

No. 63916-1-I

COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION I

LEROY BUSHNELL, as the Personal Representative
of the Estate of EVELYN BUSHNELL, Deceased,

Appellant,

v.

MEDICO INSURANCE COMPANY, a Nebraska Corporation and
MEDICO LIFE INSURANCE COMPANY, a Nebraska Corporation,

Respondents.

FILED
COURT OF APPEALS
STATE OF WASHINGTON
2009 NOV 30 AM 11:44
[Handwritten signature]

BRIEF OF RESPONDENTS

Celeste T. Stokes, WSBA #12180
Robert W. Swerk, II, WSBA #6665

Attorneys for Respondents
7016 35th Avenue NE
Seattle, WA 98115-5917
(206) 522-7633

FILED
STATE OF WASHINGTON
2009 NOV 30 AM 11:44

TABLE OF CONTENTS

Table of Authorities iv

I. INTRODUCTION 1

II. RESPONDENTS’ RESPONSES TO “ASSIGNMENTS OF ERROR” AND “ISSUES RELATED TO ASSIGNMENTS OF ERROR” 2

 A. RESPONSES TO APPELLANT’S ASSIGNMENTS OF ERROR 2

 B. RESPONSES TO APPELLANT’S ISSUES PERTAINING TO ASSIGNMENT OF ERROR 2

III. STATEMENT OF THE CASE 4

 A. STATEMENT OF FACTS 4

 1. The Policy..... 5

 2. The Policy Lapsed 6

 3. The Hospitalization Clause..... 8

 4. Medico’s Procedures and Investigation..... 9

 B. STATEMENT OF PROCEDURE..... 12

IV. SUMMARY OF ARGUMENT..... 15

V. ARGUMENT 16

 A. THE STANDARD OF REVIEW OF AN ORDER GRANTING SUMMARY JUDGMENT..... 16

 B. THE POLICY LAPSED FOR NON-PAYMENT..... 17

C.	<u>THE HOSPITALIZATION CLAUSE WAS A VALID CONDITION OF COVERAGE IN THE POLICY WHICH WAS ISSUED PRIOR TO THE EFFECTIVE DATE OF RCW 48.84, THE LONG-TERM CARE INSURANCE ACT</u>	18
1.	<u>The Washington Long Term Care Insurance Act, RCW 48.84, was not in effect when the Policy was issued to Ms. Bushnell</u>	19
2.	<u>RCW 48.84 does not apply retroactively to the Policy</u> ..	20
	(a) <u>Retroactive application of RCW 48.84 would violate Medico’s Constitutional rights</u>	20
	(b) <u>Each renewal of the Policy did not create a new contract</u>	21
D.	<u>THE TRIAL JUDGE DID NOT ERR IN CONSIDERING OR BASING HIS RULING ON VALID CASE LAW</u>	22
1.	<u>The relevance of Tebb</u>	23
2.	<u>Tebb is not a different ground for denial of coverage in this case</u>	27
	(a) <u>The Bushnell Policy was a “Continuous” Policy</u>	27
	(b) <u>Estoppel does not apply in this case</u>	28
	(c) <u>Judge Erlick may have been proactive but he was not inappropriate</u>	30
E.	<u>THE HOSPITALIZATION CLAUSE WAS NOT CONTRARY TO PUBLIC POLICY AT THE TIME THE POLICY WAS ISSUED OR AT THE TIME THE CLAIM FOR COVERAGE WAS MADE</u>	30
F.	<u>THE TRIAL COURT DID NOT ERR IN HOLDING THAT MEDICO’S DENIAL OF COVERAGE WAS REASONABLE AND NOT IN BAD FAITH</u>	34

1. <u>There are no facts in the record to support a claim of unfair and deceptive sales and marketing of the Policy</u>	34
2. <u>Appellant never raised a question of fact as to the investigation, claim handling, or denial of Ms. Bushnell’s claim. Judge Erlick properly held that Medico did not act in bad faith.</u>	35
G. <u>APPELLANT WAS NOT ENTITLED TO ATTORNEY’S FEES BELOW AND IS NOT ENTITLED TO FEES ON APPEAL</u>	36
VI. CONCLUSION	36
Appendix	37
A. CP 30-35, Policy and Schedule.....	38
B. CP 47-48, Denial Letter, June 20, 2007	39
D. CP 367-69, Order Granting Defendants’ Motion for Summary Judgment and Denying Plaintiff’s Motion for Summary Judgment	40

TABLE OF AUTHORITIES

<i>Bates v. State Farm</i> , 43 Wn. App. 720, 719 P.2d 171 (1986)	32
<i>Bordeaux, Inc. v. American Safety Insurance Company</i> , 145 Wn. App. 687, 186 P.3d 1188 (2008)	16
<i>Bosko v. Pitts & Still, Inc.</i> , 75 Wn.2d 856, 454 P.2d 229 (1969)	27, 28
<i>Cary v. Allstate Ins. Co.</i> , 130 Wn.2d 335, 922 P.2d 1335 (1996)	32, 33
<i>Degel v. Majestic Mobile Manor, Inc.</i> , 129 Wn.2d 43, 914 P.2d 728 (1996)	17
<i>Dragonslayer v. Washington State Gambling Commission</i> , 139 Wn. App. 433, 161 P.3d 428 (2007)	33
<i>Hanson v. City of Snohomish</i> , 121 Wn.2d 552, 852 P.2d 295 (1993)	30
<i>Johnson v. Farmers Ins. Co. of Wash.</i> , 117 Wn.2d 558, 570-74, 817 P.2d 841 (1991)	22
<i>Moore v. Nat. Accident Soc’y</i> , 38 Wash. 31, 80 P. 171 (1905)	29
<i>Mutual of Enumclaw v. Wiscomb</i> , 95 Wn.2d 373, 622 P.2d 1234 (1980)	34
<i>Olympic Steamship Co. v. Continental Ins. Co.</i> , 117 Wn.2d 37, 811 P.2d 673 (1991)	36
<i>Perkins v. Associated Indemnity Corp.</i> , 189 Wash. 8, 63 P.2d 499 (1936)	24
<i>Primerica Life Ins. Co. v. Madison</i> , 114 Wn.App. 364, 57 P.3d 1174 (2002)	26

<i>Ryan v. Harrison</i> , 40 Wn.App. 395, 699 P.2d 230 (1985)	25
<i>Safeco Ins. Co. v. Irish</i> , 37 Wn. App. 554, 681P.2d 1294 (1984)	17
<i>Tebb v. Continental Casualty Co.</i> , 71 Wn.2d 710, 430 P.2d 597 (1967)	22, 23, 24, 27, 29
<i>Wheeler v. Rocky Mountain Fire & Cas. Co.</i> , 124 Wn.App. 868, 103 P.3d 240 (2004)	25
<i>Whiteside v. New York Life Ins. Co.</i> , 7 Wn.App. 790, 503 P.2d 1107 (1972)	26

OUT-OF-STATE CASES

<i>Brock v. Guaranty Trust Life Insurance Company</i> , 175 Ga. App. 275, 333 S.E.2d 158 (1985)	31, 32
<i>Lancon v. Employers Nat. Life Ins. Co.</i> , 424 S.W.2d 321 (Tex. Civ. App. 1968)	29
<i>Middlebrook v. Banker's Life & Cas. Co.</i> , 126 Vt. 432, 234 A.2d 346 (1967)	29

CONSTITUTIONAL PROVISIONS

U.S. Const. Art. I, §10	20
Wash. Const. Art. I §23	20

STATUTES AND REGULATIONS

RCW 46.29	34
RCW 48.84	1, 6, 10, 12, 13, 15, 19, 20
RCW 48.84.030	19
RCW 48.84.060	19, 33, 34

RCW 48.84.910.....	6, 19, 20, 21, 22, 33
WAC 284-54	19
WAC 284-54-150(7).....	6, 19

COURT RULES

RAP 2.5(a)	30
RAP 12.1(b)	30
CR 56	30, 36
CR 56(c).....	17
CR 59	15
CR 59(b).....	15
KCLCR 59(b).....	15

OTHER AUTHORITIES

2 Couch on Insurance 3d, §19:6, at 19-14 (1995).....	21
<i>Merriam-Webster Online Dictionary</i> , retrieved 11/13/09, from http://www.merriam-webster.com/dictionary/ term	26

I. INTRODUCTION

This lawsuit arises from the denial of coverage under a Skilled and Intermediate Nursing Policy issued to Evelyn Bushnell by Respondents (hereafter “Medico”). The Policy, issued on October 9, 1986, provided nursing care coverage for any condition following the hospitalization for that condition of at least three days. Upon the enactment of the Washington State Long-Term Care Insurance Act, RCW 48.84, effective January 1, 1988, insurers could no longer issue *new* policies containing hospitalization clauses.

On February 24, 2007, Ms. Bushnell was admitted to a nursing home without any prior hospitalization. On March 1, 2007, her Policy lapsed for failure to make any further premium payments. She made a claim for benefits which was denied because (1) she had not been hospitalized prior to going to the nursing home, per the policy terms, and (2) her policy lapsed for failure to pay the required premiums.

Ms. Bushnell filed suit challenging the denial of her claim arguing that the hospitalization clause was not valid because of the change in the law. Both parties filed motions for summary judgment on the coverage issue and on the claim that Respondents Medico acted in bad faith.

The court granted summary judgment in favor of Medico finding that the hospital clause was valid, Ms. Bushnell was not entitled to

coverage, and that Medico did not act in bad faith. (CP 367-69)
Appellant moved for reconsideration which was denied. Appellant
appeals the Order Granting Summary Judgment and the Order Denying
Reconsideration.

**II. RESPONSES TO “ASSIGNMENTS OF ERROR” AND
“ISSUES RELATED TO ASSIGNMENTS OF ERROR”**

A. RESPONSES TO APPELLANT’S ASSIGNMENTS OF
ERROR

1. The hospitalization clause was valid because the
policy was issued prior to the effective date of the law prohibiting such
clauses.

2. Ms. Bushnell was not entitled to coverage as a
matter of law.

3. There is no evidence that Medico committed any
unfair or deceptive acts in the sale and marketing of the nursing care
policy.

4. There is no evidence that Medico acted
unreasonably in denying the claim.

5. Appellant was not entitled to costs and attorney’s
fees.

B. RESPONSES TO APPELLANT’S ISSUES PERTAINING
TO ASSIGNMENTS OF ERROR

1. Insurers were not prohibited from offering an insurance policy with a three-day hospital stay requirement prior to January 1, 1988.

2. Ms. Bushnell's policy did not change with the changes in the law because the law did not have retroactive application to policies issued prior to January 1, 1988.

3. The hospital stay requirement was valid and did not violate public policy at the time it was issued.

4. The trial court judge is allowed to decide an issue based on the law he sees appropriate regardless of whether or not a party initially raised a particular case in their argument.

5. Estoppel does not apply to this case to prevent the trial court judge from deciding the issues based on whatever grounds he deems proper.

6. The trial court did not inject any issue of intent.

7. There is no evidence that Medico was deceptive and misleading in marketing a policy with a hospitalization clause prior to January 1, 1988.

8. There is no evidence that Medico was deceptive and misleading in marketing a policy which it was bound to honor and could not cancel as long as Ms. Bushnell paid her premiums.

9. There is no evidence that Medico did not conduct a reasonable investigation of Ms. Bushnell's claim.

10. There is no evidence of bad faith on the part of Medico.

III. STATEMENT OF THE CASE

A. STATEMENT OF FACTS¹

Evelyn Bushnell purchased an insurance policy for nursing care (Skilled and Intermediate Nursing Policy No. OB78225; Form 3355) from Respondents on **October 8, 1986**. (CP 13; CP 552) (Hereafter referred to as the "Policy.") The Policy is not a long-term care insurance policy as contemplated by RCW 48.84. (CP 79; 448-49; 579, 597) The Policy provided benefits for skilled nursing care and intermediate nursing care upon meeting certain conditions, including (a) paying premiums; and (2) being confined to a hospital for three days prior to entering nursing care for treatment of the condition for which the customer had been hospitalized. It is clear this was a policy to provide coverage for a limited

¹ Appellant designated his trial brief and attached exhibits as Clerk's Papers for this appeal (CP 295-351). In his opening brief, Appellant has cited some of the exhibits to his trial brief as evidence. Respondents objects to these documents as proper evidence for this appeal. This case did not go to trial, but was decided on summary judgment. None of the exhibits to the trial brief were admitted into evidence below nor were they considered by the court on summary judgment. (CP 367-68) The trial brief and exhibits should not be relied upon or cited in this appeal. Appellant also relies on facts submitted in a declaration in support of his Motion for Reconsideration. (CP 370-95) These "facts" are also not properly part of the record. A separate Motion to Strike was filed by Medico on November 30, 2009, and is incorporated by reference herein.

number of conditions, i.e. those which required hospitalization first, rather than all conditions that might require long-term care for which hospitalization would not necessarily be needed or expected.

On February 24, 2007, Ms. Bushnell was admitted to Lake Vue Gardens Convalescent Center, a nursing facility, without previously being hospitalized. (CP 601, 604) On March 6, 2007, Medico received Ms. Bushnell's Proof of Loss claim for benefits under her policy.² (CP 430, 585, 602) On June 20, 2007, benefits were denied because Ms. Bushnell had not been hospitalized for three days prior to her admission to Lake Vue and because her policy had lapsed for non-payment. (CP 47)

1. The Policy

The Policy essentially consists of five pages plus a one-page schedule of benefits. (CP 30-35; attached as Appendix A) It is not a long, complicated policy and does not contain any fine print.

The Policy was issued to Ms. Bushnell, effective on October 9, 1986. (CP 35; CP 550) This is stated on the Policy Schedule. (CP 35) Appellant admitted in his October 12, 2007 letter to Medico that the policy was issued on October 9, 1987. (CP 50) In his complaint, he admitted the Policy was issued on or about October 8, 1986, that Ms. Bushnell paid her

² Medico never asserted that the Proof of Loss or claim for benefits was untimely as alleged in Appellant's brief at page 19 without citation to any facts. Medico never asserted that the date the claim was received had any effect on the denial of coverage.

first premium (for the first year) before the policy was issued, and that she then tendered her first annual renewal premium payment on November 1, 1987. (CP 13) These facts support the fact that the policy was issued effective as of October 9, 1986.

Appellant asserts that the Policy “was issued after the long term care act took effect.” (Appellant’s brief at 15) He claims it was issued on January 28, 1987, based on a letter purporting to enclose a copy of the policy to Ms. Bushnell. (Appellant’s brief at 6) (*See* CP 353) This letter does not state the date the Policy was issued and is simply not probative of the issue date. Also, RCW 48.84, and in particular WAC 284-54-150(7) concerning hospitalization clauses, were effective only for policies issued after January 1, 1988, RCW 48.84.910, a year after the issue date claimed by Appellant.³

2. The Policy Lapsed

The Policy was in force as long as Ms. Bushnell paid the required premiums. Premiums were \$124.60 for each 60-day period and remained unchanged for the duration of her policy. (CP 552, 853) The Policy granted a 31-day grace period for payment:

³ The Policy required a six-month waiting period for coverage of pre-existing conditions: “Conditions you have had in the five years before your Policy Date are not covered until your policy has been in force at least six months.” (CP 30, Part C) The six-month waiting period for pre-existing conditions thus ended on April 9, 1987. The waiting period did not change the issue date of the Policy.

PART B: RENEWAL AGREEMENT

As long as you pay the renewal premium then in effect on the date it is due or during the 31-day grace period, we cannot refuse to renew your policy Your policy stays in force during your grace period.

(CP 30)

PART M: POLICY PROVISIONS

(3) **Grace Period:** Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period. You always have your grace period unless your policy will not be renewed. . . .

(4) **Reinstatement:** Your policy will lapse if you do not pay your premium before the end of the grace period.

(CP 33)

Ms. Bushnell's last payment was received by Medico on February 1, 2007. (CP 615) This payment, on the last day of the grace period, was for the coverage period January 1, 2007-February 28, 2007. (CP 615) When no payment was received for the March 1, 2007-April 30, 2007, premium period, Ms. Bushnell was sent a reminder notice. (CP 552, 556-557) When no premium was received during the regular payment period, a "Past Due Notice" was sent on March 12, 2007, advising that coverage would lapse unless prompt action was taken. (CP 553, 556, 558) No further payments were made and coverage lapsed on March 1, 2007. (See CP 615) These facts have never been disputed.

The Policy also had a 20-day waiting (“elimination”) period before payments would begin if there was coverage:

PART F: DEFINITIONS

(2) “Elimination Period” means the number of days for which benefits are eliminated in consideration for a reduced premium. The elimination period, if any, starts on the date that benefits would otherwise begin and it is in effect for the number of days shown on the Schedule.

(CP 31) The Schedule stated a 20-day elimination period. (CP 35) If there was coverage under Ms. Bushnell’s policy, she would not have been entitled to payment of any benefits until March 16, 2007 (twenty days after entering a nursing care facility). However, it is undisputed that policy premiums were not paid for any coverage period after February 28, 2007.

3. Hospitalization Clause

The Policy contained a provision, as a prerequisite to benefits, requiring a three-day hospitalization for the medical condition causing the need for care prior to nursing home admission:

PART G: SKILLED NURSING CARE AND IMMEDIATE NURSING CASE BENEFITS

To be eligible to receive benefits under Part G (a) and Part G (b), your confinement must:

- (1) be in a Nursing Facility;
- (2) be recommended by a physician;

- (3) start within 14 days after required hospital confinement of at least three days in a row; and,
- (4) be for the continued treatment of the condition(s) for which you were hospitalized.

(CP 32) Paragraph (3) of this provision is referred to as a “hospitalization clause.”

Ms. Bushnell was admitted directly from her home to Lake Vue Gardens Convalescent Center, a nursing facility, on February 24, 2007. She was not hospitalized prior to being admitted to Lake Vue. (See CP 611).

On June 20, 2007, after investigating the claim, Medico advised Ms. Bushnell that there was no coverage because she had not been hospitalized before her admission to the nursing facility **and also** because the Policy had lapsed due to lack of premium payments. (CP 47)

4. Medico’s Procedures and Investigation

Donald Lawler is Senior Vice President and General Counsel⁴ for Medico. He has been employed with Medico since 1992. (CP 578) One of his responsibilities has been to insure that all Medico policies are in compliance with state laws, including Washington. (CP 580) He and the Medico legal and compliance departments are at all times knowledgeable

⁴ He is licensed in Nebraska and Iowa. (CP 579)

of Washington state law. They use many resources on an ongoing basis to stay current and provide company employees with current knowledge of applicable laws. (CP 580) Mr. Lawler's credentials as an insurance professional and attorney, his ability to read, understand, and evaluate Washington law, and competence to train Medico employees about Washington law have never been disputed.

It is also Mr. Lawler's responsibility along with the legal and compliance departments to evaluate whether any changes in the law require an amendment or issuance of a new policy. (CP 581) For Medico to sell any policy in the State of Washington, it must first submit the policy to the Insurance Commissioner for approval. (CP 580-81) Only after it has been determined to be in compliance with state law will it be made available for purchase. (CP 581) The Policy purchased by Ms. Bushnell, Form 3355, Skilled and Intermediate Nursing policy, had been approved by the Insurance Commissioner before it was offered to her for sale. (CP 79, 584) It has been on file with the Insurance Commissioner and in good standing, that is, no changes have been required, ever since its approval. It is still an approved policy today. (CP 584) There is no dispute that the policy purchased by Ms. Bushnell was in compliance with Washington law in October 1986.

Medico was aware of the enactment of RCW 48.84. It understood

that it could no longer offer policy Form 3355 for sale after December 31, 1987. (CP 584) It created policy Form 3358, Long Term Care Insurance Policy. The new policy was approved by the Insurance Commissioner and subsequently offered for sale as of January 1, 1988. (CP 582-83) The new policy eliminated the hospitalization clause and broadened coverage compared to Form 3355 — the nursing care policy. (CP582) The premium for the new policy was substantially higher because of the expanded coverage; the 60-day premium for Form 3358 coverage is \$312.70 compared to \$124.50 for a 60-day period for the limited Form 3355 coverage. (CP 583)

Kimberly Jackson of the Medico Claims Service Department reviewed Ms. Bushnell's claim for coverage. (CP 585) Mr. Lawler and Shelly Richard — Ms. Jackson's supervisor and Director of Claims — supervised evaluation of the claim. (CP 585-86) Both Ms. Jackson and Ms. Richard have extensive ongoing training and experience. (CP 586) These facts have not been disputed.

Ms. Jackson reviewed the applicable policy, collected and reviewed a considerable number of medical records, correspondence and other documents regarding Ms. Bushnell's medical status. (CP 585) After review and evaluation of the claim, she ascertained that Ms. Bushnell had entered Lake Vue directly from her home without being previously

hospitalized. (CP 586) Ms. Jackson also reviewed the payment history and determined that no premiums had been made for any period after February 28, 2007. (CP 586) Ms. Bushnell was timely notified of the coverage determination. (CP 47-48, 586) These facts have not been disputed.

There is no evidence that Ms. Bushnell ever requested the expanded coverage provided by policy form 3358 or that she paid the additional premiums for the expanded long-term care coverage under the new policy form.

B. STATEMENT OF PROCEDURE

By letter dated October 12, 2007, Ms. Bushnell, through her son Leroy Bushnell (Appellant herein) and her attorney, challenged the denial of coverage claiming that the enactment of RCW 48.84, The Washington Long Term Care Insurance Act, subsequent to the issuance of her policy, invalidated the hospitalization clause. (CP 50-51) She argued that the provision contained in Part M (13) controlled. Part M (13) stated:

PART M: POLICY PROVISIONS

(13) Conformity With State Statutes: The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

(CP 34) Ms. Bushnell did not address her failure to pay premiums. (CP

50-51) Upon Appellant's dispute of the denial of coverage, Mr. Lawler reviewed the Washington laws and regulations and determined that the denial of coverage was correct. (CP 586-87) He responded on October 16, 2007, stating that the policy was issued prior to the effective date of the Long-Term Care Insurance Act and that it conformed to all laws in effect at that time. (CP 53, 587)

Ms. Bushnell, again through her son and her attorney, filed a complaint with the Office of the Insurance Commissioner on November 9, 2007, again arguing that the hospitalization clause contravenes RCW 48.84, the Washington Long-Term Care Insurance Act, and that the Policy itself required it to conform to Washington law. (CP 55-56) Medico responded by providing a copy of its October 16, 2007 letter and stated that the hospitalization clause was valid for policies issued prior to January 1, 1988. (CP 587, 625) The Insurance Commissioner closed the complaint, taking no action against Medico. (CP 627)

Ms. Bushnell filed a complaint⁵:

1. Seeking a judgment declaring that (a) the hospitalization clause as a prerequisite to coverage violates the Washington Long-Term Care Insurance Act; (b) the hospitalization clause is contrary to public policy; and (c) that Plaintiff is entitled to

⁵ For this appeal, "complaint" refers to Plaintiff's "Second Amended Complaint." (CP 11-18)

receive skilled and intermediate nursing benefits under the Policy.

2. Alleging breach of written contract;
3. Alleging violation of the Consumer Protection Act;
4. Alleging violation of the Insurance Fair Conduct Act; and
5. Alleging bad faith.

(CP 11-18)

Appellant filed a “Motion for Partial Summary Judgment” as to:

1. The enforceability of the hospitalization clause;
 2. Bad faith for failing to conduct a reasonable investigation;
 3. Bad faith for unreasonably and unjustly denying coverage;
- and
4. The right to treble damages for bad faith.

(CP 80-94)

Medico also filed a Motion for Summary Judgment as to all the issues raised in the complaint. (CP 97-115⁶) Judge John Erlick granted Medico’s motion, denied Appellant’s motion, and dismissed all the claims.

⁶ Respondents initially filed their Motion for Summary Judgment by calling it “Defendants’ Response and Counter Motion for Summary Judgment.” (CP 97-115) Recognizing that the title was confusing, a few days later, Respondents re-filed the document properly calling it “Defendant’s Motion for Summary Judgment.” (CP 559-77) The two documents are identical except for page 1. Judge Erlick’s Order only refers to the first document as being considered on summary judgment, which is of no consequence because the two documents are the same. This is only brought to this court’s attention because the title of the first document is confusing.

(CP 367-69) In his Order, Judge Erlick held that: “The hospital stay requirement found in Ms. Bushnell’s policy is valid and Ms. Bushnell is not entitled to coverage as a matter of law,” and “Medico’s denial of coverage was reasonable and not in bad faith.” (CP 368) Appellant filed a Motion for Reconsideration and submitted a new declaration of Leroy Bushnell with additional facts not previously submitted.⁷ (CP 370-95) Per King County LCR 59(b), Judge Erlick denied reconsideration without requesting a response from Respondents. (CP 421)

Appellant now appeals the Order Granting Summary Judgment and the Order Denying Plaintiff’s Motion for Reconsideration.

IV. SUMMARY OF ARGUMENT

There are two main issues in this case: (1) is the hospitalization clause enforceable? and (2) did coverage lapse for non-payment? Resolution of the other issues raised by Appellant flows from a determination of these primary issues.

The hospitalization clause is valid and enforceable because Ms. Bushnell’s policy was issued prior to the effective date of RCW 48.84, Washington’s Long-Term Care Insurance Act. It conformed to state law “on the Policy date” and remains a policy in good standing today.

⁷ Again, Respondents object to the court considering Appellant’s declaration in support of his Motion for Reconsideration because it does not fall within the parameters of CR 59 and Medico had no opportunity to respond to those new “facts.” See Note 1 *supra* and Respondents’ Motion to Strike filed on November 30, 2009.

The policy was enforceable by Ms. Bushnell as long as she complied with its provisions. Medico did not have the option to cancel her policy as long as she paid the premiums. Ms. Bushnell's policy lapsed when she failed to pay any premiums. Regardless of the hospitalization clause, Ms. Bushnell did not pay for any coverage for any time when she might have been eligible for such.

There was no coverage for Ms. Bushnell because she had not been hospitalized and because she failed to pay the required premiums. Medico did not act in bad faith in denying coverage for valid reasons.

V. ARGUMENT

A. THE STANDARD OF REVIEW OF AN ORDER GRANTING SUMMARY JUDGMENT.

The appellate court reviews summary judgment orders *de novo* and engages in the same inquiry as the trial court. *Bordeaux, Inc. v. American Safety Insurance Company*, 145 Wn. App. 687, 693, 186 P.3d 1188 (2008). "Interpretation of an insurance policy is a question of law, reviewed *de novo*." *Id.* Determining whether or not the hospitalization clause was enforceable is a question of law. This is not a case involving an exclusion of coverage, but rather whether the hospitalization clause is valid at all in light of a subsequent change in the law.

In this case, both sides were moving parties. The claims process and investigation in this case was not disputed. Failure to pay premiums was not disputed. The appellate court will make the same inquiry as the trial court. *See, e.g.* CR 56(c). It will view the facts and their reasonable inferences. *Degel v. Majestic Mobile Manor, Inc.*, 129 Wn.2d 43, 48, 914 P.2d 728 (1996). The reasonable inferences from the undisputed facts are that Medico properly and timely investigated the claim, complied with the law, and denied the claim in good faith.

B. THE POLICY LAPSED FOR NON-PAYMENT.

This appeal can be easily decided on the issue of payment. “[T]he general rule is that failure of an insured to pay a renewal premium by the due date results in a lapse of coverage as of the last day of the policy period.” *Safeco Ins. Co. v. Irish*, 37 Wn. App. 554, 557, 681 P.2d 1294 (1984). Ms. Bushnell never paid any policy premiums for any coverage period after February 28, 2007. This fact has never been disputed. In fact, Appellant admits that no premiums were paid after Ms. Bushnell went into the nursing home. (Appellant’s brief at page 7) Medico denied coverage based on the failure to pay policy premiums. (CP 47)

Medico raised this issue below. (CP 166-67) Appellant never responded to this issue at that time. Again on appeal, Appellant has not cited any law that allows coverage when there has been no payment. The

Policy was clear in requiring payment of premiums as a condition of coverage and warning that the Policy would lapse for non-payment. (CP 30, 33, Part B and Part M (3) & (4)) The Policy lapsed as of March 1, 2007, for non-payment.

Furthermore, there was no coverage for any days prior to the policy lapsing on March 1, 2009, because of the 20-day “Elimination Period.” Coverage would have only been effective after the elimination period ran on March 16, 2007 (twenty days after February 24, 2007, the date Ms. Bushnell entered Lake Vue). The Policy had lapsed for non-payment before that date. It must be noted that the “Elimination Period” does not eliminate the duty to pay premiums.

Appellant seems to be arguing that Medico claimed the policy lapsed somehow based on the date the claim was made. (Appellant’s brief at 19.) This is not correct. Medico never raised any issue about the timing of Ms. Bushnell’s notice of claim. Medico has only raised “lapse” as a basis for denial of the claim because of non-payment of the required premiums.

There was no coverage for Ms. Bushnell because she failed to pay her premiums and coverage was properly denied on that basis.

C. THE HOSPITALIZATION CLAUSE WAS A VALID CONDITION OF COVERAGE IN THE POLICY WHICH WAS ISSUED PRIOR TO THE EFFECTIVE DATE OF

RCW 48.84, THE LONG-TERM CARE INSURANCE ACT.

1. The Washington Long Term Care Insurance Act, RCW 48.84, was not in effect when the Policy was issued to Ms. Bushnell.

In 1986, the Washington State Legislature passed the “Long-Term Care Insurance Act.” When the Legislature enacted the Act it stated specifically that RCW 48.84.060⁸ was to take effect on November 1, 1986, and the remainder of the Act was to “apply to policies and contracts *issued* on or after **January 1, 1988.**” RCW 48.84.910 (emphasis added). The Legislature did not apply the Act to policies *renewed* on or after January 1, 1988.

The Insurance Commissioner was given the mandate to adopt rules for implementing the Act. RCW 48.84.030. The rules were filed on July 9, 1987 (*See WAC 284-54, et seq.*), and included WAC 284-54-150(7) which provides: “No insurer may offer a contract form which requires

⁸ RCW 48.84.060, as originally enacted in 1986, defined prohibited practices under the Act:

No agent, broker, or other representative of an insurer, contractor, or other organization selling or offering long-term care insurance policies or benefit contracts may: (1) Complete the medical history portion of any form or application for the purchase of such policy or contract; (2) knowingly sell a long-term care policy or contract to any person who is receiving Medicaid; or (3) use or engage in any unfair or deceptive act or practice in the advertising, sale, or marketing of long-term care policies or contracts.

prior hospitalization as a condition of covering institutional or community based care.”

In October 1986, when Medico sold and issued the Policy to Ms. Bushnell, there was no statutory or WAC provision prohibiting the hospitalization clause. The Policy could not violate an Act that was not in effect. The Policy and its terms were valid and enforceable at the time the Policy was *issued*.

2. RCW 48.84 does not apply retroactively to the Policy.

- (a) Retroactive application of RCW 48.84 would violate Medico’s Constitutional rights.

It must first be emphasized that the Legislature clearly expressed its intention in RCW 48.84.910 that the Act and its implementing rules were prospective only from **January 1, 1988**, in other words, the Act was not to have retroactive effect. RCW 48.84.910.

The United States Constitution states: “No state shall adopt any law impairing the obligations of contracts.” U.S. Const. Art. I, §10. Our state constitution echoes that guarantee: “No ... law impairing the obligations of contracts shall ever be passed.” Wash. Const. Art. I §23. Simply stated, when retroactivity is an attempt to regulate or modify the rights of the parties to an existing contract this action is unconstitutional.

“Indeed, in most instances a statute that attempts to regulate or modify the rights of parties to a prior insurance contract is unconstitutional.” 2 Couch on Insurance 3d, §19:6, at 19-14 (1995).

- (b) Each renewal of the Policy did not create a new contract.

Appellant argues that with each annual premium paid, the Policy renewal was a new contract. This argument fails for several reasons:

First, RCW 48.84.910 specifically applies the Act to policies “issued,” not renewed, “on or after January 1, 1988.” The statute does not say that the Act applies to policies “issued and in force on January 1, 1988” as argued by Appellant. (Appellant’s brief at 16.)

Second, the conformity clause in the Policy is consistent with the constitutional rights of the parties. (CP 34) Conformity clauses refer to existing statutes and are “not to be construed as consent by the insurer that the contract may be thereafter modified by statutes subsequently enacted.” 2 Couch on Insurance 3d, §19:6, at 19-14 (1995). The “Policy Date” is October 9, 1986, more than one year before the Act took effect. The Act did not exist on the “Policy Date.”

Third, RCW 48.84.910 specifically made the Act prospective only. In specifically addressing the prospectivity of the Act, the Legislature implicitly recognized the constitutional rights of insurers not to have the

policies they issued before January 1, 1988 modified by the Washington Long-Term Care Insurance Act and its related WAC rules. The explicit language in RCW 48.84.910 cannot be changed in an attempt to incorporate the mandates of the Act into an insurance policy *issued before* January 1, 1988. The constitutional rights of Medico and the reasoning of Couch should prevail in these circumstances.

D. THE TRIAL JUDGE DID NOT ERR IN CONSIDERING OR BASING HIS RULING ON VALID CASE LAW.

Appellant argues that the trial judge improperly injected the argument that the Policy was a “continuous contract” and thus valid under *Tebb v. Continental Casualty Co.*, 71 Wn.2d 710, 430 P.2d 597 (1967).⁹ He also argues that he had no opportunity to address *Tebb*.

It must first be noted that there has been no record provided to this Court to support Appellant’s version of Judge Erlick’s actions or

⁹ The issue on which *Tebb* bore could hardly have taken Appellant by surprise since, in fact, Appellant first broached the issue of whether the policy became a “new” policy upon each renewal in his Motion for Summary Judgment. (CP 87-88) Likewise, Respondents addressed the issue below in Medico’s supplemental memorandum in opposition to Appellant’s summary judgment motion. (CP 290-91) While Medico did not specifically cite the *Tebb* decision, it relied on analogous authority from Washington UIM decisions, in which the courts have also confronted the need to distinguish between new and renewal policies. See *Johnson v. Farmers Ins. Co. of Wash.*, 117 Wn.2d 558, 570-74, 817 P.2d 841 (1991). Appellant never filed a memorandum in response to Medico’s opposition memorandum. Thus, far from “injecting” the issue of continuous vs. new policies into the proceedings *ab initio*, Judge Erlick merely invited the parties to respond to authority that his own research must have disclosed bearing on an issue the parties themselves had already placed before him.

comments.¹⁰ Appellant admits he knew the court wanted to discuss *Tebb*. (Appellant's brief at 19) He cited *Tebb* in the brief he filed the day before hearing on the motions for summary judgment. (CP 359) There is no record that Appellant requested additional time to address *Tebb* prior to the hearing, at the hearing, or after even the hearing. Only now, for the first time on appeal does he complain he had no opportunity to address *Tebb*.

1. The relevance of *Tebb*.

Tebb v. Continental Casualty Co., 71 Wn.2d 710, 430 P.2d 597 (1967), addresses the issue of whether or not renewal of an insurance policy represents a continuation of the original policy and its terms or instead a new policy which must incorporate new law. In 1942, Continental Casualty issued a policy to Neal Tebb for accidental death. The policy did not provide a grace period for payment of premiums. *Id.* at 711. In 1951, the legislature enacted a mandatory 30-day grace period. *Id.* at 712. Tebb paid his premiums through August 1964. He failed to pay the September premium. He died on September 7, 1964. *Id.* at 711. The insurer denied coverage and argued that the policy was a continuous

¹⁰ Appellant has not provided a Report of Proceedings of the hearing on the summary judgment motions and consequently cannot rely on discussions that are not part of the record on appeal.

contract and the statutory grace period could not be incorporated into the contract. *Id.* at 712.

Notably, the *Tebb* court found that the policy gave the insurer the option to exercise its discretion to accept or reject any renewal premium. This key fact was pivotal to holding that there was no automatic continuation of the policy by paying premiums. *Id.* at 713. The court determined that upon renewal, Tebb's policy was a new contract. The court held that when a renewal is subject to the insurer's consent that is a conclusive indication that the parties intended a new contract upon the acceptance of renewal. *Id.* at 714.¹¹

Continental Casualty was not required to accept Tebb's renewal premiums. Ms. Bushnell's policy, on the other hand, mandated that Medico accept premium payments: "As long as you pay the renewal premium . . . we cannot refuse to renew your policy." (CP 30, Policy Part B) Under the logic of *Tebb*, based on the terms of the Policy, Ms. Bushnell's policy was a "continuous policy" rather than a "term policy" and subsequently enacted law is not incorporated into the contract. *Cf. Tebb*, 71 Wn.2d at 714 (new law is part of "term" policy).

¹¹ Court relied on *Perkins v. Associated Indemnity Corp.*, 189 Wash. 8, 63 P.2d 499 (1936). In that case, the effect of the court's holding was that an accident policy issued for one year with the option to renew from term to term with the consent of the insurer was a term policy, not a continuous one.

Appellant relies on Part M, Policy Provisions paragraph (12) to argue that the Policy itself indicates it is meant to be a “term” rather than “continuous” contract.¹² (Appellant’s brief at 23.) Part M (12) states that a “term of coverage” starts at noon on the Policy Date and ends at noon on the first renewal date. It states that “Each time you renew your policy, the new term begins when the old term ends.” Appellant argues that this indicates an intent that “new coverage” begins when the policy is renewed.

The intention of the parties to the contract is to be ascertained by the four corners of the instrument. *See Ryan v. Harrison*, 40 Wn.App. 395, 400, 699 P.2d 230 (1985). The unexpressed intention of one party is not given any weight. *Wheeler v. Rocky Mountain Fire & Cas. Co.*, 124 Wn.App. 868, 872, 103 P.3d 240 (2004). Part M (12) does not say a “new policy” starts on renewal. It also does not use the phrase “term coverage.” It simply says a “new term” begins. “Term” is not defined.

Generally, to find the intended meaning of undefined terms, the courts give them their plain, ordinary, and popular meaning as would be understood by the average insurance purchaser. *Wheeler v. Rocky Mountain Fire & Cas. Co.*, 124 Wn.App. at 872. Where no ambiguity exists one should not be created by a strained interpretation of the policy.

¹² This issue is raised for the first time on appeal.

Whiteside v. New York Life Ins. Co., 7 Wn.App. 790, 792, 503 P.2d 1107 (1972). It is unlikely an insurance purchaser would read either “new” or “term” to mean “different coverage” as Appellant suggests. He has not provided any authority that such words used in an insurance policy are to be interpreted as he suggests.

To further show that the Policy is not ambiguous or in need of the radical interpretation suggested by Appellant, a dictionary may be consulted to define a word in an insurance contract. *Whiteside*, 7 Wn.App. at 792. Merriam-Webster defines “term” as “end, termination; *also*: a point in time assigned to something (as a payment).” *Merriam-Webster Online Dictionary*, retrieved 11/13/09, from <http://www.merriam-webster.com/dictionary/term>.

Finally, the court should look to the words and phrases in the policy surrounding the undefined term as a guide to its meaning. *Whiteside*, 7 Wn.App. at 792. In this case, Part M (12) and the word “term” must be read together with the clear language mandating renewal in Part B (CP 30) and the Schedule (CP 35).¹³ In doing so, the only logical reading of “new term” is in the context of premiums due. The Schedule states the renewal premiums in increments up to an annual

¹³ A Schedule which constitutes a part of an insurance contract should be read and construed with the entire policy. See *Primerica Life Ins. Co. v. Madison*, 114 Wn.App. 364, 366, 57 P.3d 1174 (2002) (a rider is part of a policy).

premium. (CP 35) It would not be possible to pay for a policy such as this unless a policyholder selected a defined “term of coverage” for paying premiums. The only reasonable interpretation of Part M (12) is one that is consistent with the other terms in the Policy¹⁴ and is that the Policy must be renewed as long as premiums are paid and payment of premiums are due in up to one-year term increments.

2. *Tebb* is not a different ground for denial of coverage in this case.

Appellant claims that relying on *Tebb* was inappropriate because Medico had not argued that Ms. Bushnell’s Policy was a “continuous” policy. He also argues that *Tebb* was not raised as a basis for denial of coverage and consequently Medico is estopped from relying on it now, citing *Bosko v. Pitts & Still, Inc.*, 75 Wn.2d 856, 864, 454 P.2d 229 (1969). Finally he argues that the trial judge improperly injected a new issue into the case by raising *Tebb*.

(a) The Bushnell Policy was a “Continuous” Policy.

Medico denied coverage on the basis that Ms. Bushnell had not been hospitalized prior to admission to nursing care as required by her Policy and for lack of payment. *Tebb* does not provide a new basis to deny coverage; it did not create a new issue. It merely furnishes further

¹⁴ (and is also consistent with Constitutional rights)

support for the position that the hospitalization clause was valid and a proper basis to deny Ms. Bushnell's claim. Appellant has cited no authority holding that an insurer must provide an insured a Memorandum of Authorities listing every possible statute, case, or other legal authority supporting a decision to deny coverage.

(b) Estoppel does not apply in this case.

The cases relied on by Appellant for his position that Medico is estopped from raising "continuous" policy argument are factually distinguishable. In *Bosko v. Pitts & Still, Inc.*, 75 Wn.2d 856, 864, 454 P.2d 229 (1969), Bosko, a contractor, built a sewer line for the city of Tacoma. It had an insurance policy with Lloyds to cover any damages arising out of the construction. *Id.* at 857. Bosko negligently dumped waste that led to a landslide which caused damage to a railroad engine and tracks. *Id.* at 858. Lloyds denied coverage claiming that the situation was one of trespass that was not covered by the policy and damage to the engine did not exceed the deductible. *Id.* at 859. Only after a lawsuit was filed did Lloyds raise a claim that there was no coverage because Bosko had motor vehicle insurance that would cover any damage caused by the dump trucks. This was an improper denial of coverage under a completely separate policy provision than had been previously asserted. Lloyds was estopped from raising it. *Id.* at 864.

In *Moore v. Nat. Accident Soc'y*, 38 Wash. 31, 80 P. 171 (1905), the insurer denied coverage for failure to give timely notice of the claim. *Id.* at 32. At trial the case was dismissed on the basis that Moore had failed to furnish proof of his injury. The court held that this was a different condition of the policy which the insure had waived it when it denied the claim without originally raising this ground. *Id.* The insurer was estopped from relying on a different policy provision. Medico has only relied on the hospitalization clause and the payment clause in denying Ms. Bushnell's claim.¹⁵ As previously noted (*see* note 9, *supra*), it is Appellant, rather than Medico or the trial court, that initially raised the "new" policy issue.

As stated above, any reliance on *Tebb* is not a denial of coverage based on a different policy provision. Furthermore, no prejudice has resulted to Appellant from Medico not citing *Tebb* in its denial letter to Ms. Bushnell. She did not forgo pursuing other coverage or another possible solution to her situation.

¹⁵ The out-of state cases cited by Appellant are likewise distinguishable. In each case the insurer belatedly raised a new ground to deny coverage based on a different policy provision. *See, e.g. Lancon v. Employers Nat. Life Ins. Co.*, 424 S.W.2d 321, 323 (Tex. Civ. App. 1968) (claim denied because loss did not occurred with time period allowed; later insurer claimed injury not related to covered accident. Insurer was not estopped to raise second basis because there was no evidence it knew the facts to support second basis at time claim originally denied); *Middlebrook v. Banker's Life & Cas. Co.*, 126 Vt. 432, 436, 234 A.2d 346 (1967) (insurer denied claim based on fraud; at the close of trial, it raised additional defense that the sickness claimed by plaintiff did not fall within the policy definition of sickness. The insurer was estopped from raising the late defense).

- (c) Judge Erlick may have been proactive but he was not inappropriate.

Appellant has not cited any authority for the proposition that a trial judge may decide a matter on summary judgment based only on the authorities submitted by the parties. CR 56 contains no such restriction. In this case, it was within Judge Erlick's discretion to guide oral argument and his duty to decide the law. This is not the same situation once a case is on appeal where the general rule is that an issue or theory, not first presented to the trial court will not be considered on appeal. *Hanson v. City of Snohomish*, 121 Wn.2d 552, 557, 852 P.2d 295 (1993); RAP 2.5(a). RAP 12.1(b) provides:

If the appellate court concludes that an issue which is not set forth in the briefs should be considered to properly decide a case, the court may notify the parties and give them an opportunity to present written argument on the issue raised by the court.

Certainly, if the Court of Appeals may ask for briefing on an issue not raised in the trial court, a trial court judge may ask for briefing or argument on the applicability of a particular case if it was not cited by the parties (particularly where, as noted previously, the parties themselves have first raised the issue in the trial court).

- E. THE HOSPITALIZATION CLAUSE WAS NOT CONTRARY TO PUBLIC POLICY AT THE TIME THE POLICY WAS ISSUED OR AT THE TIME THE CLAIM FOR COVERAGE WAS MADE.

Appellant claims the hospitalization clause is void because it is against public policy. This issue has not been directly addressed in Washington. However, an identical policy provision was held not to violate public policy in *Brock v. Guaranty Trust Life Insurance Company*, 175 Ga. App. 275, 333 S.E.2d 158 (1985). In that case, the plaintiff was admitted to a nursing home for Alzheimer's disease. She subsequently had two hospitalizations for urinary tract infections. Following her second hospitalization, she sought benefits under her nursing care policy. There was no dispute that she returned to the nursing facility for her Alzheimer's condition. "The record established that Mrs. Brock's confinement in the nursing home was at no time preceded by a period of hospitalization for Alzheimer's disease." *Id.* at 277, 333 S.E.2d at 160.

The plaintiff in *Brock* argued that the hospitalization clause was contrary to public policy. *Id.* The court noted that there was no authority for that position. *Id.* It reflected: "The public policy of this state is created by our Constitution, laws and judicial decisions." *Id.* The court held that there was "no established public policy impediment . . . to an insurer limiting coverage only to those first hospitalized and then confined to the nursing home for the same sickness that necessitated the hospital care." *Id.* at 277. "It would be up to the legislature in this instance to

declare the public policy sought by plaintiff, as we do not believe it within the proper sphere of judicial policy-making but more appropriately within the realm of political decisions.” *Id.*

At the time the Policy was issued to Ms. Bushnell, there was no legislatively suggested or mandated public policy that hospitalization clauses were not allowed. The Washington State Legislature explicitly expressed a public policy in RCW 48.84.910 to uphold *as written* insurance policies issued before January 1, 1988. Thus, at the time the claim for benefits was made in 2007, public policy was that the Long-Term Care Act was not applicable to policies issued prior to January 1, 1988, and consequently, policy provisions, such as the hospitalization clause, pre-dating the Act did not violate public policy.

Public policy in Washington “is generally determined by the Legislature and established through statutory provisions.” *Cary v. Allstate Ins. Co.*, 130 Wn.2d 335, 340, 922 P.2d 1335 (1996). “Generally, a contract which is not prohibited by statute, condemned by judicial decision, or contrary to the public morals contravenes no public policy.” *Bates v. State Farm*, 43 Wn. App. 720, 725, 719 P.2d 171 (1986). The starting place to look for public policy is applicable legislation. *Cary v. Allstate Ins. Co.*, 130 Wn.2d at 340. Said another way, a contract not

prohibited by statute is not against public policy. For example, in *Cary*, the plaintiff challenged an insanity exclusion. The court held:

Although Washington courts will not enforce limitations in insurance contracts which are contrary to public policy and statute, insurers are otherwise free to limit their contractual liability. This court has occasionally questioned the wisdom of certain exclusion clauses, but it has rarely invoked public policy to limit or void express terms in an insurance contract even when those terms seem unnecessary or harsh in their effect.

Id. at 339-40, 348 (footnotes omitted).

The terms of the Washington Long-Term Care Insurance Act, except for those specified in RCW 48.84.060, were expressly stated not to apply to policies issued before January 1, 1988. RCW 48.84.910. Statutes are to be given prospective effect only, unless there is legislative intent to the contrary. *Dragonslayer v. Washington State Gambling Commission*, 139 Wn. App. 433, 448, 161 P.3d 428 (2007). Since public policy derives from legislation and judicial decisions, public policy also should have prospective effect only. The clear legislative intent of the Act was that it was to have prospective effect only. Thus, as stated above, there was no stated public policy, legislative or otherwise, in Washington, contrary to the hospitalization clause at the *time the Policy was issued* and at the *time the claim for benefits was made*. Public policy was that the Long-Term Care Act was not applicable to policies issued prior to January 1, 1988.

Consequently, the hospitalization clause in Ms. Bushnell's policy did not violate public policy.¹⁶

F. THE TRIAL COURT DID NOT ERR IN HOLDING THAT MEDICO'S DENIAL OF COVERAGE WAS REASONABLE AND NOT IN BAD FAITH.

1. There are no facts in the record to support a claim of unfair and deceptive sales and marketing of the Policy.

Appellant complains about unfair or deceptive **sales and marketing** of the Policy to him in violation of RCW 48.84.060. Appellant did not raise this issue in his motion for summary judgment (CP 80-94), or in his opposition to Medico's motion for summary judgment (CP 352-50). He raised it for the first time in his motion for reconsideration of the summary judgment order. (CP 409-10) As stated several times above, the "facts" submitted to the court raising this issue were in a declaration filed with Appellant's motion for reconsideration. Medico was not given the opportunity to respond to those "facts." Those "facts" are not properly before this court and should not be considered.

¹⁶ This case is a completely different situation than that presented in *Mutual of Enumclaw v. Wiscomb*, 95 Wn.2d 373, 622 P.2d 1234 (1980), cited by Appellant. That case concerned a "family exclusion" in an auto policy that conflicted with RCW 46.29, the compulsory financial responsibility law. There was no discussion about when the auto policy had been issued and whether the policy was valid when issued.

(See Note 1, *supra*, and Respondent's Motion to Strike filed November 30, 2009.)¹⁷

2. Appellant never raised a question of fact as to the investigation, claims handling, or denial of Ms. Bushnell's claim. Judge Erlick properly held that Medico did not act in bad faith.

Appellant argues that determining if an insurer acted reasonably is a question of fact. However, the undisputed facts before the trial court showed that Medico gathered all necessary information and considered the terms of the Policy and its payment history before denying the claim. Appellant never submitted any facts or law to show that Medico's actions were deficient or unreasonable. He never submitted any facts or law to show that Medico personnel could not reasonably rely on its legal and compliance departments or upon their on-going training as to the viability of policies issued by the company. Ms. Jackson, Ms. Richard and, in particular, Mr. Lawler were well aware of the process for approval of a policy, the review of policy form 3355 in light of the enactment of the Washington Long-Term Care Act, and the determination that the new law did not affect policies issued prior to January 1, 1988. Medico knew the

¹⁷ At no time has Appellant disputed any of the facts surrounding the investigation, evaluation, and denial of the claim. He complained that Medico did not consult a Washington attorney before denying the claim. (CP 91) This was the only specifically detailed wrongdoing he claimed to substantiate his claim of a bad faith investigation or claim handling. He never cited any authority that requires an insurer to consult local counsel before denying a claim. Appellant has not raised this issue on appeal.

hospitalization clause would not be valid in any *new* policy *issued* after December 31, 1987, and it took action to change future policies.

Appellant never raised a question of fact that would have entitled him to relief under CR 56. On the other hand, Medico showed that there was no question of fact and it was entitled to judgment as a matter of law. Consequently, Judge Erlick found that denial of coverage was reasonable and not in bad faith. Here on appeal, Appellant still has not pointed to any question of fact. Judge Erlick should be affirmed.

G. APPELLANT WAS NOT ENTITLED TO ATTORNEY'S FEES BELOW AND IS NOT ENTITLED TO FEES ON APPEAL.

Appellant is only entitled to attorney's fees if he prevails. He did properly did not prevail below and should not prevail here. *See Olympic Steamship Co. v. Continental Ins. Co.*, 117 Wn.2d 37, 53, 811 P.2d 673 (1991). No attorney's fees should be awarded.

VI. CONCLUSION

The hospitalization clause in Ms. Bushnell's Policy is valid. She failed to pay premiums for any coverage after February 28, 2007. Medico properly investigated the claim and reasonably denied it. Based on undisputed facts, Medico was properly entitled to judgment as a matter of law. Summary judgment and dismissal of all claims against Medico were, therefore, entirely appropriate. Respondents Medico

respectfully request this Court to affirm Judge Erlick's Order Granting Summary Judgment and Order denying reconsideration.

Respectfully submitted this 25th day of November 2009.



CELESTE T. STOKES, WSBA # 12180
ROBERT W. SWERK, II, WSBA #6665
Attorneys for Respondents

Appendix

- A. CP 30-35, Policy and Schedule
- B. CP 47-48, Denial Letter, June 20, 2007
- C. CP 367-69, Order Granting Defendants' Motion for Summary Judgment and Denying Plaintiff's Motion for Summary Judgment.

APPENDIX A

CP 30-35, Policy and Schedule

DUPLICATE



MEDICO LIFE INSURANCE COMPANY

Omaha, Nebraska A Stock Company

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.**

The premium you, the Insured, paid put this policy in force as of the Policy Date. That date is shown in the Schedule. The Schedule is attached and is a part of this policy.

ALPHABETICAL GUIDE TO YOUR POLICY

	Part		Part
Benefits	G, H, I & J	Other Important Provisions	M
Definitions	F	Payment Of Claims	L
Exceptions	D	Pre-Existing Conditions Limitation	C
How To File A Claim	K	Renewal Agreement	B
Maximum Benefits	E	Right To Return	A

PART A

PLEASE READ 30-DAY RIGHT TO RETURN

Please read your policy. If you are not satisfied, send it back to us or to the agent who sold it to you within 30 days after you receive it. We will return your money. That will mean your policy was never in force.

PART B

RENEWAL AGREEMENT

As long as you pay the renewal premium then in effect on the date it is due or during the 31-day grace period, we cannot refuse to renew your policy unless we do the same to all policies of this form issued to persons of your class (for example, age) in your state. Your policy stays in force during your grace period. No refusal of renewal will affect a claim existing in a confinement period.

We can change your premium only if we do the same to all policies of this form issued to persons of your class (for example, age) in your state and we will notify you in advance of the due date.

PART C

PRE-EXISTING CONDITIONS LIMITATION

Conditions you have had in the five years before your Policy Date are NOT covered until your policy has been in force at least six months. This applies to any injury you received or a sickness making itself known or medically treated within five years before your Policy Date. A sickness makes itself known when it would cause a prudent person to seek medical advice or treatment.

PART D

EXCEPTIONS

We will NOT pay benefits for:

- (1) loss while this coverage is not in force;
- (2) suicide or attempted suicide;
- (3) intentional, self-inflicted injury;
- (4) mental or nervous disorder in the absence of organic brain disease; and
- (5) services for which no charge normally is made.

SKILLED AND INTERMEDIATE NURSING POLICY

PART E**MAXIMUM BENEFITS**

The maximum benefits we will pay during your lifetime are shown in the Schedule. After the maximum benefits have been paid, your coverage ends.

PART F**DEFINITIONS**

- (1) "Confinement Period" starts with the first full day you are confined in a covered facility and either receive benefits under this policy or would be qualified to receive benefits except for an elimination period. It ends when you are no longer confined in a covered facility. If you are in a confinement period, a return to the hospital for less than three days in a row will not start a new confinement period. A return to the hospital for three days in a row or more, however, will start a new confinement period.
- (2) "Elimination Period" means the number of days for which benefits are eliminated in consideration for a reduced premium. The elimination period, if any, starts on the date that benefits would otherwise begin and it is in effect for the number of days shown on the Schedule. Only one elimination period will be applied to any one confinement period.
- (3) "Home Confinement" means your continuous confinement while under the regular care and attendance of a physician (a) in your home or blood relative's home or (b) in that part of a hospital used as a convalescent or rest home or self-care facility. Visits to the doctor's office or hospital for diagnosis or treatment do not terminate confinement.
- (4) "Hospital" means a place licensed or recognized as a hospital by the appropriate authority of the state in which it is located. It does NOT mean that part of a hospital or institution which is licensed or used principally as a continued- or extended-care facility, convalescent nursing facility, nursing or rest home, or home for the aged. **NO BENEFITS ARE PAYABLE FOR HOSPITAL CONFINEMENT.**
- (5) "Injuries" mean accidental bodily injuries. They must be received while your policy is in force. Also, they must result in loss independent of sickness and other causes.
- (6) "Sickness" means a sickness or disease that first manifests itself more than 30 days after your Policy Date.
- (7) "Nursing Facility" (under Part G of this policy) means a facility or that part of one which: (a) is operated pursuant to law; (b) is engaged in providing, in addition to room and board accommodations, skilled nursing care or intermediate nursing care under the supervision of a duly licensed physician; (c) provides continuous 24-hour-a-day nursing service by or under the supervision of a graduate professional registered nurse (R.N.) or licensed practical nurse (L.P.N.); and (d) maintains a daily medical record of each patient.
It is NOT a place that is primarily used for: rest; the care and treatment of mental diseases or disorders, drug addiction or alcoholism; or custodial or educational care.
- (8) "Skilled Nursing Care" means active nursing and/or restorative rehabilitation services given to treat an unstable health condition. There must be a care plan for the patient's recovery which is carried out on a daily basis. A physician must certify that you need such care. These services must medically require the skills of licensed or certified technical or professional personnel pending stabilization.
It is NOT: supportive services of a stabilized condition; care which can be learned and given by unlicensed or uncertified medical personnel; routine health care services; general maintenance; routine administration of oral or nonprescription drugs; or general supervision of routine daily activities.
- (9) "Intermediate Nursing Care" means nursing care ordered by a physician to treat a covered injury or sickness. This care must be given, under the supervision of a physician, by licensed or certified nursing personnel. These services include, but are not limited to: active nursing or maintenance therapy; a care plan less than the level of skilled nursing care; supervision of a stabilized health condition; or environmental control to insure the patient's safety. A physician must certify that you need such care. It does NOT include skilled nursing or custodial care.

- (10) "Custodial Care Facility" means a facility or that part of one that regularly provides room, board, and personal help in feeding, dressing and other essential daily living activities. It must give care to three or more residents who, not needing daily nursing care, cannot properly care for themselves due to age, sickness, disease, or physical or mental impairment. The facility must be licensed by the state in which it is located to provide such custodial care. The owner or administrator cannot be related to you by blood or marriage.
- (11) "Custodial Care" means that care usually given to residents of a custodial care facility who, not needing daily nursing care, cannot properly care for themselves due to age, sickness, disease, or physical or mental impairment. A physician must certify that you need such care.
- (12) "Physician" means a licensed practitioner of the healing arts acting within the scope of his/her license.
- (13) "Schedule" is attached to and is a part of this policy.
- (14) "You" or "Your" means the Insured named in the Schedule.
- (15) "We," "Us" or "Our" means Medico Life Insurance Company.

PART G**SKILLED NURSING CARE AND
INTERMEDIATE NURSING CARE BENEFITS**

To be eligible to receive benefits under Part G(a) and Part G(b), your confinement must:

- (1) be in a Nursing Facility;
- (2) be recommended by a physician;
- (3) start within 14 days after required hospital confinement of at least three days in a row; and
- (4) be for the continued treatment of the condition(s) for which you were in the hospital.

G(a) SKILLED NURSING CARE BENEFIT

When you are confined and get Skilled Nursing Care, we will pay the benefit shown in the Schedule subject to any elimination period shown in the Schedule. The maximum number of days payable in a confinement period and during your lifetime is shown in the Schedule.

Every 30 days during this time, your physician must certify that Skilled Nursing Care is still needed. The physician cannot be a proprietor or employee of the Nursing Facility. The director or administrator must certify you actually receive this level of care.

G(b) INTERMEDIATE NURSING CARE BENEFIT

When you are confined and get Intermediate Nursing Care, we will pay the benefit shown in the Schedule. The benefit we pay will be subject to any elimination period shown in the Schedule for a confinement period. The maximum number of days payable in a confinement period and during your lifetime is shown in the Schedule.

PART H**CUSTODIAL CARE BENEFIT**

When you are confined in a Custodial Care Facility and get Custodial Care, we will pay the benefit shown in the Schedule. The maximum number of days payable in a confinement period is shown in the Schedule. The confinement must:

- (1) begin immediately after confinement in a Nursing Facility for which we paid you Skilled Nursing Care or Intermediate Care benefits for 20 or more days in a row; and
- (2) be for the continued treatment of the condition(s) for which you were in the Nursing Facility.

PART I**HOME CONFINEMENT BENEFIT**

When you are confined at home immediately after a hospital stay of at least three days in a row, we will pay you the benefit shown in the Schedule. We will pay up to the same number of days as your prior hospital stay.

When you go directly from a hospital to a Nursing Facility and are then immediately home confined, we will pay up to the number of days as your combined stays.

The maximum number of days payable in a confinement period will not exceed 90. A benefit for home confinement will not be paid if we pay benefits under Custodial Care for the same confinement period.

PART J AMBULANCE BENEFIT

When you need a licensed ambulance service to or from a hospital where you are confined as a resident bed patient, we will pay the ambulance benefit shown in the Schedule. Our payment will be limited to one such benefit during any one confinement period.

PART K HOW TO FILE A CLAIM

- (1) **Notice of Claim:** You must give us written notice of a claim within 20 days (30 days in Mississippi; 60 days in Kentucky; 6 months in Montana) after loss starts or as soon as you can. You may give the notice or you may have someone do it for you. The notice should give your name and policy number. Notice should be mailed to our Home Office in Omaha, Nebraska, or to one of our agents.
- (2) **Claim Forms:** When we receive your notice, we will send you forms for filing proof of loss. If these forms are not sent to you in 15 days, you will have met the proof of loss rule below if, in 90 days after the loss began, you gave us a written statement of what happened.
- (3) **Proof of Loss:** You must give us written proof of your loss in 90 days or as soon as you can. But proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

PART L PAYMENT OF CLAIMS

All benefits will be paid as soon as we receive proof of loss.

The benefit (if any) for loss of your life will be paid to the beneficiary. Other losses will be paid to you. If no beneficiary is named, the benefit will be payable to your estate. Any other accrued benefits unpaid at your death may, at our option, be paid either to the beneficiary or to your estate.

If any benefit is payable to your estate, to a minor, or to any person not able to give a valid release, we may pay up to \$1,000.00 to any person we find entitled to the payment. Any payment we make in good faith will fully discharge us to the extent of the payment.

PART M POLICY PROVISIONS

- (1) **Entire Contract; Changes:** This policy, with any attachments (and the copy of your application, if attached), is the entire contract of insurance. No agent may change it in any way. Only an officer of ours can approve a change. That change must be shown in the policy.
- (2) **Time Limit on Certain Defenses:** After two years from the Policy Date, no misstatements, except fraudulent misstatements in the application for the policy, can be used to void the policy or to deny a claim for loss incurred or disability commencing after the expiration of such two-year period.
No claim for loss that starts more than six months after the Policy Date can be reduced or denied on the grounds that a condition not excluded from coverage existed prior to the Policy Date.
- (3) **Grace Period:** Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period. You always have your grace period unless your policy will not be renewed. We will send you notice of nonrenewal at least 30 days before your premium is due.
- (4) **Reinstatement:** Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement, this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of application, your policy will be put back in force on that 45th day.

Your reinstated policy will cover only loss due to accidental injury that begins after the date your policy was put in force. Also, it will cover only loss due to sickness that begins more than ten days after the date the policy was put back in force.

In all other respects, you and we will have the same rights under this policy that we had before it lapsed unless there are special conditions that apply to the reinstatement. If there are, they will be endorsed on or attached to the policy. The premium we accept to reinstate this policy may be used for a period for which premiums had not been paid. But it will not be used for any period more than 60 days before the reinstatement date.

- (5) **Physical Examination:** We, at our expense, can have you examined as often as needed while a claim is pending.
- (6) **Legal Action:** You can't bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You can't start such an action more than three years (five years in Kansas) after the date written proof of loss is required.
- (7) **Change of Beneficiary; Assignment:** Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make a change in this policy. Also, such consent is not required to surrender this policy or to assign the benefits.
- (8) **Misstatement of Age:** If your age has been misstated, the amount payable will be that which the premium would have bought at the correct age.
- (9) **Intoxicants and Narcotics:** We will not be liable for loss sustained because of your being intoxicated. Nor will we be liable for loss sustained because of your being under the influence of a narcotic. This provision will not apply to narcotics given on the advice of a physician.
- (10) **Illegal Occupation:** We will not be liable for any loss to which a contributing cause was your commission of or attempt to commit a felony. Nor will we be liable for any loss to which a contributing cause was your being engaged in an illegal occupation.
- (11) **Other Insurance With Us:** You may have only one policy like this one at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid for all other such policies.
- (12) **Term of Coverage:** Your coverage starts on the Policy Date at 12 o'clock noon standard time where you live. It ends at 12 o'clock noon on the same standard time on the first renewal date. Each time you renew your policy, the new term begins when the old term ends.
- (13) **Conformity With State Statutes:** The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

This policy is signed in our behalf by our President and Secretary.

A. L. Bloomington

Secretary

William M. Busch

President

MEDICO™ LIFE INSURANCE COMPANY
1515 SOUTH 75TH STREET
OMAHA, NE 68124

DUPLICATE
SCHEDULE

POLICY NO. - 0B78225

POLICY TYPE - 3355

INSURED - EVELYN R BUSHNELL
ZL F BUSHNELL
PO BOX 1450
ISSAQUAH WA 98027-0059

POLICY DATE.....	10/09/1986	----- RENEWAL PREMIUMS -----	
		60-DAY.....	\$124.50
		SEMI-ANNUAL.....	\$373.50
		ANNUAL.....	\$684.30

POLICY LIFETIME MAXIMUM BENEFITS.....	\$190,000.00
LIFETIME MAXIMUM BENEFIT DAYS PAYABLE	
SKILLED NURSING CARE.....	2190
INTERMEDIATE NURSING.....	360
ELIMINATION PERIOD FOR ANY ONE	
CONFINEMENT PERIOD.....	20 DAYS
SKILLED NURSING CARE DAILY BENEFIT	
FIRST 20 DAYS IN A CONFINEMENT PERIOD.....	\$.00
21ST DAY UP TO 101ST DAY.....	\$40.00
101ST DAY THRU 2210TH DAY.....	\$80.00
INTERMEDIATE NURSING CARE DAILY BENEFIT	
FIRST PAYABLE DAY IN A CONFINEMENT PERIOD THRU 180 DAYS.	\$20.00
181ST THRU 360TH PAYABLE DAY.....	\$40.00
CUSTODIAL CARE DAILY BENEFIT.....	\$15.00
MAXIMUM DAYS PER CONFINEMENT PERIOD.....	180
HOME CONFINEMENT DAILY BENEFIT.....	\$15.00
AMBULANCE BENEFIT.....	\$25.00

POLICY 3355 PLAN 3 OPTION B

APPENDIX B

CP 47-48, Denial Letter, June 20, 2007



MEDICO GROUP

Medico Insurance Company • Medico Life Insurance Company

June 20, 2007

COPY

Evelyn R. Bushnell
%L F Bushnell
Po Box 1450
Issaquah, WA 98027

Policy Number: 0B78225

Dear Mrs. Bushnell;

In order for benefits to be provided under this policy, certain requirements must be met. Based on the information received from Lake Vue Gardens, it has been determined that these policy requirements have not been met for the nursing facility care you have been receiving since 02-24-2007. Please let me take a moment to explain this claims determination.

For policy terms, benefits for skilled or intermediate care will be payable as long as the insured meets the following conditions:

- 1.) Be in a nursing facility;
- 2.) Be recommended by a physician;
- 3.) Start within 14 days after required hospital confinement of at least 3 days in a row;
- 4.) Be for the continued treatment of the conditions for which they were in the hospital.

Based on the documentation received from Lake Vue Gardens, you were admitted directly in the nursing facility from your home. Since you did not have a prior hospitalization for at least 3 days before your admit into Lake Vue Gardens, the policy requirements have not been met and benefits cannot be provided at this time.

Also, please be advised that your long term care policy lapsed on 03-01-07 as we did not receive a renewal premium from you.

If there is any additional information that you feel would affect the handling of this claim, please submit copies of the medical documentation in the yellow envelope that is provided and we will be happy to reconsider this claims determination.

Protecting Your Future Today®

1515 South 75th Street • Omaha, NE 68124 • (402) 391-4900 • fax (402) 391-6489 • www.garrettcp.com

Reproduced Image for Policy 0B78225, BUSHNELL, Claim Number 980003



COPY

MEDICO GROUP

Medico Insurance Company • Medico Life Insurance Company

I am sorry that I could not write to you more favorable at this time. If you should have any questions or concerns regarding this information, please do not hesitate to contact me directly at 402-391-6900 Ext-339.

Sincerely,

Kimberly A. Jackson
Claims Service Department

Protecting Your Future Today®

1515 South 75th Street • Omaha, NE 68124 • (402) 391-6900 • Fax (402) 391-6489 • www.go-medico.com

Reproduced Image for Policy 0B78225, BUSHNELL, Claim Number 980003

10/24/2007

Page 128

Reproduced Image for Policy 0B78225, BUSHNELL, Claim Number

12/17/2007

CP48

APPENDIX C

CP 367-69, Order Granting Defendants' Motion for Summary
Judgment and Denying Plaintiff's Motion for Summary Judgment

FOR YOUR INFORMATION
KEOLKER & SWERK

RECEIVED

2009 JUN -4 AM 11:31
FIFTH COUNTY
SUPERIOR COURT CLERK
SEATTLE, WA

The Honorable John Erlick
Date: June 4, 2009
Time: 9:00a.m.

RECEIVED
JUN 05 2009
BADGLEY-MULLINS LAW GR

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26

SUPERIOR COURT OF WASHINGTON
IN AND FOR THE COUNTY OF KING

EVELYN R. BUSHNELL, individually, and
LEROY F. BUSHNELL, individually, as
attorney in fact, and as guardian ad litem for
EVELYN R. BUSHNELL,

Plaintiff,

v.

MEDICO INSURANCE COMPANY, a
Nebraska Corporation, and MEDICO LIFE
INSURANCE COMPANY, a Nebraska
Corporation,

Defendants.

No. 07-2-38744-7SEA

Defendants'

ORDER GRANTING ~~PLAINTIFF'S~~
MOTION FOR ~~PARTIAL~~ SUMMARY
JUDGMENT AND DENYING ~~plaintiffs'~~
~~DEFENDANTS' CROSS-~~MOTION FOR
SUMMARY JUDGMENT

[PROPOSED]

THIS MATTER having come before the court on Plaintiff's Motion for Summary

Judgment and Defendants' Motion for Summary Judgment, and having reviewed the

following pleadings:

1. Plaintiff's Motion for Summary Judgment;
2. Declaration of Randall C. Johnson in Support of Plaintiff's Motion for Summary Judgment and attachments thereto;
3. Defendants Response and Counter Motion for Summary Judgment;

ORDER GRANTING ~~PLAINTIFF'S~~ ^{*Defendants'*} MOTION FOR
SUMMARY JUDGMENT - 1

COPY

BADGLEY ~ MULLINS
Law Group PLLC
Columbia Center
701 Fifth Avenue, Suite 4750
Seattle, Washington 98104
Telephone: (206) 621-6566
Fax: (206) 621-9666

CP367

COPY

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26

- 4. Declaration of Donald K. Lawler and attachments thereto;
- 5. Defendants' Motion for Summary Judgment;
- 6. Defendants' Opposition to Plaintiff's Motion for Summary Judgment;
- 7. Declaration of Celeste T. Stokes in Support of Defendants' Opposition to Plaintiff's Motion for Summary Judgment and attachments thereto;
- 8. Declaration of Donald Lawler and attachments thereto;
- 9. Defendants' Supplemental Opposition to Plaintiff's Motion for Summary Judgment;
- 10. Supplemental Declaration of Donald Lawler and attachments thereto;
- 11. Declaration of Counsel Supporting Defendants' Supplemental Opposition to Summary Judgment and attachments thereto, and
- 12. Plaintiffs' Response in Opposition to Defendants' Motion for Summary Judgment.

The Court having heard oral arguments, and having reviewed the files and pleadings herein, it is hereby ORDERED that ^{Defendants'} ~~Plaintiff's~~ Motion for ~~Partial~~ Summary Judgment is GRANTED and ~~Defendants' Cross-~~ ^{Plaintiff's} Motion for Summary Judgment is DENIED.

It is further ORDERED, ADJUDGED, and DECREED that:

- 1. The hospital stay requirement found in Ms. Bushnell's policy is ~~invalid~~ and Ms. Bushnell is ^{not} entitled to coverage as a matter of law.
- 2. Medico's denial of coverage was ~~un~~ ^{not} reasonable and in bad faith, ~~and in violation of Washington law~~
- 3. The case is dismissed with prejudice.

CP-368

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26

3. ~~Plaintiff is granted a trebling of damages proven at trial pursuant to RCW
48.30.015.~~

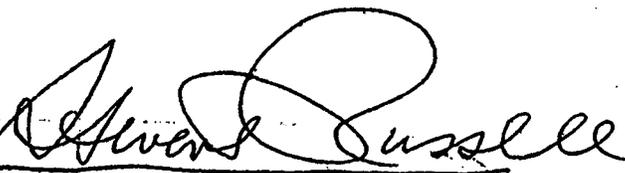
4. ~~Plaintiff is granted leave to file a supportive declaration attesting to fees for a
reasonableness hearing.~~

Done in open Court this 4th day of June, 2009.


JUDGE JOHN ERLICK

Presented By:


Randall C. Johnson, WSBA # 24556
Mark K. Davis WSBA # 38713
Attorneys for Plaintiff Leroy Bushnell


Steven Russell, WSBA # 6487
Celeste Stokes, WSBA # 12180

Defendants'
ORDER GRANTING PLAINTIFF'S MOTION FOR
SUMMARY JUDGMENT - 3

BADGLEY ~ MULLINS

Law Group PLLC
Columbia Center
701 Fifth Avenue, Suite 4750
Seattle, Washington 98104
Telephone: (206) 421-6566
Fax: (206) 421-9686

CP 369