

CONFIDENTIAL

Insurance Tactics Exposed

An Insider Look at Hidden Claim Strategies

RESTRICTED LEGAL INSIGHT

JusticeFinder.net

VERIFIED SOURCES

Every tactic, legal standard, and regulatory claim in this guide is drawn from official government sources, Supreme Court decisions, and authoritative legal reference publications. No law firm marketing content, Wikipedia, or unverified sources were used.

NAIC MODEL LAW 900 — UNFAIR CLAIMS SETTLEMENT PRACTICES ACT (1990, AMENDED 1991)

- Full text: content.naic.org/sites/default/files/model-law-900.pdf
- Adopted in most states in substantially similar form. 14 prohibited unfair claims practices defined.
- Two-tier penalty: First tier — up to \$1,000/violation / \$100,000 aggregate. Second tier — up to \$25,000/violation / \$250,000 aggregate ('flagrantly and in conscious disregard').
- Violations must constitute a 'general business practice' or be done 'flagrantly and in conscious disregard' to trigger penalties.
- State page chart (all 50 states): content.naic.org/sites/default/files/model-law-state-page-900.pdf

NAIC MODEL REGULATION 902 — UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES (1997)

- Full text: content.naic.org/sites/default/files/model-law-902.pdf
- Required timeframes: Claim acknowledgment within 10 working days of notification (most states 10-15 days).
- Denial notice: Must notify claimant within 21 days after receipt of proofs of loss if more time is needed.
- If investigation remains incomplete: Must notify claimant every 45 days thereafter.
- Payment accompanying letter must NOT say 'final' or 'release' unless policy limit paid or compromise agreed.
- Prompt payment chart (all states): content.naic.org/sites/default/files/model-law-chart-mc-50-claims-settlement-provisions.pdf

U.S. SUPREME COURT — STATE FARM MUT. AUTO. INS. CO. v. CAMPBELL, 538 U.S. 408 (2003)

- Citation: 538 U.S. 408, 123 S.Ct. 1513. Full text: law.cornell.edu/supremecourt/text/538/408
- Holding: \$145 million punitive damages award violated Due Process Clause of 14th Amendment.
- Single-digit multipliers (up to 9:1 punitive-to-compensatory) more likely to comport with due process.
- Three Gore guideposts: (1) reprehensibility of conduct; (2) ratio of punitive to compensatory; (3) civil penalties.
- On remand, Utah Supreme Court reduced award to \$9,018,780.75 — exactly 9x compensatory damages.

CORNELL LAW SCHOOL — LEGAL INFORMATION INSTITUTE (LAW.CORNELL.EDU)

- Eggshell Skull Rule: law.cornell.edu/wex/eggshell_skull_rule
- Comparative Negligence: law.cornell.edu/wex/comparative_negligence
- Contributory Negligence: law.cornell.edu/wex/contributory_negligence

STATE INSURANCE DEPARTMENT PROMPT PAYMENT DATA — NAIC CHART MC-50

- California: Acknowledge within 15 calendar days. Texas: Acknowledge within 15 business days.
- New Jersey: Acknowledge within 10 working days (N.J.A.C. 11:2-17.6(b)).
- Most states: Approve or deny within 30 days after receiving all required information.
- Source: content.naic.org/sites/default/files/model-law-chart-mc-50-claims-settlement-provisions.pdf

ADDITIONAL REFERENCES

- NAIC Unfair Trade Practices Act, Model 880 (Spring 2024): content.naic.org/sites/default/files/model-law-880.pdf
- 32 states prohibit insurers from appealing arbitration awards to compel lower settlements (NAIC analysis).
- 30 states prohibit cross-coverage delay tactics (NAIC analysis).
- Vosburg v. Putney (1891) — Wisconsin Supreme Court: foundational eggshell skull doctrine case.

TABLE OF CONTENTS

Cover & Sources Table of Contents	1-2
<i>INTRODUCTION: Why Adjusters Are Not On Your Side TACTIC 1 — The Quick Lowball Offer TACTIC 2 — The Recorded Statement Trap TACTIC 3 — Delay, Delay, Delay (SOL Pressure) TACTIC 4 — Disputing Medical Necessity TACTIC 5 — Comparative Fault Inflation TACTIC 6 — The Social Media Trap TACTIC 7 — The Independent Medical Exam (IME) Setup TACTIC 8 — The 'Pre-Existing Condition' Defense TACTIC 9 — The Friendly Adjuster Persona TACTIC 10 — The Documentation Overload Request TACTIC 11 — The Policy Language Dispute TACTIC 12 — The Final 'Take It or Leave It' Play YOUR DEFENSE ARSENAL — The 7 Most Powerful Counter-Weapons HOW TO FILE A REGULATORY COMPLAINT — Step-by-Step BAD FAITH INSURANCE — When Illegal Conduct Becomes a Lawsuit</i>	3 4 6 8 10 12 14 16 18 20 22 24
Legal Disclaimer & About JusticeFinder	26 28 30 33 35 38

Why Adjusters Are Not On Your Side

The Legal Structure, Incentive System & Regulatory Framework

Understanding what an insurance adjuster is — and is not — is the single most important piece of knowledge you can have before your first phone call with one. Most accident victims assume the adjuster is a neutral party there to help them get what they deserve. This assumption costs people thousands of dollars every day.

WHO THE ADJUSTER WORKS FOR — AND WHO THEY DON'T

An insurance adjuster is an employee or contractor of the insurance company. Their legal duty runs entirely to their employer — not to you. They have no fiduciary duty to the claimant. They are not your advisor, not your advocate, and not your friend. Under the law, they are the insurer's representative, and their job is to investigate, evaluate, and settle claims — ideally, in the insurer's favor.

THE THREE TYPES OF ADJUSTERS YOU MAY ENCOUNTER

Adjuster Type	Who They Work For	Your Risk Level
Staff Adjuster	Direct employee of the insurance company. Salaried, performance-reviewed. Metrics include reserve reductions and claim closures.	HIGH — Institutional loyalty, performance incentives tied to claim reduction
Independent Adjuster (IA)	Contract adjuster hired by insurers for overflow or specialty claims. Paid per claim closed. No incentive to leave files open.	HIGH — Per-claim payment structure incentivizes rapid closure at low values
Public Adjuster	Hired BY the policyholder. Works on policyholder's behalf for a percentage fee. Not available in third-party claims.	LOW — The only type that works for YOU (property claims only)

THE REGULATORY FRAMEWORK — AND ITS CRITICAL LIMITATION

■ The NAIC Model Act Governs Adjuster Conduct — But Does NOT Create a Private Lawsuit Right

The NAIC Unfair Claims Settlement Practices Act (Model Law 900) sets binding standards for adjuster conduct in most states. It identifies 14 specific prohibited practices. However — the model act explicitly states it does NOT create a private cause of action. Enforcement is primarily through the state insurance commissioner via administrative penalties. Some states have separately enacted bad faith statutes that DO allow private lawsuits.

[Source: NAIC Model Law 900, Section 3 and Prefatory Note. content.naic.org/sites/default/files/model-law-900.pdf]

THE 14 PROHIBITED PRACTICES UNDER NAIC MODEL LAW 900:

- 1. Misrepresenting facts or policy provisions relating to coverage at issue
- 2. Failing to acknowledge with reasonable promptness pertinent communications
- 3. Failing to adopt reasonable standards for prompt investigation of claims
- 4. Refusing to pay claims without conducting a reasonable investigation
- 5. Failing to affirm or deny coverage within a reasonable time after completing investigation
- 6. Not attempting in good faith to effectuate prompt, fair and equitable settlement when liability is reasonably clear
- 7. Compelling insureds to institute suits by offering substantially less than amounts ultimately recovered

- 8. Attempting to settle claims for less than a reasonable person would believe the claimant is entitled
- 9. Attempting to settle claims on the basis of applications materially altered without consent
- 10. Making claims payments without indicating the coverage under which payment is made
- 11. Failing in the case of claim denial to promptly provide a reasonable explanation of the basis for denial
- 12. Failing to provide claim forms within 15 calendar days of a request
- 13. Delaying settlement where liability is clear under one portion to influence settlement under other portions (30 states)
- 14. Making known a policy of appealing arbitration awards to compel lower settlements (32 states)

[Source: NAIC Model Law 900, Section 4 — Unfair Claims Practices Defined.]

*** PRO TIP: The 'General Business Practice' Threshold Is the Key**

NAIC Model Law 900 requires violations to be committed 'with such frequency as to indicate a general business practice' OR 'flagrantly and in conscious disregard' of the Act. This means a single violation may not trigger administrative penalties. However, documented repeated violations DO trigger enforcement — and a written record of each violation, sent by certified mail, establishes the pattern. Document every interaction meticulously from Day 1.

[Source: NAIC Model Law 900, Section 3.]

The Quick Lowball Offer

REGULATORY STATUS:
POTENTIALLY ILLEGAL — NAIC Model Law 900, Section 4(f)

DANGER LEVEL

★★★★★

■ WHAT THEY DO

This is the most common and financially damaging tactic deployed against accident victims. Within hours or days of an accident — before you have received medical treatment, before you know the full extent of your injuries, and before you have any idea what your damages total — the adjuster makes a settlement offer. It feels helpful. It feels fast. It is neither. The adjuster knows exactly what they are doing. They are attempting to close your file before you know what your claim is worth. Their offer is based on minimal information — usually just the police report and initial claim notice. It almost never reflects actual medical bills, future treatment costs, lost wages, or pain and suffering. It is, by definition, a lowball offer. Internally, this tactic is designed to exploit 'acute financial stress' — the period immediately after an accident when victims are dealing with wrecked vehicles, missed work, and emergency room bills, and may desperately need cash. The adjuster counts on urgency overriding judgment.

■ THE LAW BEHIND IT

NAIC Model Law 900, Section 4(f) prohibits 'not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear.' Section 4(h) prohibits 'attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured or beneficiary was entitled to.' An offer made before your injuries are known cannot by definition reflect what a reasonable person would believe you are entitled to.

[Source: NAIC Model Law 900, Sections 4(f) and 4(h). content.naic.org/sites/default/files/model-law-900.pdf]

■ REAL-WORLD EXAMPLE

Maria was rear-ended at a red light in Texas. Her car needed \$4,200 in repairs. Two days after the accident, before she had seen a doctor, the other driver's insurer called. 'We've reviewed the police report and want to get this resolved quickly for you. We can offer \$3,500 for all claims.' Maria was still in pain from what felt like neck stiffness. She almost accepted — until a friend told her to wait. Three weeks later, her MRI showed a herniated disc. Her final settlement was \$67,000.

■ YOUR EXACT COUNTER-MOVE

1. Say only this: *'Thank you for the offer. I am still receiving medical treatment and do not know the full extent of my injuries. I am not prepared to accept any settlement at this time.'*
2. Do NOT say 'I'll think about it' — this signals openness. Say *'I cannot evaluate this offer until I reach Maximum Medical Improvement (MMI).'*
3. Send a written follow-up the same day: *'This confirms our call on [date]. I declined your offer of [amount]. I am not prepared to discuss settlement until I have completed medical treatment.'*
4. Keep the offer letter. Their early lowball offer becomes evidence of bad faith if the case is later litigated and your damages far exceed their initial figure.
5. Contact a personal injury attorney for a free consultation before responding further.

■ WHAT TO DOCUMENT

- Date, time, and name of adjuster who made the offer

- Exact dollar amount offered and any conditions attached
- The phrase they used — write it word for word
- Whether they requested a response deadline
- Your written declination letter (keep a copy)
- Any recorded call if your state is a one-party consent state

*** PRO TIP: Factor 1 Pro Tip**

The offer in your file is your baseline evidence. If the insurer later claims they were acting in good faith, their own record of offering \$3,500 to a victim with a herniated disc tells a different story. Save every offer letter and document every verbal offer in writing. This documentation is admissible in a bad faith claim and gives your attorney critical leverage.

[Source: NAIC Model Law 900, Section 4(h). content.naic.org/sites/default/files/model-law-900.pdf]

The Recorded Statement Trap

REGULATORY STATUS:
LEGAL—But Strategically Dangerous; NAIC Model 900 Governs Accuracy

DANGER LEVEL

★★★★★

■ WHAT THEY DO

Within the first few days of your accident, the adjuster will call and request a 'recorded statement.' The request sounds routine: 'I just need to get your account of what happened for our file.' This is one of the most dangerous moments in your entire claim. Adjusters are trained to conduct recorded statement interviews using specific techniques: They ask open-ended questions to get you to describe your injuries ('How are you feeling?'). They note any minimization ('I'm okay, just sore') and use it to argue your injuries were minor. They ask about prior injuries, pre-existing conditions, and prior accidents. They probe for inconsistencies. The critical legal question: Are you required to give a recorded statement to the OTHER driver's insurer? The answer, in virtually all cases, is NO. You have no contractual obligation to the adverse insurer. Your obligation to cooperate runs only to YOUR OWN insurer under your policy's cooperation clause.

■ THE LAW BEHIND IT

NAIC Model Law 900, Section 4(a) prohibits misrepresenting policy provisions to claimants. There is no provision in NAIC Model Law 900 or Model Regulation 902 that requires a third-party claimant to provide a recorded statement to the adverse insurer. Your obligation to give a recorded statement to the OTHER driver's insurer is governed by state law — and in most states, third-party claimants have no such contractual obligation.

[Source: NAIC Model Law 900; NAIC Model Regulation 902. content.naic.org. State insurance codes vary.]

■ REAL-WORLD EXAMPLE

James was injured when a delivery truck ran a red light. The truck company's insurer called 48 hours later. 'We just need a recorded statement to process your claim. It'll take 10 minutes.' James felt fine that day — the adrenaline hadn't worn off. He said 'I'm doing okay, just some soreness.' Three weeks later, his doctor diagnosed a torn rotator cuff requiring surgery. The adjuster referenced his statement: 'You said you were doing okay.' His final settlement was reduced by 30% compared to similar cases.

■ YOUR EXACT COUNTER-MOVE

- 1. When the adjuster asks for a recorded statement, say: 'I am not prepared to give a recorded statement at this time. I am still receiving medical treatment. Please send all requests in writing.'*
- 2. If YOUR OWN insurer requests a statement under your cooperation clause: You may be obligated. Request to provide a written statement instead, or have an attorney present.*
- 3. If you must give a statement: Never say 'fine,' 'okay,' or 'not too bad.' Say: 'I am in pain and receiving medical treatment. I am not yet aware of the full extent of my injuries.'*
- 4. Send a written confirmation after any call: 'This confirms I declined to provide a recorded statement.'*
- 5. If they tell you a recorded statement is required by law — this is a misrepresentation. Ask them to cite the specific law. Document that they made this claim.*

■ WHAT TO DOCUMENT

- Whether any recorded statement was taken (date, who requested it, your response)

- Any claim by the adjuster that a recorded statement was 'required by law' — document this, it may be a NAIC violation
- Your written declination of any statement request
- Any statement you did give — request a copy immediately

*** PRO TIP: Facts 2 Pro Tip**

If your own insurer's adjuster asks for a recorded statement, your policy cooperation clause may require it. Even then, you have the right to prepare thoroughly. Write out your account of events first. Use specific, precise language for describing symptoms. Never speculate about fault, speed, or what the other driver was doing. Stick to what you directly observed.

[Source: NAIC Model Law 900, Section 4(a); your state insurance code's cooperation clause provisions]

Delay, Delay, Delay — SOL Pressure

REGULATORY STATUS:
POTENTIALLY ILLEGAL — NAIC Model 902 Mandatory Timeframes

DANGER LEVEL

★★★★★

■ WHAT THEY DO

Deliberate delay is one of the most insidious tactics in the insurer's playbook because it looks like bureaucracy. The adjuster 'needs more documentation.' The supervisor is 'reviewing the file.' The 'investigation is ongoing.' Weeks become months. Months become years. Meanwhile, your statute of limitations deadline — the legal deadline to file a lawsuit — quietly approaches. The strategy is calculated: a fatigued, financially stressed claimant who has been waiting 14 months for a resolution is far more likely to accept a lowball offer than a fresh claimant who understands their rights. Delay also erodes evidence — witnesses' memories fade, surveillance footage is overwritten, and you may forget key details of the accident and your initial symptoms. NAIC Model Regulation 902 establishes mandatory timeframes for claims handling that make systematic delay a regulatory violation — but only if you know the rules and document the violations.

■ THE LAW BEHIND IT

NAIC Model Regulation 902 establishes minimum standards: Insurers must acknowledge claim receipt promptly (most states: 10-15 working days). If more time is needed after receiving proof of loss, insurer must notify claimant within 21 days. Thereafter, the insurer must send written updates with reasons every 45 days. NAIC Model Law 900, Section 4(c) prohibits 'failing to adopt and implement reasonable standards for the prompt investigation of claims.' Section 4(f) prohibits failure to attempt good-faith settlement when liability is reasonably clear. State prompt payment laws impose additional requirements with interest penalties.

[Source: NAIC Model Regulation 902. content.naic.org/sites/default/files/model-law-902.pdf; NAIC Model Law 900, §§4(c) and 4(f).]

■ REAL-WORLD EXAMPLE

Patricia was hit by an at-fault driver whose insurer acknowledged her claim. Then — nothing. Calls were not returned. 'Under investigation' for 8 months. At 22 months, a letter arrived offering \$8,000. Patricia's attorney discovered her state's 2-year statute of limitations had 2 months left. The insurer had deliberately delayed to create settlement pressure. Her attorney filed suit immediately, and the case settled for \$78,000 — but only because she had an attorney monitoring deadlines.

■ YOUR EXACT COUNTER-MOVE

1. Send a certified mail letter on Day 14 if you have not received written acknowledgment of your claim.
2. Track every date: date of accident, date of first adjuster contact, date of each delay.
3. Send written follow-up emails after every phone call: 'Confirming our call today. You stated the investigation would be complete by [date].'
4. Calculate your statute of limitations deadline NOW.
5. File a complaint with your state's Department of Insurance if the insurer misses mandatory timeframes.
6. If your deadline is within 90 days and the claim is unresolved — consult an attorney immediately.

■ WHAT TO DOCUMENT

- Every date you called and every date they failed to call back

- Every written communication with postmark dates
- Each promise of a timeline that was broken
- Your statute of limitations deadline (with state citation)
- Any certified mail receipts confirming delivery of your correspondence

*** PRO TIP: Factor 3 Pro Tip**

The NAIC prompt payment chart shows state-by-state interest penalties for insurer delay. Several states, including Texas (18% per annum) and California, impose significant interest penalties when insurers fail to pay claims on time. Document every delay with dated written correspondence — this turns the insurer's tactic against them in a regulatory complaint and creates the paper trail for a bad faith claim.

[Source: NAIC Model Regulation 902; NAIC Prompt Payment Chart MC-50. content.naic.org]

Disputing Medical Necessity

REGULATORY STATUS:
GRAYAREA—*Legal if Good Faith; Illegal if Used to Deny Without Investigation*

DANGER LEVEL

★★★★■

■ WHAT THEY DO

After receiving your medical bills, the adjuster sends your records to a 'medical review' service — a vendor that employs physicians to review records without examining you. The outcome is predictable: the reviewing physician finds that some or all of your treatment was 'not medically necessary,' 'excessive,' or 'unrelated to the accident.' The insurer reduces their offer accordingly. This tactic exploits the information asymmetry between medical professionals and accident victims. Most claimants don't know that these 'independent' medical reviewers are paid vendors of the insurance industry, reviewing hundreds of claims per month, and have a structural incentive to find reasons to reduce treatment — because that's what the insurer pays them to do. Your treating physician — who examined you repeatedly over months — has far greater knowledge of your condition than a reviewer who spent 20 minutes reading your records. The law recognizes this.

■ THE LAW BEHIND IT

NAIC Model Law 900, Section 4(d) prohibits 'refusing to pay claims without conducting a reasonable investigation based on all available information.' A medical review that ignores the treating physician's findings and reaches contrary conclusions without physical examination may fail this standard. NAIC Model Regulation 902 requires that any claim denial provide the claimant written notice of the right to review by the state Department of Insurance.

[Source: NAIC Model Law 900, §4(d); NAIC Model Regulation 902 — denial notification requirements. content.naic.org]

■ REAL-WORLD EXAMPLE

David had 14 physical therapy sessions recommended by his orthopedist after a rear-end collision fractured his clavicle. The insurer's medical reviewer, reviewing records only, concluded 8 sessions were 'reasonable.' The insurer reduced the medical bills by 43%. David's orthopedist wrote a 2-page letter explaining the medical necessity of each session. The insurer ultimately paid in full after David filed a DOI complaint.

■ YOUR EXACT COUNTER-MOVE

1. Request the full medical review report in writing — you are entitled to it.
2. Have your treating physician write a 'letter of medical necessity' addressing each challenged treatment.
3. Request the credentials and methodology of the reviewing physician.
4. File a DOI complaint citing the disparity between treating physician's opinion and reviewer's conclusion.
5. Request peer-to-peer review — a call between the adjuster's reviewing doctor and your treating physician.
6. If denied: Request written explanation of denial citing the specific basis — NAIC Regulation 902 requires this.

■ WHAT TO DOCUMENT

- The date and content of every medical review denial
- Your treating physician's letter of medical necessity
- The reviewing physician's name, credentials, and report

- Your written request for the full denial rationale
- Your DOI complaint filing confirmation

*** PRO TIP: Facts & Pro Tip**

*Under NAIC Model Regulation 902, after your claim is rejected and you object, the insurer **MUST** notify you in writing of your right to review by the state Department of Insurance. If they don't do this, that omission itself is a regulatory violation. Document every denial and every failure to notify you of your DOI review right.*

[Source: NAIC Model Regulation 902 — rejection and re-review provisions. content.naic.org/sites/default/files/model-law-902.pdf]

Comparative Fault Inflation

REGULATORY STATUS:
POTENTIALLY ILLEGAL — NAIC Model 900 §4(h) if Based on Fabricated Evidence

DANGER LEVEL

★★★★★

■ WHAT THEY DO

This tactic is elegantly simple: the adjuster attributes a portion of the fault for the accident to you — and reduces their offer proportionally. If you are found 30% at fault, they reduce their liability by 30%. In 12 states that follow the 51% bar rule, if they can manufacture enough 'evidence' of your fault to reach 51%, they can argue you owe nothing at all. The tactic exploits claimant uncertainty. Most accident victims don't know exactly what the other driver was doing, how fast either car was going, or what contributed to the collision. Adjusters probe recorded statements for any admission of inattention, speed, or behavior that can be used to inflate fault percentage. In states with pure contributory negligence (Alabama, Maryland, North Carolina, Virginia, D.C.), even 1% of attributed fault can bar your entire claim. Understanding your state's fault system is essential.

■ THE LAW BEHIND IT

NAIC Model Law 900, Section 4(h) prohibits settling claims 'for less than the amount that a reasonable person would believe the insured or beneficiary was entitled.' Artificially inflating fault percentages based on speculation — rather than evidence — to reduce payments below what a reasonable person would consider fair constitutes a violation. Cornell LII confirms the four comparative negligence categories: Pure Comparative, Modified 51% Bar, Modified 50% Bar, and Pure Contributory Negligence (AL, MD, NC, VA, DC).

[Source: NAIC Model Law 900, §4(h); Cornell LII Comparative Negligence: law.cornell.edu/wex/comparative_negligence/]

■ REAL-WORLD EXAMPLE

Sandra was stopped at a yellow light when she was T-boned by a driver running a red light. The adjuster argued Sandra was 20% at fault because she 'could have accelerated through the yellow light and avoided the collision.' There was no evidence she could have done so. The adjuster reduced their offer by 20%. Sandra obtained the intersection camera footage showing she had been stopped for 3 seconds before impact. The fault attribution was dropped entirely.

■ YOUR EXACT COUNTER-MOVE

1. *Preserve all scene evidence immediately: dashcam footage, traffic camera footage, skid marks, witnesses.*
2. *Get a written statement from every witness before they leave the scene.*
3. *Request the police report and check whether the officer cited the other driver.*
4. *Ask the adjuster in writing: 'What specific evidence supports attributing [X]% fault to me? Please provide the factual basis in writing.'*
5. *Know your state's fault system — look up your state on the Cornell LII Comparative Negligence page.*
6. *If the adjuster cites speculation or unverified claims: respond in writing challenging each one.*

■ WHAT TO DOCUMENT

- Your state's negligence system (pure comparative, modified, or contributory)
- Every piece of evidence establishing the other driver's fault

- The adjuster's written fault allocation and their stated basis
- Your written challenge to any unsupported fault attribution
- Witness names and contact information

*** PRO TIP: Factor 5 Pro Tip**

In states with pure contributory negligence (Alabama, Maryland, North Carolina, Virginia, D.C.), any attribution of fault to you can theoretically bar recovery. Do not give any statement, written or recorded, that could be construed as acknowledging any fault whatsoever until you have consulted an attorney.

[Source: Cornell LII Comparative Negligence. law.cornell.edu/wex/comparative_negligence]

The Social Media Trap

REGULATORY STATUS:
LEGAL—Insurance Companies Are Permitted to Monitor Public Social Media

DANGER LEVEL
★★★★■

■ WHAT THEY DO

Your social media profiles are surveillance footage the insurer gets for free. Every post, photo, check-in, and comment you make after your accident is potentially evidence. Insurance investigators routinely review public social media accounts as part of claims investigation. This is entirely legal. What they're looking for: photos of you engaged in physical activities that contradict your injury claims, posts about traveling or events suggesting you're mobile, comments minimizing your injuries ('I'm fine, just a little sore!'), check-ins at locations that suggest full functionality, and timeline inconsistencies between your claimed injury dates and your online activity. Even content you didn't post can be used: if a friend tags you in a photo from a party two weeks after your accident, and you appear to be standing comfortably and smiling, the adjuster will use it.

■ THE LAW BEHIND IT

Public social media posts are admissible as evidence in civil litigation under the Federal Rules of Evidence. FRE Rule 401 governs relevance; FRE Rule 901 governs authentication of electronic evidence. Courts have broadly admitted social media evidence in personal injury cases where the posts are relevant to the claimant's claimed injuries. The Electronic Communications Privacy Act (18 U.S.C. §2510 et seq.) limits access to PRIVATE communications — but NOT to content voluntarily made public.

[Source: Federal Rules of Evidence, Rules 401 and 901; Electronic Communications Privacy Act (ECPA), 18 U.S.C. §2510. law.cornell.edu]

■ REAL-WORLD EXAMPLE

Kevin filed a claim for lower back injuries following a rear-end collision. Three weeks after his accident, his wife posted a family photo at a weekend barbecue on her public Facebook — Kevin was standing, holding a plate, and smiling. The adjuster found the photo and used it to argue Kevin's injuries were minor. Kevin's attorney had to produce 8 months of physical therapy records and his doctor's testimony to overcome the adjuster's argument.

■ YOUR EXACT COUNTER-MOVE

1. Set **ALL** social media profiles to private immediately — Facebook, Instagram, LinkedIn, TikTok, X, Snapchat.
2. Do **NOT** post anything about the accident, your injuries, your physical activities, or your recovery.
3. Tell family and friends: do **NOT** tag you in any photos or posts while your claim is open.
4. Do **NOT** 'like,' comment on, or share posts that could be misconstrued as showing physical activity.
5. Review your settings: ensure tagged photos require your approval before being visible.
6. Do **NOT** delete existing posts without consulting an attorney — destruction of evidence can create additional legal problems.

■ WHAT TO DOCUMENT

- Date you set all profiles to private
- Screenshot of your current privacy settings (dated)
- Any notification that the adjuster or investigator has attempted to access your profiles

** PRO TIP: Tactic & Pro Tip*

The ECPA prohibits insurers from accessing private messages and private accounts without authorization. However, anything on your public profile is fair game. The line between 'public' and 'private' varies by platform — on Facebook, even 'friends-only' posts may be discoverable in litigation if subpoenaed. Treat your social media as if the adjuster's investigator is reading every post in real time.

[Source: ECPA, 18 U.S.C. §2510 et seq. law.cornell.edu; Federal Rules of Evidence 401, 901]

The Independent Medical Exam (IME) Setup

REGULATORY STATUS:
LEGAL—*With Important Claimant Rights That Are Rarely Disclosed*

DANGER LEVEL
★★★★■

■ WHAT THEY DO

An Independent Medical Examination (IME) is a medical evaluation ordered and paid for by the insurance company or defense counsel. Despite the word 'independent,' IME physicians are selected from a roster of doctors who regularly perform insurance examinations — and are paid by the insurer, not by you. The IME physician typically meets with you once, for 15-45 minutes. They do not treat you. They do not review your complete medical history. They produce a report for the insurer that frequently minimizes your injuries, attributes them to pre-existing conditions, or concludes your treatment was excessive. This report is then used to reduce the adjuster's offer or justify a denial. In first-party claims (your own insurance), your policy's cooperation clause may require you to submit to an IME. In third-party claims (the other driver's insurer), you generally have no obligation to submit to an IME until the case is in litigation and the court orders discovery.

■ THE LAW BEHIND IT

In first-party claims, IME obligations arise from the cooperation clause in your policy — a contractual obligation. In third-party pre-litigation claims, you have NO obligation to submit to the adverse insurer's IME. Once litigation is filed, FRCP Rule 35 allows courts to order IMEs when physical condition is 'in controversy.'¹ Most states give the examined party the right to request a copy of the IME report and to have their own physician present or the examination recorded.

[Source: FRCP Rule 35 (court-ordered IMEs in litigation); your state insurance code for policy cooperation clauses. law.cornell.edu]

■ REAL-WORLD EXAMPLE

Maria received a letter from the adverse insurer requesting she attend an IME at their doctor's office before settlement. She complied without consulting an attorney. The IME physician spent 18 minutes with her and concluded her herniated disc was a pre-existing condition unrelated to the accident. Her MRI taken before and after the accident clearly showed the new herniation — but her attorney later had to spend \$8,000 on a competing expert to overcome the IME's conclusions.

■ YOUR EXACT COUNTER-MOVE

- 1. Confirm whether you are legally required to submit to this IME — verify whether it is your own insurer or the adverse insurer.*
- 2. If you must attend: Bring a support person who can document the examination duration, questions asked, and any physical tests performed.*
- 3. Request in writing that the examination be recorded — many states allow this.*
- 4. Request a copy of the IME report within 30 days — you are typically entitled to it.*
- 5. After the IME: Write a memo documenting exactly how long the exam lasted and every question asked.*
- 6. Have your treating physician review the IME report and write a rebuttal if the conclusions are inaccurate.*

■ WHAT TO DOCUMENT

- Date, location, and duration of the examination (time in/time out)

- Name and credentials of the IME physician
- Every question asked and every physical test performed
- The IME report once received — compare it line by line against your medical records
- Your treating physician's rebuttal letter

★ PRO TIP: Factor 7 Pro Tip

Research has raised questions about IME accuracy and objectivity. While government sources do not publish specific IME bias data for liability insurance claims, the structural conflict — insurer pays the physician who evaluates the insurer's claimant — is well-documented in legal literature and widely recognized by courts as a credibility issue. Treat every IME report as potentially adversarial.
[Source: Federal Rules of Civil Procedure, Rule 35. law.cornell.edu/rules/frcp/rule_35]

The 'Pre-Existing Condition' Defense

REGULATORY STATUS:
LEGAL—But Limited by the Eggshell Skull Doctrine (All 50 States)

DANGER LEVEL

★★★★■

■ WHAT THEY DO

If you have any prior medical history — a previous back injury, arthritis, a prior car accident, any chronic condition — the adjuster will weaponize it. Their argument: your current injuries are really just your pre-existing condition, not the result of this accident. They will request years of your prior medical records and mine them for anything they can use to attribute your injuries to history rather than their insured's negligence. This tactic is particularly aggressive with soft tissue injuries, back and neck conditions, joint problems, and any condition that can be classified as 'degenerative.' The adjuster doesn't need to prove your condition is entirely pre-existing — they just need enough ambiguity to justify a substantially lower offer. What they don't tell you: the law does not allow them to use your pre-existing conditions to escape full liability for injuries they aggravated or worsened. This protection is called the Eggshell Skull Doctrine, and it exists in every single state in the USA.

■ THE LAW BEHIND IT

The Eggshell Skull Doctrine is a well-established common law doctrine recognized in all 50 states. Cornell LII: 'a defendant is responsible for a victim's unforeseeable and uncommon reactions to the defendant's negligent or intentional actions.' This means: if the defendant's negligence aggravated a pre-existing condition — even one that made you more susceptible to injury — the defendant is fully liable for the actual harm caused. The defendant 'takes their victim as they find them.' The insurer cannot reduce your settlement simply because you had a prior condition. They can only argue that the ACCIDENT did not CAUSE or WORSEN the condition — a much harder burden.

[Source: Cornell LII — Eggshell Skull Rule: law.cornell.edu/wex/eggshell_skull_rule. *Vosburg v. Putney* (1891); recognized in all 50 states.]

■ REAL-WORLD EXAMPLE

Robert, age 58, had documented mild degenerative disc disease in his lumbar spine — a condition his doctor described as 'asymptomatic' and common for his age. He was rear-ended by a distracted driver. His MRI showed the same discs were now herniated and compressing nerve roots. He needed surgery. The insurer's adjuster argued his surgery was 'due to pre-existing degeneration, not our client.' His attorney cited the Eggshell Skull Doctrine: the defendant took Robert as they found him. Robert's condition made him MORE susceptible to this injury — which made the at-fault driver MORE liable, not less. Robert's case settled for \$215,000.

■ YOUR EXACT COUNTER-MOVE

1. Ask your treating physician to document: (1) your condition BEFORE the accident, (2) your condition AFTER, and (3) the causal relationship between the accident and your current symptoms.
2. Request that your doctor specifically address: 'Was this condition asymptomatic before the accident? Was it aggravated by the accident?'
3. Do NOT authorize blanket release of all your medical records — authorize only records related to the body parts injured in the accident.
4. If the adjuster asks for records from 10 years ago, ask in writing: 'What specific prior condition do you believe is relevant, and why?'

5. Research the Eggshell Skull Doctrine in your state and cite it explicitly in your response to any pre-existing condition argument.

■ **WHAT TO DOCUMENT**

- Pre-accident medical records showing your condition was asymptomatic (if applicable)
- Your treating physician's letter causally linking the accident to your current condition
- The adjuster's written statement attributing your injuries to pre-existing conditions
- Your written response citing the Eggshell Skull Doctrine

★ **PRO TIP: Treatie B Pro Tip**

The Eggshell Skull Doctrine does NOT mean you can recover for injuries that entirely pre-existed the accident. It means you CAN recover for the AGGRAVATION or WORSENING of a pre-existing condition caused by the accident. Document clearly what existed before vs. what changed after. Your treating physician's testimony on this causation question is your most powerful counter.

[Source: Cornell LII — Eggshell Skull Rule. law.cornell.edu/wex/eggshell_skull_rule]

The Friendly Adjuster Persona

REGULATORY STATUS:
LEGAL—But a Deliberate Relationship-Building Strategy

DANGER LEVEL

★★★★■

■ WHAT THEY DO

The adjuster calls you by your first name. They sound genuinely concerned about your well-being. 'How are the kids?' 'I'm sorry you're going through this.' 'We really want to help you.' This warmth is real — and it is a strategy. Adjusters are often trained in rapport-building techniques because a claimant who feels a personal connection to the adjuster is more likely to speak freely, share information they shouldn't, and accept lower offers out of reluctance to disappoint someone who seems to care. The 'friendly adjuster' creates the illusion of a shared goal. The claimant begins to think of the adjuster as their ally. This confusion of roles leads victims to make two critical mistakes: sharing unguarded information in casual conversation, and accepting settlement offers to avoid seeming difficult. 'Off the record' is a legal fiction when dealing with an insurance adjuster. There is no 'off the record' with an insurer. Every conversation is potentially documented in the claim file.

■ THE LAW BEHIND IT

NAIC Model Law 900 prohibits misrepresentation of facts or policy provisions. It does not prohibit adjusters from being friendly. However, when friendly conversation elicits statements that are then used to misrepresent the claimant's condition or to justify a below-fair settlement, the use of those statements may implicate Section 4(f) and 4(h) of the model act. The key protection: keep all substantive claims discussion in writing where it can be verified.

[Source: NAIC Model Law 900, Sections 4(a), 4(f), 4(h). content.naic.org/sites/default/files/model-law-900.pdf]

■ REAL-WORLD EXAMPLE

Sandra's adjuster called every two weeks. 'Just checking in on you!' After three months of warm calls, Sandra mentioned she had been able to take a short walk the previous weekend. The adjuster made a note. When Sandra submitted her demand letter citing severe mobility limitations, the adjuster responded: 'Our records show you reported walking comfortably as of [date].' Sandra had no written record of the conversation, and the adjuster's note was the only documentation.

■ YOUR EXACT COUNTER-MOVE

1. *Be polite but professional. You are not required to share personal updates about your recovery.*
2. *After every conversation — friendly or otherwise — send a written summary: 'Confirming our call today. We discussed [X]. I stated [Y].'*
3. *Never give unprompted health updates: 'I had a good day yesterday' can become 'claimant reported improvement.'*
4. *If the adjuster references something you said in a casual call: request their notes for that date in writing.*
5. *Redirect all substantive discussions: 'I prefer to handle all claim details in writing. Please send your requests by email.'*

■ WHAT TO DOCUMENT

- Written confirmation sent after every phone call
- A log of every conversation date, duration, and subject matter

■ Any instance where the adjuster appears to misquote or misrepresent what you said

*** PRO TIP: Friendly Pro Tip**

The most effective defense against the friendly adjuster tactic is the same as against every other tactic: put everything in writing. A warm phone relationship becomes strategically neutral the moment you send a written confirmation after every call. The adjuster can't selectively remember the calls when you have a paper trail of every substantive statement.

[Source: NAIC Model Regulation 902 — claims file documentation requirements. content.naic.org]

The Documentation Overload Request

REGULATORY STATUS:
GRAYAREA—Legitimate or Delay Tactic Depending on What Is Requested

DANGER LEVEL

★★★★

■ WHAT THEY DO

After you submit your demand, the insurer responds with a lengthy list of documentation requests: 5 years of prior medical records, complete employment history for the past decade, tax returns, surveillance footage from businesses near the accident, statements from every person who may have witnessed the accident — due within 10 business days. Some documentation requests are legitimate and required for a fair investigation. Others are designed to exhaust you, cause you to miss deadlines, and create the appearance of cooperation problems that justify denying or reducing your claim. Learning to distinguish between the two is essential. The tactic also includes requests that are legally inappropriate: blanket authorization to release your entire medical history, employment records far beyond what is needed to calculate lost wages, and personal financial information unrelated to the claim.

■ THE LAW BEHIND IT

NAIC Model Regulation 902 requires that insurers request only documentation 'reasonably necessary' for the investigation. NAIC Model Law 900, Section 4(c) requires adoption of reasonable investigation standards. Requests for documentation extending far beyond what is necessary to evaluate the specific claim may violate the reasonableness standard. Additionally, NAIC Model Regulation 902 requires that if an investigation remains incomplete, the insurer must notify the claimant every 45 days — not repeatedly demand new documentation to restart the clock.

[Source: NAIC Model Regulation 902 — investigation standards; NAIC Model Law 900, Section 4(c). content.naic.org]

■ REAL-WORLD EXAMPLE

After a moderate rear-end collision, Thomas submitted his demand with complete medical records and lost wage documentation. The adjuster responded requesting: 10 years of prior medical records, all tax returns for 5 years, authorization to contact every employer he had ever had, and a complete list of every activity he had engaged in since the accident. Thomas spent 6 weeks gathering materials, during which the insurer extended their investigation period. His attorney later characterized this as a systematic delay tactic.

■ YOUR EXACT COUNTER-MOVE

1. Respond to documentation requests in writing, item by item.
2. Provide legitimately required documents promptly.
3. For overbroad requests, respond: 'I can provide [specific relevant documents]. I do not believe [X years of unrelated records] are reasonably necessary for evaluating this claim. Please explain the specific relevance.'
4. Never sign a blanket medical authorization — use a limited authorization specifying the date range and injury type covered.
5. Track every request date and every response date — missed deadlines may be used against you.
6. File a DOI complaint if documentation requests appear designed to delay rather than investigate.

■ WHAT TO DOCUMENT

- Every documentation request received (date, content, deadline given)
- Your response to each request (date, what you provided)
- Any request you believe exceeds what is 'reasonably necessary' (document your objection)
- Limited medical authorizations used (keep copies of every authorization you sign)

★ PRO TIP: Factor In Pro Tip

Never sign a blanket medical authorization that gives the insurer unlimited access to your entire medical history. Use a limited authorization specifying: (1) the date range — accident date to present, (2) the specific body parts injured, (3) the specific providers authorized to release records. A blanket authorization allows the insurer to mine your entire medical history for the pre-existing condition defense and other attack vectors.

[Source: NAIC Model Regulation 902 — reasonably necessary investigation standards. content.naic.org/sites/default/files/model-law-902.pdf]

The Policy Language Dispute

REGULATORY STATUS:
LEGAL—But Subject to the Contra Proferentem Doctrine

DANGER LEVEL

★★★★■

■ WHAT THEY DO

The adjuster tells you that based on the policy language, your particular injury, treatment, or circumstance is not covered, or is subject to a limitation you weren't aware of. The policy has dense, technical language, and the adjuster cites a specific exclusion or limitation clause. Most claimants have never read their policy and have no way to evaluate whether the interpretation is correct. Insurance policy interpretation disputes arise frequently in: coverage exclusions, limitations on treatment types or amounts, late notice defenses, coordination of benefits disputes, and disputes about whether a particular medical provider is covered. What the adjuster does not tell you: courts apply the contra proferentem doctrine to ambiguous insurance policy language. This doctrine holds that when policy language is ambiguous — capable of two reasonable interpretations — the ambiguity is construed AGAINST the insurer and IN FAVOR OF THE INSURED. This is not a minor technicality — it is a fundamental rule of insurance contract interpretation applied in all 50 states.

■ THE LAW BEHIND IT

The contra proferentem doctrine ('against the offeror') is a foundational rule of contract interpretation in insurance law, recognized in all 50 states. It holds that ambiguous terms in an insurance policy are construed against the insurer — the party that drafted the contract. This doctrine is based on the principle that insurers have superior knowledge of policy language and should not benefit from ambiguities they created. NAIC Model Law 900, Section 4(a) prohibits misrepresenting policy provisions — using an aggressive interpretation of ambiguous language to deny coverage may constitute misrepresentation.

[Source: Contra proferentem doctrine — recognized in all 50 states. NAIC Model Law 900, Section 4(a). content.naic.org]

■ REAL-WORLD EXAMPLE

Jennifer's insurer denied her uninsured motorist coverage claim, citing a policy exclusion for injuries 'arising from the use of a vehicle.' The adjuster argued her injury occurred while exiting the vehicle — not 'during use.' Jennifer's attorney cited the contra proferentem doctrine: the ambiguous language 'arising from use' should be construed broadly in Jennifer's favor. Three similar court decisions in her state supported this interpretation. The insurer paid in full.

■ YOUR EXACT COUNTER-MOVE

1. Request the specific policy provision cited for denial — in writing, with the exact policy language quoted.
2. Read the cited provision yourself. Identify whether the language is unambiguous or could be interpreted multiple ways.
3. Research your state's insurance code for the specific coverage type in dispute.
4. File a DOI complaint citing NAIC Model Law 900, Section 4(a) if you believe the policy language is being misrepresented.
5. Consult a coverage attorney if a significant amount is at stake — coverage disputes are a specialty area.

■ WHAT TO DOCUMENT

- The specific policy provision cited in the denial letter

- Your written request for the complete policy language
- Your written challenge to any ambiguous interpretation
- Your DOI complaint (if filed)

*** PRO TIP: Tactics 11 Pro Tip**

When the insurer cites a policy exclusion, always ask: 'Is this language unambiguous, or could it be interpreted in my favor?' Print the policy provision. Read it twice. If you can construct a reasonable interpretation that covers your claim, the contra proferentem doctrine means the ambiguity resolves in your favor. Document this argument in writing to the adjuster before filing a DOI complaint.
[Source: Contra proferentem doctrine — all 50 states; NAIC Model Law 900, Section 4(a)]

The Final 'Take It or Leave It' Play

REGULATORY STATUS:
POTENTIALLY ILLEGAL if Done in Bad Faith — NAIC Model 900 §4(e)

DANGER LEVEL

★★★★■

■ WHAT THEY DO

After months of negotiation, the adjuster calls with a shift in tone. 'I've pushed as hard as I can for you internally, and this is the absolute maximum my company will approve. This offer expires in 72 hours. After that, I can't guarantee it will still be available.' The tactics deployed here are specific: artificial urgency ('expires in 72 hours'), false authority ('I've done everything I can — my hands are tied'), and manufactured scarcity ('I can't guarantee this offer next week'). Each element is designed to override deliberate decision-making with emotional pressure. Here is what you need to know: insurance companies almost always have room to negotiate above a 'final' offer. Supervisors have higher authority than line adjusters. If your claim has real merit, the insurer has a business reason to settle rather than litigate. A 'take it or leave it' framing is almost never literally true — it is a negotiating position, not a fact.

■ THE LAW BEHIND IT

NAIC Model Law 900, Section 4(e) prohibits 'compelling insureds or beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.' Creating artificial urgency to force acceptance of a settlement substantially below the claim's value may constitute a violation of Section 4(e). NAIC Model Regulation 902 also prohibits letters accompanying payment from stating the payment is 'final' or a 'release' unless policy limits have been paid or a compromise settlement has been agreed to.

[Source: NAIC Model Law 900, §4(e); NAIC Model Regulation 902 — 'final' payment letter restrictions. content.naic.org/]

■ REAL-WORLD EXAMPLE

After 8 months of claims handling, Robert received a call: 'I went to bat for you. Final offer: \$22,000. Expires Friday. After that, file gets closed and transferred to litigation.' Robert almost accepted. His claim involved a herniated disc, 6 months of treatment, and \$31,000 in bills. He consulted an attorney on Thursday. The attorney sent a counteroffer letter that same day citing the NAIC Model Act. The claim ultimately settled for \$87,000 — four times the 'final' offer.

■ YOUR EXACT COUNTER-MOVE

1. Do NOT accept any offer under artificial time pressure.
2. Say: 'I appreciate the offer. I need a reasonable amount of time to review it with counsel. Please confirm the offer in writing.'
3. Request a written offer letter — 'final' offers should be put in writing. NAIC Regulation 902 governs what payment letters can and cannot say.
4. Ask for the adjuster's supervisor and the supervisor's authority level.
5. Consult a personal injury attorney immediately — most offer free consultations within 24-48 hours.
6. Calculate whether the offer is above or below 50% of your documented damages.
7. If you decide to reject: send a written counteroffer with documentation within the 'deadline' period.

■ WHAT TO DOCUMENT

- The date and exact wording of the 'final' offer and deadline
- Whether the offer was provided in writing
- Your written request for an extension and the response
- Your counteroffer and supporting documentation
- The final resolution and comparison to the 'final' offer

★ PRACTICE TIP: Finality Is Final

Under NAIC Model Regulation 902, if the insurer sends a payment check with language calling it 'final' or a 'release' — without your agreement to a compromise — that language itself violates the regulation. Do NOT deposit or cash any check labeled 'full and final settlement' without explicitly reviewing and agreeing to the release. Cashing such a check may be construed as acceptance of the settlement.

[Source: NAIC Model Regulation 902 — final payment letter prohibition. content.naic.org/sites/default/files/model-law-902.pdf]

Your Defense Arsenal

7 Most Powerful Counter-Weapons—Grounded in Law and Regulation

Every one of the 12 tactics in this guide has a legal or regulatory vulnerability. These 7 weapons exploit those vulnerabilities directly — and most are available to every claimant, in every state, without an attorney.

The State Insurance Commissioner Complaint

A formal complaint filed with your state's Department of Insurance (DOI) triggers an official regulatory review of the insurer's conduct. Adjusters know this. A complaint creates a formal government record, requires a written response from the insurer, and can result in penalties up to \$25,000 per violation under the NAIC two-tier penalty structure. The threat of a DOI complaint changes the calculus for adjusters handling your claim.

HOW TO DEPLOY THIS WEAPON:

File online at your state's DOI website. Find your state's DOI at NAIC.org consumer portal: eapps.naic.org/cis/. Include: claim number, dates of violations, specific NAIC Model Law 900 provisions violated, and all documented evidence. Keep the confirmation number.

[Source: NAIC Model Law 900, penalty structure; State DOI complaint portal: eapps.naic.org/cis/]

The Written Communication Protocol

Every substantive communication in your claim should be in writing. Phone calls are not evidence. Emails and certified mail are. After every phone call: send an email summary within 24 hours. Send every significant communication by certified mail, return receipt requested. This protocol single-handedly neutralizes Tactics 2, 9, and 10, and creates the paper trail for a bad faith claim.

HOW TO DEPLOY THIS WEAPON:

Send after every call: 'Confirming our conversation today at [time]. You stated [X]. I stated [Y]. You agreed to [Z] by [date].' Keep every response. This record is your most powerful protection.

[Source: NAIC Model Regulation 902 — claims file documentation; contract law written evidence standards]

The Bad Faith Threat Letter

When the insurer's conduct clearly violates the NAIC Model Act, a formal bad faith letter citing *State Farm v. Campbell*, 538 U.S. 408 (2003) and your state's bad faith statute signals that you understand the legal exposure they face. Punitive damages in bad faith cases have no cap under some state statutes — and adjusters know this.

HOW TO DEPLOY THIS WEAPON:

See the Bad Faith section of this guide for the legal standard. Only send a bad faith letter if you have documented evidence of clear NAIC Model 900 violations. False bad faith allegations undermine your credibility.

[Source: *State Farm v. Campbell*, 538 U.S. 408 (2003). law.cornell.edu/supremecourt/text/538/408]

The Adjuster Communication Log

A complete, dated log of every adjuster interaction is your claims file and your bad faith evidence simultaneously. JusticeFinder's free Adjuster Communication Log provides a structured format for tracking calls, emails, promises, and violations.

HOW TO DEPLOY THIS WEAPON:

Log: Date, time, adjuster name, company, what they said, what you said, what was promised, deadline given, your follow-up action. Send a copy of significant entries to the adjuster by email.

[Source: JusticeFinder.net free resource; NAIC Model Regulation 902 claims file standards]

The Medical Documentation Shield

Complete, consistent, and physician-documented medical records neutralize Tactics 4, 7, 8, and parts of 5 simultaneously. A treating physician who documents: (1) every symptom, (2) the causal link to the accident, (3) the medical necessity of each treatment, and (4) the distinction between pre-existing conditions and new injuries, makes the adjuster's standard attack vectors extremely difficult to execute.

HOW TO DEPLOY THIS WEAPON:

Request a copy of every visit's notes within 2 weeks. Review for accuracy. Ask your physician to document specifically: accident causation, treatment necessity, pre-accident vs. post-accident status, and MMI date.

[Source: NAIC Model Law 900 — reasonable investigation must consider 'all available information']

The Attorney Retention Signal

The moment you retain a personal injury attorney — or even state that you are consulting with one — the adjuster's behavior changes. Represented claimants receive higher settlement offers on average. Attorneys file lawsuits, attorneys know NAIC Model Act violations, and attorneys create the paper trail for bad faith claims. The attorney retention signal converts your claim from a 'soft file' to a 'hard file' immediately.

HOW TO DEPLOY THIS WEAPON:

Say: 'I am consulting with a personal injury attorney. Please direct all further communications to [attorney name/office] OR send me all communications in writing while I complete my consultation.' Most consultations are free — there is no cost to making this statement truthfully.

[Source: NAIC Model Law 900; adjuster file classification standards]

The Regulatory Complaint Ecosystem

You have four regulatory channels: (1) State DOI — your primary channel for NAIC Model Act violations. (2) NAIC Consumer Portal (eapps.naic.org/cis/) — tracks complaint ratios by insurer nationally. (3) CFPB (cfpb.gov) — limited insurance jurisdiction but useful for certain credit and financial insurance products. (4) FTC (ftc.gov/complaint) — deceptive business practices. File at multiple levels when the violation is serious.

HOW TO DEPLOY THIS WEAPON:

File DOI complaints promptly — most state DOIs have response time requirements for the insurer. Keep every confirmation number and response document.

[Source: NAIC Consumer Portal: eapps.naic.org/cis/; State DOI directories via [NAIC.org](https://www.naic.org)]

How to File a Regulatory Complaint

Step-by-Step — NAIC Process + State DOI

A formal regulatory complaint is not a lawsuit. It is a free, accessible process that triggers official government review of your insurer's conduct. Every state has a Department of Insurance (DOI) empowered to investigate and penalize insurers for NAIC Model Act violations.

WHEN TO FILE — SPECIFIC NAIC MODEL 900 TRIGGER CHECKLIST

File a DOI complaint when your insurer has:

- Failed to acknowledge your claim within 10-15 business days (varies by state) — NAIC Model 900, §4(c) Failed to explain the basis for a claim denial — NAIC Model 900, §4(k) Failed to send written update every 45 days during an incomplete investigation — NAIC Regulation 902 Made a settlement offer with a payment check labeled 'final' or 'release' without your agreement — NAIC Regulation 902 Offered substantially less than your documented damages with no reasonable basis — NAIC Model 900, §4(h) Delayed settlement where liability is reasonably clear under one portion of coverage — NAIC Model 900, §4 (30 states) Misrepresented policy provisions or facts material to your claim — NAIC Model 900, §4(a) Failed to provide claim forms within 15 calendar days of request — NAIC Model 900, §4(l) Failed to notify you of your right to DOI review after rejecting your claim — NAIC Regulation 902

WHERE TO FILE — YOUR FOUR CHANNELS

Channel	What It Does	When to Use
State DOI (PRIMARY)	Your state's DOI is your most powerful channel. Find at NAIC.org. Most states allow online filing. Triggers a formal inquiry requiring insurer response.	MOST EFFECTIVE — Use for all NAIC Model Act violations
NAIC Consumer Portal <i>naic.org/consumer</i>	Tracks national complaint ratios by insurer. Filing contributes to the insurer's public visible complaint ratio.	SUPPLEMENTAL — Use alongside state DOI
CFPB <i>cfpb.gov/complaint</i>	Limited jurisdiction over insurance, but covers certain financial insurance products.	LIMITED — Use for financial insurance products
FTC <i>ftc.gov/complaint</i>	Accepts complaints about deceptive business practices. Use if the insurer has made affirmatively false representations.	SUPPLEMENTAL — Use for deceptive practices

COMPLAINT PREPARATION WORKSHEET — FILLABLE

Your Name

Claim Number

Insurance Company Name

Adjuster Name + Direct Phone

Date of Incident

State of Filing

Date of First Violation

NAIC Section Violated

Describe the Specific Violation (what happened, when, and what the adjuster said or did):

Evidence You Have to Support the Complaint:

Relief You Are Requesting from the DOI:

★ PRO TIP: A Filed Complaint Changes the Adjuster's Calendar

When you file a DOI complaint, the insurer must respond to the insurance commissioner — in writing, on the record. This creates accountability that does not exist in a private claims negotiation. Insurers track their complaint ratios (publicly visible through NAIC.org) and a high complaint ratio triggers state market conduct examinations. Filing a legitimate, documented complaint is one of the most cost-effective actions a claimant can take.

[Source: NAIC Model Law 900 penalty structure; NAIC Consumer Portal: eapps.naic.org/cis/]

Bad Faith Insurance

When Illegal Conduct Becomes a Lawsuit—*State Farm v. Campbell*

When an insurance company's misconduct crosses from regulatory violation into deliberate, knowing disregard for your rights, you may have a private cause of action for bad faith — a lawsuit that goes beyond your original claim and seeks punitive damages against the insurer itself. This is one of the most powerful legal remedies available to injury claimants.

THE CONSTITUTIONAL FRAMEWORK — *STATE FARM V. CAMPBELL*, 538 U.S. 408 (2003)

■ What *State Farm v. Campbell* Actually Holds

In *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408, 123 S.Ct. 1513 (2003), the U.S. Supreme Court held that State Farm's \$145 million punitive damages award (against \$1 million compensatory) violated the Due Process Clause of the 14th Amendment. Justice Kennedy established that 'single-digit multipliers are more likely to comport with due process' — meaning punitive damages up to 9x compensatory damages are generally permissible. On remand, the Utah Supreme Court reduced the award to \$9,018,780.75 — precisely 9x the \$1 million compensatory award. The evidence admitted at trial revealed State Farm's 'Performance, Planning and Review' (PP&R;) policy — a national scheme to cap payouts on claims company-wide through systematic bad faith handling.

[Source: *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408 (2003). law.cornell.edu/supremecourt/text/538/408/]

THE THREE-PART TEST — *BMW v. GORE* GUIDEPOSTS

Guidepost	What Courts Evaluate	Your Evidence
1. <i>Reprehensibility</i>	Was the conduct intentional? Did it involve repeated actions? Did it harm financially vulnerable people?	Document pattern of violations in your adjuster log
2. <i>Ratio (Punitive : Compensatory)</i>	Single-digit ratio (up to 9:1) generally permissible per Campbell. Larger ratios possible for small compensatory awards with egregious conduct.	Your total compensatory damages documented
3. <i>Civil Penalties for Comparable Conduct</i>	NAIC two-tier penalty: up to \$25,000/violation (\$250,000 aggregate). State bad faith statutes may impose additional penalties.	NAIC penalty tier: First (\$1K) or Second (\$25K)

BAD FAITH SELF-ASSESSMENT CHECKLIST

Check every item that applies. **Three or more = consult a bad faith insurance attorney.**

- The insurer denied my claim without conducting a reasonable investigation
- The insurer refused to pay amounts clearly owed under the policy
- The insurer offered a settlement substantially below what a reasonable person would believe I am owed
- The insurer failed to acknowledge my claim within required timeframes (10-15 business days)
- The insurer failed to send mandatory 45-day investigation updates
- The insurer misrepresented policy language to justify a denial
- The insurer delayed settlement where their insured's liability was reasonably clear
- The insurer compelled me to file a lawsuit to recover amounts I was clearly owed
- The insurer used artificial time pressure or ultimatums to force acceptance of an inadequate offer
- The insurer failed to notify me of my right to DOI review after denying my claim
- I have documented multiple NAIC Model Law 900 violations across multiple interactions

- The gap between the insurer's offer and my documented damages is substantial (50%+)

MY SCORE: _____ checked items

■ **Bad Faith Claims Are Complex — This Checklist Is Screening, Not Legal Advice**

Bad faith insurance law varies significantly by state. Some states recognize first-party bad faith as a tort cause of action; others limit claimants to administrative remedies only. If your checklist shows 3+ items, consult a licensed bad faith insurance attorney in your state before taking action.

[Source: State Farm v. Campbell, 538 U.S. 408 (2003); state bad faith insurance statutes vary]

*** PRO TIP: Bad Faith Evidence Starts at Day 1 — Not After the Denial**

Every NAIC Model Act violation you document — every late acknowledgment, every unexplained delay, every misrepresented policy provision — is potential bad faith evidence. The pattern of conduct that State Farm's PP&R; scheme revealed in Campbell was assembled from years of documented violations. Your adjuster communication log, your certified mail records, and your DOI complaint confirmations are the building blocks of a bad faith record. Start documenting from your very first interaction.

[Source: State Farm v. Campbell, 538 U.S. 408, revealing PP&R; scheme evidence. law.cornell.edu/supremecourt/text/538/408]

About JusticeFinder

JusticeFinder (JusticeFinder.net) is an independent legal education platform for accident victims across the United States. This guide is free — always. JusticeFinder accepts no payments from law firms, insurance companies, or lead generation services. All content is grounded in official government publications and verified legal authority as cited throughout this guide.

Free Tools Referenced in This Guide:

- *Adjuster Communication Log* — JusticeFinder.net/resources/insurance-adjuster-communication-log-google-sheets/
- *Car Accident Evidence Checklist* — JusticeFinder.net/tools/personal-injury-evidence-checklist/
- *Statute of Limitations Calculator* — JusticeFinder.net/tools/personal-injury-statute-of-limitations-calculator/
- *Pain and Suffering Calculator* — JusticeFinder.net/tools/pain-and-suffering-calculator/

This document is for educational purposes only. JusticeFinder.net is not a law firm and does not provide legal advice. Nothing in this guide establishes an attorney-client relationship. The Regulatory Status badges and legal citations are based on cited legal authority as of the publication date — state-specific laws vary. Always verify current law with a licensed attorney in your state.