



# CLAIM DENIAL REVERSAL ACTION KIT

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*AppealSystem · BadFaithLaw ·  
50-State Commissioner Portals*

## Legal Disclaimer & How To Use This Kit

This kit is produced by JusticeFinder.net for educational purposes only. Nothing in this document constitutes legal advice, creates an attorney-client relationship, or replaces consultation with a licensed attorney in your state. Insurance laws, bad faith statutes, and appeal deadlines vary significantly by state and change over time. All information reflects publicly available government and NAIC sources cited inline. This kit covers auto and personal injury claim denials — not health insurance (ERISA) or workers' compensation denials, which have separate federal frameworks. JusticeFinder.net is not a law firm.

### THE SINGLE MOST CRITICAL RULE

Every denial letter has a response deadline — and that deadline may **NOT** be stated in the letter. Find it immediately. Your internal appeal deadline is typically 30–180 days from the denial date. Your statute of limitations on the underlying claim runs **INDEPENDENTLY** — it does **NOT** pause while you appeal. **Complete Section 9 (Deadline Tracker) NOW before anything else.**

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## Executive Intelligence Brief

### What a Denial Letter Actually Is — And What It Is Not

An insured denial letter is a formal written communication declining to pay your claim under a specified legal or factual basis. What it is **NOT** is a final verdict. It is the opening move in an adversarial process — not the end of one.

Insurance companies know that the majority of denied claimants accept the denial and move on. The claims professionals who drafted your denial letter know that an appeal is always possible. They count on most victims not filing one.

The NAIC Unfair Claims Settlement Practices Model Act (MDL-900) establishes the legal standard for how insurance companies must handle claims. When an insurer denies a claim in violation of these standards — and the claimant documents it and responds — the insurer's position weakens significantly. A well-prepared appeal backed by complete evidence and a legal challenge to the denial basis reverses a substantial percentage of initially denied claims. [Source: NAIC MDL-900, [naic.org/store/free/MDL-900.pdf](http://naic.org/store/free/MDL-900.pdf)]

### The 3 Types of Claim Denials

| Type                    | What the Letter Says                                                   | Weakest Point                                                                     | Evidence That Reverses It                                                        |
|-------------------------|------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------------------------------|
| Type 1 Coverage Denial  | Policy exclusion cited: 'Your policy does not cover this type of loss' | Contra proferentem: ambiguous exclusions are interpreted AGAINST the insurer      | Full policy text showing exclusion is ambiguous or does not clearly apply        |
| Type 2 Liability Denial | 'Our insured was not at fault for this accident'                       | Investigation was one-sided. NAIC MDL-900 §4(d) requires objective investigation. | Police report, witness statements, photographs, accident reconstruction evidence |
| Type 3 Damages Denial   | 'The claimed damages exceed what is reasonable and necessary'          | Insurer's desk reviewer cannot override treating physician's clinical judgment    | Treating physician medical necessity letter, itemized provider documentation     |

[Source: NAIC MDL-900 §4, [naic.org](http://naic.org); FTC Consumer Guidance, [consumer.ftc.gov](http://consumer.ftc.gov)]

### Your Legal Rights Upon Receiving a Denial

- **Right to written explanation:** The insurer must state the specific policy provision relied upon. [Source: NAIC MDL-900 §4(n)]
- **Right to your complete claim file:** In most states you may request all documents in your claim file including internal communications. [Source: state insurance codes]
- **Right to appeal:** Every denied claim may be formally appealed. The deadline should be in the denial letter or your policy. [Source: NAIC Consumer Complaint Guide, [naic.org](http://naic.org)]
- **Right to file a commissioner complaint:** Free, creates a regulatory record, forces insurer to respond to government. [Source: [naic.org/consumer\\_complaint\\_help.htm](http://naic.org/consumer_complaint_help.htm)]
- **Right to pursue bad faith remedies:** If the insurer violated NAIC standards, additional damages may be available beyond the original claim. [Source: NAIC MDL-900; state bad faith statutes]

[Source: NAIC MDL-900, [naic.org](http://naic.org); state insurance codes — verify at your state legislature's .gov website]

## SECTION 1

## Parse Your Denial Letter

Why This Matters: The denial letter contains clues about the insurer's weakest arguments. Reading it like a claims professional means identifying what was NOT said — missing factual support, vague policy citations, and unsupported conclusions that become the foundation of your appeal.

## The 8 Most Common Denial Reasons — Decoded

|                                                                | What It Legally Means + Legal Vulnerability                                                                                                                                                                                        | Evidence That Reverses It                                                                                  |
|----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| 1. Fault not established ('our insured not at fault')          | Insurer conducted one-sided investigation relying on their insured's account Legal Vulnerability: NAIC MDL-900 §4(d): objective investigation required. Incomplete investigation = improper denial basis                           | Police report, witness statements, photos, expert analysis of fault                                        |
| 2. Causation dispute ('injuries not related to accident')      | Insurer's desk reviewer (never examined you) disputes your treating physician's findings Legal Vulnerability: Desk reviewer opinion < treating physician opinion. Eggshell plaintiff doctrine protects aggravated prior conditions | Treating physician causation letter; diagnostic records showing post-accident onset                        |
| 3. Policy exclusion ('excluded under Section X')               | A policy exclusion is cited, often without producing full exclusion text or acknowledging exceptions Legal Vulnerability: Contra proferentem doctrine — ambiguous exclusions interpreted AGAINST the drafter (insurer)             | Full policy text; identify ambiguity or exceptions within the exclusion section                            |
| 4. Pre-existing condition ('injuries pre-date accident')       | Insurer claims entire injury was pre-existing, eliminating all compensation Legal Vulnerability: Aggravation doctrine — defendant liable for worsening a pre-existing condition beyond prior state                                 | Treating physician letter distinguishing new injury from prior baseline; comparative imaging               |
| 5. Late notice ('timely notice not provided')                  | Insurer uses missed notice deadline as absolute bar to coverage Legal Vulnerability: Notice-prejudice rule (majority of states) — insurer must prove actual prejudice from delay                                                   | Document reason for delay + research your state's notice-prejudice rule at state legislature .gov          |
| 6. Failure to cooperate ('you failed to cooperate')            | Insurer claims refusal of recorded statement = non-cooperation Legal Vulnerability: Material prejudice required — courts distinguish between non-cooperation format and substantive non-cooperation                                | Document all cooperation offers in writing; offer alternative formats (written Q&A; attorney-attended IME) |
| 7. Damages not reasonable ('exceeds reasonable and necessary') | Insurer applies internal rate schedules below actual charges without clinical basis Legal Vulnerability: Treating physician's clinical judgment on necessity > insurer's desk review                                               | Medical necessity letter per treatment; itemized bills; comparable rate documentation                      |
| 8. Coverage period ('accident outside covered period')         | Coverage claimed to have lapsed or not applied to this vehicle/activity Legal Vulnerability: State cancellation notice laws — improper notice procedure = coverage preserved                                                       | Demand documented proof of cancellation notice procedure compliance per state law                          |

[Source: NAIC MDL-900 §4, naic.org; state insurance codes]

## INSIDER INSIGHT

The most powerful tool in reading a denial letter: look for what it does NOT say. A denial letter that does not cite a specific, complete policy provision is already vulnerable. A denial that does not describe what investigation was conducted is already challenged. A denial that does not explain exactly how each piece of your evidence was evaluated may violate NAIC MDL-900 §4(n).

## Denial Letter Analysis Worksheet

|                       |               |              |
|-----------------------|---------------|--------------|
| DATE OF DENIAL LETTER | DATE RECEIVED | CLAIM NUMBER |
|-----------------------|---------------|--------------|

|                                             |                        |                                 |                 |
|---------------------------------------------|------------------------|---------------------------------|-----------------|
| INSURER NAME                                |                        | ADJUSTER NAME & DIRECT CONTACT  |                 |
| EXACT DENIAL REASON (COPY FROM LETTER)      |                        |                                 |                 |
| POLICY SECTION CITED                        |                        | FACTUAL BASIS STATED BY INSURER |                 |
| APPEAL DEADLINE                             | APPEAL CONTACT ADDRESS |                                 | METHOD REQUIRED |
| DENIAL TYPE: COVERAGE / LIABILITY / DAMAGES |                        | MISSING EVIDENCE IDENTIFIED     |                 |
| LEGAL VULNERABILITY IDENTIFIED              |                        | TEMPLATE TO USE (1/2/3/4)       |                 |

## SECTION 2

## The 4-Stage Appeal Escalation System

From Denial to Resolution Without Giving Up

**Why This Matters:** Most claimants abandon the process after one failed internal appeal. Stages 2 through 4 create progressively greater pressure — and most claims that fail at Stage 1 succeed at Stage 2 or 3 without ever reaching litigation.

| Stage                           | What It Is                                                                             | What It Achieves                                                                                | Cost                          | When to Escalate                                                                         |
|---------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-------------------------------|------------------------------------------------------------------------------------------|
| Stage 1 Internal Appeal         | Formal challenge to insurer's own appeals unit                                         | Denial reversal or increased offer; documented basis for Stage 2                                | Free                          | No response in 30–45 days or offer remains unacceptable                                  |
| Stage 2 Commissioner Complaint  | Formal complaint filed with your state's insurance commissioner (government regulator) | Regulatory investigation; insurer must respond to government; often resolves without litigation | Free                          | Commissioner cannot compel payment; bad faith suspected; legal dispute remains           |
| Stage 3 Appraisal / Arbitration | Formal dispute resolution invoking appraisal clause or demanding arbitration           | Binding loss valuation; faster and cheaper than trial                                           | Modest — appraiser fees       | Insurer refuses; underlying legal issues cannot be resolved by value determination alone |
| Stage 4 Civil Litigation        | Filing suit for underlying claim value plus bad faith damages                          | Full claim + consequential damages + punitive damages (many states) + attorney's fees           | Contingency — no upfront cost | Stages 1–3 exhausted or documented bad faith warrants attorney investment                |

[Source: NAIC MDL-900 §4, [naic.org](http://naic.org); NAIC Consumer Complaint Process, [naic.org/consumer\\_complaint\\_help.htm](http://naic.org/consumer_complaint_help.htm)]

## INSIDER INSIGHT

The commissioner complaint is the most underused tool in the appeal arsenal. It is completely free, requires no attorney, creates a permanent regulatory record, and forces the insurer to formally justify their position to a government regulator. File Stage 2 IN PARALLEL with continued Stage 1 negotiation — not as a last resort after Stage 1 fully concludes. The simultaneous regulatory pressure changes the insurer's calculus immediately.

## SECTION 3

## The Internal Appeal Letter System

4 Complete Send Ready Templates Tracking System

**Why This Matters:** A well-structured appeal citing specific NAIC standards, presenting new evidence, and demanding a response within a defined deadline forces the insurer to either reverse or provide a more detailed legal basis — which becomes the foundation for commissioner complaint escalation.

### Template 1 — Fault / Liability Denial Appeal

[YOUR FULL NAME | Address | Phone | Email]

[DATE]

VIA CERTIFIED MAIL — RETURN RECEIPT REQUESTED AND EMAIL

[INSURANCE COMPANY] — Appeals / Claims Department

[Address]

RE: FORMAL APPEAL OF CLAIM DENIAL — FAULT/LIABILITY DISPUTE

Claimant: [YOUR NAME] | Claim No.: [NUMBER] | Date of Loss: [DATE]

Dear Claims Appeals Department,

I formally appeal the denial dated [DENIAL DATE] in which you stated: [EXACT DENIAL REASON].

#### I. THE DENIAL IS BASED ON INCOMPLETE INVESTIGATION

Under NAIC Unfair Claims Settlement Practices Act Section 4(d), you are required to conduct a prompt, fair, and objective investigation before denying a claim. Your denial does not demonstrate that a complete investigation was conducted. Specifically, your denial does not address: [IDENTIFY SPECIFIC GAPS — e.g., witness statement from [NAME] confirming your insured ran the red light / police citation issued to your insured for [VIOLATION]].

#### II. NEW EVIDENCE SUBMITTED

I submit the following additional evidence establishing that [AT-FAULT PARTY] was solely responsible for this accident: Exhibit A: [Police report with fault notation / citation] Exhibit B: [Witness statement — signed and dated] Exhibit C: [Photographs showing [SPECIFIC EVIDENCE]]

#### III. DEMAND

I demand written reversal within 30 days of receipt. Failure to reverse or provide adequate written legal basis will result in a [STATE] Insurance Commissioner complaint and legal consultation regarding bad faith remedies. All rights reserved.

Sincerely, [YOUR NAME / DATE]

ENCLOSURES: Exhibits A through [X]

### Template 2 — Causation / Pre-Existing Condition Denial Appeal

[YOUR FULL NAME | Address | Phone | Email | DATE]

VIA CERTIFIED MAIL AND EMAIL

[INSURANCE COMPANY] — Appeals Department | [Address]

RE: FORMAL APPEAL — CAUSATION / PRE-EXISTING CONDITION DENIAL

Claim No.: [NUMBER] | Date of Loss: [DATE]

Dear Claims Appeals Department,

I formally appeal the denial dated [DATE] citing [EXACT CAUSATION DENIAL LANGUAGE].

#### I. THE DENIAL MISAPPLIES THE LEGAL STANDARD

The legal standard in personal injury claims is not whether the injured party had prior conditions — it is whether the accident caused new injury or aggravated, accelerated, or exacerbated a prior condition beyond its prior state. Under settled tort law, a defendant takes a plaintiff as they find them. I am entitled to compensation for the aggravation caused by this accident regardless of any prior condition.

Your denial relies on [DESCRIBE INSURER'S BASIS — e.g., a desk review by a physician who never examined me]. My treating physician's clinical opinion, based on direct examination and full treatment history, carries substantially greater weight than a desk review.

#### II. MEDICAL EVIDENCE

I submit a causation letter from my treating physician, Dr. [NAME], dated [DATE], which addresses: (1) Specific diagnoses resulting from this accident (2) Causal relationship between accident and each diagnosis (3) Distinction between pre-existing conditions and new/aggravated injuries (4) Current status and prognosis Exhibit A: Treating Physician Causation Letter — Dr. [NAME], [DATE] Exhibit B: [Medical records showing post-accident symptom onset]

#### III. DEMAND

Written reversal demanded within 30 days. Failure to reverse will result in commissioner complaint and bad faith legal consultation. All rights reserved.

Sincerely, [YOUR NAME / DATE]

**Template 3 — Policy Exclusion Challenge Appeal**

[YOUR FULL NAME | Address | Phone | Email | DATE]

VIA CERTIFIED MAIL AND EMAIL

[INSURANCE COMPANY] — Appeals Department | [Address]

RE: FORMAL APPEAL — POLICY EXCLUSION CHALLENGE

Claim No.: [NUMBER] | Date of Loss: [DATE]

Dear Claims Appeals Department,

I formally appeal the denial dated [DATE] citing [EXCLUSION SECTION] of my policy.

**I. THE EXCLUSION DOES NOT CLEARLY AND UNAMBIGUOUSLY APPLY**

Under settled insurance law, policy exclusions are construed strictly against the insurer. When exclusion language is ambiguous, it is interpreted in favor of coverage (doctrine of contra proferentem). The exclusion cited — [SECTION X] — does not clearly and unambiguously apply to my claim for the following reasons:

[YOUR SPECIFIC ARGUMENT: e.g., 'The exclusion applies to [X] but my claim involves [Y]' / 'The term [TERM] is not defined in the policy and is reasonably interpreted to include my situation' / 'The exclusion contains an exception at Section [X.Y] that applies here']

**II. REQUEST FOR COMPLETE POLICY**

I formally request a complete copy of my insurance policy including all endorsements, as I am entitled to receive under [STATE] Insurance Code. Please provide within 10 business days.

**III. DEMAND**

Written reversal demanded within 30 days or a detailed explanation of why this exclusion clearly and unambiguously applies to my specific facts. Failure to respond will result in commissioner complaint and legal consultation. All rights reserved.

Sincerely, [YOUR NAME / DATE]

**Template 4 — Damages / Reasonableness Challenge Appeal**

[YOUR FULL NAME | Address | Phone | Email | DATE]

VIA CERTIFIED MAIL AND EMAIL

[INSURANCE COMPANY] — Appeals Department | [Address]

RE: FORMAL APPEAL — DAMAGES / REASONABLENESS CHALLENGE

Claim No.: [NUMBER] | Date of Loss: [DATE]

Dear Claims Appeals Department,

I formally appeal the denial/partial denial dated [DATE] in which you determined [EXACT LANGUAGE].

**I. THE REASONABLENESS DETERMINATION IS UNSUPPORTED**

Your determination lacks adequate support because: [IDENTIFY GAP — e.g., 'Your letter does not explain which treatments were found unreasonable' / 'Your usual-and-customary rates are not based on rates actually charged in [CITY, STATE] for comparable services']

**II. DOCUMENTATION OF MEDICAL NECESSITY**

Exhibit A: Letter from Dr. [NAME] explaining medical necessity of each disputed treatment Exhibit B: Itemized bills from all providers for services rendered

Each disputed treatment was ordered by my treating physician based on direct clinical examination. Medical necessity is a clinical judgment — not one to be overridden by a desk review applying blanket rate schedules.

### III. DEMAND

Written reversal within 30 days OR identification of each disputed treatment, the specific clinical basis for finding it unreasonable, and the rate schedule used. Failure to respond will result in commissioner complaint. All rights reserved.

Sincerely, [YOUR NAME / DATE]

## Appeal Letter Tracking System

|                                                                             |           |                                   |               |
|-----------------------------------------------------------------------------|-----------|-----------------------------------|---------------|
| TEMPLATE USED                                                               | DATE SENT | CERTIFIED MAIL TRACKING #         | EMAIL SENT TO |
| RESPONSE RECEIVED? <input type="checkbox"/> YES <input type="checkbox"/> NO |           | RESPONSE DATE                     | RESPONSE TYPE |
| 30-DAY RESPONSE DEADLINE                                                    |           | ACTION IF NO RESPONSE BY DEADLINE |               |

## SECTION 4

## The State Insurance Commissioner Complaint System

Free, Powerful, 50-State Portal Table

**Why This Matters:** This is the most underused tool available to denied claimants. Filing a commissioner complaint is completely free, takes 20–30 minutes, and forces the insurer to formally justify their position to a government regulator — creating a permanent regulatory record.

| Commissioner CAN Do                                           | Commissioner CANNOT Do                                           |
|---------------------------------------------------------------|------------------------------------------------------------------|
| Investigate insurer's claims handling conduct                 | Award money directly or compel payment of your specific claim    |
| Require insurer to respond in writing to government           | Represent you as an attorney or legal advocate                   |
| Cite insurer for unfair claims settlement practice violations | Override a valid, properly applied policy exclusion              |
| Impose fines and administrative penalties                     | Make binding legal determinations about fault or damages         |
| Trigger claims practices audits                               | Toll (pause) your statute of limitations on the underlying claim |
| Facilitate mediated resolution                                | Take action outside their state's jurisdiction                   |

[Source: NAIC Consumer Complaint Process, [naic.org/consumer\\_complaint\\_help.htm](http://naic.org/consumer_complaint_help.htm)]

## Universal Commissioner Complaint Template (Works in All 50 States — Fillable)

## INSURANCECONSUMER COMPLAINT

[STATE] Department of Insurance — Consumer Services Division

[File online at your state commissioner's .gov portal — see table on next page]

## SECTION A — YOUR INFORMATION

[Full Name | Address | City, State, ZIP | Phone | Email | Date of This Complaint]

## SECTION B — INSURER INFORMATION

Insurance Company Full Legal Name: [NAME] Policy Number: [POLICY NUMBER] | Claim Number: [CLAIM NUMBER] Adjuster Name and Contact: [NAME, PHONE, EMAIL] Date of Accident / Loss: [DATE] | Date of Denial Letter: [DATE]

## SECTION C — DESCRIPTION OF THE DISPUTE

On [DATE], I suffered [BRIEF DESCRIPTION — e.g., 'a car accident caused by the insured driver']. I filed a claim with [INSURER NAME] on [DATE] under Policy [NUMBER]. On [DATE], I received a written denial stating [EXACT DENIAL REASON]. I formally appealed on [DATE] via certified mail (tracking: [NUMBER]). As of [DATE], the insurer has [not responded / maintained the denial without adequate basis].

## SECTION D — SPECIFIC UNFAIR PRACTICES ALLEGED

I believe [INSURER NAME] has violated the following standards under the NAIC Unfair Claims Settlement Practices Act (MDL-900) and [STATE] Insurance Code: ■ Section 4(d): Failing to conduct a reasonable investigation before denying my claim ■ Section 4(f): Failing to attempt in good faith to effectuate prompt, fair settlement ■ Section 4(n): Failing to provide written notice of denial with specific policy provisions cited ■ Section 4(l): Compelling me to seek litigation to recover amounts reasonably due ■ Other: [DESCRIBE]

## SECTION E — DOCUMENTATION ENCLOSED

1. Denial letter dated [DATE] 2. My appeal letter dated [DATE] with proof of certified mail delivery 3. Insurer's response (if any) 4. Supporting evidence submitted with appeal 5. Relevant policy sections

## SECTION F — RELIEF REQUESTED

I request that your office: (1) investigate this insurer's claims handling; (2) require the insurer to provide a complete written response to my appeal; and (3) take appropriate regulatory action for violations found. Signature: \_\_\_\_\_ Date: \_\_\_\_\_ [YOUR PRINTED NAME]

## All 50 States + D.C. — Commissioner Complaint Portals

| State          | Commissioner Website                                                 | Complaint Portal                                                                           | Phone        |
|----------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------|
| Alabama        | <a href="http://aldoi.gov">aldoi.gov</a>                             | <a href="http://aldoi.gov/Consumer">aldoi.gov/Consumer</a>                                 | 269-3550     |
| Alaska         | <a href="http://commerce.alaska.gov/ins">commerce.alaska.gov/ins</a> | <a href="http://commerce.alaska.gov/ins/consumer">commerce.alaska.gov/ins/consumer</a>     | 907-465-2515 |
| Arizona        | <a href="http://insurance.az.gov">insurance.az.gov</a>               | <a href="http://insurance.az.gov/consumers">insurance.az.gov/consumers</a>                 | 602-364-3100 |
| Arkansas       | <a href="http://insurance.arkansas.gov">insurance.arkansas.gov</a>   | <a href="http://insurance.arkansas.gov/consumer">insurance.arkansas.gov/consumer</a>       | 501-371-2600 |
| California     | <a href="http://insurance.ca.gov">insurance.ca.gov</a>               | <a href="http://insurance.ca.gov/01-consumers">insurance.ca.gov/01-consumers</a>           | 800-927-4357 |
| Colorado       | <a href="http://doi.colorado.gov">doi.colorado.gov</a>               | <a href="http://doi.colorado.gov/consumers">doi.colorado.gov/consumers</a>                 | 303-894-7499 |
| Connecticut    | <a href="http://portal.ct.gov/CID">portal.ct.gov/CID</a>             | <a href="http://portal.ct.gov/CID/Consumer">portal.ct.gov/CID/Consumer</a>                 | 860-297-3800 |
| Delaware       | <a href="http://insurance.delaware.gov">insurance.delaware.gov</a>   | <a href="http://insurance.delaware.gov/consumers">insurance.delaware.gov/consumers</a>     | 302-674-7300 |
| D.C.           | <a href="http://disb.dc.gov">disb.dc.gov</a>                         | <a href="http://disb.dc.gov/file-complaint">disb.dc.gov/file-complaint</a>                 | 202-727-8000 |
| Florida        | <a href="http://myfloridacfo.com">myfloridacfo.com</a>               | <a href="http://myfloridacfo.gov/consumers">myfloridacfo.gov/consumers</a>                 | 877-693-5236 |
| Georgia        | <a href="http://oci.ga.gov">oci.ga.gov</a>                           | <a href="http://oci.ga.gov/Consumer/FileAComplaint">oci.ga.gov/Consumer/FileAComplaint</a> | 800-656-2298 |
| Hawaii         | <a href="http://cca.hawaii.gov/ins">cca.hawaii.gov/ins</a>           | <a href="http://cca.hawaii.gov/ins/consumers">cca.hawaii.gov/ins/consumers</a>             | 808-586-2790 |
| Idaho          | <a href="http://doi.idaho.gov">doi.idaho.gov</a>                     | <a href="http://doi.idaho.gov/consumers">doi.idaho.gov/consumers</a>                       | 208-334-4250 |
| Illinois       | <a href="http://insurance.illinois.gov">insurance.illinois.gov</a>   | <a href="http://insurance.illinois.gov/consumer">insurance.illinois.gov/consumer</a>       | 866-445-5364 |
| Indiana        | <a href="http://in.gov/idoi">in.gov/idoi</a>                         | <a href="http://in.gov/idoi/consumer-services">in.gov/idoi/consumer-services</a>           | 317-232-2385 |
| Iowa           | <a href="http://iid.iowa.gov">iid.iowa.gov</a>                       | <a href="http://iid.iowa.gov/consumers">iid.iowa.gov/consumers</a>                         | 515-654-6600 |
| Kansas         | <a href="http://insurance.ks.gov">insurance.ks.gov</a>               | <a href="http://insurance.ks.gov/consumers">insurance.ks.gov/consumers</a>                 | 785-296-3071 |
| Kentucky       | <a href="http://insurance.ky.gov">insurance.ky.gov</a>               | <a href="http://insurance.ky.gov/consumers">insurance.ky.gov/consumers</a>                 | 800-595-6053 |
| Louisiana      | <a href="http://ldi.la.gov">ldi.la.gov</a>                           | <a href="http://ldi.la.gov/consumer-resources">ldi.la.gov/consumer-resources</a>           | 800-259-5300 |
| Maine          | <a href="http://maine.gov/pfr/insurance">maine.gov/pfr/insurance</a> | <a href="http://maine.gov/pfr/insurance/consumers">maine.gov/pfr/insurance/consumers</a>   | 207-624-8475 |
| Maryland       | <a href="http://insurance.maryland.gov">insurance.maryland.gov</a>   | <a href="http://insurance.maryland.gov/Consumer">insurance.maryland.gov/Consumer</a>       | 800-492-6116 |
| Massachusetts  | <a href="http://mass.gov/orgs/doi">mass.gov/orgs/doi</a>             | <a href="http://mass.gov/file-insurance-complaint">mass.gov/file-insurance-complaint</a>   | 617-521-7794 |
| Michigan       | <a href="http://michigan.gov/difs">michigan.gov/difs</a>             | <a href="http://michigan.gov/difs/consumers">michigan.gov/difs/consumers</a>               | 877-999-6442 |
| Minnesota      | <a href="http://mn.gov/commerce">mn.gov/commerce</a>                 | <a href="http://mn.gov/commerce/consumers">mn.gov/commerce/consumers</a>                   | 651-539-1500 |
| Mississippi    | <a href="http://mid.ms.gov">mid.ms.gov</a>                           | <a href="http://mid.ms.gov/consumers">mid.ms.gov/consumers</a>                             | 601-359-3569 |
| Missouri       | <a href="http://insurance.mo.gov">insurance.mo.gov</a>               | <a href="http://insurance.mo.gov/consumers">insurance.mo.gov/consumers</a>                 | 800-726-7390 |
| Montana        | <a href="http://csimt.gov">csimt.gov</a>                             | <a href="http://csimt.gov/consumers">csimt.gov/consumers</a>                               | 800-332-6148 |
| Nebraska       | <a href="http://doi.nebraska.gov">doi.nebraska.gov</a>               | <a href="http://doi.nebraska.gov/consumer">doi.nebraska.gov/consumer</a>                   | 402-471-2201 |
| Nevada         | <a href="http://doi.nv.gov">doi.nv.gov</a>                           | <a href="http://doi.nv.gov/Consumers">doi.nv.gov/Consumers</a>                             | 775-687-0700 |
| New Hampshire  | <a href="http://nh.gov/insurance">nh.gov/insurance</a>               | <a href="http://nh.gov/insurance/consumers">nh.gov/insurance/consumers</a>                 | 603-271-2261 |
| New Jersey     | <a href="http://dobi.nj.gov">dobi.nj.gov</a>                         | <a href="http://dobi.nj.gov/complaints">dobi.nj.gov/complaints</a>                         | 609-292-7272 |
| New Mexico     | <a href="http://osi.state.nm.us">osi.state.nm.us</a>                 | <a href="http://osi.state.nm.us/consumer">osi.state.nm.us/consumer</a>                     | 505-827-4601 |
| New York       | <a href="http://dfs.ny.gov">dfs.ny.gov</a>                           | <a href="http://dfs.ny.gov/complaint">dfs.ny.gov/complaint</a>                             | 800-342-3736 |
| North Carolina | <a href="http://ncdoi.gov">ncdoi.gov</a>                             | <a href="http://ncdoi.gov/consumers">ncdoi.gov/consumers</a>                               | 855-408-1212 |

| State          | Commissioner Website      | Complaint Portal                          | Phone 701-   |
|----------------|---------------------------|-------------------------------------------|--------------|
| North Dakota   | nd.gov/ndins              | nd.gov/ndins/consumers                    | 328-2440     |
| Ohio           | insurance.ohio.gov        | insurance.ohio.gov/consumer               | 800-686-1526 |
| Oklahoma       | ok.gov/oid                | ok.gov/oid/Consumers                      | 405-521-2828 |
| Oregon         | insurance.oregon.gov      | insurance.oregon.gov/consumers            | 503-947-7984 |
| Pennsylvania   | insurance.pa.gov          | insurance.pa.gov/Consumers                | 877-881-6388 |
| Rhode Island   | dbr.ri.gov                | dbr.ri.gov/consumers                      | 401-462-9520 |
| South Carolina | doi.sc.gov                | doi.sc.gov/consumers                      | 803-737-6160 |
| South Dakota   | dlr.sd.gov/insurance      | dlr.sd.gov/insurance/consumer             | 605-773-3563 |
| Tennessee      | tn.gov/commerce/insurance | tn.gov/commerce/insurance/consumers       | 800-342-4029 |
| Texas          | tdi.texas.gov             | tdi.texas.gov/consumer                    | 800-252-3439 |
| Utah           | insurance.utah.gov        | insurance.utah.gov/consumers              | 801-538-3800 |
| Vermont        | dfr.vermont.gov           | dfr.vermont.gov/consumers                 | 802-828-3301 |
| Virginia       | scc.virginia.gov          | scc.virginia.gov/file-insurance-complaint | 800-552-7945 |
| Washington     | insurance.wa.gov          | insurance.wa.gov/consumers/file-complaint | 800-562-6900 |
| West Virginia  | wvinsurance.gov           | wvinsurance.gov/consumers                 | 888-879-9842 |
| Wisconsin      | oci.wi.gov                | oci.wi.gov/Pages/Consumers                | 800-236-8517 |
| Wyoming        | doi.wyo.gov               | doi.wyo.gov/consumers                     | 307-777-7401 |

[Source: NAIC, [naic.org/consumer\\_complaint\\_help.htm](https://naic.org/consumer_complaint_help.htm); individual state commissioner .gov sites, 2024]

## SECTION 5

## Bad Faith Insurance Law

15 NAIC Indicators · Documentation System · State-by-State Remedies

**Why This Matters:** Bad faith insurance law exists because insurers hold enormous power over claimants. When an insurer wrongfully denies a claim in violation of the NAIC standards, the damages available can far exceed the original claim value — including punitive damages and attorney's fees in many states.

## The 15 Bad Faith Indicators — NAIC Model Act MDL-900 §4

[Source: NAIC Unfair Claims Settlement Practices Model Act MDL-900 §4, [naic.org/store/free/MDL-900.pdf](http://naic.org/store/free/MDL-900.pdf)]

| #  | Indicator                                                 | What It Looks Like                                                                      | How to Document It                                                                                               |
|----|-----------------------------------------------------------|-----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|
| 1  | Misrepresenting facts or policy provisions                | Adjuster tells you exclusion covers your situation when it does not                     | Keep all adjuster communications in writing; compare statements to actual policy text                            |
| 2  | Failing to acknowledge and act promptly                   | Weeks pass with no acknowledgment of filed claim or appeal                              | Log every contact with dates; most states require acknowledgment within 10 business days                         |
| 3  | Failing to adopt reasonable investigation standards       | Denial based on only one party's account; available witnesses not interviewed           | Send written list of witnesses and evidence not yet reviewed; demand confirmation of investigation completed     |
| 4  | Refusing to pay without reasonable investigation          | Denial issued before investigation is completed                                         | Request the date investigation was completed and all documents generated                                         |
| 5  | Failing to affirm or deny coverage within reasonable time | Neither accepting nor denying coverage — leaving you in limbo                           | Send written demand for coverage decision within 30 days; document date sent                                     |
| 6  | Not attempting in good faith to settle                    | Offering 30–40% of documented damages without explanation                               | Document damages calculation; compare to offer; disparity of 50%+ without basis is documented evidence           |
| 7  | Compelling unnecessary litigation                         | Denying valid, fully-documented claim — forcing you to sue to recover                   | Create complete documented claim file showing all evidence was submitted before denial                           |
| 8  | Settling for less than reasonable without basis           | Offer dramatically below documented damages with no reasoned basis                      | Request in writing the exact methodology and data used to calculate the offer amount                             |
| 9  | Settling using altered documents                          | Policy language or documents cited in altered or incomplete form                        | Request original, complete versions of all documents cited in denial letter                                      |
| 10 | Payments without coverage explanation                     | Partial payment made without explaining what it covers or whether a release is required | Before accepting any payment, demand written statement of what it covers and whether it waives future claims     |
| 11 | Unreasonable policy interpretations                       | Exclusion applied to situations it was clearly not designed to cover                    | Request written interpretation; present alternative reasonable interpretation in appeal                          |
| 12 | Delay by excessive documentation requests                 | Same documents requested repeatedly; requests unrelated to the claim                    | Log every document request with dates; note repeat requests for same items                                       |
| 13 | Failing to provide written denial notice                  | Verbal or informal denial without written statement citing specific policy provision    | Request written denial confirmation citing specific policy provisions per NAIC MDL-900 §4(n)                     |
| 14 | Not maintaining complete claim file                       | Claim file has gaps; documents missing from investigation record                        | Request complete claim file copy in writing; document any gaps or missing items                                  |
| 15 | Failing to respond to communications                      | Calls, letters, and emails go unanswered for days or weeks                              | Document every unanswered communication; after 10 business days, follow up in writing with date of prior contact |

## State-by-State Bad Faith Reference

| State          | Bad Faith Statute       | 1st Party? | Punitive?    | Atty Fees? | BF SOL   |
|----------------|-------------------------|------------|--------------|------------|----------|
| Alabama        | Ala. Code §27-12-24     | Yes        | Yes          | Sometimes  | 2 yrs    |
| Alaska         | AS §21.36.125           | Yes        | Yes          | Yes        | 3 yrs    |
| Arizona        | A.R.S. §20-461          | Yes        | Yes          | Yes        | 2 yrs 2– |
| California     | Cal. Ins. Code §790.03  | Yes        | Yes          | Yes        | 4 yrs 3  |
| Colorado       | C.R.S. §10-3-1115       | Yes        | Yes (treble) | Yes        | yrs      |
| Florida        | Fla. Stat. §624.155     | Yes        | Yes          | Yes        | 5 yrs    |
| Georgia        | OCGA §33-4-6            | Yes        | 25% penalty  | Yes        | 2 yrs    |
| Illinois       | 215 ILCS 5/155          | Yes        | 60% penalty  | Yes        | 5 yrs    |
| Kentucky       | KRS §304.12-230         | Yes        | Yes          | Yes        | 1 yr     |
| Louisiana      | La. R.S. §22:1973       | Yes        | 50% penalty  | Yes        | 10 yrs   |
| Maryland       | Md. Code Ins. §27-303   | Yes        | No           | Limited    | 3 yrs    |
| Massachusetts  | M.G.L. c. 176D §3       | Yes        | Yes          | Yes        | 3 yrs    |
| Michigan       | MCL §500.2026           | Yes        | Yes          | Yes        | 3 yrs    |
| Missouri       | RSMo §375.420           | Yes        | Yes          | Yes        | 5 yrs    |
| Nevada         | NRS §686A.310           | Yes        | Yes          | Yes        | 3 yrs    |
| New Jersey     | N.J.S.A. §17:29B-4      | Yes        | Yes          | Yes        | 6 yrs    |
| New York       | NY Ins. Law §2601       | Yes        | Limited      | Limited    | 6 yrs    |
| North Carolina | N.C.G.S. §58-63-15      | Yes        | Yes          | Yes        | 3 yrs    |
| Ohio           | Ohio Rev. Code §3901.21 | Yes        | Yes          | Yes        | 4 yrs    |
| Oregon         | ORS §746.230            | Yes        | Yes          | Yes        | 2 yrs    |
| Pennsylvania   | 42 Pa. C.S. §8371       | Yes        | Yes          | Yes        | 4 yrs    |
| Texas          | Tex. Ins. Code §541.060 | Yes        | Treble       | Yes        | 2 yrs    |
| Virginia       | Va. Code §38.2-510      | Yes        | Limited      | No         | 5 yrs    |
| Washington     | RCW 48.30.015           | Yes        | Yes          | Yes        | 3 yrs    |
| Wisconsin      | Wis. Stat. §628.46      | Yes        | Yes          | Yes        | 3 yrs    |

[Source: NAIC MDL-900, [naic.org](http://naic.org); individual state statutes at state legislature .gov sites. Verify current law in your state. All 50 states have adopted unfair claims practices regulation. 2024]

## SECTION 6

## Evidence Rebuilding System

Audit What Was Missing · Gap Analysis · Doctor Letter Request

**Why This Matters:** Most initial claim denials are not based on the insurer having strong evidence against you — they are based on you not providing sufficient evidence to overcome the insurer's default position. A denial is often an invitation to build a stronger case.

## Evidence Audit — What You Need vs. What You Submitted

| Evidence Item                           | Why It Matters                                         | Status                                        |
|-----------------------------------------|--------------------------------------------------------|-----------------------------------------------|
| Police Accident Report                  | Establishes accident facts and fault indicators        | ■ Submitted ■ Need to Submit ■ Need to Obtain |
| Medical Records (accident date forward) | Proves injuries, treatment, and causation timeline     | ■ Submitted ■ Incomplete ■ Need to Submit     |
| Medical Bills (itemized)                | Documents economic damages with specificity            | ■ Submitted ■ Only Summary ■ Need Itemized    |
| Lost Wage Documentation                 | Proves income loss with employer confirmation          | ■ Submitted ■ Need to Submit ■ Missing        |
| Treating Physician Causation Letter     | Most powerful single document for causation denials    | ■ Submitted ■ Need to Request ■ Not Obtained  |
| Photographs (scene, vehicle, injuries)  | Visual evidence of impact and injury severity          | ■ Submitted ■ Incomplete ■ Not Submitted      |
| Witness Statements (signed and dated)   | Independent corroboration of your account              | ■ Submitted ■ Need to Submit ■ Not Obtained   |
| Daily Symptom Journal                   | Documents ongoing pain and functional limitations      | ■ Submitted ■ Need to Start ■ Not Maintained  |
| Expert Opinion (if applicable)          | Accident reconstruction, medical, or vocational expert | ■ Submitted ■ Consider Obtaining ■ N/A        |

## Evidence Gap Analysis Worksheet

## GAP 1

| MISSING EVIDENCE ITEM | DENIAL REASON IT ADDRESSES | HOW TO OBTAIN NOW |
|-----------------------|----------------------------|-------------------|
|                       |                            |                   |

## GAP 2

| MISSING EVIDENCE ITEM | DENIAL REASON IT ADDRESSES | HOW TO OBTAIN NOW |
|-----------------------|----------------------------|-------------------|
|                       |                            |                   |

## GAP 3

| MISSING EVIDENCE ITEM | DENIAL REASON IT ADDRESSES | HOW TO OBTAIN NOW |
|-----------------------|----------------------------|-------------------|
|                       |                            |                   |

## Treating Physician Causation Letter — What to Request

A causation letter from your treating physician directly reverses most causation-based and pre-existing condition denials. Request this in writing and ask the physician to specifically address:

- Specific diagnoses resulting from the accident on [DATE]
- The causal relationship between the accident and each diagnosis
- Distinction between pre-existing conditions and new or aggravated injuries caused by this accident
- Whether pre-existing conditions were worsened, accelerated, or aggravated beyond their prior state
- Current functional limitations and how they differ from the pre-accident baseline
- Prognosis — whether injuries will resolve, persist, or worsen
- Whether future treatment is required and at what estimated cost

[Source: NHTSA biomechanics research, [nhtsa.gov/research-data](https://www.nhtsa.gov/research-data); NAIC Claims Guide, [naic.org](https://www.naic.org)]

## SECTION 7

## Special Denial Scenarios

6 Specific Situations — Strategy for Each

## Scenario 1 — Denial for 'Late Notice'

|                             |                                                                                                                                                                                                                                                                                                                                                                                                                               |
|-----------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>The law / standard</b>   | Most states have adopted the 'notice-prejudice rule' — the insurer must prove the late notice actually prejudiced their ability to investigate before using it as a complete defense. In most jurisdictions, a denial based on late notice alone is not valid without demonstrated actual prejudice. [Source: NAIC Consumer Guide, naic.org; verify your state's notice-prejudice rule at your state legislature's .gov site] |
| <b>How it is exploited</b>  | Insurers rarely disclose the prejudice requirement in a late-notice denial. They state the deadline was missed and stop — expecting most claimants not to know the prejudice standard exists.                                                                                                                                                                                                                                 |
| <b>Your action strategy</b> | Appeal immediately citing your state's notice-prejudice rule. State: 'Under [STATE] law, a denial based on late notice requires demonstration of actual prejudice from the delay. Please provide in writing the specific ways the delay prejudiced your investigation.' Document the reason for the delay.                                                                                                                    |

## Scenario 2 — Denial for 'Failure to Cooperate'

|                             |                                                                                                                                                                                                                                                                                                   |
|-----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>The law / standard</b>   | Cooperation clauses are real but limited. Refusing a recorded statement without counsel does not automatically constitute material non-cooperation. Courts require the insurer to prove the non-cooperation caused material prejudice to their investigation. [Source: NAIC MDL-900 §4, naic.org] |
| <b>How it is exploited</b>  | The recorded statement request is weaponized against claimants who give statements that minimize injuries or concede partial fault. The denial follows when victims decline — counting on them not knowing that alternatives exist.                                                               |
| <b>Your action strategy</b> | Respond in writing offering cooperation in alternative formats: written questions and answers, document production, attorney-attended IME. Document every cooperation offer. Challenge the insurer to explain specifically how your non-cooperation materially prejudiced their investigation.    |

## Scenario 3 — Insurer Denied Then Stopped Responding

|                             |                                                                                                                                                                                                                                                                      |
|-----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>The law / standard</b>   | Non-response after formal notice is documented bad faith under NAIC MDL-900 §4(b) and §4(o). Most states have prompt payment laws specifying maximum response times. Your state's law is in Section 9 of this kit. [Source: NAIC Prompt Payment Model Law, naic.org] |
| <b>How it is exploited</b>  | Insurer silence is a calculated delay strategy. Many claimants give up when responses stop. The insurer is waiting for the statute of limitations to expire. This is one of the clearest documented bad faith patterns.                                              |
| <b>Your action strategy</b> | File commissioner complaint IMMEDIATELY — simultaneously with continued written contact. Create a documented non-response timeline. Cite NAIC MDL-900 §4(b) and your state's prompt payment law in the complaint.                                                    |

### Scenario 4 — Lowball Offer as Constructive Denial

|                             |                                                                                                                                                                                                                                                                |
|-----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>The law / standard</b>   | When a settlement offer is so far below documented claim value that no reasonable person would accept it, this may constitute a constructive denial under NAIC MDL-900 §4(f) — failing to attempt in good faith to settle. [Source: NAIC MDL-900 §4, naic.org] |
| <b>How it is exploited</b>  | Adjusters are often trained to open at 40–60% of claim value expecting claimants to accept. Each round tests whether the claimant knows their actual claim value.                                                                                              |
| <b>Your action strategy</b> | Respond in writing with a documented counter-offer using the Template in Section 8. Show your math. Set a 14-day deadline. If the offer does not improve meaningfully, file a commissioner complaint citing NAIC MDL-900 §4(f) and document the disparity.     |

### Scenario 5 — Exclusion That Seems Wrong

|                             |                                                                                                                                                                                                                                                                                                                                                                                                                      |
|-----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>The law / standard</b>   | The contra proferentem doctrine: ambiguous policy language is interpreted in favor of coverage and against the insurer who drafted it. If you believe an exclusion does not clearly apply, that ambiguity is a legal argument in your favor. [Source: NAIC MDL-900; state insurance codes]                                                                                                                           |
| <b>How it is exploited</b>  | Insurers cite exclusion headings in denial letters knowing most claimants never read the full exclusion section of their policy — including exceptions and defined terms that may eliminate the exclusion's application. Use Template 3. Demand the complete policy. Read the full exclusion — including every exception and defined term. If any ambiguity exists, cite contra proferentem directly in your appeal. |
| <b>Your action strategy</b> |                                                                                                                                                                                                                                                                                                                                                                                                                      |

### Scenario 6 — Government Entity Involved

|                             |                                                                                                                                                                                                                                                                                        |
|-----------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>The law / standard</b>   | Claims against government entities are governed by federal or state Tort Claims Acts with drastically shorter notice requirements — sometimes as short as 60–180 days from the date of injury. [Source: Federal Tort Claims Act, 28 U.S.C. §§ 1346, 2671–2680; state tort claims acts] |
| <b>How it is exploited</b>  | Government tort claims acts were designed to limit public entity liability. The notice periods are intentionally short and strictly enforced — missing them permanently bars most claims.                                                                                              |
| <b>Your action strategy</b> | If a government entity may be responsible, consult an attorney IMMEDIATELY — these deadlines are far shorter than standard insurance appeal windows and cannot be missed.                                                                                                              |

## SECTION 8

## The Negotiation System Post-Denial

Counter-Offer Template - Negotiation Tracker

**Why This Matters:** A formal appeal backed by a commissioner complaint shifts the power dynamic dramatically. The insurer is now on a regulatory record, has been formally challenged, and faces documented bad faith exposure. This is the moment to re-engage negotiation from a position of documented strength.

## Counter-Offer Letter Template

[YOUR FULL NAME | Address | Phone | Email | DATE]

VIA CERTIFIED MAIL AND EMAIL

[INSURANCE COMPANY] — Claims / Appeals Department | [Address]

RE: COUNTER-OFFER IN RESPONSE TO OFFER DATED [DATE]

Claim No.: [NUMBER]

Dear [ADJUSTER/APPEALS NAME],

I am in receipt of your [offer / position] dated [DATE] in the amount of \$[THEIR AMOUNT].

I am unable to accept this offer. My documented damages are as follows:

Medical expenses (fully itemized): \$[AMOUNT] Lost wages (with employer confirmation): \$[AMOUNT] Future medical costs (per physician estimate): \$[AMOUNT] Property damage (per appraisal): \$[AMOUNT] Other documented expenses: \$[AMOUNT] TOTAL ECONOMIC DAMAGES: \$[TOTAL] Non-economic damages ([METHOD] method): \$[AMOUNT] TOTAL DOCUMENTED CLAIM VALUE: \$[GRAND TOTAL]

In the interest of resolving this matter, I am prepared to accept \$[YOUR COUNTER] in full and final settlement.

I request written response within 14 days.

Please note that I have also filed a complaint with the [STATE] Insurance Commissioner (reference: [COMPLAINT NUMBER]) and am documenting this claim file for potential bad faith review.

This counter-offer is submitted without prejudice to all legal rights.

Sincerely, [YOUR NAME / DATE]

## Negotiation Tracker — 4 Rounds

## ROUND 1

| DATE                   | PARTY | AMOUNT (\$) | STATED BASIS      |
|------------------------|-------|-------------|-------------------|
| YOUR RESPONSE STRATEGY |       |             | RESPONSE DEADLINE |

## ROUND 2

| DATE | PARTY | AMOUNT (\$) | STATED BASIS |
|------|-------|-------------|--------------|
|      |       |             |              |

|                        |                   |
|------------------------|-------------------|
| YOUR RESPONSE STRATEGY | RESPONSE DEADLINE |
|------------------------|-------------------|

**ROUND 3**

|                        |       |             |                   |
|------------------------|-------|-------------|-------------------|
| DATE                   | PARTY | AMOUNT (\$) | STATED BASIS      |
| YOUR RESPONSE STRATEGY |       |             | RESPONSE DEADLINE |

**ROUND 4**

|                        |       |             |                   |
|------------------------|-------|-------------|-------------------|
| DATE                   | PARTY | AMOUNT (\$) | STATED BASIS      |
| YOUR RESPONSE STRATEGY |       |             | RESPONSE DEADLINE |

|                       |                      |             |
|-----------------------|----------------------|-------------|
| FINAL SETTLEMENT (\$) | NET AFTER LIENS (\$) | DATE SIGNED |
|-----------------------|----------------------|-------------|

## SECTION 9

**Claim Denial Timeline & Deadline Tracker**

An Critical Dates: 50-State Prompt Payment Laws

**Why This Matters:** Deadlines are the #1 way victims permanently lose their rights. A missed internal appeal deadline, an expired SOL, or a lapsed commissioner complaint window eliminates rights that no evidence or argument can restore.

**Master Deadline Tracker — Complete This Immediately**

|                                                                          |                               |
|--------------------------------------------------------------------------|-------------------------------|
| DATE OF DENIAL LETTER                                                    | TODAY'S DATE                  |
| INTERNAL APPEAL DEADLINE (FROM DENIAL LETTER OR POLICY)                  | DAYS REMAINING                |
| SOL FOR UNDERLYING CLAIM (SEE SOL CALCULATOR AT JUSTICEFINDER.NET/TOOLS) | DAYS REMAINING                |
| BAD FAITH SOL (STATE TABLE IN SECTION 5 OF THIS KIT)                     | DAYS REMAINING                |
| COMMISSIONER COMPLAINT FILED? ■ YES ■ NO                                 | COMPLAINT FILED DATE          |
| CRITICAL: MUST CONSULT ATTORNEY BY                                       | CRITICAL: MUST FILE APPEAL BY |

**50-State Prompt Payment Laws — Maximum Insurer Response Times**

| State       | Ack. (days) | Investigation (days) | Pay/Deny (days)          | Penalty            | Statute                |
|-------------|-------------|----------------------|--------------------------|--------------------|------------------------|
| Alabama     | 15          | No specific          | 45                       | 10%+ damages       | Ala. Code §27-12-24 AS |
| Alaska      | 10          | 30                   | 30                       | Interest + penalty | §21.36.125             |
| Arizona     | 10          | 30                   | 15 after proof           | 12% interest       | A.R.S. §20-461         |
| Arkansas    | 10          | 45                   | 45                       | 12% per year       | Ark. Code §23-79-208   |
| California  | 15          | 40                   | 30                       | 15% + atty fees    | Cal. Ins. Code §790.03 |
| Colorado    | 10          | 45                   | 45                       | Penalty + fees     | C.R.S. §10-3-1115      |
| Connecticut | 10          | 45                   | 45                       | Penalty interest   | C.G.S. §38a-816        |
| Delaware    | 10          | 45                   | 45                       | Penalty interest   | 18 Del. C. §2304       |
| D.C.        | 15          | 45                   | 45                       | Penalty interest   | D.C. Code §31-2231.17  |
| Florida     | 14          | 30                   | 20 after agreement<br>45 | 12% per year       | Fla. Stat. §624.155    |
| Georgia     | 15          | 45                   | 15                       | 25% penalty        | OCSA §33-4-6           |
| Hawaii      | 10          | 30                   |                          | Penalty interest   | HRS §431:13-103        |

| State          | Ack.<br>(days) | Investigation<br>(days) | Pay/Deny<br>(days) | Penalty            | Statute                  |
|----------------|----------------|-------------------------|--------------------|--------------------|--------------------------|
| Idaho          | 10             | 45                      | 30                 | 12% interest       | Idaho Code §41-1329      |
| Illinois       | 15             | 45                      | 45                 | 60% penalty        | 215 ILCS 5/155           |
| Indiana        | 10             | 45                      | 30                 | Treble damages     | IC §27-4-1-4.5           |
| Iowa           | 15             | 30                      | 30                 | Interest           | Iowa Code §507B.4        |
| Kansas         | 15             | 30                      | 30                 | Interest + penalty | K.S.A. §40-2404          |
| Kentucky       | 15             | 45                      | 45                 | 12% per year       | KRS §304.12-230          |
| Louisiana      | 30             | 45                      | 30                 | 50% + fees         | La. R.S. §22:1973        |
| Maine          | 30             | 30                      | 30                 | Interest           | 24-A M.R.S. §2164-F      |
| Maryland       | 10             | 30                      | 30                 | Interest           | 24-A M.R.S. §2164-F      |
| Massachusetts  | 15             | No specific             | 45                 | Penalty interest   | Md. Code Ins. §27-303    |
| Michigan       | 10             | 45                      | 30                 | 12% + fees         | M.G.L. c. 176D           |
| Minnesota      | 10             | 30                      | 60                 | 12% per year       | MCL §500.2026            |
| Mississippi    | 10             | 45                      | 45                 | Interest + fees    | Minn. Stat. §72A.201     |
| Missouri       | 10             | 30                      | 25                 | 25% penalty        | Miss. Code §83-11-107    |
| Montana        | 10             | 45                      | 45                 | Interest           | RSMo §375.420            |
| Nebraska       | 10             | 45                      | 45                 | Interest + penalty | Mont. Code §33-18-201    |
| Nevada         | 15             | 30                      | 30                 | Interest           | Neb. Rev. Stat. §44-1525 |
| New Hampshire  | 15             | 30                      | 15                 | Interest + fees    | NRS §686A.310            |
| New Jersey     | 10             | 30                      | 30                 | Interest           | RSA §417:4               |
| New Mexico     | 10             | 30                      | 15                 | Interest           | N.J.S.A. §17:29B-4       |
| New York       | 10             | 45                      | 30                 | Interest + penalty | NMSA §59A-16-20          |
| North Carolina | 15             | 15                      | 30                 | Interest + fees    | NY Ins. Law §2601        |
| North Dakota   | 10             | 45                      | 45                 | Interest + penalty | N.C.G.S. §58-63-15       |
| Ohio           | 10             | 30                      | 30                 | Interest           | N.D.C.C. §26.1-04-03     |
| Oklahoma       | 15             | 45                      | 45                 | Interest           | Ohio Rev. Code §3901.21  |
| Oregon         | 10             | 45                      | 45                 | Interest           | 36 O.S. §1250.7          |
| Pennsylvania   | 10             | 45                      | 30                 | Interest + penalty | ORS §746.230             |
| Rhode Island   | 10             | 45                      | 30                 | Interest + fees    | 40 Pa. C.S. §1171.5      |
| South Carolina | 10             | 45                      | 45                 | Interest           | R.I. Gen. Laws §27-9.1-3 |
| South Dakota   | 15             | 45                      | 30                 | Interest + penalty | S.C. Code §38-59-20      |
| Tennessee      | 10             | 45                      | 30                 | Interest           | SDCL §58-33-67           |
| Texas          | 15             | 45                      | 45                 | 25% penalty        | T.C.A. §56-7-105         |
|                | 15             | 15                      | 5 after acceptance | 18% + fees         | Tex. Ins. Code §542.051  |
|                | 15             |                         | 30                 |                    |                          |
| Utah           | 10             | 45                      | 30                 | Interest + penalty | Utah Code §31A-26-303    |
| Vermont        | 10             | 30                      |                    | Interest           | 8 V.S.A. §4724           |

| State         | Ack.<br>(days) | Investigation<br>(days) | Pay/Deny<br>(days) | Penalty            | Statute               |
|---------------|----------------|-------------------------|--------------------|--------------------|-----------------------|
| Virginia      | 10             | 45                      | 45                 | Interest           | Va. Code §38.2-510    |
| Washington    | 10             | 45                      | 15                 | Interest + fees    | RCW 48.30.015         |
| West Virginia | 10             | 45                      | 45                 | Interest + penalty | W. Va. Code §33-11-4  |
| Wisconsin     | 10             | 30                      | 30                 | Interest           | Wis. Stat. §628.46    |
| Wyoming       | 10             | 45                      | 45                 | Interest           | Wyo. Stat. §26-13-124 |

[Source: NAIC Prompt Payment Model Law, [naic.org](https://naic.org); individual state insurance codes at state legislature .gov sites, 2024]

## SECTION 10

**When to Hire an Attorney**

7 Non-Negotiable Triggers · Bad Faith Litigation · Attorney-Ready File

**Why This Matters:** Self-representation through appeal and commissioner complaint stages is appropriate for many denied claims. But certain situations require professional legal representation — and failing to recognize them can be costly or permanently fatal to your case.

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**The 7 Situations That Require an Attorney — No Exceptions**

- **1. Claim value exceeds \$25,000.** Professional negotiation statistically produces significantly better outcomes at this level. Attorney fees are earned back in higher settlements in the vast majority of cases. [Source: Insurance Research Council, ircweb.org]
- **2. You believe the insurer is acting in bad faith.** Bad faith claims require attorneys experienced in insurance litigation. Punitive damages and attorney's fees make these cases viable on contingency.
- **3. SOL is within 90 days.** An attorney can file suit to preserve your rights while negotiations continue. Missing the SOL eliminates everything permanently — there are no exceptions.
- **4. You have been asked to sign a release.** Releases are written to waive all future claims including injuries that have not yet manifested. Never sign without attorney review.
- **5. Injuries are permanent, involve surgery, or include disability.** Future damages require expert medical and vocational evidence. Self-representation consistently under-values these claims.
- **6. Multiple parties or insurers are involved.** Multi-party claims require coordinated legal strategy and ability to pursue multiple defendants simultaneously.
- **7. Claim has been denied more than once.** Two denial cycles without resolution means the insurer will not voluntarily pay. The credible threat of litigation is required to change this.

[Source: NAIC Consumer Guide, naic.org; Insurance Research Council, ircweb.org; ABA Model Rules, americanbar.org]

**The Attorney-Ready Denial File Checklist**

- ■ Complete denial letter (original, with date received)
- ■ All prior claim correspondence in chronological order
- ■ Your appeal letter(s) with certified mail proof of delivery
- ■ Insurer's responses to your appeals
- ■ Commissioner complaint filed (if any) with confirmation
- ■ Complete adjuster communication log with dates and summaries
- ■ All evidence submitted to date (organized by exhibit number)
- ■ Evidence gap analysis (Section 6 worksheet completed)
- ■ Bad faith documentation (Section 5 — all 15 indicators checked against your situation)
- ■ Completed deadline tracker (Section 9)
- ■ Your documented damages total (economic + non-economic)
- ■ Policy documents (complete — including all endorsements)
- ■ Medical records from accident date forward
- ■ Treating physician causation letter (if obtained)
- ■ SOL deadline for underlying claim (calculated and confirmed)

## Official Resources & Government Links

| Resource                                       | Website                              | Use For                                                               |
|------------------------------------------------|--------------------------------------|-----------------------------------------------------------------------|
| NAIC — Natl. Assoc. of Insurance Commissioners | naic.org                             | PRIMARY: MDL-900 model act, consumer complaint finder, all model laws |
| NAIC Unfair Claims Practices Model Act         | naic.org/store/free/MDL-900.pdf      | The exact legal standard governing all insurer conduct                |
| NAIC Consumer Complaint Help                   | naic.org/consumer_complaint_help.htm | Instantly find your state's complaint portal                          |
| FTC — Federal Trade Commission                 | consumer.ftc.gov                     | Consumer rights in insurance; deceptive practices                     |
| CFPB — Consumer Financial Protection           | consumerfinance.gov                  | Medical debt and billing arising from claim denials                   |
| DOJ — Access to Justice                        | justice.gov/atj                      | Federal resources for legal access                                    |
| Congress.gov                                   | congress.gov                         | Federal statutes cited in this kit                                    |
| USA.gov — Auto Accidents                       | usa.gov/car-accident                 | General federal guidance for accident victims                         |

## JusticeFinder.net — Full Product Series & Free Tools

| Product / Tool                                               | URL                                                                       | Use With This Kit                                      |
|--------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------|
| Product 6 — Rideshare Accident Legal Kit                     | justicefinder.net                                                         | If denial involves an Uber/Lyft accident claim         |
| Product 7 — Personal Injury Demand Letter Builder Kit        | justicefinder.net                                                         | Build demand letter supporting the appeal              |
| Product 8 — Attorney Consultation Prep Kit                   | justicefinder.net                                                         | Prepare for attorney consultation this kit recommends  |
| Product 9 — Truck Accident Federal Evidence Preservation Kit | justicefinder.net                                                         | If denial involves a commercial truck accident         |
| Pain & Suffering Calculator                                  | justicefinder.net/tools/pain-and-suffering-calculator                     | Calculate non-economic damages for your counter-offer  |
| Lost Wages Calculator                                        | justicefinder.net/tools/lost-wages-calculator                             | Document income losses for the appeal evidence package |
| Medical Lien Calculator                                      | justicefinder.net/tools/medical-lien-settlement-reduction-calculator      | Model net recovery after liens if denial is reversed   |
| SOL Calculator                                               | justicefinder.net/tools/personal-injury-statute-of-limitations-calculator | Verify exact SOL deadline (Section 9 tracker)          |
| Demand Letter Generator                                      | justicefinder.net/tools/personal-injury-demand-letter-generator           | Draft formal demand to accompany your appeal           |
| Evidence Checklist                                           | justicefinder.net/tools/personal-injury-evidence-checklist                | Cross-reference with Section 6 evidence audit          |

# CLAIM DENIAL REVERSAL ACTION KIT

*AppealSystem · BadFaithLaw · 50-StateCommissionerPortals*

Not a law firm. Not legal advice.

**Your information. Your power. Your rights.**

A denial is not the end. It is the beginning.

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All information sourced from official U.S. government and regulatory agencies.

**NAIC · FTC · CFPB · DOJ · Congress.gov · State Insurance Commissioners (.gov)**

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Free Calculators · Legal Tools · Claim Guides · Resources

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