MINNESOTA NO-FAULT CHECKLIST

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INTRODUCTION

This booklet is intended to be a road map for the handling of no-fault claims under the Minnesota No-Fault Automobile Insurance Act. It highlights various issues that may arise in the course of handling a no-fault claim. Accordingly, we have attempted to point out the issues and pitfalls in Minnesota no-fault disputes in a chronological fashion. In this manner, the booklet may be used as a checklist for the claims representative and consulted as a claim progresses. As a checklist, this booklet is abbreviated and is not intended by any means to be an exhaustive explanation of the law. Rather, we opted to highlight various issues to provide the claims representative with practice pointers and some insight to the strategies that will be used by claimant's counsel and which might also be implemented by the insurance representatives. For a more thorough look at any particular issue, you may consult *The Minnesota Motor Vehicle Insurance Manual, Third Edition* (2000), and the 2001 and 2004 Supplements to the *Minnesota Motor Vehicle Insurance Manual*, along with a variety of Minnesota Automobile Practioner's Guides, including the *Minnesota Motor Vehicle Accident Deskbook* , 5th Ed. (updated in 2015 and 2016).

A CHECKLIST FOR HANDLING MINNESOTA NO-FAULT CLAIMS

I. COVERAGE ISSUES.

The first item to be considered in any no-fault claim should be coverage. Do not assume coverage exists just because a claim has been submitted. It is important to spot coverage difficulties early before any no-fault payments have been made. Although the Minnesota No-Fault Act provides for reimbursement if mistaken payments are made, there are numerous difficulties in effecting that repayment. If there is no coverage for an injury, the no-fault insurer has no obligation to pay. If the challenge to coverage is undisputed, the claim will go away. If coverage will be a disputed issue, it is important to recognize that fact early.

The following is a list of some of the more common coverage issues:

A. Was the injury within the **policy period**?

B. Did the injury arise out of the **maintenance or use** of a motor vehicle?

C. Was a **motor vehicle** involved in causing the injury?

1. Motorcycles. A motorcycle is not a motor vehicle for purposes of no-fault coverage. Persons injured while on, mounting or alighting from a motorcycle are not entitled to no-fault benefits. However, there is a limited exception: A **pedestrian** struck by a motorcycle is entitled to no-fault coverage.

D. Was the injury caused by an **accident**?

E. Is the injured claimant an **insured**?

1. Named insureds. Questions often arise when the named insured is a business or corporation under a commercial auto policy. Generally, employees and owners of businesses are **not** named insureds under such policies unless the policies have been specifically endorsed to provide coverage to particular individuals when not occupying a covered vehicle.

Where the named insured is a sole proprietor, "doing business as . . .", (e.g., "John Doe, d/b/a Doe's Cleaning Service") questions also arise. Several factors must be examined to determine whether or not such a policy intended to provide personal coverage, commercial coverage, or both.

2. **Resident Relatives**. Under Minn. Stat. §65B.43, subd. 5, a resident relative is an insured. Questions frequently arise regarding the status of individuals as resident relatives.

F. Does your company have **priority** for payment?

1. The priority rules for payment of no-fault benefits are set forth in Minn. Stat. §65B.47. The claims representative must determine initially whether your company has the responsibility for payment of no-fault benefits or whether the claimant should be directed elsewhere. The statute also provides for pro rata payment between no-fault insurers on the same priority and for indemnity from another no-fault insurer if your company makes payment of benefits for which another insurer has responsibility.

   In Minnesota, claimants generally should submit their claims to their own insurer. **See *General Rules For PIP Priority Chart* attached as Appendix I**. As a result, however, no-fault insurers have become accustomed to processing and paying too automatically. Look for the exceptions, i.e., cases involving taxi drivers, buses, daycare, school or commuters or the less obvious case involving a vehicle furnished by an employer.

G. Can the no-fault benefits be **stacked**?

1. **Accidents after October 1, 1985**. If the accident causing injury occurs on or after October 1, 1985, no-fault benefits may not be stacked unless the policyholder made "a specific election to have two or more policies added together". Prior to making any payment, the claims representative must determine whether or not the policyholder elected to stack no-fault coverages. Stacking will affect not only the total limit of benefits available, but will also impact the amount that may be paid as wages. *See* Minn. Stat. §65B.47, subd. 7.

   a. **Non-named insureds.** A claimant who qualifies as an insured solely by virtue of her presence as a passenger in the covered vehicle is **not** entitled to the no-fault stacking option elected by the named insured. *Johnson v. State Farm Ins. Co.*, 556 N.W.2d 214, (Minn. 1996).

2. **Accidents before October 1, 1985.** Prior to October 1, 1985, stacking was permitted without specific election, but only if the injured claimant was an insured (named insured or resident relative).

3. If stacking applies, an injured claimant will be able to add together the limits of all coverages. Disability and income loss benefits may be stacked concurrently. In other words, a claimant may be entitled to the maximum weekly benefit multiplied by the number of coverages stacked.

H. Are any **statutory exclusions** applicable?

1. **One-year lapse** in disability and treatment. Minn. Stat. §65B.55, subd. 2.

a. **Disability.** Just what is "disability" which, if present, would allow the claimant to continue no-fault entitlement despite the passage of time? The Minnesota Supreme Court has now held that the term "disability" in the Lapse Provision should be given its "plain and ordinary meaning." *Thomas v. Western Nat'l Ins. Group*, (Minn. April 1997). The majority of the Court further held that an arbitrator did not err in deciding that the plain and ordinary meaning of disability is "anything affecting the normal, physical or mental abilities of a person", however, it did not necessarily state that this definition was exclusive. It is possible that another arbitrator may define "disability" in more objective terms which would survive review by the court.

2. **Late Notice**. Minn. Stat. §65B.55, subd. 1. (Caveat: A failure to provide notice will not render an individual ineligible to receive no-fault benefits unless the insurer has suffered "actual prejudice". Because of that requirement, late notice is not generally a good coverage defense unless there are extremely unusual and compelling circumstances.)

3. **Conversion** of a motor vehicle. Minn. Stat. §65B.58 and §65B.64, subd. 1(a).

4. **Racing**. Minn. Stat. §65B.59.

5. **Intentional Injuries**. Minn. Stat. §65B.60.

I. Do any **policy exclusions** apply?

1. **Operating an Owned but Uninsured Vehicle**. Although claimants will be excluded from uninsured and underinsured motorist coverage when they are occupying an owned but uninsured vehicle, the Minnesota Courts have so far **refused** to extend that exclusion to no-fault coverage.

J. **Strategy When Faced with a Coverage Issue.** If the claims representative believes there is a potential coverage question involved, it is advisable to consult counsel immediately and possibly before any denial of the claim. Claimants' attorneys will not generally agree that there is a coverage dispute. If the insurer identifies the issue early and consults with counsel, the insurer can often retain the advantage in any ensuing litigation. It is advantageous for the insurer to seize the initiative in instituting a declaratory judgment action for resolution of the coverage question. This can often prevent the claimant from filing an improper arbitration.

II. HANDLING THE CLAIM FOR NO-FAULT BENEFITS.

A. Claims Handling and the Unfair Claims Practices Act.

Minnesota's Unfair Claims Practices Act applies to the processing of all insurance claims. *See, generally* Minn. Stat. §72A.201. That Act does not create a private cause of action; if there is a claimed violation, the Commissioner of Commerce (Insurance) may enforce the Act with an eye upon business practices of insurers. Many of the provisions are intended to regulate the *process* of handling claims or, in other words, to make certain that the claim keeps moving. Some of the provisions are, however, quite specific to the point of creating obligations on a no-fault insurer. The following are some of the more noteworthy features of that Act.

1. Initial Correspondence on the Claim: Looking Ahead to the End of the Claim at the Very Beginning. Preservation of Lapse.

Most no-fault policies incorporate the No-Fault Act's provision that a no-fault claim may be terminated if there has been a lapse of 12 months in treatment and disability. *The Unfair Claims Practices Act requires that an insurer notify a claimant of the possibility of a lapse at least sixty (60) days prior to the expiration of the lapse period*. Minn. Stat. §72A.201, subd. 6(12). What should the insurer do to comply? What if the notice has not been given?

First of all, the insurer can easily and effectively protect its rights in advance by notifying the claimant of the lapse provision at the outset of the claim by forwarding each application for benefits with a letter such as our Appendix A.

If the notice has not been given, some claimant attorneys take the position that an insurer simply cannot reject a claim based upon lapse no matter how long the lapse in treatment and disability. The Act does not say that; it *does* say that it is "unfair" to have a business practice of raising the defense without notice to claimants. But the Act does not say that the defense cannot be asserted if appropriate.

2. General Claims Processing and the Unfair Claims Practices Act.

It is an unfair claims practice if the insurer does not:

a. Acknowledge a claim within ten days of notification. Minn. Stat. §72A.201, subd. 4(1).

b. Reply to an insured or claimant within ten days to communications about a claim "that reasonably indicate a response is requested or needed." Minn. Stat. §72A.201, subd. 4(2).

c. Complete, if possible, the investigation and notify of acceptance or denial of a claim within 30 days. If the investigation cannot be completed, the Act is satisfied if the insurer notifies the insured or claimant of the reasons why it is not complete and the expected date of completion. Minn. Stat. §72A.201, subd. 4(3).

3. Duties Created by the Unfair Claims Practices Act.

By labeling certain actions/inactions as "unfair claims practices" that Act imposes certain duties upon a no-fault insurer as follows:

a. Independent Medical Examinations.

An insurer requesting an IME for a no-fault claim as allowed in Minn. Stat. §65B.56, subd. 1 is to "notify the insured of all of the insured's rights and obligations under that statute including the right to request, in writing, and to receive a copy of the report of the examination." Minn. Stat. §72A.201, subd. 6(12).

b. Interest.

Interest for overdue benefits must be paid as required by the No-Fault Act. Minn. Stat. §72A.201, subd. 6(11).

c. Disclosure of the No-Fault Claim File.

A no-fault claimant is entitled to request, and to receive, "a complete copy of the insurer's claim file on the insured, *excluding internal company memoranda, all materials that relate to any insurance fraud investigation, materials that constitute attorney work-product or that qualify for the attorney-client privilege* . . . within 10 business days of receiving a written request from the insured. The insurer may charge the insured a reasonable copying fee." Minn. Stat. §72A.201, subd. 6(13). Note that this does not require the company release its "internal memoranda" or claim notes. Similarly any "attorney work product" or other communications, *including notes of the company's telephone calls to its attorneys*, need not be released.

4. Policy Limits Must be Disclosed.

The Unfair Claims Practices Act now requires that "an insurer must disclose the coverage and limits of an insurance policy within 30 days" after the policy information is requested in writing. Minn. Stat. §72A.201, subd. 11. In the past, Minnesota insurers were under no duty to disclose the liability (or any other) limits unless litigation was commenced.

B. Monitoring Payments.

An expense or payment log of the sort illustrated by Appendix B is advisable. Not only does such a system help avoid overpayment and double payment, but it is quite useful if the claim is denied. The log may help determine the amount in dispute (which will, in turn, tell whether it must be arbitrated) and is usually accepted as proof of the no-fault payments. Claimants may inadvertently offer medical bills in arbitration that have previously been paid. It is then necessary for the insurer to be able to demonstrate actual payment to avoid an inadvertent award of paid medical expenses.

1. Coverage Limits.

The statutorily required coverage is **$20,000** for medical expense, mileage and rehabilitation expense, and **$20,000** for all other benefits including disability and income loss benefits, survivors' benefits and funeral expense. Higher limits may be offered by the insurer in addition to stacking. If coverage is imposed on an out-of-state policy as a matter of law, only the statutory minimum coverage applies.

C. Medical Expense Benefits.

No-fault benefits are payable for reasonable and necessary expenses pursuant to Minn. Stat. §65B.44, subd. 2. Compensability will be determined by the claims representative based upon medical records, an independent medical examination, the claimant's statements, and other relevant materials. The following are a few points to keep in mind when handling a claim for medical expense benefits:

1. Other Causes of Injury.

a. Record Retrieval.

If there is a possibility that the injury claimed may be the result of other accidents or a pre-existing condition, the insurer is advised to

request and collect the claimant's medical records from all doctors and chiropractors consulted prior to the covered automobile accident. The American Arbitration Association No-Fault Arbitration Rules allow the insurer to request authorizations for all medical providers consulted by the claimant in the seven years prior to the accident. The number of years of prior records to collect will depend upon the nature of the injury or condition.

Collecting the claimant's prior medical records early on will aid the insurer in its evaluation of the medical claim. The insurer cannot rely upon the claimant to volunteer information of prior injuries or pre-existing conditions. The insurer is entitled to ask for this information since injuries that do not arise out of the automobile accident are not compensable.

All medical records, including prior records, should be collected *prior to* scheduling of an independent medical exam and provided to the doctor when the independent medical examination takes place. This bolsters the credibility of the examiner's opinion and broadens its scope. The examiner's opinion will be less credible if prior records are supplied to the examiner at a later date and cause him or her to change an opinion.

It may not be necessary to collect prior medical records in all cases and the claims representative must use his or her own judgment in determining when it will be appropriate. Our belief, however, is that collecting prior medical records almost always helps in properly evaluating the compensability of the claim.

b. Apportionment.

Where the claimant receives treatment for prior or subsequent injuries, what must the No-Fault insurer pay? The answer is simple but the mechanics are not. The answer is that the No-Fault insurer must pay for the "loss" which includes all treatment made necessary by the accident.

What if the claimant had prior problems? What about "apportionment?" "Apportionment" is a term to be avoided. In the past, it described a method by which the doctor could delineate what treatment was necessary as a result of the specific accident; No-Fault was responsible for that. But "apportionment" has been misused as a term; some No-Fault insurers have tried to pay for only a portion of the treatment even though, but for the accident, the claimant would have required no treatment. All "loss" caused by the accident, including all reasonable and necessary medical treatment

made necessary because of the injury, is compensable as PIP. It remains a valid objective to determine what that "loss" is in every case. But it is better to frame the question in terms of causation, just what treatment and disability results from the covered accident. Avoid using buzzwords such as "apportionment" or "percentages."

2. Finance Charges.

The Minnesota No-Fault Act does not provide for reimbursement of finance charges assessed by a health care provider. Such charges are not compensable medical expenses. The No-Fault Act provides for 15 percent simple interest per annum on overdue benefits. *See* Minn. Stat. §65B.54. Statutory interest will be paid to the claimant and is not for the direct benefit of the medical provider unless the claimant so chooses to allocate the interest in that fashion.

3. Minnesota Health Care Tax.

The Minnesota Legislature has imposed a 2.0% tax on most medical services provided in the state as a means of financing the state's comprehensive health care system. The patient is responsible for paying this tax and the providers must charge it. Because it is a necessary expense for which the insured is responsible, it should be considered a reasonable and necessary expense.

D. Rehabilitative Services.

The types of rehabilitative expenses compensable under the No-Fault Act are set forth in Minn. Stat. §65B.45, subd. 1.

1. Health Club Memberships.

Claimants frequently submit claims for the cost of a health club membership. This type of claim may be compensable if prescribed by a doctor. However, when analyzing such an expense, it is important to determine what sort of program is actually needed and for what duration that program might be necessary. A no-fault insurer is not obligated to furnish "lifetime memberships" if the claimant is expected to recover or plateau in a relatively specific period of time. The insurer is also not obligated to pay for "social atmospheres". An insurer need not pay the cost of a membership at the trendiest club with the best restaurant and fruit bar, when the same equipment and facilities required may be available at the local YMCA. The focus here is reasonable cost for necessary rehabilitative services.

Nothing in the No-Fault Act requires the insurer to pay the entire cost of a lengthy membership up front. The insurer should consider payment on a monthly basis so that the claimant's attendance and progress may be monitored. This leaves the insurer the option to refuse payment of the health club benefits should it appear that the claimant is not utilizing the facility as prescribed.

Such services are compensable if "reasonable in relation to its probable rehabilitative effects". An insurer is authorized to monitor the claimant's participation in any program. If disputes arise between the claimant and the insurer, Minn. Stat. §65B.45, subd. 3 authorizes the insurer to bring a motion in the District Court for a determination of its responsibility for payment of procedures and/or training which the claimant has proposed or undertaken.

E. Disability and Income Loss Benefits Claims.

A claimant is entitled to 85 percent of gross income loss proximately resulting from an inability to work due to a covered accident which is subject to a weekly maximum limit of $500.00. Minn. Stat. §65B.44, subd. 3. A claimant's disability is typically viewed with respect to his or her regular occupation at the time of the accident. A claimant may be considered "unable to work" if they cannot return full time to their regular employment. Claimant is still eligible for benefits even though not totally disabled from all forms of employment.

1. Calculation of Benefits.

The greatest difficulty with disability and income loss benefits claims arises in properly calculating the amount of benefits. "Gross income" includes salary, wages, tips, commissions and earnings. *See* Minn. Stat. §65B.43, subd. 6. The hourly or salaried wage earner with regular hours will not be a problem. But, many employees work irregular hours or receive occasional bonus pay, overtime pay or gratuities. For variable income, it is reasonable to calculate wage loss based upon an average of pre-accident pay. Appendix C is a wage and salary verification form that is designed to provide the insurer with the necessary information on pre-accident income if averaging is necessary.

a. The Self-Employed Claimant.

Self-employed claimants must prove an actual calculable economic loss to collect income loss benefits. Such loss cannot be based upon speculation. Lost time is not compensable without proof that it resulted in an actual measurable economic loss. It is imperative that these claims be properly documented.

Generally, the self-employed individual is entitled to 85 percent of the reduction of gross income **or** the cost of hiring substitute labor. If the self-employed claimant opts to employ substitute labor, the claimant is entitled to payment of 85 percent of the substitute employee's wages up to the weekly maximum. Some claimants will argue that they are entitled to collect 100 percent of the substitute employee's wages. A claimant is entitled to 85 percent of the gross income loss under all circumstances.

Supporting and calculating the income loss of a self-employed claimant can be difficult. The claims representative should request personal and business income tax returns, business records, banking account statements, and other relevant business documents when reviewing such a claim.

b. Lost Wages Incurred for Medical Appointments.

Prior to May 26, 1989, the no-fault statute contained no provision for payment of income losses sustained as a result of claimant's medical appointments. On or after May 26, 1989, the statute provides as follows:

> An injured person who is "unable by reason of the injury to work continuously" includes, but is not limited to, a person who misses time from work, including reasonable travel time, and loses income, vacation, or sick leave benefits, to obtain medical treatment for an injury arising out of the maintenance or use of a motor vehicle.

As with other claims, reasonable verification of the time missed from work, distance traveled, etc. will be required.

c. Consider the Effect and Impact of Unemployment Compensation.

The Minnesota No-Fault Act provides that a claimant may be entitled to disability and income loss benefits if the claimant is eligible to receive or is collecting unemployment compensation at the time of the accident and loses eligibility for unemployment compensation as a result of injuries caused by the accident. No-fault benefits may be payable to the full extent of unemployment compensation benefits lost subject to the weekly no-fault maximum.

For an unemployed claimant who is not receiving unemployment benefits, there is a challenge for the claimant to prove that he or she

would have been eligible to receive unemployment benefits. An unemployed claimant who is not eligible to receive unemployment compensation, may qualify for disability and income loss benefits to the extent that the claimant can prove with reasonable certainty that the claimant would have been working at some point in time at some certain employment at a reasonably calculable wage, but for the disability caused by the injury. Admittedly, this requires quite a bit of proof by the claimant.

Insurers should be alert to a claimant's collection of unemployment compensation benefits after an accident. Unemployment compensation benefits and no-fault benefits are usually mutually exclusive. To be eligible for unemployment compensation benefits, claimants must represent that they are "able to work" and are currently looking for employment. This is inconsistent with a claimed "inability to work". Insurers should be able to deny payment of no-fault benefits for any period during the claimant's alleged disability for which the claimant received unemployment compensation.

2. Coordination with Workers' Compensation Benefits.

Workers' compensation benefits are primary to no-fault benefits. *See* § 65B.61, subds. 2 and 2a. However, No-Fault benefits may be coordinated with workers' compensation benefits, and offset the weekly income loss benefit, even though the work-related disability and the auto-related disability result from separable injuries. *See, Griebel v. Tri-State Ins. Co.*, 311 N.W.2d 156 (Minn. 1981). Therefore, the insurer must determine whether or not workers' compensation will be applicable to a particular claim.

F. Claimant's Cooperation and Discovery.

Minn. Stat. §65B.56 imposes an affirmative obligation upon claimants seeking no-fault benefits to "do all things reasonably necessary to enable the obligor to obtain medical reports and other needed information to assist in determining the nature and extent of the injured person's injuries and loss." That obligation applies both "before and after the commencement of suit."

The statute implicitly requires the claimant to provide the insurer with authorizations for the release of medical records, employment records, income tax returns, etc.

1. Noncompliance.

A claimant's failure to cooperate may be viewed as a breach of the insurance contract. Minn. Stat. §65B.56, subd. 1 provides that evidence of non-compliance is admissible in any subsequent hearing or trial for no-fault benefits or in a personal injury lawsuit. In cases where the insured fails to attend a scheduled independent medical examination, the admissibility of a claimant's non-cooperation is not the exclusive sanction for the failure to attend an IME.

In *Weaver v. State Farm Ins. Cos.*, 609 N.W.2d 878 (Minn. 2000), the court set forth the procedure to be followed in non-compliance cases. They held that the arbitrator should initially make a factual determination on whether the request to attend and the subsequent refusal to attend the IME was "reasonable" or "unreasonable." Once there is a determination into the "reasonableness," the arbitrator may suspend, deny or award the benefits. However, the Court determined that either party has the opportunity to appeal the suspension, denial or award to the district court level for a *trial de novo*. The Court also made it clear that an arbitrator is *not* authorized to award payment for medical treatment after finding the IME request with respect to that treatment was reasonable and necessary to the determination of benefits and the refusal to attend was unreasonable.

G. Independent Medical Examinations.

Minn. Stat. §65B.56, subd. 1 authorizes an insurer to demand that the claimant submit to an independent physical examination by a qualified physician selected by the insurer. Typically, such an examination should precede the denial of benefits. An independent medical examination may be sufficient proof for denial of benefits. *Wolf v. State Farm Ins. Co.* , 450 N.W.2d 359 (Minn. Ct. App. 1990); *Hovland v. State Farm Ins. Cos.*, 593 N.W.2d 271 (Minn. Ct. App. 1999). It is good practice to seek the advice of a physician or other medically qualified professional before denying a claim for medical benefits on the basis that they are not reasonable or necessary. You must give the claimant reasonable notice of the time and place of the examination illustrated in Appendix D.

1. When.

An independent medical examination can be scheduled at any time so long as it meets the "reasonableness" requirement of the statute. The timing of the independent medical examination will vary depending upon the nature of the injury and the nature and extent of the treatment being provided.

2. Where.

The examination should be conducted "within the city, town or statutory city of residence of the injured person" if there is a qualified physician in that area. If a qualified physician is not available in that particular location, the insurer may request that the claimant attend an examination at another place in "closest proximity" to the claimant's residence. *Ortega v. Farmers' Ins. Group*, 474 N.W.2d 7 (Minn. Ct. App. 1991).

3. Choosing the Physician.

The statute permits the insurer to choose the examiner. *Ortega v. Farmers Ins. Group*, 474 N.W.2d 7 (Minn. Ct. App. 1991). The examiner should be one chosen appropriately for the nature of the claimant's injuries. An insurer need not retain a chiropractic independent examiner for the purpose of evaluating chiropractic treatment. A medical doctor (for example, an orthopedist) is qualified to render an opinion as to the necessity of chiropractic treatment. *Wolf v. State Farm Ins. Co.*, 450 N.W.2d 359 (Minn. Ct. App. 1990).

It is absolutely imperative that the insurer select a physician with a reputation for honesty and thoroughness. The great majority of no-fault claims will end up in arbitration where they will be decided by a local attorney. Oftentimes, arbitrations are won and lost on the credibility of the physicians' opinions.

4. Number of Exams.

Claimants may refuse to attend more than one examination. The only statutory requirement is that the examination requested be "reasonable." If you believe multiple examinations may be necessary, there must be some reasonable factual basis. The statute does refer to examination(s) in the plural sense. Some cases may require examination by more than one medical specialist due to the diverse nature of the injuries.

H. Rejection of the Claim and Preparation of the Denial Letter.

1. The claimant must receive **prompt written notice** of the rejection of the claim. Minn. Stat. §65B.54, subd. 4.

2. Advice regarding arbitration.

Minn. Stat. §65B.525 requires that the insurer who denies a claim **which is subject to mandatory arbitration** must so advise the claimant. The insurer must advise the claimant that the information on arbitration

procedures may be obtained from the American Arbitration Association and give the address of AAA. *See* Appendix E.

If the insurer denies a claim which is **not subject to mandatory arbitration**, the insurer must advise the claimant whether the insurer would be willing to submit to a voluntary arbitration as well as advising that the claimant may contact the American Arbitration Association as above.

Effective March 1, 2016, in all cases, the insurance company must also advise the claimant that information on arbitration procedures may be obtained from the arbitration association, and must also provide the arbitration associate's current address and e-mail address. The address for the American Arbitration Association (AAA) is 200 South 6th Street, Suite 700, Minneapolis, MN 55402. The general e-mail address for AAA is MinnesotaNoFaultArbInfo@adr.org. This must be included in all letters to the claimant or his/her attorneys denying additional no-fault benefits. See Minn. NF. Arb. R. 5c. It is important to remember that a failure by insurer to respond within 30 days is deemed to be a denial sufficient to trigger the No-Fault Arbitration Rules.

3. Notice Regarding Minnesota Assigned Claims Bureau.

If a claim is rejected for reason that the claimant is not entitled to no-fault benefits under the insurer's policy, the insurer must advise the claimant that (s)he may file a claim with the Minnesota Automobile Assigned Claims Bureau and must provide the claimant with the name and address of the Bureau. Minn. Stat. §65B.54. Currently, the address of the Minnesota Assigned Claims Bureau is 227 Central Ave., Suite 103, Osseo, Minnesota 55369; phone number (763) 425-6634.

4. Form of Denial Letter.

The denial letter should be specific but should also preserve other defenses that the insurer may have. The denial letter should include the following:

a. Reason for Denial. (Findings by the independent medical examiner that treatment is not reasonable or necessary, lapse in treatment and disability, failure to cooperate, etc.)

b. General Statement Preserving Other Defenses that the Insurer May Have or Which Might Arise.

c. The Type of Benefit and/or Treatment Denied (Chiropractic expenses, all medical benefits, income loss, etc.)

d. The Date of Termination.

e. The Insurance Company's Position on Arbitration and Arbitration Advice including specific information about AAA. (See 2 above.)

Attached as Appendix E is a sample denial letter.

III. ARBITRATION OF NO-FAULT CLAIMS.

A. Jurisdiction.

Arbitration is mandatory for all no-fault claims "where the total amount of the claim, at the commencement of arbitration, is in an amount of $10,000 or less." The Minnesota No-Fault Act provides that all such claims will be arbitrated through the American Arbitration Association (AAA). The amount in controversy is to be determined as of the date the claimant files a Petition for Arbitration or otherwise demands litigation of the no-fault claim.

The no-fault arbitration rules state that the "total amount of the claim" must be $10,000 or less on the date of filing to be subject to mandatory arbitration. "Total amount of the claim" includes all claims of any nature (medical, income, etc.) incurred that are outstanding whether or not they have been denied by the insurer. Efforts to improperly secure mandatory arbitration of claims in excess of $10,000 by splitting the claim into separate arbitrations for smaller sums have been rejected by Minnesota courts. When a Petition for Arbitration is received or a demand for arbitration of a no-fault claim is made, the claims representative must immediately determine whether or not the total claim is in excess of $10,000.

If the total claim is in excess of $10,000, the insurer may voluntarily agree to arbitration or require that the claim be put in suit. The insurer should be sure to preserve its right to put the matter in suit when it sends the denial letter.

1. Coverage Disputes.

Coverage questions are not subject to mandatory arbitration. The Minnesota Supreme Court has held that questions involving interpretation of the Minnesota No-Fault Act should be tried in the District Court. It is usually advisable to institute a declaratory judgment action. However, there may be some special cases in which the insurer might want to agree to have the coverage question arbitrated. Counsel should be consulted in making that decision. Beware of an invitation to arbitrate that is worded so broadly as to include any coverage issues.

B. AAA Arbitration.

1. Claimant's Petition.

The arbitration is commenced upon the claimant's filing of a signed Petition and payment of a filing fee. Within 30 days of the date of filing, the claimant must file an itemization of benefits claimed and supporting documentation. Medical and replacement services claims must detail the name of providers, dates of services claimed, and total amounts owing. Income loss claims must detail employers, rates of pay, dates of loss, method of calculation, and total amounts owing. The insurer is charged a respondent's filing fee after it is notified of arbitration.

2. Insurer's Response.

Counsel should be secured immediately upon receipt of a Petition for Arbitration. The arbitration procedure moves extremely quickly. Insurers are required to file a response to the Petition within 30 days setting forth the grounds for the denial. Selection of the arbitrator and dates for arbitrations will be made shortly after the Petition is filed. The insurer should contact AAA by telephone or in writing to inform them of the identity of counsel on behalf of the insurer.

a. Insurer's Petition? Can the insurer file a Petition to: 1) eliminate or reduce the statutory interest claim; or 2) collect fees and/or costs resulting from a claimant's unreasonable failure to attend an IME? To date, AAA and the Minnesota No-Fault Standing Committee have <u>not</u> allowed insurers to commence arbitration solely to cut off future obligations. Additionally, the Minnesota No-Fault Standing Committee will not allow insurers to commence arbitration solely to recover expenses incurred (such as costs for failure to attend an IME). However, if the no-fault insurer has any claim for recovery of benefits paid, AAA will allow filings by the insurer.

3. Selection of the Arbitrator.

The hearing will be conducted before a single arbitrator. The arbitrator is not actually selected by the parties. Rather, the arbitrator is arrived at through a process of elimination. AAA randomly selects four names of attorneys on its panel of arbitrators and submits them to the parties. Each party is permitted to strike one arbitrator that it feels is unacceptable. Generally, claimants will strike attorneys who do defense work, and insurers will strike attorneys who do solely plaintiff's work. Parties then list the remaining names in order of their preference and the AAA then appoints the arbitrator.

The appointed arbitrator can only be removed on the basis of some sort of direct conflict. In that case, AAA appoints another arbitrator from the panel.

Often, the selection of the arbitrator can decide the arbitration. The choice of arbitrator may influence whether the claim is arbitrated or compromised before arbitration.

4. Place of Arbitration.

No-Fault Arbitration Rule 14 requires that the arbitration hearing be held "in the arbitrator's office or some other appropriate place in the general locale within a 50 mile radius of the claimant's residence, or other place agreed upon by the parties". The claimant can always select their city of residence as the hearing location. However, some claimants have attempted to forum shop for a favorable arbitrator by requesting a hearing locale other than their residence (e.g., the claimant resides in Minneapolis, but chooses an outer lying city as the hearing locale because the only attorneys who work in that area do plaintiff's work). The insurer should evaluate the claimant's location choice carefully to determine whether an attempt has been made to skew the arbitrator strike list. In making this evaluation, the insurer must be aware that when the claimant chooses a hearing location other than their residence, it may be for the convenience of their attorney, and may be a location where the available arbitrator pool includes more defense attorneys.

5. Date of Arbitration.

AAA attempts to schedule the arbitrations within four months of the claimant's filing of the Petition for Arbitration. There is a $100.00 fee assessed for postponement.

If the parties are able to settle the no-fault petition, then they must notify AAA of this settlement. Settlement (or withdrawal of a claim) at any time up to 24 hours prior to the scheduled hearing but after the appointment of the arbitrator will result in an Arbitrator fee totaling $50.00. If the settlement or withdrawal of the claim, **or if the case is postponed**, within 24 hours of the scheduled hearing, then the Arbitrator fee shall be $300.00. Generally, these fees are split equally among the parties unless agreed upon otherwise or ordered by the arbitrator.

6. Discovery.

The arbitration rules provide for voluntary exchange of information, and formal discovery is discouraged except that a party is entitled to: 1) exchange of medical reports; 2) medical authorizations directed to all medical providers consulted by the claimant in the 7 years prior to the

accident; 3) employment records and authorizations for 2 years prior to the accident; and 4) other exhibits to be offered at the hearing.

7. The Arbitration Hearing.

The arbitration hearing generally lasts two to four hours depending upon the complexity of the claim, number of witnesses, and volume of the records. Neither party is required to have live witnesses. The medical testimony is customarily introduced by way of medical records and reports. The arbitration procedure is intended to be economical. Generally, the claimant will appear as the sole witness. However, issues of wage loss, or replacement services may require calling in other witnesses to substantiate or rebut the claim.

8. The Arbitration Award.

The arbitrator will issue his or her award within 30 days after the close of the hearing. Failure to do so may result in a loss of jurisdiction by the arbitrator.

IV. SETTLEMENT AND COMPROMISE -- CAN THE CLAIM BE SETTLED?

A. General Considerations.

There are two main concerns. The first is whether there is a bona fide dispute regarding entitlement to no-fault benefits and the second has to do with the style, terminology, and effect of the release.

1. Is There a Dispute to be Settled?

There is no such thing as an absolute right to no-fault benefits. Each particular claim depends upon factual determinations and, occasionally, legal interpretations. In other words, no-fault claims are little different than any other claim as far as providing opportunities for settlement.

2. Are No-Fault Settlements Valid?

The public policy of the state of Minnesota, as enunciated by the Supreme Court, is clearly to encourage settlement. So long as there is a bona fide dispute, the best interests of both insurer and insured are often served by a settlement. In Minnesota, there is a rather broad range of views on whether no-fault settlements should be encouraged or avoided as improper altogether. We have in fact entered into no-fault releases with most of the more aggressive and most experienced plaintiffs' firms. It may well be that their greater familiarity and experience with no-fault claims allows them to be comfortable with the fact of settlement. So long as the competing claims

of insurer and insured are balanced in determining the consideration for the release, settlement should certainly be workable.

CAUTION: The release language must be appropriate to the case. The more significant the exposure, the more care that should be taken. Perhaps the key ingredient in ensuring that a settlement will survive attack at a later date is to incorporate recitals as part of the agreement. The purpose of the recitals is to make it clear to any reader that there existed, at the time of the settlement, the basis for bona fide compromise.

3. Types of No-Fault Settlements.

a. Lump Sum Single Payment.

With these materials is a form release, Appendix F, the purpose of which is to accomplish a lump sum single payment settlement of all past, present, or future no-fault claims. This is appropriate to the relatively small no-fault claim settled for a single payment. More substantial no-fault claims require that the operative language of this release be used only after the appropriate recitations are made.

b. Settlement Variants.

With care, virtually any aspect of a no-fault claim can be treated to a settlement which is in the best interest of both insurer and insured. The variations are endless and would include settlement of past disputed benefits for a lump sum leaving the future open, settling wage loss and leaving open only medical care, settling chiropractic medical care claims, leaving open other, non-chiropractic medical care, etc.

V. REALLOCATING THE LOSS: WHEN THE NO-FAULT INSURER RECOVERS ITS PAYMENTS.

When, if ever, can the no-fault insurer pass along responsibility for no-fault payments? If the benefits have already been paid, when can it recover those payments? Because the no-fault statute requires prompt payment of no-fault benefits, the no-fault insurer sometimes finds itself in the position where it has paid benefits to an insured that would have been rightfully paid by another insurer or party. The No-Fault Act provides two remedies to the insurer in this predicament: indemnity and subrogation.

A. Indemnity.

The No-Fault Act provides indemnity for payments of no-fault benefits where a "commercial vehicle," i.e., a vehicle weighing in excess of 5,500 pounds curb weight, is at least 50% at fault for the accident. This right of indemnity under Minn.

Stat. §65B.53, subd. 1, must be brought against the insurer of the commercial vehicle. The claim is brought in intercompany arbitration and is governed by intercompany arbitration rules.

The purpose of the indemnity statute is to properly allocate the risk and accompanying costs associated with the use of commercial vehicles. The indemnity provision merely shifts the expense of operating commercial vehicles from the private passenger no-fault insurer to the insurer of the heavy vehicle. The claim of the insured remains intact and is not affected by the indemnity claim.

1. How and When to Bring the Claim.

An indemnity claim must be brought within six years of the date the first no-fault payment is made to the claimant. *Metropolitan Prop. & Cas. Ins. Co. v. Metropolitan Transit Comm'n*, 538 N.W. 2d 692 (Minn. 1995).

2. Proving Up your Indemnity Claim.

In proving up the indemnity claim, the no-fault insurer proceeds much like the plaintiff in the underlying tort case. The arbitrators have to make determinations of degree of fault and whether the no-fault benefits paid were reasonable, necessary, and related to the accident.

The right of indemnity *is subject* to the comparative fault provisions of Minn. Stat. §604.1. An injured claimant is prevented from recovering when he or she is more at fault than the tortfeasor. The same is true for a no-fault insurer seeking indemnity from a commercial vehicle for benefits it has paid. As long as the commercial vehicle is at least 50 % at fault, then the no-fault insurer with recoup the reasonable and necessary benefits it paid - equal to the percent of causal negligence attributable to the commercial vehicle. *Great West v. State Farm Ins. Co.*, 590 N.W.2d 675 (Minn. Ct. App. 1999). In reality, the "indemnity" claim is little more than a glorified name for "subrogation."

B. Subrogation.

The No-Fault Act provides an insurer a right of subrogation against the insured or the insured's recovery. Note this is *not* the same as a subrogation right *against a tortfeasor directly*. The purpose of the subrogation right is to prevent double recovery of the same items of economic loss. The no-fault insurer should consider the following issues when determining whether subrogation is available:

Identifying the cause of action pursued by the insured; determining whether the insured has received or will receive full compensation; and lastly, determining whether the insured's recovery includes an amount representing duplication of no-fault benefits.

1. Identifying the Cause of Action.

a. Automobile Negligence Claims: In-State Claims.

The statute provides the no-fault insurer with a right of subrogation only against recoveries in certain causes of action. Since Minn. Stat. §65B.51, subd. 1 provides for a set-off of no-fault benefits in the tort action, the no-fault insurer is precluded from any right of subrogation if the cause of action is based on negligence in the maintenance or use of a motor vehicle occurring in the state of Minnesota.

b. Negligence Claims in Another State.

In contrast to Minnesota, some other states allow the injured plaintiff to collect for all losses regardless of whether benefits have been paid by a no-fault insurer. Therefore, if the no-fault insurer has paid benefits for an out-of-state accident, and the insured has been fully compensated, subrogation against the insured's recovery in that other state is completely proper. But in Minnesota, an out of state insurer who is not licensed to issue motor-vehicle insurance in Minnesota is not required to include no-fault benefits. *Founders Ins. Co. v. Yates*, 876 N.W.2d 344 (Minn. Ct. App. 2016), rev. granted May 17, 2016.

It is questionable whether subrogation is appropriate if the accident includes only Minnesota insureds and insurers in an out-of-state accident. If the tortfeasor's insurer is a Minnesota insurer, the purpose of subrogation is not really served.

c. Other Causes of Action.

Minn. Stat. §65B.53, subd. 3 allows subrogation for a no-fault insurer in order to shift the loss to the appropriate party outside the automobile insurance industry, for example, to homeowners' insurers, products manufacturers, etc. This avoids the unfair practice of having the motoring public subsidize other industries.

(1) Dram Shop Claims.

Prior to July 1, 1985, no-fault insurers paying benefits for automobile accidents caused by an illegal sale of intoxicating liquor by a dram shop *were* allowed to subrogate against the dram shop. However, the dram shop law changed on July 1, 1985. For causes of action accruing

on or after that date, the no-fault insurer can no longer subrogate against recoveries from dram shops.

(2) Claims Against Uninsured Tortfeasors.

The no-fault insurer making payments pursuant to the Assigned Claims Bureau is provided with a right of indemnification against an uninsured tortfeasor pursuant to legislation passed August 1, 1989. Minn. Stat. §65B.64, subd. 2. The legislature's purpose was to avoid rewarding uninsured tortfeasors for their irresponsibility. There is no specific provision in the Act which addresses other no-fault obligor's right to subrogate against an uninsured motorist for benefits paid as a result of that uninsured motorist's negligence.

2. Intervention, the Action of Asserting Subrogation Rights.

The no-fault insurer may intervene in the insured's tort action. If the no-fault insurer did not intervene, there is no assurance that the parties to the tort action would resist an application of the offset provision of §65B.51. If the plaintiff's recovery is offset, the no-fault insurer's subrogation right is destroyed. Since the plaintiff has not made a double recovery in that situation, there is no right of subrogation. Thus, the no-fault insurer may have to intervene in order to protect is rights of subrogation.

Likewise, a no-fault insurer is allowed to intervene in the injured party's workers' compensation claim where a determination has been made that the injuries, for which no-fault benefits were paid, are covered under the Workers' Compensation Act. However, if the injured party does not pursue the workers' compensation claim, the no-fault insurer does not have the right to bring a separate claim directly against the workers' compensation insurer. The courts have indicated that the no-fault insurer would lack standing in not only the district court, but also the workers' compensation courts for such a reimbursement claim.

3. How to Settle Subrogation Claims.

The amount of the subrogation interest is identical to the amount of duplicative benefits or reimbursement of the same loss received by the insured. This amount is easily determined after a jury verdict if the litigants have submitted a detailed special verdict form. In the absence of a jury verdict, the subrogated insurer bears the burden of proving the amount of double recovery. The subrogated insurer will not receive any reimbursement until and unless the insured is first made whole.

Generally speaking, it is difficult to recover a subrogation interest where the plaintiff settles with the tortfeasor. If the settlement is discounted to reflect the fact plaintiff has already been paid no-fault, then there is no double recovery, and there is arguably no purpose for subrogation. It is, however, improper for the plaintiff and tortfeasor to conspire for purposes of avoiding a legitimate subrogation claim. Therefore, a settlement that does include damages duplicative of no-fault benefits would be improper. The no-fault insurer should put both plaintiff and tortfeasor's insurer on notice of the subrogation claim early so that the no-fault insurer may participate in settlement negotiations.

VI. WHAT COVERAGE MUST THE OUT-OF-STATE INSURER PROVIDE?

An out-of-state policy may provide all Minnesota coverages, it may provide none of them. Where a particular policy will fall along this spectrum depends primarily upon two factors: (1) whether the out-of-state insurer filed a certification form with Minnesota; and (2) whether the insurer is licensed to do business in Minnesota. Note that there is an important difference in terms of required coverage for residents and non-residents. Therefore, even if the out-of-state policy is rewritten, a non-resident's policy is altered only insofar as (a) the BI limits are written up to Minnesota's 30/60/10 limit and (b) PIP is imposed on the policy. **Non-residents are not required to have UM or UIM coverage.** Therefore even if your company's out-of-state policy is rewritten when your insured travels to Minnesota, your policy will not have UM or UIM coverage imposed upon it.

A. Did the Out-of-State Insurer File a Certification Form with Minnesota?

1. If so, then the policy's BI limits are raised to 30/60/10 and no-fault coverage (with minimum limits) is imposed on the policy. See "Certification Form", Appendix G. To determine if your company has filed a certification form, contact Bob Boyce of the Policy Analysis division of the Minnesota Department of Commerce at (651) 296-0139.

a. Note that *non-residents* are only required to have BI and no-fault coverage; *neither uninsured nor underinsured coverage is imposed on non-resident's policies*. Minn. Stat. §65B.48, subd. 1; Minn. Stat. §65B.49, subd. 3a(2).

b. Note that if the policy as written has some type of med pay or no-fault coverage, then Minnesota coverage is imposed to the extent necessary to *supplement* the med pay. For example, if the policy as written has $2,000 of med pay, then no-fault *medical expense* benefits are imposed in the sum of $18,000. The total paid will equal the Minnesota minimum coverage limit.

B. Is the Insurer Licensed to do Business in Minnesota?

1. If the out-of-state insurer did not file a certification, was the out-of-state insurer *licensed to do business* in Minnesota? To determine if your company is licensed in Minnesota, contact Sue Porter of the Department of Commerce, Insurance Department, Licensing Division, at (651) 296-6907.

a. Insurers *licensed to do business* in Minnesota must "conform" their policies *when the insured vehicle is in the state of Minnesota*. Minn. Stat. §65B.50.

(1) Note that the insured vehicle must be physically present in the state to trigger this rule but the vehicle does not have to be involved in the accident. The presence of the vehicle within the state of Minnesota determines whether there is an adequate basis to *apply the statute* to the licensed insurer.

(2) Note that *non-residents* are only required to have BI and no-fault coverage; *neither uninsured nor underinsured coverage is imposed on non-resident's policies*.

b. If the insurer is *not* licensed to do business in Minnesota, then the policy will not likely be rewritten; the coverage types and amounts will not be changed *unless*:

(1) The insurance policy contains language by which the insurer *agrees to conform its coverage* to include the types and amounts required in the state (Minnesota) where the vehicle is operated. This may be either a "conformity" clause or be labeled "out-of-state coverage." While most policies contain some provision contemplating the operation of the vehicle in states other than the one in which the policy was issued not all clauses are identical.

(a) Some apply only if the policy is "certified as proof of financial responsibility." That does not likely apply to Minnesota accidents and will not likely rewrite the policy.

(b) Other policies may use language in their "out-of-state coverage" clause which is broader and more generous with the result that companies voluntarily agree to provide "at least the required minimum amounts and types of coverages." This language will likely cause the policy to be revised so that the *liability coverage* is at least 30/60/10 *and*

no-fault coverage is imposed. Again, neither UM nor UIM coverage is required for a non-resident.

(c) Yet other "out-of-state coverage" clauses provide for modifying the coverage *but only if doing so does not increase the policy limits*.

(d) The current state of the law in Minnesota is that if an insurer is not licensed to write motor-vehicle insurance in Minnesota, then the statute that requires every motor vehicle insurance contract "wherever issued" to include no-fault benefits does not apply to that insurer. *Founders Ins. Co. v. Yates*, 876 N.W.2d 344 (Minn. Ct. App. 2016), rev. granted May 17, 2016. The Supreme Court has granted review of this appellate decision and will likely issue a final opinion on this issue by the summer of 2017.

(2) There is a very slight chance that the Minnesota courts would try to rewrite every out-of-state policy no matter whether the insurer is licensed to do business under Minn. Stat. §65B.50, subd. 2. Doing so would probably violate the United States and Minnesota Constitutions. As a result, cases involving out-of-state insurance policies will be rewritten only as provided in this summary.

C. An "Out-of-State" Summary.

If the out-of-state insurer did *not* file a certification form, is <u>not</u> licensed to do business in Minnesota, and *does not voluntarily agree to conform its policy provisions* to comply with Minnesota law, then the policy will likely provide only the types and amounts of coverage that were set forth in the policy when it was written.

VII. CONCLUSION.

Over the years, our *Checklist for Handling No-Fault Claims* has grown as different issues and strategies take center stage. The basic format remains unchanged. The issues of the day arise in the context of the processing of Minnesota no-fault claims and, when taken in context, can be understood, used or dealt with effectively. This is not an exhaustive summary. Please feel free to call our firm's specialists who deal with these issues on a daily basis.

APPENDIX A

[Date]

[Claimant]
[Claimant's Address]

Re: Policy:
Date of Accident:
Claim:

Dear [Claimant]:

Enclosed is an Application for Benefits form. Please complete the Application and execute the attached authorizations and return them promptly so that your claim may be processed without delay.

Please be advised that in accordance with Minn. Stat. §65B.55, subd. 2, your insurance policy provides that eligibility for no-fault benefits will terminate upon a one-year lapse in disability and medical treatment.

Your cooperation is appreciated.

Sincerely,

Claims Representative

APPENDIX B

_____ NO FAULT _____ MED. PAY _____ NO. VEHICLES

Name Claim No. Date of Loss

Medical Payments:

Date	Draft No.	Payee	Amount	Total Paid	Current Res.

Economic

Loss Payments: Hourly Wage: Weekly Wage:

Date	Draft No.	W.	R.	Disability Dates	Amount	Total Paid	Current Res.

APPENDIX C

WAGE AND SALARY VERIFICATION

Date	Claim Number	Date of Accident

Employee's Name and Address

_____

_____

_____

Social Security No. _____

INSURANCE COMPANY CLAIM OFFICE:

_____

_____

_____

Phone Number _____

Sir or Madam:

The above named person has applied for benefits following injuries received in an automobile accident on the date indicated. We understand this individual is or was your employee. To determine wage benefits due, we ask that this form be completed and returned to us in the attached postage paid envelope. A signed authorization for the release of this information is enclosed.

Thank you for your cooperation,

_____

Claim Representative

1. Dates of Employment: From _____ thru _____.	2. Dates Absent Following Accident: From _____ thru _____.
3. Was Employee Paid During this Absence? Yes ☐ No ☐ If yes, Amount $_____	4. Is Employee Entitled to Benefits Under a Wage or Salary Continuation Plan? Yes ☐ No ☐
5. Name of Your Workers' Compensation Insurer: _____	6. Has or Will a Claim Be Filed Under Any Workers' Compensation Law for This Accident? Yes ☐ No ☐

SCHEDULE OF WEEKLY EARNINGS--FOR 13 WEEKS PRIOR TO DATE OF ACCIDENT

Weeks No.	Dates From	Dates To	Number of Days Worked	Wage Paid Per Hour	Number of Hours Worked	Gratuities Tips, etc.	Gross Earnings
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							

SIGNATURE_____TITLE_____PHONE NO._____DATE_____

(Person Completing Form)

APPENDIX D

[Date]

[Claimant]
[Claimant's Address] BY CERTIFIED MAIL

Re: Independent Medical Examination
Policy:
Date of Accident:
Claim Number:

Dear [Claimant]:

Pursuant to the terms and conditions of the no-fault coverage under your insurance policy, we have scheduled an independent medical examination for you with Dr. [Name] to take place at [time] in the doctor's offices, which are located at [street address]. This examination has been scheduled for purposes of determining the compensability of your claims under the no-fault coverage of your insurance policy. Significant costs may be incurred for a missed appointment or a late cancellation. It is imperative that you make every effort to attend this examination.

In scheduling this examination, we do not waive our rights to schedule further medical examinations as may be required. We specifically preserve our rights pursuant to the terms and conditions of the uninsured and/or underinsured motorist coverage to schedule such further medical examinations as may be required in the event that you have made or will make an uninsured or underinsured motorist benefits claim under this policy.

If you have any questions or concerns relative to the independent medical examination, please contact the undersigned. Thank you for your anticipated cooperation.

Sincerely,

Claims Representative

[cc: Claimant's attorney, if applicable
Defense counsel, if applicable]

APPENDIX E

[Date]

[Claimant]
[Claimant's Address] BY CERTIFIED MAIL

Re: Policy:
Date of Accident:
Claim:

Dear [Claimant]:

Based upon [the IME doctor's findings, one year lapse, etc.], we must deny all further claims for [medical and/or chiropractic expenses, income loss, etc.]. [May add a sentence or two further specifying the findings, policy provisions, or other reasons for denial.] We will make no further payments for [medical expenses, income losses, etc.] incurred after the date of this letter.

Although benefits are being denied for the above-stated reason(s), we do not waive our right to deny payment upon other grounds that may exist or which may arise with respect to this claim.

(Alternate A: Claims $10,000 or less.)

If you do not agree with our decision, you have the right to request arbitration of this matter. Information on arbitration procedures may be obtained through the American Arbitration Association, 200 South Sixth Street, Suite 700, Minneapolis, MN 55402. However, please be informed that we do not agree to arbitrate no-fault claims in excess of $10,000.

(Alternate B: Claims in excess of $10,000, no agreement to arbitrate.)

Since your claim is in excess of $10,000, it is not subject to mandatory arbitration. Please be informed that we do not agree to arbitrate this matter.

(Alternate C: Claims in excess of $10,000 -- agreement to arbitrate.)

Although your claim exceeds $10,000 and is not subject to mandatory arbitration, we will agree to arbitrate this matter upon condition that the Minnesota Rules of Evidence will apply, discovery will be permitted pursuant to the Minnesota Rules of Civil Procedure, and a neutral arbitrator will be selected by Mutual Agreement. Please advise in writing whether you will agree to arbitrate on those terms.

Information on arbitration procedures may be obtained from the American Arbitration Association (AAA) located at 200 South 6th Street, Suite 700, Minneapolis, MN 55402, or by e-mail at MinnesotaNoFaultArbInfo@adr.org.

Sincerely,
Claims Representative

APPENDIX F

MINNESOTA NO FAULT CLAIMS: COMPLETE RELEASE AND SETTLEMENT AGREEMENT

RECITALS

1. On or about _____, at or near _____
(Date loss) (Location)

in _____, _____,
(City, County, State) (Claimant)

("Releasing Party") was involved in an incident ("the accident") as a result of which it is claimed that Releasing Party has sustained injury.

2. Releasing Party claims that the accident and injuries arose out of the maintenance and use of a motor vehicle.

3. At the time of the accident there was in effect a policy or policies of automobile insurance issued by _____("Insurer") which included
(Insurer)

Minnesota No-Fault (personal injury protection - "PIP") coverage.

4. Insurer disputes Releasing Party's entitlement to No-Fault benefits.

5. It is the desire of the parties to this Complete Release and Settlement Agreement, in exchange for a payment by insurer, to settle all of the claims of Releasing Party against Insurer for No-Fault benefits, now or in the future, **including all claims for past, present, future, known or unknown injuries and damages.**

RELEASE:

NOW, THEREFORE, FOR THE SOLE CONSIDERATION of _____
(Amount of Settlement)

_____ ($_____) Dollars, receipt of which is hereby acknowledged, the Releasing Party does hereby fully and forever release and discharge Insurer of and from any

and all claims and causes of actions which Releasing Party may have for No-Fault benefits, **now or in the future**, arising out of the accident and resulting in injury to Releasing Party.

IT IS FURTHER UNDERSTOOD AND AGREED

1. That the Releasing Party is of legal age and acknowledges receipt of the consideration set forth above.

2. That this Complete Release and Settlement Agreement is intended to bind not only the Releasing Party but also his/her heirs, successors, executors, administrators and assigns on the one hand and to release not only Insurer but also its agents, servants and employees.

3. That this is a full, final and complete release of all claims for Minnesota No-Fault benefits **past, present or future**, which the Releasing Party has, had or may have against Insurer under any and all policies of insurance covering any and all motor vehicles and, having received the consideration set forth above, the Releasing Party acknowledges that he/she will receive **no further sums as and for No-Fault benefits** and that **Insurer will have no further obligation to pay any amount as No-Fault benefits to or on behalf of the Releasing Party.**

4. That the term "No-Fault benefits" as used in this Release refers to any obligation of Insurer to pay either to or on behalf of the Releasing Party, whether designated No-Fault benefits, personal injury protection benefits, or by any other term, and whether those benefits or obligations are set forth in the policy or policies of insurance applicable or alleged to be applicable to this claim or contained in the Minnesota No-Fault Automobile Insurance Act.

5. That this settlement is the compromise of doubtful and disputed claims of entitlement between the Releasing Party and Insurer and is entered into merely to avoid litigation and to buy peace between the parties and that the payment made as consideration for this Release is not to be construed as an admission of liability or coverage on the part of Insurer.

6. That the Releasing Party declares, acknowledges and represents that the injuries are or may be permanent and progressive and that recovery therefrom is uncertain and indefinite and that, in entering into this Release, it is understood and agreed that the Releasing Party relies wholly upon the judgment, belief and knowledge of the Releasing Party (and that of the Releasing Party's own physician or attorney, if any) of the nature, extent, effect and duration of said injuries and the obligations for No-Fault benefits arising therefrom and that this Release is entered into without relying upon any statement or representation on behalf of Insurer, its agents, employees, or any physician or surgeon employed by Insurer.

7. That nothing herein is intended to release or discharge any rights which the Insurer may have for subrogation or indemnity as may be provided in the applicable policy of insurance or pursuant to the Minnesota No-Fault Act. Minn. Stat. §65B.41 et. seq.

8. That the Releasing Party further declares and represents that no promise, inducement, or agreement not herein expressed has been made to the Releasing Party and that this Release contains the entire agreement between the parties hereto, and that the terms of this Release are contractual and not a mere recital.

THE RELEASING PARTY HAS READ THE FOREGOING COMPLETE RELEASE AND SETTLEMENT AGREEMENT AND, HAVING HAD OPPORTUNITY FOR ADVICE OF COUNSEL, FULLY UNDERSTANDS IT.

IN WITNESS WHEREOF, _____ executed this
(Claimant)

Complete Release and Settlement Agreement this _____ day of _____, _____.
(Day) (Month) (Year)

_____
(Claimant)

STATE OF MINNESOTA)
)ss.
COUNTY OF _____)

On the _____ day of _____, _____, before me personally appeared
(Day) (Month) (Year)

_____ to me known to be the person named herein
(Claimant)

and who executed the foregoing Complete Release and Settlement Agreement and further acknowledged to me that the same was voluntarily executed.

_____
Notary Public

APPENDIX G

Sample No-Fault Certification Form of the sort initially used by the State of Minnesota:

MINNESOTA NO-FAULT CERTIFICATION FORM

The _____ (company) of _____ (address) hereby certifies that any automobile liability policy issued by said company with respect to a motor vehicle as to which the owner is required to maintain security under Minnesota No-Fault Automobile Insurance Act, Senate Bill #96, Chapter 408, of the Laws of 1974, shall be deemed to provide the security required by such Act, provided that, if such policy also provides direct benefits without regard to fault pursuant to the law of any other state or territory, (1) the benefits for economic loss provided for and in accordance with this certification, shall not apply to any element of economic loss paid, payable or required to be provided under such law of any other state or territory, and (2) the total amount of benefits which would be payable in accordance with this certification shall be reduced by the amount paid, payable or required to be provided for the same elements of economic loss under the provisions of the law of such other state or territory.

_____ _____

(Name) (Title of Officer)

_____ _____

(Date) (Signature)