury may not be commenced later than 1 year after the [*175] date of the accident causing the injury unless written notice of injury as provided herein has been given to the insurer within 1 year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury. If the notice has been given or a payment has been made, [**914] the action may be commenced at any time within 1 year after the most recent allowable expense, work loss [***11] or survivor's loss has been incurred. However, the claimant may not recover benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced.

Were it not for the saving provision of the Revised Judicature Act, we would hold that plaintiff's claim was time-barred. However, HN7[] the general saving provision of the Revised Judicature Act applies to all causes of action created by Michigan statutes even when the statute creating the right contains its own limitation period. Rawlins v Aetna Casualty & Surety Co, 92 Mich. App. 268, 277; 284 N.W.2d 782 (1979). The saving provision applies to actions for the recovery of personal protection insurance benefits under the no-fault act. Geiger v DAIIE, 114 Mich. App. 283, 290-291; 318 N.W.2d 833 (1982). HN8[] MCL 600.5851; MSA 27A.5851 provides in pertinent part:

> (1) Except as otherwise provided in subsections (7) and (8), if the person first entitled to make an entry or bring an action under this act is under 18 years of age or insane at the time the claim accrues, the person or those claiming under the person shall have 1 year after the disability is removed through death or otherwise, to make [***12] the entry or bring the action although the period of limitations has run. This section does not lessen the time provided for in section 5852.
>
> (2) The term insane as employed in this chapter means a condition of mental derangement such as to prevent the sufferer from comprehending rights he or she is otherwise [*176] bound to know and is not dependent on whether or not the person has been judicially declared to be insane.

Defendant argues, and the district court apparently agreed, that the appointment of a guardian for Clifford Lay constituted removal of his disability, and that Cherrie Lay thus had the responsibility to file a lawsuit for the collection of the disallowed payments within one year of her appointment as Clifford's guardian. We disagree. In Paavola v Saint Joseph Hosp Corp, 119 Mich. App. 10; 325 N.W.2d 609 (1982), this Court held that HN9[] the appointment of a guardian for a mentally incompetent person is not a removal of the disability under MCL 600.5851(1); MSA 27A.5851(1). "Periods of limitation, therefore, do not begin to run against insane persons upon such appointment." Paavola, supra at 14. The disability saving provision provides that an individual mentally incompetent [***13] at the time a cause of action accrues may file the claim before the applicable limitation period runs after the disability is removed. Calladine v Dana Corp, 679 F. Supp. 700, 702 (ED Mich, 1988). The period does not begin to run with the appointment of a guardian on behalf of a mentally incompetent person. *Id.*

Thus, in response to the Supreme Court's directive on remand and to plaintiff's argument on appeal, we find that the district court erred in holding that the one-year-back rule barred the claim in the present case because Clifford Lay's guardian had not filed suit within one year of appointment. Whether Clifford Lay had a condition of mental derangement such that the insanity saving provision applies is a question of fact that also rendered summary disposition inappropriate and must be determined on remand to the district court.

[*177] We note that defendant appears to concede this issue on appeal and contends that if plaintiff had demonstrated to the district court that it commenced its action within one year of its assignment, the lawsuit would not have been barred by the one-year-back rule. Contrary to defendant's claim that plaintiff never made the assignment a part of [***14] the district court record, we note that the assignment was attached as an exhibit to plaintiff's brief in opposition to defendant's motion for summary disposition in the district court and was thus part of

the record below. Moreover, we note that HN10[↑] an assignee stands in the shoes of the assignor and acquires the same rights as the assignor possessed. *First of America Bank v Thompson, 217 Mich. App. 581, 587; 552 N.W.2d 516 (1996)*. Therefore, plaintiff stands in the shoes of Clifford Lay and possesses whatever **[**915]** right Clifford would have to collect past due or presently due benefits from defendant.

We find that the district court erred as a matter of law in granting summary disposition to defendant, and the circuit court erred in affirming the grant. We therefore reverse the circuit court's order affirming the district court's order, and we remand to the district court for proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Hilda R. Gage

/s/ Kathleen Jansen

/s/ Martin M. Doctoroff

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EXHIBIT 3

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MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF RIGHTS FORM

I, George K. Hensley, ("Assignor"), hereby assign to **(Jawad A Shah MD PC)**
(Print Patient's Name)

("Assignee") all rights, privileges and remedies to payment for health care services, products or accommodations ("Services") provided by Assignee to Assignor to which Assignor is or may be entitled under MCL 500.3101, *et seq*, the No Fault Act. This Assignment is for the right to payment of Assignee's charges, only, and not for the right to payment of any other No Fault insurance benefits.

The Assignment as set forth above is for all services already provided to Assignor by Assignee prior to or at the time of Assignor's execution of this agreement. Specifically, this Assignment **does not** include an Assignment of any future No Fault benefits.

Assignor hereby certifies that Assignor has incurred charges for services provided by Assignee for which the rights, privileges and remedies for payment are hereby assigned.

Assignor hereby certifies its understanding that while Assignee may, pursuant to this Assignment, pursue payment from a person or entity other than Assignor, this agreement may be revoked by Assignee upon a determination by it, or if a determination is made pursuant to judicial or quasi-judicial proceedings, that Assignor lacks Michigan No Fault ("PIP" or "Personal Injury Protection") coverage or that the services subject to this Assignment are not payable pursuant to any such coverage for any reason under MCL 500.3101, *et seq*, The No Fault Act, any applicable policy of insurance, and/or due to any actions or conduct of Assignor.

As consideration for the Assignment hereby granted, Assignor accepts Assignee's assumption of the burden and/or cost of pursuit of payment from any person or entity from whom payment for the above referenced services is or might be owed under MCL 500.3101, *et seq*, The No Fault Act. This Assignment is not revocable by Assignor so long as Assignee's performance as described in this paragraph is underway.

Assignor understands that should Assignor contract with or retain his/her own counsel to seek his/her own No Fault benefits, that counsel shall have no right to pursue payment of these assigned benefits nor shall counsel be entitled to any payment of an attorney fee from the services provided by Assignee.

Assignor and Assignee agree that in the event any terms or provisions of this agreement are declared invalid or unenforceable by any Court or Federal or State Government Agency having jurisdiction over the subject matter of this agreement, the remaining terms and provisions that are not affected thereby shall remain in full force and effect.

George K. Hensley
(Print Name of Patient or Legal Guardian)

George K. Hensley
(Signature of Patient or Legal Guardian)

7-11-17
(Date of Signature)

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MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF RIGHTS FORM

I, GEORGE L. HENSLEY ("Assignor"), hereby assign to **(Integrated Hospital Specialists PC)**
(Print Patient's Name)

("Assignee") all rights, privileges and remedies to payment for health care services, products or accommodations ("Services") provided by Assignee to Assignor to which Assignor is or may be entitled under MCL 500.3101, *et seq*, the No Fault Act. This Assignment is for the right to payment of Assignee's charges, only, and not for the right to payment of any other No Fault insurance benefits.

The Assignment as set forth above is for all services already provided to Assignor by Assignee prior to or at the time of Assignor's execution of this agreement. Specifically, this Assignment **does not** include an Assignment of any future No Fault benefits.

Assignor hereby certifies that Assignor has incurred charges for services provided by Assignee for which the rights, privileges and remedies for payment are hereby assigned.

Assignor hereby certifies its understanding that while Assignee may, pursuant to this Assignment, pursue payment from a person or entity other than Assignor, this agreement may be revoked by Assignee upon a determination by it, or if a determination is made pursuant to judicial or quasi-judicial proceedings, that Assignor lacks Michigan No Fault ("PIP" or "Personal Injury Protection") coverage or that the services subject to this Assignment are not payable pursuant to any such coverage for any reason under MCL 500.3101, *et seq*, The No Fault Act, any applicable policy of insurance, and/or due to any actions or conduct of Assignor.

As consideration for the Assignment hereby granted, Assignor accepts Assignee's assumption of the burden and/or cost of pursuit of payment from any person or entity from whom payment for the above referenced services is or might be owed under MCL 500.3101, *et seq*, The No Fault Act. This Assignment is not revocable by Assignor so long as Assignee's performance as described in this paragraph is underway.

Assignor understands that should Assignor contract with or retain his/her own counsel to seek his/her own No Fault benefits, that counsel shall have no right to pursue payment of these assigned benefits nor shall counsel be entitled to any payment of an attorney fee from the services provided by Assignee.

Assignor and Assignee agree that in the event any terms or provisions of this agreement are declared invalid or unenforceable by any Court or Federal or State Government Agency having jurisdiction over the subject matter of this agreement, the remaining terms and provisions that are not affected thereby shall remain in full force and effect.

GEORGE L. HENSLEY
(Print Name of Patient or Legal Guardian)

George L. Hensley
(Signature of Patient or Legal Guardian)

7-11-17
(Date of Signature)

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MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF RIGHTS FORM

I, George L. Hensley ("Assignor"), hereby assign to **(Insight Radiologists PC)**
(Print Patient's Name)

("Assignee") all rights, privileges and remedies to payment for health care services, products or accommodations ("Services") provided by Assignee to Assignor to which Assignor is or may be entitled under MCL 500.3101, *et seq*, the No Fault Act. This Assignment is for the right to payment of Assignee's charges, only, and not for the right to payment of any other No Fault insurance benefits.

The Assignment as set forth above is for all services already provided to Assignor by Assignee prior to or at the time of Assignor's execution of this agreement. Specifically, this Assignment **does not** include an Assignment of any future No Fault benefits.

Assignor hereby certifies that Assignor has incurred charges for services provided by Assignee for which the rights, privileges and remedies for payment are hereby assigned.

Assignor hereby certifies its understanding that while Assignee may, pursuant to this Assignment, pursue payment from a person or entity other than Assignor, this agreement may be revoked by Assignee upon a determination by it, or if a determination is made pursuant to judicial or quasi-judicial proceedings, that Assignor lacks Michigan No Fault ("PIP" or "Personal Injury Protection") coverage or that the services subject to this Assignment are not payable pursuant to any such coverage for any reason under MCL 500.3101, *et seq*, The No Fault Act, any applicable policy of insurance, and/or due to any actions or conduct of Assignor.

As consideration for the Assignment hereby granted, Assignor accepts Assignee's assumption of the burden and/or cost of pursuit of payment from any person or entity from whom payment for the above referenced services is or might be owed under MCL 500.3101, *et seq*, The No Fault Act. This Assignment is not revocable by Assignor so long as Assignee's performance as described in this paragraph is underway.

Assignor understands that should Assignor contract with or retain his/her own counsel to seek his/her own No Fault benefits, that counsel shall have no right to pursue payment of these assigned benefits nor shall counsel be entitled to any payment of an attorney fee from the services provided by Assignee.

Assignor and Assignee agree that in the event any terms or provisions of this agreement are declared invalid or unenforceable by any Court or Federal or State Government Agency having jurisdiction over the subject matter of this agreement, the remaining terms and provisions that are not affected thereby shall remain in full force and effect.

George L. Hensley
(Print Name of Patient or Legal Guardian)

George L. Hensley
(Signature of Patient or Legal Guardian)

9-11-17
(Date of Signature)

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MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF RIGHTS FORM

I, GEORGE L. HENSLEY ("Assignor"), hereby assign to **(Precision Surgical Associates)**
(Print Patient's Name)

("Assignee") all rights, privileges and remedies to payment for health care services, products or accommodations ("Services") provided by Assignee to Assignor to which Assignor is or may be entitled under MCL 500.3101, *et seq*, the No Fault Act. This Assignment is for the right to payment of Assignee's charges, only, and not for the right to payment of any other No Fault insurance benefits.

The Assignment as set forth above is for all services already provided to Assignor by Assignee prior to or at the time of Assignor's execution of this agreement. Specifically, this Assignment **does not** include an Assignment of any future No Fault benefits.

Assignor hereby certifies that Assignor has incurred charges for services provided by Assignee for which the rights, privileges and remedies for payment are hereby assigned.

Assignor hereby certifies its understanding that while Assignee may, pursuant to this Assignment, pursue payment from a person or entity other than Assignor, this agreement may be revoked by Assignee upon a determination by it, or if a determination is made pursuant to judicial or quasi-judicial proceedings, that Assignor lacks Michigan No Fault ("PIP" or "Personal Injury Protection") coverage or that the services subject to this Assignment are not payable pursuant to any such coverage for any reason under MCL 500.3101, *et seq*, The No Fault Act, any applicable policy of insurance, and/or due to any actions or conduct of Assignor.

As consideration for the Assignment hereby granted, Assignor accepts Assignee's assumption of the burden and/or cost of pursuit of payment from any person or entity from whom payment for the above referenced services is or might be owed under MCL 500.3101, *et seq*, The No Fault Act. This Assignment is not revocable by Assignor so long as Assignee's performance as described in this paragraph is underway.

Assignor understands that should Assignor contract with or retain his/her own counsel to seek his/her own No Fault benefits, that counsel shall have no right to pursue payment of these assigned benefits nor shall counsel be entitled to any payment of an attorney fee from the services provided by Assignee.

Assignor and Assignee agree that in the event any terms or provisions of this agreement are declared invalid or unenforceable by any Court or Federal or State Government Agency having jurisdiction over the subject matter of this agreement, the remaining terms and provisions that are not affected thereby shall remain in full force and effect.

GEORGE L HENSLEY
(Print Name of Patient or Legal Guardian)

(Signature of Patient or Legal Guardian)

7-16-19
(Date of Signature)

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EXHIBIT 4

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Questioned
As of: June 1, 2017 5:26 PM Z

Welke v. Kuzilla

Court of Appeals of Michigan

November 13, 1984, Submitted ; February 6, 1985, Decided

Docket No. 75515

Reporter
140 Mich. App. 658 *; 365 N.W.2d 205 **; 1985 Mich. App. LEXIS 2454 ***

ROBERT J. WELKE, personal Representative of the Estate of JUDITH L. WELKE, Deceased, Plaintiff-Appellant, v. SHARLYN MARGARET KUZILLA, a/k/a SHARLYN MARGARET LYONS, and BRADFORD G. CAPPER, D.O., Defendants-Appellees

Subsequent History: Later proceeding at *Welke v. Kuzilla, 144 Mich. App. 245, 375 N.W.2d 403, 1985 Mich. App. LEXIS 2808 (1985)*

Leave to appeal denied by *Welke v. Kuzilla, 424 Mich. 861, 1985 Mich. LEXIS 1962 (1985)*

Disposition: [***1] Affirmed.

Core Terms

discovery, trial court, malpractice, amend, patient, medical malpractice, decedent, motion to amend, denial of motion, psychiatrist, malpractice action, physician-patient, malpractice claim, circumstances, foreseeable, special relationship, endangered, motion for leave, opposing party, no duty, identifiable, requires, argues, futile, insure, plaintiff's claim, reasonable care, instant case, preparation, deposition

Case Summary

Procedural Posture
Plaintiff husband appealed an order of the trial court (Michigan), which denied plaintiff's motion for leave to amend his wrongful death compliant against defendant driver after plaintiff's wife was killed in an auto accident with defendant, to add a medical malpractice count against defendant doctor who was treating defendant driver with medication. Plaintiff contended that lack of time for discovery was an invalid reason for the denial.

Overview
Plaintiff husband filed a wrongful death action against defendant driver after plaintiff's wife was killed in an automobile accident with defendant. Defendant doctor owned the car that defendant driver was operating, and plaintiff later filed a motion for leave to amend the compliant to add a medical malpractice count against defendant doctor because he was treating defendant driver with medication at the time of the accident and failed to prevent her from driving. The trial court made arrangements for plaintiff to file a separate complaint against defendant doctor, which plaintiff did, and denied the motion to consolidate the actions because there was not sufficient time left to conduct discovery. Plaintiff appealed and contended that the trial court abused its discretion and that the little time left for discovery was not a sufficient reason for denial. The court affirmed and held that the trial court did not abuse its discretion because adding a medical malpractice count was adding an entirely different theory and defendant would not have time to prepare. Since plaintiff was able to file a separate malpractice action, neither party was prejudiced.

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Outcome

The court affirmed an order which denied plaintiff husband's motion for leave to amend his wrongful death complaint against defendant driver after plaintiff's wife was killed in an auto accident with defendant, to add a medical malpractice action count against defendant doctor who was treating driver with medication because additional time consuming discovery would have been necessary and plaintiff was able to file a separate action.

LexisNexis® Headnotes

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Leave of Court

Governments > Courts > Judges

HN1[] GCR 1963, 118.1, permits a party to amend its pleading by leave of court which shall be freely given when justice so requires. While the decision to grant or deny leave is within the discretion of the trial court, the decision will not be reversed absent an abuse of discretion. This discretion is not unlimited. This language that leave shall be freely given when justice so requires imposes a limitation on the discretion of the court necessitating a finding that justice would not be served by an amendment to pleadings. The allowance of an amendment is not an act of grace, but a right of a litigant who can show that an amendment will not work an injustice on the opposing party.

Counsel: *Chambers, Steiner, Mazur, Ornstein & Amlin, P.C.* (by *Courtney E. Morgan, Jr.*, and *Angela J. Nicita)*, for plaintiff.

Highland & Currier, P.C. (by *John N. Highland)*, for Bradford G. Capper, D.O.

Judges: H. Hood, P.J., and S. J. Bronson and R. L. Tahvonen, * JJ. R. L. Tahvonen, J., concurred. Bronson, J. *(dissenting)*.

Opinion by: HOOD

Opinion

[*662] [206]** Plaintiff appeals as of right from the trial court's order denying his motion for leave to amend his complaint to add a medical malpractice count against defendant Dr. Bradford G. Capper.

[*663] On October 13, 1981, plaintiff filed this wrongful death action against defendant Sharlyn Kuzilla alleging that she negligently caused the death of plaintiff's decedent and wife Judith Welke in an automobile crash occurring September 11, 1981. Defendant Dr. Capper owned the automobile driven by defendant Kuzilla. On August 30, 1983, plaintiff filed a motion for leave to amend to add several new tort theories and allegations of damages including a medical malpractice count against Dr. Capper.

In his proposed amended complaint **[***2]** regarding the medical malpractice count, plaintiff alleged that Dr. Capper was defendant Kuzilla's treating physician prior to the accident. As such, Dr. Capper allegedly had a duty to protect the public and, in particular, plaintiff's decedent from any imminent foreseeable danger posed by defendant Kuzilla. Dr. Capper allegedly breached this duty by prescribing many controlled substances to defendant Kuzilla without warning her of the drugs' effects on her driving ability and by allowing her to drive his motor vehicle while she was under the influence of the drugs.

* Circuit judge, sitting on the Court of Appeals by assignment.

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On September 9, 1983, the trial court heard arguments regarding the motion to amend the complaint limited to adding only the medical malpractice count because the period of limitations on that action was about to run. Defendant's argument that amending to add a medical malpractice count a few months short of the discovery cut-off date (WCCR 301.3[c]) and so soon before mediation and trial would prejudice defendant convinced the court to deny the motion. Nevertheless, the trial court did not deny the motion to amend the complaint to add the medical malpractice count until it ascertained that plaintiff could still [***3] timely file a separate medical malpractice action against Dr. [*664] Capper. The trial court made arrangements for plaintiff to file the complaint on the date of hearing despite the fact that the clerk's office was officially closed. Plaintiff did file the separate action on September 9, 1983.

In a subsequent order, the trial court granted plaintiff's remaining motion for leave to amend the complaint. However, the trial court denied plaintiff's motion to consolidate the medical malpractice action with this case. On March 15, 1984, the trial court ordered defendant's motion for summary judgment in the medical malpractice action granted stating that plaintiff failed to state a claim, GCR 1963, 117.2(1), because this state does not recognize a third-party cause of action based upon a physician-patient relationship. Plaintiff also filed a separate claim of appeal from that order. (Docket No. 77810).

Plaintiff argues in this appeal that the trial court abused its discretion by denying his motion for leave to amend the complaint to add a medical malpractice count. Plaintiff argues that the little time left for discovery was not a sufficient reason alone to find the necessary [***4] prejudice to defendant to deny the motion. Plaintiff argues that defendant was already fully aware of the facts underlying the action.

Defendant argues that the trial court did not abuse its discretion because adding a medical malpractice claim would require Dr. Capper's medical malpractice insurer to become involved and, most certainly, new counsel. Trial would have to be delayed to allow additional discovery, particularly deposition of expert witnesses. The original complaint did not act as notice to Dr. Capper's malpractice carrier that it would need to prepare a defense despite the commonality of underlying facts. Defendant also argues, even though the trial [*665] court did not decide the motion for this reason, that plaintiff's amendment would have been futile.

HN1[☎] GCR 1963, 118.1 permits a party to amend its pleading by leave of court which "shall be freely given when justice so requires". While the decision to grant or [**207] deny leave is within the discretion of the trial court, the decision will not be reversed absent an abuse of discretion. *McCalla v Ellis, 129 Mich App 452, 457; 341 NW2d 525 (1983)*. This discretion is not unlimited.

"'This language [that [***5] "leave shall be freely given when justice so requires"] imposes a limitation on the discretion of the court necessitating a finding that justice would not be served by an amendment to pleadings. The allowance of an amendment is not an act of grace, but a right of a litigant who can show that an amendment will not work an injustice on the opposing party.' *Midura v Lincoln Consolidated Schools, 111 Mich App 558, 563; 314 NW2d 691 (1981)*." *McCalla, supra, p 457*.

Such a motion should be granted absent undue delay, bad faith, a dilatory motive or when an amendment would be futile. *Meyer v Hubbell, 117 Mich App 699, 705-706; 324 NW2d 139 (1982)*. Mere lateness in moving to amend is an insufficient reason to deny the motion, absent unfair prejudice to the opposing party. *Rubino v Sterling Heights, 94 Mich App 494, 499-500; 290 NW2d 43 (1979)*.

In this case, the trial court was faced with an uncomfortable dilemma. Although plaintiff's motion to amend came late in the proceedings, a few months of discovery time was still available to defendant. However, the trial court recognized that adding a medical malpractice count was adding an entirely different theory of which defendant [***6] would not previously have had notice and, therefore, time to prepare. Defendant's medical malpractice [*666] insurer would need to be notified and new counsel would probably be retained. Discovery would undoubtedly need to be extended by order. Even though plaintiff stated that he was willing to agree to an extension of discovery, the trial court could not guarantee that the Chief Judge of the Wayne County Circuit Court would grant such an extension. See WCCR 301.3(g)(1).

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We find that because prejudice to defendant was possible, the trial court did not abuse its discretion by denying the motion for leave to amend to add the medical malpractice count. Nevertheless, we do so *only* given the special circumstances of this case, *i.e.*, that the trial court compromised the interests of both parties by denying the motion but facilitated plaintiff's filing of the medical malpractice action in a timely manner. By ruling in this manner, the trial court furthered the spirit of GCR 1963, 118.1, not by granting the motion for leave to amend, but by helping plaintiff preserve the cause of action he desired to add to the complaint. Thus, neither plaintiff nor defendant were ultimately [***7] prejudiced.

Because we affirm on the grounds given by the trial court, we need not address defendant's argument that, alternatively, the trial court could have denied plaintiff's motion because his medical malpractice claim would have been futile. We do, however, refer defendant to this Court's recent decision in *Duvall v Goldin, 139 Mich App 342; 362 NW2d 275 (1984)*.

Affirmed.

Dissent by: BRONSON

Dissent

Bronson, J. *(dissenting)*.

Plaintiff appeals from an order denying his motion for leave to amend his complaint to add a claim of medical malpractice [*667] against the defendant doctor. The majority holds that, due to possible prejudice to defendant, the motion to amend was properly denied. I cannot agree with the majority's determination, and, therefore, I respectfully dissent for the reasons stated herein.

On October 13, 1981, plaintiff, Robert J. Welke, filed this action as the personal representative of his wife's estate. The initial complaint alleged that the decedent, Judith Welke, was killed due to injuries sustained when a vehicle owned by defendant Bradford Capper, D.O., and driven by defendant Sharlyn Kuzilla crossed the center line resulting in a head-on collision [***8] with the vehicle operated by the decedent. Defendant Kuzilla is not a party to this appeal.

[**208] On November 5, 1982, a substitution of attorneys was filed and plaintiff's current counsel made their appearance. On December 1, 1982, the first deposition was taken in this matter, that of the defendant driver.

On January 26, 1983, the deposition of defendant Dr. Capper was partially taken, but has not yet been completed. On May 11, 1983, the deposition of the investigating police officer was taken. The husband of the defendant driver was deposed on June 30, 1983.

During the course of these discovery depositions there was testimony that defendant Dr. Capper had prescribed several drugs for defendant Kuzilla over a period of several months prior to the fatal accident. These drugs included pain pills, muscle relaxants, diet pills and Valium.

There was also testimony that on the evening prior to the accident in question, defendant Dr. Capper injected defendant Kuzilla with some substance and perhaps dispensed other drugs to her.

On August 30, 1983, plaintiff filed a motion for [*668] leave to amend his complaint. In his proposed amended complaint, plaintiff sought to [***9] add a malpractice claim against Dr. Capper. The proposed amended complaint alleged that defendant Capper breached the standard of care for his profession by prescribing controlled substances for other than lawful medical purposes, by failing to warn his patient of the dangers of operating a vehicle while under the influence of controlled substances, by allowing his patient, defendant Kuzilla, to operate a motor vehicle when he knew that she was under the influence of controlled substances, and by placing his patient in a position which threatened the health and safety of the public.

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Oral argument on plaintiff's motion was heard on September 9, 1983, before the Honorable Paul S. Teranes of the Wayne County Circuit Court. Judge Teranes was sitting as a substitute because the judge who had been assigned to the case for pretrial matters was unavailable. Plaintiff's motion to amend was denied because the lower court felt that the amendment was sought too late. Discovery was to be cut off on December 13, 1983, and the court felt that this would not permit sufficient time for defendant Capper to conduct discovery on the malpractice claim.

When his motion to amend was denied, plaintiff [***10] filed a new action against defendant Capper on September 9, 1983. This second complaint included a malpractice claim. On September 27, 1983, plaintiff filed a motion to consolidate the September, 1983, action with the instant case. This motion was denied without prejudice on November 18, 1983. Defendant then filed a motion for summary judgment in the September, 1983, action arguing that plaintiff's malpractice action failed to state a claim upon which relief could be granted. Defendant's motion was granted in March, 1984. In [*669] December, 1983, defendant Kuzilla filed a separate malpractice action against defendant Capper, seeking, *inter alia*, damages for emotional distress caused her by the death of Mrs. Welke, and blaming the fatal crash on the fact that Dr. Capper gave her illicit substances causing her to lose control of the vehicle. The instant appeal, however, involves only Judge Teranes' denial of plaintiff's motion to amend his original complaint to include a count of malpractice against Dr. Capper.

I

Plaintiff contends that the trial court abused its discretion in denying his motion to amend his complaint. The decision to grant or deny an amendment is [***11] one within the discretion of the trial court. *Rubino v Sterling Heights, 94 Mich App 494; 290 NW2d 43 (1979)*; *McCalla v Ellis, 129 Mich App 452; 341 NW2d 525 (1983)*. Due to the mandate of GCR 1963, 118.1, however, the trial judge's discretion to grant or deny leave to amend pleadings is not unlimited. *Ben P Fyke & Sons v Gunter Co, 390 Mich 649, 656-657; 213 NW2d 134 (1973)*; *Rubino, supra, p 499*; *Midura v Lincoln Consolidated Schools, 111 Mich App 558, 562-563; 314 NW2d 691 [**209] (1981)*; *McCalla, supra, p 457*. As this Court explained in *Midura, supra, pp 562-563*:

"The discretion invested in trial judges under the standard 'leave shall be freely given when justice so requires' is not boundless. This language imposes a limitation on the discretion of the court necessitating a finding that justice would not be served by an amendment to pleadings. The allowance of an amendment is not an act of grace, but a right of a litigant who can show that an amendment will not work an injustice on the opposing party. *Fyke & Sons, supra, 659*."

Absent some specific finding of injustice to the [*670] opposing party, amendment should be granted as [***12] a matter of right.

In *Fyke & Sons, supra*, the Michigan Supreme Court indicated several factors which should be examined by a judge in determining whether an injustice would result if amendment was granted. *Id., p 656*. In *Fyke*, the Court made clear that a delay in seeking amendment, without a finding of bad faith or actual prejudice caused by delay, will not justify denial of a motion to amend. *Id., pp 663-664*.

The trial court in this case denied plaintiff's motion to amend because it believed that plaintiff sought to amend his complaint "too late". The judge was concerned that the defendant doctor would have insufficient time to complete necessary discovery on the malpractice claim within the three months remaining prior to the cut-off date for discovery. From the record, this appears to have been the trial court's only reason for denying the motion to amend.

The fact that there is little time left for discovery is not sufficient reason in and of itself to deny amendment. This is particularly true where it is possible to extend discovery. *Rubino, supra, p 500*.

"Mere lateness in moving to amend is an insufficient reason to deny the motion, absent unfair [***13] prejudice to the opposing party. *Spartan Asphalt Paving Co v Grand Ledge Mobile Home Park, 71 Mich App 177; 247 NW2d 589 (1976)*. In the instant case, defendant is not prejudiced by the addition to the complaint of the counts of nuisance and breach of contract. Discovery is not precluded merely because a pretrial conference has occurred.

Jacob Bryant

GCR 1963, 301.7 permits the court to order subsequent discovery 'on written notice for good cause shown'. Nor does sufficient prejudice exist because the added counts involve complex legal and factual issues." *Id., p 500.*

[*671] Plaintiff's counsel agreed to an extension of the discovery period to permit defendant Capper the opportunity to do any necessary discovery and obtain any necessary expert witnesses, thereby eliminating any possible prejudice to defendant resulting from the amendment. Further, at the time of the hearing on plaintiff's motion to amend, there were still seven months remaining before trial.

While this Court has upheld the denial of a motion to amend on the ground that there is insufficient opportunity for the opposing party to obtain discovery, it has done so only under the extreme circumstances where trial [***14] is imminent and prior discovery completed in the case will contribute nothing to discovery on the claim sought to be added by amendment. *Messer v Floyd Rice Ford, Inc, 91 Mich App 644, 649-650; 284 NW2d 139 (1979), rev'd on other grounds 407 Mich 962; 288 NW2d 352 (1980).* Such is not true of the case at bar. The trial court failed to make any inquiry into the discovery which had been conducted in the case. However, the factual circumstances which have been the subject of discovery thus far are the same factual circumstances which underlie the proposed malpractice claim.

The result of the trial court's decision to deny amendment is that plaintiff filed a second action, thus placing two cases on the court's docket involving substantially the same factual circumstances. An additional set of discovery proceedings, mediation [**210] and trial were added to the trial court's already crowded docket when discovery in the original action could have simply been extended to accommodate the new claim.

In the absence of any actual prejudice to defendant, the trial court must allow plaintiff leave to amend his complaint. I would therefore instruct [*672] the trial court to [***15] allow the amendment, extending the time of discovery to accommodate the amendment and eliminate any possible prejudice to defendant. *Rubino, supra.*

II

Defendant contends that, even absent prejudice, the motion to amend was properly denied because amendment would have been futile. Futility is a recognized reason to deny leave to amend only if the complaint is "legally insufficient on its face". *Fyke & Sons, supra, p 660.* Defendant alleges that a cause of action in malpractice cannot exist in the case at bar because there is no physician-patient relationship between the plaintiff's decedent and defendant doctor. Defendant argues that, in the absence of a doctor-patient relationship, there was no duty owed to plaintiff's decedent and such an action will not lie. While it is undisputed that plaintiff's decedent and Dr. Capper were not in a direct patient-physician relationship, neither is it disputed that Dr. Capper and Sharlyn Kuzilla did have such a relationship.

In a negligence action, whether for medical malpractice or any other personal injury action based upon negligence, the question of whether a duty exists is one of law for the court's resolution. *Elbert v Saginaw [***16], 363 Mich 463; 109 NW2d 879 (1961); 57 Am Jur 2d, Negligence, § 34,* p 381.

"Duty" comprehends whether the defendant is under any obligation to the plaintiff to avoid negligent conduct. It does not include, where there is an obligation, the nature of the obligation and the standard of care. *Moning v Alfono, 400 Mich 425, 437; 254 NW2d 759 (1977).*

"It is better to reserve 'duty' for the problem of the [*673] relation between individuals which imposes upon one a legal obligation for the benefit of the other, and to deal with particular conduct in terms of a legal standard of what is required to meet the obligation. In other words, 'duty' is a question of whether the defendant is under any obligation for the benefit of the particular plaintiff; and in negligence cases, the duty is always the same, to conform to the legal standard of reasonable conduct in the light of the apparent risk. What the defendant must do, or must not do, is a question of the standard of conduct required to satisfy the duty. The distinction is one of convenience only, and it must be remembered that the two are correlative, and one cannot exist without the other." Prosser, Torts (4th ed), § 53, [***17] p 324.

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Generally, there is no duty to control the conduct of a third person to prevent him or her from causing harm to another absent a special relationship between the actor and the third person which imposes a duty upon the actor to control the third person's conduct. 2 Restatement Torts, 2d, § 315(a), p 122; Davis v Lhim, 124 Mich App 291, 299; 335 NW2d 481 (1983).

In the effort to resolve the question of whether the defendant doctor owed a duty of care to plaintiff's decedent, we are guided by decisions of this state and decisions from other jurisdictions which have considered the issue of liability to a third party. Courts in Michigan have recognized under a variety of factual circumstances that a third party may have a claim grounded in negligence against a defendant based upon the defendant's relationship with another party. See, *e.g.*, Moning, supra (manufacturer, wholesaler, and retailer of manufactured product owe a legal obligation of due care to a bystander affected by the use of the product); Clark v Dalman, 379 Mich 251; 150 NW2d 755 (1967) (general contractor owed a duty in general not to endanger employees of the subcontractor or inspectors or anyone [***18] else lawfully on the project [*674] site); Davis, supra (psychiatrist owes a duty of reasonable care to persons who are readily identifiable as [**211] foreseeably endangered by his patient); Romeo v Van Otterloo, 117 Mich App 333; 323 NW2d 693 (1982) (employer may owe duty to third party to supervise the activity of his employee); Duvall v Goldin, 139 Mich App 342; 362 NW2d 275 (1984) (doctor owed duty of reasonable care to protect the driving public where doctor's negligence in diagnosis or treatment of patient contributes to plaintiff's injuries). *Contra*, see, Friedman v Dozorc, 412 Mich 1; 312 NW2d 585 (1981) (attorney owes no duty of care to an adverse party in litigation).

In Davis, supra, p 305, relying on Tarasoff v Regents of University of California, 17 Cal 3d 425; 131 Cal Rptr 14; 551 P2d 334 (1976), this Court held that a psychiatrist does owe a professional duty of care to those who could foreseeably be injured by his patient.

"[When] a psychiatrist determines or, pursuant to the standard of care of his profession, should determine that his patient poses a serious danger of violence to a readily identifiable person, the psychiatrist [***19] has a duty to use reasonable care to protect that individual against such danger."

This Court's imposition of a duty on psychiatrists in Davis, supra, was based upon the physician-patient relationship and general tort law principles.

"Under the common law, no one owes any duty to protect an individual who is endangered by a third person *unless* he has *some special relationship* with either the dangerous person or the potential victim. Tarasoff, supra, p 435. See, *e.g.*, American States Ins Co v Albin, 118 Mich App 201, 206; 324 NW2d 574 (1982). [*675] *The California court found that a psychiatrist has such a 'special relationship' to his patient.* Consequently, the court held that, under certain circumstances, a psychiatrist owes a duty to use reasonable care to protect persons endangered by his patient.

"Michigan case law supports the *Tarasoff* holding. 'Duty' is one of six elements of an action for negligence. Moning v Alfono, 400 Mich 425, 437; 254 NW2d 759 (1977). Moreover, 'in negligence cases, the duty is always the same, to conform to the legal standard of reasonable conduct in light of the apparent risk'. Prosser, Torts (4th ed), § 53, [***20] p 324, cited in Moning v Alfono, supra, p 437." Davis, supra, pp 299-300. (Emphasis added.)

Although *Tarasoff* did not expressly limit the scope of duty to identifiable victims, *Davis* stated that the duty of the psychiatrist is limited to only those persons readily identifiable as foreseeably endangered. *Davis*, p 303. The Court noted that, under Michigan law, once a duty is imposed, that duty is owed to any person within the scope of foreseeable risk. In the case of a psychiatrist's duty to persons endangered by his or her patient, however, the Court held that a narrower scope of duty was required for reasons of public policy. Id., p 304.

In *Duvall*, this Court recently extended *Davis* to uphold a negligence claim against a physician based upon allegations similar to those presented in the instant case. The Court reasoned that while *Davis* was factually limited to readily identifiable persons, *Davis* does not preclude recognizing a "special relationship" between the doctor and

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patient, and therefore the imposition of a duty in a broader context. See, 2 Restatement Torts, 2d, § 315, p 122. The Court, therefore, held that:

"[Defendant] [***21] did in fact have a special relationship with his patient, the so-called 'dangerous person', which [*676] we believe is sufficient to place this case within the exception to the common-law rule that no one has a duty to protect an individual who is endangered by the conduct of another. Where the actor stands in a special relationship with *either* the third-party victim or the person causing the injury, a duty of reasonable care may arise." Duvall, supra, [**212] pp 350-351. (Emphasis in original.)

Implicit in *Duvall* is a recognition that *Davis* fashioned an exception to the general foreseeability rule in holding that a psychiatrist only has a duty to readily identifiable persons threatened by his or her patient.

Duvall is in accord with the opinions of courts in other jurisdictions which have examined this issue. Davis v Mangelsdorf, 138 Ariz 207; 673 P2d 951 (Ariz App, 1983); Gooden v Tips, 651 SW2d 364 (Tex App, 1983); Wharton Transport Corp v Bridges, 606 SW2d 521 (Tenn, 1980); Watkins v United States, 589 F2d 214 (CA 5, 1979); Freese v Lemmon, 210 NW2d 576 (Iowa, 1973); Kaiser v Suburban Transportation System, 65 Wash 2d [***22] 461; 398 P2d 14 (1965).

I would hold, therefore, that defendant Dr. Capper owed a duty to plaintiff's decedent, an innocent driver within the scope of foreseeable risk, by virtue of his special relationship with Sharlyn Kuzilla.

III

Having found that defendant owed a duty to plaintiff's decedent, it is necessary to return to defendant's original argument that a doctor owes no duty and that an action for malpractice cannot stand in the absence of a physician-patient relationship. In Duvall, supra, p 358, the Court circumvented this issue by finding that plaintiff's action was not founded upon medical malpractice. The [*677] Court did, however, find a duty based upon general principles of negligence law. Of the cases from other jurisdictions which have addressed this issue, only two courts addressed the duty issue directly. Gooden v Tips, supra; Davis v Mangelsdorf, supra. The remaining courts dealt with this issue in terms of foreseeability of the injury and proximate causation, Watkins v United States, supra, or merely assumed the existence of a duty owed. Wharton Transport Corp v Bridges, supra; Kaiser v Suburban Transportation System, supra; Freese v Lemmon, [***23] supra. Although each court recognized, either explicitly or implicitly, that the doctor owed a duty to the plaintiff, no court to my knowledge has directly addressed the issue of whether a case such as the one at bar may sound in malpractice in the absence of a direct physician-patient relationship between the defendant doctor and the plaintiff's decedent. I would hold that, for reasons of logical consistency and public policy, plaintiff's claim is properly considered as one sounding in medical malpractice.

To hold, as defendant urges, that plaintiff's proposed amendment is futile because it alleges malpractice as opposed to negligence, would be to elevate form over substance. In order for plaintiff to prove his claim against defendant, whether under negligence or malpractice, it is necessary for plaintiff to demonstrate: 1) the existence of a physician-patient relationship between defendant doctor and the third person who was a cause-in-fact of plaintiff's injury; 2) the breach of the applicable standard of care required by the doctor in the treatment of his or her patient. The applicable standard of care requires the physician to exercise that degree of skill, care and diligence [***24] exercised by members of the same profession, practicing in the same or a similar locality, in light of the present [*678] state of medical science. Kambas v St Joseph's Mercy Hospital of Detroit, Michigan, 389 Mich 249, 254-255; 205 NW2d 431 (1973). Duvall, supra, pp 350-352; Kaiser, supra, p 464; Watkins, supra, p 217; Gooden, *surpa*, pp 369-370; see generally, Wharton Transport Corp, supra, pp 526-527; Freese, supra p 579. In Michigan, the testimony of experts is required to establish that a doctor has breached the standard of care required. Marchlewicz v Stanton, 50 Mich App 344, 347; 213 NW2d 317 (1973); and 3) that the negligent treatment of the patient was a proximate cause of plaintiff's injury. Duvall, supra, p 352; Gooden, supra, pp 369-370; Watkins, supra, p 219.

[**213] It is clear that a prerequisite to plaintiff's claim is the proving of malpractice in the doctor's treatment of his or her patient. Without demonstrating malpractice in the doctor-patient relationship, plaintiff will not be able to show

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proximate causation. Thus, although plaintiff's decedent and the defendant doctor are not in a direct doctor-patient [***25] relationship, the necessity of plaintiff's proving that the doctor's malpractice was a proximate cause of plaintiff's decedent's injury requires us to treat plaintiff's claim as one sounding in malpractice.

Defendant relies on Rogers v Horvath, 65 Mich App 644; 237 NW2d 595 (1975), in arguing that there is no duty owed to plaintiff's decedent in the absence of a patient-physician relationship. In *Rogers*, plaintiff was examined by the defendant doctor in preparation for the doctor's testimony before a workers' compensation referee. Subsequent to the examination, the doctor testified that plaintiff was not injured and was a malingerer. This Court upheld the dismissal of plaintiff's malpractice claim, holding:

[*679] "The examination of plaintiff was performed on behalf of her employer in preparation for testifying before the workmen's compensation referee, and it was not performed for the plaintiff's benefit to diagnose or treat an ailment. The trial court was correct in ruling that plaintiff had no cause of action for malpractice.

"The term 'malpractice' denotes a breach of the duty owed by one in rendering professional services to a person who has contracted for [***26] such services; in physician-malpractice cases, the duty owed by the physician arises from the physician-patient relationship. No such relationship existed in the case at bar. Defendant was employed by General Motors to examine one of its employees in preparation for a workmen's compensation hearing. Plaintiff did not employ the defendant, nor did she seek or receive medical advice or treatment. Under such circumstances, the defendant did not owe plaintiff any duty arising from a physician-patient relationship. This is not to say that a physician who examines a person for reasons other than diagnosis or treatment and for the benefit of some one other than the examinee owes no duty of due care to that person. Rather, we hold that the physician in such a case does not owe such a duty of care as will subject him to liability for malpractice." (Footnotes omitted.) Rogers, supra, pp 646-647.

Of critical importance to our holding in *Rogers* was our finding that plaintiff's claim did not rest upon a patient-physician relationship, either directly or, as in the instant case, derivatively and as a prerequisite to plaintiff's claim. Unlike *Rogers*, however, the instant case [***27] requires a finding of malpractice in a direct physician-patient relationship between the defendant doctor and the injured patient.

Of further importance to my holding are the policy concerns regarding the imposition of liability on doctors in a case such as the one at bar. As stated in Duvall, supra, we do not intend to make physicians highway accident insurers. I do believe, [*680] however, that liability is properly imposed where a doctor's malpractice is the proximate cause of a plaintiff's injuries. An important consideration in the willingness of courts to impose malpractice liability on doctors is the ability of the defendants to pass on to the general public, through malpractice insurance and individual billings, the inevitable damages resulting from their activities, or at least to distribute them over a relatively large group. See, Prosser, *Palsgraf Revisited*, 52 Mich L Rev 1, 30-32 (1953). In the typical malpractice action, the doctor is able to insure against the risk of liability through the required malpractice insurance. By characterizing the instant action as one in malpractice, the risk of liability now imposed upon the defendant is already insured [***28] against through his malpractice insurance in effect. It would be anomalous to impose liability on a doctor for injuries arising out of his treatment of a patient, and to require the doctor to insure against this risk of liability separately [**214] and distinctly from the risk imposed under traditional malpractice actions.

I would reverse the trial court's denial of plaintiff's motion to amend and instruct the court to extend the time of discovery to accommodate the amendment and eliminate any possible prejudice to defendant.

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EXHIBIT 5

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Shelton v. Auto-Owners Ins. Co.

Court of Appeals of Michigan

February 14, 2017, Decided

No. 328473

Reporter
2017 Mich. App. LEXIS 242 *; 2017 WL 603591

TYANN SHELTON, Plaintiff-Appellee, and DWAYNE WILLIAMS, Plaintiff, and MICHIGAN CRNAS STAFFING, LLC, Intervening Plaintiff, v AUTO-OWNERS INSURANCE COMPANY, Defendant-Appellant.

Notice: THIS OPINION IS UNCORRECTED AND SUBJECT TO REVISION BEFORE PUBLICATION IN THE MICHIGAN COURT OF APPEALS REPORTS.

Prior History: [*1] Wayne Circuit Court. LC No. 13-010612-NF.

Shelton v. Auto-Owners Ins. Co., 2015 Mich. App. LEXIS 2533 (Mich. Ct. App., Dec. 21, 2015)

Core Terms

insurer, benefits, no-fault, fraudulent, services, replacement, photographs, insurance policy, trial court, occurrence, coverage, summary disposition, question of fact, claimant, applies, argues, investigative report, deposition, lifting, spouse, shirt

Case Summary

Overview
HOLDINGS: [1]-The exclusionary provision in the insurer's no-fault policy did not apply to the passenger and could not operate to bar her claim; [2]-The appellate court found that the photographs and investigator's reports were insufficient to establish beyond a question of fact that the passenger committed fraud despite the testimony, medical reports, and affidavits that supported the passenger's claim of injury and need for medical care and assistance; [3]-The types of inconsistencies found with the passenger's statements were not sufficient to establish the elements of fraud beyond a question of fact; [4]-The wrongful conduct doctrine did not apply.

Outcome
Judgment affirmed.

LexisNexis® Headnotes

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

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HN1[] Personal injury protection benefits are mandated by statute under the no-fault act, MCL 500.3105, and, therefore, the statute is the rule book for deciding the issues involved in questions regarding awarding those benefits. On the other hand, the insurance policy itself is the contract between the insurer and the insured.

Governments > Legislation > Interpretation

HN2[] The primary rule of statutory construction is that, where the statutory language is clear and unambiguous, the statute must be applied as written. Additionally, the primary task in construing a statute is to discern and give effect to the intent of the Legislature. A court must give effect to every word, phrase, and clause and avoid a construction that would render any part of the statute surplusage or nugatory.

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

HN3[] Under Subsection 1 of the no-fault priority statute, a personal protection insurance policy applies to the person named in the policy, the person's spouse, and a relative of either domiciled in the same household, MCL 500.3114(1).

Insurance Law > ... > Coverage > No Fault Coverage > Personal Injury Protection

HN4[] MCL 500.3114(4) does not state that the owner or operator's insurance policy "applies" to the passenger's claim for benefits, and its text, unlike that of Subsection (1), omits any mention of a personal protection insurance policy, instead providing that the injured person is to claim personal protection insurance benefits from insurers, beginning with the insurer of the owner or registrant of the vehicle occupied.

Insurance Law > Claim, Contract & Practice Issues > Policy Cancellation, Denial & Nonrenewal > Material Misrepresentations

Insurance Law > Remedies > Costs & Attorney Fees > Unreasonable & Vexatious Actions

HN5[] As always, if an insurer concludes that a claim is fraudulent, it may deny the claim. Should the claimant then file suit, the burden is on the claimant to prove that he is entitled to his claimed benefits, a burden that is highly unlikely to be met if the factfinder concludes that the claim is fraudulent. And insurers can obtain attorney fees for having to litigate any claims that are determined to be fraudulent. MCL 500.3148.

Insurance Law > Claim, Contract & Practice Issues > Policy Interpretation > Exclusions

Insurance Law > ... > Procedure > Evidence & Trial > Burdens of Proof

Insurance Law > Claim, Contract & Practice Issues > Policy Cancellation, Denial & Nonrenewal > Material Misrepresentations

HN6[] Reliance on an exclusionary clause in an insurance policy is an affirmative defense and so defendant has the burden of proof. An insurance company has the burden to prove that one of the policy's exclusions applies. Thus, to obtain summary disposition the insurer must show that there is no question of material fact as to any of the elements of its affirmative defense. The elements, as set forth in Bahri, are as follows: To void a policy because the insured has wilfully misrepresented a material fact, an insurer must show that (1) the misrepresentation was material, (2) that it was false, (3) that the insured knew that it was false at the time it was made or that it was made recklessly, without any knowledge of its truth, and (4) that the insured made the material misrepresentation with the

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intention that the insurer would act upon it. A statement is material if it is reasonably relevant to the insurer's investigation of a claim.

Civil Procedure > Appeals > Standards of Review > De Novo Review

Civil Procedure > Appeals > Summary Judgment Review > Standards of Review

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Genuine Disputes

HN7[] The appellate court reviews de novo motions for summary disposition under *MCR 2.116(C)(10)*. In doing so, it is required to view the affidavits, pleadings, depositions, admissions, and other documentary evidence in the light most favorable to the nonmovant. Similarly, all reasonable inferences must be drawn in favor of the nonmovant. Summary disposition is only appropriate under *MCR 2.116(C)(10)* when there is no genuine issue with respect to any material fact and the moving party is entitled to judgment as a matter of law. A genuine issue of material fact exists when the record, giving the benefit of reasonable doubt to the opposing party, leaves open an issue upon which reasonable minds could differ.

Civil Procedure > Appeals > Appellate Briefs

HN8[] Reply briefs must be confined to rebuttal, and a party may not raise new or additional arguments in its reply brief.

Torts > ... > Elements > Causation > Causation in Fact

HN9[] The wrongful conduct rule applies to activities or behavior that occur prior to, and are causative of, the injury.

Counsel: For TYANN SHELTON, Plaintiff-Appellee: STEVEN A. HICKS.

For DWAYNE WILLIAMS, Plaintiff: TIMOTHY P. LUXON.

For AUTO-OWNERS INSURANCE COMPANY, Defendant-Appellant: CHRISTOPHER P. ENDRES.

Judges: Before: K. F. KELLY, P.J., and GLEICHER and SHAPIRO, JJ. K. F. KELLY, P.J. (concurring).

Opinion by: Douglas B. Shapiro

Opinion

SHAPIRO, J.

In this No-Fault personal injury protection (PIP) case, defendant sought summary disposition based upon a fraud exclusion clause in its policy. Defendant asserted that plaintiff made fraudulent statements concerning her need for replacement services and so was excluded by the policy from all PIP benefits. The trial court granted summary

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disposition as to replacement services, a ruling from which plaintiff has not appealed.[1] The trial court denied the motion as to payment for medical services and from that ruling, defendant appeals by leave granted.[2] We affirm.

Shelton alleges she was injured in a single-car collision on January 22, 2013. The vehicle was owned and operated by Timothy Williams; Shelton was a passenger. She sought PIP benefits from defendant because she did not own a vehicle nor reside with a relative who did. [*2] Thus, defendant, as Williams's insurer, was to provide her with those PIP benefits to which she was entitled under the No-Fault Act. MCL 500.3114(4)(a). Plaintiff claimed PIP benefits that included medical expenses and replacement services for household chores, beginning in January 2013.[3] Defendant denied the claim and plaintiff brought suit.

Defendant moved for summary disposition asserting that plaintiff was not entitled to PIP benefits under an exclusionary clause in the policy reading:

> We will not cover any person seeking coverage under this policy who has made fraudulent statements or engaged in fraudulent conduct with respect to procurement of this policy or to any **OCCURRENCE** for which coverage is sought.

Defendant argues that this policy exclusion applies to plaintiff despite the fact that she is not a policyholder, and that the evidence demonstrates beyond a question of fact that plaintiff engaged in fraud as defined in the policy. Defendant relies largely on Bahri v IDS Prop Cas Ins Co, 308 Mich App 420, 423-426; 864 NW2d 609 (2014), in which we held that a fraud provision in an insurance contract could bar a claim for PIP benefits when the policyholder filed a claim for replacement services for a date prior to the subject accident. However, both the law and the facts [*3] of this case differ substantially from those that existed in Bahri.

The law governing application of the policy exclusion in *Bahri* is not applicable in this case. In *Bahri*, the provision applied to the plaintiff in that case because "defendant issued [the subject] no-fault automobile policy to [the] plaintiff." Bahri, 308 Mich App at 421. In this case, however, plaintiff was not a party to, nor an insured under, the policy; she was injured while a passenger and because neither she nor her spouse or resident relative had a no-fault policy, defendant was required to pay her benefits pursuant to statute, not pursuant to a contractual agreement.

The Michigan Supreme Court stated in Rohlmann v Hawkeye Security, 442 Mich 520, 524-525; 502 NW2d 310 (1993), that

> HN1[↑] "PIP benefits are mandated by statute under the no-fault act, MCL 500.3105; MSA 24.13105, and, therefore, the statute is the 'rule book' for deciding the issues involved in questions regarding awarding those

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[1] The record does not make clear the basis for the dismissal of the replacement services claim. Defendant asserts that the trial court's decision implies that the court made a finding of fraud, and plaintiff argues the decision was based on a lack of proofs for the replacement services claim. Defendant refers us to the trial courts remark during the hearing that she "[doesn't] like people misrepresenting the truth." However, the court also stated that after a review of the plaintiff's deposition she could not conclude that plaintiff lied. And in making its ruling, the trial court did not cite or discuss the elements of fraud, make findings regarding those elements, or even use the word "fraud." Neither party asked the court to clarify its ruling or to make a finding of fraud. Because the dismissal of the replacement services claim has not been appealed we need not address it further.

[2] Shelton v. Auto-Owners Ins. Co., unpublished order of the Court of Appeals, entered December 21, 2015 (Docket No. 328473), 2015 Mich. App. LEXIS 2533.

[3] Before the trial court, defendant also argued that plaintiff fraudulently misrepresented her preaccident history by failing to disclose that she made a PIP claim following a 2005 accident. The trial court rejected the argument regarding the prior auto accident noting that plaintiff's statement about the 2005 accident could have simply been a mistake or a failure of memory and that "it really becomes an issue for the jury to decide whether or not she's credible." Defendant has not argued on appeal that the trial court erred in its ruling as to the 2005 claim. Moreover, the materials submitted by defendant with its brief on appeal relevant to the 2005 claim are not in the lower court record and were stricken, with consent, at oral argument.

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> benefits. On the other hand, the insurance policy itself . . . is the contract between the insurer and the insured . . . ."

The Supreme Court adhered to this principle in *Harris v Auto Club Ins Ass'n, 494 Mich 462, 471-472; 835 NW2d 356 (2013)*, a case involving a motorcycle-automobile collision. *MCL 500.3114(5)(a)*, using language paralleling the language used in *MCL 500.3114(4)(a)*, provided that if the injured motorcyclist, his spouse or a resident [*4] relative did not have a no-fault policy then his no-fault benefits would be paid by the insurer of the owner or registrant of the automobile. In *Harris*, the Court stated that plaintiff could not take advantage of the uncoordinated medical benefit provision in the policy because his claim did not flow from the subject policy, but "solely by statute." *Harris, 494 Mich at 472* The Court held that:

> [The plaintiff] is not claiming benefits under a no-fault insurance policy that he or anyone else procured. [He] is neither a third-party beneficiary nor a subrogee of the no-fault policy issued to the person that struck him and thus he [was] not eligible to receive benefits under that policy. Rather, [the plaintiff's] right to PIP benefits arises solely by statute. [*Id.*]

Defendant's argument is directly contrary to the grounds for the holdings in both *Rohlman* and *Harris*. Here, as in those cases, plaintiff's no-fault benefits are governed "solely by statute." Thus, the exclusionary provision in defendant's no-fault policy does not apply to plaintiff and cannot operate to bar plaintiff's claim.

This is also consistent with the text of the relevant statutes. *HN2*[↑] "The primary rule of statutory construction is that, where the [*5] statutory language is clear and unambiguous, the statute must be applied as written." *Cruz v State Farm Mut Auto Ins Co, 466 Mich 588, 594; 648 NW2d 591 (2002)*. Additionally, the "primary task in construing a statute is to discern and give effect to the intent of the Legislature." *Farmers Ins Exch v Farm Bureau Gen Ins Co, 272 Mich App 106, 111; 724 NW2d 485 (2006)* (citation and quotations omitted). "[A] court must give effect to every word, phrase, and clause and avoid a construction that would render any part of the statute surplusage or nugatory." *Id.*

HN3[↑] Under Subsection 1 of the no-fault priority statute, "a personal protection insurance policy . . . *applies* to the person named in the policy, the person's spouse, and a relative of either domiciled in the same household." *MCL 500.3114(1)* (emphasis added). Plaintiff is not an individual named in defendant's policy, a person named in the policy's spouse, or a relative of either the person named in defendant's policy or his spouse. Therefore, pursuant to the statute, defendant's policy does not "apply" to plaintiff. Rather, plaintiff received no-fault benefits pursuant to Subsection 4, which reads:

> Except as provided in *subsections (1) to (3)*, a person suffering accidental bodily injury arising from a motor vehicle accident while an occupant of a motor vehicle shall claim personal protection insurance benefits from insurers in [*6] the following order of priority:
> (a) The insurer of the owner or registrant of the vehicle occupied.
>
> (b) The insurer of the operator of the vehicle occupied. [*MCL 500.3114(4)*.]

HN4[↑] *Subsection (4)* does not state that the owner or operator's insurance policy "applies" to the passenger's claim for benefits, and its text, unlike that of *Subsection (1)*, omits any mention of a personal protection insurance *policy*, instead providing that the injured person is to "claim personal protection insurance benefits from insurers," beginning with "[t]he insurer of the owner or registrant of the vehicle occupied." *MCL 500.3114(4)(a)*.

Defendant argues that as a matter of public policy we should depart from the statute because if we do not, no-fault insurers will lose the ability to deny fraudulent no-fault claims. This argument is meritless.*HN5*[↑] As always, if an insurer concludes that a claim is fraudulent, it may deny the claim.[4] Should the claimant then file suit, the burden is

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[4] This Court has long held that insurers should be afforded an opportunity to review claims for lack of coverage, excessiveness, and fraud. *Advocacy Org for Patients & Providers v Auto Club Ins Ass'n, 257 Mich App 365, 378; 670 NW2d 569 (2003)*.

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on the claimant to prove that he is entitled to his claimed benefits, a burden that is highly unlikely to be met if the factfinder concludes that the claim is fraudulent.[5] And insurers can obtain attorney fees for having to litigate any claims that are determined to be fraudulent. MCL 500.3148.

This case also presents [*7] very different facts than did *Bahri*.[6] In *Bahri*, the insurer presented unrebutted evidence (a) that plaintiff claimed replacement services benefits for three weeks *before the auto accident even occurred*; and (b) that over a period of seven weeks she repeatedly engaged in a wide range of chores on the days for which she claimed that someone else did them for her. 308 Mich App at 425-426. In this case, it is clear that a questions of fact exist as to whether plaintiff made material misrepresentations and, if so, whether they were made with the intent to defraud defendant.

HN6[↑] Reliance on an exclusionary clause in an insurance policy is an affirmative defense and so defendant has the burden of proof. An "insurance company has the burden to prove that one of the policy's exclusions applies." Auto Owners Ins Co v Seils, 310 Mich App 132, 146; 871 NW2d 530 (2015). Thus, to obtain summary disposition the insurer must show that there is no question of material fact as to any of the elements of its affirmative defense. The elements, as set forth [*8] in *Bahri*, are as follows:

> "To void a policy because the insured has wilfully misrepresented a material fact, an insurer must show that (1) the misrepresentation was material, (2) that it was false, (3) that the insured knew that it was false at the time it was made or that it was made recklessly, without any knowledge of its truth, and (4) that the insured made the material misrepresentation with the intention that the insurer would act upon it. A statement is material if it is reasonably relevant to the insurer's investigation of a claim. [Mina v Gen Star Indemnity Co, 218 Mich App 678, 686; 555 NW2d 1 (1996), rev'd in part on other grounds *455 Mich. 866, 568 N.W.2d 80 (1997)* (citation omitted).]" [Bahri, 308 Mich App at 424-25.]

HN7[↑] We review de novo motions for summary disposition under *MCR 2.116(C)(10)*. Dressel v Ameribank, 468 Mich 557, 561; 664 NW2d 151 (2003). In doing so, we are required to view the affidavits, pleadings, depositions, admissions, and other documentary evidence in the light most favorable to the nonmovant. Liparoto Constr, Inc v

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[5] MCL 500.3107(1), subsections (a), (b) and (c), respectively require plaintiff to prove: that the medical expenses were "reasonable charges incurred for reasonably necessary [medical care]," that the costs for replacement services were "reasonably incurred in obtaining ordinary and necessary services," and that plaintiff has lost "income from work [he or she] would have performed during the first 3 years from the date of the accident if he or she would not have been injured."

[6] We note that the policy language in the instant case differs significantly from that in Bahri, 308 Mich App at 424-425. In *Bahri*, the exclusion read: "We do not provide coverage for any insured who has made fraudulent statements or engaged in fraudulent conduct in connection with any accident or loss for which coverage is sought under this policy." Id. at 423-424. The exclusion in this case states:

> We will not cover any person seeking coverage under this policy who has made fraudulent statements or engaged in fraudulent conduct *with respect to procurement of this policy or to any* **OCCURRENCE** for which coverage is sought. [Emphasis added.]

Defendant has not provided us with the policy definition of "occurrence," but in all cases dealing with the term, it has been defined as the accident or event during which the injury occurs. See, e.g. Frankenmuth Mut Ins Co v Masters, 460 Mich 105, 112-113; 595 NW2d 832 (1999) (stating that the applicable insurance policy defined the term "occurrence" as "an accident, . . . which occurs during the policy period"), Group Ins Co v Czopek, 440 Mich 590, 597-598; 489 NW2d 444 (1992) (stating that the term "occurrence" was defined in the policy as "an accident, . . . which results, during the policy term, in bodily injury or property damage."), and Mich Basic Prop Ins Ass'n v Wasarovich, 214 Mich App 319, 327-328; 542 NW2d 367 (1995) (finding that the definition of "occurrence" in the policy included an accident that resulted in personal injury during the policy period). Defendant has not alleged any fraud "with respect to the procurement of the policy" nor with respect to the "occurrence." The claimed fraud was in the reporting of services later provided, an event not referenced in the provision. However, as the issue was not considered below we decline to rule on this basis. Mich Ed Ass'n v Secretary of State, 280 Mich App 477, 488; 761 NW2d 234 (2008), aff'd 489 Mich 194; 801 N.W.2d 35 (2011); People v Byrne, 199 Mich App 674, 677; 502 NW2d 386 (1993).

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Gen Shale Brick, Inc, 284 Mich App 25, 29; 772 NW2d 801 (2009). Similarly, all reasonable inferences must be drawn in favor of the nonmovant. Dextrom v Wexford Co, 287 Mich App 406, 415; 789 NW2d 211, lv den 488 Mich. 853, 787 N.W.2d 508 (2010). Summary disposition is only appropriate under MCR 2.116(C)(10) when there is no genuine issue with respect to any material fact and the moving party is entitled to judgment as a matter of law. Maiden v Rozwood, 461 Mich 109, 120; 597 NW2d 817 (1999). "A genuine issue of material fact exists when the record, giving the benefit of reasonable doubt to [*9] the opposing party, leaves open an issue upon which reasonable minds could differ." West v GMC, 469 Mich 177, 183; 665 NW2d 468 (2003).

In support of its motion, defendant relied on an investigator's reports and some photographs counsel represents were taken by the investigator on June 1.[7] Defendant argues that the photographs and investigator's reports are sufficient to establish beyond a question of fact that defendant committed fraud despite the testimony, medical reports, and affidavits that support plaintiff's claim of injury and need for medical care and assistance. We disagree. First, many of the photographs are so blurred and distant that it is impossible to determine who is being photographed and what they are doing. Second, the descriptions in defendant's brief are at times inconsistent with the investigator's reports. For example, defendant's brief states that on June 1 plaintiff "is observed outstretching both of her arms above her head to lift and pass a child." However, the investigator's report dated June 1, 2013 states that the "claimant" being observed is "Timothy Williams," not plaintiff, and all of the report's references to "the claimant" use the pronoun "he." The only person that the report identifies as being "observed [*10] lifting the toddler" is Williams.[8] The only women referred to in that report are two "female subject[s]" neither of whom are identified in the report as plaintiff despite the fact that plaintiff had been watched by this investigator on two prior occasions. Moreover, the only photographs submitted by defendant are dated June 1, 2013, the date that the report does not identify plaintiff as being present.

Defendant also argues that plaintiff fraudulently claimed assistance with doing laundry on June 1, because the investigator's report states that on that date he saw plaintiff wringing out a shirt while on the front lawn of her home.[9] A single instance of a single shirt being wrung out does not demonstrate beyond question that plaintiff can operate a washer or dryer, carry loads of laundry or the like. Nor does it conclusively demonstrate an intent to defraud. Similarly, the fact that plaintiff was seen walking without a visible brace[10] and was observed to bend on two occasions does not establish beyond a question of fact that she has defrauded defendant.[11] By contrast, as noted above, the insurer in *Bahri* [*11] presented uncontested evidence (a) that plaintiff claimed replacement services benefits for three weeks before the auto accident even occurred; and (b) that over a period of seven weeks she repeatedly engaged in a wide range of chores on the days for which she claimed that someone else did them for her. 308 Mich App at 425-426. While such repeated activities are sufficient to establish the elements of fraud

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[7] While not raised in the briefing, based on the record before us it appears that many of the documents on which defendant relies including the three surveillance reports and the photographs, do not meet the evidentiary requirements of ***MCR 2.116(G)(6)*** and should not have been considered. That rule provides that "affidavits, depositions, admissions and documentary evidence offered in support of or in opposition to a motion based on ***subrule (C)(1)-(7)*** or ***(10) shall only be considered to the extent that the content or substance would be admissible as evidence.***" (emphasis added). The relied upon reports appear to be hearsay. Their ostensible author did not testify and has not provided an affidavit that the statements in his reports are true and that he will so testify at trial. The same is true of the photographs on which defendant relies.

[8] The report states, "The claimant is also observed lifting the toddler and shaking him as he is playing with the toddler."

[9] In fact, the report is equivocal as to this fact, stating that plaintiff "*appears* to be wringing it out." (emphasis added). And there is no reference to any photographs or videotape to confirm even this self-serving statement.

[10] Plaintiff testified that she is able to walk. She also testified that she always wore a back brace but stated that sometimes she wore it under her clothing and sometimes over.

[11] Defendant's brief refers us to a passage in plaintiff's deposition that is not in the record in support of its position. On that page plaintiff states that she "normally" wears a back brace and that if wearing a loose fitting shirt she wears it under her shirt. Defendant also refers us to one of the June 1, 2013 photos in which a woman is seen carrying what appears to be a small plastic bag (contents unknown) and argues this was inconsistent with her deposition testimony. However, plaintiff testified that she could walk to nearby stores and that she could lift a bag containing five regular size cans of vegetables.

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beyond a question of fact, a single episode of wringing out a shirt does not; nor do isolated examples of an injured person participating in simple physical actions such as bending, modest lifting, or other basic physical movements that they testify are painful or difficult. These types of inconsistencies with a claimant's statements are not sufficient to establish any of the elements of fraud beyond a question of fact.

Defendant raises an alternative argument in its reply brief, claiming that plaintiff's no fault claim is barred by the wrongful-conduct rule. However, HN8[↑] "[r]eply briefs must be confined to rebuttal, and a party may not raise new or additional arguments in its reply brief." *Kinder Morgan Michigan, LLC v City of Jackson, 277 Mich App 159, 174; 744 NW2d 184 (2007)*, citing *MCR 7.212(G)*. Accordingly, we need not reach the issue. However, were we to do so, we would reject the argument. HN9[↑] The wrongful [*12] conduct rule applies to activities or behavior that occur prior to, and are causative of, the injury.[12] See *Cervantes v Farm Bureau Gen Ins Co, 272 Mich App 410, 417; 726 NW2d 73 (2006)* (stating that "the wrongful conduct rule only applies if a plaintiff's wrongful conduct is a proximate cause of his injuries") and see *Orzel v Scott Drug Co, 449 Mich 550, 558; 537 NW2d 208 (1995)* ("[The plaintiff's] injury must have been suffered while and as a proximate result of committing an illegal act.") (internal quotations and citations omitted). Defendant makes no such claim here.

Affirmed. We do not retain jurisdiction.

/s/ Douglas B. Shapiro

/s/ Elizabeth L. Gleicher

Concur by: Kirsten Frank Kelly

Concur

K. F. KELLY, P.J. (*concurring*).

I concur in the result only.

/s/ Kirsten Frank Kelly

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[12] Defendant's brief provides no citation to cases applying the wrongful conduct rule as it seeks to do. And when asked at oral argument for supporting caselaw, defendant could provide none.

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EXHIBIT 6

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Roger Williams Ins. Co. v. Carrington

Supreme Court of Michigan

April 7, 1880, Submitted ; April 14, 1880, Decided

No Number in Original

Reporter
43 Mich. 252 *; 5 N.W. 303 **; 1880 Mich. LEXIS 776 ***

The Roger Williams Insurance Company v. Mark Carrington.

Prior History: [***1] Error to St. Clair. Submitted April 7. Decided April 14.

Disposition: The judgment must be affirmed with costs.

Core Terms

insured, premium, removal

Case Summary

Procedural Posture
Defendant insurer appealed from a judgment of the Circuit Court for the County of St. Clair (Michigan), which was entered in favor of plaintiff assignee of the insured in an action seeking recovery for property which was destroyed by fire.

Overview
The insured had obtained an insurance policy over his livery stable stock which was destroyed by fire. He assigned the interest therein to an assignee who commenced an action against the insurer upon the insurer's denial that there was a policy in effect. At the time of the fire, the horses, carriages, and other livery property had been in another stable, where the business had been moved to. The assignment had not been consented to by the insurer, however, it had occurred after the fire and accordingly, no consent was required. The insurer contended that although there was originally a policy, it had been cancelled due to non-payment of the premium which fact it contended was told to the insurance agent. However, the court held that the agent was one for the insurer and not for the insured. Additionally, the factual determinations on that issue, as well as whether the agent made the arrangements with the insurer for the movement of the insured property, were properly considered by the jury and they were supported by sufficient evidence.

Outcome
The court affirmed the judgment of the trial court in favor of the assignee of the insured.

LexisNexis® Headnotes

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43 Mich. 252, *252; 5 N.W. 303, **303; 1880 Mich. LEXIS 776, ***1

Contracts Law > Standards of Performance > Assignments > General Overview

Criminal Law & Procedure > Sentencing > Forfeitures > Proceedings

Insurance Law > Liability & Performance Standards > Bad Faith & Extracontractual Liability > Assignment of Claims

HN1[] It is the absolute right of every person--secured in Michigan by statute--to assign insurance claims, and such a right cannot be thus prevented. It cannot concern the debtor, and it is against public policy.

Contracts Law > Contract Modifications > General Overview

Contracts Law > Procedural Matters > Statute of Frauds > General Overview

Insurance Law > Contract Formation > Oral Contracts

Insurance Law > ... > Policy Interpretation > Parol Evidence > General Overview

HN2[] There is no rule of law which, in cases outside of the Statute of Frauds, prevents written contracts from being changed by parol, or which requires insurance contracts to be in writing.

Headnotes/Syllabus

Headnotes

Insurance -- Assignment of policy after loss -- Parol change in policy.

The right to assign an accrued cause of action is statutory in Michigan and cannot be defeated.

A clause in an insurance policy providing for its forfeiture if assigned without the company's consent, cannot in Michigan prevent its assignment after the loss.

The finding of a jury cannot be disturbed if there was evidence to justify it, unless the jury were allowed to find under improper directions.

Insurance policies are not required by law to be in writing, and outside of the statute of frauds there is no rule of law which prevents written contracts from being changed by parol.

Syllabus

Action on insurance policy. Defendant brings error.

Counsel: Whipple & Voorhies for plaintiff in error.

O'Brien J. Atkinson and Elliott G. Stevenson for defendant in error. An insurance policy can be changed or enlarged by parol, *Seaman v. O'Hara 29 Mich. 66*; Kennebec Co. v. Augusta Ins. Co. 6 Gray 209; *First Baptist Church v. Brooklyn Ins. Co. 19 N.Y. 305*.

Judges: Campbell, J. The other Justices concurred.

Opinion by: Campbell

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Opinion

[***2] [*253] [**303] Action was brought in the circuit court for the county of St. Clair by Carrington as assignee of a policy of insurance originally issued by plaintiff in error to Angeline James on a livery stable stock in Port Huron. The policy bore date October 16, 1876, and was assigned after the property insured was burned up. The fire which destroyed the property was in September, 1877. The policy was by its terms made payable to Carrington as his interest should appear. It was thus arranged to secure a debt due him from Mrs. James and secured.

At the time of the fire the horses and carriages and other livery property destroyed were in a livery stable at Lexington, to which place the business had been removed in November, 1876, and one of the questions presented related to the effect of this removal.

The company after the loss repudiated any liability on the ground that no such policy was in force.

There is some difficulty in applying the assignments of error in this case, but perhaps they present sufficiently the more important issues.

Proof of loss was made in final shape about three months after the fire. It was not objected to for delay, [*254] but for want of any insurance. [***3] There was evidence bearing very plainly on difficulties of proof caused by this dispute as to the existence of the policy, and we do not think there was anything which, as matter of law, made the delay sufficient for a forfeiture. [**304] The assignment having been made after the loss, did not require consent of the company. The provision of the policy forfeiting it for an assignment without the company's consent is invalid, so far as it applies to the transfer of an accrued cause of action. *HN1*[↑] It is the absolute right of every person--secured in this State by statute--to assign such claims, and such a right cannot be thus prevented. It cannot concern the debtor, and it is against public policy.

Two principal questions arose on the trial, *first*, whether the policy was originally valid and continued uncanceled; and *second*, whether the removal to Lexington put an end to its force if otherwise in existence.

The original execution of the policy was admitted, but it was claimed to have been canceled for non-payment of premium. It is not claimed that notice of cancellation was given to the insured, and the verdict negatives it. But it is claimed that Linnaeus Noble, the insurance agent who [***4] issued the policy, was acting in the capacity of agent for Mrs. James, and that the company by notifying him sufficiently notified her.

Upon most of the leading facts Noble's testimony is contradicted, and it was a question of fact for the jury what transactions really occurred throughout.

There was a conflict as to the precise relations of the parties concerning the obtaining of this particular policy, and how far Noble acted for Mrs. James concerning it. There was evidence of a particular bargain made about it. There was evidence that the premium was actually paid by a note, which was taken up after renewal. There was evidence that the company drew for and obtained the amount of this premium from Noble, and while he testifies it was afterwards made up to him, he does not [*255] show how or why, and he does not show that the payment to the company was after the pretended cancellation, which was for non-payment of premium.

Upon all of these questions the jury have found in favor of the insured, and there was evidence to justify the finding. Unless they were allowed to do this under improper directions their finding cannot be disturbed.

The charges asked, which called for instructions [***5] that Noble was agent for Mrs. James, were all too broad. Upon the testimony it cannot properly be said that there was anything more than an open question of fact. The court could not be asked to charge either that he was her agent or that a partial detail of facts would make him such, when there were other facts explaining them, besides many contradicting them. The charges [**305] asked were not so drawn as to leave the jury any discretion upon matters of dispute. And we are strongly inclined to think that there was no testimony which fairly tended to show that in this particular transaction Noble could have been found

Jacob Bryant

by the jury to have acted for any material purpose as agent for any but the company, whatever may have been his position in regard to other transactions.

Upon the question of assent to the transfer of the insured property to Lexington there is also some conflict of testimony. There was positive testimony that before the removal the agent was notified of the desire to remove it, and that it would not be removed until provision was made to keep it protected by the insurance, and that Noble told James, the husband and agent of the insured, before the removal that the proper steps **[***6]** had been taken. There was also evidence, which though objected to was clearly relevant, that shortly before the loss Noble was written to for the purpose of having the policy renewed when it should run out, and answered promising to attend to it. There was also other evidence on the same subject. The agent's own books showed a memorandum purporting to be a new insurance for a year from the **[*256]** time of the removal, covering the property at Lexington, but claimed it was a mere memorandum of a proposed insurance that was never made. Upon all these facts the jury certainly had a right to believe the agent had done what James said he had, and that there had been an absolute representation of insurance and an agreement to that effect. The policy contained an express authority in the insured to surrender the policy and get back a part of the premium, and no return of premium was pretended to have been made, while the jury must have found it had all been paid.

The objection that such change in the policy was void unless in writing, is disposed of by our own previous decisions. *HN2*[↑] There is no rule of law which, in cases outside of the Statute of Frauds, prevents written contracts from **[***7]** being changed by parol, or which requires insurance contracts to be in writing. The subject was fully considered in *Westchester Fire Ins. Co. v. Earle 33 Mich. 143*, where the cases are cited and commented on. We think there is no difficulty in the way of the contract relied on.

Some question arose whether a certain stallion was properly included among the stock. There was testimony that except at certain seasons he was used as a livery horse, and we think he was properly so found by the jury. **[**306]** We do not discover anything in the record indicating that any action has been had of which plaintiff in error can complain.

The judgment must be affirmed with costs.

The other Justices concurred.

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EXHIBIT 7

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Action Auto Stores v. United Capitol Ins. Co.

United States District Court for the Western District of Michigan, Southern Division

February 8, 1993, Decided ; February 8, 1993, Filed

File No. 5:91-CV-32

Reporter
845 F. Supp. 417 *; 1993 U.S. Dist. LEXIS 4464 **

ACTION AUTO STORES, INC., a Michigan corporation, Plaintiff, v. UNITED CAPITOL INSURANCE COMPANY, Garnishee-defendant, and OSCAR W. LARSON COMPANY, a Michigan corporation, Defendant.

Core Terms

Garnishee, insured, summary judgment motion, insurance policy, coverage, pollutants, settlement agreement, exclusions, argues, court finds, summary judgment, operations, settlement, damages, parties, garnishment, defenses, relieve, contends, property damage, containment, products, asserts, install, invalid, removal, notice, disclosure statement, insurance company, real property

Case Summary

Procedural Posture
Plaintiff judgment creditor sought summary judgment to allow it to receive proceeds from an insurance contract between its judgment debtor and defendant garnishee, the insurer of judgment debtor. Defendant sought judgment stating it was not indebted to the judgment debtor and should not be subject to garnishment.

Overview
Plaintiff judgment creditor sought to garnish proceeds under an insurance policy issued by defendant garnishee after plaintiff and the judgment debtor settled some of plaintiff's claims and a verdict was rendered in plaintiff's favor on the remaining claims. Defendant alleged it was not indebted to judgment debtor and should not be subject to garnishment. Both parties filed motions for summary judgment. The court denied the motions for summary judgment insofar as a question of fact existed as to whether the cooperation clause of the insurance policy was violated by judgment debtor's alleged refusal to cooperate and prepare a defense of the underlying suit. It further found that defendant did not waive the defense that a policy exclusion prevented coverage for damage done to land and that the issue should be more fully addressed by the parties. The court requested defendant to reassess its position regarding several of its defenses and declined to address the issue of coverage as it was improperly raised in a responsive pleading. Plaintiff's motion was granted to the extent that it sought a declaration that the balance of defendant's defenses were invalid.

Outcome
The court denied defendant garnishee's motion for summary judgment and granted plaintiff judgment creditor's motion in part and denied it in par. Summary judgment was not proper when a question of fact existed as to whether judgment debtor violated the cooperation clause of the insurance policy and the issue of coverage needed to be more fully addressed.

LexisNexis® Headnotes

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Civil Procedure > ... > Summary Judgment > Evidentiary Considerations > Scintilla Rule

Civil Procedure > Judgments > Summary Judgment > Evidentiary Considerations

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > General Overview

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Appropriateness

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Genuine Disputes

HN1[] Summary judgment is appropriate only where no genuine issue of fact remains to be decided so that the moving party is entitled to judgment as a matter of law. There is no material issue of fact for trial unless, in viewing the evidence in favor of the nonmoving party, a reasonable factfinder could return a verdict for that party. If the evidence is merely colorable or is not significantly probative, summary judgment may be granted.

Civil Procedure > ... > Summary Judgment > Burdens of Proof > General Overview

Civil Procedure > ... > Summary Judgment > Burdens of Proof > Nonmovant Persuasion & Proof

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > General Overview

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > Appropriateness

HN2[] The party moving for summary judgment bears the initial responsibility of informing the court of the basis of its motion and identifying those portions of the record which demonstrate the absence of a material issue of fact. Once this has been done, the nonmoving party must come forward with specific facts showing that there is a material issue of fact on an issue that the nonmoving party will bear the burden of proof at trial. *Fed. R. Civ. P. 56(e)*. If, after adequate discovery, the party bearing the burden of proof fails to make a showing sufficient to establish an essential element of his claim, summary judgment is appropriate.

Civil Procedure > Preliminary Considerations > Federal & State Interrelationships > General Overview

Civil Procedure > ... > Federal & State Interrelationships > Choice of Law > General Overview

Civil Procedure > Preliminary Considerations > Federal & State Interrelationships > Erie Doctrine

HN3[] A federal court sitting in diversity must apply the law of the state in which it sits, including that state's choice of law principles.

Insurance Law > ... > Obligations of Parties > Policyholders > Duty to Cooperate

HN4[] The insurer must show that the insured's lack of compliance materially injured its ability to contest the merits of the claims.

Contracts Law > Defenses > Ambiguities & Mistakes > General Overview

Insurance Law > ... > Policy Interpretation > Ambiguous Terms > General Overview

Insurance Law > ... > Policy Interpretation > Ambiguous Terms > Construction Against Insurers

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Insurance Law > Claim, Contract & Practice Issues > Policy Interpretation > Exclusions

Insurance Law > Claim, Contract & Practice Issues > Policy Interpretation > Ordinary & Usual Meanings

Insurance Law > Claim, Contract & Practice Issues > Policy Interpretation > Plain Language

HN5[] An ambiguous contract provision must be construed against the insurer and in favor of the insured and exclusionary clauses in insurance policies are to be strictly construed against the insurer. If the meaning of terms used in the contract are clear and unambiguous, however, their terms are to be taken and understood in their plain, ordinary, and popular sense.

Counsel: [**1] For ACTION AUTO STORES, INC. plaintiff: L. David Lawson, Winegarden, Shedd, Haley, Lindholm, et al, 501 Citizens Bank Bldg., Flint, MI 48502, Genesee, (313) 767-3600.

For UNITED CAPITOL INSURANCE COMPANY, a foreign corporation garnishee: Constantine N. Kallas, Leonard A. Henk, Kathlyn M. Rasmussen, Kallas & Henk, PC, 1471 Woodward Ave., Suite 200, Bloomfield Hills, MI 48302, Oakland, (313) 335-5450.

Judges: GIBSON

Opinion by: BENJAMIN F. GIBSON

Opinion

[*418] Hon. Benjamin F. Gibson

OPINION

Pending before the Court are cross-motions for summary judgment. The issue before the Court is whether garnishee-defendant United Capitol Insurance Company [*419] ("garnishee") is obligated under an insurance contract to pay garnishee-plaintiff Action Auto Company ("plaintiff") funds that plaintiff was awarded in a lawsuit it brought against defendant Oscar W. Larson Company. Plaintiff contends that garnishee has a contractual obligation to pay the sum. Garnishee asserts that a settlement agreement between defendant and plaintiff negates any duty it may have had to pay, and it further argues that various exclusions contained in the insurance policy preclude its obligation to pay. [1] Finally, garnishee argues that "known risk" [**2] and "loss in progress" doctrines bar coverage.

I.

Defendant was employed by plaintiff and Sun Oil Company to install gasoline containment systems at three Action Auto locations. In 1988, defendant filed various actions in state court for money it claimed plaintiff owed it for the work it had done. Plaintiff counterclaimed for breach of express and implied warranties, alleging that defendant had negligently installed the systems. Plaintiff also alleged that defendant failed to remove contaminated soil from some of the locations. The actions were consolidated.

Garnishee agreed to defend defendant in the action but reserved the right to contest coverage, at least for some claims. [2] Plaintiff and defendant entered a partial settlement prior to trial. [**3] Garnishee was not a party to this

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[1] Larson has filed no motions in this action. The dispute is essentially between Action and United Capitol. As discussed in the Court's Opinion and Order of January 13, 1992, Larson's interests are aligned with Action's, thus creating complete diversity of parties.

[2] Two reservation of rights letters were sent to defendant. The first letter, dated October 3, 1989, cited section F(2) of the "absolute pollution exclusion" clause of the policy. The October 3 letter also stated that "United Capitol Insurance Company does not waive any other defenses is (sic) may have under the Policy including the late notification of the loss." The second letter, dated March 26, 1990, cites other exclusions at issue in this lawsuit.

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settlement, and it apparently had no knowledge of the agreement until after it was made. [3] According to the settlement, defendant dismissed its claims with prejudice. In return, plaintiff dismissed same of its claims and agreed not to execute on or enforce a judgment against any of defendant's assets except on those arising out of insurance policies or contracts. Defendant apparently stopped contesting some claims and a default was entered in the amount of $ 2,197,000.00. Plaintiff's other claims were tried in state court where a jury rendered a verdict of two million dollars against defendant.

[**4] Plaintiff filed a writ of garnishment in the Ingham County Circuit Court against garnishee. Garnishee filed a garnishee disclosure statement in which it alleged that it was not indebted to defendant and that it should not be subject to garnishment. Garnishee argued that no underlying debt existed since the settlement agreement released defendant from liability, and it also argued that various provisions in the insurance policy prevented garnishment. On May 15, 1991, garnishee removed the case to this Court. Plaintiff moved to remand, but in an Opinion and Order dated January 13, 1992, this Court determined that it had subject matter jurisdiction over the action and that remand was improper. Cross-motions for summary judgment were subsequently filed.

II.

HN1[↑] Summary judgment is appropriate only where no genuine issue of fact remains to be decided so that the moving party is entitled to judgment as a matter of law. Atlas Concrete Pipe, Ins. v. Roger J. Au & Son, Ins. (In re Atlas Concrete Pipe, Inc.), 668 F.2d 905, 908 (6th Cir. 1982). There is no material issue of fast for trial unless, in viewing the evidence in favor of the nonmoving party, a reasonable [**5] fact finder could return a verdict for that party. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 249, 91 L. Ed. 2d 202, 106 S. Ct. 2505 (1986). "If the evidence is merely colorable or is not significantly [*420] probative, summary judgment may be granted." Anderson, 477 U.S. at 249 (citations omitted).

HN2[↑] The party moving for summary judgment bears the initial responsibility of informing the court of the basis of its motion and identifying those portions of the record which demonstrate the absence of a material issue of fact. Celotex Corp. v. Catrett, 477 U.S. 317, 323, 91 L. Ed. 2d 265, 106 S. Ct. 2548 (1986). Once this has been done, the nonmoving party must come forward with specific facts showing that there is a material issue of fact on an issue which the nonmoving party will bear the burden of proof at trial. Fed. R. Civ. P. 56(e); Celotex, 477 U.S. at 322-24. If after adequate discovery the party bearing the burden of proof fails to make a showing sufficient to establish an essential element of his claim, summary judgment is appropriate. *Id.*

III.

Garnishee's motion for summary judgment asks this Court to find that it [**6] has no obligation to pay damages either because the insurance policy prohibits liability in situations in which a settlement agreement is executed without the insurer's consent or because exclusions contained in the policy prohibit liability for the kind of damage at issue in this litigation. Plaintiff has made a separate motion for summary judgment in which it asks that various defenses to garnishment be declared legally insufficient.

The Court notes that while the parties have submitted several briefs apiece, the number of issues in contention has made it impossible for any one issue to be extensively briefed. While this Opinion is dispositive of some issues, it requires that others be briefed more fully and resubmitted for the Court's consideration.

IV.

Garnishee argues that because a settlement agreement was entered between plaintiff and defendant, defendant was not legally obligated to pay the judgment, negating garnishee's obligation under the insurance policy. In

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[3] This is implied by garnishee though not overtly stated. The settlement agreement itself states that defendant "through its counsel, disclosed its intent to enter into, and provided the draft dated May 1, 1990 of, (sic) this Agreement to any and all actual or potential insurers of claims against it . . . ." Settlement Agreement, Garnishee's Motion for Summary Judgment, Exhibit 3, at 5, P C.

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addition, garnishee contends that entering the agreement without its consent was a violation of the insurance contract releasing it from any obligation to pay.

A.

Garnishee argues that because plaintiff agreed [**7] to collect its judgment only from insurance proceeds instead of other assets of defendant, defendant is not legally obligated to pay any damages. Garnishee concludes that because the insurance agreement *only* covers casts the insured must pay, the fact that defendant has avoided incurring a legal obligation relieves it of its duty.

This case is governed by Michigan law. [4] The Michigan case most closely on point is *Alyas v. Gillard, 180 Mich App. 154, 446 N.W.2d 610 (1989)*. In this case, the Michigan Court of Appeals held that a consent judgment compelling a plaintiff to collect only from defendant's insurer did not relieve defendant from "any and all liability" and thus relieve the insurer from its contractual obligation to pay the claim. Garnishee claims that this case is distinguishable, however, because the insurer involved in *Alyas* refused to defend the insured.

[**8] The *Alyas* court first reasoned that the settlement agreement did not release defendant from liability but that, instead, it merely limited the assets plaintiff could recover to insurance proceeds. Using this line of reasoning, plaintiff argues that the agreement in the instant case did not relieve defendant of liability but merely created a separate contract in which plaintiff agreed not to execute judgment against certain assets. According to plaintiff, while defendant may sue for breach of contract if plaintiff fails to abide by this clause, the contract does not relieve defendant of liability.

The *Alyas* court, however, gave other reasons for its decision. The court discussed [*421] *Sargent v. Johnson,* [5] an Eighth Circuit case which held that an insurer had no obligation to pay insurance when an insured entered a settlement agreement which relieved the insured from any obligation and placed all obligation on the insurer. The *Alyas* court noted that the case before it was distinguishable because *Sargent* concerned the bad faith of the insured while the case before it concerned the bad faith of the insurer. This reasoning indicates that the enforceability of settlement [**9] agreements turns on an examination of whether or not the parties have acted in good faith or bad faith.

After closely reading the case, the Court interprets *Alyas* to be based primarily on the first rationale discussed by the court. The Court finds that the case turns on the fact that the settlement agreement was not a release from liability but a separate contract limiting the assets which could be collected. The court finds that *Sargent* does not apply Michigan law and that *Alyas* should be followed. The Court therefore grants plaintiff's motion for summary judgment to the extent that it asks the Court to declare this defense insufficient.

B.

Garnishee also claims that no coverage exists because various provisions in the insurance policy preclude coverage in situations in which the insured reaches a settlement without the insurer's consent. Garnishee claims that the settlement agreement [**10] was executed in violation of § 4, P 2(c), (d) and § *4 P 3* of the Insurance Policy. These paragraphs read as follows:

2. Duties in the Event of Occurrence, Claim or Suit.

. . . .

c. You and any other involved insured must

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[4] *HN3*[↑] A federal court sitting in diversity must apply the law of the state in which it sits, including that state's choice of law principles. *Klaxon Co. v. Stentor Electric Mfg. Co., 313 U.S. 487, 85 L. Ed. 1477, 61 S. Ct. 1020 (1941)*. This Court is confident that the Michigan court would apply Michigan law to resolve this case. The parties have also assumed that Michigan law applies.

[5] *Sargent v. Johnson, 551 F.2d 221 (8th Cir. 1977)*. The case applied Minnesota law.

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(1) Immediately send us copies of any demands, notices, summonses or legal papers received in connection with the claim or "suit";
(2) Authorize us to obtain records and other information;
(3) Cooperate with us in the investigation, settlement or defense of the claim or "suit" and
(4) Assist us, upon our request, in the enforcement of any right against any person or organization which may be liable to the insured because of injury or damage to which this insurance may also apply.

d. No insured will, except at their own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent.

3. Legal Action Against Us.

No person or organization has a right under this Coverage Part:

a. To join us as a party or otherwise bring us into a "suit" asking for damages from an insured; or

b. To sue us on this Coverage Part unless all of its terms have been [**11] fully complied with.

A person or organization may sue us to recover on an agreed settlement or on a final judgment against an insured obtained after an actual trial. . . . An agreed settlement means a settlement and release of liability signed by us, the insured and the claimant or the claimant's legal representative.

Insurance Policy, Garnishee's Motion for Summary Judgment, Exhibit 1, § *4 P 2*(c), (d) and § *4 P 3*.

The Court finds that there was no violation of paragraphs 2(d) or 3 of the Insurance Policy and that there is a question of fact as to whether there was a violation of paragraph 2(c). Paragraph 2(d) was clearly not violated because it requires only that the insured not voluntarily make a payment, assume any legal obligation, or incur expense without the consent of the insurer. Defendant did *not* assume a legal obligation to pay any damages to plaintiff through the settlement agreement. The agreement *relieved* defendant of same liability and directed plaintiff as to the assets that could be collected *in the event* defendant was later found to be liable. The agreement did not compel [*422] defendant or [**12] garnishee to make any payment or incur any expense nor did it obligate defendant or garnishee to pay the plaintiff anything. Therefore, it did not violate section 2(d) of the insurance policy. [6]

Garnishee states that under paragraph 3, it can only be sued to recover on "an agreed upon settlement" or a "final judgment." Because an agreed upon settlement is defined as one in which the insurer participates, garnishee argues that the insured cannot recover based upon the settlement. The Court agrees with garnishee's logic, and if the settlement agreement were the basis of the obligation, this paragraph would prevent coverage. A final judgment of a court, however, not the settlement agreement, forms the basis of the judgment that garnishee is being asked to pay. The provision, therefore, does not prohibit garnishee's liability.

There is a question of fact as to whether paragraph 2(c)(3) was violated. This provision requires that [**13] the insured cooperate with the insurer in defending a claim. Garnishee argues that after entering the settlement agreement defendant lost all incentive to help garnishee prepare a defense and that defendant's refusal to cooperate relieves it of liability. Garnishee has presented no proof, however, of defendant's lack of cooperation. Furthermore, under Michigan law, *HN4*[↑] the insurer must show that the insured's lack of compliance materially injured its ability to contest the merits of the claims. *Anderson v. Kemper Insurance Co., 128 Mich. App. 249, 253-54, 340 N.W.2d 87, 90 (1983)*. The question of prejudice is one of fact which is best left far resolution by a jury. Because a question of fact exists as to whether the cooperation clause was violated, the Court denies both plaintiff's and defendant's motion for summary judgment on this issue.

C.

Garnishee maintains that the settlement agreement violates paragraph E of the "Common Policy Conditions" section of the insurance policy. According to garnishee, the settlement agreement constituted the assignment of the insurance policy which is expressly forbidden by paragraph E of the document. [**14] Paragraph E refers to

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[6] This factor also distinguishes the case from the case authority cited by plaintiff.

premiums, and the Court sees nothing in the section prohibiting assignment or transfer of the policy. Paragraph F of the "Common Policy Conditions" document does prohibit the transfer of rights and duties under the policy without the insurer's written consent except in the case of death of an individual named insured. [7]

Garnishee relies on Employers Mutual v. Michigan Mutual, 101 Mich. App. 697, 300 N.W.2d 682 (1980), for the proposition that the assignment of a right in violation of an anti-assignment clause in an insurance policy voids coverage. Plaintiff points out, however, that *Employers* is distinguishable from the instant case because in *Employers* [**15] the insured property was transferred prior to the loss the insurance covered. The case is also distinguishable because the policy's prohibition was far more clear and unambiguous than that contained in the instant policy. The policy in *Employers* specifically stated that the insurance "shall be void" in case either the policy or the insured interest is "sold, assigned, transferred or pledged without the previous consent in writing of the company." The clause at issue in this case does not contain language making the insurance void [8] nor does it specifically mention assignment.

Plaintiff also cites Section 792 of Volume 43 of *American Jurisprudence*, Second Edition, for the proposition that such general stipulations prohibiting assignment without the insurer's consent apply only to assignments before loss and not against assignment after loss. The cited paragraph notes that a provision against [**16] assignment after loss is null [*423] and void as inconsistent with the covenant of indemnity and contrary to public policy. 43 Am. Jur. 2d Insurance § 792 (1982). *See also* Roger Williams Insurance Company v. Carrington, 43 Mich. 252, 5 N.W. 303 (1880) (invalidating a provision which required forfeiture of a policy for post-lost assignment without consent of the insurer.)

Because the clause at issue is itself ambiguous and because there is a strong public policy in favor of assignment of such contract rights, the court holds that paragraph F of the "Common Policy Conditions" prohibits only transfer and assignment of a right prior to loss and does not prohibit assignment of an accrued cause of action. Plaintiff's motion for summary judgment is granted to the extent that it asks that the court find that the defense of assignment of the insurance policy does not bar coverage.

V.

Garnishee asserts several arguments as to why various exclusions contained in its policy prohibit garnishment. The Court discusses each in turn. When interpreting the insurance policy at issue, the Court bears in mind that Michigan courts have held "(1) that HN5[↑] an ambiguous contract provision [**17] must be construed against the insurer and in favor of the insured, and (2) that exclusionary clauses in insurance policies are to be strictly construed against the insurer" Farm Bureau Mutual Ins. Co. v. Stark, 437 Mich. 175, 181, 468 N.W.2d 498, 501 (1991). If the meaning of terms used in the contract are clear and unambiguous, however, their terms are "to be taken and understood in their plain, ordinary, and popular sense." *Id.* (internal citations omitted).

A.

Garnishee claims that it is released from liability through an "absolute pollution exclusion" endorsement which was contained in all three policies it issued to defendant. That exclusion reads as follows:

F. This insurance does not apply to:
(1) "bodily injury" or "property damage" arising out of the actual, alleged or threatened discharge, dispersal, release or escape of pollutants;
(a) at or from premises you own, rent or occupy;
(b) at or from any site or location used by or for you or others for the handling, storage, disposal, processing or treatment of waste material;

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[7] In addition to the arguments discussed below, plaintiff maintains that no assignment was made in the settlement agreement because the agreement merely promises that an assignment will be made at a future time. Plaintiff argues that such a promise is distinguishable from an assignment itself.

[8] The document does state that "All Coverage Parts included in this policy are subject to the following conditions."

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(c) which are at any time transported, handled, stored, treated, disposed of, or [**18] processed as waste by or for you or any person or organization for whom you may be legally responsible; or

(d) at or from any site or location on which you or any contractors or subcontractors working directly or indirectly on your behalf are performing operations

(i) to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize pollutants

(ii) if the pollutants are brought on or to the site or location by or for you,

The word "pollutants" as used herein means any solid, liquid, gaseous or thermal irritants or contaminants, including smoke, vapor, soot, fumes, acids, biological elements and agents, and visual esthetics, the presence of any or all which (sic) adversely affects human health or welfare, unfavorably alters ecological balances of importance to human life, adversely affects other species of importance to mankind, or degrades the vitality of the environment for esthetic, cultural, and/or historical purposes.

The word "waste material" as used herein means materials which are intended to be or have been recycled, reconditioned or reclaimed.

Insurance Policy, Garnishee's Motion for Summary Judgment, Exhibit 1, UC-253(9-87) § F.

Garnishee appears [**19] to rely on sections F(1)(d)(i) and F(2) of the exclusion agreement. The Court finds that section F(2) is clearly inapplicable because there is no evidence that the government ever directed defendant [*424] to take any action whatsoever with regard to the pollutants. [9]

Plaintiff argues that section F(1)(d)(i) does not apply because the issue before the jury in the state suit involved only damages arising from leaks or discharges of fuel from equipment on which Larson performed defective work and that the jury [**20] was told not to award damages based upon the cleanup of contamination which was on the sites prior to the contract. [10] [**21] Plaintiff maintains that any claims against defendant based upon improper cleanup were dismissed prior to the trial and are not the subject of the present garnishment action. Plaintiff asserts that the work at issue in the state action was unrelated to testing and cleanup of pollutants and does not fall within the scope of F(1)(d)(i). Plaintiff supports this position by quoting the instructions given to the jury. *Oscar W. Larson v. Action Auto Stores, Inc.*, 88-61169-CK, Trial Transcript at 92-93 (Ingham County Cir. Ct. June 7, 1990). While garnishee provides evidence that defendant's cleanup efforts were mentioned at trial, it sets forth no evidence showing that the jury considered any claims for testing, cleaning up, monitoring, etc., of pollutants. The Court thus cannot grant garnishee's motion for summary judgment based upon this exclusion. [11] Plaintiff's motion for summary judgment, however, is granted to the extent that it asks the Court to find this defense to garnishment to be invalid.

B.

Garnishee maintains that exclusion 2(j)(5) negates its duty to pay. Plaintiff claims that garnishee is estopped from asserting this defense because it was not mentioned until its second "reservation of rights" letter. Plaintiff relies primarily upon *Meirthew v. Last, 376 Mich. 33, 135 N.W.2d 353 (1965)*. *Meirthew* held that an insurer could not rely on a general reservation of rights letter to claim that it had no duty to pay after it had defended the insured in an action. *Meirthew* is distinguishable [**22] from the case *sub judice* because the insurance company did not give

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[9] Garnishee notes that if the government *had* ordered defendant to clean the pollutants, it would not have to pay for such costs. Garnishee argues that plaintiff is seeking to get reimbursement for costs for which it is liable as an owner under the same statutes, therefore it should not have to pay the costs. The Court finds such an argument unpersuasive as the language of the contract limits the application of section F(2) to situations in which the *insured* is ordered to conduct cleanup by the government.

[10] Garnishee has filed a separate summary judgment motion in which it claims that this same pollution exclusion policy applies to exclude money awarded to plaintiff through the default judgment entered against defendant in state court. Plaintiff's time for responding to this motion has not yet expired, so the Court does not address it at this time.

[11] Garnishee may be attempting to argue that because Larson was hired to install equipment to "contain gasoline," (see Garnishee's Brief in Support of its Motion for Summary Judgment at 17), it was performing operations relating to containment of pollution. The court, however, agrees with plaintiff's analysis that the gasoline was not a pollutant nor was it considered a pollutant while it was in the container. The primary purpose for installing the system was to promote consumer use of gasoline, not to remedy a pollution problem.

notice of the particular exclusion it intended to rely upon until garnishment proceedings. In this case, garnishee gave a detailed notice stating that it intended to rely on provision 2(j)(5) two months in advance of trial. There is no evidence that garnishee knew that it would rely on this exclusion earlier or that it delayed in informing defendant of its intent. In addition, eight months before trial it provided a general reservation of rights letter which at least put defendant on notice that the insurer might contest coverage. There is no evidence that defendant suffered prejudice from garnishee's actions. The Court therefore holds that the defense was not waived.

Plaintiff asserts that exclusion 2(j)(5) should not apply by its own terms as defendant was not performing operations *on* the real property that was damaged. Exclusion 2(j)(5) states:

2. This insurance does not apply to:

. . . .

j. "Property damage" to:

. . . .

[*425] (5) That particular part of real property on which you or any contractors or subcontractors working directly or indirectly on your behalf are performing operations, if the **[**23]** "property damage" arises out of those operations;

Insurance Policy, Garnishee's Brief in Support of its Motion for Summary Judgment, Exhibit 1, § 1 P 2(j)(5).

Plaintiff claims that Larson was only performing operations "on" dispensers, pipes, and related products. It argues that the exclusion was designed to cover damages to such items which may constitute fixtures, and therefore real property, when installed on real property. Plaintiff claims that the exclusion is not meant to refer to the surrounding property which was polluted.

Garnishee claims that Larson performed operations on the polluted property in question by physically digging the real property to install the gasoline containment equipment. Garnishee argues that the narrow reading of the clause suggested by plaintiff renders the clause nonsensical as other exclusions in the contract already exclude damage done to the insured's product and materials.

The Court does not read the exclusion provision as narrowly as plaintiff, and it holds that the exclusion prevents coverage for damage done to land or other property that defendant physically worked on. However, the facts presented do not **[**24]** reveal whether all of the property damage at issue was done to such land. The Court finds that this issue should be more fully addressed by the parties. [12] Specifically, the parties should inform the Court of what property was found to be polluted in the state action and of the type of work performed "on" such property. At this time, both plaintiff's and garnishee's motions for summary judgment must be denied.

C.

Garnishee contends that exclusion 2(m) also precludes its duty to provide coverage That exclusion reads:

2. The insurance does not apply to:

. . . .

m. property damage to "impaired property" or property that has not been physically injured, arising out of:

(1) A defect, deficiency, inadequacy or dangerous condition in "your product" or "your work"; or

(2) A delay or failure **[**25]** by you or anyone acting on your behalf to perform a contract or agreement in accordance with its terms.

This exclusion does not apply to the loss of use of other property arising out of sudden and accidental physical injury to "your product" or "your work" after it has been put to its intended use.

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[12] Plaintiff also asserts that the exclusion does not apply because it is limited to damage which occurs at the time work is being performed. The Court holds that this issue should also be re-briefed by the parties.

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Insurance Policy, Garnishee's Brief in Support of its Motion for Summary Judgment, Exhibit 1, § 1 P 2(m).

Impaired property is defined as follows:

5. "Impaired property" means tangible property, other than "your product" or "your work," that cannot be used or is less useful because:

a. It incorporates "your product" or "your work" that is known or thought to be defective, deficient, inadequate or dangerous; or

b. You have failed to fulfill the terms of a contract or agreement;

if such property can be restored to use by:

a. The repair, replacement, adjustment or removal of "your product" or "your work"; or

b. Your fulfilling the terms of the contract or agreement,

Insurance Policy, Garnishee's Brief in Support of its Motion for Summary Judgment, Exhibit 1, § 5 P 5.

Plaintiff argues that this **[**26]** exclusion is inapplicable because the property at issue cannot be restored to use by repair, replacement, adjustment, or removal of the containment **[*426]** system. [13] Garnishee relies upon *Reliance Insurance Co. v. Mogavero* [14] in which the federal court for the District of Maryland found that a similar exclusion prohibited coverage for property damage caused by defective construction work performed by the insured. While the allegation against the insured in *Mogavero* was similarly for breach of contract and breach of warranty, the exclusion in that case was not identical to the one at issue here. Significantly, it did not limit the exclusion to impaired property defined as property that can be restored to use by the repair, replacement, adjustment, or removal of the insured's product or work or the insured's fulfilling the terms of the contract or agreement. Therefore, the Court declines to adopt the *Mogavero* court's holding.

[27]** The Court finds that no evidence has been presented that any damage done to property surrounding the containment system can be remedied by the repair, replacement, or adjustment of defendant's work product. Furthermore, such a result is illogical as any pollution done to surrounding property could not possibly be remedied or rectified by the removal of the defective work product. Garnishee's motion for summary judgment must therefore be denied on this issue. Plaintiff's motion is granted to the extent that it asks that the Court hold this defense to be invalid.

D.

Garnishee also contends that the exclusionary provision contained in section 2(n) precludes coverage. Section 2(n) states:

2. This insurance does not apply to:

. . . .

n. Damages claimed for any loss, cost or expense incurred by you or others for the loss of use, withdrawal, recall, inspection, repair, replacement, adjustment, removal or disposal of:

(1) "Your product";

(2) "Your work"; or

(3) "Impaired property";

if such product, work, or property is withdrawn or recalled from the market or from use by any person or organization because of a known or suspected defect, deficiency, inadequacy or dangerous **[**28]** condition in it.

Insurance Policy, Garnishee's Brief in Support of its Motion for Summary Judgment, Exhibit 1, § 1 P 2(n).

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[13] None of the subsequent briefs filed by garnishee address this exclusion.

[14] Reliance Insurance Co. v. Mogavero, 640 F. Supp. 84 (D. Md. 1986).

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Garnishee contends that this provision applies because polluted property had to be removed because of a defect in said property caused by defendant's product. Plaintiff responds that paragraph 2(n) applies only to products, work, or property that is taken out of the market or out of use because of withdrawal or recall. Plaintiff maintains that the exclusion is referred to as the "sistership" exclusion because it arises from the recall of a group of airplanes when one of its "sister" ships evidenced a structural defect.

Plaintiff cites Honeycomb Systems, Inc. v. Admiral Insurance Company, 567 F. Supp. 1400, 1406-07 (D. Me. 1983). In *Honeycomb*, the District of Maine cites multiple district cases and an insurance treatise to conclude that a similar provision was designed "to limit the insurer's exposure in cases where, because of the actual failure of the insured's product, similar products are withdrawn from use to prevent the failure of those other products, which have not yet failed." Id. at 1406. **[**29]** It concluded that the rationale behind the exclusion was to prevent the insurer from being saddled with the cost of preventing other failures. *Id.*

The Court finds that plaintiff's reading of the exclusion is more logical than garnishee's. In addition to relying on the analysis done in the *Honeycomb* case, the Court notes that the language of the exclusion itself does not support garnishee's reading of the clause. The exclusion refers to "withdrawal from the market or from use." This language does not encompass the removal of polluted earth from the work site. Garnishee's motion for summary judgment cannot be granted based upon this exclusion. Plaintiff's motion for summary judgment is granted to the extent **[*427]** that it asks this Court to find the defense to be invalid.

E.

Plaintiff's motion for summary judgment asks that this Court find invalid several other defenses based upon specific exclusions in the policy. These defenses were raised by garnishee in its original garnishee disclosure statement. Specifically, plaintiff asks that the Court find invalid:

(1) the defense that United Capitol has no liability under its policies for "products completed operations hazard" **[**30]** (plaintiff's Motion for Summary Judgment at P C);
(2) the defense that coverage is barred by exclusion 2(g) of the Policy (plaintiff's Motion for Summary Judgment at P H);
(3) the defense that coverage is barred by exclusion 2(l) (Plaintiff's Motion for Summary Judgment at P I;
(4) the defense that coverage is barred by exclusion 2(b) (plaintiff's Motion for Summary Judgment at P K);
(5) the defense that there is no coverage due to late notice or lack of notice (plaintiff's Motion for Summary Judgment at P L); and
(6) the defense that there is no coverage under exclusion J(1) or J(6) of the insurance policy (Plaintiff's Motion for Summary Judgment at P B). [15]

Garnishee's reply to plaintiff's summary judgment **[**31]** motion does not respond to plaintiff's arguments about these exclusions. [16] While plaintiff has addressed each of the exclusions, they were not extensively briefed. After reading plaintiff's arguments and examining the exclusions of the policy on which they are based, the Court denies the motions based upon insufficient briefing. This is not a decision on the merits, and either party may submit a renewed summary judgment based upon these exclusions if the motion is accompanied by a more detailed brief.

Because garnishee has not used these exclusions as a basis for its own summary judgment motion and because it has not responded to the arguments plaintiff's summary judgment motion raises **[**32]** about the exclusions, the Court questions whether garnishee itself wishes to continue to rely upon these defenses. Garnishee is urged to

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[15] Paragraph B of plaintiff's motion for summary judgment refers to exclusion J of the insurance policy. The Court has addressed exclusion J(5) of the Policy and found that the issue should be further briefed by the parties. The Court did not address exclusions J(1) or J(6) in its Opinion.

[16] Garnishee does address the "products complete operations hazard" clause in its reply brief. Garnishee states that any coverage plaintiff had under this section is negated by the Absolute Pollution Exclusion Endorsement. Garnishee should reconsider its position in light of the Court's decision with regard to that exclusion.

reassess it position regarding these defenses and, if it no longer wishes to rely upon them, it is urged to inform the Court through stipulation or motion that it will withdraw any defense based upon such exclusions.

VI.

In its brief in response to plaintiff's motion for summary judgment, garnishee contends that there is no coverage under the insurance policies at issue because of the "loss in progress" doctrine and the "known risk" doctrine. Plaintiff argues that because its motion for summary judgment sought dismissal of certain defenses plead by garnishee, it is inappropriate at this time for garnishee to raise the question of coverage. Plaintiff argues that, at the very least, it should be allowed more time and space to fully brief the issues. The Court determines that while this argument may well be the appropriate subject of a summary judgment motion brought by garnishee, it is not properly raised in a responsive brief. [17] The Court therefore declines to address the issue at this time. The Court makes clear that this is not a decision **[**33]** on the merits, and, as the issue may well be dispositive to the case, it allows garnishee time to **[*428]** file another summary judgment motion addressing the issue.

VII.

Garnishee's motion for summary judgment requests that this Court find that it has no obligation to pay the judgment entered against defendant because such payment is prohibited because defendant entered a settlement agreement with plaintiff or because various exclusions in the insurance policy prohibit coverage. For the reasons stated above, garnishee's motion must be denied. Also for the reasons stated above, plaintiff's motion is granted in part and denied in part.

BENJAMIN F. GIBSON

U.S. DISTRICT JUDGE

DATED: February 8, 1993

ORDER

At a session of the **[**34]** Court held in and for said District and Division, in the City of Grand Rapids, Michigan, this 8th day of February, 1993.

PRESENT: HON. BENJAMIN F. GIBSON, U.S. DISTRICT JUDGE

In accordance with the Opinion dated February 8, 1993,

IT IS HEREBY ORDERED that garnishee United Capitol Insurance Company's motion for summary judgment (pleading no. 33) is HEREBY DENIED.

IT IS FURTHER ORDERED that plaintiff Action Auto Stores' motion for summary judgment (pleading no. 35) is hereby GRANTED IN PART and DENIED IN PART.

IT IS FURTHER ORDERED that the parties shall have thirty (30) days to file renewed motions for summary judgment briefing the issues that the Court has indicated in its Opinion should be addressed.

IT IS FURTHER ORDERED that the times for filing responsive pleadings shall be governed by Rule 29 of the Western District of Michigan's Local Court Rules.

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[17] Plaintiff also contends that the issue is improperly raised because the defense was not contained in garnishee's garnishee disclosure statement. Garnishee has since filed a motion to amend the garnishee disclosure statement, and the Court determines that said motion should be granted.

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IT IS FURTHER ORDERED that garnishee United Capitol Insurance Company's motion (pleading no. 45) to file an amended garnishee disclosure statement adding the defenses based upon the "Loss in Progress" and "Known Risk Doctrines" is GRANTED.

IT IS SO ORDERED,

BENJAMIN F. GIBSON

U.S. DISTRICT JUDGE

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EXHIBIT 8

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Labar v. Cooper

Supreme Court of Michigan

June 10, 1965, Submitted ; October 4, 1965, Decided

Docket Nos. 50,884, 50,885

Reporter
376 Mich. 401 *; 137 N.W.2d 136 **; 1965 Mich. LEXIS 232 ***

LaBAR v. COOPER

Prior History: [***1] Appeal from Van Buren; Anderson (David J.), J.

Disposition: Reversed and remanded.

Core Terms

amend, original pleading, limitations, cases, arm, court rule, shot, trial judge, set forth, cause of action, occurrence, deceased, injected, motions, upper

Case Summary

Procedural Posture
Appellants, patient and her husband, sought review of a judgment from the trial court (Michigan) which denied their motion to amend the pleadings of their complaint in order to charge respondent doctor with general negligence.

Overview
The patient was injured when she was administered an intermuscular shot in the upper arm, which allegedly damaged her radial nerve. The patient and her husband sued the doctor for medical malpractice. They brought a motion to amend their complaint, primarily to charge the doctor with general acts of negligence in sending the patient to the hospital when he knew the standard of care employed by the nurses was faulty and that the shots were administered by them in a dangerous place. The trial court denied the motions. On appeal the court held that the amendment was not barred by the running of the statute of limitations because the new charge arose out of the conduct, transaction, or occurrence alleged in the original pleading. The court was unable to ascertain whether the trial judge exercised his discretion properly in denying the motion and remanded the case for further disposition, stating that the exercise of discretion should be supported by specific findings.

Outcome
The court ruled against the doctor and remanded the patient and husband's motion to amend the pleadings of their medical malpractice case to the trial court.

LexisNexis® Headnotes

376 Mich. 401, *401; 137 N.W.2d 136, **136; 1965 Mich. LEXIS 232, ***1

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Leave of Court

Civil Procedure > Pleading & Practice > Pleadings > General Overview

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

HN1[] **Amendment of Pleadings, Leave of Court**

Mich. Gen. Ct. R. 118.1 read as follows: 1 Amendments. A party may amend his pleading once as a matter of course at any time before or within 15 days after a responsive pleading is served or, if the pleading is one to which no responsive pleading is required and the action has not been placed upon the trial calendar, he may amend it at any time before or within 15 days after it is served. Otherwise, a party may amend his pleading only by leave of court or by written consent of the adverse party. Leave shall be freely given when justice so requires. All amendments shall be filed in writing, dated, and numbered consecutively. Unless otherwise indicated therein, an amended pleading shall supersede the former pleading.

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Relation Back

HN2[] **Amendment of Pleadings, Relation Back**

Mich. Gen. Ct. R. 118.4 reads: 4 Relation Back of Amendments. Except for the purpose of demanding a trial by jury under sub-rule 508.2, the amendment relates back to the date of the original pleading whenever the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading.

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Relation Back

Governments > Legislation > Statute of Limitations > Time Limitations

Civil Procedure > Pleading & Practice > Pleadings > General Overview

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

Governments > Legislation > Statute of Limitations > General Overview

HN3[] **Amendment of Pleadings, Relation Back**

The relationship between the original pleading and a proposed amendment becomes important when the date of filing the amendment raises a question of limitations. The doctrine of relation back was devised by the courts to associate the amended matter with the date of the original pleading, so that it would not be barred by the statute of limitations. But some restrictions had to be placed upon the doctrine, or claims clearly barred could be resurrected by pleading them in an amendment to an unrelated claim which was not barred. Previous Michigan cases had set this restriction in terms of whether the amended matter involved a new cause of action.

Civil Procedure > ... > Affirmative Defenses > Statute of Limitations > Borrowing Statutes

Governments > Legislation > Statute of Limitations > General Overview

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Relation Back

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HN4[] **Statute of Limitations, Borrowing Statutes**
Mich. Gen. Ct. R. 118.4 is intended to introduce a more liberal and workable test, borrowed from the federal rules. The test is no longer conceptual, but rather functional. The amendment relates back to the date of the original pleading and, therefore, is not barred by limitations, whenever the claim or defense asserted in the amendment arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading. It is thus beside the point that the amendment introduces new facts, a new theory, or even a different cause of action, so long as it springs from the same transactional setting as that pleaded originally. The new test satisfies the basic policy of the statute of limitations, because the transactional base of the claim must still be pleaded before the statute runs, thereby giving defendant notice within the statutory period that he must be prepared to defend against all claims for relief arising out of that transaction.

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

HN5[] **Pleadings, Amendment of Pleadings**
Federal courts uniformly hold that amendments, which conform to Fed. R. Civ. P. 15, should be decided on their merits, not on technicalities.

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

HN6[] **Pleadings, Amendment of Pleadings**
An amendment which arises out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading is permitted under Mich. Gen. Ct. R. 118.4. The test, therefore, is no longer whether an amendment states a new cause of action, but is whether it arises out of the conduct, transaction, or occurrence alleged in the original pleading sought to be amended.

Headnotes/Syllabus

Headnotes

1. Pleading -- Amendment.

An amendment of a pleading relates back to the date of the original pleading whenever the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading, since the opposite party has been made aware of the claim sought to be enforced (GCR 1963, 118.1, 118.4).

2. Same -- Amendments.

Amendments to pleadings should be decided on their merits, not on technicalities (GCR 1963, 118.1, 118.4).

3. Courts -- Court Rules -- Amendment of Pleadings.

The new court rules apply to amendments sought to be made following the effective date of the rules, to pleadings filed before the effective date (GCR 1963, 14, 118.1, 118.4).

4. Pleading -- Amendment -- Malpractice.

Denial of amendments to plaintiffs' complaints in actions arising out of defendants' alleged malpractice *held,* improper, where they were based on the same transaction, and gave no occasion for claim of surprise, but merely

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sharpened the precise issue in order that defendants might know the legal theories upon which [***2] plaintiffs were proceeding (GCR 1963, 118.1, 118.4).

5. Same -- Amendment.

Amendments to pleadings shall be freely given when justice so requires (CLS 1961, § 600.2301; GCR 1963, 118).

6. Same -- Amendment -- Remand -- Discretion of Court.

Orders denying plaintiffs the right to amend their complaints in actions arising from defendants' alleged malpractice in injuring radial nerve in plaintiff wife's arm are reversed and case remanded with direction that if the amendments are again denied, such exercise of discretion be supported by specific findings as to reasons for such denial (GCR 1963, 118).

Syllabus

Declaration by Henry LaBar against Joseph E. Cooper and Kathleen Deja for alleged malpractice in the injection of plaintiff's wife's arm. Similar action by Lois LaBar. Plaintiffs' motions to amend declarations denied. Plaintiffs appeal.

Counsel: *Doyle, James & Dark*, for plaintiffs.

Howard & Howard (*William J. Howard*, of counsel), for defendants.

Judges: Adams, J. T. M. Kavanagh, C. J., and Dethmers, Kelly, Black, Souris, Smith, and O'Hara, JJ., concurred.

Opinion by: ADAMS

Opinion

[*402] [**137] These are husband and wife companion cases for alleged medical malpractice. [***3] The claim of injury to Mrs. LaBar arises out of an intermuscular shot which was administered July 30, 1960, [*403] in the upper arm, allegedly damaging the radial nerve.

Suits were begun March 27, 1962. Pretrial was completed January 17, 1963. The cases were ready at the November, 1963, term. Plaintiffs requested adjournment to the January, 1964, term which was granted upon stipulation.

The deposition of defendant Joseph E. Cooper was taken on May 16 and May 27, 1963. He testified:

> "Q. And Doctor, when you mention shots being given in the upper arm, where is the acceptable place in the upper arm for administering intermuscular shots?
>
> "A. Personally acceptable or medically acceptable?
>
> "Q. Medically acceptable.
>
> "A. Medically acceptable is usually in the upper half of the arm; mostly it is recommended if it must be given in or near the tip of the deltoid muscle. I personally do not adhere to this and haven't for many years. My training was to give intermuscular shot in the glutaneous area since it is much less apt to cause pain and discomfort and there's remote or slight chance of any nerve injury."

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He could not remember giving any orders as to [***4] where Mrs. LaBar was to receive the shot. Prior to when she was given it, he had expressed himself, time and again, to the nursing staff about the proper place for administering such a shot.

> "The reason for my mentioning it was that even in the doctors' offices in the area, this is, the upper arm is the popular spot to receive injections and having observed many many sore arms and lumps as the result of injections in this area and having been taught, where I was schooled, that this was not the proper or the best place to give them, I frequently expressed my opinion as I was taught [*404] and for the reason I've seen many sore arms, I could see no reason for it when the injection could go equally as well in the buttocks."

Before the doctor's deposition was taken, the plaintiffs' allegations of malpractice had consisted primarily of a charge that defendants negligently injected or caused to be injected a needle in Mrs. LaBar's arm which damaged the left radial nerve, causing nerve palsy and ensuing injuries.

Two weeks before the January, 1964, term was to begin, and some six months after Dr. Cooper was deposed, plaintiffs' attorneys moved to amend the declarations, primarily [***5] to charge Dr. Cooper with general [**138] acts of negligence in sending Mrs. LaBar to the hospital when he knew the standard of care employed by the nurses was faulty and that shots were administered by them in a dangerous place. The trial judge denied the motions and this Court granted leave to appeal.

I.

The trial judge stated:

> "Prior to filing the motions the statute of limitations, both as to malpractice and ordinary negligence, had run. Prior to the effective date of GCR 1963, the motion would have been denied, because of the running of the statute." [1]

HN1[↑] Michigan General Court Rules 118.1 and 118.4 read as follows:

> ".1 Amendments. A party may amend his pleading once as a matter of course at any time before or within 15 days after a responsive pleading is served or, if the pleading is one to which no responsive pleading is required and the action has not [*405] been placed upon the trial calendar, he [***6] may amend it at any time before or within 15 days after it is served. Otherwise, a party may amend his pleading only by leave of court or by written consent of the adverse party. *Leave shall be freely given when justice so requires.* All amendments shall be filed in writing, dated, and numbered consecutively. Unless otherwise indicated therein, an amended pleading shall supersede the former pleading." (Emphasis supplied.)
>
> HN2[↑] ".4 Relation Back of Amendments. Except for the purpose of demanding a trial by jury under sub-rule 508.2, the amendment relates back to the date of the original pleading *whenever the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading."* (Emphasis supplied.)

GCR 1963, 118 is an adoption of Federal Rule 15. The purpose of its adoption is stated by Honigman and Hawkins, 1 Michigan Court Rules Annotated, page 416:

> HN3[↑] "The relationship between the original pleading and a proposed amendment becomes important when the date of filing the amendment raises a question of limitations. The doctrine of 'relation back' was devised by the courts [***7] to associate the amended matter with the date of the original pleading, so that it would not be barred by the statute of limitations. But some restrictions had to be placed upon the doctrine, or claims clearly barred could be resurrected by pleading them in an amendment to an unrelated claim which was not barred. Previous Michigan cases had set this restriction in terms of whether the amended matter involved a new cause of action.

[1] CLS 1961, § 600.5805(3) (Stat Ann 1962 Rev § 27A.5805[3]). -- Reporter.

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HN4[↑] "Sub-rule 118.4 is intended to introduce a more liberal and workable test, borrowed from the Federal rules. See committee comment (5), *supra*. The test is no longer conceptual, but rather functional. **[*406]** The amendment relates back to the date of the original pleading and, therefore, is not barred by limitations, whenever the claim or defense asserted in the amendment arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading. *It is thus beside the point that the amendment introduces new facts, a new theory, or even a different cause of action, so long as it springs from the same transactional setting as that pleaded originally.* The new test satisfies the basic policy of the statute **[***8]** of limitations, because the transactional base of the claim must still be pleaded before the statute runs, thereby giving defendant notice within the statutory **[**139]** period that he must be prepared to defend against all claims for relief arising out of that transaction." (Emphasis supplied.)

Defendants place great stress upon their substantive rights by virtue of the statute of limitations, asserting that the Supreme Court lacks the power to change by court rule the substantive law. Mr. Justice Black, speaking for the United States Supreme Court, in the case of *Tiller v. Atlantic Coast Line Railroad Company (1945), 323 U.S. 574, 581 (65 S Ct 421, 89* L ed 465) said:

> "The original complaint in this case alleged a failure to provide a proper lookout for deceased, to give him proper warning of the approach of the train, to keep the head car properly lighted, to warn the deceased of an unprecedented and unexpected change in manner of shifting cars. The amended complaint charged the failure to have the locomotive properly lighted. Both of them related to the same general conduct, transaction and occurrence which involved the death of the deceased. There was therefore **[***9]** *no departure. The cause of action now, as it was in the beginning, is the same -- it is a suit to recover damages for the wrongful death of the deceased.* 'The effect of the amendment **[*407]** here was to facilitate a fair trial of the existing issues between plaintiff and defendant.' *Maty v. Grasselli Co., 303 U.S. 197, 201 (58 S Ct 507, 82* L ed 745). *There is no reason to apply a statute of limitations when, as here, the respondent has had notice from the beginning that petitioner was trying to enforce a claim against it because of the events leading up to the death of the deceased* in the respondent's yard." (Emphasis supplied.)

We adopt the above reasoning of the United States Supreme Court.

HN5[↑] Federal courts uniformly hold that amendments, which conform to *FRCP 15*, should be decided on their merits, not on technicalities. *Copeland Motor Co. v. General Motors Corp. (CA 5), 199 F2d 566, 567, 568*; *Cooper v. American Employers' Insurance Company (CA 6), 296 F2d 303, 306*. For a recent application of this rule, see *Link Aviation, Inc., v. Downs (1963), 117 App DC 40, 42 (325 F2d 613, 615)*, and the cases cited therein. See, also, the **[***10]** discussion in *United States v. Memphis Cotton Oil Co., 288 U.S. 62, 67-69 (53 S Ct 278, 77* L ed 619); 3 *Moore's Federal Practice, § 15.02[1]*, p 814; 1A Barron and Holtzoff, § 442, p 712.

Under prior decisions, before adoption of the General Court Rules of 1963, we have generally followed the rule that an amendment which states a new cause of action is barred. *Gorman v. Newaygo Circuit Judge, 27 Mich 138, 140*; *Michigan Central R. Co. v. Kalamazoo Circuit Judge, 35 Mich 227*; *Nugent v. Kent Circuit Judge, 93 Mich 462, 463*; *Wingert v. Wayne Circuit Judge, 101 Mich 395, 397*; *Bockoff v. Curtis, 241 Mich 553, 558*; *O'Rourke v. Deffenbaugh, 280 Mich 407, 414, 415*; *Talbot v. Stoller, 366 Mich 296, 301*. However, in adopting new court rules it was our intention to depart from some of the strictures of the old rule and to permit HN6[↑] an amendment which arises "out of the conduct, **[*408]** transaction, or occurrence set forth or attempted to be set forth in the original pleading." GCR 1963, 118.4. The test, therefore, is no longer whether an amendment states a new cause of action, but is whether it arises out of the conduct, transaction, **[***11]** or occurrence alleged in the original pleading sought to be amended. From the effective date of the new court rules, [2] the old rule cited in the cases immediately above was meant no longer to be followed. Accordingly, the new court rules govern in this case.

[140]** II.

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[2] See GCR 1963, 14. -- Reporter.

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If the amendments were not barred by the running of the statute of limitations, there remains the question of exercise of discretion by the trial judge. Defendants also opposed the motions on the ground that the cases had been pretried, placed on the calendar, and adjourned over one term at the request of the plaintiffs.

The trial judge stated:

> "Granting of the motions would require the allowance of additional time to defendants to answer, require further discovery depositions subjecting defendants to further expense in attending or participating or to peril of nonattendance, and the possibility of further delay through requests for further pretrial conference. The transaction occurred nearly 4 **[***12]** years ago. The case should be heard and disposed of before time dims further the memories of witnesses."

There is nothing in the record before us to support the judge's statement that further discovery depositions would be required. No such claim was made by counsel for either of the parties. It would appear that all medical witnesses had been deposed. Further **[*409]** pretrial would at best be summary and could be disposed of quickly. There can be no claim of surprise. The testimony upon which plaintiffs' new theory is based comes from defendant Cooper's own mouth. The amendments were based upon the same transaction as the original declaration. They merely sharpened the precise issue of malpractice or negligence in order that defendants might know the legal theories upon which plaintiffs were proceeding. From the record before us, no reason appears why the amendments could not have been allowed and the cases tried as scheduled.

It should always be borne in mind that GCR 1963, 118 provides that leave to amend shall be freely given when justice so requires, and that RJA § 2301 (CLS 1961, § 600.2301 [Stat Ann 1962 Rev § 27A.2301]) provides for amendment either in **[***13]** form or substance for the furtherance of justice.

While the conclusions upon which the trial judge based his exercise of discretion are before us, his findings are not. Consequently, we are unable to say whether he exercised his discretion properly. The cases are remanded to the trial judge for further disposition in the light of this opinion. In the event the motions are denied, such exercise of discretion should be supported by specific findings as to reasons for the same.

Reversed and remanded. Costs to appellants.

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EXHIBIT 9

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Grist v. Upjohn Co.

Court of Appeals of Michigan

January 18, 1965, Submitted Division Three ; April 19, 1965, Decided

Docket No. 238

Reporter
1 Mich. App. 72 *; 134 N.W.2d 358 **; 1965 Mich. App. LEXIS 185 ***

GRIST v. THE UPJOHN COMPANY

Subsequent History: [***1] Leave to Appeal Denied by Supreme Court July 1, 1965.

Prior History: Appeal from Kalamazoo; Fox (Raymond W.), J.

Disposition: Affirmed.

Core Terms

slander, amend, amended declaration, trial court, supplemental pleading, employees, statute of limitations, original declaration, cause of action, declaration, libel, original pleading, allegations, supplied, supplemental declaration, set forth, counts

Case Summary

Procedural Posture
Plaintiff employee sought review of the judgment of a trial court in Kalamazoo County (Michigan), which held that the employee's amended pleadings in her slander claim against defendants, employer and employees, was an amended declaration, and ordered the striking of certain statements in the pleading.

Overview
Originally, the employee filed a five count declaration, and in the first four counts, separately sued the employees for slander. In the fifth count, the employee alleged that the employees and the employer conspired together to use the claimed slanderous statements to destroy the employee's "good name." After several proceedings, the employer's motion to dismiss was granted, and the employee filed an amended pleading. The employee appealed from the judgment granting the employer's motion to strike portions of the amended pleading and for a more definite statement. On appeal, the court affirmed the judgment of the trial court. The court found that the employee's supplemental leading was properly treated as an amended declaration, because the employee did not obtain leave of the trial court to file a supplemental pleading. Therefore, the employee filed the pleading subject to the objections of the employer. The court found that the trial court properly granted the employer's motion for a more definite statement in order to eliminate the claimed slanderous acts that were not a proper basis for relief.

Outcome
The court affirmed the judgment of the trial court, which held that the employee's amended pleadings in her slander claim against the employer was an amended declaration, and ordered the striking of certain statements in the pleading.

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LexisNexis® Headnotes

Governments > Legislation > Statute of Limitations > Time Limitations

Torts > Intentional Torts > Defamation > Libel

Torts > ... > Defamation > Defenses > Statute of Limitations

Torts > Intentional Torts > Defamation > Slander

Torts > Procedural Matters > Statute of Limitations > General Overview

HN1[icon] **Statute of Limitations, Time Limitations**
The statutory provisions concerning limitation of personal actions provide in part: 5. Actions founded upon libel or slander shall be brought within one year from the time the cause of action accrues and not afterwards. Mich. Comp. Laws § 609.13 (1956); Mich. Stat. Ann § 27.605 (1959 Cum Supp.).

Civil Procedure > ... > Affirmative Defenses > Statute of Limitations > Revival

Governments > Legislation > Statute of Limitations > Extensions & Revivals

Torts > Intentional Torts > Defamation > General Overview

Governments > Legislation > Statute of Limitations > General Overview

Torts > ... > Defamation > Defenses > Statute of Limitations

Torts > Intentional Torts > Defamation > Libel

Torts > Intentional Torts > Defamation > Slander

Torts > Procedural Matters > Statute of Limitations > General Overview

HN2[icon] **Statute of Limitations, Revival**
The right of action accrues from the time of publication. The time within which an action for libel or slander must be commenced is usually fixed by statute, and there can be no legal trial of such an action while a plea by defendant of the statute of limitations remains unanswered and undisposed. The general rule is that the statute begins to run from the time when the defamation is published, even though the person defamed has no knowledge thereof until some time afterward; and this, it has been intimated, even though plaintiff's ignorance may be due to fraud on the part of defendant. Admissions or repetitions. When a right of action for slander has been once barred by the statute of limitations, it cannot be revived by an admission of defendant that he did utter the slanderous words, nor can the running of the statute be prevented by repetitions of the slander, although of course a separate action will lie for any repetition within the statutory time.

Governments > Legislation > Statute of Limitations > Time Limitations

Torts > Procedural Matters > Statute of Limitations > General Overview

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Governments > Legislation > Statute of Limitations > General Overview

Torts > ... > Defamation > Defenses > Statute of Limitations

Torts > Intentional Torts > Defamation > Slander

HN3[] **Statute of Limitations, Time Limitations**
Each act of slander is the basis for a separate action, but all such separate acts of slander may be joined in one declaration provided the statute of limitations has not run.

Governments > Legislation > Statute of Limitations > General Overview

Torts > Intentional Torts > Defamation > Libel

Torts > ... > Defamation > Defenses > Statute of Limitations

HN4[] **Legislation, Statute of Limitations**
With respect to so-called "black list" reports wherein an employer states his reasons for discharging a former employee, the view has been taken that if such a writing is exhibited to a third person at some time within the applicable limitation period prior to a commencement of a libel suit based on alleged defamatory matter appearing in the writing, there is a new and independent publication against which limitations then commence to run and the action may consequently be maintained, even though it appears that the statement was originally exhibited to some third person at a time which antedates the statutory period.

Civil Procedure > Pleading & Practice > Pleadings > Rule Application & Interpretation

Governments > Legislation > Statute of Limitations > Time Limitations

Torts > ... > Defamation > Defenses > Statute of Limitations

Governments > Legislation > Statute of Limitations > General Overview

Torts > Intentional Torts > Defamation > Slander

Torts > Procedural Matters > Statute of Limitations > General Overview

HN5[] **Pleadings, Rule Application & Interpretation**
Each act of slander constitutes a separate cause of action and the statute of limitations commences to run from the date of each such utterance. Separate acts of slander may be joined in the same pleading provided they all occur within the statutory period.

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Relation Back

Criminal Law & Procedure > ... > Warrantless Searches > Consent to Search > Sufficiency & Voluntariness

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Leave of Court

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Civil Procedure > Pleading & Practice > Pleadings > Supplemental Pleadings

HN6[] **Amendment of Pleadings, Relation Back**
Amended and supplemental pleadings are governed by Mich. Gen. Ct. R. 118.1, 118.4, and 118.5 (1963): 1 A party may amend his pleading once as a matter of course at any time before or within 15 days after a responsive pleading is served or, if the pleading is one to which no responsive pleading is required and the action has not been placed upon the trial calendar, he may amend it at any time before or within 15 days after it is served. Otherwise, a party may amend his pleading only by leave of court or by written consent of the adverse party. Leave shall be freely given when justice so requires. All amendments shall be filed in writing, dated, and numbered consecutively. Unless otherwise indicated therein, an amended pleading shall supersede the former pleading. 4 Except for the purpose of demanding a trial by jury under Mich. Gen. Ct. R. 508.2, the amendment relates back to the date of the original pleading whenever the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading.

Civil Procedure > Pleading & Practice > Pleadings > Supplemental Pleadings

HN7[] **Pleadings, Supplemental Pleadings**
Amended and supplemental pleadings are governed by Mich. Gen. Ct. R. 118.1, 118.4, and 118.5 (1963):Upon motion of a party the court may, upon reasonable notice and upon such terms as are just, permit him to serve a supplemental pleading to set forth any transactions or occurrences or events which have happened since the date of the pleading sought to be supplemented, whether or not the original pleading is defective in its statement of a claim for relief or defense. If the court deems it advisable that the adverse party plead thereto, it shall so order, specifying the time therefor.

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Relation Back

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

Civil Procedure > Pleading & Practice > Pleadings > Supplemental Pleadings

HN8[] **Amendment of Pleadings, Relation Back**
Mich. Gen. Ct. R. 118.4 (1963), permits the amendment to relate back to the date of the original pleading. However, there is no provision for relating back as to supplemental pleadings, Mich. Gen. Ct. R. 118.5 (1963). (6) Any transactions or occurrences arising after the original pleading may be set forth by supplemental pleading under this subsection. To preclude any hard and fast distinction between amended and supplemental pleadings, this subsection includes the proposed amendment to the federal rule which authorizes supplemental pleading whether or not the original pleading is defective. Thus a supplemental pleading which does present a valid statement of claim will allow the action to proceed, even if the original pleading remains defective for lack of amendment. Because there is no provision for relation back, a supplemental pleading based upon new facts must be filed before the statutory period of limitations has expired.

Civil Procedure > ... > Pleadings > Amendment of Pleadings > Leave of Court

Civil Procedure > ... > Pleadings > Amendment of Pleadings > General Overview

Civil Procedure > Pleading & Practice > Pleadings > Supplemental Pleadings

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HN9[] **Amendment of Pleadings, Leave of Court**

Under Mich. Ct. R. 72, § 1 (a) (1945), provides that the Supreme Court may exercise any or all of the procedures of amendment of the trial court.

Headnotes/Syllabus

Headnotes

1. Libel and Slander -- Limitation of Actions.

An action for libel or slander must be brought within 1 year from the time the cause of action accrues and not afterwards (CLS 1956, § 609.13).

2. Same -- Accrual of Cause of Action.

An action for libel or slander accrues from the time of publication (CLS 1956, § 609.13).

3. Same -- Limitation of Actions -- Trial on Merits.

There can be no legal trial on the merits of an action for libel or slander after a plea of the statute of limitations is interposed until after disposition of such plea (CLS 1956, § 609.13).

4. Same -- Limitation of Actions -- Admission.

A right of action for libel or slander cannot be revived by an admission of defendant after the statute of limitations has barred the action that he did utter the defamatory matter (CLS 1956, § 609.13).

5. Same -- Limitation of Actions -- Repetition.

The running of the statute of limitations as to a slander cannot be prevented by repetitions of the slander, although a separate action will lie for any repetition within the statutory time (CLS 1956, [***2] § 609.13).

6. Same -- Limitation of Actions -- Separate Acts.

Each slander is the basis for a separate action, but all such separate acts may be joined in 1 declaration provided the statute of limitations has not run (CLS 1956, § 609.13).

7. Same -- Limitation of Actions -- Separate Acts.

Separate acts of slander may be joined in the same pleading provided they all occur within the period before being barred by the statute of limitations (CLS 1956, § 609.13).

8. Pleading -- Amendment -- Leave of Court.

An amendment to a pleading following 15 days after a responsive pleading has been served may be made only by leave of court or by written consent of the adverse party (GCR 1963, 118.1).

9. Same -- Amendment.

An amendment of a pleading relates back to the date of the original pleading whenever the claim asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading (GCR 1963, 118.4).

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10. Same -- Supplemental Pleading.

A supplemental pleading may be permitted in order to set forth any transactions or occurrences or events which have happened since the date of the pleading sought to be supplemented, [***3] upon motion of the party who gives reasonable notice thereof and upon such terms as the court may impose (GCR 1963, 118.5).

11. Same -- Supplemental -- Relation Back.

The court rules do not provide for the relating back of a supplemental pleading to the date of the original pleading as is permitted to amendment of a pleading (GCR 1963, 118.4, 118.5).

12. Same -- Supplemental Pleading -- Limitation of Actions.

A supplemental pleading based upon new facts must be filed before the statutory period of limitations has expired (CLS 1956, § 609.13; GCR 1963, 118.5).

13. Same -- Amendment -- Libel and Slander Action.

Authorization by the Supreme Court to amend pleading, subject to the objections of defendant, accorded plaintiff in libel and slander action, did not accord her the right to file a supplemental pleading, hence, the pleading adopted pursuant to the authorization given must be treated as an amended declaration, subject to the objections of the defendant (GCR 1963, 118.4, 118.5).

14. Same -- Amendment -- Objections.

Supreme Court's authorization to plaintiff to amend her pleading, subject to objections of defendant, did not effectuate an estoppel upon defendant from objecting [***4] to plaintiff's pleading on the ground that it alleged subsequent matters for which leave of court had to be obtained, since the same source for authority to make the amendment also gave defendant the right to object to any matters contained in such amendment (Court Rule No 72, § 1 [a] [1945]).

15. Same -- Amendment -- More Definite Statement -- Limitation of Actions.

Amended declaration in libel and slander action was properly limited to acts of slander to which the pleaded statute of limitations could not be used as a bar, hence, it was not improper on the part of the court to require a more definite statement as to claimed acts of slander in order to advise defendant if the same were subject to the statute of limitations, subsequent acts being barred by such statute (CLS 1956, § 609.13; GCR 1963, 118.4, 118.5).

16. Costs -- Third Appeal -- Assessment.

Costs are awarded to defendant on third appeal by plaintiff, in action for libel and slander, where trial court's determination on defendant's motion for a more definite statement, to strike portions of amended declaration, and for accelerated judgment is affirmed and the cause remanded for further proceedings, but assessment [***5] of costs is to await determination on the merits.

Syllabus

Declaration by Arletta T. Grist against The Upjohn Company, a Michigan corporation, and others for alleged slander. From order granting motion to strike certain portion of declaration and to dismiss as to defendant corporation, plaintiff appeals.

Counsel: *Thomas S. Stearns* and *Hoffman, McDonald & Hoffman* (*Leo W. Hoffman*, of counsel), for plaintiff.

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Robert H. Hosick, Robert C. Carson, Murray D. Welch, Jr., Gerard Thomas, and *E. Raymond Stanhope* (*Ford, Kriekard & Brown*, of counsel), for defendant Upjohn Company.

Judges: Holbrook, J. Fitzgerald, P. J., and Burns, J., concurred.

Opinion by: HOLBROOK

Opinion

[*75] **[**359]** This is the third appeal [1] to be considered concerning the proceedings originally brought by Arletta T. Grist, plaintiff and appellant, against The Upjohn Company, a Michigan corporation, defendant and appellee, for alleged slander. The suit was commenced by summons being issued on December 5, 1957, with declaration being filed February 17, 1958.

[*6]** Plaintiff, Arletta T. Grist, claimed continuous employment with the defendant, Upjohn Company, from September 15, 1938, until April 5, 1957, upon which date she was dismissed.

Plaintiff employed a five count declaration, and in the first four counts, separately sued defendant's employees for slander. The fifth count alleged defendant employees together with defendant, Upjohn Company (The Upjohn Company being the fifth defendant) conspired together to employ the claimed slanderous statements of the defendant's employees for the purpose of "destroying plaintiff's good name".

Defendant Upjohn, being a corporation, moved to strike and for dismissal in its favor, assigning as the reason that the declaration contained no allegation that the alleged slanderous statements had been authorized or ratified by it. The trial court granted defendant Upjohn's motion relying on the rule of *Robertson v. New York Life* **[**360]** *Insurance Company (1945), 312 Mich 92*.

The order granting defendant Upjohn's motion was dated July 15, 1959. On August 7, 1959, plaintiff filed a "motion for rehearing" and an alternative motion for "leave to amend as to The Upjohn **[*76]** Company". On **[***7]** January 6, 1960, the trial court denied such last mentioned motion, basing its decision upon the *Robertson Case*, and ruling further that the proposed amendment offered after "the statute of limitations had now run," introduced a new, statute-barred cause. From the order granting defendant Upjohn's motion to dismiss, and from such order denying plaintiff's motion, plaintiff appealed to the Supreme Court.

This appeal was considered in the case of *Grist v. The Upjohn Company (1961), 362 Mich 470*, and on p 472, of said opinion the Court stated:

> "The motion to dismiss was granted on authority of applicable law as same stood when that motion and the subsequent motion were decided against plaintiff's pleaded right of action. However, after plaintiff's appendix and both briefs on appeal were filed here, the rule of *Robertson* -- on which Judge Fox properly relied -- was overruled by *Poledna v. Bendix Aviation Corp., 360 Mich 129, 140*. In these circumstances fairness suggests remand, rather than reversal, in order that the trial judge may reconsider in *Poledna's* light defendant Upjohn's motion to dismiss."

Thereafter, plaintiff filed a motion to amend together **[***8]** with the proposed amended declaration on May 19, 1961. On May 23, 1961, the action against the individual defendants (employees of defendant) was dismissed by stipulation. The trial court postponed the hearing, on plaintiff's motion "to amend" until after the court's decision on the defendant's "motion to dismiss". The trial court then took defendant's original motion to dismiss under advisement. On August 4, 1961, opinion granting defendant's original motion was filed. The trial court held that "even in *Poledna's* light," plaintiff did not state a cause of action because she "fails to allege that the slanderous

[1] For prior appeals see *362 Mich 470* and *368 Mich 578*. -- Reporter.

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remarks were made in the discharge [*77] of the duty of the employees or in relation to a matter about which their duty permitted or required them to act".

Order granting motion to dismiss was filed August 14, 1961. Hearing on plaintiff's motion for leave to amend was held on August 31, 1961. On the same day, plaintiff took an appeal from the trial judge's order granting the defendant's motion to dismiss. On November 29, 1961, the trial judge ruled that because the plaintiff had appealed, the circuit court lacked jurisdiction to consider motion to amend.

[***9] This appeal was considered in the case of *Grist v. The Upjohn Company (1962), 368 Mich 578*, wherein Mr. Justice Adams stated on pp 581-585:

"The first question to be considered is whether or not the plaintiff's original declaration states a cause of action against Upjohn. Count 5 of plaintiff's original declaration alleges:

"'Defendant Margery White was employed in the personnel department of the defendant Upjohn Company and it was a part of her duties as such employee to consider the work and conduct of plaintiff and other women employees, to inform her superiors thereof and to handle matters pertaining thereto, and to the discharges of any woman employee, including inquiries regarding previous employees.' * * *

"Count 1 alleges that defendant White falsely stated to various persons that the plaintiff was a poor worker, was guilty of a great deal of absenteeism and that she sold or delivered eggs on company time. It is alleged that when plaintiff applied for work with other companies an inquiry was made about plaintiff to defendant [**361] White, defendant White falsely stated that plaintiff was discharged because she had an unsatisfactory attendance record and [***10] poor performance record. Counts 2, 3, and 4 allege that the other individual defendants made the [*78] same false statements about plaintiff, resulting in her being unable to obtain employment in the Kalamazoo area.

"Are these allegations sufficient to come under the rule of *Poledna?* It is as follows (pp 139, 140):

"'A corporation may be held liable for slander uttered by an agent while in the discharge of his duty as agent and in relation to the matter about which his duty as agent permits or requires him to act in the same way and to the same extent as an individual could be held liable for the same slander.'

"The allegations of count 5 of plaintiff's declaration in effect allege that each of the individual defendants was an employee of Upjohn, was in some sort of supervisory capacity over plaintiff and was responsible for assessing the work and performance of plaintiff. It is then alleged that for the purpose of destroying plaintiff's good name and reputation, and preventing her from obtaining employment or damaging her in her attempts to obtain employment, they made false assessments of her work performances, causing her discharge, and that defendant White directly [***11] and in her capacity as an employee of Upjohn made representations to other possible employers that prevented plaintiff from securing employment. There has been alleged a direct causal connection by the agents of Upjohn acting in discharge of their duties as such agents or employees with the damage to plaintiff. It was therefore erroneous of the trial court to grant the defendant's motion to dismiss.

"As to the 2 attempts which were made by plaintiff to amend, it will be recalled that the first of these was made prior to the first appeal to this Court. * * *

"Plaintiff alleges therein that the slanderous statements of Upjohn's employees were 'expressly' authorized or 'ratified' by Upjohn. Express authorization or ratification was not alleged in the original declaration. The evidence necessary to support the original declaration and that to support [*79] the amended declaration would not be the same. 'The amendment represented a change in plaintiff's theory and amounted to introducing a new cause of action'. *Cook v. Wolverine Stockyards Co., 344 Mich 207, 210*. The trial court did not abuse its discretion in denying plaintiff's motion to amend.

"Finally, what is [***12] the present status of the second attempt to amend the declaration which was noticed for hearing on August 31, 1961, the same day the court heard the defendant's motion to dismiss? * * * The trial court lost jurisdiction to rule on the motion to amend when the second appeal was taken to this Court. However, in view of the ruling of this Court at this time, *plaintiff may now, if she chooses, amend as a matter of right, subject, of course, to objection to the contents of the amendment by defendant.*

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"Remanded. Costs to plaintiff." (Emphasis supplied.)

The proceedings were again returned to the trial court for further action. Plaintiff elected, pursuant to the order of the Supreme Court by notice filed in the trial court on February 18, 1963, "to stand upon her *amended declaration* heretofore filed herein May 19, 1961". (Emphasis supplied.)

Thereafter, defendant, The Upjohn Company, filed on March 6, 1963, a motion for **[**362]** more definite statement, to strike portions of amended declaration and for accelerated judgment.

The trial judge, Honorable Raymond W. Fox, circuit judge, ruled on said motion and granted the motion to strike portions of the amended declaration **[***13]** in part, denied the motion for accelerated judgment and granted the motion for more definite statement.

The order of the court in accordance with the opinion was filed November 7, 1963. In said order, the trial court held that plaintiff's amended pleading of May 19, 1961, was an *amended declaration* **[*80]** and ordered the striking of all allegations alleging slanderous statements and acts of interference with plaintiff's employment occurring after the date of filing of the original declaration, and required plaintiff to allege specifically, instead of generally, slanderous statements and acts of interference with plaintiff's employment as to persons performing such acts, and time when such statements and acts occurred. From this order the plaintiff and appellant has appealed to this Court claiming: (1) The court erred in holding and ruling that plaintiff's pleading was an amended declaration, instead of an amended and supplemental declaration; (2) defendant waived its objection, and is estopped now from objecting to plaintiff's pleading on the ground that it alleged subsequent matters and it was necessary to obtain leave of court; (3) regardless of whether plaintiff's amendment **[***14]** be considered an amended declaration, a supplemental declaration, or an amended and supplemental declaration, it properly pleaded plaintiff's case; (4) plaintiff's pleading was not defective for uncertainty.

This Court deems it imperative to consider the law concerning libel and slander insofar as limitation of actions are concerned in dealing with the objections of the plaintiff to the trial court's order of November 7, 1963.

HN1[↑] The statutory provisions concerning limitation of personal actions provide in part:

"5. Actions founded upon libel or slander shall be brought within 1 year from the time the cause of action accrues and not afterwards." CLS 1956, § 609.13 (Stat Ann 1959 Cum Supp § 27.605). [2]

The general rule concerning limitation of actions is found in 37 CJ, Libel and Slander, § 314, p 17:

> **[*81]** *HN2*[↑] "The right of action accrues from the time of publication. The time within **[***15]** which an action for libel or slander must be commenced is usually fixed by statute, and there can be no legal trial of such an action while a plea by defendant of the statute of limitations remains unanswered and undisposed of. The general rule is that the statute begins to run from the time when the defamation is published, even though the person defamed has no knowledge thereof until some time afterward; and this, it has been intimated, even though plaintiff's ignorance may be due to fraud on the part of defendant. * * *
>
> "Admissions or repetitions. When a right of action for slander has been once barred by the statute of limitations, it cannot be revived by an admission of defendant that he did utter the slanderous words, *nor can the running of the statute be prevented by repetitions of the slander,* although of course a separate action will lie for any repetition within the statutory time." (Emphasis supplied.)

Plaintiff in her amended declaration of May 19, 1961, alleged numerous acts of slander by the defendant; some specifically, many generally, and others of a continuing **[**363]** nature. Defendant does not object to any of the separate acts of alleged slander **[***16]** but does object to any allegations concerning slander occurring subsequent to the date of the filing of the first declaration, February 17, 1958.

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[2] For current provisions, see PA 1961, No 236, § 5805 (CLS 1961, § 600.5805 [Stat Ann 1962 Rev § 27A.5805]).

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Michigan follows the general rule as recited in 37 CJ, *supra*, that HN3[] each act of slander is the basis for a separate action, but that all such separate acts of slander may be joined in one declaration provided the statute of limitations has not run. See *Randall v. Wayne Circuit Judge (1893), 96 Mich 284*.

The rule concerning publication of libel for purposes of statute of limitations is further set forth in *1 ALR2d 384, 392, 399*:

> "§ 4 * * * *Age-Herald Pub. Co. v. Waterman (1914), 188 Ala 272 (66 So 16*, Ann Cas 1916E, 900), **[*82]** where the libel sued on was set up in one count of the complaint as having appeared in defendant's newspaper and, more than a year after the date of such publication, other counts were added which alleged publication of the same libel in newspapers in other cities at the inducement of the defendant. Although the additional counts had been eliminated at the trial on plaintiff's request, the court took occasion to observe that such counts, setting up republications in other papers, stated **[***17]** different causes of action from that alleged in the original complaint, and pointed out that since they were filed more than one year after the original publication, the rule that an amendment of a complaint which sets up a new cause of action rather than restates the original cause of action in different language is not allowable after expiration of limitations on the original cause of action applied. * * *
>
> "§ 9 -- 'Black list' reports. As to statement with reference to discharge from private employment as actionable per se, see annotation in 66 ALR 1499.
>
> HN4[] *"With respect to so-called 'black list' reports wherein an employer states his reasons for discharging a former employee, the view has been taken that if such a writing is exhibited to a third person at some time within the applicable limitation period prior to a commencement of a libel suit based on alleged defamatory matter appearing in the writing, there is a new and independent publication against which limitations then commence to run and the action may consequently be maintained, even though it appears that the statement was originally exhibited to some third person at a time which antedates the statutory period."* **[***18]** (Emphasis supplied.)

It appears without question that HN5[] each act of slander constitutes a separate cause of action and the statute of limitations commences to run from the date of each such utterance. Separate acts of slander may be joined in the same pleading provided they all occur within the statutory period.

[*83] The plaintiff and appellant has urged that in four particulars the trial judge erred in his opinion concerning the amended declaration filed May 19, 1961. Plaintiff claims that the court should have considered such pleading as an amended *and* supplemental declaration. Plaintiff advances in effect that the same should be classified as neither fish nor fowl, but both. There may be instances in the law that justify such a conclusion, but is this one of them?

HN6[] Amended and supplemental pleadings are governed by GCR 1963, 118.1, 118.4, 118.5:

> ".1 Amendments. A party may amend his pleading once as a matter of course at any time before or within 15 days after a responsive pleading is served or, if the pleading is one to which no responsive pleading is required and the action has not been **[**364]** placed upon the trial calendar, he may amend it at any time **[***19]** before or within 15 days after it is served. Otherwise, a party may amend his pleading only by leave of court or by written consent of the adverse party. Leave shall be freely given when justice so requires. All amendments shall be filed in writing, dated, and numbered consecutively. Unless otherwise indicated therein, an amended pleading shall supersede the former pleading. * * *
>
> ".4 Relation Back of Amendments. Except for the purpose of demanding a trial by jury under sub-rule 508.2, *the amendment relates back to the date of the original pleading whenever the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading.*
>
> HN7[] ".5 Supplemental Pleadings. *Upon motion of a party the court may, upon reasonable notice and upon such terms as are just, permit him to serve a supplemental pleading to set forth any transactions or*

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occurrences or events which have happened since the date of the pleading sought to be supplemented, [*84] whether or not the original pleading is defective in its statement of a claim for relief or defense. If the court deems it advisable that [***20] the adverse party plead thereto, it shall so order, specifying the time therefor." (Emphasis supplied.)

The right of the plaintiff to file an amended declaration would be predicated upon the court rule, *supra*, and by reason of the ruling in the case of *Grist v. The Upjohn Company (1962), 368 Mich 578*, wherein the Court said on pp 584, 585:

"However, in view of the ruling of this Court at this time, plaintiff may now, if she chooses, amend as a matter of right, subject, of course to objection to the contents of the amendment by defendant." (Emphasis supplied.)

The Supreme Court, as above stated, permitted plaintiff to *amend* her declaration. This she elected to do by adopting the amended declaration filed May 19, 1961.

HN8[] GCR 1963, 118.4, permits the amendment to relate back to the date of the original pleading. However, there is no provision for relating back as to supplemental pleadings, GCR 1963, 118.5. In 1 Michigan Court Rules Annotated, by Honigman and Hawkins (2d ed), p 409, we find committee notes:

"(6) Supplemental Pleadings. Any transactions or occurrences arising after the original pleading may be set forth by supplemental pleading under [***21] this subsection. To preclude any hard and fast distinction between amended and supplemental pleadings, this subsection includes the proposed amendment to the federal rule which authorizes supplemental pleading whether or not the original pleading is defective. Thus a supplemental pleading which does present a valid statement of claim will allow the action to proceed, even if the original pleading remains defective for lack of amendment.

[*85] *"Because there is no provision for relation back, a supplemental pleading based upon new facts must be filed before the statutory period of limitations has expired."* (Emphasis supplied.)

The dismissal of the plaintiff by defendant took place April 5, 1957; the original declaration for slander brought by plaintiff against defendant was filed February 17, 1958, and the amended pleading was filed May 19, 1961, alleging, among other things, the original claimed slanderous acts, and in addition slanderous acts occurring subsequent to the filing of the original declaration. Inasmuch as each slanderous act is a basis for an action and the statute of limitations runs from the date of each such act, we have a condition wherein the pleading [***22] [**365] of May 19, 1961, cannot be a supplemental pleading, without eliminating all claimed acts of slander occurring more than one year prior to the last mentioned date.

In any event, the provisions in the GCR, *supra,* for filing of supplemental pleadings requires an order of the court allowing the same. *HN9*[] Under Court Rule No 72, § 1 (a) (1945), in effect at the time of the last appeal to the Supreme Court, provided that the Supreme Court may exercise any or all of the procedures of amendment of the trial court. This the Court did not do, but only allowed plaintiff to amend if she so desired, subject to objections of defendant. Inasmuch as the plaintiff did not obtain leave of the trial court to file a supplemental pleading, the pleading of May 19, 1961, in all events must be treated as an amended declaration.

The second error claimed by plaintiff is "defendant waived its objection and is estopped now from objecting to plaintiff's pleading on the ground that it alleged subsequent matters and it was necessary to obtain leave of court". This Court cannot agree with plaintiff. There is no estoppel applicable for the reason [*86] that plaintiff's election to stand on [***23] the May 19, 1961, pleading, was predicated upon the authority of the Supreme Court which also gave to defendant the right to object to any matters contained in such amendment.

The third error claimed by plaintiff is "regardless of whether plaintiff's amendment be considered an amended declaration, a supplemental declaration, or an amended and supplemental declaration, it properly pleaded plaintiff's case". The Court can agree with this statement subject to the qualifications that subsequent alleged acts of slander claimed against the defendant after the filing of the original declaration, February 17, 1958, are improper by reason of the statute of limitations. The subsequent acts of slander cannot be charged as a cause for damages. Further,

the requirement of a more definite statement as to such claimed acts of slander was necessary so that defendant might be advised if same could be subject to objections, particularly, the statute of limitations.

The fourth and last alleged error claimed by plaintiff is "plaintiff's pleading was not defective for uncertainty". The Court has dealt with this claim of the plaintiff in this opinion. It would appear that the main reason for this [***24] requirement was to eliminate the claimed slanderous acts which were not a proper basis for relief.

The history of this case indicates that on occasion courts of justice may move slowly but also surely, best illustrated by the quotation: "Though the mills of God grind slowly, yet they grind exceeding small; Though with patience He stands waiting, with exactness grinds He all". [3]

The first appeal provided plaintiff with a right of action not then available to her under her pleadings [*87] because of the ruling in the *Robertson Case.* The second appeal clarified the proper application of the *Poledna Case.* This third appeal, will permit, we hope, the plaintiff and the defendant both to have a trial upon the merits without further delay.

The trial court properly disposed of all the matters brought by defendant's motion "for more definite statement, to strike portions of amended declaration [***25] and for accelerated judgment". Affirmed and remanded for further proceedings. Costs to defendant, assessment of same to await determination on the merits.

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[3] Friedrich von Logau, 1604-1655, Retribution (Translation by Henry W. Longfellow (Cambridge ed), p 616).

Jacob Bryant

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EXHIBIT 10

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STATE OF MICHIGAN
IN THE CIRCUIT COURT FOR THE COUNTY OF OAKLAND

SHEILA R. GRANDISON,

Plaintiff,

and

Case Number **2016-152313-NF**
Honorable Nanci J. Grant

SUPERIOR DIAGNOSTICS, INC., and
MENDELSON ORTHOPEDICS, P.C.

Intervening Plaintiffs,

-v-

FARM BUREAU GENERAL INSURANCE
COMPANY OF MICHIGAN, a Michigan
Insurance Company,

Defendant,

ORDER AND OPINION

At a session of said Court, held in the Courthouse in the City of Pontiac, County of Oakland, State of Michigan on 10th day of July, 2017.

PRESENT: HONORABLE NANCI J. GRANT, CHIEF JUDGE

The matters are before the Court on Defendant Farm Bureau General Insurance Company's motions for summary disposition regarding Intervening Plaintiff Superior Diagnostics, Inc. and Intervening Plaintiff Mendelson Orthopedics, PC's intervening

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complaints.[1] Also before the Court are Intervening Plaintiffs' motions for leave to amend the intervening complaints and Farm Bureau's "Emergency Motion for Second Adjournment of Trial Date." After oral arguments were held on June 28, 2017, the Court took the matters under advisement. The Court now rules as follows:

This matter arises from Plaintiff Sheila Grandison being involved in a motor vehicle accident. She filed suit against Farm Bureau, seeking first-party benefits. Superior Diagnostics and Mendelson Orthopedics were permitted to file intervening complaints in this action in relation to medical services they provided to Plaintiff.

With respect to Farm Bureau's motions for summary disposition on the intervening complaints, it argues that the claims should be "stricken" pursuant to *Covenant Medical Center v State Farm*, __ Mich __, issued May 25, 2017 (Docket No. 152758), slip op at 22-24, which held that healthcare providers do not have a statutory cause of action against a no-fault insurer for the payment of no-fault benefits.

In response, Intervening Plaintiffs argue that Plaintiff assigned them her rights to obtain payment for the services that they provided to her. They correctly argue that the Supreme Court in *Covenant* stated in a footnote that its "conclusion . . . is not intended to alter an insured's ability to assign his or her right to past or presently due benefits to a healthcare provider." *Covenant*, slip op at 24 n 40.

In a reply brief, however, Farm Bureau correctly argues that the plain language of the insurance contract prohibited Plaintiff from assigning rights or duties under the policy without its written consent. See *Harbor Park Market Inc v Gronda*, 277 Mich App 126, 130 (2007) (contracts are interpreted according to their plain meaning). According to Farm Bureau, it is undisputed that it never gave Plaintiff consent to assign rights under the insurance contract to Intervening Plaintiffs, therefore establishing that the assignments are invalid. Intervening

[1] Although Farm Bureau's motions were labeled motions in limine, the parties acknowledged at oral arguments that they treated the motions as motions for summary disposition and that the notice requirements outlined in the relevant court rules have been followed. Accordingly, this Court will treat the instant motions as motions for summary disposition, despite the manner in which Farm Bureau labeled them.

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Plaintiffs anticipated Farm Bureau's argument. In their response brief, they argue that the anti-assignment clause cannot be invoked post-loss. This Court agrees.

"Although, as a general rule, courts must provide competent parties the utmost liberty to engage in contractual relations, a contract is valid only if it involves a proper subject matter. A proposed contract is concerned with a proper subject matter only if the contract performance requirements are not *contrary to public policy.*" *Morris & Doherty v Lockwood*, 259 Mich App 38, 54 (2003) (citations and quotations omitted; emphasis in original).

While all legitimate causes of action are generally assignable, *Grand Traverse Convention & Visitor's Bureau v Park Place Motor Inn, Inc*, 176 Mich App 445, 448 (1998), Michigan law also recognizes the validity of contractual provisions against assignment of contracts, including insurance policies, see *Employers Mut Liab Ins Co v Mich Mut Auto Ins Co,* 101 Mich App 697, 702 (1980). An anti-assignment clause will not be enforced, however, where a loss occurs before the assignment, because in that situation the assignment of the claim under the policy is viewed no differently than any other assignment of an accrued cause of action. *Action Auto Stores, Inc v United Capitol Ins Co*, 845 F Supp 417, 423 (WD Mich 1993), citing *Roger Williams Insurance Co v Carrington,* 43 Mich 252, 254 (1880). More specifically, the Court in *Roger Williams Insurance Co,* 43 Mich at 254, observed the following:

> The assignment having been made after the loss did not require consent of the company. The provision of the policy forfeiting it for an assignment without the company's consent is invalid, so far as it applies to the transfer of an accrued cause of action. It is the absolute right of every person—secured in this state by statute—to assign such claims, and such a right cannot be thus prevented. It cannot concern the debtor, and it is against public policy.

Thus, the rule stated in *Roger Williams Insurance* recognizes a distinction between pre-loss assignments and post-loss assignments.

The majority of Courts in other jurisdictions follow the rule that clauses in insurance policies prohibiting assignments do not prevent an assignment after the loss has occurred, although sometimes for different reasons than that stated in *Roger Williams Insurance*. See e.g., *Millard Gutter Company v Farm Bureau Property & Casualty Insurance Company*, 295 Neb

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419, 427 (Neb 2016) ("The majority of courts follow the rule that clauses in insurance policies prohibiting assignments do not prevent an assignment after the loss has occurred."); *Gopher Oil Co v American Hardware Mut Ins Co*, 588 NW2d 756, 763-764 (Minn App 1999) (observing that "[t]he great majority of courts follow this distinction between risk and loss and allow an insured to assign a loss" despite a standard consent-to-assignment clause and commenting that doing otherwise would provide "an insurer . . . the windfall of not having to insure an occurrence that it received premiums for covering"); *Wehr Constructors v Assurance Co of Am*, 384 SW3d 680, 682 (Ky 2012) ("the majority rule holds that an anti-assignment clause such as the one we examine is unenforceable once an insured occurrence takes place"); *Fluor Corp v Superior Ct*, 61 Cal 4th 1175, 1213-1215 (Cal 2015).

The rationale for such a distinction has been explained as follows by a treatise on contract law:

> Antiassignment clauses in insurance policies are strictly enforced against attempted transfers of the policy itself before a loss has occurred, because this type of assignment involves a transfer of the contractual relationship and, in most cases, would materially increase the risk to the insurer. Policy provisions that require the company's consent for an assignment of rights are generally enforceable only before a loss occurs, however. As a general principle, a clause restricting assignment does not in any way limit the policyholder's power to make an assignment of the rights under the policy—consisting of the right to receive the proceeds of the policy—after a loss has occurred. The reasoning here is that once a loss occurs, an assignment of the policyholder's rights regarding that loss in no way materially increases the risk to the insurer. After a loss occurs, the indemnity policy is no longer an executory contract of insurance. It is now a vested claim against the insurer and can be freely assigned or sold like any other chose in action or piece of property. [17 Richard A. Lord, A Treatise on the Law of Contracts by Samuel Williston, § 49:119 (4th ed. 2015).]

The Court agrees with this reasoning. It properly focuses upon the policy supporting anti-assignment clauses: ensuring that the insurer is not subjected to a risk it did not agree to

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insure. Here, Farm Bureau does not explain or rationalize why it inserted the anti-assignment clause in its policy or why it should be enforced after a loss occurs. There is no indication in the record as to how Farm Bureau would face an increased risk or any other adverse consequence as a result of the post-loss assignment. In this Court's opinion, when the event giving rise to the insurer's liability occurs, the reason for enforcing an anti-assignment clause disappears because the insurer's liability becomes fixed, and its risk is no longer dependent upon the unique characteristics of the insured.

Further, as argued by Intervening Plaintiffs, the No-Fault Act only prohibits assignment of a right to benefits payable in the future. MCL 500.3143 ("An agreement for assignment of a right to benefits payable in the future is void."). This was discussed extensively in *Professional Rehab Assoc v State Farm Mut Auto Ins Co*, 228 Mich App 167, 172 (1998), and the *Covenant* majority cited both MCL 500.3143 and *Professional Rehab Assoc*, see *Covenant*, slip op at 24 n 40. Thus, Plaintiff had an assignable interest so long as she was not assigning rights concerning future benefits.

When reviewing both of the assignments, it is clear that Plaintiff only assigned Intervening Plaintiffs rights with respect to past due and presently due benefits. Because Plaintiff made valid assignments to Intervening Plaintiffs, Farm Bureau's motions for summary disposition are denied. Based on this holding, it is not necessary for this Court to decide whether the Supreme Court's holding in *Covenant* is retroactive. See *B P 7 v Bureau of State Lottery*, 231 Mich App 356, 359 (1998) (holding that Courts will not generally not decide moot issues).

Turning to Intervening Plaintiffs' motions for leave to amend, a motion to amend ordinarily should be granted, unless one of the following particularized reasons exists:

> [1] undue delay, [2] bad faith or dilatory motive on the part of the movant, [3] repeated failure to cure deficiencies by amendments previously allowed, [4] undue prejudice to the opposing party by virtue of allowance of the amendment, [and 5] futility. . . . [*Sands Appliance Servs Inc v Wilson*, 463 Mich 231, 239 (2000) (alternation in original), citing *Ben P Fyke & Sons v Gunter Co*, 390 Mich 649, 656 (1973).]

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The Court agrees with Intervening Plaintiffs that, after applying the above listed factors, there is no reason to deny the motions for leave to amend. Although Farm Bureau alleges that it would be prejudiced, it does not provide any meaningful analysis to support this. As argued by Mendelson Orthopedics, Intervening Plaintiffs have been litigating the substantive merits of this case with Farm Bureau for nearly one year. By allowing amendment, this Court is merely allowing Intervening Plaintiffs to exchange one theory of standing for another based on a change in the law that occurred mid-litigation.

As such, Intervening Plaintiffs' motions for leave to amend their intervening complaints are granted. Intervening Plaintiffs must file the amended pleadings within seven (7) days of the date of this order.

In so holding, the Court notes that Farm Bureau argues that, even if Intervening Plaintiffs are permitted to amend or supplement their complaints, part of their claims will be barred under MCL 500.3145. To support this, Farm Bureau argues that any alteration to the complaints would amount to supplemental pleadings and that there is no relation back provision for a supplemental pleading.

MCR 2.118 addresses amendment and supplemental pleadings, and MCR 2.118(D) states in relevant part that "[a]n amendment that adds a claim or defense relates back to the date of the original pleading if the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth, or attempted to be set forth, in the original pleading." Here, Intervening Plaintiffs merely seek to add additional facts concerning standing to the original cause of action and are not relying on conduct or a transaction or occurrence different from the one involved in the original action. Accordingly, the Court rejects Farm Bureau's arguments that part of Intervening Plaintiffs' claims will be barred under MCL 500.3145. See *Miller v Chapman Contracting*, 477 Mich 102, 105-107 (2007). See also Wright and Miller's Federal Practice and Procedure, Civil § 1508.

Finally, Farm Bureau's "Emergency Motion for Second Adjournment of Trial Date" is denied because the Court is not persuaded that it is entitled to the relief it seeks. Trial will commence at 8:30 a.m. on Tuesday, July 18, 2017.

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In sum, Farm Bureau's motions for summary disposition on the Intervening Plaintiffs' claims are denied. Intervening Plaintiffs' motions for leave to amend are granted, and they must file the amended pleadings within seven (7) days of the date of this order. Farm Bureau's second motion for adjournment of trial is denied.

IT IS SO ORDERED.

NANCI J. GRANT, Chief Judge

PROOF OF SERVICE

I certify that a copy of the above instrument was served upon the attorneys/parties of record in the above case via the United States Postal Service at the addresses above on 7/10/17.

/s/ Brenda Beiter
Judicial Assistant to the Hon. Nanci J. Grant

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EXHIBIT D

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STATE OF MICHIGAN

IN THE CIRCUIT COURT FOR THE COUNTY OF GENESEE

JAWAD A. SHAH, MD, PC,
INTEGRATED HOSPITAL SPECIALISTS, PC,
INSIGHT ANESTHESIA PLLC and
STERLING ANESTHESIA, PLLC,
(George Hensley),

Plaintiff,

v

STATE FARM MUTUAL AUTOMOBILE
INSURANCE COMPANY,

Defendant.

File No.: 17-108637-NF

Hon. Judith A. Fullerton

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(616) 257-3900

DEFENDANT STATE FARM'S REPLY BRIEF IN SUPPORT OF ITS MOTION FOR SUMMARY DISPOSITION

NOW COMES the Defendant, State Farm Mutual Automobile Insurance Company ("State Farm"), by and through its attorneys, Hackney Grover PLC, and for its Reply Brief in Support of its Motion for Summary Disposition, State Farm states as follows:

A. Plaintiffs' Breach of Contract Claim Must Be Dismissed Because It Is Based Upon an Assignment That Is Prohibited by the Very Policy That Plaintiffs Seek to Enforce.

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Plaintiffs' breach of contract claim is predicated upon an alleged assignment from State Farm's insured of his right under the applicable No Fault policy to seek reimbursement for incurred medical expenses. That policy, however, contains an assignment clause which expressly provides: "No assignment of benefits or other transfer of rights is binding upon us unless approved by us." There is no dispute that State Farm has never approved the assignment that Plaintiffs seek to wield against it in this lawsuit. Accordingly, Plaintiffs' breach of contract claim must be dismissed.

Any argument by Plaintiffs that this assignment clause should be disregarded is without merit. The Michigan Supreme Court has recognized that "insurance policies are subject to the same contract construction principles that apply to any other species of contract." *Rory v. Continental Ins Co*, 473 Mich 457, 461, 703 NW2d 23 (2005). Parties are "generally free to agree to whatever they like, and, in most circumstances, it is beyond the authority of the courts to interfere with the parties' agreement." *Wilkie v Auto-Owners Ins Co*, 469 Mich 41, 62, 664 NW2d 776 (2003).

Indeed, the circumstances under which courts may refuse to enforce unambiguous insurance policy provisions are narrow. *DeFrain v. State Farm Mut Auto Ins Co*, 491 Mich 359, 372, 817 NW2d 504 (2012). Such provision must be enforced as written unless it would violate law or public policy. *Id.* "A mere judicial assessment of 'reasonableness' is an invalid basis upon which to refuse to enforce contractual provisions" and "the circumstances under which a contract provision can be said to violate law or public policy are likewise narrow." *Id.* As noted by *DeFrain*:

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> In ascertaining the parameters of our public policy, we must look to 'policies that, in fact, have been adopted by the public through our various legal processes, and are reflected in our state and federal constitutions, our statutes, and the common law.' That a contract provision fails to comport with the personal predilections of the majority of the deciding tribunal about what is reasonable or fair does not make the provision violative of law or public policy. Judicial notions of reasonableness are not 'clearly rooted in the law' and are therefore not a valid basis for refusing to enforce an unambiguous contract provision.

Id. (citations omitted; quoting *Rory*, 473 Mich at 472).

The *Rory* Court also recognized that because the responsibility of evaluating and approving insurance policy provisions rests with the Commissioner of Insurance, the explicit 'public policy' of Michigan is that the reasonableness of insurance contracts is a matter for the executive, not judicial, branch of government. *Rory*, 473 Mich at 476. *See also Auto Club Group Ins Co v. Booth*, 289 Mich App 606, 797 NW2d 695 (2010) (rejecting public policy argument and noting "our Supreme Court has determined that 'the explicit 'public policy' of Michigan is that the reasonableness of insurance contracts is a matter for the executive, not judicial, branch of government").

Consistent with the foregoing, the Michigan Supreme Court has held that non-assignment clauses are enforceable provided that the contractual prohibition against assignment is clear and unambiguous. *See Detroit Greyhound Employees Federal Credit Union v. Aetna Life Ins. Co.*, 381 Mich. 683, 689-690 (1969) ("[T]hose who would compose a contractual bar against alienation must use 'The plainest words.'"); *accord Burkhardt v. Bailey*, 260 Mich. App. 636, 653 (2004) (holding that assignments are invalid if "clearly restricted" by contract).

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The Michigan courts have not been hesitant to enforce such clauses in the context of claims for insurance benefits. In *Kreindler v. Waldman*, 2006 WL 859447, at *2 (Mich. Ct. App. Apr. 4, 2006) (**Exhibit A**), for example, the plaintiff sought to make a claim for professional liability coverage under an assignment from the defendant's insured. The applicable policy, however, expressly prohibited the insured's assignment of "claims and causes of action" thereunder. *Id.* The court dismissed plaintiff's breach of contract claim, holding that the anti-assignment clause "must be enforced as written," and that plaintiff thus had "no interest under the policy" and "no standing to sue" the insurer. *Id.*

Similarly, in *Edwards v. Concord Dev. Corp.*, 1996 WL 33358104, at * (Mich. Ct. App. Sept. 17, 1996) (**Exhibit B**), the plaintiff sought to make a claim against an insurer under an assignment of rights to benefits arising under a fire policy. The policy in question, however, contained language stating that the "[a]ssignment of this policy will not be valid unless we give our written consent." *Id.* at *1. The insurer had never consented to the assignment on which plaintiff's claim was based. Accordingly, the *Edwards* court affirmed the dismissal of plaintiff's breach of contract claim. It held that "there is no prohibition against requiring consent to effectuate an assignment" and confirmed that an assignment may be "precluded by agreement." *Id.*

The assignment clause in the policy at issue in this case is fully enforceable under this standard. It plainly provides that "[n]o assignment of benefits or other transfer of rights" is valid without the consent of State Farm. The word "no" is unambiguous and permits no exceptions. It encompasses any and all benefits available under the policy,

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including the core medical expenses that the Plaintiffs seek to recover here. This Court should not permit the Plaintiffs to assert a breach of contract claim that would "render nugatory the policy's prohibition against assignments." *Kreindler*, 2006 WL 859447, at *3 n.2.

Any reliance by the Plaintiffs on the 1880 case of *Roger Williams Ins Co v Carrington* is without merit for multiple reasons. That court found an assignment clause in a property insurance policy was invalid, stating:

> It is the absolute right of every person –secured in this state by statute[1] – to assign such claims, and such a right cannot be thus prevented. It cannot concern the debtor, and it is against public policy.

Subsequent to this 1880 decision, and even subsequent to the other Michigan decisions cited by the Plaintiffs, the Michigan Supreme Court changed and/or clarified the standards governing insurance policy interpretation in *Rory* and *DeFrain*. As set forth above, courts are required to enforce unambiguous insurance policy provisions unless it violates the law or public policy. Plaintiffs in this case have identified no statute that precludes the assignment clause. And, pursuant to *DeFrain* and *Rory*, the public policy of Michigan is that the reasonableness of the assignment clause is a matter for the Commissioner of Insurance, and not the court.

Plaintiffs' argument fails for the additional reason that it presumes the injured party has fully performed his obligations under the policy and there is no potential prejudice to the insurer from the assignment. This case is unlike *Roger Williams* which

[1] The *Roger Williams* case does not identify the referenced statute. Plaintiffs, here, likewise do not identify any statute that bars assignment clauses.

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involved a fire loss and there was no evidence of continuing obligations by the insured party. Here, the injured party's duties under the policy are ongoing. For example, under the policy, the insured must:

- Submit to an examination and/or provide a statement under oath. See also *Cruz v State Farm Mut Auto Ins Co*, 466 Mich 588, 590; 648 NW2d 591 (2002) ("EUO provisions may be included in no-fault policies, but are only enforceable to the extent that they do not conflict with the statutory requirements of the no-fault act.").
- Cooperate with State Farm, and when asked, assist State Farm in securing and giving evidence.
- Provide State Farm all details of the injury, treatment and other information as soon as reasonably possible.
- Submit to an independent medical examination.
- Authorize State Farm to obtain medical records, medical bills, employment information, and "any other information [State Farm] deem[s] necessary to substantiate the claim."

State Farm Car Policy Booklet at 33-36 (**Exhibit C**).

The insured has obligations under the policy that exist throughout the entirety of the claim. The performance of these obligations by the injured party is essential to State Farm's ability to review and consider claims. If the insured is permitted to assign his "rights" under the policy, he will have no incentive to perform his ongoing obligations under the policy because he has transferred his rights to payment to a third party. Just as was the case prior to Covenant, the courts and State Farm will be faced with multiple provider lawsuits wherein the insured – who has ongoing contractual obligations – may fail to perform those obligations.

For all of the foregoing reasons, Plaintiffs' argument that the assignment clause is invalid, is without merit. The clause is unambiguous; Plaintiffs do not suggest otherwise.

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The Court's decision in *Roger Williams* is no longer good law, and is distinguishable in any event. Accordingly, the assignment clause is enforceable pursuant to *Rory*, *DeFrain*, and *Detroit Greyhound*.

B. Plaintiffs' Assignment is Invalid and Unenforceable for the Additional Reason that the Assigned Interest is Barred by the One-Year-Back Rule, MCL 500.3145.

In addition to the reasons previously stated, the purported assignment is further inapplicable here because the assigned claims (or a portion of the assigned claims) are barred by the one-year-back rule. Assignment "is defined as '[a] transfer or making over to another of the whole of any property, real or personal, in possession or in action, or of any estate or right therein.'" *Weston v Dowty*, 163 Mich App 238, 242; 414 NW2d 165 (1987) quoting Black's Law Dictionary (4th ed.). "[A]n assignee stands in the shoes of the assignor and acquires the same rights as the assignor possessed." *Prof Rehab Assoc v State Farm Mut Auto Ins Co*, 228 Mich App 167, 177; 577 NW2d 909 (1998). Accordingly, if the assignor has no claim, the assignee acquires no rights by virtue of the assignment because "the assignment created nothing." *Jones v. Chamber*, 353 Mich 674, 681, 91 N.W.2d 889 (1958). To hold otherwise "would be to give to such an assignment some strange alchemistic power to transform a dross and worthless cause of action into the pure gold from which a judgment might be wrought." *Id* The issue presented in this Section is whether the interest assigned by the injured party (even if valid – which it is not for reasons set forth in Section A) transferred a viable chose in action to Plaintiffs. For reasons detailed below, no such action was transferred and "relation back" principles cannot alter the nonviable nature of the rights assigned by the injured party.

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1. The Injured Party's Right To No Fault Benefits Were Barred When He Assigned Them to Plaintiffs

Pursuant to MCL 500.3145(a), a "claimant may not recover [no-fault] benefits for any portion of the loss incurred more than 1 year before the date on which the action was commenced." The one-year-back rule is not a statute of limitations governing when a lawsuit may be filed, but a limitation on what benefits may be recovered in an otherwise timely lawsuit. See *Devillers v Auto Club Ins Ass'n*, 473 Mich 562, 574; 702 NW2d 539 (2005); and *Joseph v Auto Club Ins Ass'n*, 491 Mich 200, 207; 815 NW2d 412 (2012). The one-year-back rule is not subject to any tolling. *Devillers*, 476 Mich at 586 (neither judicial nor equitable tolling apply to MCL 500.3145(1)); *Joseph*, 491 Mich at 203 (MCL 500.3145(1) is not tolled by insanity or minority tolling statutes).

Here, the injured party executed an assignment for each Plaintiff, assigning his rights to Plaintiffs on July 11, 2017. (See Exhibit 1 of Plaintiffs' Response to Defendant's Motion for Summary Disposition). The rights acquired by Plaintiffs with the assignment can be no greater than those held by the injured party. Had the injured party brought an action for Plaintiffs' bills on the date of the assignment, it would be dismissed with prejudice pursuant to MCL 500.3145(1). The same outcome is necessary in this case because the court should not "give to such an assignment some strange alchemistic power to transform a dross and worthless cause of action into the pure gold from which a judgment might be wrought." *Jones*, 353 Mich at 681.

Further, the injured party had his own lawsuit. However, this lawsuit has since resolved and is no longer pending.

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2. "Relation Back" Principles Do Not Apply To Revive The Worthless Cause Of Action That Was Assigned To Plaintiffs

Plaintiffs' reliance on "relation back" principles is flawed. In essence, plaintiffs contend that they can revive an otherwise statutorily barred claim by: (1) obtaining an assignment from an injured party who could not assert the claim under MCL 500.3145(1), (2) amending their complaint to assert the assignment, and (3) arguing the amended complaint relates back to the provider's original complaint. This argument fails to recognize the distinct and separate nature of the underlying assignment (to which relation back principles *do not apply*) and the amended complaint asserting a breach of contract (to which relation back principles *may* apply to amended pleadings). Plaintiffs' relation-back argument extends beyond their First Amended Complaint by requesting the ***assignment itself*** to relate back. This cannot happen because the assignment did not exist on the date of the original filing.

A plaintiff, in particular, may bring an original action based on breach of contract. It may seek to amend to add an additional breach of contract claim based on a purported assignment. The breach of contract claim may relate back to the original action (if all prerequisites of relation back apply); however, the viability of that action is still dependent upon whether the assignor assigned any viable claims to the assignee. If no viable claims were assigned, then the breach of contract action fails too, irrespective of whether "relation back" applied to the breach of contract claim. Plaintiffs' theory to the contrary would mean an assignment of worthless rights could be revived and transformed into something of value in contravention of MCL 500.3145 and the maxims that an

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assignee stands in the shoes of the assignor and that an assignee gains no rights greater than the assignor. *Jones*, 353 Mich at 681.

3. In Addition, Relation Back Does Not Apply To Supplemental Pleadings

Plaintiffs' "relation back" argument fails for the additional reason that their pleading is a supplemental pleading and relation back does not apply to such pleadings. In particular, the true nature of Plaintiffs' request to amend is a request to supplement the Complaint to allege a subsequently-acquired assignment. Amending and supplementing pleadings are both governed by MCR 2.118.

> **(A) Amendments.**
>
> (1) A party may amend a pleading once as a matter of course within 14 days after being served with a responsive pleading by an adverse party, or within 14 days after serving the pleading if it does not require a responsive pleading.
>
> (2) Except as provided in subrule (A)(1), a party may amend a pleading only by leave of the court or by written consent of the adverse party. Leave shall be freely given when justice so requires. . . .
>
> **(D) Relation Back of Amendments.** An amendment that adds a claim or a defense relates back to the date of the original pleading if the claim or defense asserted in the amended pleading arose out of the conduct, transaction, or occurrence set forth, or attempted to be set forth, in the original pleading. In a medical malpractice action, an amendment of an affidavit of merit or affidavit of meritorious defense relates back to the date of the original filing of the affidavit.
>
> **(E) Supplemental Pleadings.** On motion of a party the court may, on reasonable notice and on just terms, permit the party to serve a supplemental pleading to state transactions or events that have happened since the date of the pleading sought to be supplemented, whether or not the original pleading is defective in its statement of a claim for relief or a defense. The court may order the adverse party to plead, specifying the time allowed for pleading.

MCR 2.118 distinguishes between ***amended*** and ***supplemental*** pleadings. Supplemental pleadings allege "transactions or events that have happened since the date of the pleading

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sought to be supplemented." MCR 2.118(E). Amended pleadings allege events or transactions that existed at the time of the pleading to be amended. This is why amended pleadings stating a new claim arising out the same transaction or occurrence relate back to the original date of filing while supplemental pleadings do not. See MCR 2.118(D). See also *Gist v Upjohn Co*, 1 Mich App 72, 84-85; 134 NW2d 358 (1965) (supplemental pleadings do not relate back to the original filing date).

Here, Plaintiffs' First Amended Complaint is a supplemental complaint alleging a subsequently-acquired assignment, and it is governed by MCR 2.118(E). The assignment was acquired July 11, 2017, almost five months after this lawsuit was filed in this Court. Thus, the assignment constitutes a "transaction or event that ha[s] happened since the date of the pleading sought to be supplemented." MCR 2.118(E). Plaintiffs' First ***Amended*** Complaint is actually a supplemental pleading, which does not relate back to the date of the original Complaint. *Gist*, 1 Mich App at 84-85.;

Alternatively, if amendment pursuant to MCR 2.118(A) is the proper tool, the amendment does not allege a new claim arising out of the same "conduct, transaction, or occurrence" as alleged in the original Complaint, and the amendment does not relate back. MCR 2.118(D). Here, the original Complaint alleged a statutory no-fault "provider" case – an invalid cause of action. See *Covenant Med Ctr*, slip op at 24. In an effort to resurrect their invalid claim, Plaintiffs now assert a new claim based on an assignment signed months after their initial lawsuit was filed. In other words, the transactional setting of the initial Complaint was the claim for no-fault benefits whereas the transactional setting for the proposed amended complaint is the assignment.

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Plaintiffs' only vehicle to establish a viable cause of action is through an assignment that, when made, was no good. Thus, a proposed amended complaint would not arise out of the same conduct, transaction, or occurrence as the original Complaint, and would not relate back. Plaintiffs have failed to even attach a proposed amended complaint to their Motion for Leave to Amend Their Complaint.

Finally, Mr. Hensley is a named insured of State Farm. Please see his declaration page attached as **Exhibit D**.

WHEREFORE, Defendant State Farm respectfully requests that this Honorable Court grant its motion for summary disposition and enter an order dismissing with prejudice the claim for personal injury protection benefits asserted by the Plaintiffs, under the no-fault act.

HACKNEY GROVER PLC
Attorneys for Defendant

Dated: September 6, 2017 By: _____

Robert J. Johnson (P42458)
Ross L. Janecyk (P78233)

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CERTIFICATION OF SERVICE

Hillary Fidler certifies that on September 6, 2017 she served a copy of ***Defendant State Farm's Reply Brief in Support of its Motion for Summary Disposition*** on the above attorneys of record by mailing same to them at their addresses of record via first class mail with postage prepaid thereupon.

Hillary Fidler

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2006 WL 859447
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UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Court of Appeals of Michigan.

Alfred M. KREINDLER, Plaintiff/Counter-Defendant-Appellant,
and
Daniel J. GOLDSTONE, Plaintiff/Counter-Defendant,
v.
Martin WALDMAN, Defendant,
and
AMERICAN GUARANTEE & LIABILITY INSURANCE COMPANY, Defendant/Counter-Plaintiff-Appellee.

No. 265045.
|
April 4, 2006.

Before: OWENS, P.J., and KELLY and FORT HOOD, JJ.

[UNPUBLISHED]

PER CURIAM.

*1 Plaintiff Alfred M. Kreindler appeals as of right from the trial court's order granting summary disposition to defendant American Guarantee and Liability Insurance Company.[1] We affirm.

Plaintiff alleges that the trial court erred in concluding that Goldstone was not entitled to coverage based on the errors and omissions policy with defendant. Specifically, plaintiff alleges that there was a genuine issue of material fact with regard to whether Goldstone had uninterrupted professional liability coverage since 1996, a prerequisite for coverage under the policy, the policy was ambiguous, and the trial court erred in concluding that he had the burden of proof with regard to the issue of coverage. We disagree.

A trial court's decision granting summary disposition is reviewed de novo, on the entire record, to determine whether the prevailing party was entitled to judgment as a matter of law. *Maiden v. Rozwood,* 461 Mich. 109, 118; 597 NW2d 817 (1999). When reviewing a motion brought under MCR 2.116(C)(10), this Court must examine the documentary evidence presented below and, drawing all reasonable inferences in favor of the nonmoving party, determine whether a genuine issue of material fact exists. *Quinto v. Cross & Peters Co,* 451 Mich. 358, 361-362; 547 NW2d 314 (1996). Contrary to plaintiff's argument, the test is not whether a record *may* be developed upon which reasonable minds may differ, or whether the court is satisfied that the nonmoving party cannot prevail at trial because of a deficiency that cannot be overcome. *Smith v. Globe Life Ins Co,* 460 Mich. 446, 454-455, n 2; 597 NW2d 28 (1999). Once the moving party supports its position with documentary evidence, the nonmoving party has the burden of coming forward with evidence of specific facts to establish the existence of a material factual dispute. *Quinto, supra* at 362, 371. If the nonmoving party fails to establish that a material fact is at issue, the motion is properly granted. *Id.* at 363.

In this case, plaintiff concedes that defendant's policy will not provide coverage for Goldstone's alleged negligence in handling plaintiff's disability insurance matter unless it can be established that Goldstone maintained uninterrupted professional liability coverage dating back to 1996. When the issue involves the question of coverage, plaintiff has the burden of showing that the insurance policy covers the matter alleged. *Solomon v Royal Maccabees Life Ins Co,* 243 Mich.App 375, 379; 622 NW2d 101 (2000). Further, because defendant supported its motion with documentary evidence demonstrating that there was a breach in coverage, plaintiff was required to come forward with evidence showing that there was a genuine issue of fact for trial in order to avoid summary disposition. *Quinto, supra* at 361-362.

Contrary to plaintiff's argument, the policy at issue is not ambiguous. Even if there was some confusion concerning Goldstone's contract date with another insurance company, this alleged confusion did not involve the meaning of defendant's policy. Furthermore, the alleged confusion is immaterial to the question of coverage because coverage under defendant's policy extends back only to the insured's contract date *or* the first gap in errors and omissions coverage, whichever is earlier.

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Because the negligent act occurred in 1996, well before Goldstone's gap in coverage-April 1, 2001, to August 1, 2001-and well before his contract date, it is immaterial whether Goldstone's contract date was September 2000, or September 2001.

*2 Plaintiff failed to come forward with documentary evidence showing the existence of a genuine issue of material fact with regard to whether Goldstone had uninterrupted professional liability coverage dating back to 1996. Goldstone's mere assertion that he believed he had uninterrupted coverage, without any factual support for this position, was insufficient to show that a question of material fact exists. *Willis v. Deerfield Twp,* 257 Mich.App 541, 550; 669 NW2d 279 (2003); see also *Quinto, supra* at 371-372. Indeed, Goldstone conceded that he could not produce any evidence showing that uninterrupted coverage was in place. Accordingly, the trial court properly granted defendant's motion for summary disposition under MCR 2.116(C)(10).

Plaintiff also alleged that the policy at issue was ambiguous because it failed to define the term "proof," and therefore, must be construed against defendant as the drafter. The failure to define a contractual term does not render a contract ambiguous. *Henderson v State Farm Fire & Casualty Co,* 460 Mich. 348, 354; 596 NW2d 190 (1999). In that case, a term must be examined in light of its plain and ordinary meaning. The plain and ordinary meaning of a term can be ascertained by utilizing the dictionary definition. *Echelon Homes, LLC v. Carter Lumber Co.* 472 Mich. 192, 196; 694 NW2d 544 (2005). In the present case, defendant's representative indicated that any type of proof, including paycheck stubs, would be satisfactory. Plaintiff did not present any proof, but made a blanket assertion that he had obtained the required policy. Moreover, the rule of contra proferentem, the rule that construes a contract against the drafter, is a rule of last resort that does not apply unless there is a true ambiguity and the parties' intent cannot be discerned. *Twichel v. MIC General Ins Corp,* 469 Mich. 524, 535 n 6; 676 NW2d 616 (2004).

We reject plaintiff's argument that defendant was estopped from denying liability in this case. Although defendant initially agreed to defend Goldstone, it did so under an explicit reservation of rights. Because defendant timely notified Goldstone that it was proceeding under a reservation of rights, it is not estopped from denying coverage. *Kirschner v. Process Design Assoc, Inc,* 459 Mich. 587, 593; 592 NW2d 707 (1999).

Furthermore, although the trial court did not address the question of plaintiff's standing, we agree that plaintiff lacked standing to pursue this action against defendant. Whether a party has standing is a question of law to be reviewed de novo. *Crawford v. Dep't of Civil Service,* 466 Mich. 250, 255; 645 NW2d 6 (2002).

"[I]n order to have standing a party must have a 'legally protected interest that is in jeopardy of being adversely affected.' " *Bowie v. Arder,* 441 Mich. 23, 42; 490 NW2d 568 (1992). In this case, plaintiff has no legally protected interest in defendant's policy, apart from whatever interest was assigned to him by Goldstone. Thus, plaintiff's standing, if any, arises by virtue of his agreement with Goldstone. While prohibitions against assignments are disfavored, where a clause prohibiting assignments is clear and unambiguous, it must be enforced as written. *Detroit Greyhound Employees Fed Credit Union v Aetna Life Ins Co,* 381 Mich. 683, 689-690; 167 NW2d 274 (1969); see also *Quality Products & Concepts Co v Nagel Precision, Inc,* 469 Mich. 362, 375; 666 NW2d 251 (2003). Here, defendant's policy expressly prohibited Goldstone's assignment of his "claims and causes of action" under the policy.[2] Thus, plaintiff has no interest under the policy and, therefore, has no standing to sue defendant. This provides an alternative basis for affirming the trial court's summary disposition order against plaintiff.

*3 In light of our decision, it is unnecessary to address whether plaintiff's claims against defendant were extinguished by his agreement with Goldstone.

Affirmed.

All Citations

Not Reported in N.W.2d, 2006 WL 859447

Footnotes

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1 Plaintiff Daniel J. Goldstone acted as an insurance agent for plaintiff Kreindler and allegedly failed to properly advise and maintain a disability insurance policy for plaintiff Kreindler's business. These individuals entered into a settlement agreement that assigned Goldstone's claims against defendant insurance company to plaintiff Kreindler. Accordingly, the singular plaintiff refers to Kreindler and the singular defendant refers to the insurance company. The claims against defendant Martin Waldman are not at issue in this appeal.

2 Goldstone's "claims and causes of action," if any, stem from his rights under the policy. Accordingly, there is no meaningful distinction between an assignment of Goldstone's "claims and causes of action," and an assignment of Goldstone's "interest" under the policy. A contrary result would render nugatory the policy's prohibition against assignments. *Klapp v United Ins Group Agency, Inc,* 468 Mich. 459, 468; 663 NW2d 447 (2003).

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1996 WL 33358104
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UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Court of Appeals of Michigan.

Joey EDWARDS and Kathy Edwards,
Plaintiffs/Counter Defendants/Appellees,
v.
CONCORD DEVELOPMENT CORPORATION, INC., Defendant/Counter Plaintiff/Cross Plaintiff/Appellant, [1]
and
TIFFANY'S CONSTRUCTION COMPANY, INC., Defendant/Counter Plaintiff/Cross Plaintiff/Appellant,
and
FLEET FINANCE, INC, Defendant/Counter Plaintiff/Cross Defendant/Appellee,
and
HASTINGS MUTUAL INSURANCE COMPANY, Defendant/Cross Defendant/Appellee.

No. 174487.
|
Sept. 17, 1996.

Before: DOCTOROFF, C.J. and HOOD and BANDSTRA, JJ.

UNPUBLISHED

PER CURIAM.

*1 Defendant Concord Development Corporation (Concord) appeals as of right from the trial court's judgment of no cause of action in favor of plaintiffs and the orders granting summary disposition in favor of defendants Hastings Mutual Insurance Company (Hastings) and Fleet Finance, Inc. We affirm.

After plaintiffs' home was severely damaged by fire, they entered into a fire repair agreement with Concord, in which Concord agreed to repair plaintiffs' home, in return for plaintiffs' assignment of insurance proceeds from their insurer, Hastings. Although Hastings paid plaintiff the actual cash value of the repairs on their home, plaintiffs' mortgage company, Fleet Finance, withheld a portion of the proceeds from Concord and applied it to plaintiffs' mortgage by order of the trial court. Because Concord did not complete the repairs on plaintiffs' home, plaintiffs brought an action against Concord for breach of contract. Plaintiffs also joined their insurance company (Hastings), their mortgage company (Fleet Finance), and Colonel Lee, an employee of Concord. [2] The trial court found that Concord breached the fire repair agreement by not completing work on plaintiffs' home and awarded damages to plaintiffs in the amount of $14,389.22, setting off plaintiffs' total damages by the value of work that was performed by Concord. The court granted summary disposition to Hastings and Fleet Finance pursuant to MCR 2.116(C)(10).

Concord first argues that the trial court erred in granting Hastings' motion for summary disposition because the assignment between plaintiffs and Concord was valid. We review grants or denials of motions for summary disposition de novo. *Lytle v. Malady,* 209 Mich.App 179, 183-184; 530 NW2d 135 (1995). Concord claims that Hastings was bound to include its name on the insurance draft that it issued to plaintiffs because the assignment of insurance proceeds from plaintiffs to Concord was legally valid and binding. That provision stated in pertinent part that plaintiffs "hereby give unto the CONCORD DEVELOPMENT CORPORATION, INC., all the necessary authority to have this fire loss adjusted and assigns to them the proceeds as payment in full for repairs." Hastings argues that the assignment was invalid and it was not bound by it because the contract it had with plaintiffs stated in relevant part that "[a]ssignment of this policy will not be valid unless we give our written consent" and Hastings did not give its written consent. However, Concord avers that non-assignment clauses are invalid and that even if they were valid, Hastings consented by virtue of its conduct in negotiating with its representative, Colonel Lee.

This Court has held that, as a general rule, contractual restrictions against assignability are strictly construed. *Stenke v. Masland Development,* 152 Mich.App 562, 575; 394 NW2d 418 (1986). However there is no prohibition against requiring consent to effectuate an assignment. *Hy King Associates v. Versatech Mfg Industries,* 826 F Supp

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231, 238-239; (ED Mich, 1993); *Kaczmarck v. La Perriere,* 337 Mich. 500, 504-506; 60 NW2d 327 (1953). The general presumption then is that a contractual right may be assigned, *Auto Electric & Service Corp v. Rockwell Int'l Corp,* 111 Mich.App 292, 300-301; 314 NW2d 562 (1981), but conversely that assignment may also be precluded by agreement: "A contractual right can be assigned unless ... assignment is validly precluded by contract." Restatement Contracts 2d, § 317(2).

***2** Although plaintiff cites *Roger Williams Ins Co v. Carrington,* 43 Mich. 252; 5 NW 303 (1880), to support its contention that non-assignment clauses are invalid, that case is distinguishable from the present case. In *Roger Williams,* the insurance company was attempting to avoid payment of its contract, whereas here, Hastings did not attempt to avoid its obligation under the contract; rather Hastings paid the full amount owed under the contract to plaintiffs. Thus, the provision requiring Hastings' written consent to assignment by plaintiffs was valid and, since Hastings did not give its written consent to plaintiffs' assignment of insurance proceeds to Concord, that assignment was not binding on Hastings.

Concord also argues that Hastings effectively consented to the assignment by virtue of negotiating the settlement amount with Lee. We disagree. We note that it does not appear that plaintiffs or Concord ever requested the consent of Hastings to the assignment. Concord claimed that it sent a copy of the fire repair agreement to Hastings and that Hastings was therefore on notice of the assignment when it dealt with Lee.

In *Hy King Associates, supra,* 826 F Supp 231, King agreed to be the exclusive sales representative of the defendant. King retired and transferred the stock in his corporation to Cozzi, who then acted as sales representative for the defendant for a brief period. The defendant claimed there was no valid assignment because it did not give its written consent as required by its contract with King. The court held that the defendant did not consent to the assignment because it did not recognize Cozzi as its sales representative, even though the defendant was enthusiastic about King bringing Cozzi into the business. *Id.* at 238.

Similarly, in the instant case, Hastings did not give its written or oral consent to the assignment. Rather, it dealt with Lee as a representative of plaintiffs for purposes of negotiating a settlement, but it continued to deal with plaintiffs at the same time. Edward Whalen, the insurance adjuster assigned to plaintiffs' claim, testified that he did not consider the assignment to be valid, and he dealt with Lee only as an agent of plaintiffs. We agree with the reasoning of *Hy King,* that such limited dealing with the purported assignee does not alone equate to consent.

Hastings contends that, even if the assignment to Concord was valid, Concord does not have any cause of action against it. An insured must actually repair, rebuild, or replace the property before the insurer becomes liable to pay the difference between actual cash value and replacement cost. *Smith v Michigan Basic Property Ins Ass'n,* 441 Mich. 181, 183; 490 NW2d 864 (1992). In this case, Concord did not complete the repairs on plaintiffs' home. Whalen testified that Hastings paid to plaintiffs $58,000 for the actual cash value of their home. Since there was no testimony that the actual cash value of plaintiffs home was more than $58,000 or that Hastings owed plaintiffs more money for the repairs, Hastings fulfilled its obligation to plaintiffs. Since an assignee receives only those rights which the assignor possessed, Concord would not have any claim against Hastings for additional money over what was paid for the actual cash value. *Damerau v. CL Rieckhoff Co,* 155 Mich.App 307, 313; 399 NW2d 502 (1986). Therefore, the granting of Hastings' motion for summary disposition pursuant to MCR 2.116(C)(10) was proper because there was no genuine issue of material fact regarding liability under the assignment clause of the fire repair agreement.

***3** Concord further argues that Hastings acted with malice through its agent Whalen by ignoring the agreement between plaintiffs and Concord, while at the same time acknowledging that Concord, through Lee, represented plaintiffs in negotiating the settlement of their claim. Therefore, Concord asserts, Hastings should have been found liable for tortious interference with a contractual relationship.

The elements of tortious interference with a contractual relationship are (1) a contract, (2) a breach, and (3) instigation of the breach without justification by the defendant....

> "One who alleges tortious interference with a contractual or business relationship must allege the intentional doing of a per se wrongful act or

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> the doing of a lawful act with malice and unjustified in law for the purpose of invading the contractual rights or business relationship of another."

... [A] defendant is not liable for tortious interference of a contract where he is motivated by legitimate personal or business interests. [*Wood v Herndon & Herndon Investigations, Inc,* 186 Mich.App 495, 499-500; 465 NW2d 5 (1990).]

Hastings did not approve the assignment of insurance proceeds from plaintiffs to Concord. Therefore Hastings was not required to make any payments to Concord. Hastings took no action to interfere with the contract between plaintiffs and Concord. The reason that Concord was not paid from the insurance proceeds was that Fleet Finance intervened and held the proceeds in escrow. If Fleet Finance had not intervened, then plaintiffs would have been able to pay Concord with those proceeds. Thus, although Hastings did not include Concord's name on the insurance draft, they did not instigate a breach without legal justification and did not perform a wrongful act or a lawful act with malice for the purpose of invading the contractual rights of plaintiffs or Concord. Hastings only ignored the assignment which it was justified in doing for legitimate business reasons.[3] Accordingly, the trial court properly granted Hastings' motion for summary disposition because there was no genuine issue of material fact as to whether Hastings tortiously interfered with the contract between plaintiffs and Concord.

Concord next argues that the court's finding that Concord breached its contract with plaintiffs was clearly erroneous. We review findings of fact in a bench trial under a clearly erroneous standard, MCR 2.613(C), *Hoffman v. ACIA.* 211 Mich.App 55, 98, 101; 535 NW2d 529 (1995). A breach of contract is the failure to perform when performance is due. *Woody v. Tamer,* 158 Mich.App 764, 771; 405 NW2d 213 (1987). Plaintiffs argue that Concord breached the fire repair agreement by failing to complete the repairs on their home. Concord argues that plaintiffs were the ones that failed to perform under the fire repair agreement by not paying Concord for the work it performed on their home. On appeal, neither party disputes the existence of a contract.

*4 The trial court weighed the credibility of the witnesses and determined that the testimony of plaintiffs and Whalen was more credible than the testimony of Colonel Lee. Whalen testified that in his twenty-eight years as an insurance adjuster, he has never paid a contractor before work has begun. Lee testified that even though he was not paid up front, he proceeded to work on plaintiffs' house and continued to do so even after his requests for payment were not honored. However, at some point, Concord ceased work on the house and the repairs were never finished. Whalen testified that a contractor is paid after the work is completed and that a contractor funds the repairs until that time. Thus, the court's finding that Concord breached its contract by not completing the work despite not being paid was not clearly erroneous.

Concord claims that the court considered the evidence of plaintiffs' understanding of the terms of the contract in violation of the parol evidence rule. Where a contract is clear and unambiguous, parol evidence of negotiations cannot be admitted to vary the contract. *Central Transport, Inc v. Fruehauf Corp,* 139 Mich.App 536, 544; 362 NW2d 823 (1984). The parol evidence rule also bars admission of prior or contemporaneous agreements that contradict or vary the written contract. *Id.* Prerequisite to application of the parol evidence rule is a finding that the parties intended the writing to be a complete expression of their agreement. *Id.* Extrinsic evidence of prior or contemporaneous agreements or negotiations is admissible as it bears on this threshold question. *Id.* Parol evidence is also admissible to explain the terms of the contract and has application only after the terms of the agreement have been challenged. *Stefanac v Cranbrook Educational Community,* 435 Mich. 155, 171-172; 458 NW2d 56 (1990).

The contract between plaintiffs and Concord stated that "endorsement of the fire draft to the Concord Development Corporation, Inc., will be payment in full for all services rendered ." The contract also contained a "draw down schedule" providing for payment installments of one-third up front, one-third after a third of the work is completed, eighteen percent after ninety percent of the work is completed, and the balance upon final completion. These two provisions are contradictory on their face. The former provision indicates that whatever money is paid by the insurance company in one check will be payment in full for the repairs. However, the latter provision requires payment installments. The parol

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evidence rule only bars extrinsic evidence if a contract is clear and unambiguous. *Central Transport, supra.* This contract was not clear and unambiguous because the two provisions contradict each other.

Furthermore, extrinsic evidence may be admitted to explain the terms of a contract. *Stefanac, supra.* Thus, plaintiffs' testimony as to their understanding of the contract was admissible to explain its terms. Both plaintiffs and Lee testified that Lee told them that the repairs would be paid for with the insurance proceeds in the form of a draft by the insurance company in the names of both plaintiffs and Concord. That evidence does not contradict the written contract. Plaintiffs further testified that Lee told them that the draw down schedule provisions did not apply to them. Accordingly, plaintiffs' testimony as to their understanding of the contract was proper to explain the terms of the contract.[4] Accordingly, because we are not left with a definite and firm conviction that a mistake was made, the trial court's finding that Concord breached its contract with plaintiffs and its award of $14,390 in damages was not clearly erroneous.

*5 Next, Concord argues that the trial court erred in granting Fleet Finance's motion for summary disposition because Fleet Finance tortiously interfered with the contract between plaintiffs and Concord. However, the trial court correctly found that the elements of tortious interference were not met. First, although there was a contract between plaintiffs and Concord, Concord did not suffer a breach at the hands of plaintiffs. Furthermore, even if there was a breach, Fleet Finance did not instigate a breach without legal justification. The mortgage contract between Fleet Finance and plaintiffs provided that Fleet Finance was entitled to payment of the mortgage balance if their security interest in the home was impaired. The fire destroying plaintiffs' home caused such an impairment. However, instead of instantly applying the insurance funds to the mortgage balance, Fleet Finance negotiated with plaintiffs and entered into an escrow/loan construction agreement. The agreement would allow payment of the insurance funds toward repair of the home if certain conditions were met. Because there was no testimony that those conditions were met,[5] Fleet Finance was not obligated to make payments to Concord from the escrow fund. Since there was no indication that Fleet Finance had any motivation other than protecting its security interest in plaintiffs' home, and it adhered to the terms of its mortgage agreement with plaintiffs, there was no per se wrongful act on the part of Fleet Finance. Fleet Finance appeared to be motivated solely by the legitimate business interest of protecting its investment. Accordingly, there was no genuine issue of material fact that Fleet Finance tortiously interfered in the contract between plaintiffs and Concord, and the trial court properly granted summary disposition pursuant to MCR 2.116(C)(10).

Affirmed.

All Citations

Not Reported in N.W.2d, 1996 WL 33358104

Footnotes

1 Although Concord is not listed as appellant, it is in fact the appellant.

2 The trial court entered a judgment of no cause of action in Lee's favor, and no appeal was taken from that order.

3 Moreover, as will be dscussed below, the court properly held that plaintiffs did not breach their contract with Concord, therefore, the second element required for tortious interference with a contract has not been met.

4 Concord does not explain in its brief why the court's award of damages was erroneous, other than addressing the issue in its question presented. However, the court's award of $14,390 to plaintiffs was not clearly erroneous because the court appeared to use reasonable calculations, based on the figures submitted into evidence by the parties, to arrive at that figure.

5 Fleet Finance's counsel, during the hearing on its motion for summary disposition stated that Concord did not comply with the terms and conditions of the escrow agreement.

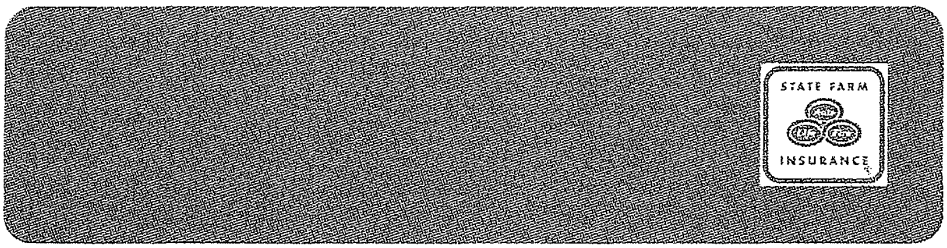
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Please read the policy carefully. If an insured has an accident, contact your State Farm agent or one of our Claim Offices at once. (See "INSURED'S DUTIES" in this policy.)

State Farm®
Car Policy
Booklet

Michigan
Policy Form 9822B

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THIS POLICY

1. This policy is issued by the State Farm Mutual Automobile Insurance Company or the State Farm Fire and Casualty Company, as shown by the company's name on the Declarations Page.
2. This policy consists of:
   a. the most recently issued Declarations Page;
   b. the policy booklet version shown on that Declarations Page; and
   c. any endorsements that apply, including those listed on that Declarations Page as well as those issued in connection with any subsequent renewal of this policy.
3. This policy contains all of the agreements between all the named insureds who are shown on the Declarations Page and all applicants and:
   a. ***us***; and
   b. any of ***our*** agents.
4. ***We*** agree to provide insurance according to the terms of this policy:
   a. based on payment of premium for the coverages chosen; and
   b. unless otherwise stated in EXCEPTIONS, POLICY BOOKLET, & ENDORSEMENTS on the Declarations Page, in reliance on the following statements:
      (1) ***Your car*** is ***owned by*** the named insured shown on the Declarations Page.
      (2) ***Your car*** is used for pleasure and business.
5. All named insureds shown on the Declarations Page and all applicants agree by acceptance of this policy that:
   a. the statements in 4.b. above are made by such named insured or applicant and are true; and
   b. ***we*** provide this insurance on the basis those statements are true.
6. ***Your*** purchase of this policy may allow you to purchase certain coverages, coverage options, coverage deductibles, coverage limits, or coverage terms on other policies from the ***State Farm Companies***, subject to their applicable eligibility rules.

DEFINITIONS

We define certain words and phrases below for use throughout the policy. Each coverage includes additional definitions only for use with that coverage. These definitions apply to the singular, plural, possessive, and any other form of these words and phrases. Defined words and phrases are printed in boldface italics.

Bodily Injury means bodily injury to a ***person*** and sickness, disease, or death that results from it, including damage to or loss of a ***person's*** prosthetic devices in connection with the bodily injury.

Car means a land motor vehicle with four or more wheels, designed for use primarily on public roads.

Car does not include:

1. Any vehicle while located for use as a dwelling or other premises; or
2. A truck-tractor designed to pull any type of trailer.

Car Business means a business or job where the purpose is to sell, lease, rent, repair, service, modify, transport, store, or park land motor vehicles or any type of trailer.

Newly Acquired Car means a ***car*** newly ***owned by you***. A ***car*** ceases to be a ***newly acquired car*** on the earlier of:

1. the effective date and time of a policy, including any binder, issued by *us* or any other company that describes the *car* as an insured vehicle; or
2. the end of the 14th calendar day immediately following the date the *car* is delivered to *you*.

If a *newly acquired car* is not otherwise afforded comprehensive coverage or any collision coverage by this or any other policy, then this policy will provide Comprehensive Coverage or Collision Coverage for that *newly acquired car*, subject to a deductible of $500. Any coverage provided as a result of this paragraph will apply only until the end of the 5th calendar day immediately following the date the *newly acquired car* is delivered to *you*.

Non-Owned Car means a *car* that is in the lawful possession of *you* or any *resident relative* and that is not *owned by*:

1. *you*;
2. any *resident relative*;
3. any other *person* domiciled in *your* household; or
4. an employer of any *person* described in 1., 2., or 3. above.

Occupying means in, on, entering, or alighting from.

Our means the Company issuing this policy as shown on the Declarations Page.

Owned By means:

1. rented or available for use, under a lease or otherwise, for a period that is greater than 30 days by;
2. legally titled to or registered to; or
3. available for the immediate right of possession under an installment sale contract by.

Person means a human being.

Private Passenger Car means:

1. a *car* of the private passenger type, other than a pickup truck, van, minivan, or sport utility vehicle, designed primarily to carry *persons* and their luggage; or
2. a pickup truck, van, minivan, or sport utility vehicle:
   a. that is not used for:
      (1) wholesale; or
      (2) retail
      pick up or delivery; and
   b. that has a Gross Vehicle Weight Rating of 10,000 pounds or less.

Resident Relative means a *person*, other than *you*, domiciled in the same household with the first *person* shown as a named insured on the Declarations Page and who is:

1. related to that named insured or his or her *spouse* by blood, marriage, or adoption, including an unmarried and unemancipated child of either who is away at school and otherwise maintains his or her domicile with that named insured; or
2. a ward or a foster child of that named insured, his or her *spouse*, or a person described in 1. above.

Spouse means a *person* who is:

1. legally married to the first *person* shown as a named insured on the Declarations Page; and
2. domiciled in:
   a. the same household as that named insured; or
   b. a different household from that named insured but shares economic and non-economic burdens with that named insured.

State Farm Companies means one or more of the following:

1. State Farm Mutual Automobile Insurance Company;
2. State Farm Fire and Casualty Company; and
3. Subsidiaries or affiliates of either 1. or 2. above.

Temporary Substitute Car means a *car* that is in the lawful possession of the *person* operating it and that:

1. replaces *your car* for a short time while *your car* is out of use due to its:
   a. breakdown;
   b. repair;
   c. servicing;
   d. damage; or
   e. theft; and
2. neither *you* nor the *person* operating it own or have registered.

If a *car* qualifies as both a *non-owned car* and a *temporary substitute car*, then it is considered a *temporary substitute car* only.

Trailer means:

1. a trailer:
   a. designed to be pulled by a *private passenger car*;
   b. not designed to carry *persons*; and
   c. while not used as premises for office, store, or display purposes; or
2. a farm implement or farm wagon while being pulled on public roads by a *car*.

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Us means the Company issuing this policy as shown on the Declarations Page.

We means the Company issuing this policy as shown on the Declarations Page.

You or *Your* means the named insured or named insureds shown on the Declarations Page. If a named insured shown on the Declarations Page is a *person*, then "*you*" or "*your*" includes the *spouse* of the first *person* shown as a named insured on the Declarations Page.

Your Car means the vehicle shown under "YOUR CAR" on the Declarations Page. *Your Car* does not include a vehicle that *you* no longer own or lease.

If a *car* is shown on the Declarations Page under "YOUR CAR", and *you* ask *us* to replace it with a *car* newly *owned by you*, then the *car* being replaced will continue to be considered *your car* until the earliest of:

1. the end of the 30th calendar day immediately following the date the *car* newly *owned by you* is delivered to *you*;
2. the date this policy is no longer in force; or
3. the date *you* no longer own or lease the *car* being replaced.

LIABILITY COVERAGES

The liability coverages are Liability Coverage and Limited Property Damage Liability Coverage.

This policy provides:

1. Liability Coverage if "A";
2. Limited Property Damage Liability Coverage if "Y",

is shown under "Symbols" on the Declarations Page.

Additional Definition – Liability Coverage and Limited Property Damage Liability Coverage

Insured means:

1. *you* and *resident relatives* for:
   a. the ownership, maintenance, or use of:
      (1) *your car*;
      (2) a *newly acquired car*; or
      (3) a *trailer*; and
   b. the maintenance or use of:
      (1) a *non-owned car*; or
      (2) a *temporary substitute car*;
2. the first *person* shown as a named insured on the Declarations Page and that named insured's *spouse*, for the maintenance or use of a *car* that is *owned by*, or furnished by an employer to, a *person* domiciled in *your* household, but only if such *car* is neither *owned by*, nor furnished by an employer to, the first *person* shown as a named insured on the Declarations Page or that *person's spouse*;
3. any other *person* for his or her use of:
   a. *your car*;
   b. a *newly acquired car*;
   c. a *temporary substitute car*; or
   d. a *trailer* while attached to a *car* described in a., b., or c. above.

   Such vehicle must be used with *your* express or implied permission; and
4. any other *person* or organization vicariously liable for the use of a vehicle by an *insured* as defined in 1., 2., or 3. above. This provision applies only if the vehicle is neither *owned by*, nor hired by, that other *person* or organization.

Insuring Agreement

1. **Liability Coverage**

   We will pay damages an *insured* becomes legally liable to pay because of:
   a. *bodily injury* to others; and
   b. damage to property

   caused by an accident that involves a vehicle for which that *insured* is provided Liability Coverage by this policy.

2. **Limited Property Damage Liability Coverage**

   We will pay for damage to a motor vehicle for which the *insured* becomes legally liable to pay pursuant to Section 500.3135, Subsection (3)(e) of the Michigan Insurance Code.

   The *insured* must appear and defend himself or herself in any action commenced for this damage in the Small Claims Division of the District Court or the Municipal Court. FAILURE OF THE *INSURED* TO APPEAR AND DEFEND HIMSELF OR HERSELF VOIDS THE COVERAGE PROVIDED FOR THESE DAMAGES.

3. **Liability Coverage and Limited Property Damage Liability Coverage**

   a. *We* will pay:

      (1) except where prohibited by Michigan law, attorney fees for attorneys chosen by *us* to defend an *insured* who is sued for such damages; and

      (2) court costs charged to an *insured* and resulting from that part of a lawsuit:

         (a) that seeks damages payable under this policy's Liability Coverage or Limited Property Damage Liability Coverage; and

         (b) against which *we* defend an *insured* with attorneys chosen by *us*; or

         (c) against which an *insured* defends himself or herself in a small claims court action.

      We have no duty to pay attorney fees and court costs incurred after *we* deposit in court or pay the amount due under this policy's Liability Coverage or Limited Property Damage Liability Coverage.

   b. *We* have the right to:

      (1) investigate, negotiate, and settle any claim or lawsuit;

      (2) defend an *insured* in any claim or lawsuit, with attorneys chosen by *us*, except when prohibited by Michigan law; and

      (3) appeal any award or legal decision

      for damages payable under this policy's Liability Coverage or Limited Property Damage Liability Coverage.

Supplementary Payments – Liability Coverage and Limited Property Damage Liability Coverage

We will pay, in addition to the damages, fees, and costs described in the **Insuring Agreements** above, the costs or expenses listed below that result from such accident:

1. Interest on damages owed by the *insured* that accrues:

   a. before a judgment, where owed by law, but only on that part of the judgment *we* pay; and

   b. after a judgment. *We* will not pay interest on damages paid or payable by a party other than the *insured* or *us*.

   We have no duty to pay interest that accrues after *we* deposit in court, pay, or offer to pay, the amount due under this policy's Liability Coverage or Limited Property Damage Liability Coverage;

2. Premiums for bonds, provided by a company chosen by *us*, required to appeal a decision in a lawsuit against an *insured*. *We* have no duty to:

   a. pay for bonds that exceed this policy's applicable Liability Coverage or Limited Property Damage Liability Coverage limit;

   b. furnish or apply for any bonds; or

   c. pay premiums for bonds purchased after *we* deposit in court, pay, or offer to pay, the amount due under this policy's Liability Coverage or Limited Property Damage Liability Coverage; and

3. The following costs and expenses if related to and incurred after a lawsuit has been filed against an *insured*:

   a. Loss of wages or salary, but not other income, up to $200 for each day an *insured* attends, at *our* request:

      (1) an arbitration;

      (2) a mediation; or

      (3) a trial of a lawsuit; and

   b. Reasonable expenses incurred by an *insured* at *our* request other than loss of wages, salary, or other income.

   The amount of any of the costs or expenses listed above that are incurred by an *insured* must be reported to *us* before *we* will pay such incurred costs or expenses.

Limits – Liability Coverage

The Liability Coverage limits for *bodily injury* are shown on the Declarations Page under "Liability Coverage – Bodily Injury Limits – Each Person, Each Accident."

The limit shown under "Each Person" is the most *we* will pay for all damages resulting from *bodily injury* to any one *person* injured in any one accident, including all damages sustained by other *persons* as a result of that *bodily injury*. The limit shown under "Each Accident" is the most *we* will pay, subject to the limit for "Each Person", for all damages resulting from *bodily injury* to two or more *persons* injured in the same accident.

The Liability Coverage limit for damage to property is shown on the Declarations Page under "Liability Coverage – Property Damage Limit – Each Accident". The limit shown is the most *we* will pay for all damages resulting from damage to property in any one accident.

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These Liability Coverage limits are the most *we* will pay regardless of the number of:

1. *insureds*;
2. claims made;
3. vehicles insured; or
4. vehicles involved in the accident.

Nonduplication – Liability Coverage and Limited Property Damage Liability Coverage

We will not pay any damages or expenses under Liability Coverage or Limited Property Damage Liability Coverage:

1. that have already been paid as expenses under Property Protection Coverage of any policy issued by the ***State Farm Companies*** to *you* or any *resident relative*; or
2. that have already been paid under Uninsured Motor Vehicle Coverage or Underinsured Motor Vehicle Coverage of any policy issued by the ***State Farm Companies*** to *you* or any *resident relative*.

Exclusions – Liability Coverage and Limited Property Damage Liability Coverage

THERE IS NO COVERAGE FOR AN ***INSURED***:

1. WHO INTENTIONALLY CAUSES DAMAGE TO PROPERTY;
2. FOR DAMAGES ARISING OUT OF THE OWNERSHIP, MAINTENANCE, OR USE OF A VEHICLE WHILE IT IS RENTED TO OR LEASED TO OTHERS BY AN ***INSURED***;
3. FOR DAMAGES ARISING OUT OF THE OWNERSHIP, MAINTENANCE, OR USE OF A VEHICLE WHILE IT IS BEING USED TO CARRY ***PERSONS*** FOR A CHARGE.

   This exclusion does not apply to the use of a *private passenger car*:

   a. on a share-the-expense carpool basis;
   b. for volunteer or charitable purposes; or
   c. for which the only reimbursement involved is for normal operating expenses.
4. WHILE MAINTAINING OR USING A VEHICLE IN CONNECTION WITH THAT ***INSURED'S*** EMPLOYMENT IN OR ENGAGEMENT OF ANY KIND IN A ***CAR BUSINESS***. This exclusion does not apply to:

   a. *you*; or
   b. any *resident relative*
   c. any agent, employee, or business partner of a. or b. above

   while maintaining or using *your car*, a *newly acquired car*, a *temporary substitute car*, or a *trailer owned by you*;
5. WHILE THAT ***INSURED*** IS VALET PARKING A VEHICLE;
6. WHILE MAINTAINING OR USING ANY VEHICLE OTHER THAN ***YOUR CAR***, A ***NEWLY ACQUIRED CAR***, A ***TEMPORARY SUBSTITUTE CAR***, OR A ***TRAILER*** IN ANY BUSINESS OR OCCUPATION OTHER THAN A ***CAR BUSINESS*** OR VALET PARKING. This exclusion does not apply to the maintenance or use of a *private passenger car*;
7. FOR DAMAGE TO PROPERTY WHILE IT IS:

   a. ***OWNED BY***;
   b. RENTED TO;
   c. USED BY;
   d. IN THE CARE OF; OR
   e. TRANSPORTED BY

   YOU, A ***RESIDENT RELATIVE***, OR THE ***PERSON*** WHO IS LEGALLY LIABLE FOR THE DAMAGE. This exclusion does not apply to damage to a:

   a. motor vehicle *owned by* the employer of *you* or any *resident relative* if such damage is caused by an *insured* while operating another motor vehicle;
   b. residence while rented to or leased to an *insured*; or
   c. private garage while rented to or leased to an *insured*;
8. FOR LIABILITY ASSUMED UNDER ANY CONTRACT OR AGREEMENT;
9. FOR ANY ORDER OF RESTITUTION ISSUED BY A COURT IN A CRIMINAL PROCEEDING OR EQUITABLE ACTION;
10. FOR THE OWNERSHIP, MAINTENANCE, OR USE OF ANY VEHICLE WHILE IT IS:

    a. OFF PUBLIC ROADS AND BEING PREPARED FOR, USED IN PRACTICE FOR, OR OPERATED IN ANY RACING CONTEST, SPEED CONTEST, HILL-CLIMBING CONTEST, JUMPING CONTEST, OR ANY SIMILAR CONTEST; OR
    b. ON A TRACK DESIGNED PRIMARILY FOR RACING OR HIGH SPEED DRIVING. This exclusion (10.b.) does not apply if the vehicle is being used in connection

with an activity other than racing, high-speed driving, or any type of competitive driving;

11. WHO IS AN EMPLOYEE OF THE UNITED STATES OF AMERICA OR ANY OF ITS AGENCIES, IF THE PROVISIONS OF THE FEDERAL TORT CLAIMS ACT APPLY;
12. IF THAT ***INSURED*** IS THE UNITED STATES OF AMERICA OR ANY OF ITS AGENCIES; OR
13. FOR THE OWNERSHIP, OPERATION, MAINTENANCE OR USE OF ANY VEHICLE ***OWNED BY***:
    a. ***YOU***;
    b. ANY ***RESIDENT RELATIVE***;
    c. ANY OTHER ***PERSON*** DOMICILED IN ***YOUR*** HOUSEHOLD; OR
    d. AN EMPLOYER OF ANY ***PERSON*** DESCRIBED IN a., b., OR c. ABOVE.

    This exclusion does not apply to:
    a. ***your car***, a ***newly acquired car***, a ***temporary substitute car***, or a ***trailer***; and
    b. the first ***person*** shown as a named insured on the Declarations Page and that named insured's ***spouse,*** for the maintenance or use of a ***car*** that is ***owned by***, or furnished by an employer to, a ***person*** domiciled in ***your*** household, but only if such ***car*** is neither ***owned by***, nor furnished by an employer to, the first ***person*** shown as a named insured on the Declarations Page or that ***person's spouse***.

Exclusions – Liability Coverage Only

THERE IS NO COVERAGE FOR AN ***INSURED***:

1. WHO INTENTIONALLY CAUSES ***BODILY INJURY***;
2. OR FOR THAT ***INSURED'S*** INSURER FOR ANY OBLIGATION UNDER ANY TYPE OF WORKERS' COMPENSATION, DISABILITY, OR SIMILAR LAW;
3. FOR ***BODILY INJURY*** TO THAT ***INSURED'S*** EMPLOYEE WHICH ARISES OUT OF THAT EMPLOYEE'S EMPLOYMENT. This exclusion does not apply to that ***insured's*** household employee who is neither covered, nor required to be covered, under workers' compensation insurance;
4. FOR ***BODILY INJURY*** TO THAT ***INSURED'S*** FELLOW EMPLOYEE WHILE THE FELLOW EMPLOYEE IS IN THE COURSE AND SCOPE OF HIS OR HER EMPLOYMENT. This exclusion does not apply to ***you*** and ***resident relatives*** who are legally liable for ***bodily injury*** to fellow employees;
5. WHILE USING A ***TRAILER*** WITH A MOTOR VEHICLE IF THAT ***INSURED*** IS NOT PROVIDED LIABILITY COVERAGE BY THIS POLICY FOR THE USE OF THAT MOTOR VEHICLE; OR
6. FOR PROPERTY DAMAGE TO A MOTOR VEHICLE FOR WHICH THAT ***INSURED*** IS LIABLE, PURSUANT TO SECTION 500.3135, SUBSECTION (3)(e) OF THE MICHIGAN INSURANCE CODE.

If Other Liability Coverage Applies

1. If Liability Coverage provided by this policy and one or more other Car Policies issued to ***you*** or any ***resident relative*** by the ***State Farm Companies*** apply to the same accident, then:
    a. the Liability Coverage limits of such policies will not be added together to determine the most that may be paid; and
    b. the maximum amount that may be paid from all such policies combined is the single highest applicable limit provided by any one of the policies. ***We*** may choose one or more policies from which to make payment.
2. The Liability Coverage provided by this policy applies as primary coverage for the ownership, maintenance, or use of ***your car*** or a ***trailer*** attached to it.
    a. If:
        (1) this is the only Car Policy issued to ***you*** or any ***resident relative*** by the ***State Farm Companies*** that provides Liability Coverage which applies to the accident as primary coverage; and
        (2) liability coverage provided by one or more sources other than the ***State Farm Companies*** also applies as primary coverage for the same accident,

    then ***we*** will pay the proportion of damages payable as primary that ***our*** applicable limit bears to the sum of ***our*** applicable limit and the limits of all other liability coverage that apply as primary coverage.
    b. If:
        (1) more than one Car Policy issued to ***you*** or any ***resident relative*** by the

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State Farm Companies provides Liability Coverage which applies to the accident as primary coverage; and

(2) liability coverage provided by one or more sources other than the *State Farm Companies* also applies as primary coverage for the same accident,

then the *State Farm Companies* will pay the proportion of damages payable as primary that the maximum amount that may be paid by the *State Farm Companies* as determined in 1. above bears to the sum of such amount and the limits of all other liability coverage that apply as primary coverage.

3. Except as provided in 2. above, the Liability Coverage provided by this policy applies as excess coverage.

   a. If:

      (1) this is the only Car Policy issued to *you* or any *resident relative* by the *State Farm Companies* that provides Liability Coverage which applies to the accident as excess coverage; and

      (2) liability coverage provided by one or more sources other than the *State Farm Companies* also applies as excess coverage for the same accident,

      then *we* will pay the proportion of damages payable as excess that *our* applicable limit bears to the sum of *our* applicable limit and the limits of all other liability coverage that apply as excess coverage.

   b. If:

      (1) more than one Car Policy issued to *you* or any *resident relative* by the *State Farm Companies* provides Liability Coverage which applies to the accident as excess coverage; and

      (2) liability coverage provided by one or more sources other than the *State Farm Companies* also applies as excess coverage for the same accident,

      then the *State Farm Companies* will pay the proportion of damages payable as excess that the maximum amount that may be paid by the *State Farm Companies* as determined in 1. above bears to the sum of such amount and the limits of all other liability coverage that apply as excess coverage.

Required Out-of-State Liability Coverage

If:

1. an *insured* is in another state of the United States of America, a territory or possession of the United States of America, the District of Columbia, or any province or territory of Canada, and as a nonresident becomes subject to its motor vehicle compulsory insurance law, financial responsibility law, or similar law; and
2. this policy does not provide at least the minimum liability coverage required by such law for such nonresident,

then this policy will be interpreted to provide the minimum liability coverage required by such law.

This provision does not apply to liability coverage required by law for motor carriers of passengers or motor carriers of property.

Financial Responsibility Certification

When this policy is certified under any law as proof of future financial responsibility, and while required during the policy period, this policy will comply with such law to the extent required.

PERSONAL INJURY PROTECTION COVERAGE AND ADDITIONAL WORK LOSS COVERAGE

This policy provides:

1. Personal Injury Protection Coverage if "P" or "P" with a number beside it;
2. Additional Work Loss Coverage if "Q1" or "Q2";

is shown under "Symbols" on the Declarations Page.

Additional Definitions

Dependent survivor means:

1. the *insured's* spouse who lived with, or was dependent on, the *insured* at the time of the *insured's* death. Survivor's benefits end for a spouse when he or she remarries or dies; and

2. any other *person* who was dependent on the *insured* at the time of the *insured's* death. Such *person* qualifies for benefits if, and only so long as, he or she is alive and:
   a. under the age of 18 years;
   b. physically or mentally incapacitated from earning; or
   c. engaged full time in a formal program of academic or vocational education or training.

Insured for Personal Injury Protection Coverage means:

1. *you* or any *resident relative*; and
2. any other *person* while *occupying* or injured as a *pedestrian* by:
   a. *your car*;
   b. a *newly acquired car*; or
   c. any other *motor vehicle* that is being operated by *you* or a *resident relative* and for which that operator is provided Liability Coverage by this policy.

Insured for Additional Work Loss Coverage means a *person* whose name is shown under either "Additional Work Loss Coverage – Q1 – Persons Insured" or "Additional Work Loss Coverage – Q2 – Persons Insured" on the Declarations Page.

Motor Vehicle means a vehicle, including a trailer:

1. operated or designed to be operated on public highways by power other than muscular power; and
2. which has more than two wheels.

Motor Vehicle does not include a *motorcycle*, moped, farm tractor, or other implement of husbandry as defined by Michigan law.

Motorcycle means a vehicle:

1. having a saddle or seat for the use of the rider;
2. designed to travel on not more than three wheels; and
3. with a motor that exceeds 50 cubic centimeters piston displacement.

Motorcycle does not include a moped as defined by Michigan law.

No-Fault Act means Chapter 31 of the Michigan Insurance Code and any amendments.

Pedestrian means a *person* who is not *occupying* a *motor vehicle*.

Insuring Agreement

1. **Personal Injury Protection Coverage**

   We will pay, subject to the provisions of the *No-Fault Act*, for accidental *bodily injury* to an *insured* arising out of the ownership, operation, maintenance or use of a *motor vehicle* as a *motor vehicle*:

   a. **Allowable Expense Benefits**

      Allowable expenses are all reasonable charges incurred for reasonably necessary products, services and accommodations for an *insured's* care, recovery or rehabilitation.

      The most *we* will pay for a hospital room is the reasonable and customary charge for semiprivate accommodations, unless special or intensive care is required.

      Any charges:

      (1) agreed to by both the *insured's* healthcare provider and *us*; or

      (2) agreed upon between the *insured's* healthcare provider and a third party when *we* have a contract with such third party

      are considered reasonable charges.

      We have the right to enter into a contract with a third party that has an agreement with the *insured's* healthcare provider to charge fees as determined by that agreement.

      Allowable expenses also includes funeral and burial expenses. The most *we* will pay for funeral and burial expenses incurred for any one *insured* is $3,000.

   b. **Work Loss Benefits**

      Work loss is the *insured's* actual loss of earnings from work the *insured* would have performed during the first three years after the date of the accident if he or she had not been injured. Work loss does not include any loss after the date the injured *insured* dies.

      Work loss for an *insured* who is temporarily unemployed at the time of the accident or during the period of disability shall be based on the earned income for the last month he or she was employed full time prior to the accident.

      The most *we* will pay for work loss in any single 30-day period shall not exceed the amount in effect on the date of the accident as determined by the Commissioner of Insurance subject to the provisions of the *No-Fault Act*.

      The maximum amount for any 30-day period is reduced by any income earned by the *insured* in that period.

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If a period of work loss is less than 30 days, the maximum amount payable for that period is the pro-rata amount of the 30-day maximum.

The benefits payable for such loss of income shall be reduced by 15% unless the ***insured*** presents to ***us*** reasonable proof of a lower value of the income tax advantage in his or her case, in which case the lower value shall apply.

c. **Loss of Services Benefits**

Loss of services expenses are expenses reasonably incurred for ordinary and necessary services the ***insured*** would have done, except for the injury, during the first three years after the date of the accident:

(1) not for income; and

(2) for the benefit of the ***insured*** or his or her dependents.

Loss of services benefits does not pay any expenses incurred after the date the injured ***insured*** dies.

The most ***we*** will pay for expenses for ordinary and necessary services is $20 per day.

d. **Survivors' Benefits**

Survivors' benefits cover:

(1) the loss of tangible things of economic value, except services, the ***insured*** would have contributed to his or her ***dependent survivors*** for support during their dependency and after the date on which the injured ***insured*** died; and

(2) expenses reasonably incurred by ***dependent survivors***, up to $20 per day, for ordinary and necessary services the ***insured*** would have done for their benefit during their dependency and after the date on which the injured ***insured*** died,

if the ***insured*** had not been fatally injured.

Subject to the daily limit for ordinary and necessary services, the most ***we*** will pay in survivor's loss benefits in any single 30-day period for all ***dependent survivors*** as the result of the death of any one ***insured*** shall not exceed the amount in effect on the date of the accident as determined by the Commissioner of Insurance subject to the provisions of the *No-Fault Act*.

Survivors' loss must be sustained during the first three years after the date of the accident.

2. **Additional Work Loss Coverage**

The Personal Injury Protection Coverage work loss benefit is changed for an ***insured*** by:

a. changing the first paragraph of the provision to read:

Work loss is the ***insured's*** actual loss of earnings from work the ***insured*** would have performed during the first five years after the date of the accident if he or she had not been injured. Work loss does not include any loss after the date the injured ***insured*** dies.

b. increasing the most ***we*** will pay for work loss in any 30-day period by:

(1) $1,000 for an ***insured*** whose name is shown under "Additional Work Loss Coverage – Persons Insured" for Q1 on the Declarations Page; or

(2) $5,000 for an ***insured*** whose name is shown under "Additional Work Loss Coverage – Persons Insured" for Q2 on the Declarations Page.

All other Personal Injury Protection Coverage provisions apply to Additional Work Loss Coverage other than as specifically indicated under exclusions.

Our Payment Options

We may, in accordance with applicable law, make payment to one or more of the following:

1. The injured ***insured***;
2. Any ***person*** or organization that provides the services;
3. The ***insured's*** surviving spouse;
4. The ***insured's dependent survivors***;
5. A parent or guardian of the ***insured***, if the ***insured*** or ***dependent survivor*** is a minor or an incompetent ***person***; or
6. A ***person*** authorized by law to receive such payment.

Payments will be made on a monthly basis for incurred expenses and loss within 30 days after ***we*** receive proof of the amount due.

Reductions in Benefits

The symbol shown for Personal Injury Protection Coverage on the Declarations Page indicates the coverage option chosen out of those listed in the schedule that follows.

1. Any amount payable under Personal Injury Protection Coverage shall be reduced by any amount paid, payable or required to be paid

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under any federal or state law. This reduction does not apply to:

a. Medicare payments;

b. Workers' Compensation benefits an employer is required to provide, but fails to do so; or

c. Social Security old-age benefits.

2. If benefits are shown as "Primary", after making any reductions in accordance with 1. above, *we* will pay any remaining amount regardless of whether it is payable by any other source. However, if the symbol shown is P300 *we* will not pay the first $300 of the remaining allowable expenses, work loss, loss of services expenses, or survivors' loss that was incurred by *you* or a *resident relative*. This deductible applies once per accident and does not apply separately to each *person*.

3. If benefits are shown as "Coordinated", after making any reductions in accordance with 1. above, any remaining amount will be further reduced for *you* or any *resident relative* by any amount paid or payable to that *person* under any:

a. vehicle or premises insurance;

b. individual, blanket or group accident or disability insurance; or

c. medical or surgical reimbursement plan.

If allowable expense benefits are shown as "Coordinated", *we* will not pay the first $500 of the remaining allowable expenses that were incurred for *bodily injury* to *you* or any *resident relative* if there is no other medical insurance applicable to the *bodily injury* at the time of the accident. This deductible for allowable expense benefits applies once per accident.

If work loss benefits are shown as "Coordinated", *we* will not pay the first $500 of the remaining work loss that was incurred by *you* or any *resident relative* if there is no other disability insurance applicable to the *bodily injury* at the time of the accident. This deductible for work loss benefits applies once per accident.

Schedule – Personal Injury Protection Coverage

Symbol	Allowable Expense Benefits	Work Loss Benefits	Loss of Services Benefits	Survivor's Benefits	Deductible Amount
P	Primary	Primary	Primary	Primary	None
P2	Coordinated	Coordinated	Primary	Primary	None
P3	Primary	Coordinated	Primary	Primary	None
P4	Coordinated	Primary	Primary	Primary	None
P300	Primary	Primary	Primary	Primary	$300

Exclusions – Personal Injury Protection Coverage and Additional Work Loss Coverage

THERE IS NO COVERAGE:

1. FOR *BODILY INJURY* TO ANY *INSURED*:

a. WHO INTENTIONALLY INJURES HIMSELF, HERSELF, OR ANOTHER;

b. WHILE USING A *MOTOR VEHICLE* OR *MOTORCYCLE* THAT HE OR SHE HAD TAKEN UNLAWFULLY.

This exclusion (1.b.) does not apply if that *insured* reasonably believed that he or she was entitled to take and use the vehicle.

c. ARISING OUT OF THE OWNERSHIP, OPERATION, MAINTENANCE, OR USE OF A PARKED *MOTOR VEHICLE*.

This exclusion (1.c.) does not apply if:

(1) the *motor vehicle* was parked in such a way as to cause unreasonable risk of the *bodily injury* which occurred;

(2) the *bodily injury* was a direct result of physical contact with:

(a) the *motor vehicle's* permanently attached equipment while the equipment was in use;

(b) property while being lifted onto or lowered from the *motor vehicle*; or

(3) the *bodily injury* was to a *person* while *occupying* the *motor vehicle*.

HOWEVER, EXCEPTIONS c.(2) and c.(3) ABOVE DO NOT APPLY TO ANY EMPLOYEE IF BENEFITS UNDER THE

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WORKERS' DISABILITY COMPENSATION ACT, OR SIMILAR STATE OR FEDERAL LAW ARE AVAILABLE AND IF THE ***BODILY INJURY*** WAS SUSTAINED IN THE COURSE OF HIS OR HER EMPLOYMENT WHILE DOING EITHER OF THE FOLLOWING:

(1) LOADING, UNLOADING OR DOING MECHANICAL WORK ON A VEHICLE UNLESS THE ***BODILY INJURY*** AROSE FROM THE USE OR OPERATION OF ANOTHER VEHICLE WHICH WAS NOT BEING LOADED ON, UNLOADED FROM, OR SECURED TO, AS CARGO OR FREIGHT, A ***MOTOR VEHICLE***.

(2) ENTERING OR ALIGHTING FROM THE VEHICLE UNLESS:

(a) THE ***BODILY INJURY*** WAS SUSTAINED WHILE ENTERING INTO OR ALIGHTING FROM THE VEHICLE IMMEDIATELY AFTER THE VEHICLE BECAME DISABLED, AND

(b) THE INJURY AROSE FROM THE USE OR OPERATION OF ANOTHER VEHICLE WHICH WAS NOT BEING LOADED ON, UNLOADED FROM, OR SECURED TO, AS CARGO OR FREIGHT, A ***MOTOR VEHICLE***.

d. WHILE ***OCCUPYING*** A ***MOTOR VEHICLE*** THAT IS LOCATED FOR USE AS A DWELLING OR OTHER PREMISES.

2. FOR ***BODILY INJURY*** TO ANY ***INSURED*** OTHER THAN ***YOU*** OR A ***RESIDENT RELATIVE***:

a. INJURED AS A ***PEDESTRIAN*** OUTSIDE THE STATE OF MICHIGAN.

b. ENTITLED TO NO-FAULT BENEFITS UNDER ANOTHER POLICY AS A NAMED INSURED OR RELATIVE.

This exclusion (2.b.) does not apply to an ***insured***:

(1) injured while operating or riding as a passenger on a ***motorcycle*** involved in the accident;

(2) if injured while ***occupying your car***, a ***newly acquired car***, or a ***temporary substitute car***, and who is ***your*** employee or who is:

(a) that employee's spouse;

(b) a relative of that employee, if that relative is domiciled in the same household as that employee; or

(c) a relative of that employee's spouse, if that relative is domiciled in the same household as that employee's spouse; or

(3) while operating or as a passenger in a ***motor vehicle*** which is operated in the business of transporting passengers.

c. WHILE ***OCCUPYING*** OR STRUCK AS A ***PEDESTRIAN*** BY A ***MOTOR VEHICLE***:

(1) WHICH IS NOT ***YOUR CAR*** OR A ***NEWLY ACQUIRED CAR***;

(2) OPERATED BY ***YOU*** OR ANY ***RESIDENT RELATIVE***; AND

(3) FOR WHICH THE OWNER OR REGISTRANT IS COVERED BY SECURITY AS REQUIRED BY THE ***NO-FAULT ACT***.

d. WHILE ***OCCUPYING*** A ***MOTOR VEHICLE*** WHICH IS:

(1) NOT ***YOUR CAR*** OR A ***NEWLY ACQUIRED CAR***;

(2) OPERATED OUTSIDE THE STATE OF MICHIGAN BY ***YOU*** OR ANY ***RESIDENT RELATIVE***; AND

(3) NOT REQUIRED TO BE COVERED BY SECURITY UNDER THE ***NO-FAULT ACT***.

3. FOR ***BODILY INJURY*** TO THE OWNER OR REGISTRANT OF A ***MOTOR VEHICLE*** OR ***MOTORCYCLE*** INVOLVED IN THE ACCIDENT AND WHICH IS NOT COVERED BY SECURITY AS REQUIRED BY THE ***NO-FAULT ACT***.

4. FOR ANY ***PERSON*** WHO IS:

a. NOT A RESIDENT OF THE STATE OF MICHIGAN;

b. WHILE ***OCCUPYING*** A ***MOTOR VEHICLE*** OR ***MOTORCYCLE*** NOT REGISTERED IN MICHIGAN; AND

c. NOT INSURED BY A COMPANY WHICH HAS FILED A CERTIFICATION IN COMPLIANCE WITH THE ***NO-FAULT ACT***.

Exclusions – Personal Injury Protection Coverage Only

THERE IS NO COVERAGE FOR ***BODILY INJURY*** TO:

1. *YOU* WHILE *OCCUPYING* OR WHEN STRUCK AS A *PEDESTRIAN* BY A *MOTOR VEHICLE OWNED BY YOU* BUT WHICH IS NOT *YOUR CAR* OR A *NEWLY ACQUIRED CAR*.
2. ANY *RESIDENT RELATIVE*:
   a. WHILE *OCCUPYING* OR WHEN STRUCK AS A *PEDESTRIAN* BY A *MOTOR VEHICLE OWNED BY* THAT *RESIDENT RELATIVE*; OR
   b. WHO IS ENTITLED TO PERSONAL INJURY PROTECTION BENEFITS UNDER ANOTHER POLICY AS A NAMED INSURED.
3. *YOU* OR ANY *RESIDENT RELATIVE* WHILE *OCCUPYING* A *MOTOR VEHICLE*:
   a. *OWNED BY* THE EMPLOYER OF *YOU* OR ANY *RESIDENT RELATIVE*; AND
   b. COVERED BY SECURITY AS REQUIRED BY THE *NO-FAULT ACT*.
4. AN *INSURED* WHILE OPERATING OR AS A PASSENGER IN A *MOTOR VEHICLE*, OTHER THAN *YOUR CAR*, A *NEWLY ACQUIRED CAR*, OR A *TEMPORARY SUBSTITUTE CAR*, WHICH IS:
   a. OPERATED IN THE BUSINESS OF TRANSPORTING PASSENGERS, AND
   b. COVERED BY SECURITY AS REQUIRED BY THE *NO-FAULT ACT*.

   This exclusion does not apply to *you* or any *resident relative* while a passenger in:
   a. a school bus providing transportation not prohibited by law;
   b. a bus operated by a common carrier of passengers certified by the department of transportation;
   c. a bus operated under a government sponsored transportation program;
   d. a bus operated by or servicing a nonprofit organization;
   e. a taxicab; or
   f. a bus operated by a watercraft, bicycle or horse livery used only to transport passengers to or from a destination point.
5. AN *INSURED* WHO IS A PASSENGER IN *YOUR CAR*, A *NEWLY ACQUIRED CAR*, OR A *TEMPORARY SUBSTITUTE CAR*, IF THAT *CAR* IS:
   a. A SCHOOL BUS PROVIDING TRANSPORTATION NOT PROHIBITED BY LAW;
   b. A BUS OPERATED BY A COMMON CARRIER OF PASSENGERS CERTIFIED BY THE DEPARTMENT OF TRANSPORTATION;
   c. A BUS OPERATED UNDER A GOVERNMENT SPONSORED TRANSPORTATION PROGRAM;
   d. A BUS OPERATED BY OR SERVICING A NONPROFIT ORGANIZATION;
   e. A TAXICAB; OR
   f. A BUS OPERATED BY A WATERCRAFT, BICYCLE OR HORSE LIVERY USED ONLY TO TRANSPORT PASSENGERS TO OR FROM A DESTINATION POINT.

   This exclusion does not apply if the *insured* is not entitled to personal injury protection coverage under any other policy.

If Other Benefits or Security Applies

1. **No Duplication**

   No *person* shall recover more than once for the same expense or loss from any source of personal injury protection benefits.
2. **Motorcycle Accidents**

   If an *insured* sustains *bodily injury* in a *motor vehicle* accident while an operator or passenger of a *motorcycle*, the *insured* must claim personal injury protection benefits from insurers in the following order of priority:
   a. The insurer of the owner or registrant of the *motor vehicle* involved in the accident.
   b. The insurer of the operator of the *motor vehicle* involved in the accident.
   c. The *motor vehicle* insurer of the operator of the *motorcycle* involved in the accident.
   d. The *motor vehicle* insurer of the owner or registrant of the *motorcycle* involved in the accident.
3. **If More Than One Policy Provides Coverage**

   Subject to 1. and 2. above, if two or more policies apply to the same accident, then:
   a. the benefit limits of such policies will not be added together to determine the most that may be paid; and
   b. the total amount payable under all such policies combined is the single highest applicable limit provided by any one of the policies. If more than one of *our* policies apply, *we* may choose one or more policies from which to make payment.
4. **Priority of Payment**

   Subject to 1., 2., and 3. above, if two or more policies have the same order of priority, we will pay our pro rata share of any benefits.

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PROPERTY PROTECTION COVERAGE

This policy provides Property Protection Coverage if "N" is shown under "Symbols" on the Declarations Page.

Additional Definitions

Damage means physical injury to or destruction of tangible property including loss of its use.

Insured means:

1. *you* and *resident relatives* for:
   a. the ownership, operation, maintenance, or use of:
      (1) *your car*; or
      (2) a *newly acquired car*; and
   b. the maintenance or use of:
      (1) a *non-owned car*; or
      (2) a *temporary substitute car*

   as a *motor vehicle*.
2. the first *person* shown as a named insured on the Declarations Page and that named insured's *spouse*, for the maintenance or use as a *motor vehicle* of a *car* that is *owned by*, or furnished by an employer to, a *person* domiciled in *your* household, but only if such *car* is neither *owned by*, nor furnished by an employer to, the first *person* shown as a named insured on the Declarations Page or that *person's spouse*;
3. any other *person* for his or her use of:
   a. *your car*; or
   b. a *newly acquired car*

   as a *motor vehicle*.

Motor Vehicle means a vehicle, including a trailer:

1. operated or designed to be operated on public highways by power other than muscular power; and
2. which has more than two wheels.

Motor Vehicle does not include a *motorcycle*, moped, farm tractor, or other implement of husbandry as defined by Michigan law.

Motorcycle means a vehicle:

1. having a saddle or seat for the use of the rider;
2. designed to travel on not more than three wheels; and
3. with a motor that exceeds 50 cubic centimeters piston displacement.

Motorcycle does not include a moped as defined by Michigan law.

No-Fault Act means Chapter 31 of the Michigan Insurance Code and any amendments.

Insuring Agreement

We will pay for an *insured*, subject to the provisions of the *No-Fault Act*, *damage* caused by accident that involves a vehicle for which that *insured* is provided Property Protection Coverage by this policy.

Limits

1. The most *we* will pay for accidental *damage* is the lesser of:
   a. reasonable repair costs; or
   b. replacement costs less depreciation,

   and, if applicable, the value of loss of use.
2. Subject to 1. above, the most *we* will pay for all *damage* arising from any one accident is $1,000,000.

Exclusions

THERE IS NO COVERAGE:

1. FOR ***DAMAGE*** TO ANY PROPERTY:
   a. WHILE THE VEHICLE INSURED UNDER PROPERTY PROTECTION COVERAGE IS LOCATED FOR USE AS A RESIDENCE OR PREMISES.
   b. ***OWNED BY YOU*** OR A ***RESIDENT RELATIVE*** IF ***YOU*** OR A ***RESIDENT RELATIVE*** ARE THE OWNER, REGISTRANT OR OPERATOR OF A VEHICLE INVOLVED IN THE ACCIDENT OUT OF WHICH THE ***DAMAGE*** AROSE.
   c. CAUSED INTENTIONALLY BY THE ***PERSON*** MAKING CLAIM.
   d. OF ANY ***PERSON*** USING ***YOUR CAR*** A ***NEWLY ACQUIRED CAR***, A ***NON-OWNED CAR*** OR A ***TEMPORARY SUBSTITUTE CAR*** WITHOUT ***YOUR*** PERMISSION.
   e. TO THE EXTENT THE OWNER OR REGISTRANT OF A ***MOTOR VEHICLE*** OPERATED BY, BUT NOT ***OWNED BY, YOU*** OR A ***RESIDENT RELATIVE*** HAS PROVIDED COVERAGE REQUIRED BY THE ***NO-FAULT ACT***.
   f. ACCEPTED FOR TRANSPORTATION BY ***YOU***, TO THE EXTENT OTHER COVERAGE IS PROVIDED OR WOULD BE PROVIDED EXCEPT FOR A DEDUCTIBLE.

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This exclusion (1.f.) applies only if *you* are a motor carrier as defined by Michigan Law, and evidence of security has been filed on *your* behalf with a regulatory body.

g. THAT OCCURS WITHIN THE COURSE OF A BUSINESS OF REPAIRING, SERVICING, OR OTHERWISE MAINTAINING ***MOTOR VEHICLES***.

2. FOR ***DAMAGE*** TO ANY VEHICLE, INCLUDING ITS TRAILER AND THEIR CONTENTS, OPERATED OR DESIGNED TO BE OPERATED ON PUBLIC ROADS BY OTHER THAN MUSCULAR POWER.

   This exclusion does not apply for *damage* to a vehicle or trailer that is:

   a. parked in a manner that does not cause unreasonable risk of *damage*; and

   b. other than *your car*, a *newly acquired car*, a *non-owned car*, or a *temporary substitute car*.

3. FOR ***DAMAGE*** TO ANY UTILITY TRANSMISSION LINES, WIRES OR CABLES ARISING FROM FAILURE TO LOCATE POLES, WIRES OR CABLES AS REQUIRED BY MICHIGAN LAW.

4. FOR THE OWNERSHIP, OPERATION, MAINTENANCE OR USE OF ANY VEHICLE ***OWNED BY***:

   a. ***YOU***;

   b. ANY ***RESIDENT RELATIVE***;

   c. ANY OTHER ***PERSON*** DOMICILED IN ***YOUR*** HOUSEHOLD; OR

   d. AN EMPLOYER OF ANY ***PERSON*** DESCRIBED IN a., b., OR c. ABOVE.

   This exclusion does not apply to:

   a. *your car*, a *newly acquired car*, or a *temporary substitute car*; and

   b. the first *person* shown as a named insured on the Declarations Page and that named insured's *spouse*, for the maintenance or use of a *car* that is *owned by*, or furnished by an employer to, a *person* domiciled in *your* household, but only if such *car* is neither *owned by*, nor furnished by an employer to, the first *person* shown as a named insured on the Declarations Page or that *person's spouse*.

5. FOR THE OPERATION, MAINTENANCE OR USE OF ANY VEHICLE THAT IS NOT IN THE LAWFUL POSSESSION OF THE ***PERSON*** OPERATING IT.

If Other Benefits or Security Applies

1. **No Duplication**

   No *person* shall recover more than once for the same *damages*.

2. **If More Than One Policy Provides Coverage**

   Subject to 1. above, if two or more policies apply to the same accident, then:

   a. the benefit limits of such policies will not be added together to determine the most that may be paid; and

   b. the total amount payable under all such policies combined is the single highest applicable limit provided by any one of the policies. If more than one of *our* policies apply, *we* may choose one or more policies from which to make payment.

UNINSURED MOTOR VEHICLE COVERAGE

This policy provides Uninsured Motor Vehicle Coverage if "U" is shown under "Symbols" on the Declarations Page.

Additional Definitions

Insured means:

1. *you*;
2. *resident relatives*;
3. any other *person* while *occupying*:
   a. *your car*;
   b. a *newly acquired car*; or
   c. a *temporary substitute car*.

   Such vehicle must be used with *your* express or implied permission. Such other *person occupying* a vehicle used to carry *persons* for a charge is not an *insured*; and
4. any *person* entitled to recover compensatory damages as a result of *bodily injury* to an *insured* as defined in 1., 2., or 3. above.

Uninsured Motor Vehicle means:

1. a land motor vehicle or motorcycle the ownership, maintenance, and use of which is:

a. not insured or bonded for bodily injury liability at the time of the accident; or

b. insured or bonded for bodily injury liability at the time of the accident; but

(1) the limits are less than required by the financial responsibility act of Michigan; or

(2) the insuring company:

(a) denies that its policy provides liability coverage for compensatory damages that result from the accident; or

(b) is or becomes insolvent; or

2. a "hit-and-run" land motor vehicle or motorcycle the owner and driver of which remain unknown and which strikes:

a. the ***insured***; or

b. the vehicle the ***insured*** is ***occupying***

and causes ***bodily injury*** to the ***insured***.

Uninsured Motor Vehicle does not include a land motor vehicle or motorcycle:

1. whose ownership, maintenance, or use is provided Liability Coverage by this policy;
2. ***owned by***, rented to, or furnished or available for the regular use by ***you*** or any ***resident relative***;
3. ***owned by***, rented to, or operated by a self-insurer under any motor vehicle financial responsibility law, a motor carrier law, or any similar law;
4. ***owned by*** or rented to any government or any of its political subdivisions or agencies;
5. designed for use primarily off public roads except while on public roads; or
6. while located for use as a dwelling or other premises.

Insuring Agreement

We will pay compensatory damages for ***bodily injury*** an ***insured*** is legally entitled to recover from the owner or driver of an ***uninsured motor vehicle***. The ***bodily injury*** must be:

1. sustained by an ***insured***, and
2. caused by an accident that involves the operation, maintenance, or use of an ***uninsured motor vehicle*** as a motor vehicle.

Deciding Fault and Amount

1. a. The ***insured*** and ***we*** must agree to the answers to the following two questions:

(1) Is the ***insured*** legally entitled to recover compensatory damages from the owner or driver of the ***uninsured motor vehicle***?

(2) If the ***insured*** and ***we*** agree that the answer to 1.a.(1) above is yes, then what is the amount of the compensatory damages that the ***insured*** is legally entitled to recover from the owner or driver of the ***uninsured motor vehicle***?

b. If there is no agreement on the answer to either question in 1.a. above, then the ***insured*** shall:

(1) file a lawsuit, in a state or federal court that has jurisdiction, against:

(a) ***us***; and

(b) the owner and driver of the ***uninsured motor vehicle*** unless ***we*** have consented to a settlement offer proposed by or on behalf of such owner or driver; and

(c) any other party or parties who may be legally liable for the ***insured's*** damages;

(2) consent to a jury trial if requested by ***us***;

(3) agree that ***we*** may contest the issues of liability and the amount of damages; and

(4) secure a judgment in that action. The judgment must be the final result of an actual trial and any appeals, if any appeals are taken.

2. ***We*** are not bound by any:

a. judgment obtained without ***our*** written consent; and

b. default judgment against any ***person*** or organization other than ***us***.

3. Regardless of the amount of any award, including any judgment or default judgment, ***we*** are not obligated to pay any amount in excess of the available limits under this coverage of this policy.

Limits

The Uninsured Motor Vehicle Coverage limits are shown on the Declarations Page under "Uninsured Motor Vehicle Coverage – Bodily Injury Limits – Each Person, Each Accident".

The limit shown under "Each Person" is the most ***we*** will pay for all damages resulting from ***bodily***

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injury to any one *insured* injured in any one accident, including all damages sustained by other *insureds* as a result of that *bodily injury*. The limit shown under "Each Accident" is the most *we* will pay, subject to the limit for "Each Person", for all damages resulting from *bodily injury* to two or more *insureds* injured in the same accident.

These Uninsured Motor Vehicle Coverage limits are the most *we* will pay regardless of the number of:

1. *insureds*;
2. claims made;
3. vehicles insured; or
4. vehicles involved in the accident.

Nonduplication

We will not pay under Uninsured Motor Vehicle Coverage any damages:

1. that have already been paid to or for the *insured*:
   a. by or on behalf of any *person* or organization who is or may be held legally liable for the *bodily injury* to the *insured*; or
   b. for *bodily injury* under Liability Coverage of any policy issued by the *State Farm Companies* to *you* or any *resident relative*;
2. that:
   a. have already been paid;
   b. could have been paid; or
   c. could be paid

   to or for the *insured* under any workers' compensation law, disability benefits law, or similar law; or
3. that have already been paid as benefits under the Personal Injury Protection Coverage of this or any other policy.

Exclusions

THERE IS NO COVERAGE:

1. FOR AN *INSURED* WHO, WITHOUT *OUR* WRITTEN CONSENT, SETTLES WITH ANY *PERSON* OR ORGANIZATION WHO MAY BE LIABLE FOR THE *BODILY INJURY*;
2. FOR AN *INSURED* WHO SUSTAINS *BODILY INJURY*:
   a. WHILE *OCCUPYING* A MOTOR VEHICLE OR MOTORCYCLE *OWNED BY YOU* OR ANY *RESIDENT RELATIVE* IF IT IS NOT *YOUR CAR* OR A *NEWLY ACQUIRED CAR*; OR
   b. THROUGH BEING STRUCK BY A MOTOR VEHICLE OR MOTORCYCLE *OWNED BY* ANY *RESIDENT RELATIVE*.

   This exclusion does not apply to the first *person* shown as a named insured on the Declarations Page and that named insured's *spouse*, while *occupying* or through being struck by a motor vehicle or motorcycle not *owned by* one or both of them;
3. FOR AN *INSURED* WHOSE *BODILY INJURY* RESULTS FROM THE DISCHARGE OF A FIREARM;
4. TO THE EXTENT IT BENEFITS:
   a. ANY WORKERS' COMPENSATION OR DISABILITY BENEFITS INSURANCE COMPANY;
   b. A SELF-INSURER UNDER ANY WORKERS' COMPENSATION LAW, DISABILITY BENEFITS LAW, OR SIMILAR LAW; OR
   c. ANY GOVERNMENT OR ANY OF ITS POLITICAL SUBDIVISIONS OR AGENCIES;
5. FOR PUNITIVE OR EXEMPLARY DAMAGES; OR
6. FOR ANY ORDER OF RESTITUTION ISSUED BY A COURT IN A CRIMINAL PROCEEDING OR EQUITABLE ACTION.

If Other Uninsured Motor Vehicle Coverage Applies

1. If Uninsured Motor Vehicle Coverage provided by this policy and one or more other vehicle policies issued to *you* or any *resident relative* by the *State Farm Companies* apply to the same *bodily injury*, then:
   a. the Uninsured Motor Vehicle Coverage limits of such policies will not be added together to determine the most that may be paid; and
   b. the maximum amount that may be paid from all such policies combined is the single highest applicable limit provided by any one of the policies. *We* may choose one or more policies from which to make payment.
2. The Uninsured Motor Vehicle Coverage provided by this policy applies as primary coverage for an *insured* who sustains *bodily injury* while *occupying your car*.

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a. If:

(1) this is the only vehicle policy issued to *you* or any *resident relative* by the *State Farm Companies* that provides Uninsured Motor Vehicle Coverage which applies to the accident as primary coverage; and

(2) uninsured motor vehicle coverage provided by one or more sources other than the *State Farm Companies* also applies as primary coverage for the same accident,

then *we* will pay the proportion of damages payable as primary that *our* applicable limit bears to the sum of *our* applicable limit and the limits of all other uninsured motor vehicle coverage that apply as primary coverage.

b. If:

(1) more than one vehicle policy issued to *you* or any *resident relative* by the *State Farm Companies* provides Uninsured Motor Vehicle Coverage which applies to the accident as primary coverage; and

(2) uninsured motor vehicle coverage provided by one or more sources other than the *State Farm Companies* also applies as primary coverage for the same accident,

then the *State Farm Companies* will pay the proportion of damages payable as primary that the maximum amount that may be paid by the *State Farm Companies* as determined in 1. above bears to the sum of such amount and the limits of all other uninsured motor vehicle coverage that apply as primary coverage.

3. Except as provided in 2. above, the Uninsured Motor Vehicle Coverage provided by this policy applies as excess coverage.

a. If:

(1) this is the only vehicle policy issued to *you* or any *resident relative* by the *State Farm Companies* that provides Uninsured Motor Vehicle Coverage which applies to the accident as excess coverage; and

(2) uninsured motor vehicle coverage provided by one or more sources other than the *State Farm Companies* also applies as excess coverage for the same accident,

then *we* will pay the proportion of damages payable as excess that *our* applicable limit bears to the sum of *our* applicable limit and the limits of all other uninsured motor vehicle coverage that apply as excess coverage.

b. If:

(1) more than one vehicle policy issued to *you* or any *resident relative* by the *State Farm Companies* provides Uninsured Motor Vehicle Coverage which applies to the accident as excess coverage; and

(2) uninsured motor vehicle coverage provided by one or more sources other than the *State Farm Companies* also applies as excess coverage for the same accident,

then the *State Farm Companies* will pay the proportion of damages payable as excess that the maximum amount that may be paid by the *State Farm Companies* as determined in 1. above bears to the sum of such amount and the limits of all other uninsured motor vehicle coverage that apply as excess coverage.

Our Payment Options

We may, in accordance with applicable law, make payment to one or more of the following:

1. The *insured*;
2. The *insured's* surviving spouse;
3. A parent or guardian of the *insured*, if the *insured* is a minor or an incompetent *person*; or
4. A *person* authorized by law to receive such payment.

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UNDERINSURED MOTOR VEHICLE COVERAGE

This policy provides Underinsured Motor Vehicle Coverage if "W" is shown under "SYMBOLS" on the Declarations Page.

Additional Definitions

Insured means:

1. *you*;
2. *resident relatives*;
3. any other *person* while *occupying*:
   a. *your car*;
   b. a *newly acquired car*; or
   c. a *temporary substitute car*.

   Such vehicle must be used with *your* express or implied permission. Such other *person occupying* a vehicle used to carry *persons* for a charge is not an *insured*; and
4. any *person* entitled to recover compensatory damages as a result of *bodily injury* to an *insured* as defined in 1., 2., or 3. above.

Underinsured Motor Vehicle means a land motor vehicle or motorcycle:

1. the ownership, maintenance, and use of which is either:
   a. insured or bonded for bodily injury liability at the time of the accident; or
   b. self-insured under any motor vehicle financial responsibility law, any motor carrier law, or any similar law; and
2. for which the total limits of insurance, bonds, and self-insurance for bodily injury liability from all sources:
   a. are less than the Underinsured Motor Vehicle Coverage limits of this policy; or
   b. have been reduced by payments to *persons* other than *you* and *resident relatives* to less than the Underinsured Motor Vehicle Coverage limits of this policy.

Underinsured Motor Vehicle does not include a land motor vehicle or motorcycle:

1. whose ownership, maintenance, or use is provided Liability Coverage by this policy;
2. *owned by*, rented to, or furnished or available for the regular use of *you* or any *resident relative*;
3. *owned by* or rented to any government or any of its political subdivisions or agencies;
4. designed for use primarily off public roads except while on public roads;
5. while located for use as a dwelling or other premises; or
6. defined as an *uninsured motor vehicle* under Uninsured Motor Vehicle Coverage of this policy.

Insuring Agreement

We will pay compensatory damages for *bodily injury* an *insured* is legally entitled to recover from the owner or driver of an *underinsured motor vehicle*. The *bodily injury* must be:

1. sustained by an *insured*; and
2. caused by an accident that involves the operation, maintenance, or use of an *underinsured motor vehicle* as a motor vehicle.

We will pay only if the full amount of all available limits of all bodily injury liability bonds, policies, and self-insurance plans that apply to the *insured's bodily injury* have been used up by payment of judgments or settlements, or have been offered to the *insured* in writing.

Consent to Settlement

The *insured* must inform *us* of a settlement offer for the full amount of all available limits proposed by or on behalf of the owner or driver of the *underinsured motor vehicle*, and the *insured* must request *our* written consent to accept such settlement offer.

If *we*:

1. consent in writing, then the *insured* may accept such settlement offer.
2. inform the *insured* in writing that *we* do not consent, then the *insured* may not accept such settlement offer and:
   a. *we* will make payment to the *insured* in an amount equal to such settlement offer. This payment is considered a payment made by or on behalf of the owner or driver of the *underinsured motor vehicle*; and
   b. any recovery from or on behalf of the owner or driver of the *underinsured motor vehicle* shall first be used to repay *us*.

Deciding Fault and Amount

1. a. The *insured* and *we* must agree to the answers to the following two questions:
      (1) Is the *insured* legally entitled to recover compensatory damages from the owner or driver of the *underinsured motor vehicle*?
      (2) If the *insured* and *we* agree that the answer to 1.a.(1) above is yes, then what is the amount of the compensatory

damages that the ***insured*** is legally entitled to recover from the owner or driver of the ***underinsured motor vehicle***?

b. If there is no agreement on the answer to either question in 1.a. above, then the ***insured*** shall:

(1) file a lawsuit, in a state or federal court that has jurisdiction, against:

(a) ***us***;

(b) the owner and driver of the ***underinsured motor vehicle*** unless ***we*** have consented to a settlement offer proposed by or on behalf of such owner or driver; and

(c) any other party or parties who may be legally liable for the ***insured's*** damages;

(2) consent to a jury trial if requested by ***us***;

(3) agree that ***we*** may contest the issues of liability and the amount of damages; and

(4) secure a judgment in that action. The judgment must be the final result of an actual trial and any appeals, if any appeals are taken.

2. ***We*** are not bound by any:

a. judgment obtained without ***our*** written consent; and

b. default judgment against any ***person*** or organization other than ***us***.

3. Regardless of the amount of any award, including any judgment or default judgment, ***we*** are not obligated to pay any amount in excess of the available limits under this coverage of this policy.

Limits

1. The Underinsured Motor Vehicle Coverage limits are shown on the Declarations Page under "Underinsured Motor Vehicle Coverage – Bodily Injury Limits – Each Person, Each Accident".

a. The most ***we*** will pay for all damages resulting from ***bodily injury*** to any one ***insured*** injured in any one accident, including all damages sustained by other ***insureds*** as a result of that ***bodily injury***, is the lesser of:

(1) the limit shown under "Each Person" reduced by the sum of all payments for damages resulting from that ***bodily injury*** made by or on behalf of any ***person*** or organization who is or may be held legally liable for that ***bodily injury***; or

(2) the amount of all damages resulting from that ***bodily injury*** reduced by the sum of all payments for damages resulting from that ***bodily injury*** made by or on behalf of any ***person*** or organization who is or may be held legally liable for that ***bodily injury***.

b. Subject to a. above, the most ***we*** will pay for all damages resulting from ***bodily injury*** to two or more ***insureds*** injured in the same accident is the limit shown under "Each Accident" reduced by the sum of all payments for ***bodily injury*** made to all ***insureds*** by or on behalf of any ***person*** or organization who is or may be held legally liable for the ***bodily injury***.

2. These Underinsured Motor Vehicle Coverage limits are the most ***we*** will pay regardless of the number of:

a. ***insureds***;

b. claims made;

c. vehicles insured; or

d. vehicles involved in the accident.

Nonduplication

We will not pay under Underinsured Motor Vehicle Coverage any damages:

1. that have already been paid to or for the ***insured***:

a. by or on behalf of any ***person*** or organization who is or may be held legally liable for the ***bodily injury*** to the ***insured***; or

b. for ***bodily injury*** under Liability Coverage of any policy issued by the ***State Farm Companies*** to ***you*** or any ***resident relative***;

2. that:

a. have already been paid;

b. could have been paid; or

c. could be paid

to or for the ***insured*** under any workers' compensation law, disability benefits law, or similar law; or

3. that have already been paid as either benefits or expenses under medical payments coverage, no-fault coverage, personal injury protection coverage, or any similar coverage provided by any vehicle insurance policy.

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Exclusions

THERE IS NO COVERAGE:

1. FOR AN ***INSURED*** WHO, WITHOUT ***OUR*** WRITTEN CONSENT, SETTLES WITH ANY ***PERSON*** OR ORGANIZATION WHO MAY BE LIABLE FOR THE ***BODILY INJURY***;
2. FOR AN ***INSURED*** WHO SUSTAINS ***BODILY INJURY***:
   a. WHILE ***OCCUPYING*** A MOTOR VEHICLE OR MOTORCYCLE ***OWNED BY YOU*** OR ANY ***RESIDENT RELATIVE*** IF IT IS NOT ***YOUR CAR*** OR A ***NEWLY ACQUIRED CAR***; OR
   b. THROUGH BEING STRUCK BY A MOTOR VEHICLE OR MOTORCYCLE ***OWNED BY*** ANY ***RESIDENT RELATIVE***.

   This exclusion does not apply to the first ***person*** shown as a named insured on the Declarations Page and that named insured's ***spouse***, while ***occupying*** or through being struck by a motor vehicle or motorcycle not ***owned by*** one or both of them;
3. FOR AN ***INSURED*** WHOSE ***BODILY INJURY*** RESULTS FROM THE DISCHARGE OF A FIREARM;
4. TO THE EXTENT IT BENEFITS:
   a. ANY WORKERS' COMPENSATION OR DISABILITY BENEFITS INSURANCE COMPANY;
   b. A SELF-INSURER UNDER ANY WORKERS' COMPENSATION LAW, DISABILITY BENEFITS LAW, OR SIMILAR LAW; OR
   c. ANY GOVERNMENT OR ANY OF ITS POLITICAL SUBDIVISIONS OR AGENCIES;
5. FOR PUNITIVE OR EXEMPLARY DAMAGES; OR
6. FOR ANY ORDER OF RESTITUTION ISSUED BY A COURT IN A CRIMINAL PROCEEDING OR EQUITABLE ACTION.

If Other Underinsured Motor Vehicle Coverage Applies

1. If Underinsured Motor Vehicle Coverage provided by this policy and one or more other vehicle policies issued to ***you*** or any ***resident relative*** by the ***State Farm Companies*** apply to the same ***bodily injury***, then:
   a. the Underinsured Motor Vehicle Coverage limits of such policies will not be added together to determine the most that may be paid; and
   b. the maximum amount that may be paid from all such policies combined is the single highest applicable limit provided by any one of the policies. ***We*** may choose one or more policies from which to make payment.
2. The Underinsured Motor Vehicle Coverage provided by this policy applies as primary coverage for an ***insured*** who sustains ***bodily injury*** while ***occupying your car***.
   a. If:
      (1) this is the only vehicle policy issued to ***you*** or any ***resident relative*** by the ***State Farm Companies*** that provides Underinsured Motor Vehicle Coverage which applies to the accident as primary coverage; and
      (2) underinsured motor vehicle coverage provided by one or more sources other than the ***State Farm Companies*** also applies as primary coverage for the same accident,

      then ***we*** will pay the proportion of damages payable as primary that ***our*** applicable limit bears to the sum of ***our*** applicable limit and the limits of all other underinsured motor vehicle coverage that apply as primary coverage.
   b. If:
      (1) more than one vehicle policy issued to ***you*** or any ***resident relative*** by the ***State Farm Companies*** provides Underinsured Motor Vehicle Coverage which applies to the accident as primary coverage; and
      (2) underinsured motor vehicle coverage provided by one or more sources other than the ***State Farm Companies*** also applies as primary coverage for the same accident,

      then the ***State Farm Companies*** will pay the proportion of damages payable as primary that the maximum amount that may be paid by the ***State Farm Companies*** as determined in 1. above bears to the sum of such amount and the limits of all other underinsured motor vehicle coverage that apply as primary coverage.
3. Except as provided in 2. above, the Underinsured Motor Vehicle Coverage provided by this policy applies as excess coverage.

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a. If:

(1) this is the only vehicle policy issued to *you* or any *resident relative* by the *State Farm Companies* that provides Underinsured Motor Vehicle Coverage which applies to the accident as excess coverage; and

(2) underinsured motor vehicle coverage provided by one or more sources other than the *State Farm Companies* also applies as excess coverage for the same accident,

then *we* will pay the proportion of damages payable as excess that *our* applicable limit bears to the sum of *our* applicable limit and the limits of all other underinsured motor vehicle coverage that apply as excess coverage.

b. If:

(1) more than one vehicle policy issued to *you* or any *resident relative* by the *State Farm Companies* provides Underinsured Motor Vehicle Coverage which applies to the accident as excess coverage; and

(2) underinsured motor vehicle coverage provided by one or more sources other than the *State Farm Companies* also applies as excess coverage for the same accident,

then the *State Farm Companies* will pay the proportion of damages payable as excess that the maximum amount that may be paid by the *State Farm Companies* as determined in 1. above bears to the sum of such amount and the limits of all other underinsured motor vehicle coverage that apply as excess coverage.

Our Payment Options

We may, in accordance with applicable law, make payment to one or more of the following:

1. The *insured*;
2. The *insured's* surviving spouse;
3. A parent or guardian of the *insured*, if the *insured* is a minor or an incompetent *person*; or
4. A *person* authorized by law to receive such payment.

PHYSICAL DAMAGE COVERAGES

The physical damage coverages are Comprehensive Coverage, Collision Coverage, Limited Collision Coverage, Broadened Collision Coverage, Emergency Road Service Coverage, and Car Rental and Travel Expenses Coverage.

This policy provides:

1. Comprehensive Coverage if "D";
2. Collision Coverage if "G";
3. Limited Collision Coverage if "J";
4. Broadened Collision Coverage if "GJ";
5. Emergency Road Service Coverage if "H";
6. Car Rental and Travel Expenses Coverage if "R1",

is shown under "Symbols" on the Declarations Page. If a deductible applies to a coverage then it is shown on the Declarations Page for that coverage.

Additional Definitions

Covered Vehicle means:

1. *your car*;
2. a *newly acquired car*;
3. a *temporary substitute car*;
4. a camper designed to be mounted on a pickup truck and shown on the Declarations Page;
5. a *non-owned car* while it is:
   a. being driven by an *insured*; or
   b. in the custody of an *insured* if at the time of the *loss* it is:
      (1) not being driven; or
      (2) being driven by a *person* other than an *insured* and being *occupied* by an *insured*;
6. a *non-owned trailer* while it is being used by an *insured*; and
7. a *non-owned camper* while it is being used by an *insured*;

including its parts and its equipment that are common to the use of the vehicle as a vehicle. However, parts and equipment of *trailers* and campers must be securely fixed as a permanent part of the *trailer* or camper.

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Daily rental charge means the sum of:

1. the daily rental rate;
2. mileage charges; and
3. related taxes.

Fungi means any type or form of fungus or fungi and includes:

1. Mold;
2. Mildew; and
3. Any of the following that are produced or released by fungi:
   a. Mycotoxins;
   b. Spores;
   c. Scents; or
   d. Byproducts.

Insured means *you* and *resident relatives*.

Loss means:

1. direct, sudden, and accidental damage to; or
2. total or partial theft of

a *covered vehicle*. *Loss* does not include any reduction in the value of any *covered vehicle* after it has been repaired, as compared to its value before it was damaged.

Loss Caused By Collision means a *loss* caused by:

1. a *covered vehicle* hitting or being hit by another vehicle or other object; or
2. the overturning of a *covered vehicle*.

Any *loss* caused by missiles, falling objects, windstorm, hail, fire, explosion, earthquake, water, flood, total or partial theft, malicious mischief, vandalism, riot, civil commotion, or hitting or being hit by a bird or an animal is not a *Loss Caused By Collision*.

Non-Owned Camper means a camper designed to be mounted on a pickup truck that is in the lawful possession of an *insured* and that is not *owned by*:

1. an *insured*;
2. any other *person* domiciled in the same household as an *insured*; or
3. an employer of any *person* described in 1. or 2. above.

Non-Owned Trailer means a *trailer* that is in the lawful possession of an *insured* and that is not *owned by*:

1. an *insured*;
2. any other *person* domiciled in the same household as an *insured*; or
3. an employer of any *person* described in 1. or 2. above.

Substantially At Fault means a *person's* action or inaction was more than 50% of the cause of the accident.

Insuring Agreement

1. **Comprehensive Coverage**

   We will pay

   a. for *loss*, except *loss caused by collision*, to a *covered vehicle*; and

   b. transportation expenses incurred by an *insured* as a result of the total theft of *your car* or a *newly acquired car*. These transportation expenses are payable:

      (1) during a period that:

         (a) starts on the date *you* report the theft to *us*; and

         (b) ends on the earliest of:

            (i) the date the vehicle is returned to *your* possession in a drivable condition;

            (ii) the date *we* offer to pay for the *loss* if the vehicle has not yet been recovered; or

            (iii) the date *we* offer to pay for the *loss* if the vehicle is recovered, but is a total loss as determined by *us*; and

      (2) during the period that:

         (a) starts on the date the vehicle is left at a repair facility if the stolen vehicle is recovered, returned to *your* possession in a drivable condition, and has unrepaired damage that resulted from the total theft; and

         (b) ends on the date the vehicle is repaired.

      These transportation expenses must be reported to *us* before *we* will pay such incurred expenses.

2. **Collision Coverage**

   We will pay for *loss caused by collision* to a *covered vehicle*.

3. **Limited Collision Coverage**

   We will pay for *loss caused by collision* to a *covered vehicle* if the operator of the *covered vehicle* is not *substantially at fault*.

4. **Broadened Collision Coverage**

   We will pay for *loss caused by collision* to a *covered vehicle*. *You* do not have to pay the

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deductible amount if the operator of the *covered vehicle* is not *substantially at fault*.

5. **Emergency Road Service Coverage**

We will pay the fair cost incurred by an *insured* for:

a. up to one hour of labor to repair a *covered vehicle* at the place of its breakdown;

b. towing to the nearest repair facility where necessary repairs can be made if a *covered vehicle* is not drivable;

c. towing a *covered vehicle* out of a location where it is stuck if the vehicle is on or immediately next to a public road;

d. delivery of gas, oil, battery, or tire necessary to return a *covered vehicle* to driving condition. *We* do not pay the cost of the gas, oil, battery, or tire; and

e. up to one hour of labor for locksmith services to unlock a *covered vehicle* if its key is lost, stolen, or locked inside the vehicle.

6. **Car Rental and Travel Expenses Coverage**

a. **Car Rental Expense**

We will pay the *daily rental charge* incurred when *you* rent a *car* from a *car business* while *your car* or a *newly acquired car* is:

(1) not drivable; or

(2) being repaired

as a result of a *loss* which would be payable under Comprehensive Coverage or any of the Collision Coverages.

We will pay the *daily rental charge* incurred during a period that:

(1) starts on the date:

(a) the vehicle is not drivable as a result of the *loss*; or

(b) the vehicle is left at a repair facility if the vehicle is drivable, and

(2) ends on the earliest of:

(a) the date the vehicle has been repaired or replaced;

(b) the date *we* offer to pay for the *loss* if the vehicle is repairable but *you* choose to delay repairs; or

(c) five days after *we* offer to pay for the *loss* if the vehicle is:

(i) a total loss as determined by *us*; or

(ii) stolen and not recovered.

The amount of any such *daily rental charge* incurred by *you* must be reported to *us* before *we* will pay such amount.

b. **Travel Expenses**

We will pay expenses for commercial transportation, lodging, and meals if *your car* or a *newly acquired car* is not drivable as a result of a *loss* which would be payable under Comprehensive Coverage or any of the Collision Coverages. The *loss* must occur more than 50 miles from *your* home. *We* will only pay these expenses if they are incurred by:

(1) an *insured* during the period that:

(a) starts after the *loss* occurs; and

(b) ends on the earlier of:

(i) the *insured's* arrival at his or her destination or home if the vehicle is left behind for repairs; or

(ii) the repair of the vehicle if the *insured* waits for repairs before continuing on to his or her destination or returning home; and

(2) *you*, or any *person you* choose, to travel to retrieve the vehicle and drive it to either the original destination or *your* home if the vehicle was left behind for repairs.

These expenses must be reported to *us* before *we* will pay such incurred expenses.

c. **Rental Car – Repayment of Deductible Expense**

We will pay the comprehensive deductible or collision deductible an *insured* is required to pay the owner of a *car* rented from a *car business*.

Arbitration

1. If there is disagreement as to whether the operator of the *covered vehicle* was *substantially at fault* for the *loss*, then the disagreement will be resolved by arbitration upon written request of the owner or *us*.

2. The arbitration will take place in the county in which the owner resides unless *we* agree to another place. State court rules governing procedure and admission of evidence shall be used.

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The owner and *we* will each select a competent arbitrator. These two arbitrators will select the third competent arbitrator. If they are unable to agree on a third arbitrator within 30 days, then either the owner or *we* may petition a court that has jurisdiction to select the third arbitrator.

Each party will pay the cost of its own arbitrator and any attorney or expert witness hired by that party. Both parties will share equally the cost of the third arbitrator and by agreement any other expenses of the arbitration.

3. The arbitrators shall only decide whether the operator of the *covered vehicle* was *substantially at fault* for the *loss*. Arbitrators shall have no authority to decide any other questions of fact, decide any questions of law, or conduct arbitration on a class-wide or class-representative basis.
4. A written decision that is both agreed upon by and signed by any two arbitrators, and that also contains an explanation of how they arrived at their decision, will be binding on the owner and *us*.
5. Subject to 1., 2., 3., and 4. above, state court rules governing procedure and admission of evidence will be used.
6. *We* do not waive any of *our* rights by submitting to arbitration.
7. *We* are not bound by any judgment against any *person* or organization obtained without *our* written consent.

Supplementary Payments – Comprehensive Coverage and Collision Coverages

If Symbol "D" is shown on the Declarations Page and the *covered vehicle* sustains *loss* for which *we* make a payment under Comprehensive Coverage, or if Symbol "G", "J", or "GJ" is shown on the Declarations Page and the *covered vehicle* sustains *loss* for which *we* make a payment under the collision coverage *you* carry, then *we* will pay reasonable expenses incurred to:

1. tow the *covered vehicle* immediately after the *loss*:
   a. for a reasonable distance from the location of the *loss* to any one repair facility chosen by an *insured* or the owner of the *covered vehicle*, if the *covered vehicle* is not drivable; or
   b. to any one repair facility or commercial storage facility, neither of which was chosen by an *insured* or the owner of the *covered vehicle*. *We* will also pay reasonable expenses incurred to tow the *covered vehicle* for a reasonable distance from this facility to any one repair facility chosen by an *insured* or the owner of the *covered vehicle*, if the *covered vehicle* is not drivable.
2. store the *covered vehicle*, if it is not drivable immediately after the *loss*, at:
   a. any one repair facility or commercial storage facility, neither of which was chosen by an *insured* or the owner of the *covered vehicle*; and
   b. any one repair facility chosen by the owner of the *covered vehicle*, and *we* determine such vehicle is a total loss.

   If the owner of the *covered vehicle* consents, then *we* may move the *covered vehicle* at *our* expense to reduce storage costs. If the owner of the *covered vehicle* does not consent, then *we* will pay only the storage costs that would have resulted if *we* had moved the damaged *covered vehicle*; and
3. clean up debris from the *covered vehicle* at the location of the *loss*. The most *we* will pay to clean up the debris is $250 for any one *loss*.

Limits and Loss Settlement – Comprehensive Coverage and Collision Coverages

1. *We* have the right to choose to settle with *you* or the owner of the *covered vehicle* in one of the following ways:
   a. Pay the cost to repair the *covered vehicle* minus any applicable deductible.
      (1) *We* have the right to choose one of the following to determine the cost to repair the *covered vehicle*:
         (a) The cost agreed to by both the owner of the *covered vehicle* and *us*;
         (b) A bid or repair estimate approved by *us*; or
         (c) A repair estimate that is written based upon or adjusted to:
            (i) the prevailing competitive price;
            (ii) the lower of paintless dent repair pricing established by an agreement *we* have with a third party or the paintless dent repair price that is competitive in the market; or
            (iii) a combination of (i) and (ii) above.

         The prevailing competitive price means prices charged by a majority of the repair market in the area where the *covered vehicle* is

to be repaired as determined by a survey made by *us*. If asked, *we* will identify some facilities that will perform the repairs at the prevailing competitive price. The estimate will include parts sufficient to restore the *covered vehicle* to its pre-loss condition.

You agree with *us* that the repair estimate may include new, used, recycled, and reconditioned parts. Any of these parts may be either original equipment manufacturer parts or non-original equipment manufacturer parts.

You also agree that replacement glass need not have any insignia, logo, trademark, etching, or other marking that was on the replaced glass.

(2) The cost to repair the *covered vehicle* does not include any reduction in the value of the *covered vehicle* after it has been repaired, as compared to its value before it was damaged.

(3) If the repair or replacement of a part results in betterment of that part, then *you* or the owner of the *covered vehicle* must pay for the amount of the betterment.

(4) If *you* and *we* agree, then windshield glass will be repaired instead of replaced.

(5) If *we* choose, *we* may require that any damaged parts that are replaced must be given to *us* in exchange for *our* payment, unless *we* agree that the owner may keep them.

b. Pay the actual cash value of the *covered vehicle* minus any applicable deductible.

(1) The owner of the *covered vehicle* and *we* must agree upon the actual cash value of the *covered vehicle*. If there is disagreement as to the actual cash value of the *covered vehicle*, then the disagreement will be resolved by appraisal upon written request of the owner or *us*, using the following procedures:

(a) The owner and *we* will each select a competent appraiser.

(b) The two appraisers will select a third competent appraiser. If they are unable to agree on a third appraiser within 30 days, then either the owner or *we* may petition a court that has jurisdiction to select the third appraiser.

(c) Each party will pay the cost of its own appraiser, and any attorney or expert witness hired by that party. Both parties will share equally the cost of the third appraiser and, by agreement, any other expenses of the appraisal.

(d) The appraisers shall only determine the actual cash value of the *covered vehicle*. Appraisers shall have no authority to decide any other questions of fact, decide any questions of law, or conduct appraisal on a class-wide or class-representative basis.

(e) A written appraisal that is both agreed upon by and signed by any two appraisers, and that also contains an explanation of how they arrived at their appraisal, will be binding on the owner of the *covered vehicle* and *us*.

(f) *We* do not waive any of *our* rights by submitting to an appraisal.

(2) The damaged *covered vehicle* must be given to *us* in exchange for *our* payment, unless *we* agree that the owner may keep it. If the owner keeps the *covered vehicle*, then *our* payment will be reduced by the value of the *covered vehicle* after the *loss*.

c. Return the stolen *covered vehicle* to its owner and pay, as described in 1.a. above, for any direct, sudden, and accidental damage that resulted from the theft.

2. The most *we* will pay for transportation expenses under Comprehensive Coverage is $25 per day subject to an aggregate limit of $750 per *loss*.

3. The most *we* will pay for *loss* to a *non-owned trailer* or a *non-owned camper* is $2,500.

Limits – Car Rental and Travel Expenses Coverage

1. **Car Rental Expense**

The limit for Car Rental Expense is shown on the Declarations Page under "Limit – Car Rental Expense – Each Day, Each Loss".

a. The limit shown under "Each Day" is the most *we* will pay for the *daily rental charge*. If

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(1) a dollar amount is shown, then *we* will pay the *daily rental charge* up to that dollar amount;

(2) a percentage amount is shown, then *we* will pay that percentage of the *daily rental charge*.

b. Subject to the "Each Day" limit, the limit shown under "Each Loss" is the most *we* will pay for Car Rental Expense incurred as a result of any one *loss*.

2. **Travel Expenses**

The most *we* will pay for Travel Expenses incurred by all *insureds* as a result of any one *loss* is $500.

3. **Rental Car – Repayment of Deductible Expense**

The most *we* will pay for Rental Car – Repayment of Deductible Expense incurred as a result of any one *loss* is $500.

Nonduplication

We will not pay for any *loss* or expense under the Physical Damage Coverages for which the *insured* or owner of the *covered vehicle* has already received payment from, or on behalf of, a party who is legally liable for the *loss* or expense.

Exclusions

THERE IS NO COVERAGE FOR:

1. ANY ***COVERED VEHICLE*** THAT IS:
   a. INTENTIONALLY DAMAGED; OR
   b. STOLEN

   BY OR AT THE DIRECTION OF AN ***INSURED***;
2. ANY ***COVERED VEHICLE*** WHILE IT IS RENTED TO OR LEASED TO OTHERS BY AN ***INSURED***;
3. ANY ***COVERED VEHICLE*** WHILE IT IS USED TO CARRY ***PERSONS*** FOR A CHARGE.

   This exclusion does not apply to the use of a private passenger car:
   a. on a share-the-expense carpool basis;
   b. for volunteer or charitable purposes; or
   c. for which the only reimbursement involved is for normal operating expenses;
4. ANY ***COVERED VEHICLE*** DUE TO:
   a. THEFT;
   b. CONVERSION;
   c. EMBEZZLEMENT; OR
   d. SECRETION

   BY AN ***INSURED***, A CONSIGNEE, AN AGENT OF A CONSIGNEE, OR A ***PERSON*** WHO OBTAINS POSSESSION OF THE ***COVERED VEHICLE*** WITH THE PERMISSION OF A CONSIGNEE OR AGENT OF A CONSIGNEE;
5. ***LOSS*** TO ***YOUR CAR*** OR A ***NEWLY ACQUIRED CAR*** IF AN ***INSURED*** VOLUNTARILY RELINQUISHES POSSESSION OF THAT ***CAR*** TO A ***PERSON*** OR ORGANIZATION UNDER AN ACTUAL OR PRESUMED SALES AGREEMENT;
6. ANY ***COVERED VEHICLE*** TO THE EXTENT ***OUR*** PAYMENT WOULD BENEFIT ANY CARRIER OR OTHER BAILEE FOR HIRE THAT IS LIABLE FOR ***LOSS*** TO SUCH ***COVERED VEHICLE***;
7. ***LOSS*** TO ANY ***COVERED VEHICLE*** DUE TO ***FUNGI***. THIS APPLIES REGARDLESS OF WHETHER OR NOT THE ***FUNGI*** RESULT FROM A ***LOSS*** THAT IS PAYABLE UNDER ANY OF THE PHYSICAL DAMAGE COVERAGES. ***WE*** WILL ALSO NOT PAY FOR ANY TESTING OR REMEDIATION OF ***FUNGI***, OR ANY ADDITIONAL COSTS REQUIRED TO REPAIR ANY ***COVERED VEHICLE*** THAT ARE DUE TO THE EXISTENCE OF ***FUNGI***;
8. ***LOSS*** TO ANY ***COVERED VEHICLE*** THAT RESULTS FROM:
   a. NUCLEAR REACTION;
   b. RADIATION OR RADIOACTIVE CONTAMINATION FROM ANY SOURCE; OR
   c. THE ACCIDENTAL OR INTENTIONAL DETONATION OF, OR RELEASE OF RADIATION FROM, ANY NUCLEAR OR RADIOACTIVE DEVICE.
9. ***LOSS*** TO ANY ***COVERED VEHICLE*** THAT RESULTS FROM THE TAKING OF OR SEIZURE OF THAT ***COVERED VEHICLE*** BY ANY GOVERNMENTAL AUTHORITY;
10. ***LOSS*** TO ANY ***COVERED VEHICLE*** THAT RESULTS FROM WAR OF ANY KIND;
11. ***YOUR CAR*** WHILE SUBJECT TO ANY:
    a. LIEN AGREEMENT;
    b. RENTAL AGREEMENT;
    c. LEASE AGREEMENT; OR
    d. SALES AGREEMENT

    NOT SHOWN ON THE DECLARATIONS PAGE;

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12. ANY *NON-OWNED CAR* WHILE IT IS:
    a. BEING MAINTAINED OR USED BY ANY ***PERSON*** WHILE THAT ***PERSON*** IS EMPLOYED IN OR ENGAGED IN ANY WAY IN A ***CAR BUSINESS***; OR
    b. USED IN ANY BUSINESS OR OCCUPATION OTHER THAN A ***CAR BUSINESS***. This exclusion (12.b.) does not apply to a *private passenger car*;
13. ANY PART OR EQUIPMENT OF A ***COVERED VEHICLE*** IF THAT PART OR EQUIPMENT:
    a. FAILS OR IS DEFECTIVE; OR
    b. IS DAMAGED AS A DIRECT RESULT OF:
        (1) WEAR AND TEAR;
        (2) FREEZING; OR
        (3) MECHANICAL, ELECTRICAL, OR ELECTRONIC BREAKDOWN OR MALFUNCTION

    OF THAT PART OR EQUIPMENT.

    This exclusion does not apply if the *loss* is the result of theft of the *covered vehicle*;
14. ANY PART OR EQUIPMENT:
    a. THAT IS NOT LEGAL FOR USE IN OR ON THE ***COVERED VEHICLE*** IN THE STATE WHERE THE ***COVERED VEHICLE*** IS REGISTERED; OR
    b. THE USE OF WHICH IS NOT LEGAL IN THE STATE WHERE THE ***COVERED VEHICLE*** IS REGISTERED BECAUSE OF HOW OR WHERE THAT PART OR EQUIPMENT IS INSTALLED IN OR ON THE ***COVERED VEHICLE***.

    However, if there is a legal version of the part or equipment that is necessary for the safe operation of the *covered vehicle*, then *we* will pay the cost that *we* would otherwise have paid to repair the vehicle with the legal version of the part or equipment. *We* will not pay any cost necessary to modify the vehicle for installation of the legal version of the part or equipment.
15. TIRES. This exclusion does not apply if:
    a. *loss* is caused by missiles, falling objects, windstorm, hail, fire, explosion, earthquake, water, flood, total or partial theft, malicious mischief, vandalism, riot, civil commotion, or hitting or being hit by a bird or an animal; or
    b. *loss caused by collision* to another part of the *covered vehicle* causes *loss* to tires;
16. REMOVABLE PRODUCTS USED FOR STORAGE OF AUDIO, VIDEO, OR OTHER DATA, INCLUDING BUT NOT LIMITED TO TAPES, DISCS, AND MEMORY CARDS, NOR IS THERE COVERAGE FOR THE RECONSTRUCTION OF DATA CONTAINED THEREIN;
17. ANY EQUIPMENT USED TO DETECT OR INTERFERE WITH SPEED MEASURING DEVICES;
18. A CAMPER, INCLUDING ITS PARTS AND ITS EQUIPMENT, THAT IS:
    a. DESIGNED TO BE MOUNTED ON A PICKUP TRUCK;
    b. ***OWNED BY*** AN ***INSURED***; AND
    c. NOT SHOWN ON THE DECLARATIONS PAGE.
19. ANY ***COVERED VEHICLE*** WHILE IT IS:
    a. BEING PREPARED FOR, USED IN PRACTICE FOR, OR OPERATED IN ANY RACING CONTEST, SPEED CONTEST, HILL-CLIMBING CONTEST, JUMPING CONTEST, OR ANY SIMILAR CONTEST; OR
    b. ON A TRACK DESIGNED PRIMARILY FOR RACING OR HIGH-SPEED DRIVING. This exclusion (19.b.) does not apply if the vehicle is being used in connection with an activity other than racing, high-speed driving, or any type of competitive driving;
20. ***LOSS*** TO ANY VEHICLE ***OWNED BY***:
    a. ***YOU***;
    b. ANY ***RESIDENT RELATIVE***;
    c. ANY OTHER ***PERSON*** DOMICILED IN ***YOUR*** HOUSEHOLD; OR
    d. AN EMPLOYER OF ANY ***PERSON*** DESCRIBED IN a., b., OR c. ABOVE.

    This exclusion does not apply to *your car*, a *newly acquired car*, or a *temporary substitute car*; OR
21. ***LOSS*** TO ANY ***COVERED VEHICLE*** UNDER COLLISION COVERAGE, LIMITED COLLISION COVERAGE, OR BROADENED COLLISION COVERAGE:
    a. CAUSED BY MISSILES, FALLING OBJECTS, WINDSTORM, HAIL, FIRE, EXPLOSION, EARTHQUAKE, WATER, FLOOD, TOTAL OR PARTIAL THEFT, MALICIOUS MISCHIEF, VANDALISM, RIOT, CIVIL COMMOTION, OR DUE

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TO HITTING OR BEING HIT BY A BIRD OR AN ANIMAL.

b. TO THE EXTENT PAYMENT HAS BEEN MADE UNDER PROPERTY PROTECTION COVERAGE.

If Other Physical Damage or Similar Coverage Applies

1. If the same *loss* or expense is payable under more than one of the Physical Damage Coverages provided by this policy, then only the one coverage that pays the most for that *loss* or expense applies.
2. If any of the Physical Damage Coverages provided by this policy and one or more other policies issued to an ***insured*** by one or more of the ***State Farm Companies*** apply to the same *loss* or expense, then only one policy applies. *We* will select a policy that pays the most for the *loss* or expense.
3. The Physical Damage Coverages provided by this policy apply as primary coverage for a *loss* to *your car*.

   If similar coverage provided by one or more sources other than the ***State Farm Companies*** also applies as primary coverage for the same *loss*, then the ***State Farm Companies*** will pay the proportion of the *loss* or expense payable as primary that the maximum amount that may be paid by the ***State Farm Companies*** bears to the sum of such amount and the limits of all other similar coverage that applies as primary.
4. Except as provided in 3. above, the Physical Damage Coverages provided by this policy apply as excess coverage.

   If similar coverage provided by one or more sources other than the ***State Farm Companies*** also applies as excess coverage for the same *loss* or expense, then the ***State Farm Companies*** will pay the proportion of the *loss* or expense payable as excess that the maximum amount that may be paid by the ***State Farm Companies*** bears to the sum of such amount and the limits of all other similar coverage that applies as excess coverage.

Financed Vehicle

1. If a creditor is shown on the Declarations Page, then any Comprehensive Coverage, Collision Coverage, Limited Collision Coverage, or Broadened Collision Coverage provided by this policy applies to that creditor's interest in *your car*. Coverage for the creditor's interest is only provided for a *loss* that is payable to *you*.

   However, if this policy is cancelled or nonrenewed, then *we* will provide coverage for the creditor's interest until *we* notify the creditor of the termination of such coverage. This coverage for the creditor's interest is only provided for a *loss* that would have been payable to *you* if this policy had not been cancelled or nonrenewed. The date such termination is effective will be at least 10 days after the date *we* mail or electronically transmit a notice of the termination to the creditor.
2. If *we* pay such creditor, then *we* are entitled to the creditor's right of recovery against *you* to the extent of *our* payment. ***Our*** right of recovery does not impair the creditor's right to recover the full amount of its claim.

Our Payment Options

1. **Comprehensive Coverage and Collision Coverages**
   a. *We* may, in accordance with applicable law, make payment to one or more of the following for *loss* to a *covered vehicle owned by you*:
      (1) *You*;
      (2) The repairer;
      (3) A creditor shown on the Declarations Page, to the extent of its interest.
   b. *We* may, in accordance with applicable law, make payment to one or more of the following for *loss* to a *covered vehicle* not *owned by you*:
      (1) *You*;
      (2) The owner of such vehicle;
      (3) The repairer; or
      (4) A creditor.
2. **Emergency Road Service Coverage and Car Rental and Travel Expenses Coverage**

   We may, in accordance with applicable law, make payment to one or more of the following:
   a. *You*;
   b. The *insured* who incurred the expense; or
   c. Any party that provided the service for which payment is owed.

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DEATH, DISMEMBERMENT AND LOSS OF SIGHT COVERAGE

This policy provides Death, Dismemberment and Loss of Sight Coverage if "S" is shown under "Symbols" on the Declarations Page.

Additional Definitions

Insured means a *person* whose name is shown under "Death, Dismemberment and Loss of Sight Coverage – Persons Insured" on the Declarations Page.

Pedestrian means a *person* who is not *occupying*:

1. a motorized vehicle; or
2. a vehicle designed to be pulled by a motorized vehicle.

Insuring Agreement

We will pay the highest applicable benefit shown in the following Death, Dismemberment and Loss of Sight Benefits Schedules if an *insured*:

1. dies; or
2. suffers dismemberment or permanent loss of sight, as described in the schedule

as the direct result of an accident that involves the use of a land motor vehicle or any type of trailer as a vehicle and not due to any other cause.

The *insured* must be *occupying* or be struck as a *pedestrian* by a land motor vehicle or any type of trailer at the time of the accident. The death, dismemberment, or permanent loss of sight must occur within one year immediately after the date of the accident.

Benefit

The applicable benefit shown in the schedule is the most *we* will pay for any one *insured* in any one accident. Any benefit paid or payable for dismemberment or permanent loss of sight reduces the death benefit.

DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFITS SCHEDULES	
If the amount shown on the Declarations Page for the *insured* is $5,000, *we* will pay the applicable benefit shown below for death or the described dismemberment or permanent loss of sight:	
Death	$5,000
Loss of both hands; both feet; all sight of both eyes; one hand & one foot; or one hand or one foot & all sight of one eye	$5,000
Loss of one hand or one foot; or all sight of one eye	$2,500
Loss of the thumb & a finger on one hand; or any three fingers	$1,500
Loss of any two fingers	$1,000
The hand must be cut off through or above the wrist. The foot must be cut off through or above the ankle. The whole thumb or finger must be cut off.	

If the amount shown on the Declarations Page for the *insured* is $10,000, *we* will pay the applicable benefit shown below for death or the described dismemberment or permanent loss of sight:	
Death	$10,000
Loss of both hands; both feet; all sight of both eyes; one hand & one foot; or one hand or one foot & all sight of one eye	$10,000
Loss of one hand or one foot; or all sight of one eye	$5,000
Loss of the thumb & a finger on one hand; or any three fingers	$3,000
Loss of any two fingers	$2,000
The hand must be cut off through or above the wrist. The foot must be cut off through or above the ankle. The whole thumb or finger must be cut off.	

The benefits shown in the schedules are doubled for an *insured* who at the time of the accident was *occupying* a *private passenger car* and using a seat belt in the manner recommended by the vehicle's manufacturer.

Exclusions

THERE IS NO COVERAGE FOR AN *INSURED*:

1. WHILE IN THE COURSE AND SCOPE OF HIS OR HER EMPLOYMENT IN A *CAR BUSINESS*;
2. WHILE *OCCUPYING*, LOADING, OR UNLOADING:
   a. AN EMERGENCY VEHICLE IN THE COURSE AND SCOPE OF HIS OR HER EMPLOYMENT;
   b. A VEHICLE, OTHER THAN AN EMERGENCY VEHICLE, WHILE USED IN THE:
      (1) *INSURED'S* BUSINESS; OR
      (2) COURSE AND SCOPE OF HIS OR HER EMPLOYMENT IN OTHER THAN A *CAR BUSINESS*.

      This exclusion (2.b.) does not apply if the vehicle is a *private passenger car*;
   c. A MILITARY VEHICLE; OR
   d. A VEHICLE WHILE IT IS:
      (1) BEING PREPARED FOR, USED IN PRACTICE FOR, OR OPERATED IN ANY RACING CONTEST, SPEED CONTEST, HILL-CLIMBING CONTEST, JUMPING CONTEST, OR ANY SIMILAR CONTEST; OR

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(2) ON A TRACK DESIGNED PRIMARILY FOR RACING OR HIGH SPEED DRIVING. This exclusion (2.d.(2))does not apply if the vehicle is being used in connection with an activity other than racing, high-speed driving, or any type of competitive driving;

3. WHILE ***OCCUPYING***, LOADING, UNLOADING, OR WHO IS STRUCK AS A ***PEDESTRIAN*** BY:
   a. A MOTOR VEHICLE THAT RUNS ON RAILS OR CRAWLER-TREADS;
   b. A MOTOR VEHICLE THAT IS DESIGNED FOR USE PRIMARILY OFF PUBLIC ROADS WHILE OFF PUBLIC ROADS; OR
   c. A MOTOR VEHICLE OR ANY TYPE OF TRAILER, EITHER OF WHICH IS LOCATED FOR USE AS A DWELLING OR OTHER PREMISES; OR
4. FOR DEATH, DISMEMBERMENT, OR LOSS OF SIGHT, THAT RESULTS FROM:
   a. WAR OF ANY KIND;
   b. NUCLEAR REACTION, RADIATION OR RADIOACTIVE CONTAMINATION FROM ANY SOURCE, OR THE ACCIDENTAL OR INTENTIONAL DETONATION OF, OR RELEASE OF RADIATION FROM, ANY NUCLEAR OR RADIOACTIVE DEVICE;
   c. THE DISCHARGE OF A FIREARM;
   d. EXPOSURE TO ***FUNGI***;
   e. SUICIDE OR ATTEMPTED SUICIDE REGARDLESS OF WHETHER THE ***INSURED*** WAS SANE OR INSANE; OR
   f. DISEASE except pus-forming infection due to ***bodily injury*** sustained in the accident.

Our Payment Options

We may, in accordance with applicable law, make payment to one or more of the following:

1. The ***insured***;
2. The ***insured's*** surviving spouse;
3. A parent or guardian of the ***insured,*** if the ***insured*** is a minor or an incompetent ***person***; or
4. A ***person*** or organization authorized by law to receive such payment.

INSURED'S DUTIES

1. **Notice to Us of an Accident or Loss**

   The ***insured***, or another ***person*** on behalf of the ***insured,*** must give ***us*** or one of ***our*** agents notice of the accident or ***loss*** as soon as reasonably possible. The notice must give ***us***:
   a. ***your*** name;
   b. the names and addresses of all ***persons*** involved in the accident or ***loss***;
   c. the hour, date, place, and facts of the accident or ***loss***; and
   d. the names and addresses of witnesses to the accident or ***loss***.
2. **Notice to Us of Claim or Suit**
   a. If a claim is made against an ***insured***, then that ***insured***, or another ***person*** on behalf of that ***insured***, must immediately send ***us*** every demand, notice, and claim received.
   b. If a lawsuit is filed against an ***insured,*** then that ***insured,*** or another ***person*** on behalf of that ***insured***, must immediately send ***us*** every summons and legal process received.
3. **Insured's Duty to Cooperate With Us**
   a. The ***insured*** must cooperate with ***us*** and, when asked, assist ***us*** in:
      (1) making settlements;
      (2) securing and giving evidence;
      (3) attending, and getting witnesses to attend, depositions, hearings, and trials.
   b. The ***insured*** must not, except at his or her own cost, voluntarily:
      (1) make any payment to others; or
      (2) assume any obligation to others

      unless authorized by the terms of this policy.
   c. Any ***person*** or organization making claim under this policy must, when ***we*** require, give ***us*** proof of loss on forms ***we*** furnish.

4. **Questioning Under Oath**

Under:

a. the Liability Coverages, each *insured*;

b. Personal Injury Protection Coverage, Additional Work Loss Coverage, Uninsured Motor Vehicle Coverage, Underinsured Motor Vehicle Coverage, or Death, Dismemberment and Loss of Sight Coverage, each *insured*, or any other *person* or organization making claim or seeking payment; and

c. Property Protection Coverage and the Physical Damage Coverages, each *insured* or owner of a *covered vehicle*, bailee, or any other *person* or organization making claim or seeking payment;

must, at *our* option, submit to an examination under oath, provide a statement under oath, or do both, as reasonably often as *we* require. Such *person* or organization must answer questions under oath, asked by anyone *we* name, and sign copies of the answers. *We* may require each *person* or organization answering questions under oath to answer the questions with only that *person's* or organization's legal representative, *our* representatives, any *person* or *persons* designated by *us* to record the questions and answers, and no other *person* present.

5. **Other Duties Under the Physical Damage Coverages**

When there is a *loss*, *you* or the owner of the *covered vehicle* must:

a. protect the *covered vehicle* from additional damage. *We* will pay any reasonable expense incurred to do so that is reported to *us*;

b. make a prompt report to the police when the *loss* is the result of theft;

c. allow *us* to:

(1) inspect any damaged property before its repair or disposal;

(2) test any part or equipment before that part or equipment is removed or repaired; and

(3) move the *covered vehicle* at *our* expense in order to conduct such inspection or testing

if the *covered vehicle* is within *your* or *your* representative's control when inspection or testing is requested;

d. provide *us* all:

(1) records;

(2) receipts; and

(3) invoices

that *we* request and allow *us* to make copies; and

e. not abandon the *covered vehicle* to *us*.

6. **Other Duties Under Personal Injury Protection Coverage, Additional Work Loss Coverage, Uninsured Motor Vehicle Coverage, Underinsured Motor Vehicle Coverage, and Death, Dismemberment and Loss of Sight Coverage**

A *person* making claim, or a *person* making a claim on behalf of another, under:

a. Personal Injury Protection Coverage, Additional Work Loss Coverage, Uninsured Motor Vehicle Coverage, Underinsured Motor Vehicle Coverage, or Death, Dismemberment and Loss of Sight Coverage must:

(1) notify *us* of the claim and give *us* all the details about the death, injury, treatment, and other information that *we* may need as soon as reasonably possible after the injured *insured* is first examined or treated for the injury. If the *insured* is unable to give *us* notice, then any other *person* may give *us* the required notice;

(2) be examined as reasonably often as we may require by physicians, doctors, and healthcare professionals chosen and paid by *us*. A copy of the report will be sent to the *person* upon written request;

(3) provide written authorization for *us* to obtain:

(a) medical bills;

(b) medical records;

(c) wage, salary, and employment information; and

(d) any other information *we* deem necessary to substantiate the claim.

If an injured *insured* is a minor, unable to act, or dead, then his or her legal representative must provide *us* with the written authorization.

If the holder of the information refuses to provide it to *us* despite the authorization, then at *our* request the *person* making claim or his or her legal

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representative must obtain the information and promptly provide it to *us*; and

(4) allow *us* to inspect the vehicle that the *insured occupied* in the accident;

b. Uninsured Motor Vehicle Coverage must report an accident, involving a "hit-and-run" motor vehicle to the police within 24 hours and to *us* within 30 days, but if it is shown that it was not reasonably possible to report the accident within this time frame, then that *person* must report the accident to both the police and *us* as soon as is reasonably possible; and

c. Personal Injury Protection Coverage, Additional Work Loss Coverage, Uninsured Motor Vehicle Coverage, and Underinsured Motor Vehicle Coverage must send *us* immediately a copy of all lawsuit papers if the *insured* files a lawsuit against the party liable for the accident.

7. **Other Duties Under Property Protection Coverage**

When there is a loss:

a. the *damaged* property must be protected from further loss. *We* will pay any reasonable expense incurred to do so. IF THE PROPERTY IS NOT PROTECTED FROM FURTHER LOSS, THE FURTHER LOSS IS NOT PAYABLE UNDER THIS COVERAGE.

b. sworn proof of loss must be filed with *us* within a reasonable time. It must be:

(1) on the form; and

(2) contain the information

we require.

c. *we* must be allowed to inspect any *damaged* property before its repair or disposal if that damaged property is within *your* or *your* representative's control.

GENERAL TERMS

1. **When Coverage Applies**

The coverages provided by this policy are shown on the Declarations Page and apply to accidents and *losses* that occur during the policy period. The policy period is shown on the Declarations Page and is for successive periods of six months each for which the renewal premium is paid. The policy period begins and ends at 12:01 AM Standard Time at the address shown on the Declarations Page.

2. **Where Coverage Applies**

The coverages provided by this policy are shown on the Declarations Page and apply to accidents and *losses* that occur:

a. in the United States of America and its territories and possessions;

b. in Canada; and

c. while a vehicle for which coverage is provided by this policy is being shipped between the ports of the United States of America, its territories, its possessions, and Canada.

The Liability Coverages, Personal Injury Protection Coverage, and the Physical Damage Coverages also apply in Mexico within 50 miles of the United States of America border. A Physical Damage Coverage loss in Mexico is determined on the basis of cost at the nearest United States of America point.

Death, Dismemberment and Loss of Sight Coverage applies anywhere in the world.

HOWEVER, PROPERTY PROTECTION COVERAGE APPLIES ONLY TO ACCIDENTS THAT OCCUR IN MICHIGAN.

3. **Newly Owned or Newly Leased Car**

If *you* want to insure a *car* newly *owned by you* with the *State Farm Companies* after that *car* ceases to be a *newly acquired car*, then *you* must either:

a. request *we* replace the *car* currently shown on the Declarations Page of this policy with the *car* newly *owned by you* and pay *us* any added amount due. If *you* make such request while this policy is in force and:

(1) before the *car* newly *owned by you* ceases to be a *newly acquired car*, then that *car* newly *owned by you* will be insured by this policy as *your car* beginning on the date the *car* newly *owned by you* is delivered to *you*. The added amount due will be calculated based on that date; or

(2) after the *car* newly *owned by you* ceases to be a *newly acquired car*, then that *car* newly *owned by you* will be insured by this policy as *your car* beginning on the date and time *you* make the request. The added amount due will be calculated based on that date; or

b. apply to the *State Farm Companies* for a separate policy to insure the *car* newly *owned by you*. Such policy will be issued only if both the applicant and the vehicle are eligible for coverage at the time of the application.

4. **Changes to This Policy**

a. **Changes in Policy Provisions**

We may only change the provisions of this policy by:

(1) issuing a revised policy booklet, a revised Declarations Page, or an endorsement; or

(2) revising this policy to give broader coverage without an additional premium charge. If any coverage provided by this policy is changed to give broader coverage, then *we* will give *you* the broader coverage as of the date *we* make the change effective in the state of Michigan without issuing a revised policy booklet, a revised Declarations Page, or an endorsement.

b. **Change of Interest**

(1) No change of interest in this policy is effective unless *we* consent in writing.

(2) Except under Additional Work Loss Coverage and Death, Dismemberment and Loss of Sight Coverage, if a named insured shown on the Declarations Page dies, then the definition of *insured* under each of the coverages provided by this policy is changed to include:

(a) any *person* with lawful custody of *your car*, a *newly acquired car*, or a *temporary substitute car* until a legal representative is qualified; and then

(b) the legal representative of the deceased named insured.

This only applies while such *person* is maintaining or using *your car*, a *newly acquired car*, or a *temporary substitute car*.

Policy notice requirements are met by mailing the notice to the most recent policy address that *we* have on record for the deceased named insured.

c. **Joint and Individual Interests**

If *you* consists of more than one *person* or entity, then each acts for all to change or cancel the policy.

d. **Change of Policy Address**

We may change the named insured's policy address as shown on the Declarations Page and in *our* records to the most recent address provided to *us* by:

(1) *you*; or

(2) the United States Postal Service.

5. **Premium**

a. Unless as otherwise provided by an alternative payment plan in effect with the *State Farm Companies* with respect to the premium for this policy, the premium is due and payable in full on or before the first day of the policy period shown on the most recently issued Declarations Page or Renewal Notice.

b. The renewal premium for this policy will be based upon the rates in effect, the coverages carried, the applicable limits, deductibles, and other elements that affect the premium that apply at the time of renewal.

c. The premium for this policy may vary based upon the purchase of other insurance from the *State Farm Companies*.

d. The premium for this policy is based upon information *we* have received from *you* or other sources. *You* must inform *us* if any information regarding the following is incorrect or incomplete, or changes during the policy period, and *you* must answer questions *we* ask regarding the following:

(1) *Your car*, or its use, including annual mileage;

(2) The *persons* who regularly drive *your car*, including newly licensed family members; or

(3) The location where *your car* is primarily garaged.

If the above information or any other information used to determine the premium is incorrect, incomplete, changes during the policy period, or is not provided to *us* when *we* ask, then *we* may decrease or increase the premium during the policy period. If *we*

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decrease the premium during the policy period, then *we* will provide a refund or a credit in the amount of the decrease. If *we* increase the premium during the policy period, then *you* must pay the amount of the increase.

This provision (5.d.) does not waive *our* right to rescind or reform this policy from its inception where this policy was procured through *your* misrepresentation of a material fact in the application for this insurance.

6. **Renewal**

We agree to renew this policy for the next policy period upon payment of the renewal premium when due, unless *we* mail or deliver a nonrenewal notice or a cancellation notice as set forth in 7. and 8. below.

7. **Nonrenewal**

If *we* decide not to renew this policy, then, at least 30 days before the end of the current policy period, *we* will mail or deliver a nonrenewal notice to the most recent policy address that *we* have on record for the named insured who is shown on the Declarations Page.

8. **Cancellation**

a. **How You May Cancel**

On or before the date cancellation is effective, *you* may cancel this policy by providing to *us* notice of that date.

b. **How and When We May Cancel**

(1) *We* may cancel this policy by mailing or delivering a written notice to the most recent policy address that *we* have on record for the named insured who is shown on the Declarations Page. The notice will provide the date cancellation is effective.

(2) If *we* mail or deliver a cancellation notice because the premium is not paid when due, then the date cancellation is effective will be at least 10 days after the date *we* mail or deliver the cancellation notice.

Otherwise, the date cancellation is effective will be at least:

(a) 20 days after the date *we* mail or deliver the cancellation notice if *we* mail or deliver it during the first 55 days following the policy effective date; or

(b) 30 days after the date *we* mail or deliver the cancellation notice if *we* mail or deliver it after the policy has been in force for more than 55 days.

(3) After the policy has been in force for more than 55 days, *we* will not cancel this policy before the end of the current policy period unless:

(a) the premium is not paid when due;

(b) *you*, any *resident relative*, or any other *person* who customarily drives *your car* has had his or her operator's license suspended or revoked during the policy period and the revocation or suspension has become final; or

(c) such cancellation is for any other reason allowed by law.

c. **Return of Unearned Premium**

If *you* cancel this policy, then a minimum premium may be applied. If *we* cancel this policy, then premium will be earned on a pro rata basis.

Any unearned premium may be returned within a reasonable time after cancellation. Delay in the return of any unearned premium does not affect the cancellation date.

9. **Assignment**

No assignment of benefits or other transfer of rights is binding upon *us* unless approved by *us*.

10. **Bankruptcy or Insolvency of the Insured**

Bankruptcy or insolvency of the *insured* or his or her estate will not relieve *us* of *our* obligations under this policy.

11. **Concealment or Fraud**

There is no coverage under this policy if *you* or any other *person* insured under this policy has made false statements with the intent to conceal or misrepresent any material fact or circumstance in connection with any claim under this policy.

12. **Our Right to Recover Our Payments**

a. Death, Dismemberment and Loss of Sight Coverage payments are not recoverable by *us*.

b. Under all other coverages the following apply:

(1) **Subrogation**

If *we* are obligated under this policy to make payment to or for a *person* or organization who has a legal right to

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recover from another *person* or organization, then *we* will be subrogated to that right to the extent of *our* payment.

The *person* or organization to or for whom *we* make payment must help *us* recover *our* payments by:

(a) doing nothing to impair that legal right;

(b) executing any documents *we* may need to assert that legal right; and

(c) taking legal action through *our* representatives when *we* ask; and

(2) **Reimbursement**

If *we* make payment under this policy and the *person* or organization to or for whom *we* make payment recovers or has recovered from another *person* or organization, then that *person* or organization to or for whom *we* make payment must:

(a) hold in trust for *us* the proceeds of any recovery; and

(b) reimburse *us* to the extent of *our* payment.

(3) Under Personal Injury Protection Coverage and Property Protection Coverage, *we* have a lien to the extent of *our* payments. Notice of the lien may be given to:

(a) the liable party;

(b) that party's agent or insurer; or

(c) a court that has jurisdiction.

13. **Legal Action Against Us**

As described below, *you* may file a lawsuit against *us* in order to have a dispute settled by a court that has proper jurisdiction.

Legal action may not be brought against *us* until there has been full compliance with all the provisions of this policy. In addition, legal action may only be brought against *us* regarding:

a. The Liability Coverages after the amount of damages an *insured* is legally liable to pay has been finally determined by:

(1) judgment after actual trial, and appeal of that judgment if an appeal is made; or

(2) agreement between the claimant and *us*.

b. Personal Injury Protection Coverage if the legal action is brought against *us* within one year after:

(1) the date of the accident; or

(2) the date on which the most recent expense or loss has been incurred if *we* have either received written notice of the *bodily injury* within one year from the date of the accident, or have made a payment under this coverage for the *bodily injury*.

NO LEGAL ACTION MAY SEEK BENEFITS FOR LOSS INCURRED MORE THAN ONE YEAR BEFORE THE DATE ON WHICH THE ACTION WAS COMMENCED.

c. Property Protection Coverage if the legal action relating to this coverage is brought against *us* within one year after the date of the accident.

d. Uninsured Motor Vehicle Coverage and Underinsured Motor Vehicle Coverage if the *insured* or that *insured's* legal representative within six years immediately following the date of the accident:

(1) presents either an Uninsured Motor Vehicle Coverage claim or an Underinsured Motor Vehicle Coverage claim to *us*; and

(2) files a lawsuit in accordance with the **Deciding Fault and Amount** provision of the involved coverage.

Except as provided in d.(2) above, no other legal action may be brought against *us* relating to Uninsured Motor Vehicle Coverage or Underinsured Motor Vehicle Coverage for any other causes of action that arise out of or are related to these coverages until there has been full compliance with the provision titled **Deciding Fault and Amount**.

e. Physical Damage Coverages if the legal action relating to these coverages is brought against *us* within six years immediately following the date of the accident or *loss*.

Subject to a., b., c., d., and e. above, legal action may also be brought against *us* anytime within the limitation of the applicable statute, if *you* have an unresolved dispute related to:

a. *our* responses to *your* requests concerning court proceedings; or

b. how *we* handled *your* claim.

14. **Choice of Law**

Without regard to choice of law rules, the law of the State of:

a. Michigan will control, except as provided in b. below, in the event of any disagreement as to the interpretation and application of any provision in this policy; and

b. Illinois will control in the event of any disagreement as to the interpretation and application of this policy's:

(1) Mutual Conditions provision found on the most recently issued Declarations Page, if this policy was issued by the State Farm Mutual Automobile Insurance Company; or

(2) Participating Policy provision found on the most recently issued Declarations Page, if this policy was issued by any subsidiary or affiliate of the State Farm Mutual Automobile Insurance Company.

15. **Severability**

If any provision of this policy is held invalid or unenforceable by a court that has jurisdiction, then:

a. such provision will remain in full force to the extent not held invalid or unenforceable; and

b. all other provisions of this policy will remain valid and enforceable.

16. **Constitutionality**

If a court declares any part of the ***No-Fault Act*** invalid, ***we*** may change these coverages and refigure future rates. These revised rates would be subject to review by the Michigan Insurance Bureau. ***You*** would be notified at least 10 days before these changes are made.

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State Farm Mutual Automobile Insurance Company

2550 Northwestern Avenue
West Lafayette IN 47906

NAMED INSURED

HENSLEY, GEORGE
1718 E WEBSTER RD LOT 129
FLINT MI 48505-5705

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6-14 (2-5-A MOTL VOL

DECLARATIONS PAGE

POLICY NUMBER 382 1274-D03-22A
POLICY PERIOD NOV 12 2013 to APR 03 2014
12:01 A.M. Standard Time

STATE FARM PAYMENT PLAN NUMBER
1166290004

AGENT
JENNIFER BLUMER
2510 LAKE LANSING RD
LANSING, MI 48912-5669

PHONE: (517)372-0200

DO NOT PAY PREMIUMS SHOWN ON THIS PAGE.
IF AN AMOUNT IS DUE, THEN A SEPARATE STATEMENT IS ENCLOSED.

YOUR CAR

YEAR	MAKE	MODEL	BODY STYLE	VEHICLE ID. NUMBER	CLASS
1997	MITSUBISHI	MONTERO	SPORT WG	JA4MR51R9VJ006182	30NHB61100

SYMBOLS	COVERAGE & LIMITS	PREMIUMS
A P4 N	Combined Premium	$939.59
A	Liability Coverage Bodily Injury Limits Each Person, Each Accident $20,000 $40,000 Property Damage Limit Each Accident $10,000	
P4	Personal Injury Protection Coverage (See Policy Schedule)	
N	Property Protection Coverage	
U	Uninsured Motor Vehicle Coverage Bodily Injury Limits Each Person, Each Accident $20,000 $40,000	$6.97
W	Underinsured Motor Vehicle Coverage Bodily Injury Limits Each Person, Each Accident $20,000 $40,000	$1.72
S	Death, Dismemberment and Loss of Sight Coverage Persons Insured - $10,000 HENSLEY, GEORGE	$1.88
Y	Limited Property Damage Liability Coverage	$6.28
	Total premium for NOV 12 2013 to APR 03 2014.	$956.44 This is not a bill

IMPORTANT MESSAGES

Replaced policy number 3821274-22

Your total renewal premium for OCT 03 2013 to APR 03 2014 is $1,221.52.

Semiannual premium includes Catastrophic Claims premium $105.92

Semiannual premium includes Statutory Assessments $1.07

Customer Rating Index: 1489

EXCEPTIONS, POLICY BOOKLET & ENDORSEMENTS (See policy booklet & individual endorsements for coverage details.)

YOUR POLICY CONSISTS OF THIS DECLARATIONS PAGE, THE POLICY BOOKLET -
FORM 9822B, AND ANY ENDORSEMENTS THAT APPLY, INCLUDING THOSE ISSUED TO YOU
WITH ANY SUBSEQUENT RENEWAL NOTICE.
9922B AMENDATORY ENDORSEMENT.

Agent: JENNIFER BLUMER
Telephone: (517)372-0200
Prepared: DEC 10 2013 7264-A6A

2525/002956

See Reverse Side

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Please read the following explanation of the Collision Coverage (Private Passenger Automobiles) or Physical Damage Coverage (Recreational Vehicles) options offered by State Farm®. The Symbol or Physical Damage option and applicable amount, if any, you have selected are shown in the "COVERAGE & LIMITS" area on the front of the Declarations Page. The letters shown below in parentheses correspond to those indicated under SYMBOLS on the front of the page.

COLLISION COVERAGE OPTIONS-PRIVATE PASSENGER AUTOMOBILES

Option 1

- LIMITED COLLISION COVERAGE WITHOUT A DEDUCTIBLE (U) - State Farm will pay for collision damage only when the driver of the insured vehicle is not more than 50% the cause of the accident. If the driver of the insured vehicle is more than 50% the cause of the accident, your policy does not pay for collision damage.
- LIMITED COLLISION COVERAGE WITH A DEDUCTIBLE (U) - State Farm will pay for collision damage only when the driver of the insured vehicle is not more than 50% the cause of the accident and you must pay the deductible amount you have chosen. If the driver of the insured vehicle is more than 50% the cause of the accident, you do not have to pay for collision damage.

Option 2

REGULAR COLLISION COVERAGE (C) - State Farm will pay for collision damage to the insured vehicle regardless of who is responsible for the accident, and you must pay the deductible amount you have chosen.*

Option 3

BROADENED COLLISION COVERAGE (CJ) - State Farm will pay for collision damage to the insured vehicle regardless of who is responsible for the accident. If the driver of the insured vehicle is more than 50% the cause of the accident, you must pay the deductible amount you have chosen. However, if the driver of the insured vehicle is not more than 50% the cause of the accident, you do not have to pay the deductible amount.

Option 4

NO COLLISION COVERAGE - Your policy does not provide coverage for collision damage to the insured vehicle.*

PHYSICAL DAMAGE COVERAGE OPTIONS-RECREATIONAL VEHICLES

Option 1

LIMITED COLLISION COVERAGE WITHOUT A DEDUCTIBLE (U - travel and camping trailers only) - State Farm will pay for collision damage only when the driver of the insured vehicle is not more than 50% the cause of the accident. If the driver of the insured vehicle is more than 50% the cause of the accident, your policy does not pay for collision damage.

Option 2

COMBINED PHYSICAL DAMAGE COVERAGE (I - off-road vehicles and travel and camping trailers) - State Farm will pay for physical damage to the insured vehicle regardless of who is responsible for the accident. And you must pay the deductible amount you have chosen.*

Option 3

BROADENED COMBINED PHYSICAL DAMAGE COVERAGE (IJ - travel and camping trailers only) - State Farm will pay for physical damage to the insured vehicle. If the damage is not caused by collision, or if the damage is caused by collision and the driver of the insured vehicle is more than 50% the cause of the accident, you must pay the deductible amount you have chosen. However, if the driver of the insured vehicle is not more than 50% the cause of the accident, you do not have to pay the deductible amount.

Option 4

BROADENED COLLISION COVERAGE (CJ - travel and camping trailers only) - State Farm will pay for collision damage to the insured vehicle regardless of who is responsible for the accident. If the driver of the insured vehicle is more than 50% the cause of the accident, you must pay the deductible amount you have chosen. However, if the driver of the insured vehicle is not more than 50% the cause of the accident, you do not have to pay the deductible amount.

Option 5

NO PHYSICAL DAMAGE COVERAGE - Your policy does not provide coverage for physical damage to the insured vehicle.*

* If the driver of another insured vehicle is 50% or more the cause of an accident occurring in the state of Michigan, which results in damages to the insured vehicle, you may sue that driver to recover up to $500 in collision damages. You must originate action against the other driver in the municipal court or the small claims division of the district court. If the other driver is found to be 50% or more but less than 100% the cause of the accident, the award to you may be reduced by the percentage to which you were the cause of the accident. State Farm is not responsible for filing the suit on your behalf, and the other driver's insurance company may not be responsible to pay any award to you on behalf of the other driver.

If you would like to change your Collision Coverage or Physical Damage Coverage option, please contact your State Farm agent.

This policy is issued by State Farm Mutual Automobile Insurance Company

MUTUAL CONDITIONS

1. **Membership.** While this policy is in force, the first insured named in the declarations is entitled to vote at all meetings of members and to receive dividends the Board of Directors in its discretion may declare in accordance with reasonable classifications and groupings of policyholders established by such Board.
2. **No Contingent Liability.** This policy is non-assessable.
3. **Annual Meeting.** The annual meeting of the members of the company shall be held at its home office at Bloomington, Illinois, on the second Monday of June at the hour of 10:00 A.M., unless the Board of Directors shall elect to change the time and place of such meeting, in which case, but not otherwise, due notice shall be mailed each member at the address disclosed in this policy at least 10 days prior thereto.

In Witness Whereof, the State Farm Mutual Automobile Insurance Company has caused this policy to be signed by its President and Secretary at Bloomington, Illinois.

Secretary

President

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6922B AMENDATORY ENDORSEMENT

this endorsement is issued to the State Farm Mutual Automobile Insurance Company or the State Farm Fire and Casualty Company as shown on the Declarations Page. This endorsement is a part of the policy. Except for the changes made in this endorsement, all other provisions of the policy remain the same and apply to this endorsement.

1. **THIS POLICY**
   Item 6 is changed to read
   Your purchase of this policy does not allow:
   a. you to purchase or obtain certain coverages, options, or endorsements, coverage deductibles, coverage limits, or coverage terms on other products from the *State Farm Companies* subject to their applicable eligibility rules; or
   b. the payment of premiums for other products or services purchased by you including noninsurance products or services, to earn such other products or services may be provided by the *State Farm Companies* or by an organization that is related to an agreement or contract with the *State Farm Companies*. The *State Farm Companies* do not warrant the merchantability, fitness, or quality of any product or service offered or provided by that organization.

2. **LIABILITY COVERAGES**
   Insuring Agreement and **Supplementary Payments** are replaced by the following.
   Insuring Agreement
   1. **Liability Coverage**
      a. *We* will pay damages an *insured* becomes legally liable to pay because of:
         (1) *bodily injury* to others; and
         (2) damage to property
         caused by an accident that involves a vehicle for which that *insured* is provided Liability Coverage by this policy.
      b. *We* have the right to:
         (1) investigate, negotiate, and settle any claim or lawsuit
         (2) defend an *insured* in any claim or lawsuit with attorneys chosen by us except when prohibited by Michigan law; and
         (3) appeal any award of legal decision
         for damages payable under this policy's Liability Coverage.
      c. *We* will pay damages to a motor vehicle for which the *insured* becomes legally liable to pay pursuant to Section 3009(1), subsection (3)(c) of the Michigan insurance code.
      The *insured* must appear and defend himself or herself in any action commenced by the damaged in the Small Claims Division of the District Court or the Municipal Court (SMALL CLAIMS DIVISION) BUT APPEARS AND DEFENDS HIMSELF OR HERSELF IN ALL OTHER COVERAGES PROVIDED FOR UNDER THIS POLICY.
      d. *We* have the right to:
         (1) investigate, negotiate, and settle any claim or lawsuit
         (2) defend an *insured* in any claim or lawsuit with attorneys chosen by us except when prohibited by Michigan law; and
         (3) appeal any award of legal decision
         for damages payable under this policy's Limited Property Damage Liability Coverage.
      We will pay, in addition to the damages described in the **Insuring Agreement** of this policy's Liability Coverage and the **Insuring Agreement** of this policy's Limited Property Damage Liability Coverage, all other expenses of the policy certain to the same and apply to this endorsement.

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this policy's Liability Coverage and the **Insuring Agreement** of this policy's Limited Property Damage Liability Coverage these items listed below that result from such accident.

1. Except where prohibited by Michigan law attorney fees for damages chosen by us to defend an *insured* who is sued for such damages. *We* have no duty to pay attorney fees incurred after *we* deposit in court or pay the amount due under the **Insuring Agreement** of this policy's Liability Coverage or the **Insuring Agreement** of this policy's Limited Property Damage Liability Coverage.
2. Court costs awarded by the court against an *insured* and nothing from that part of the lawsuit
   a. that seeks damages payable under this policy's Liability Coverage or this policy's Limited Property Damage Liability Coverage.
   b. against which *we* defend an *insured* with attorneys chosen by us; and
   c. against which an *insured* defends himself or herself in a small claims court action.

   We have no duty to pay court costs incurred after *we* deposit in court or pay the amount due under the **Insuring Agreement** of this policy's Liability Coverage or the **Insuring Agreement** of this policy's Limited Property Damage Liability Coverage.
3. The interest on that part of the judgment that is within the limits of liability of this policy's Liability Coverage and Limited Property Damage Liability Coverage.
4. Interest on the *insured's* legal right to pay on damages payable under the **Insuring Agreement** of this policy's Liability Coverage or the **Insuring Agreement** of this policy's Limited Property Damage Liability Coverage.
   a. before a judgment but only the amount on the lesser of
      (1) that part of the damages we pay or
      (2) the policy's applicable Liability Coverage limit or the policy's applicable Limited Property Damage Liability Coverage limit; and
   b. after a judgment

We have no duty to pay interest that accrues after *we* deposit or offer to pay the amount due under the **Insuring Agreement** of this policy's Liability Coverage or the **Insuring Agreement** of this policy's Limited Property Damage Liability Coverage. *We* also have no duty to pay interest that accrues on any damages paid or payable by a person or entity other than the *insured* or us.

4. Premiums for bonds provided by a company chosen by us required to appeal a decision in a lawsuit against an *insured*. *We* have no duty to:
   a. pay for any bond with a face amount that exceeds the policy's applicable Liability Coverage limit or the policy's applicable Limited Property Damage Liability Coverage limit.
   b. furnish or apply for any bond; or
   c. pay premiums for bonds purchased after we deposit in court or offer to pay the amount due under the policy's **Insuring Agreement** of this policy's Liability Coverage and the policy's **Insuring Agreement** of this policy's Limited Property Damage Liability Coverage.
5. The ordinary costs and expenses of retained and incurred after a lawsuit has been filed against an *insured*
   a. Loss of wages or salary but not other income, up to $200 for each day an *insured* attends, at our request
      (1) to attorneys
      (2) in arbitration or
      (3) a mediation or
      (4) a trial of a lawsuit and
   b. Reasonable expenses incurred by an *insured* at *our* request other than loss of wages, salary, or other income.

   The amount of any of the costs or expenses listed above that are incurred by an *insured* must be reported to us before we will pay such incurred costs or expenses.
5. PERSONAL INJURY PROTECTION COVERAGE AND ADDITIONAL WORK LOSS COVERAGE

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Item 5 of **Reduction in Benefits** is changed to read:

5. If benefits are shown as "Coordinated" after making any reductions as stated above, with respect to any **resident relative** the amount will be further reduced by **you** or any **resident relative** for any amount paid or payable to that ***person*** under:

   a. School or premises insurance;

   b. individual, blanket or group accident or disability insurance or medical or surgical reimbursement plan.

   If allowable expense benefits are shown as "Coordinated" we will not pay the first $500 of the Limit(s) shown above. The expenses that are charged to ***bodily injury*** to **you** or any **resident relative** or their or the **resident** insurer applicable to the ***bodily injury*** at the time of the accident. This benefit for each loss before this applies once per accident.

   If work loss benefits are shown as "Coordinated", we will not pay the first $500 of the maximum work loss that was incurred by **you** or any **resident relative** if there is any other applicable insurance applicable to the ***bodily injury*** at the time of the accident. This benefit for each loss before this applies once per accident.

Death, Dismemberment and Loss of Sight Coverage applies anywhere in the world.

HOWEVER PROPERTY DAMAGE COVERAGE DOES NOT APPLY TO PROPERTY OWNED OR LEASED BY ANY ***INSURED*** OR ANY OTHER ***PERSON*** WHILE IN MEXICO.

The following is added:

Limited Coverage in Mexico

The policy does not provide Mexican auto insurance and does not comply with Mexican auto insurance requirements. If **you** or any other ***insured*** plans to drive in Mexico, then auto insurance providing coverage in Mexico should be purchased from a Mexican insurance company.

Subject to the above paragraph the following coverages apply in Mexico, but only for accidents and ***losses*** that occur in Mexico within 30 miles of the United States of America border and only for ***insureds*** as defined under each of the following coverages:

a. Liability Coverage

   For claims brought against an ***insured*** in Mexico the **Supplementary Payments** provisions of this policy and Liability Coverage are changed to read:

   We may, in addition to the Limits of Liability described in Item 4 of the **Declarations** Page of this policy and the **Hearing Agreement** of this policy, Liability Coverage pay on behalf of an ***insured*** all sums which the ***insured*** shall become legally obligated to pay as damages because of ***bodily injury*** or ***property damage*** to which this coverage applies, caused by an accident resulting from the ownership, maintenance or use of a ***motor vehicle*** or ***trailer*** in Mexico.

   We will defend any suit for such damages, but we may make such investigation and settlement of any claim or suit as we deem expedient. We will not defend any suit after the limit of our liability has been exhausted by payment of judgments or settlements.

   We will pay all premiums on bonds to release attachments for an amount not in excess of the applicable limit of liability of this coverage, but we have no obligation to apply for or furnish any such bond.

   We will pay all expenses we incur. Our payments will be in addition to the applicable limit of liability of this coverage.

   Our duties after an accident or loss, our duties in the event of a claim or suit and our duties with respect to cooperation will be performed exclusively in the state of Texas.

   Our limit of liability for this coverage will be the higher of the minimum limit of liability specified by the motor vehicle financial responsibility law of Mexico or the limit of liability for this coverage as shown in the **Declarations** Page of this policy. All premiums for this coverage will be calculated in accordance with the rules and rates in effect for this policy in Texas at the time we issue or renew this coverage.

   The limit of liability for this coverage is the limit for the sum of all damages because of all ***bodily injury*** and ***property damage*** arising out of any one accident.

   Any person or organization qualifying as an ***insured*** under this Liability Coverage is an ***insured*** under no other liability coverage in this policy.

   No one will be obligated to share with another under this coverage any loss payable under this coverage. Any insurance we provide with respect to a vehicle you do not own shall be excess over any other collectible insurance.

b. Comprehensive Coverage and Collision Coverage

   The provision of this policy will be limited to the cost to repair or replace, the *covered vehicle* in the United States of America.

   IF HAIL DAMAGE IS TO BE PROVIDED, A DEDUCTIBLE FOR ANY OTHER LOSS MUST BE SHOWN IN THE DECLARATIONS.

   IF A VEHICLE IS DESCRIBED AS A TRAILER OR IS USED FOR CAMPING OR RECREATION, IT IS COVERED ONLY WHILE ON PUBLIC ROADS AND PARKING AREAS.

   THERE IS NO COVERAGE FOR ANY LOSS CAUSED BY OR RESULTING FROM THE CONFISCATION OR DESTRUCTION OF THE ***COVERED VEHICLE*** BY ANY GOVERNMENTAL OR PUBLIC AUTHORITY.

   No other policy provisions are to conflict with the provisions in the Limited Coverage in Mexico provision of this policy.

If Other Coverage Applies

No coverage provided by this Limited Coverage for Mexico provision is excess over any other applicable insurance.

Legal Action Against Us

No legal action against us arising out of an accident or ***loss*** occurring in Mexico must be brought in a court that

has jurisdiction in the state of Texas in the United States of America.

Paragraph c. of **Premium** is changed to read:

c. The premium for the policy shall be based upon:

   (1) the purchase of other products or services from the *State Farm Companies*;

   (2) the purchase of products or services from an organization that has entered into an agreement or contract with the *State Farm Companies* to do so; and

   (3) other policy provisions that are not prohibited by law.

Paragraph **e.** of **Premium** is changed to read:

e. If an application or renewing the insurance provided by this policy, that the *State Farm Companies* has with an organization which entitles a member, subscriber or client to a discount or purchase

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EXHIBIT E

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UNIFORM MOTOR VEHICLE ACCIDENT REPARATIONS ACT

Drafted by the

NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS

and by it

APPROVED AND RECOMMENDED FOR ENACTMENT IN ALL THE STATES

at its

ANNUAL CONFERENCE
MEETING IN ITS EIGHTY-FIRST YEAR
AT SAN FRANCISCO, CALIFORNIA
AUGUST 4-11, 1972

OFFICIAL DRAFT
WITH
PREFATORY NOTE AND COMMENTS

November 1, 1972 Edition

SECTION 29. [*Assignment of Benefits*]

An assignment of or agreement to assign any right to benefits under this Act for loss accruing in the future is unenforceable except as to benefits for:

(1) work loss to secure payment of alimony, maintenance, or child support; or

(2) allowable expense to the extent the benefits are for the cost of products, services, or accommodations provided or to be provided by the assignee.

COMMENT

One of the objectives of this Act is to pay benefits periodically (see Section 23) to sustain the person suffering loss as expenses are accrued and, incidentally, to reduce the chances that payments will be applied to improvident purposes. This Section prevents that objective from being circumvented by assignment of the right to benefits for future loss. Two types of assignments which are not inconsistent with this objective are authorized. Paragraph (1) allows a person to satisfy familial support obligations through an assignment of rights to benefits for work loss. Paragraph (2) allows an injured person to secure needed products, services, and accommodations by authorizing assignment of benefits to hospitals, physicians, druggists, and others providing those needs. Assignments permitted by paragraph (2) are only of those benefits which are attributable to the cost of the benefits, services, or accommodations provided. Section 23(a) permits an insurer to make direct payment to the suppliers even if no assignment of benefits has been executed.

SECTION 30. [*Deduction and Set-off*]

Except as otherwise provided in this Act, basic reparation benefits shall be paid without deduction or set-off.

COMMENT

This provision has a number of disparate applications, such as: where the injured person is entitled to basic reparation benefits from an insurer asserting a right of indemnity (Section 6(c)); where the same reparation obligor is required to pay tort claims arising from an accident involving an uninsured owner (Section 5(a)(1)) and reparation benefits to the uninsured owner; and where the reparation obligor, having paid reparation benefits to an insured owner and tort claims on his behalf to other persons injured in an accident, asserts a cause of action for damages for breach of the policy's co-operation clause.

SECTION 31. [*Exemption of Benefits*]

(a) Basic or added reparation benefits for allowable expense are exempt from garnishment, attachment, execution, and any other process or claim, except upon a claim of a

creditor who has provided products, services, or accommodations to the extent benefits are for allowable expense for those products, services, or accommodations.

(b) Basic reparation benefits other than those for allowable expense are exempt from garnishment, attachment, execution, and any other process or claim to the extent that wages or earnings are exempt under any applicable law exempting wages or earnings from process or claims.

COMMENT

This Section protects basic reparation benefits, except those for allowable expense which receive greater protection, to the same extent that earnings or wages are protected from process under either applicable state or federal law. While benefits for allowable expense enjoy absolute protection from process under this Section, there is authorization for direct payment by the insurer under Section 23(a), and a creditor with a claim for goods, services, or accommodations which constituted an item of allowable expense may reach benefits for that item of allowable expense.

SECTION 32. [*Mental or Physical Examinations*]

(a) If the mental or physical condition of a person is material to a claim for past or future basic or added reparation benefits, the reparation obligor may petition the [ ] court for an order directing the person to submit to a mental or physical examination by a physician. Upon notice to the person to be examined and all persons having an interest, the court may make the order for good cause shown. The order shall specify the time, place, manner, conditions, scope of the examination, and the physician by whom it is to be made.

(b) If requested by the person examined, the reparation obligor causing a mental or physical examination to be made shall deliver to the person examined a copy of a detailed written report of the examining physician setting out his findings, including results of all tests made, diagnoses, and conclusions, and reports of earlier examinations of the same condition. By requesting and obtaining a report of the examination ordered or by taking the deposition of the physician, the person examined waives any privilege he may have, in relation to the claim for basic or added reparation benefits, regarding the testimony of every other person who has examined or may thereafter examine him respecting the same condition. This subsection does not preclude discovery of a report of an examining physician, taking a

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EXHIBIT F

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STATE OF MICHIGAN

IN THE SUPREME COURT

COVENANT MEDICAL CENTER, INC.,

Plaintiff-Appellee,

vs. CASE NO: 152758

STATE FARM MUTUAL AUTO INSURANCE COMPANY,

Defendant-Appellant.
_____/

EXCERPT OF ORAL ARGUMENT

DECEMBER 7, 2016

APPEARANCES:

For the Plaintiff: JILL M. WHEATON (P49921)
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For the Defendant: RICHARD Z. HILLARY II (P56092)
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Commerce Township, MI 48382
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EXCERPT OF ORAL ARGUMENT

DECEMBER 7, 2016

* * * * *

JUSTICE BERNSTEIN: But, Counsel, isn't the -- isn't the practical implication of this that, you know, I like to kind of keep things simple, but in -- and in terms of this case, which is complicated, the real practical implication is, is that you're really gonna turn hospitals against patients because ultimately what you're asking for --

CHIEF JUSTICE YOUNG: They are against us.

JUSTICE BERNSTEIN: Well but -- but you're basically gonna codify the idea that it's -- it's basically your hospital is now gonna have to -- the only way that the hospital's gonna be able to collect is to go after the individual patients.

And you pretty much know that individual patients are gonna be somewhat judgement-proof. So, for all intents and purposes, your goal is to kind of get the insurance companies out of it, which is gonna result in having hospitals have to come after patients.

MS. WHEATON: Not necessarily. They could go after patients, they could get an assignment of the claim from the patient --

CHIEF JUSTICE YOUNG: Was there an assignment here?

MS. WHEATON: What?

CHIEF JUSTICE YOUNG: Was -- was there an assignment here?

MS. WHEATON: In this case, no. Covenant could not seek one. But you could seek one. And in fact, in that case, then there would be no question on the part of the insurance company. When resolving the claim they would have all the defensives available to it that it would have were it the injured person bringing the claim. And a resolution of that would -- would have some finality to it. So they could sue the injured person, the injured person could then bring in the insurance company, they could get an assignment and sue, or they could just take whatever they got and -- and, you know, move on to the next --

JUSTICE BERNSTEIN: But, Counsel, why is it that when you're entering into a settlement with -- with a Plaintiff, you're entering into a settlement, why is it that you, as the insurance

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company, can't simply indicate when you're entering into that settlement that you want to make sure that all people are paid and that everything is satisfied? Why can't you do that?

MS. WHEATON: That's what we thought we did in this case. It gave --

JUSTICE BERNSTEIN: But you -- but you specifically left out the healthcare provider.

MS. WHEATON: No. The healthcare providers were included, and they were included by name in the release and settlement agreement.

JUSTICE BERNSTEIN: But to the Plaintiff, the -- the whole point here is, is -- is that -- the -- the thing that I'm concerned about is, is that in terms of how this is gonna play out in terms of the practice of law, is that if you're able to go to the individual Plaintiff, make a deal with the Plaintiff, then ultimately, you know, that Plaintiff can enter into a deal with you, and the healthcare provider is really left out, you know -- left out with nothing after they've provided hundreds of thousands of dollars in services in many situations.

MS. WHEATON: And again --

JUSTICE BERNSTEIN: Isn't that kind of

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the reality of what's gonna wind up happening if we were to rule in your favor?

MS. WHEATON: I don't think so. I think what's gonna wind up happening is what I just talked to you about, about the getting assignments. I think some of the frequent flyer litigants, the providers who provide a lot of services at a big, high cost, and bring massive lawsuits, I think they might go away. I'm okay with that. Otherwise, settlement are going to be the way they used to be, the way they are in other personal injury claims where you --

CHIEF JUSTICE YOUNG: What was --

MS. WHEATON: -- where you assume that that person's attorney is negotiating a lean down with the healthcare providers --

CHIEF JUSTICE YOUNG: What was the universe before it became recognized in the Court of Appeals, that there was a direct cause of action for no-fault benefits by provider?

JUSTICE MCCORMACK: Yeah. How do they get -- how do they get paid for the first 30 years that the statute was imposed?

MS. WHEATON: Before my time. I -- I assume regular --

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CHIEF JUSTICE YOUNG: Okay. Well --

MS. WHEATON: No, I mean, I -- I don't mean to be flippant. I'm just saying I'm assuming the regular way. If, for example, there's, you know, a tornado and a tree falls on my house and I have to get a new roof, and I go get a roofer. And the insurance company gives me the check and I pocket it, the roofer can't turn around and pay -- and sue the insurance company. He has to sue me because I'm not allowed to pocket and profit from my injury. I have to pay. Why should it be any different when it's a no-fault situation?

JUSTICE BERNSTEIN: Because doesn't this really just allow you to do -- and again, I'm just looking at this from how the practice of law is gonna go based on how this decision is made. I mean, I guess my -- help me to alleviate my concerns. Isn't this just gonna allow you to do end run around the providers, around the hospitals in a -- in a -- in a way that's gonna really benefit you? It just kind of creates an end run for you.

MS. WHEATON: No, it -- it -- it doesn't. And like I said, it's like anything else. If you are a doctor and you set someone's broken arm because the arm has been broken because I, you know,

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tripped over my own feet, and I don't pay, they're gonna have to sue me. Why should it be different? Why do you get a special right because I broke my arm in a car accident? It -- they're asking for this to be kind of a super right --

JUSTICE BERNSTEIN: Isn't that the whole idea of no-fault though? Wasn't that -- I mean, in a -- in a way, wasn't that, when you look at why no-fault was created, isn't it kind of a general compromise that you're limiting, you know, certain rights in order to protect others? Isn't that kind of the essence of the bargain and the idea behind the Michigan No-Fault Statute?

MS. WHEATON: Yes. But it's -- it is meant to protect the injured person so that they don't -- aren't left with a -- a whole bunch of medical bills. And -- and when you work together with the injured person to pay the bills, they're not being left out of the equation. So you're not making an end run around the doctor. You are dealing with the person with whom you have the contractual relationship. Just like if the provider isn't paid, he, she, it needs to deal with the person with whom it has the contractual relationship, the person to who it gave the services. They have no legal

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relationship with the insurance company.

JUSTICE LARSEN: Is there any problem here that -- with respect to at least emergency room providers? They can't refuse service, so under EMTALA, various --

MS. WHEATON: Correct.

JUSTICE LARSEN: -- statutes. They can't refuse service. So it's not maybe quite like the roofer. The roofer can say, hey, I think you might be judgment proof for your insurance might not be so great, I'm not quite sure you're gonna get paid, or if you are gonna get paid, you're probably gonna go off to Vegas and spend the money and you'll never pay me, so I'm not gonna fix your roof. But if you show up at an emergency room, the hospital can't turn you away. Does that affect our thinking at all here?

MS. WHEATON: No. Because again, they -- they can bring an action against that person, there is -- sometimes in some specific situations there is an assignment of rights built into the consent to treat.

JUSTICE LARSEN: Oh, so that's interesting. So couldn't this whole problem be solved that way, if the providers just got an

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assignment of rights from everybody who showed up for treatment? Couldn't this problem just go away?

MS. WHEATON: It --

JUSTICE LARSEN: I won't treat you unless you assign to me your rights under any insurance that you may have.

MS. WHEATON: It definitely decreases the problem. And when that happens, it helps the insurance companies. Yes, there's still litigation, but at least it is clear that the person is standing in the shoes of the insurer --

CHIEF JUSTICE YOUNG: But what is --

MS. WHEATON: But what Covenant's arguing is, we don't even stand in the shoes of the insurer -- or -- or the injured person. We're better than them.

JUSTICE LARSEN: Right. I understand.

CHIEF JUSTICE YOUNG: Equal.

MS. WHEATON: Equal.

JUSTICE LARSEN: But can you just -- you made a factual claim. You say that this -- this is kind of run of the mill, that ordinarily people get -- the providers get an assignment of rights?

MS. WHEATON: So I've been told.

CHIEF JUSTICE YOUNG: Well let me --

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let me -- what is the problem here? If -- if I, as you say, if I broke my arm and go to the emergency room and get it repaired, would -- is -- is -- the difference is whether I broke my car (sic) in an auto accident covered by no-fault versus I fell in the -- on my own esteem?

MS. WHEATON: Right.

CHIEF JUSTICE YOUNG: And so the emergency room gets the benefit if I happen to have no-fault coverage and so they could -- they don't have to sue me. But if --

MS. WHEATON: Exactly.

CHIEF JUSTICE YOUNG: -- if I just broke my arm without it being in an auto accident, the emergency room has to come after me to their their -- their reimbursement?

MS. WHEATON: That's exactly what I'm saying.

CHIEF JUSTICE YOUNG: So it's entirely fortuitous of how you get your injury?

MS. WHEATON: Right.

CHIEF JUSTICE YOUNG: Whether you're a no-fault system or outside the --

MS. WHEATON: Right.

CHIEF JUSTICE YOUNG: -- no-fault

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system.

MS. WHEATON: The No-Fault Act was not meant to make it exciting when an accident victim goes in, because the healthcare provider now knows, wow, I have a direct right of action if this person doesn't pay me as opposed to something else. That's antithetical to the whole goals of the no-fault system, which is to keep costs down.

CHIEF JUSTICE YOUNG: It's hard for me to understand what -- whether costs are up or down by whether we, by penumbras and emanations find a right of direct action under 3112 and the other provisions. I -- I don't -- I don't have any idea what the cost effect of --

MS. WHEATON: Right.

CHIEF JUSTICE YOUNG: -- of precluding insurers from having these direct actions or not. Do you?

MS. WHEATON: Well I certainly know that the litigation costs would go down. 'Cause right now what you have is you have lawsuits in numerous different jurisdictions, numerous different claims. You might be subject to double liability, like Covenant was here. I settled with the injured person, but now this provider, and this provider, and

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this provider have popped up and, you know -- go to a circuit court or a district court any day of the week and you are going to see a provider action, a provider action, a Covenant hearing, and a Covenant hearing. It is a large portion of their docket. It would drastically increase their costs, that's for certain.

JUSTICE ZAHRA: If -- if you win this case, you indicated that it's in all likelihood going to result in assignment of rights being routine, which may or may not be the case now. But you said something else. You said the only thing that'll happen is that the providers that are bringing a lot of litigation will go away. Help me understand --

MS. WHEATON: Exactly.

JUSTICE ZAHRA: -- what you mean by that --

MS. WHEATON: Well there are --

JUSTICE ZAHRA: -- and why that would be so.

MS. WHEATON: -- there are some providers out there -- and again, I don't do the in-the-trenches work, so I'm just telling you what the trenches guys told me. There are some folks who some along and they do this $1,000 MRI, and this $1,000

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MRI, this $1,000 MRI, and then they -- they file all sorts of lawsuits. If they have to prove themselves that the claim was warranted, that the charge was reasonable to be subjected to a scrutiny of it, they might not file this litigation as quickly as they -- if they have to go through --

JUSTICE ZAHRA: But if they have the assignment of right --

MS. WHEATON: Yup.

JUSTICE ZAHRA: -- and they show that they provided the service --

MS. WHEATON: Yup.

JUSTICE ZAHRA: -- why is -- why do they have to jump through all these additional hoops? All they have to say is I've got a right, this patient received this service, under the no-fault --

CHIEF JUSTICE YOUNG: It's reasonable.

JUSTICE ZAHRA: Yeah.

MS. WHEATON: Well, that's the question. They have to prove it's reasonable.

CHIEF JUSTICE YOUNG: But that's the whole point. If -- if there's an assignment, then it seems to me they are seeking the benefit that the -- the insured would have had.

MS. WHEATON: Yes.

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CHIEF JUSTICE YOUNG: So I think that does make them a -- a -- a proper claimant for personal protection insurance benefits within the meaning of 3112. Then -- then there is -- if -- if the patient says, look, you -- you go after the insurance company. They can have a conventional action where the provider said this is the charge, and the insurer can say it doesn't -- it doesn't conform to the -- the -- the section --

MS. WHEATON: 3157.

CHIEF JUSTICE YOUNG: -- that regulates the amounts that providers can charge under no-fault.

MS. WHEATON: 3157.

CHIEF JUSTICE YOUNG: Yeah.

MS. WHEATON: And if you, as the insurance company, had, for example, a priority argument or some sort of fraud argument, or --

CHIEF JUSTICE YOUNG: It's --

MS. WHEATON: -- whatever --

CHIEF JUSTICE YOUNG: -- it -- but you --

MS. WHEATON: -- you could make it.

CHIEF JUSTICE YOUNG: -- this -- this is an assignment is respectful of -- of who is

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protected --

MS. WHEATON: Yes.

CHIEF JUSTICE YOUNG: -- and -- and -- and whose interests are paramount under no-fault.

MS. WHEATON: Right. It recognizes the legal formalities of the party. It's the insurer who owns the claim -- insured who owns the claim, the injured person, he or she assigns it to the provider. That is why the provider can bring suit, not simply because they're a provider, which is what prior Court of Appeals' opinions have held, and what Covenant is arguing.

JUSTICE VIVIANO: So your belief is if there's an assignment we're basically back where we started except if it's a derivative claim?

MS. WHEATON: Not necessarily back where we started, but -- but I like -- yes, it's a derivative claim.

CHIEF JUSTICE YOUNG: Is it a derivative claim?

CHIEF JUSTICE YOUNG: Well -- well hold on --

MS. WHEATON: No, it's not --

JUSTICE VIVIANO: -- hold on.

MS. WHEATON: -- a derivative claim.

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JUSTICE VIVIANO: You're going several steps away now. So why are we not back where we started except that it's a derivative claim? Why are we somewhere else?

JUSTICE LARSEN: Can I just ask, what do you mean when you say back where we started?

JUSTICE VIVIANO: Well sort of in the world that we live in now where providers will have a right to bring suit because this claim's been assigned to them, they can bring suit either in the same court or a different court, and so on and so forth. And we have all this proliferation of all these cases.

JUSTICE MCCORMACK: Sixteen lawsuits with one injury. Why are --

JUSTICE ZAHRA: There's no change. I don't see any change --

JUSTICE MCCORMACK: (Talking over) have that.

MS. WHEATON: Well, no. Again -- wow. So whether or not the assignment is always valid is gonna be a question, whether arguably I don't -- I think they should be required to sue the injured person, then the injured person brings in the other parties.

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CHIEF JUSTICE YOUNG: (Talking over)

MS. WHEATON: Then you're in one court.

CHIEF JUSTICE YOUNG: (Talking over)

MS. WHEATON: You're not in a thousand courts. You're in one court --

CHIEF JUSTICE YOUNG: -- claim, right?

MS. WHEATON: What? What's that?

UNIDENTIFIED SPEAKER: If -- if I'm the patient and I assign my -- my claim to my insur -- to my provider so I'm out of the mix, I don't understand any -- I mean, it may result in as many pieces of litigation as are existing now under the Covenant doctrine that there's a direct cause of action for the provider, but so what?

MS. WHEATON: Well we wouldn't have your lawsuit. Right now you've got both lawsuits. You have the injured person suing saying pay me my medical bills, and the provider is saying pay us their medical bills. If you have an assignment, you won't have that. That person is taken out of the mix.

CHIEF JUSTICE YOUNG: Let me get something clear. I -- I think this Court, and certainly the Court of Appeals, has been imprecise in

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talking about derivative. If I assigned you my claim, your claim isn't derivative.

MS. WHEATON: No. No, it's not. It's -- it's a direct, it's subrogated --

CHIEF JUSTICE YOUNG: Yeah.

MS. WHEATON: -- by standing issues.

CHIEF JUSTICE YOUNG: Okay. Anything else?

MS. WHEATON: No. Can I ask --

JUSTICE LARSEN: Can I ask one more question? It -- it occurs to me that if we're thinking about assignment as a panacea and you go and you present at the emergency room and you say I just had this car accident, and the provider says, I won't treat you unless you assign me your claim, and you say, well sure, I just -- like I've got -- you know, I'm gonna die if you don't treat me. Here's the claim. Are you worried that there will be suits about, you know, whether the assignment was made under duress or blah, blah, blah?

MS. WHEATON: Me?

JUSTICE LARSEN: Is that something you're worried about?

MS. WHEATON: No. I mean, it might happen, but --

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CHIEF JUSTICE YOUNG: Should we --

JUSTICE LARSEN: But should we be worried about that?

MS. WHEATON: No, I don't think so. I mean, again, there's not always gonna be an assignment. I probably shouldn't have said that. But -- but what I'm saying is there is a way -- in response to Justice Bernstein's question, how can -- how can providers get paid? Well, that's one way. Suing the injured person and being brought in is another way. So even if the assignment is invalid, you could sue the injured person directly. They could bring in the in -- the injured person -- or the insurance company. There are ways.

JUSTICE BERNSTEIN: So again, you're -- it's the hospital versus the pe -- the patient.

MS. WHEATON: Well right now they're kind of -- no, it's not the hospital versus the patient. It's --

CHIEF JUSTICE YOUNG: Isn't it?

MS. WHEATON: What?

CHIEF JUSTICE YOUNG: Isn't that the contractual undertaking of the provider and a patient?

MS. WHEATON: Exactly. I mean --

CHIEF JUSTICE YOUNG: Why are you scared about that?

MS. WHEATON: Well, I don't know. It does sound bad to say hospital versus the patient, but you know -- but right now they're -- they're trying to phrase it that way. They're basically saying we can do it better, we should -- leave -- leave the injured person out of all this. And no, the injured person is at the heart of all this. You can't leave them out of it.

JUSTICE ZAHRA: How -- how does this affect other areas of tort laws? Let's say that there's no threshold injury and there's been an assignment, can you still then ask for your medical expenses as damages or have they been assigned away and now you can only ask for pain and suffering?

MS. WHEATON: For wage loss or whatever? I don't know. Probably. Possibly. But this Court doesn't have to say there has to be an assignment. What I'm saying this Court should say is that the Court of Appeals got it wrong, there is no independent right for a provider, and a settlement with the injured person resolves the claims. And then, you know, there will be fallout no matter what your decision is, but the bottom line is the No-Fault

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Act does not give providers a direct right of action.

There will be a whole industry that comes up to figure out a way to do it, and we'll cross that bridge when we come to it --

CHIEF JUSTICE YOUNG: You have three minutes left. Do you want to use them?

MS. WHEATON: No. Later. Thanks.

MR. HILLARY: Good afternoon.

CHIEF JUSTICE YOUNG: Not quite, but --

MR. HILLARY: My name is Dick Hillary.

JUSTICE MCCORMACK: You wish it was afternoon.

MR. HILLARY: Yeah. Good morning. It feels -- it feels like afternoon. This case isn't titillating and interesting enough for you, Justice McCormack?

My name's Dick Hillary. I represent Covenant Healthcare. Thank you for the time. I do want to say, because I may forget, if Justice Bernstein doesn't re-ask the question, but there was a question posed to the Appellant's lawyer about doesn't -- doesn't her proposal and her proposed rule, couldn't that result in providers getting kind of cut out of this discussion and left holding the

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bag? And I want -- I want everyone to be perfectly clear here, that's exactly what happened in this case. Covenant was never paid. And so that scenario is not a parade of horribles. That happens when providers are not invited to the table. And so in this very case, a settlement was reached with release language that represented that it included Covenant Healthcare's bill, the money was paid not to Covenant Healthcare as a payee under the No-Fault Act, but to the injured person, and the injured person never paid Covenant. So I -- I -- I just want -- this -- this -- this can and does happen.

So what I do want to do briefly is simply address the three questions that this Court proposed in its grant order, give you my answers, and then I'm available to answer any questions.

Question number one, whether a healthcare provider has an independent or derivative claim against the no-fault insurer for no-fault benefits. I share the Chief Justice's comments about derivative and what that means and what the courts have said about that. My answer to that question is this. Under the No-Fault Act, a healthcare provider has an independent claim that is dependent upon the injured person's eligibility to receive benefits.

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Whether that makes the claim derivative as this Court has defined it in various ways, I don't know. My answer though is if it is derivative, it's derivative only to the extent of the injured person's eligibility.

In other words, if the injured person is not covered or is ineligible for benefits under the No-Fault Act, the healthcare provider's claim is hollow. It has no right to receive benefits. So -- so the Court understands this, I have been in the trenches for the better part of 15 years litigating these cases, and my law firm for 25 or more. Provider lawsuits have been part of our courts' jurisprudence for years. They did not just appear on the horizon with Wyoming Chiropractic and recent case law. We have been filing these suits when we have not been paid for our medical bills by no-fault insurers for many, many, many years. This is not new, this is not something that's novel.

In fact, in 1992 -- and this is cited at length in CPAN's amicus brief, which was very well done. In 1992, the insurance commissioner, now called OFIS (ph.), issued a bulletin that says when there are disputes between healthcare providers and insurers, the injured person needs to be out of that

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dispute. The payment obligation by the insurer is to the healthcare provider, and that insurance bulletin says very clearly leave the injured person out of it. Now I know this Court isn't bound by insurance -- insurance bulletins, but it does give deference to how these agencies interpret laws which regulate them.

Question number two, whether a healthcare provider constitutes some other person under 3112 of the No-Fault Act. Absolutely, yes. My answer is an emphatic yes. That answer does not change because the healthcare provider's claim, which is independent, is dependent upon the injured person's eligibility. Some other person says what it says. Our legislature, in my judgment, could not have used broader language to describe this classification or category of payees.

Question number three, the extent to which a 3112 hearing is required. Our answer, a 3112 hearing is never required. It's permitted. It's a procedural mechanism that's permissible, that any interested person can initiate if there is doubt about the proper payee to receive benefits. It's neither mandatory in any sense of the word, it is only permissible when there is doubt.

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Those are my answers --

CHIEF JUSTICE YOUNG: Okay. And you used your five minutes very well. I -- I'm having a -- a framing problem that is -- I'm trying to understand your arguments and the Court of Appeals' arguments based on the text of the sections that it relied upon to conclude that there was a provider direct claim in no-fault. And you -- you heard my questioning of opposing counsel, it -- it appears to me -- at least I want to offer you a -- a -- an opportunity to -- to respond to -- it -- it looks to me that 3112 creates a -- concerns two classes of individuals. First is the insured, who is entitled to pip insurance benefits, that -- and that are -- those benefits are payable to that individual or on -- on that person's behalf, or in the event of the -- the beneficiary's death it's -- his dependents. Everything else, if that's an accurate framing of what this provision covers, is comprehensible and that the -- the fact that there's a reference to the claim of some other person is entirely contextually related to the fact that if you're dealing with somebody who is dead, and they've got decedents who may have claims as decedents, that -- that that's what's being talked about here.

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So I -- I -- I mean I'm just having difficulty understanding how the fact that a provision dealing with -- with dependent claims and then creates what I think is, in fact, a -- a statutory interpleader for -- for resolving those things, and makes reference to an equitable apportionment, which is something to do with dependents who have multiple claims, but not with providers. Do you think -- do you think -- do you think a provider is entitled only to an apportionment of this payment or an entirety?

MR. HILLARY: Well I think there could be many circumstances where a circuit court in certain circumstance would make an equitable apportionment to a provider. I can give you an example. Let's assume --

CHIEF JUSTICE YOUNG: That's not the question I asked. Is the provider only entitled to a portion of the charge made? Entitled.

MR. HILLARY: From the insurer? I think a court could entertain a motion and make that kind of an order depending on the circumstances. I -- I think that's possible. I can -- I can envision a circumstance where that could -- could occur.

CHIEF JUSTICE YOUNG: I understand why

an insurer might accept an apportionment, but I don't understand why they're -- they're not entitled to more if they meet the other requirements of the No-Fault Act.

MR. HILLARY: Well I -- I -- I wouldn't disagree with that. But I could -- I could certainly understand if there was -- I -- I mean --

CHIEF JUSTICE YOUNG: I mean I really need to point out that apportionment is an odd concept when -- when you're claiming there is a direct entitlement of an -- a provider to make a claim. And particularly when it's in the context of a provision for making persons who are entitled to insurance benefits --

MR. HILLARY: I don't find it odd.

CHIEF JUSTICE YOUNG: Okay. Well let me ask you this. Is your client's bill for services rendered to the insured an insurance benefit or is it a --

MR. HILLARY: I'm not --

CHIEF JUSTICE YOUNG: -- a claim for payment?

MR. HILLARY: -- evan -- and I'm not even sure I understand that question.

CHIEF JUSTICE YOUNG: I'll -- I'll

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rephrase it.

MR. HILLARY: Thank you.

CHIEF JUSTICE YOUNG: Is a claim for payment a -- an insurance benefit?

MR. HILLARY: A claim for pay -- is the claim itself --

CHIEF JUSTICE YOUNG: I -- I'm Dr. Young, I have provided $30 of medical services to you. Now I want payment. Is my -- my bill for $30 an insurance benefit?

JUSTICE MCCORMACK: You've overcharged, first of all.

CHIEF JUSTICE YOUNG: I'm a very good doctor -- by proxy.

MR. HILLARY: I -- I -- I think the answer is yes.

CHIEF JUSTICE YOUNG: And why would that be?

MR. HILLARY: The -- the -- the services and -- and the bill, and the -- they're -- they're all the same.

CHIEF JUSTICE YOUNG: The bill is a -- an insurance benefit? Not a charge --

MR. HILLARY: Well -- well of course not.

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CHIEF JUSTICE YOUNG: All right. Okay.

MR. HILLARY: The -- the -- the -- the paper -- the paper bill is -- is not an insurance benefit.

CHIEF JUSTICE YOUNG: I -- don't -- don't -- I'm not trying to be -- be coy here. What we're -- what I've got is a charge but not an insurance benefit. I'm -- I'm hoping to recover my charge from insurance benefits, am I not?

MR. HILLARY: The services have been provided.

CHIEF JUSTICE YOUNG: I agree. I got the bill. I sent you the bill. Is that -- is that bill for service, is -- are the services themselves an insurance benefit? I think they're clearly not, right?

MR. HILLARY: I think they are under the No-Fault Act.

CHIEF JUSTICE YOUNG: Why?

MR. HILLARY: The -- in -- in -- in -- in my judgment, when -- when a -- a medical provider provides reasonably necessary services, accommodations, and products, those are benefits. Those are benefits that --

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CHIEF JUSTICE YOUNG: Insurance benefits?

MR. HILLARY: I -- I take the position that they are. They are --

CHIEF JUSTICE YOUNG: Okay. I understand --

MR. HILLARY: -- they are --

CHIEF JUSTICE YOUNG: -- I -- at least I understand your position. Okay.

MR. HILLARY: And so -- but I -- I do -- I do -- I do need to quarrel with you somewhat --

CHIEF JUSTICE YOUNG: Okay.

MR. HILLARY: -- on -- well more deeply on your -- on your reading of 3112 of the No-Fault Act -- and I -- I -- I believe with all respect to the Court, you're misreading the very first sentence which says, "Personal protection insurance benefits are payable to or for the benefit of the injured person."

CHIEF JUSTICE YOUNG: Correct.

MR. HILLARY: So we know that they're paid to the injured person in certain circumstances. We also know that they are paid for the benefit of the injured person.

CHIEF JUSTICE YOUNG: Yeah.

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MR. HILLARY: (Talking over)

CHIEF JUSTICE YOUNG: (Talking over)

MR. HILLARY: -- this is -- this is -- this is --

CHIEF JUSTICE YOUNG: But benefits being paid is not the same thing as bills for services that are -- are payable from the benefits.

MR. HILLARY: But I --

CHIEF JUSTICE YOUNG: That's the question I'm asking.

MR. HILLARY: And -- and I -- and I -- and I -- and I believe, and I disagree with you, that they are. But I -- I need to finish my thought here because I think you said to me that you read 3112 as dealing only in circumstances where you have benefits payable directly to the injured person, or in the case of his death, to his dependents or survivors.

CHIEF JUSTICE YOUNG: Payable to or for on the benefits.

(Excerpt concluded at this time)

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STATE OF MICHIGAN)
) SS
COUNTY OF OAKLAND)

C E R T I F I C A T E

I hereby certify that this foregoing testimony and proceedings, consisting of thirty-one (31) typewritten pages, was mechanically recorded at the time and place hereinbefore set forth; was thereafter reduced to typewritten form; and that the foregoing is a full, true, and correct transcript of the recording so taken.

Sheila L. Boensch

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Dated: July 5, 2017

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Unpublished Cases

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Document (1)

1. *EDWARDS v. CONCORD DEV. CORP., 1996 Mich. App. LEXIS 1807*

Client/Matter: -None-
Search Terms: 1996 MICH APP LEXIS 1807
Search Type: Natural Language
Narrowed by:

Content Type	Narrowed by
Cases	Court: Michigan

Cited
As of: July 3, 2018 9:59 PM Z

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EDWARDS v. CONCORD DEV. CORP.

Court of Appeals of Michigan

September 17, 1996, Decided

No. 174487

Reporter
1996 Mich. App. LEXIS 1807 *; 1996 WL 33358104

JOEY EDWARDS and KATHY EDWARDS, Plaintiffs/Counter Defendants/Appellees, v CONCORD DEVELOPMENT CORPORATION, INC., Defendant/Counter Plaintiff/Cross Plaintiff/Appellant, [1] and TIFFANY'S CONSTRUCTION COMPANY, INC., Defendant/Counter Plaintiff/Cross Plaintiff/Appellant, and FLEET FINANCE, INC, Defendant/Counter Plaintiff/Cross Defendant/Appellee, and HASTINGS MUTUAL INSURANCE COMPANY, Defendant/Cross Defendant/Appellee.

Notice: [*1] IN ACCORDANCE WITH THE MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Prior History: LC No. 91-010724.

Disposition: Affirmed.

Core Terms

repairs, plaintiffs', summary disposition, trial court, contractual, negotiating, mortgage, argues, tortious interference, insurance proceeds, parol, actual cash value, clearly erroneous, insurance company, written consent, assigned, breached, damages

Case Summary

Procedural Posture
Defendant development corporation sought review of a decision of the trial court (Michigan), which entered a judgment of no cause of action in favor of plaintiff home owners in their breach of contract action against the developer and defendants, insurer and mortgage company. The corporation also challenged the grant of summary disposition in favor of the insurer and the company.

Overview
The owners contracted with the corporation for repair of their home damaged by fire; agreeing to assign insurance proceeds to the corporation. The insurer paid the owners for repairs on their home; however the company withheld a portion of the proceeds and applied it to the owners' mortgage by order of the trial court. The owners sued the corporation for breach of contract when it failed to complete the work, joining the insurer and the company. The trial court found in favor of the owners; but granted summary disposition to the insurer and the company. On appeal, the court held that: 1) the insurer had not consented to the assignment, and was not bound it; 2) summary disposition in favor of the insurer was proper as it fulfilled its obligations in paying the cash value of the home, and had not interfered with the contract between the owner and the corporation; 3) the trial court's determination of breach and award of damages was not clearly erroneous, 4) parol evidence was admissible to explain the terms of the agreement; and 5) the company acted legally in protecting its business interests, and summary disposition was properly granted.

Outcome
The court affirmed the decision of the trial court, which found that the corporation breached its contract with the owners, entering a judgment of no cause of action in favor of the owners in their breach of contract action. The court further affirmed the trial court's grant of summary disposition in favor of the insurer and the finance company.

LexisNexis® Headnotes

Civil Procedure > Appeals > Standards of Review > De Novo Review

Civil Procedure > Appeals > Summary Judgment

[1] Although Concord is not listed as appellant, it is in fact the appellant.

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Review > General Overview

Civil Procedure > Appeals > Summary Judgment Review > Standards of Review

Civil Procedure > ... > Summary Judgment > Motions for Summary Judgment > General Overview

Civil Procedure > ... > Summary Judgment > Entitlement as Matter of Law > General Overview

HN1[] Standards of Review, De Novo Review

An appellate court reviews grants or denials of motions for summary disposition de novo.

Business & Corporate Compliance > ... > Assignments > Assignment of Obligations > Consent Requirements

Contracts Law > Standards of Performance > Assignments > General Overview

HN2[] Assignments, Consent Requirements

As a general rule, contractual restrictions against assignability are strictly construed. However there is no prohibition against requiring consent to effectuate an assignment. The general presumption then is that a contractual right may be assigned, but conversely that assignment may also be precluded by agreement: A contractual right can be assigned unless assignment is validly precluded by contract.

Insurance Law > Types of Insurance > Property Insurance > Actual Cash Value

Insurance Law > ... > Property Insurance > Coverage > Replacement Costs

Insurance Law > ... > Property Insurance > Obligations > Cooperation With Carriers

HN3[] Property Insurance, Actual Cash Value

An insured must actually repair, rebuild, or replace the property before the insurer becomes liable to pay the difference between actual cash value and replacement cost.

Contracts Law > Standards of Performance > Assignments > General Overview

HN4[] Standards of Performance, Assignments

An assignee receives only those rights which the assignor possessed.

Contracts Law > Breach > General Overview

Torts > ... > Contracts > Intentional Interference > Elements

Contracts Law > Breach > Breach of Contract Actions > General Overview

Contracts Law > Remedies > Damages > Punitive Damages

Torts > Business Torts > General Overview

Torts > Business Torts > Commercial Interference > General Overview

Torts > ... > Commercial Interference > Business Relationships > General Overview

Torts > ... > Commercial Interference > Contracts > General Overview

Torts > ... > Contracts > Intentional Interference > Defenses

HN5[] Contracts Law, Breach

The elements of tortious interference with a contractual relationship are (1) a contract, (2) a breach, and (3) instigation of the breach without justification by the defendant. One who alleges tortious interference with a contractual or business relationship must allege the intentional doing of a per se wrongful act or the doing of a lawful act with malice and unjustified in law for the purpose of invading the contractual rights or business relationship of another. A defendant is not liable for tortious interference of a contract where he is motivated by legitimate personal or business interests.

Business & Corporate Compliance > ... > Contracts Law > Breach > Nonperformance

Civil Procedure > Trials > Bench Trials

Civil Procedure > Appeals > Standards of

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Review > Clearly Erroneous Review

Commercial Law (UCC) > Sales (Article 2) > Form, Formation & Readjustment > General Overview

Contracts Law > Breach > Breach of Contract Actions > General Overview

Contracts Law > Breach > General Overview

HN6[] **Breach, Nonperformance**

An appellate court reviews findings of fact in a bench trial under a clearly erroneous standard, *Mich. Ct. R. 2.613(C)*. A breach of contract is the failure to perform when performance is due.

Contracts Law > Contract Interpretation > Parol Evidence > General Overview

Evidence > Admissibility > Statements as Evidence > Parol Evidence

Evidence > Types of Evidence > Documentary Evidence > Parol Evidence

HN7[] **Contract Interpretation, Parol Evidence**

Where a contract is clear and unambiguous, parol evidence of negotiations cannot be admitted to vary the contract. The parol evidence rule also bars admission of prior or contemporaneous agreements that contradict or vary the written contract. Prerequisite to application of the parol evidence rule is a finding that the parties intended the writing to be a complete expression of their agreement. Extrinsic evidence of prior or contemporaneous agreements or negotiations is admissible as it bears on this threshold question. Parol evidence is also admissible to explain the terms of the contract and has application only after the terms of the agreement have been challenged.

Judges: Before: Doctoroff, C.J. and Hood and Bandstra, JJ.

Opinion

PER CURIAM.

Defendant Concord Development Corporation (Concord) appeals as of right from the trial court's judgment of no cause of action in favor of plaintiffs and the orders granting summary disposition in favor of defendants Hastings Mutual Insurance Company (Hastings) and Fleet Finance, Inc. We affirm.

After plaintiffs' home was severely damaged by fire, they entered into a fire repair agreement with Concord, in which Concord agreed to repair plaintiffs' home, in return for plaintiffs' assignment of insurance proceeds from their insurer, Hastings. Although Hastings paid plaintiff the actual cash value of the repairs on their home, plaintiffs' mortgage company, Fleet Finance, withheld a portion of the proceeds from Concord and applied it to plaintiffs' mortgage by order of the trial court. Because Concord did not complete the repairs on plaintiffs' home, plaintiffs brought an action against Concord for breach of contract. Plaintiffs also joined **[*2]** their insurance company (Hastings), their mortgage company (Fleet Finance), and Colonel Lee, an employee of Concord. [2] The trial court found that Concord breached the fire repair agreement by not completing work on plaintiffs' home and awarded damages to plaintiffs in the amount of $ 14,389.22, setting off plaintiffs' total damages by the value of work that was performed by Concord. The court granted summary disposition to Hastings and Fleet Finance pursuant to *MCR 2.116(C)(10)*.

Concord first argues that the trial court erred in granting Hastings' motion for summary disposition because the assignment between plaintiffs and Concord was valid. ***HN1***[] We review grants or denials of motions for summary disposition de novo. *Lytle v Malady, 209 Mich. App. 179, 183-184; 530 N.W.2d 135 (1995)*. Concord claims that Hastings was bound to include its name on the insurance draft that **[*3]** it issued to plaintiffs because the assignment of insurance proceeds from plaintiffs to Concord was legally valid and binding. That provision stated in pertinent part that plaintiffs "hereby give unto the CONCORD DEVELOPMENT CORPORATION, INC., all the necessary authority to have this fire loss adjusted and assigns to them the proceeds as payment in full for repairs." Hastings argues that the assignment was invalid and it was not bound by it because the contract it had with plaintiffs stated in relevant part that "assignment of this policy will not be valid unless we give our written consent" and Hastings did not give its written consent. However, Concord avers that non-assignment clauses are invalid and that even if they were valid, Hastings consented by virtue of its conduct in negotiating with its representative, Colonel Lee.

This Court has held that, ***HN2***[] as a general rule, contractual restrictions against assignability are strictly construed. *Stenke v Masland Development, 152 Mich. App.*

[2] The trial court entered a judgment of no cause of action in Lee's favor, and no appeal was taken from that order.

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562, 575; 394 N.W.2d 418 (1986). However there is no prohibition against requiring consent to effectuate an assignment. Hy King Associates v Versatech Mfg Industries, 826 F. Supp. 231, 238-239; **[*4]** (ED Mich., 1993); Kaczmarck v La Perriere, 337 Mich. 500, 504-506; 60 N.W.2d 327 (1953). The general presumption then is that a contractual right may be assigned, Auto Electric & Service Corp v Rockwell Int'l Corp, 111 Mich. App. 292, 300-301; 314 N.W.2d 592 (1981), but conversely that assignment may also be precluded by agreement: "A contractual right can be assigned unless . . . assignment is validly precluded by contract." Restatement Contracts 2d, § 317(2).

Although plaintiff cites Roger Williams Ins Co v Carrington, 43 Mich. 252; 5 N.W. 303 (1880), to support its contention that non-assignment clauses are invalid, that case is distinguishable from the present case. In *Roger Williams*, the insurance company was attempting to avoid payment of its contract, whereas here, Hastings did not attempt to avoid its obligation under the contract; rather Hastings paid the full amount owed under the contract to plaintiffs. Thus, the provision requiring Hastings' written consent to assignment by plaintiffs was valid and, since Hastings did not give its written consent to plaintiffs' assignment of insurance proceeds **[*5]** to Concord, that assignment was not binding on Hastings.

Concord also argues that Hastings effectively consented to the assignment by virtue of negotiating the settlement amount with Lee. We disagree. We note that it does not appear that plaintiffs or Concord ever requested the consent of Hastings to the assignment. Concord claimed that it sent a copy of the fire repair agreement to Hastings and that Hastings was therefore on notice of the assignment when it dealt with Lee.

In Hy King Associates, supra, 826 F. Supp. 231, King agreed to be the exclusive sales representative of the defendant. King retired and transferred the stock in his corporation to Cozzi, who then acted as sales representative for the defendant for a brief period. The defendant claimed there was no valid assignment because it did not give its written consent as required by its contract with King. The court held that the defendant did not consent to the assignment because it did not recognize Cozzi as its sales representative, even though the defendant was enthusiastic about King bringing Cozzi into the business. Id. at 238.

Similarly, in the instant case, Hastings did not give its **[*6]** written or oral consent to the assignment. Rather, it dealt with Lee as a representative of plaintiffs for purposes of negotiating a settlement, but it continued to deal with plaintiffs at the same time. Edward Whalen, the insurance adjuster assigned to plaintiffs' claim, testified that he did not consider the assignment to be valid, and he dealt with Lee only as an agent of plaintiffs. We agree with the reasoning of *Hy King*, that such limited dealing with the purported assignee does not alone equate to consent.

Hastings contends that, even if the assignment to Concord was valid, Concord does not have any cause of action against it. ***HN3***[⬆] An insured must actually repair, rebuild, or replace the property before the insurer becomes liable to pay the difference between actual cash value and replacement cost. Smith v Michigan Basic Property Ins Ass'n, 441 Mich. 181, 183; 490 N.W.2d 864 (1992). In this case, Concord did not complete the repairs on plaintiffs' home. Whalen testified that Hastings paid to plaintiffs $ 58,000 for the actual cash value of their home. Since there was no testimony that the actual cash value of plaintiffs home was more than $ 58,000 or **[*7]** that Hastings owed plaintiffs more money for the repairs, Hastings fulfilled its obligation to plaintiffs. Since ***HN4***[⬆] an assignee receives only those rights which the assignor possessed, Concord would not have any claim against Hastings for additional money over what was paid for the actual cash value. Damerau v CL Rieckhoff Co, 155 Mich. App. 307, 313; 399 N.W.2d 502 (1986). Therefore, the granting of Hastings' motion for summary disposition pursuant to MCR 2.116(C)(10) was proper because there was no genuine issue of material fact regarding liability under the assignment clause of the fire repair agreement.

Concord further argues that Hastings acted with malice through its agent Whalen by ignoring the agreement between plaintiffs and Concord, while at the same time acknowledging that Concord, through Lee, represented plaintiffs in negotiating the settlement of their claim. Therefore, Concord asserts, Hastings should have been found liable for tortious interference with a contractual relationship.

> ***HN5***[⬆] The elements of tortious interference with a contractual relationship are (1) a contract, (2) a breach, and (3) instigation of the breach without justification **[*8]** by the defendant. . . .
> "One who alleges tortious interference with a contractual or business relationship must allege the intentional doing of a per se wrongful act or the doing of a lawful act with malice and unjustified in law for the purpose of invading the contractual rights or business relationship of another."
>
> . . . [A] defendant is not liable for tortious interference of a contract where he is motivated by legitimate personal or business interests. [Wood v Herndon & Herndon Investigations, Inc, 186 Mich. App. 495, 499-500; 465 N.W.2d 5 (1990).]

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Hastings did not approve the assignment of insurance proceeds from plaintiffs to Concord. Therefore Hastings was not required to make any payments to Concord. Hastings took no action to interfere with the contract between plaintiffs and Concord. The reason that Concord was not paid from the insurance proceeds was that Fleet Finance intervened and held the proceeds in escrow. If Fleet Finance had not intervened, then plaintiffs would have been able to pay Concord with those proceeds. Thus, although Hastings did not include Concord's name on the insurance draft, they did not instigate a breach without **[*9]** legal justification and did not perform a wrongful act or a lawful act with malice for the purpose of invading the contractual rights of plaintiffs or Concord. Hastings only ignored the assignment which it was justified in doing for legitimate business reasons. [3] Accordingly, the trial court properly granted Hastings' motion for summary disposition because there was no genuine issue of material fact as to whether Hastings tortiously interfered with the contract between plaintiffs and Concord.

Concord next argues that the court's finding that Concord breached its contract with plaintiffs was clearly erroneous. ***HN6***[↑] We review findings of fact in a bench trial under a clearly erroneous standard, *MCR 2.613(C)*, *Hofmann v ACIA, 211 Mich. App. 55, 98, 101; 535 N.W.2d 529 (1995).* **[*10]** A breach of contract is the failure to perform when performance is due. *Woody v Tamer, 158 Mich. App. 764, 771; 405 N.W.2d 213 (1987)*. Plaintiffs argue that Concord breached the fire repair agreement by failing to complete the repairs on their home. Concord argues that plaintiffs were the ones that failed to perform under the fire repair agreement by not paying Concord for the work it performed on their home. On appeal, neither party disputes the existence of a contract.

The trial court weighed the credibility of the witnesses and determined that the testimony of plaintiffs and Whalen was more credible than the testimony of Colonel Lee. Whalen testified that in his twenty-eight years as an insurance adjuster, he has never paid a contractor before work has begun. Lee testified that even though he was not paid up front, he proceeded to work on plaintiffs' house and continued to do so even after his requests for payment were not honored. However, at some point, Concord ceased work on the house and the repairs were never finished. Whalen testified that a contractor is paid after the work is completed and that a contractor funds the repairs until that time. Thus, **[*11]** the court's finding that Concord breached its contract by not completing the work despite not being paid was not clearly erroneous.

Concord claims that the court considered the evidence of plaintiffs' understanding of the terms of the contract in violation of the parol evidence rule. ***HN7***[↑] Where a contract is clear and unambiguous, parol evidence of negotiations cannot be admitted to vary the contract. *Central Transport, Inc v Fruehauf Corp, 139 Mich. App. 536, 544; 362 N.W.2d 823 (1984)*. The parol evidence rule also bars admission of prior or contemporaneous agreements that contradict or vary the written contract. *Id.* Prerequisite to application of the parol evidence rule is a finding that the parties intended the writing to be a complete expression of their agreement. *Id.* Extrinsic evidence of prior or contemporaneous agreements or negotiations is admissible as it bears on this threshold question. *Id.* Parol evidence is also admissible to explain the terms of the contract and has application only after the terms of the agreement have been challenged. *Stefanac v Cranbrook Educational Community, 435 Mich. 155, 171-172; 458 N.W.2d 56 (1990).* **[*12]**

The contract between plaintiffs and Concord stated that "endorsement of the fire draft to the Concord Development Corporation, Inc., will be payment in full for all services rendered." The contract also contained a "draw down schedule" providing for payment installments of one-third up front, one-third after a third of the work is completed, eighteen percent after ninety percent of the work is completed, and the balance upon final completion. These two provisions are contradictory on their face. The former provision indicates that whatever money is paid by the insurance company in one check will be payment in full for the repairs. However, the latter provision requires payment installments. The parol evidence rule only bars extrinsic evidence if a contract is clear and unambiguous. *Central Transport, supra.* This contract was not clear and unambiguous because the two provisions contradict each other.

Furthermore, extrinsic evidence may be admitted to explain the terms of a contract. *Stefanac, supra.* Thus, plaintiffs' testimony as to their understanding of the contract was admissible to explain its terms. Both plaintiffs and Lee testified that Lee **[*13]** told them that the repairs would be paid for with the insurance proceeds in the form of a draft by the insurance company in the names of both plaintiffs and Concord. That evidence does not contradict the written contract. Plaintiffs further testified that Lee told them that the draw down schedule provisions did not apply to them. Accordingly, plaintiffs' testimony as to their understanding of the contract was proper to explain the terms of the contract. [4]

[3] Moreover, as will be discussed below, the court properly held that plaintiffs did not breach their contract with Concord, therefore, the second element required for tortious interference with a contract has not been met.

[4] Concord does not explain in its brief why the court's award of

Accordingly, because we are not left with a definite and firm conviction that a mistake was made, the trial court's finding that Concord breached its contract with plaintiffs and its award of $ 14,390 in damages was not clearly erroneous.

[*14] Next, Concord argues that the trial court erred in granting Fleet Finance's motion for summary disposition because Fleet Finance tortiously interfered with the contract between plaintiffs and Concord. However, the trial court correctly found that the elements of tortious interference were not met. First, although there was a contract between plaintiffs and Concord, Concord did not suffer a breach at the hands of plaintiffs. Furthermore, even if there was a breach, Fleet Finance did not instigate a breach without legal justification. The mortgage contract between Fleet Finance and plaintiffs provided that Fleet Finance was entitled to payment of the mortgage balance if their security interest in the home was impaired. The fire destroying plaintiffs' home caused such an impairment. However, instead of instantly applying the insurance funds to the mortgage balance, Fleet Finance negotiated with plaintiffs and entered into an escrow/loan construction agreement. The agreement would allow payment of the insurance funds toward repair of the home if certain conditions were met. Because there was no testimony that those conditions were met, [5] Fleet Finance was not obligated to make payments **[*15]** to Concord from the escrow fund. Since there was no indication that Fleet Finance had any motivation other than protecting its security interest in plaintiffs' home, and it adhered to the terms of its mortgage agreement with plaintiffs, there was no per se wrongful act on the part of Fleet Finance. Fleet Finance appeared to be motivated solely by the legitimate business interest of protecting its investment. Accordingly, there was no genuine issue of material fact that Fleet Finance tortiously interfered in the contract between plaintiffs and Concord, and the trial court properly granted summary disposition pursuant to *MCR 2.116(C)(10)*.

Affirmed.

/s/ Martin M. Doctoroff

/s/ Harold Hood

/s/ Richard A. Bandstra

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damages was erroneous, other than addressing the issue in its question presented. However, the court's award of $ 14,390 to plaintiffs was not clearly erroneous because the court appeared to use reasonable calculations, based on the figures submitted into evidence by the parties, to arrive at that figure.

[5] Fleet Finance's counsel, during the hearing on its motion for summary disposition stated that Concord did not comply with the terms and conditions of the escrow agreement.

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Document (1)

1. *Farm Bureau Ins. Co. v. Chukwueke, 2013 Mich. App. LEXIS 61*
   Client/Matter: -None-
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   Search Type: Natural Language
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Cases	Court: Michigan

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Farm Bureau Ins. Co. v. Chukwueke

Court of Appeals of Michigan

January 17, 2013, Decided

No. 306827

Reporter
2013 Mich. App. LEXIS 61 *; 2013 WL 195865

FARM BUREAU INSURANCE COMPANY, Plaintiff-Appellee, v EUCHERIA CHUKWUEKE, Defendant, and ALLSTATE INSURANCE COMPANY, Defendant-Appellant.

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Subsequent History: Leave to appeal denied by *Farm Bureau Ins. Co. v. Chukwueke, 2013 Mich. LEXIS 850 (Mich., May 28, 2013)*

Prior History: **[*1]** Wayne Circuit Court. LC No. 10-009501-NF.

Core Terms

claimant, reimbursement, benefits, insurer, one year, injured person, medical provider, limitations period, no-fault, date of last payment, summary disposition, set forth, one-year-back, indemnity, Assigned, trial court, assignee, one-year, argues

Judges: Before: DONOFRIO, P.J., and FORT HOOD and SERVITTO, JJ.

Opinion

PER CURIAM.

Defendant Allstate Insurance Company[1] appeals as of right the trial court's order granting summary disposition for plaintiff in this reimbursement action. Because the one-year-back rule set forth in *MCL 500.3145(1)* of the no-fault act, *MCL 500.3101 et seq.*, is inapplicable in this action and the term "the claimant" in *MCL 500.3175(3)* includes a medical provider that provides services to an insured, but it is unclear whether plaintiff's action was timely with respect to each claimant regarding which reimbursement is sought, we affirm in part, reverse in part, and remand for further proceedings.

I. FACTUAL BACKGROUND AND PROCEDURAL HISTORY

This case arises out of a motor vehicle-pedestrian accident that occurred on September 1, 2007. Defendant Eucheria Chukwueke owned the 2001 Pontiac Grand Am that her father was driving when he struck pedestrian Merrill Hall, causing his injuries. Hall filed an application for personal injury protection (PIP) benefits **[*2]** with the Assigned Claims Facility, which assigned his claim to plaintiff. Plaintiff administered Hall's claim and paid $448,693 in medical expenses on his behalf.

Plaintiff filed this action against defendant seeking reimbursement of its loss adjustment costs and benefits paid.[2] Plaintiff alleged that defendant insured the vehicle through a no-fault policy at the time of the accident and, pursuant to *MCL 500.3114* and *MCL 500.3115*, defendant was higher in priority than plaintiff to pay Hall's PIP benefits. Defendant moved for summary disposition pursuant to *MCR 2.116(C)(7)* and *(10)*. Defendant admitted that it insured the vehicle at the time of the accident but argued that the statute of limitations barred plaintiff's claim because plaintiff did not file its complaint within two years after it was assigned Hall's claim and it did not make any payments directly to Hall. Defendant also argued that the one-year-back rule set forth in *MCL 500.3145(1)* barred the recovery of benefits paid before

[1] Because defendant Eucheria Chukwueke is not a party to this appeal, our reference to "defendant" refers to Allstate Insurance Company.

[2] Plaintiff also filed suit against Chukwueke on the basis that the vehicle was uninsured, entitling plaintiff to recover the benefits paid **[*3]** and loss adjustment costs from Chukwueke as the owner of the vehicle. The trial court dismissed that claim with prejudice after defendant admitted that it insured the vehicle at the time of the accident.

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August 18, 2009, one year before plaintiff filed its complaint.

In response, plaintiff argued that the one-year-back rule was inapplicable because this case involves the Assigned Claims Facility and the assignee insurer's, i.e., plaintiff's, claim for reimbursement against a higher priority insurer. Plaintiff asserted that its statutory right to reimbursement gave it an independent right of action to which the two-year limitation period in MCL 500.3175(3) applied. Plaintiff also argued that because its most recent payment on behalf of Hall was made within one year before it filed its complaint, the complaint was timely pursuant to MCL 500.3175(3). Plaintiff asserted that it was irrelevant that the payment was not made directly to Hall because it was made on Hall's behalf. The trial court agreed with plaintiff and denied defendant's motion.

Thereafter, plaintiff filed a motion for summary disposition pursuant to MCR 2.116(C)(8) and (10), arguing that it was entitled to reimbursement from defendant pursuant to MCL 500.3172(1). Plaintiff maintained **[*4]** that its claim was not time barred because it filed its complaint within one year after making a payment to the claimant as stated in MCL 500.3175(3). Plaintiff further argued that the no-fault act authorizes payments to and on behalf of injured persons and that it was not necessary that the payment be made directly to Hall. Finally, plaintiff argued that the one-year-back rule was inapplicable.

In response to plaintiff's motion, defendant primarily reasserted the arguments that it previously raised. The trial court again agreed with plaintiff and granted plaintiff's motion. The court entered a judgment in plaintiff's favor in the amount of $480,684.82.

II. STANDARD OF REVIEW

We review de novo a trial court's decision on a motion for summary disposition. Latham v Barton Malow Co, 480 Mich 105, 111; 746 NW2d 868 (2008). Summary disposition under MCR 2.116(C)(10) "is appropriate if there is no genuine issue regarding any material fact and the moving party is entitled to judgment as a matter of law." *Id*. We also review de novo as a question of law the proper interpretation of a statute. Plunkett v Dep't of Transp, 286 Mich App 168, 174; 779 NW2d 263 (2009).

III. MEANING OF "THE CLAIMANT" **[*5]** WITHIN MCL 500.3175(3)

Defendant first argues that the trial court erroneously granted summary disposition for plaintiff because its claim was barred by the limitation period set forth in MCL 500.3175(3). That provision states:

> An action to enforce rights to indemnity or reimbursement against a third party shall not be commenced after the later of 2 years after the assignment of the claim to the insurer or 1 year after the date of the last payment to the claimant.

It is undisputed that plaintiff filed its complaint more than two years after it was assigned Hall's claim. Thus, in order to be timely, plaintiff must have filed its complaint within one year after its last payment *to the claimant*. Defendant argues that because plaintiff made payments to Hall's medical providers and did not make any payments directly to Hall, plaintiff's claim is time barred. Accordingly, this issue involves the proper interpretation of the term "the claimant" in MCL 500.3175(3).

"When interpreting the meaning of a statute, our primary goal is to discern the intent of the Legislature by first examining the plain language of the statute." Driver v Naini, 490 Mich 239, 246-247; 802 NW2d 311 (2011). We must read **[*6]** statutory provisions in the context of the entire act and accord every word its plain and ordinary meaning. Id. at 247. If statutory language is clear and unambiguous, we must apply the language as written and must not engage in judicial construction. *Id*. Courts should give effect to every word and phrase in a statute and avoid an interpretation that renders any part of a statute surplusage or nugatory. Dep't of Environmental Quality v Worth Twp, 491 Mich 227, 238; 814 NW2d 646 (2012).

Defendant argues that the term "the claimant" in MCL 500.3175(3) refers to the injured party and that a medical provider is not included within the singular term "the claimant." Plaintiff, on the other hand, contends that a medical provider is a claimant within the meaning of MCL 500.3175(3). Defendant's argument that the term "the claimant" is synonymous with "the injured party" lacks merit. Courts should give effect to every word and phrase in a statute. Dep't of Environmental Quality, 491 Mich at 238. MCL 500.3109(2) defines "injured person" as "a natural person suffering accidental bodily injury." Interpreting the term "the claimant" in MCL 500.3175(3) identical to the phrase "injured person" would **[*7]** not give effect to every word in the statute and would render the term "the claimant" mere surplusage.

This Court has previously recognized that the terms "claimant" and "injured person" have two different meanings. In Lakeland Neurocare Ctrs v State Farm Mut Auto Ins Co, 250 Mich App 35; 645 NW2d 59 (2002), this Court discussed the meanings of the terms in the context of the no-fault act when it addressed whether a rehabilitation services provider could recover its attorney fees under MCL 500.3148(1), the attorney fee provision of the no-fault act. This Court stated:

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> Defendant contends that the word "claimant" means that only the injured person may pursue attorney fees. However, undefined words contained in statutes are given meaning as understood in common language, considering the text and subject matter in which they are used. *Maxwell v Citizens Ins Co of America, 245 Mich App 477, 482; 628 NW2d 95 (2001)*; *Marcelle v Taubman, 224 Mich App 215, 219; 568 NW2d 393 (1997)*. We also may refer to a dictionary for the definition of a word that is not defined in the statute. *Maxwell, supra*; *Marcelle, supra.* The word "claimant" is defined as "a person who makes a claim." *Random House Webster's* ***[*8]*** *College Dictionary* (1997). The relevant dictionary definitions of the word "claim" include "a demand for something as due; an assertion of a right or an alleged right," and "a request or demand for payment in accordance with an insurance policy . . . ." *Id.*
>
> In this case, . . . because plaintiff properly submitted a claim for personal protection insurance benefits for the benefit of defendant's insured, plaintiff was entitled to such payment within the time limits imposed by the no-fault act. Consequently, plaintiff was a claimant within the plain meaning of the statute and, thus, had the right to attempt recovery of its attorney fees expended in pursuit of recovering overdue benefits. [*Lakeland Neurocare Ctrs, 250 Mich App at 40-41*.]

Further, this Court recognized that the no-fault act "specifically contemplates the payment of benefits to someone other than the injured person . . . ." *Id. at 39*. *MCL 500.3112* states that "[p]ersonal protection insurance benefits are payable to *or for the benefit of* an injured person or, in case of his death, to or for the benefit of his dependents." (Emphasis added.) "As a result, it is common practice for insurers to directly reimburse health care providers **[*9]** for services rendered to their insureds." *Lakeland Neurocare Ctrs, 250 Mich App at 39*.

Therefore, the term "the claimant" in *MCL 500.3175(3)* is not synonymous with "the injured person." Rather, "the claimant" refers to a party that files a claim for PIP benefits. Thus, the medical providers that submitted claims in this case were claimants within the meaning of *MCL 500.3175(3)*.

Notwithstanding that the medical providers were claimants, *MCL 500.3175(3)* states that "[a]n action to enforce rights to indemnity or reimbursement against a third party shall not be commenced after . . . 1 year after the date of the last payment to *the* claimant." (Emphasis added.) The provision uses the definite article "the" instead of the indefinite article "a."

> Traditionally in our law, to say nothing of our classrooms, we have recognized the difference between "the" and "a." "The" is defined as "definite article. 1. (used, esp. before a noun, with a specifying or particularizing effect, as opposed to the indefinite or generalizing force of the indefinite article a or an) . . . ." *Random House Webster's College Dictionary*, p 1382. Further, we must follow these distinctions between "a" and "the" as the Legislature **[*10]** has directed that "[a]ll words and phrases shall be construed and understood according to the common and approved usage of the language . . . ." *MCL 8.3a*[.] [*Robinson v Detroit, 462 Mich 439, 461-462; 613 NW2d 307 (2000)* (citation omitted).]

The Legislature's use of the word "the" instead of "a" indicates that each claimant must be considered individually. Giving effect to the word "the," an action may not be commenced more than one year after the date of the last payment to the individual claimant with respect to which indemnity or reimbursement is sought. This approach is consistent with *MCL 500.3142(1)* and *(2)*, which state that "[PIP] benefits are payable as loss accrues" and that "benefits are overdue if not paid within 30 days after an insurer receives reasonable proof of the fact and of the amount of loss sustained." Accordingly, an action seeking indemnity or reimbursement may not be commenced more than one year after the date of the last payment to the particular claimant regarding which indemnity or reimbursement is sought.[3]

Because it is unclear from the record whether plaintiff filed its complaint within one year after the date of the last payment made to each individual claimant, we remand this case to the trial court for a determination regarding that issue. Defendant concedes that plaintiff made four payments to medical providers after August 18, 2009, one year before plaintiff filed its complaint. Those payments totaled $10,729.18 and were paid to Howard L. Dubin, D.O., Bloomfield Hills Head Injury, and Orthopedic Trauma Specialists. The record reflects, however, that after plaintiff filed its complaint, it continued to make payments to medical providers on behalf of Hall. Because the date of the last payment to each individual claimant is unclear, we remand this case to the trial

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[3] We note that in *Allstate Ins Co v Faulhaber, 157 Mich App 164, 168; 403 NW2d 527 (1987)*, this Court opined that the plaintiff's action was timely because **[*11]** it was filed within one year after it last paid benefits "to or on behalf of JacLynn Faulhaber," the injured person. The issue presented in that case did not involve the interpretation of the term "the claimant" in *MCL 500.3175(3)*. Thus, the Court's conclusion that any payment made within one year to or on behalf of the injured person satisfies the limitation period set forth in *MCL 500.3175(3)* is mere dicta.

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court to determine **[*12]** whether plaintiff's claim for reimbursement is timely with respect to each claimant regarding which reimbursement is sought.

IV. THE ONE-YEAR-BACK RULE OF *MCL 500.3145*

Defendant also argues that although *MCL 500.3175(3)* sets forth the limitation period that controls in this case, the one-year-back rule of *MCL 500.3145(1)* nevertheless bars the recovery of any benefits paid before August 18, 2009, one year before plaintiff filed its complaint. *MCL 500.3145(1)* provides, in relevant part:

> An action for recovery of personal protection insurance benefits payable under this chapter for accidental bodily injury may not be commenced later than 1 year after the date of the accident causing the injury unless written notice of injury as provided herein has been given to the insurer within 1 year after the accident or unless the insurer has previously made a payment of personal protection insurance benefits for the injury. If the notice has been given or a payment has been made, the action may be commenced at any time within 1 year after the most recent allowable expense, work loss or survivor's loss has been incurred. *However, the claimant may not recover benefits for any portion of the loss incurred **[*13]** more than 1 year before the date on which the action was commenced*. [Emphasis added.]

In *Allen v Farm Bureau Ins Co, 210 Mich App 591, 595-598; 534 NW2d 177 (1995)*, this Court held that the one-year period of limitation in *MCL 500.3145(1)* is inapplicable when an assignee of the Assigned Claims Facility brings a claim for reimbursement pursuant to its statutory right to reimbursement set forth in *MCL 500.3172(1)*. This Court reasoned that in such cases the assignee's claim asserts an independent, statutorily created right to reimbursement and the assignee did not bring its claim as a subrogee of the injured party. *Id. at 595-597*.

Defendant argues that *Allen* is inapplicable because the *Allen* Court discussed the oneyear limitation period of *MCL 500.3145(1)* and did not address the one-year back rule set forth in the provision. Defendant's argument lacks merit. The reasoning in *Allen* applies with respect to both the limitation period and the one-year back rule. In a reimbursement action, the plaintiff's claim is not derivative of the injured party. Rather, it is an independent claim brought pursuant to *MCL 500.3172(1)*, which authorizes an assignee to bring a claim for reimbursement from a **[*14]** defaulting insurer. *MCL 500.3145(1)* does not apply to such claims and instead, by its very terms, pertains to "[a]n action for recovery of [PIP] benefits." A claim for reimbursement is not an action for recovery of PIP benefits. Rather, a claim seeking reimbursement is "[a]n action to enforce rights to indemnity or reimbursement against a third party" as stated in *MCL 500.3175(3)*. Accordingly, *MCL 500.3175(3)* applies to reimbursement actions and the one-year back rule of *MCL 500.3145(1)* is inapplicable.

Affirmed in part, reversed in part, and remanded for further proceedings. We do not retain jurisdiction. Neither party having prevailed in full, no costs are taxable pursuant to *MCR 7.219*.

/s/ Pat M. Donofrio

/s/ Karen M. Fort Hood

/s/ Deborah A. Servitto

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KREINDLER v. WALDMAN

Court of Appeals of Michigan

April 4, 2006, Decided

No. 265045

Reporter
2006 Mich. App. LEXIS 945 *; 2006 WL 859447

ALFRED M. KREINDLER, Plaintiff/Counter-Defendant-Appellant, and DANIEL J. GOLDSTONE, Plaintiff/Counter-Defendant, v MARTIN WALDMAN, Defendant, and AMERICAN GUARANTEE & LIABILITY INSURANCE COMPANY, Defendant/Counter-Plaintiff-Appellee.

Notice: [*1] THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Prior History: Oakland Circuit Court. LC No. 2004-055949-CK.

Disposition: Affirmed.

Core Terms

coverage, summary disposition, material fact, uninterrupted, assignments, ambiguous

Judges: Before: Owens, P.J., and Kelly and Fort Hood, JJ.

Opinion

PER CURIAM.

Plaintiff Alfred M. Kreindler appeals as of right from the trial court's order granting summary disposition to defendant American Guarantee and Liability Insurance Company. [1] We affirm.

[*2] Plaintiff alleges that the trial court erred in concluding that Goldstone was not entitled to coverage based on the errors and omissions policy with defendant. Specifically, plaintiff alleges that there was a genuine issue of material fact with regard to whether Goldstone had uninterrupted professional liability coverage since 1996, a prerequisite for coverage under the policy, the policy was ambiguous, and the trial court erred in concluding that he had the burden of proof with regard to the issue of coverage. We disagree.

A trial court's decision granting summary disposition is reviewed de novo, on the entire record, to determine whether the prevailing party was entitled to judgment as a matter of law. *Maiden v Rozwood, 461 Mich. 109, 118; 597 N.W.2d 817 (1999)*. When reviewing a motion brought under *MCR 2.116(C)(10)*, this Court must examine the documentary evidence presented below and, drawing all reasonable inferences in favor of the nonmoving party, determine whether a genuine issue of material fact exists. *Quinto v Cross & Peters Co, 451 Mich. 358, 361-362; 547 N.W.2d 314 (1996)*. Contrary to plaintiff's **[*3]** argument, the test is not whether a record *may* be developed upon which reasonable minds may differ, or whether the court is satisfied that the nonmoving party cannot prevail at trial because of a deficiency that cannot be overcome. *Smith v Globe Life Ins Co, 460 Mich. 446, 454-455, n 2; 597 N.W.2d 28 (1999)*. Once the moving party supports its position with documentary evidence, the nonmoving party has the burden of coming forward with evidence of specific facts to establish the existence of a material factual dispute. *Quinto, supra at 362, 371*. If the nonmoving party fails to establish that a material fact is at issue, the motion is properly granted. *Id. at 363*.

In this case, plaintiff concedes that defendant's policy will not provide coverage for Goldstone's alleged negligence in handling plaintiff's disability insurance matter unless it can be established that Goldstone maintained uninterrupted professional liability coverage dating back to 1996. When the

[1] Plaintiff Daniel J. Goldstone acted as an insurance agent for plaintiff Kreindler and allegedly failed to properly advise and maintain a disability insurance policy for plaintiff Kreindler's business. These individuals entered into a settlement agreement that assigned Goldstone's claims against defendant insurance company to plaintiff Kreindler. Accordingly, the singular plaintiff refers to Kreindler and the singular defendant refers to the insurance company. The claims against defendant Martin Waldman are not at issue in this appeal.

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issue involves the question of coverage, plaintiff has the burden of showing that the insurance policy covers the matter alleged. *Solomon v Royal Maccabees Life Ins Co, 243 Mich. App. 375, 379; **[*4]** 622 N.W.2d 101 (2000)*. Further, because defendant supported its motion with documentary evidence demonstrating that there was a breach in coverage, plaintiff was required to come forward with evidence showing that there was a genuine issue of fact for trial in order to avoid summary disposition. *Quinto, supra at 361-362*.

Contrary to plaintiff's argument, the policy at issue is not ambiguous. Even if there was some confusion concerning Goldstone's contract date with another insurance company, this alleged confusion did not involve the meaning of defendant's policy. Furthermore, the alleged confusion is immaterial to the question of coverage because coverage under defendant's policy extends back only to the insured's contract date *or* the first gap in errors and omissions coverage, whichever is earlier. Because the negligent act occurred in 1996, well before Goldstone's gap in coverage--April 1, 2001, to August 1, 2001--and well before his contract date, it is immaterial whether Goldstone's contract date was September 2000, or September 2001.

Plaintiff failed to come forward with documentary evidence showing the existence of a genuine issue of **[*5]** material fact with regard to whether Goldstone had uninterrupted professional liability coverage dating back to 1996. Goldstone's mere assertion that he believed he had uninterrupted coverage, without any factual support for this position, was insufficient to show that a question of material fact exists. *Willis v Deerfield Twp, 257 Mich. App. 541, 550; 669 NW2d 279 (2003)*; see also *Quinto, supra at 371-372*. Indeed, Goldstone conceded that he could not produce any evidence showing that uninterrupted coverage was in place. Accordingly, the trial court properly granted defendant's motion for summary disposition under *MCR 2.116(C)(10)*.

Plaintiff also alleged that the policy at issue was ambiguous because it failed to define the term "proof," and therefore, must be construed against defendant as the drafter. The failure to define a contractual term does not render a contract ambiguous. *Henderson v State Farm Fire & Casualty Co, 460 Mich. 348, 354; 596 N.W.2d 190 (1999)*. In that case, a term must be examined in light of its plain and ordinary meaning. The plain and ordinary meaning of **[*6]** a term can be ascertained by utilizing the dictionary definition. *Echelon Homes, LLC v Carter Lumber Co, 472 Mich 192, 196; 694 N.W.2d 544 (2005)*. In the present case, defendant's representative indicated that any type of proof, including paycheck stubs, would be satisfactory. Plaintiff did not present any proof, but made a blanket assertion that he had obtained the required policy. Moreover, the rule of contra proferentem, the rule that construes a contract against the drafter, is a rule of last resort that does not apply unless there is a true ambiguity and the parties' intent cannot be discerned. *Twichel v MIC General Ins Corp, 469 Mich. 524, 535 n 6; 676 N.W.2d 616 (2004)*.

We reject plaintiff's argument that defendant was estopped from denying liability in this case. Although defendant initially agreed to defend Goldstone, it did so under an explicit reservation of rights. Because defendant timely notified Goldstone that it was proceeding under a reservation of rights, it is not estopped from denying coverage. *Kirschner v Process Design Assoc, Inc, 459 Mich. 587, 593; 592 N.W.2d 707 (1999).* **[*7]**

Furthermore, although the trial court did not address the question of plaintiff's standing, we agree that plaintiff lacked standing to pursue this action against defendant. Whether a party has standing is a question of law to be reviewed de novo. *Crawford v Dep't of Civil Service, 466 Mich 250, 255; 645 N.W.2d 6 (2002)*.

"In order to have standing a party must have a 'legally protected interest that is in jeopardy of being adversely affected.'" *Bowie v Arder, 441 Mich. 23, 42; 490 N.W.2d 568 (1992)*. In this case, plaintiff has no legally protected interest in defendant's policy, apart from whatever interest was assigned to him by Goldstone. Thus, plaintiff's standing, if any, arises by virtue of his agreement with Goldstone. While prohibitions against assignments are disfavored, where a clause prohibiting assignments is clear and unambiguous, it must be enforced as written. *Detroit Greyhound Employees Fed Credit Union v Aetna Life Ins Co, 381 Mich. 683, 689-690; 167 NW2d 274 (1969)*; see also *Quality Products & Concepts Co v Nagel Precision, Inc, 469 Mich. 362, 375; 666 N.W.2d 251 (2003).* **[*8]** Here, defendant's policy expressly prohibited Goldstone's assignment of his "claims and causes of action" under the policy. [2] Thus, plaintiff has no interest under the policy and, therefore, has no standing to sue defendant. This provides an alternative basis for affirming the trial court's summary disposition order against plaintiff.

In light of our decision, it is unnecessary to address whether plaintiff's claims against defendant were extinguished by his agreement with Goldstone.

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[2] Goldstone's "claims and causes of action," if any, stem from his rights under the policy. Accordingly, there is no meaningful distinction between an assignment of Goldstone's "claims and causes of action," and an assignment of Goldstone's "interest" under the policy. A contrary result would render nugatory the policy's prohibition against assignments. *Klapp v United Ins Group Agency, Inc, 468 Mich. 459, 468; 663 N.W.2d 447 (2003)*.

Affirmed.

/s/ Donald S. Owens

/s/ Kirsten Frank Kelly **[*9]**

/s/ Karen M. Fort Hood

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1. *MARSACK v. CITIZENS INS. CO., 1996 Mich. App. LEXIS 2239*

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MARSACK v. CITIZENS INS. CO.

Court of Appeals of Michigan

December 6, 1996, Decided

No. 190356

Reporter
1996 Mich. App. LEXIS 2239 *

THOMAS MARSACK, Plaintiff-Appellee, v CITIZENS INSURANCE COMPANY, Defendant-Appellee, and THE HOSPITAL REGIONAL MEDICAL CENTER and LAPEER REGIONAL HOSPITAL, Intervening Plaintiffs-Appellants.

Notice: [*1] IN ACCORDANCE WITH THE MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Prior History: LC No. 94-013287-CK.

Disposition: Reversed.

Core Terms

intervene, benefits, summary disposition, hospital's, attorney's fees, discovery, mediation, one-third, contingency fee, circuit court

Case Summary

Procedural Posture

Intervening plaintiff hospital appealed from the order of the circuit court (Michigan), which granted summary disposition to plaintiff patient and against defendant insurer in the patient's action for personal protection benefits under Michigan's no-fault act, *Mich. Comp. Laws § 500.3101 et seq.*

Overview
The patient was severely injured when he was hit by a car operated by the driver, the insurer's insured. The insurer denied liability, alleging that the patient was ineligible for benefits because his injuries were the result of a suicide attempt. The hospital filed a motion to intervene, alleging that it was owed money, that the patient was believed to be indigent, and that the patient was expected to obtain insurance proceeds to pay for his hospital bill from the insurer. On appeal, the court reversed and held that the hospital should have been permitted to intervene. The hospital was directly affected by the trial court's grant of summary disposition and was an aggrieved party entitled to bring the instant appeal. Intervention was necessary to permit the hospital to protect its interest in the benefits paid to the patient, who had an outstanding bill with the hospital. The hospital, which provided the patient with medical care for his injuries, had an interest in the subject matter of the litigation, the payment of benefits. Because the hospital asserted its desire to intervene within four months after the insurer filed its answer, its motion was timely.

Outcome
The court reversed the trial court's grant of summary disposition to the patient and remanded the cause with directions that the hospital be permitted to intervene in the action.

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Civil Procedure > Appeals > Reviewability of Lower Court Decisions > Adverse Determinations

Civil Procedure > Appeals > Summary Judgment Review > General Overview

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HN1[] **Reviewability of Lower Court Decisions, Adverse Determinations**

Jonathan Green

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The appellate court has jurisdiction over appeals from a circuit court's summary disposition order. *Mich. Comp. Laws § 600.308*. *Mich. Ct. R. 7.203(A)* provides that the appellate court has jurisdiction over an appeal of right filed by "an aggrieved party." An "aggrieved party" is one who has an interest in the subject matter of the litigation.

Civil Procedure > Parties > Intervention > Intervention of Right

Commercial Law (UCC) > Sales (Article 2) > Form, Formation & Readjustment > General Overview

Insurance Law > ... > No Fault Coverage > Personal Injury Protection > General Overview

Civil Procedure > Parties > Intervention > General Overview

HN2[] **Intervention, Intervention of Right**

Intervention by right is governed by *Mich. Ct. R. 2.209(A)(3)*, which provides that, on timely application, a person has the right to intervene in an action when the applicant claims an interest relating to the property or transaction which is the subject of the action and is so situated that the disposition of the action may as a practical matter impair or impede the applicant's ability to protect that interest, unless the applicant's interest is adequately represented by existing parties.

Judges: Before: Bandstra, P.J., and Neff and M.E. Dodge, * JJ.

Opinion

PER CURIAM.

McLaren Regional Medical Center, along with its affiliate Lapeer Regional Hospital (the hospital), appeals from a circuit court order granting summary disposition to plaintiff Thomas Marsack and against defendant Citizens Insurance Company in plaintiff's action for personal protection benefits (PIP benefits) under Michigan's no-fault act. *MCL 500.3101 et seq.*; MSA 24.13101 et seq. We reverse and remand this case for entry of an order permitting the hospital to intervene and for further proceedings consistent with this opinion.

I

The underlying facts are largely undisputed. On November 27, 1993, plaintiff was severely injured when he was hit by a car operated by Norah Germain, defendant's insured. Germain reported that plaintiff was lying on highway M-24 when she hit him. Plaintiff was hospitalized for several months, [*2] incurring hospital bills totaling over $ 173,000. Because plaintiff had no insurance himself, he looked to defendant for coverage. Defendant initially denied liability and alleged that plaintiff was ineligible for PIP benefits because his injuries were the result of a suicide attempt. Defendant refused to pay any of plaintiff's medical expenses while its investigation continued.

Plaintiff eventually sought the assistance of attorney Ronald Gricius, and entered into a contingent fee agreement under which Gricius would be entitled to a fee of one-third of any amount recovered. Gricius advised defendant of this arrangement and requested an application for benefits and other documents for plaintiff to fill out and submit to defendant. Before submitting these documents, however, plaintiff filed a complaint seeking PIP benefits under the no-fault act and attorney fees pursuant to *MCL 500.3148*; MSA 24.13148, which provides that an insurance company is liable for attorney fees where benefits are unreasonably delayed.

The hospital filed a motion to intervene, alleging that it was owed over $ 166,000, that plaintiff was believed to be indigent, that plaintiff was [*3] expected to obtain insurance proceeds to pay for his hospital bill from defendant, and that if Gricius' expected fee of approximately $ 57,000 were deducted from the PIP benefits the hospital would not be able to collect a significant portion of its bill from plaintiff. The hospital further argued that Gricius's one-third contingent fee was unreasonable, and that he should receive only the fair value of services rendered. The trial court entered an order permitting the hospital to intervene, for a period of three months, for the limited purpose of conducting discovery regarding whether Gricius' services were necessary to secure payment of PIP benefits. The court further ordered that on completion of discovery the hospital would be permitted to petition for an unlimited order of intervention and that, until such time, the hospital would not be required to file a formal pleading.

By stipulation, the hospital's time for conducting discovery was extended twice, and the hospital ultimately filed a motion to compel discovery from defendant. The only attorney to appear at the hearing on the motion was counsel for the hospital, who informed the court that defendant recently had complied with [*4] the discovery request. Counsel then orally requested permission to intervene to contest the reasonableness of Gricius' proposed $ 57,000 attorney fee. The court orally granted the hospital's request, and a proposed

* Circuit judge, sitting on the Court of Appeals by assignment.

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order was prepared. However, plaintiff objected to the order, stating that the order permitted relief which was not asked for in the motion filed by the hospital. That is, the hospital's motion was to compel discovery and the relief in the order was to grant intervention.

Meanwhile, plaintiff and defendant both accepted the proposed settlement amount of the mediation panel. Plaintiff then filed a motion for summary disposition, arguing that the case had been mediated, that the hospital had never filed a motion to intervene, and that Gricius' one-third contingent fee should be paid from the PIP benefits paid by defendant. In its response to the motion defendant agreed that the case should be summarily resolved, but noted that defendant had not unreasonably delayed payment and thus was not liable for attorney fees in addition to the PIP benefits it had already agreed to pay. The hospital also responded to plaintiff's motion for summary disposition and asked that the motion **[*5]** be denied, that the hospital be permitted to intervene, and that a hearing be held to determine an appropriate attorney fee to Gricius.

At the hearing held on plaintiff's motion for summary disposition and to settle the court's order granting intervention, plaintiff argued that the case essentially had been settled because both parties accepted the mediation award, which was the full amount of the medical bills owing to the hospital. Counsel for the hospital suggested that questions of fact remained regarding whether the PIP benefits were unreasonably delayed, which would result in defendant being liable for Gricius' attorney fees, or whether the benefits were merely overdue, in which case a reasonable attorney fee would be deducted from the PIP benefits. Counsel for the hospital renewed its request to intervene and file a complaint outlining its position regarding the attorney fee issue.

The circuit court held that although defendant investigated plaintiff's claim for PIP benefits, the benefits were overdue and summary disposition was appropriate. The court granted plaintiff's motion for summary disposition but failed to rule on the hospital's request to intervene.

II

At the outset, **[*6]** we must determine whether we have jurisdiction to consider this appeal. It is without question that *HN1*[↑] this Court has jurisdiction over appeals from a circuit court's summary disposition order. *MCL 600.308*; MSA 27A.308. This is not the only consideration, however. *MCR 7.203(1)* provides that this Court has jurisdiction over an appeal of right filed by "an aggrieved party." The question thus becomes whether the hospital, which was never formally granted the status of an intervening party, is nonetheless an "aggrieved party" entitled to appeal the summary disposition order. We conclude it is.

An "aggrieved party" is one who has an interest in the subject matter of the litigation. See *In re Freeman Estate, 218 Mich. App. 151, 155; 553 N.W.2d 664 (1996)*. The hospital, which provided plaintiff with medical care for his injuries, has an interest in the subject matter of the litigation, i.e., the payment of PIP benefits to plaintiff. Indeed, PIP benefits are payable for "allowable expenses," which are defined as "consisting of all reasonable charges incurred for reasonably necessary products, services and accommodations for an injured person's **[*7]** care, recovery, or rehabilitation." *MCL 500.3107(1)(a)*; MSA 24.13107(1)(a). The PIP benefits defendant agreed to pay will be diminished, from the hospital's perspective, if reduced by Gricius' proposed one-third contingent fee. Accordingly, the hospital was directly affected by the trial court's grant of summary disposition and is "an aggrieved party" entitled to bring the instant appeal.

III

Having determined that this case is properly before us, we now turn to the issues raised by the hospital on appeal. The hospital first argues that it should have been permitted to intervene in this matter. We agree.

HN2[↑] Intervention by right is governed by *MCR 2.209(A)*, which provides that, on timely application, a person has the right to intervene in an action:

> (3) when the applicant claims an interest relating to the property or transaction which is the subject of the action and is so situated that the disposition of the action may as a practical matter impair or impede the applicant's ability to protect that interest, unless the applicant's interest is adequately represented by existing parties.

As demonstrated above, the hospital has an interest in the subject **[*8]** matter of the litigation. Further, insofar as Michigan law does not permit a "hospital lien" on insurance proceeds, we find that intervention is necessary to permit the hospital to protect its interest in the PIP benefits paid to plaintiff, who has an outstanding bill with the hospital. Cf. *Tucker v Clare Bros Limited, 196 Mich. App. 513, 517-518; 493 N.W.2d 918 (1992)*. Finally, neither plaintiff nor defendant represented the hospital's interest in being paid in full. We conclude that the hospital fulfilled the requirements to intervene in the present action as of right.

Plaintiff insists that the hospital's motion to intervene was both untimely and defective because it was not accompanied by "a pleading stating the claim or defense for which intervention is sought," as required by *MCR 2.209(C)(2)*. We disagree. The hospital first asserted its desire to intervene

within four months after defendant filed its answer, and well before this case was submitted to mediation. The hospital's motion was not untimely. See *Karrip v Cannon Twp, 115 Mich App 726, 731; 321 NW2d 690 (1982)* (right to intervene should be asserted within a reasonable [*9] time).

Further, although the hospital did not file a pleading along with its motion to intervene as required by the court rule, the hospital made clear its position and the supporting authority throughout these proceedings. Moreover, the trial court's order granting the hospital the right to temporarily intervene expressly provided that it would not be required to file a pleading until it was granted full intervention. In addition, plaintiff acknowledged that it was aware of the hospital's position by moving for summary disposition following acceptance of the mediation award, instead of simply seeking a judgment under *MCR 2.403(M)(1)*. We will not elevate form over substance, *Tucker, 196 Mich App at 518-520*, and thus remand this matter to the circuit court for entry of an order granting the hospital permission to intervene.

IV

We now turn to the question of whether, because the hospital's motion to intervene was still pending, the circuit court's grant of summary disposition was premature. No question remains with regard to defendant's liability for PIP benefits in the amount recommended by the mediation panel and accepted by plaintiff and defendant. However, defendant [*10] and the hospital insist that the PIP proceeds were not "overdue" because plaintiff filed the instant action before providing defendant with "reasonable proof of a fact and the amount of the loss sustained." *MCL 500.3142*; MSA 24.13142.

Moreover, throughout these proceedings the hospital has maintained that Gricius' one-third contingent fee is unreasonable, and that whatever fee Gricius is permitted should be paid by defendant in addition to the PIP benefits it has already agreed to pay plaintiff. Because the hospital was not permitted to intervene, the trial court did not address these matters before granting plaintiff's motion for summary disposition.

Our review of the record reveals that genuine issues of material fact remain in regard to whether Gricius is entitled to an attorney fee pursuant to *MCL 500.3148(1)*; MSA 24.13148(1) and, if so, the reasonableness of Gricius' one-third contingent fee and the appropriate source of that fee. These issues are to be resolved by the circuit court on remand.

The circuit court's order granting summary disposition is reversed. We remand this case to the circuit court for entry of an order [*11] permitting the hospital to intervene, and for further proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Richard A. Bandstra

/s/ Janet T. Neff

/s/ Michael E. Dodge

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1. *Mich. Head & Spine Inst., P.C. v. Mich. Assigned Claims Plan, 2018 Mich. App. LEXIS 3464*

Client/Matter: -None-
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Cases	Court: Michigan

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Mich. Head & Spine Inst., P.C. v. Mich. Assigned Claims Plan

Court of Appeals of Michigan

November 13, 2018, Decided

No. 339766

Reporter
2018 Mich. App. LEXIS 3464 *; 2018 WL 5929065

MICHIGAN HEAD & SPINE INSTITUTE, P.C., Plaintiff-Appellant/Cross-Appellee, v MICHIGAN ASSIGNED CLAIMS PLAN, Defendant-Appellee/Cross-Plaintiff/Cross-Appellee, and HOME-OWNERS INSURANCE COMPANY, Defendant-Appellee/Cross-Defendant/Cross-Appellant, and UNNAMED ASSIGNEE OF THE MICHIGAN ASSIGNED CLAIMS PLAN, Defendant.

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Prior History: **[*1]** Oakland Circuit Court. LC No. 2016-153530-NF.

Core Terms

insured, benefits, healthcare provider, circuit court, assigned, summary disposition, no-fault, services, provider's, parties, cause of action, motion to amend, opposing party, constructive, coverage, uninsured, healthcare, rights, supplemental pleading, amended complaint, splitting, joinder, amend, second amended complaint, provide coverage, right to collect, possessed, join

Judges: Before: MURRAY, C.J., and METER and GLEICHER, JJ.

Opinion

PER CURIAM.

Following a recent pronouncement of our Supreme Court, healthcare providers no longer have a direct cause of action against no-fault insurers to collect for services provided to injured parties. The injured party in this case, however, assigned her right to collect benefits to the healthcare provider. The circuit court improperly denied the healthcare provider's motion to amend its complaint based on the assignment and therefore erroneously dismissed its action for lack of standing. We reverse that part of the circuit court's opinion and order denying the motion to amend, vacate that portion summarily dismissing the action for lack of standing, and remand for further proceedings.

I

Maureen Calcatera was seriously injured in a motor vehicle accident on February 9, 2016, while driving a Toyota Camry owned by and registered to her father, Michael Cuddihy, Jr. Calcatera did not live with Cuddihy, but had some level of permission to drive the vehicle, which was kept in the driveway at Cuddihy's house. On the day in question, Calcatera entered Cuddihy's home while he was sleeping, picked **[*2]** up the keys, and took the Camry to run errands.

Unfortunately, the Camry was not insured. On June 3, 2015, Cuddihy's grandson, Sean Horvath, allegedly called the Lenahan-Versical Insurance Agency, at Cuddihy's request, and cancelled a no-fault insurance policy covering the Camry because Cuddihy intended to transfer title to Calcatera.[1] According to the insurance agent, Calcatera contacted the agency approximately two weeks later to confirm that the Camry's policy had been cancelled. Calcatera denied making such a call and claimed that she "assumed" the vehicle was insured. Cuddihy never followed through with his gift, but also never restarted coverage. And Calcatera personally did not own a motor vehicle and therefore did not possess her own no-fault insurance coverage.

Michigan Head & Spine Institute (MHSI) provided medical and rehabilitative services to Calcatera from February 10 through June 6, 2016, leaving her with a $95,123 bill. MHSI had difficulty identifying the no-fault policy covering Calcatera in her accident. It therefore pursued reimbursement for Calcatera's treatment from the Michigan Assigned Claims

[1] Cuddihy remembered that he intended to transfer title to Calcatera and that he changed his mind. However, Cuddihy did not remember that he had ever insured the vehicle. During his deposition, Cuddihy indicated that at age 81, his memory was not what it used to be.

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Plan (MACP).[2] The MACP "serves as the insurer of last priority." *Titan Ins Co v American Country Ins Co, 312 Mich App 291, 298; 876 NW2d 853 (2015)*. Pursuant [*3] to *MCL 500.3172*, the MACP is required to investigate whether any policy of higher priority exists (as enumerated in *MCL 500.3114*) and if none are found, to assign an insurer to bear the duty of coverage. The MACP delayed in assigning the claim to a no-fault insurer, leading MHSI to file the instant lawsuit on June 16, 2016. Two months after MHSI filed suit, Calcatera assigned to MHSI her "right to collect no-fault insurance benefits, if any, for unpaid services rendered by [MHSI] to date." The assignment was consistent with *MCL 500.3143*, which precludes the assignment of a right to collect future benefits.

The MACP investigated coverage options and eventually discovered that Cuddihy possessed no-fault insurance through Home-Owners Insurance Company, although the parties later discovered that this policy actually covered only Cuddihy's other vehicle—a Jeep. The circuit court granted MHSI's motion to add Home-Owners as a party defendant in its first amended complaint and the MACP filed a cross-complaint against Home-Owners as well, claiming that Home-Owners had first priority to provide coverage to Calcatera.

Home-Owners sought summary disposition of both MHSI's and the MACP's claims, asserting that Calcatera knowingly operated [*4] an uninsured vehicle and therefore was not entitled to personal protection insurance (PIP) benefits under the no-fault act. Home-Owners explained that Cuddihy had maintained insurance on the vehicle through June 3, 2015, when he and his grandson contacted the agency to remove the Camry. Home-Owners further argued that Calcatera did not fall within the three categories of individuals entitled to benefits under *MCL 500.3114(1)*: she was not the named insured or the named insured's spouse, and she was not a resident relative of the insured.

The MACP challenged Home-Owners' motion with evidence that Calcatera believed the Camry was insured. It also contended that Home-Owners was on the hook because Cuddihy "remained a Home-Owners insured" by virtue of his other vehicle. MHSI added that Home-Owners relied upon the inadmissible hearsay statements of its agent, making the motion "[a]t best . . . premature as the facts regarding insurance coverage have not been fl[e]shed out due to the fact that no discovery has been served upon Home-Owners."

Before the circuit court had considered Home-Owners' motion,[3] the Michigan Supreme Court issued *Covenant Med Ctr, Inc v State Farm Mut Auto Ins Co, 500 Mich 191; 895 NW2d 490 (2017)*, on May 25, 2017. In *Covenant, 500 Mich at 196*, the Court held "that healthcare providers do not [*5] possess a statutory cause of action against no-fault insurers for recovery of [PIP] benefits under the no-fault act." Healthcare providers still "may seek payment from the injured person for the provider's reasonable charges," *id. at 217*, and the injured person may in turn fight the insurance battle. *Covenant*'s ruling also was "not intended to alter an insured's ability to assign his or her right to past or presently due benefits to a healthcare provider." *Id. at 217 n 40*. Accordingly, an injured party could still assign his or her right to recover benefits.

The very next day, Home-Owners filed a renewed motion for summary disposition. Home-Owners clarified its initial argument, asserting that Calcatera was a "constructive owner" of the Camry as she regularly used it under a blanket grant of permission, and knowingly drove it without mandatory no-fault insurance coverage. Accordingly, neither she nor her medical service providers were entitled to recovery or reimbursement pursuant to *MCL 500.3113(b)*.[4] Home-Owners added that MHSI lacked standing to bring suit under *Covenant*.

The MACP responded by playing both sides of the field. It contended that evidence showed that Calcatera was not a constructive owner of the Camry and denied [*6] that *Covenant* applied to eliminate MHSI's standing. "However," the MACP argued, "should it be demonstrated that Calcatera is barred from PIP benefits . . . [under *MCL 500.3113(b)*], she would also be barred from claiming benefits through" the Plan.

MHSI retorted that Home-Owners still had not presented admissible evidence to support that Cuddihy had cancelled the insurance or that Calcatera knew the Camry was uninsured. Ultimately, MHSI argued, there remained questions of fact regarding whether the Camry was insured. MHSI contended that the testimony of Cuddihy and Calcatera established that Calcatera did not use the vehicle in a manner consistent with ownership.

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[2] Calcatera was also treated at McLaren Macomb Hospital and the hospital joined MHSI in seeking reimbursement from the MACP outside of court. The hospital is not a party to this lawsuit and there is no record indication whether McLaren pursued separate legal action.

[3] In its final opinion and order, the circuit court indicated that it had previously dismissed Home-Owners' first summary disposition motion as moot. No such order appears in the lower court record.

[4] *MCL 500.3113(b)* excludes a person from claiming PIP benefits when he or she "was the owner or registrant of a motor vehicle . . . involved in the accident with respect to which the security required by [*MCL 500.3101* or *MCL 3103*] was not in effect."

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In response to the standing argument, MHSI emphasized that *Covenant* preserved a healthcare provider's right to recover benefits "based on the insured's assignment of rights." Calcatera validly assigned her right to collect for MHSI's prior services to MHSI pursuant to MCL 500.3143 and MHSI then stood in Calcatera's shoes.

MHSI concurrently filed a motion to file a second amended complaint based on Calcatera's August 2016 assignment. MHSI noted that it had a direct cause of action and did not need to rely on the assignment for standing until the *Covenant* [*7] decision. MHSI further contended that neither the MACP nor Home-Owners would be prejudiced as its claim for recovery raised no new facts or legal premises; rather MHSI would simply be standing in Calcatera's shoes seeking the same recovery.

Home-Owners challenged MHSI's motion to file a second amended complaint based on Calcatera's assignment. Home-Owners accused Calcatera of splitting her cause of action according to the debts owed to different healthcare providers and assigning her cause of action piecemeal. Such splitting is prohibited. Home-Owners argued, "to prevent vexation and expense to a defendant. It is a rule of justice that one shall present his whole cause of action in one suit." Quoting *Szostak v Chevrolet Motor Co*, 279 Mich 603, 607; 273 NW 284 (1937). The cause-of-action-splitting prohibition is now embodied by MCR 2.203, Home-Owners asserted, which requires a party to join every claim he or she has against a particular defendant arising out of a singular accident.[5]

At the hearing on the parties' motions, Home-Owners contended that it did not rely solely on the insurance agent's affidavit to classify Calcatera as a constructive owner of the Camry. Rather, it relied on Calcatera's and Cuddihy's testimony regarding the frequency of Calcatera's vehicle use and the fact that Calcatera was not required to ask Cuddihy permission before using the car.) Home-Owners also relied on the insurance declarations page, to establish that the Camry was uninsured at the time of the accident. This evidence was not inadmissible hearsay.

Home-Owners rejected that it was required to cover Calcatera under MCL 500.3114(4)(a) because it was "[t]he insurer [*9] of the owner or registrant of the vehicle occupied" based on insurance Cuddihy held for another car. Home-Owners asserted that as Calcatera was a constructive owner of the Camry, she had to be the insured owner of a separate vehicle for the statutory subsection to apply. Home-Owners thereby implied that the MACP should determine that no insurer had priority to provide coverage and accept its role as the insurer of last priority.[6]

In relation to its argument that MHSI lacked standing to file suit, Home-Owners added that MHSI had an assignment from Calcatera since August 15, 2016, and "never pled that cause of action all this time. Never once." Home-Owners questioned why MHSI should be allowed to amend nearly a year after it received the assignment. As a result of this delay, the parties were then one month before trial and Home-Owners was unable to "ask[] questions about bargained for consideration, was the assignment valid, [etc.]" Rather than an amendment, Home-Owners asserted, MHSI's claims based on assignment would be "really a new filing, because it's a completely separate element." As a new complaint filed in August 2017, the claims would be barred by the one-year-back rule as services [*10] only continued through June 2016. The delay was therefore "extremely prejudicial," in Home-Owners' estimation.

MHSI responded by summarizing the evidence it felt created a genuine issue of material fact regarding ownership and constructive ownership of the uninsured Camry. As to the standing argument, MHSI asserted that it had possessed a valid assignment since August 2016, but had not earlier filed an amended complaint, or pleaded a right to recovery on assignment as an alternative argument, because it had no need to until *Covenant* was decided. MHSI emphasized that Michigan is a notice pleading state and that its earlier complaint placed Home-Owners and the MACP on notice of the basis of its claim. The nature of the claim did not change simply because Home-Owners no longer possessed a direct cause of action and instead had to rely on the assignment for standing.

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[5] MCR 2.203 provides, in relevant part:

> (A) Compulsory Joinder. In a pleading that states a claim against an opposing party, the pleader must join every claim that the pleader has against that opposing party at the time of serving the pleading, if it arises out of the transaction or occurrence that is the subject matter [*8] of the action and does not require for its adjudication the presence of third parties over whom the court cannot acquire jurisdiction.
>
> (B) Permissive Joinder. A pleader may join as either independent or alternate claims as many claims, legal or equitable, as the pleader has against an opposing party. If a claim is one previously cognizable only after another claim has been prosecuted to a conclusion, the two claims may be joined in a single action; but the court may grant relief only in accordance with the substantive rights of the parties.

[6] We note that the circuit court has yet to consider the priority of insurers for coverage of Calcatera as it has not yet considered whether Calcatera is precluded from any coverage based on her status as a constructive owner of an uninsured motor vehicle.

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The MACP argued at the hearing that Home-Owners was "clearly in the highest order of priority pursuant to MCL 500.3114(4)." Specifically, Cuddihy "was a Home-Owners' insured" and it should provide coverage despite that the Camry was not insured. Alternatively, the MACP contended that if the court granted summary disposition based on Calcatera's [*11] status as a constructive owner of an uninsured vehicle, then she similarly would be barred from benefits through the MACP.

Ultimately, the circuit court denied MHSI's motion to file a second amended complaint and dismissed its action. The court noted that MHSI admitted that it was a healthcare provider and that *Covenant* had recently held that a healthcare provider has no direct cause of action under the no-fault act for recovery of PIP benefits. However, MHSI relied upon Calcatera's assignment executed after suit was filed. The court denied MHSI's motion to file a second amended complaint based on undue delay (MHSI sat on the assignment for 11 months without filing its motion), undue prejudice (given that the trial had been adjourned twice and the new trial date was then only 30 days away), and failure to cure this deficiency in the previously allowed amendment.

Without an amendment, the court determined that MHSI's claims against Home-Owners and the MACP were legally unsustainable under *Covenant*. Without an independent cause of action against the insurer and the MACP, summary disposition was granted under MCR 2.116(C)(8) but without prejudice. Given its resolution of this issue, the court did not [*12] resolve Home-Owners' alternate ground for summary disposition—whether Calcatera was a constructive owner of the Camry ineligible for coverage for owning an uninsured vehicle.

II

MHSI challenges the circuit court's denial of its motion to file an amended complaint based on Calcatera's assignment. We review for an abuse of discretion a trial court's decision on a party's motion to amend its pleading or to serve a supplemental pleading. Boylan v Fifty Eight LLC, 289 Mich App 709, 727; 808 NW2d 277 (2010).

This Court recently addressed an issue similar to that now before us. In Shah v State Farm Mut Auto Ins Co, 324 Mich. App. 182; ___ NW2d ___ (Docket No. 340370, issued May 8, 2018), lv pending, this Court considered a healthcare provider's standing to seek recovery for PIP benefits when the provider belatedly secured an assignment from the injured party. In *Shah*, George Hensley was injured in a motor vehicle accident on November 30, 2014, and his healthcare providers filed suit against his no-fault insurer, State Farm, on February 24, 2017, seeking payment for their services. 324 Mich. App. 182; Id., slip op at 1. Following the Supreme Court's decision in *Covenant*, State Farm sought summary dismissal of the healthcare providers' claims. 324 Mich. App. 182; Id., slip op at 2. "Apparently anticipating defendant's motion, plaintiffs had obtained an assignment of rights from Hensley" to seek recovery [*13] for services "already provided." *Id.* The healthcare providers relied on this assignment in opposing summary disposition and in filing a motion to amend their complaint "to reflect that the suit was being pursued through the assignment of rights obtained from Hensley." 324 Mich. App. at 188. The circuit court denied the healthcare providers' motion to amend based on futility and granted summary disposition after determining that the insurance policy contained an anti-assignment clause and that any claims would be time-barred in any event by the one-year-back rule.[7] 324 Mich. App. 182; Id., slip op at 4, 14.

State Farm argued that Hensley's assignment to his healthcare providers was unenforceable because its insurance policy included an anti-assignment clause. 324 Mich. App. 182; Id. at 7. However, this Court held based on Roger Williams Ins Co v Carrington, 43 Mich 252; 5 NW2d 303 (1880), that "an accrued cause of action may be freely assigned after the loss and that an anti-assignment clause is not enforceable to restrict such assignment because such a clause violates public policy in that situation." Shah, 324 Mich. App. at 200.

This Court rejected the healthcare providers' contentions, however, that the assignment related back to the date the complaint was filed. This Court noted that an assignee stands in the shoes of the assignor, "possessing the same rights and [*14] being subject to the same defenses." 324 Mich. App. at 204 (cleaned up).[8] "Thus," this Court continued, "plaintiffs could not obtain any greater rights from Hensley on the date of the assignments—July 11, 2017—than Hensley himself possessed on that date." *Id.* Hensley was limited by the one-year-back rule to recover only for those services accruing from July 11, 2016, and plaintiffs took no more than the right to recover for services provided on or after that date. *Id.*

Moreover, the healthcare providers did not actually seek to file an "amended" complaint, but rather a "supplemental

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[7] MCL 500.3145(1) limits an injured party's recovery of PIP benefits to those costs incurred in the year before the action is filed.

[8] This opinion uses the new parenthetical (cleaned up) to improve readability without altering the substance of the quotation. The parenthetical indicates that nonsubstantive clutter such as brackets, alterations, internal quotation marks, and unimportant citations have been omitted from the quotation. See Metzler, *Cleaning Up Quotations*, 18 J App Pract & Process 143 (2017).

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pleading" based on the assignment, this Court held. *Id.* MCR 2.118(D) and (E) provide that an amended complaint is treated as if filed on the date of the original complaint, i.e., that it relates back. *Id.* But "'there is no provision for relating back as to supplemental pleadings.'" *Id.*, quoting *Grist v Upjohn Co*, 1 Mich App 72, 84; 134 NW2d 358 (1965). Through their supplemental pleading, the healthcare providers in *Shah* "only obtained the rights Hensley actually held *at the time of the execution of the assignment*." *Shah*, 324 Mich App at 205 (emphasis added).

Based on *Shah*, MHSI should have filed a motion to file a supplemental, rather than second amended, complaint. The supplemental complaint would be **[*15]** based on Calcatera's August 15, 2016 assignment. As held in *Shah*, MHSI obtained the rights that Calcatera actually held on August 15, 2016.

The lower court in *Shah* dismissed the healthcare providers' action after finding that a supplement would be futile because the one-year-back rule and inapplicability of the relation-back doctrine barred all recovery. The lower court in this case likely recognized that MHSI's supplement would *not* be futile as it had secured an assignment in August 2016, and the assignment's timing would allow for full recovery of the incurred benefits provided by MHSI. Instead, the circuit court faulted MHSI for holding onto the assignment for 11 months before seeking amendment. This delayed the proceedings and prejudiced the MACP and Home-Owners, the court concluded.

A court has discretion to grant a motion to file a supplemental pleading "on reasonable notice and on just terms." MCR 2.118(E). Motions to file supplemental pleadings are treated similarly to motions to amend. See *Casey v Auto-Owners Ins Co*, 273 Mich App 388, 401; 729 NW2d 277 (2006). The right to amend is usually "a matter of right rather than grace." *PT Today, Inc v Comm'r of Office of Fin & Ins Servs*, 270 Mich App 110, 143; 715 NW2d 398 (2006). "Thus, a motion to amend should ordinarily be denied only for particularized reasons, including undue delay, bad faith or a dilatory **[*16]** motive, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party, or futility." *Id.*

> Delay, alone, does not warrant denial of a motion to amend. However, a court may deny a motion to amend if the delay was in bad faith or if the opposing party suffered actual prejudice as a result. "Prejudice" in this context does not mean that the allowance of the proffered amendment may cause the opposing party to ultimately lose on the merits. Rather, "prejudice" exists if the amendment would prevent the opposing party from receiving a fair trial, if for example, the opposing party would not be able to properly contest the matter raised in the amendment because important witnesses have died or necessary evidence has been destroyed or lost. [*Weymers v Khera*, 454 Mich 639, 659; 563 NW2d 647 (1997) (cleaned up).]

Prejudice occasioned by delay may be found

> when the moving party seeks to add a new claim or a new theory of recovery on the basis of the same set of facts, after discovery is closed, just before trial, and the opposing party shows that he did not have reasonable notice, from any source, that the moving party would rely on the new claim or theory at trial. [*Id.* at 659-660.]

When MHSI filed suit, caselaw stated **[*17]** that healthcare providers had standing in their own right to pursue recovery claims. See *Covenant*, 500 Mich at 203 n 23. That still held true when MHSI filed its first amended complaint to name Home-Owners as a defendant. The circuit court abused its discretion in denying MHSI's motion to file a second amended complaint based on its failure "to cure deficiencies" in the first amendment. No "deficiency" existed at that time.

Similarly, MHSI did not cause any delay or prejudice to Home-Owners or the MACP. Home-Owners filed its summary disposition motion the day after *Covenant* was decided. Clearly, Home-Owners had completed its legal work in advance of *Covenant*'s change in the law; it would have expended these legal resources regardless of *Covenant*'s outcome. The circuit court's ruling suggests that *Covenant* was the starting pistol for a filing race—MHSI was required to file a motion to amend or supplement its complaint based on its assignee status before Home-Owners or be deemed to have caused delay and prejudice. Only MHSI could not win because Home-Owners sought to enforce *Covenant* before the ink had time to dry. Home-Owners had run its lap and was waiting at the finish line before the filing race could begin. It is fundamentally **[*18]** unfair to punish MHSI for not beating Home-Owners in a filing contest that began and ended only one day after a significant change in the law.

Further, MHSI did not fundamentally alter its cause of action. In the original and first amended complaints, MHSI asserted that Calcatera had been injured in a motor vehicle accident, either Home-Owners was first in priority to provide coverage or the MACP was required to assign an insurer to provide coverage, and it was entitled to payment for the services it had provided to Calcatera. MHSI would raise the same claims as before, only as Calcatera's assignee to collect for the services rendered. Contrary to Home-Owners' objections, this was not a radical change in legal theories requiring additional discovery or significant work. The circuit court thereby abused its discretion in denying MHSI's motion to amend (or

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supplement) its complaint. As the court should have permitted the amendment/supplement, it erroneously granted summary disposition in Home-Owners' favor based on the lack of standing.[9]

Home-Owners alternatively argues that the circuit court could have denied MHSI's motion to file a supplemental complaint because Calcatera invalidly split **[*19]** her cause of action when she assigned to MHSI only her right to collect benefits for the services provided by MHSI. Allowing MHSI's suit by assignment would leave them open for a second lawsuit by McLaren Macomb or by Calcatera directly for recovery of costs incurred at McLaren, Home-Owners complains.

Following the Supreme Court's decision in *Covenant* and this Court's opinion in *Shah*, this Court considered this very issue in the unpublished opinion of *Michigan Head & Spine Institute, Inc v Hastings Mut Ins Co*, unpublished per curiam opinion of the Court of Appeals, issued September 18, 2018 (*Docket No. 340656, 2018 Mich. App. LEXIS 3157*), lv pending.[10] Just as in this case, the defendant insurance company in *Hastings* relied on antiquated caselaw prohibiting the splitting of causes of action. *2018 Mich. App. LEXIS 3157, Id. at 2*. And just as MHSI argues in this case, this Court noted that the defendant in *Hastings* "ignore[d]" that the Supreme Court's adoption of *MCR 2.205* had superseded and replaced the former common-law rule against claim splitting. *Id.*, citing *United States Auto Ass'n v Notheifer, 195 Mich App 87, 89; 489 NW2d 150 (1992)*.

MCR 2.205(A) provides for the necessary joinder of certain parties:

> Subject to the provisions of *subrule (B)* and *MCR 3.501*, persons having such interests in the subject matter of an action that their presence in the action **[*20]** is essential to permit the court to render complete relief must be made parties and aligned as plaintiffs or defendants in accordance with their respective interests.

Under the court rule, "joinder is required for the benefit of the defendant." *United States Auto Ass'n, 195 Mich App at 89*. The burden is therefore on the defendant to "make a timely assertion of the position that separate suits violate the rule prohibiting the splitting of actions, modernly known as the joinder rule." *Id. at 89-90*.

Here, as in *Hastings*, there is no record indication that any other person or entity who provided services to Calcatera has filed or will file a separate lawsuit in connection with Calcatera's accident. Neither the MACP nor Home-Owners has requested joinder of McLaren Macomb or any other individual as a necessary party plaintiff. Accordingly, we follow *Hastings*'s example and conclude that denial of MHSI's motion to amend or supplement its complaint or granting Home-Owners' summary disposition motion on this ground would be improper.

III

Home-Owners alternatively argued below that the circuit court should summarily dismiss MHSI's recovery claim because Calcatera was barred from recovery of PIP benefits as the constructive owner of an uninsured vehicle. **[*21]** Home-Owners continues to raise this argument on appeal. However, the circuit court did not reach this issue. Once MHSI has filed its supplemental complaint in the circuit court, that court may consider Home-Owners' summary disposition motion in the first instance.

We reverse the order denying MHSI's motion to file a second amended (or supplemental) complaint, vacate the order granting Home-Owners' motion for summary disposition based on lack of standing, and remand for further proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Christopher M. Murray

/s/ Patrick M. Meter

/s/ Elizabeth L. Gleicher

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[9] Although we are vacating the circuit court's summary disposition order, we note that we share Home-Owners' confusion regarding the lower court's decision to enter the order "without prejudice." We need not resolve Home-Owners' claim on cross-appeal on the merits, however, as it has been rendered moot.

[10] "Although unpublished opinions of this Court are not binding precedent, *MCR 7.215(C)(1)*; *In re Application of Indiana Michigan Power Co, 275 Mich App 369, 380; 738 NW2d 289 (2007)*, they may . . . be considered instructive or persuasive." *Paris Meadows, LLC v City of Kentwood, 287 Mich App 136, 145 n 3; 783 NW2d 133 (2010)*.

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Mich. Head & Spine Inst., PC v. Hastings Mut. Ins. Co.

Court of Appeals of Michigan

September 18, 2018, Decided

No. 340656

Reporter
2018 Mich. App. LEXIS 3157 *

MICHIGAN HEAD & SPINE INSTITUTE, PC, Plaintiff-Appellant, v HASTINGS MUTUAL INSURANCE COMPANY, Defendant-Appellee.

Notice: THIS IS AN UNPUBLISHED OPINION. IN ACCORDANCE WITH MICHIGAN COURT OF APPEALS RULES, UNPUBLISHED OPINIONS ARE NOT PRECEDENTIALLY BINDING UNDER THE RULES OF STARE DECISIS.

Prior History: [*1] Oakland Circuit Court. LC No. 2017-160314-NF.

Core Terms

summary disposition, promise, trial court, benefits, beneficiary, cause of action, third-party, splitting, no-fault, insured

Judges: Before: SWARTZLE, P.J., and JANSEN and O'BRIEN, JJ.

Opinion

PER CURIAM.

Plaintiff appeals as of right the trial court's order granting summary disposition in favor of defendant. We affirm in part, reverse in part, and remand for further proceedings consistent with this opinion.

I. BACKGROUND

Kelly Potocki was covered under a personal-injury-protection (PIP) policy with defendant. Plaintiff provided medical services to Potocki for injuries she allegedly suffered in an automobile accident. Following treatment, Potocki assigned her right to payment to plaintiff. Plaintiff submitted claims for payment to defendant—the alleged first-party no-fault insurer—but defendant allegedly did not fully reimburse plaintiff for the services it provided to Potocki. Plaintiff commenced this action against defendant for recovery of first-party no-fault benefits, asserting entitlement to recovery under assignment-of-benefits and third-party-beneficiary theories. The trial court granted summary disposition in favor of defendant concluding that Potocki's assignment of her claim was barred by the anti-assignment clause in defendant's policy and that plaintiff was not an intended [*2] beneficiary of the policy and was therefore not entitled to enforce it.

This appeal followed.

II. ANALYSIS

A trial court's decision on a motion for summary disposition is reviewed de novo. *Dell v Citizens Ins Co of America, 312 Mich App 734, 739; 880 NW2d 280 (2015)*. Defendant sought summary disposition under *MCR 2.116(C)(8)* and *(C)(10)*. The trial court did not indicate under which court rule it was granting summary disposition; however, because the issues presented to the trial court entailed consideration of material outside the pleadings, we conclude that *MCR 2.116(C)(10)* is the relevant court rule. "A motion for summary disposition under *MCR 2.116(C)(10)* tests the factual sufficiency of the claim, and is appropriately granted when, except as to the amount of damages, there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law." *Tomra of North America, Inc v Dep't of Treasury, 2018 Mich. App. LEXIS 2810, ; NW2d (2018) (Docket No. 336871); at 4*.

Assignment of Benefits. Plaintiff argues that the trial court erred by granting summary disposition to defendant with respect to its assignment-of-benefits theory of recovery. We agree.

In *Covenant Med Ctr, Inc v State Farm Mut Auto Ins Co, 500 Mich 191, 195-196, 217-218; 895 NW2d 490 (2017)*, our Supreme Court held that healthcare providers lack an independent statutory cause of action against no-fault insurers to recover PIP benefits. Yet, the *Covenant* Court also stated that its holding was "not intended to alter [*3] an insured's ability to assign his or her right to past or presently due benefits to a healthcare provider." *500 Mich at 217 n 40*.

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Rather, only the assignment of future benefits is prohibited. *Id.*, citing *MCL 500.3143* and *Prof Rehab Assoc v State Farm Mut Auto Ins Co, 228 Mich App 167, 172; 577 NW2d 909 (1998)*. Moreover, this Court has recently held that an anti-assignment clause in a no-fault policy is unenforceable to prohibit an assignment that occurred after the loss or the accrual of the claim to payment "because such a prohibition of assignment violates Michigan public policy that is part of our common law as set forth by our Supreme Court." *Jawad A Shah, MD, PC v State Farm Mut Auto Ins Co, 2018 Mich. App. LEXIS 2266, at 18; NW2d (2018)*, citing *Rory v Continental Ins Co, 473 Mich. 457, 469-471; 703 N.W.2d 23 (2005)*, and *Roger Williams Ins Co v Carrington, 43 Mich 252, 254; 5 NW 303 (1880)*.

Here, Potocki's assignment to plaintiff was for past or presently due benefits. Under *Shah*, the anti-assignment provision in defendant's policy is void as against public policy and presents no obstacle to plaintiff's claim under an assignment-of-benefits theory. The trial court erred by concluding otherwise. To the extent that defendant invites this Court to declare a conflict with *Shah*, we decline to do so.

Defendant also argues that prohibiting an assignment would be consistent with "the broader rule in Michigan prohibiting the splitting of causes of action." Defendant cites *Gen Accident Fire & Life Assurance Corp v Sircey, 354 Mich 478, 482; 93 NW2d 315 (1958)*, for the following proposition: "In this state **[*4]** the rule against splitting of causes of action is strictly enforced to prevent vexation and expense to a defendant. It is a rule of justice that one shall present his whole cause of action in one suit." Yet, defendant ignores subsequent case law holding that "*MCR 2.205* has replaced the common-law rule against splitting a cause of action." *United Servs Auto Ass'n v Notheifer, 195 Mich App 87, 89; 489 NW2d 150 (1992)*. *MCR 2.205(A)* provides that "persons having such interests in the subject matter of an action that their presence in the action is essential to permit the court to render complete relief must be made parties and aligned as plaintiffs or defendants in accordance with their respective interests."

The burden is on a defendant to object to nonjoinder or misjoinder—"the defendant must make a timely assertion of the position that separate suits violate the rule prohibiting the splitting of actions." *United Servs Auto Ass'n, 195 Mich App at 89-90*. In the present case, there is no indication of any separate suit filed by Potocki or anyone else against defendant with respect to this matter, and defendant has made no request for joinder in accordance with *MCR 2.205*. Defendant's argument concerning the purported splitting of a cause of action thus lacks merit. Accordingly, we reverse the trial court's grant of summary disposition on **[*5]** plaintiff's assignment-of-benefits claim.

Third-Party Beneficiary. Next, plaintiff argues that the trial court erred in granting summary disposition to defendant on plaintiff's third-party-beneficiary claim. We disagree.

In *Covenant, 500 Mich at 217 n 39*, our Supreme Court declined to make a "blanket assertion" that "healthcare providers are incidental rather than intended beneficiaries of a contract between the insured and the insurer." The determination would rest "on the specific terms of the contract between the relevant parties." *Id.* The third-party-beneficiary statute, *MCL 600.1405*, states, in relevant part:

> Any person for whose benefit a promise is made by way of contract, as hereinafter defined, has the same right to enforce said promise that he would have had if the said promise had been made directly to him as the promisee.
> (1) A promise shall be construed to have been made for the benefit of a person whenever the promisor of said promise had undertaken to give or to do or refrain from doing something directly to or for said person.

"The plain language of this statute reflects that not every person incidentally benefitted by a contractual promise has a right to sue for breach of that promise. Thus, only intended, not **[*6]** incidental, third-party beneficiaries may sue for a breach of a contractual promise in their favor." *Schmalfeldt v North Pointe Ins Co, 469 Mich 422, 427; 670 NW2d 651 (2003)* (cleaned up). "A person is a third-party beneficiary of a contract only when that contract establishes that a promisor has undertaken a promise 'directly' to or for that person." *469 Mich at 428* (cleaned up). "By using the modifier 'directly,' the Legislature intended to assure that contracting parties are clearly aware that the scope of their contractual undertakings encompasses a third party, directly referred to in the contract, before the third party is able to enforce the contract." *Id.* (cleaned up). The objective form and meaning of the contract itself is used to determine whether a person is an intended third-party beneficiary. *Id.* "A third-party beneficiary may be a member of a class, but the class must be sufficiently described." *Shay v Aldrich, 487 Mich 648, 663; 790 NW2d 629 (2010)* (cleaned up).

Here, plaintiff has not identified any language in the no-fault insurance policies that directly refers to plaintiff or that sufficiently describes a class of which plaintiff is a member. Thus, plaintiff has not shown than an issue of fact exists regarding whether it was an intended beneficiary of the PIP policies. The trial court thus properly granted **[*7]** summary disposition to defendant on plaintiff's third-party-beneficiary claim.

Affirmed in part, reversed in part, and remanded for further

proceedings consistent with this opinion. We do not retain jurisdiction.

/s/ Brock A. Swartzle

/s/ Kathleen Jansen

/s/ Colleen A. O'Brien

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