INSURANCE

COURT REVERSES AWARD OF EXEMPLARY DAMAGES AND RENDERS TAKE NOTHING JUDGMENT ON CLAIMS FOR BREACH OF DUTY OF GOOD FAITH AND FAIR DEALING, UNCONSIONABLE CONDUCT, AND UNFAIR OR DECEPTIVE ACT OR PRACTICE

Allstate Texas Lloyds v. Mason, 123 S.W.3d 690 (Tex. App.—Fort Worth 2003).

FACTS: The Masons purchased a home insurance policy, from Allstate Texas Lloyds, which only covered foundation damage loss caused by "Accidental Discharge, Leakage or Overflow of Water or Steam from within a plumbing, heating or air conditioning system or household appliance." The Masons suffered damage to their foundation from what they claimed to have been a plumbing leak. Allstate provided an expert to determine the extent and cause of the damage. The expert determined that plumbing leaks had not caused the damage. Based on this report Allstate denied coverage on the grounds that the foundation damage was due to soil movement, not a plumbing leak.

In 2003, the Masons filed suit against Allstate under the Texas Deceptive Trade Practices Act ("DTPA") and Texas Insurance Code claiming that their denial of coverage was a breach of contract, breach of duty of good faith and fair dealing, unconscionable conduct, and unfair or deceptive acts or practices.

The trial court found that Allstate was liable to the Masons for $163,159.76 in actual damages, $88,561.97 in statutory damages, $74,600 in attorney's fees, $49,216.02 in pre and post-judgment costs, and $3.5 million in exemplary damages. Allstate appealed the award of exemplary damages.

HOLDING: Reversed.

REASONING: Evidence that merely shows a bona fide dispute about the insurer's liability on the contract does not rise to the level of bad faith. *Transp. Ins. Co. v. Moriel*, 879 S.W.2d 10, 17 (Tex.1994). The court determined that Allstate reasonably relied on the report of their expert and in good faith denied the claim because they felt that the damage was not covered under the policy. Therefore, a "bona fide" dispute about the liability of Allstate arose, which meant that their conduct was not in bad faith. An insured claiming bad faith must prove that the insurer had no reasonable basis for denying payment of a claim and that it knew or should have known that fact. *Id.* at 18. The court found that Allstate denied the claim based upon the expert's opinion, and that this was reasonable. Even though Allstate's expert was wrong, bad faith is not established if the insurer was merely wrong about the factual basis for their denial of the claim. *Lyons v. Millers Cas. Ins. Co.*, 866 S.W.2d 597, 601 (Tex. 1993).

The court based its reversal of the exemplary damages on the fact that there was no evidence that Allstate acted in bad faith when it denied the Mason's claim. Therefore, there was no evidence to support the trial court's verdict that Allstate breached its duty of good faith and fair dealing. The court also found that the evidence did not support a finding of unconscionability on the part of Allstate because they reasonably relied upon the expert's report and therefore did not come within the definition of unconscionability found in Tex. Bus. & Comm.Code Ann. § 17.45(5) (Vernon 2003). Finally, the court stated that because it was clear that Allstate had not breached its duty of good faith and fair dealing, and that it had not acted unconscionably that there was no evidence to support the finding that Allstate failed to attempt in good faith to settle the claim when its liability had become clear. The court reversed the award of exemplary damages.

EMPLOYER MUST SATISFY THE FAIR NOTICE REQUIREMENTS OF THE EXPRESS NEGLIGENCE DOCTRINE AND CONSPICUOUSNESS WHEN IT ENROLLS EMPLOYEES IN A NON-SUBSCRIBER WORKERS' COMPENSATION BENEFITS PLAN

Reyes v. Storage & Processors, Inc., 86 S.W.3d 344 (Tex. App.—Texarkana 2002).

FACTS: Storage & Processors, Inc. ("S&P") provided an optional Accident Employee Welfare Benefit Plan for its employees. When Reyes began his employment with S&P, he first signed a document, written in Spanish, stating that he had read and understood the benefit plan. He then signed the agreement. The agreement provided that in the event an employee suffered a work related illness or injury, the employee would waive any potential common law claims against S&P or any of its employees or agents. The employee's sole remedy would be the specified benefits provided by the benefit plan. Reyes became injured when a co-worker severed Reyes' foot by driving over it with a forklift. Reyes sued S&P to recover damages caused by its negligence. S&P moved for summary judgment, arguing that Reyes waived his common law claims pursuant to the benefit plan. The trial court granted summary judgment against Reyes and Reyes appealed.

HOLDING: Reversed and remanded.

REASONING: Summary judgment is proper only when the movant establishes there is no genuine issue of material fact and it is entitled to judgment as a matter of law. TEX. R. CIV. P. 166a. The benefit plan was subject to the fair notice requirements of conspicuousness and the express negligence doctrine. Under the express negligence doctrine, a party wishing to contractually shift risk from itself for consequences of its future negligence must specifically express that intent within the four corners of the agreement. *Dresser Indus., Inc. v. Page Petroleum, Inc.*, 853 S.W.2d 505, 508 (Tex. 1993). The fair notice requirement of conspicuousness requires that release or indemnity be written in such a manner that a reasonable person can understand it. A liability release or indemnity agreement that is deficient as to fair notice requirements is unenforceable as a matter of law unless the employee has actual knowledge.

As summary evidence that Reyes had knowledge, S&P noted that the person responsible for conducting safety meetings stated that she was fluent in English and Spanish and that she

reviewed the benefit plan with Reyes. She stated that Reyes signed the form written in Spanish and stated that he understood the plan. Reyes, however, stated that he could neither read nor write English, and that no one explained the plan to him in English or Spanish. Thus, the court found there was a genuine issue of material fact as to whether Reyes had actual knowledge of waiver in the benefit plan he signed and summary judgment was premature.

IN AN UNINSURED MOTORIST SUIT, AN AWARD OF ATTORNEYS' FEES TO A PREVAILING PLAINTIFF RECOVERING ON A CLAIM FOUNDED ON A WRITTEN CONTRACT IS MANDATORY

State Farm Mut. Auto. Ins., Co. v. Nickerson, 130 S.W.3d 487 (Tex. App.—Texarkana 2004).

FACTS: Nickerson was involved in an automobile accident, which resulted in injuries to her back and neck. Both she and the driver of the other vehicle were insured by State Farm Mutual Automobile Insurance Company ("State Farm"). Nickerson filed suit in 1994 and received $25,000 under the other driver's liability policy, and $10,000 for medical expenses under her own personal injury protection policy. Nickerson then sued State Farm in order to recover under the uninsured motorist portion of her policy. She won a jury trial and the court awarded her actual damages, and prejudgment interest from the date the suit was filed. The trial court also ordered State Farm to pay Nickerson's attorneys fees, which were calculated to be $46,500. State Farm appealed the granting of attorneys fees.
HOLDING: Affirmed.
REASONING: State Farm argued there was no breach of contract because the obligation to pay under the uninsured motorist claim arose only after a judicial determination of liability was made. State Farm claimed that when the trial court determined that they were liable, they paid immediately, and, therefore, no breach was committed. The court did not agree with this reasoning. Instead, it found an award of attorney's fees was mandatory in an uninsured motorist suit where a plaintiff seeks recovery on a properly presented, valid claim founded on a written contract. *Whitehead v. State Farm Mut. Auto. Ins. Co.*, 952 S.W.2d 79 (Tex. App.—Texarkana 1997). Nickerson had properly presented her claim for uninsured motorist assistance to State Farm and was denied. Because the trial court found her claim to be valid she was entitled to attorney's fees.

The court analyzed TEX. CIV. PRAC. & REM. CODE ANN. § 38.002(3) which states in a contractual dispute, in order to recover attorneys fees "payment for the just amount owed must not have been tendered before the expiration of the 30th day after the claim is presented." The court held that "[t]he phrase 'claim presented' was not equivalent to 'judgment rendered.'" When Nickerson presented her claim to State Farm it had thirty days to comply with her request or it would be liable for any attorney's fees incurred from her suit to recover on the contract. It was of no relevance that State Farm eventually made a timely payment after a judicial determination. What was important was that State Farm did not pay within 30 days after the claim was properly presented to them, and as a result Nickerson was required to enforce her right to a payment through the courts. In a contract situation such as this, attorney's fees were properly recoverable.

COMPUTER SOFTWARE PROBLEMS ARE NOT PHYSICAL DAMAGE TO TANGIBLE PROPERTY

American Online, Inc. v. St. Paul Mercury Ins. Co., 347 F.3d 89 (4th Cir. 2003).

FACTS: After American Online, Inc. ("AOL") released to the public its Version 5.0 access software, consumers filed class actions against AOL. The consumers alleged the software had substantial "bugs" and was incompatible with other software and operating systems, causing the consumers' computers to be damaged. AOL tendered the defense of these actions to its insurers, St. Paul Mercury Insurance Co. ("St. Paul"), its primary insurer, and to Underwriters at Lloyd's of London, its professional liability insurer. St. Paul denied coverage because the damages claimed by the consumers were not "property damage" as defined by the policy. AOL filed suit for a declaratory judgment against St. Paul and alleged that St. Paul had a duty to defend and indemnify AOL for damages. The district court granted summary judgment to St. Paul on the grounds that the consumers' underlying complaints did not allege physical damage to tangible property and that any damage from loss of use of tangible property fell within a policy exclusion.
HOLDING: Affirmed.
REASONING: Virginia law states that if the language of an insurance policy is unambiguous, the court will give the words their ordinary meaning and enforce the policy as written. *United Servs. Auto. Ass'n v. Webb*, 369 S.E.2d 196, 198 (Va. 1988). The court understood the word "tangible" to mean, "capable of being touched: able to be perceived as materially existent esp. by the sense of touch: palpable, tactile." *See* Webster's Third New Int'l Dictionary of the English Language Unabridged 2337 (1993). The court understood "tangible property" to mean, "having physical substance apparent to the senses." The court concluded that employing those meanings, the physical magnetic material on the hard drive of the computer that retains data, information, and instructions were tangible property, but the data, information, and instructions, which were codified in a binary language for storage on the hard drive, were not tangible property. The court found that while the loss of the idea represented by the configuration of the computer might amount to damage, such damage is damage to intangible property, and not damage to the physical components of the computer that have "physical substance apparent to the senses." AOL's insurance policy with St. Paul covered liability for "physical damage to tangible personal property," not damage to data and software. Therefore, St. Paul possessed no duty to defend or indemnify AOL under the policy.

The court understood "tangible property" to mean, "having physical substance apparent to the senses."

AN INSURER MAY FORFEIT ITS RIGHT TO CONTROL SETTLEMENTS WHEN IT VIOLATES ITS OWN CONTRACTUAL OBLIGATION TO AN INSURED

Comsys Info. Tech. Services, Inc., v. Twin City Fire Ins. Co. & Specialty Risk Services, 130 S.W.3d 181 (Tex. App.—Houston [14th Dist.] 2003).

FACTS: Texas State Low Cost Insurance, Inc. ("TSLCI") sued Compsys Information Technology Services, Inc. ("Compsys"), who they hired to develop and implement a project. In August 1997, TSLCI notified Comsys that it intended to bring suit for negligence and negligent misrepresentation in failing to properly perform and supervise work performed. Compsys subsequently notified Twin City Fire Insurance Company and Specialty Risk Services ("Twin City"), from whom Compsys had purchased an Excess Temporary Employment Contractors Errors or Omissions Liability Insurance Policy. Twin City was aware that the amount of TSLCI's alleged damages might exceed the $250,000 self-insured retainer and after a preliminary coverage review, determined that certain exclusions might apply to preclude coverage of some of TSLCI's damages. Twin City did not, however, exercise its right to defend Compsys, but simply asked Compsys if it could obtain a settlement for less than $250,000.

Discussions were made over the next two years regarding the case's true value and how much it would take to settle the case. In February 2000, Compsys settled with TSLCI at mediation for $275,000 and forgiveness of $114,000 in unpaid work that Compsys had performed for TSLCI. Twin City was requested by Compsys to be at the mediation, but was not present. Accordingly, Comsys sought recovery of approximately $139,000 on its insurance claim. Twin City denied coverage for Compsys' claim because Compsys settled the lawsuit without obtaining consent in violation of the policy. Compsys sued Twin City for breach of contract, violations of articles 21.21 and 21.55 of the Texas Insurance Code, and breach of duty of good faith and fair dealing. Both parties moved for summary judgment. The trial court granted Twin City's motion for summary judgment and denied Compsys' motion for partial summary judgment. Compsys appealed.

HOLDING: Reversed and remanded.

REASONING: An insurer must, "within a reasonable time," either "affirm or deny coverage of a claim" or "submit a reservation of rights" to the policyholder. Tex. Ins. Code Ann. Art. 21.21 § 4(10)(v) (Vernon Supp. 2003). The policy at issue obligated Twin City to indemnify, but not defend Compsys. The policy also provided that if the suit was "reasonably likely" to result in damages in excess of the self-insured retention, Twin City had "the right, but not the duty to assume control of the defense." The current court reasoned that if Twin City wanted to exercise its right to defend, it was obligated to decide coverage issues within a reasonable time after TSLCI filed its suit. If Twin City chose only to indemnify, it was obliged to decide coverage issues within a reasonable time after the settlement.

The court found that under the terms of the policy, Twin City was obligated either to consent to the settlement agreement, or assume responsibility of defending Compsys. Twin City did neither. Twin City chose not to participate in the settlement negotiations after Compsys requested its attendance more than a week prior. Although Twin City claimed that the reason for not attending the settlement was that it did not have sufficient time to investigate the coverage issues, the court observed that there were no coverage issues to be resolved prior to settlement unless Twin City exercised its option to defend. Twin City did not choose to do so during the two-and-a-half years in which the suit was pending.

The court also noted that the Supreme Court of Texas has held that a waiver of the consent provision can be established by silence or inaction for so long a period as to show an intention to yield the known right. *Tenneco, Inc. v. Enterprise Prods. Co.*, 925 S.W.2d 640, 643 (Tex. 1996). Furthermore, remaining silent was not an option under the terms of the policy since Twin City was required to either consent to the settlement or assume the defense. If an insurer has breached its covenant, whether the breach is express or implied, the insured is free, despite limiting policy provisions, to protect his or her own interest in minimizing potential liability in excess of limits by agreeing to a reasonable good-faith settlement.

THE INSURED MUST ALLEGE FACTS THAT A DEFENDANT VIOLATED THE LAW OR OFFER EVIDENCE THAT NO FACTS SUPPORT A DENIAL, TO MAKE A CLAIM OF BREACH OF CONTRACT OR BAD FAITH

Coury v. Allstate Texas Lloyd's, ____ F.Supp. 2d ____ (S.D. Tex. 2003).

FACTS: Tanya Coury purchased a home in August 2000. Prior to closing, she employed the Home Team Inspection Service ("Home Team") to inspect the property. The inspector did not note any leaks or mold in the vicinity of the dishwasher. Unbeknownst to Coury at the time, the prior owners made a claim under their homeowners policy in April 2000 for damage caused when the dishwasher flooded the house. The prior owners withdrew the insurance claim a week later, before coverage was determined. Relying on Home Team's inspection report, Coury bought the home and purchased a homeowners policy from Defendant.

Soon after purchase, Coury discovered water damage and mold in the house and filed a claim with Defendant. Defendant hired Rimkus Consulting Group, Inc., ("Rimkus") to determine the original cause of the mold and the date of onset. Rimkus made the determination that the water damage and mold was a preexisting condition. Based on the determination, Defendant denied the claim. Coury contested the denial and brought suit against the Defendant. Defendant filed a motion for summary judgment.

HOLDING: Summary judgment granted.

REASONING: The insurer breaches a duty in denying a claim if "the insurer knew or should have known that it was reasonably clear that the claim was covered." *United States Fire Ins. Co. v. Williams*, 955 S.W.2d 267 (Tex.1997). Even if the insurer is wrong in denying a claim, it is not liable for bad faith if it can establish the existence of a bona fide dispute. Whether an insurer has a reasonable basis for a denial is to be judged

according to the facts before the insurer at that time. *Harbor Ins. Co. v. Urban Constr. Co.*, 990 F.2d 195 (5th Cir.1993). In order to support a claim of bad faith, the insured must offer evidence that the insurer had no facts to support a denial. As a reasonable basis for denial, an insurer may rely on the investigation and report of its expert. However, an expert report supporting Defendant's denial cannot be relied on in good faith if the insurer knows or should know that the report is not objective. Evidence casting doubt on the reliability of the insurer's expert's opinions may support a bad-faith finding.

For evidence of bad faith, Coury relied on the Rimkus report and argued Rimkus "engaged in [an] outcome-oriented investigation designed to place the loss in question outside the coverage period." Coury argued that Defendant had no facts before it to support its denial because the decision was based solely on an unreliable and biased expert report. To support this contention, Coury must have produced some evidence that the Rimkus report lacked objectivity or that Defendant's reliance on the report was unreasonable. Coury failed in this endeavor. Coury did not challenge the methodologies relied on by Rimkus in reaching his conclusions. This suggests that Rimkus performed an adequate investigation before writing the report.

Coury's allegations of bias did not rise above bald accusations. Coury failed to offer any evidence that the report was factually unreliable or that Defendant acted unreasonably in relying on it. Defendant's motion for summary judgment was granted.

INSURER HAD NO DUTY TO DEFEND AUTO DEALERS

Landmark Chevrolet Corp. v. Universal Underwriters Ins. Co., 121 S.W.3d 886 (Tex. App.—Houston [1st Dist.] 2003).

FACTS: Landmark Chevrolet, Bill Heard Chevrolet, and Bill Heard Enterprises, ("Dealerships"), were sued by two classes of former customers for charging a "Consumer Services Fee" along with their vehicle purchases in return for a worthless coupon book. The dealerships did not explain the service fee to the class members, except that it was part of the price of the vehicle. The classes alleged violations of the Texas Deceptive Trade Practices Act and fraud. The classes did not allege that the dealerships extended credit in connection with the automobile, nor did they allege any violations of state or federal truth-in-lending laws.

Dealerships had Statute and Title E&O coverage insurance policies from Universal Underwriters Insurance Company ("Universal"). The policies created a duty to defend any claims arising out of an alleged violation of any federal, state, or local truth-in-lending or truth-in-leasing law. Universal declined to defend Dealerships and filed a declaratory judgment action, seeking a declaration that it did not owe a duty to defend Dealerships in the underlying lawsuits. The trial court granted summary judgment in favor of Universal, holding that Universal had no duty to defend Dealerships. The Dealerships appealed.

HOLDING: Affirmed.

REASONING: If a petition does not allege facts within the scope of coverage, an insurer is not required to defend a suit against its insured. *Nat'l Union Fire Ins. Co. v. Merchs. Fast Motor Lines, Inc.*, 939 S.W.2d 139, 141 (Tex.1997). To determine Universal's duty to defend, the court applied the "eight-corners" rule, comparing the factual allegations within the four corners of the pleadings with the language within the four corners of the insurance policy. Even giving the pleadings liberal construction, the court concluded that they did not allege facts indicating that Dealerships were seeking damages for a violation of a federal or state truth-in-lending or truth-in-leasing law.

Dealerships also argue that the court should have created an exception to the "eight corners rule" and considered unpleaded, but undisputed, factual allegations. Dealerships wanted the court to consider unplead factual allegations, namely that the automobile sales were made on credit, so that their pleadings would fall under the truth-in-lending act. Under the "eight-corners" rule, the court may not look outside of the pleadings to imagine factual scenarios that might trigger coverage. The Texas Supreme Court has never recognized an exception to the "eight-corners" rule to permit the introduction of extraneous evidence. Under the policies, Universal had no duty to defend Dealerships.

AN INSURED IS TOTALLY DISABLED WHEN HE IS UNABLE TO PERFORM ALL OF THE IMPORTANT AND USUAL DUTIES OF HIS OCCUPATION

Provident Life and Accident Ins. Co. v. Knott, 128 S.W.3d 211 (Tex. 2003).

FACTS: In June 1985, Dr. James Knott suffered a spinal fracture and underwent surgery. Except for a two-month period immediately following the 1985 injury, Knott continued his work as a physician. He was able to perform all of his pre-accident duties except for certain surgical and office examination procedures that aggravated his back injury. Knott had two Provident insurance policies that provided benefits for total disability and partial disability.

A few months after Knott turned sixty-five, he submitted a claim for total disability to Provident. No new event or accident precipitated the claim. Provident made total disability payments to Knott for twenty-four months and then notified Knott that it was closing his claim because it had paid him the maximum benefits to which he was entitled. Under the "policy schedule" in both disability insurance policies at issue, the maximum benefit period for total disability commencing on or after the insured's sixty-fifth birthday was twenty-four months. However, an insured whose total disability commenced prior to his sixty-fifth birthday was entitled to lifetime benefits under the policies. Knott had failed to satisfy the "90-day elimination period," which was a condition of total disability coverage. The ninety-day elimination period referred to a requirement that the total disability continue for more than ninety days before benefits for total disability could commence.

Knott sued Provident for breach of contract. Provident explained that it had not breached its insurance contract with Knott because he was able to perform some of his duties as a physician and, therefore, was not totally disabled under

the policies' definition, as a matter of law. Knott argued that whether he was totally disabled is a fact question that depends on whether he is unable to do any substantial portion of the work connected with his occupation. The trial court granted Provident's motions for summary judgment without specifying the grounds for its judgment. The court of appeals reversed the trial court's judgment on Knott's breach of contract claim, remanding the claim to the trial court. Provident and Knott filed petitions for review.

HOLDING: Reversed.

REASONING: In the insurance policies at issue, partial disability was defined as the inability to perform at least one important or usual duty of the insured's business at least some of the time. Total disability exists when the insured is unable to perform all of the important daily duties of his occupation. Knott testified that he could perform some of his occupational duties, albeit on a part-time basis, when he made his claim for total disability in December 1985. Knott identified certain surgical and office examination procedures that involved bending and stress to his back that he was unable to perform at the time of his December 1985 claim. Likewise, Knott testified that he could perform some of his occupational duties on at least a part-time basis when he made his claim in December 1995 and admitted that he continued to see patients, perform some types of surgeries, consult with other physicians, and perform certain administrative duties through the date of his deposition in this case. From no later than 1990 to 1995, Knott worked full-time performing some of his occupational duties. These facts placed Knott's claim squarely within the partial disability provision of the policies and outside the scope of the total disability provision. Provident met its burden to show that Knott was not unable to perform all of the important daily duties of his occupation and summary judgment was appropriate.

SUIT UNDER THE TELEPHONE PROTECTION ACT IS WITHIN SCOPE OF COVERAGE FOR ADVERTISING INJURY

ARTICLE 21.55 DOES NOT APPLY TO A CLAIM FOR DEFENSE

TIG Ins. Co. v. Dallas Basketball, Ltd., 129 S.W.3d 232 (Tex. App.— Dallas 2004).

FACTS: Two class action law suits claimed the Mavericks violated the Telephone Consumer Protection Act by sending unsolicited advertisements for basketball tickets to plaintiffs' telephone fax machines. The Mavericks requested that TIG defend and indemnify them against both suits under their insurance policies issued by TIG, which included a commercial general liability insurance policy. TIG denied coverage in both cases. The Mavericks then filed suit against TIG, alleging breach of insurance contract and violation of Article 21.21 of the Texas Insurance Code. The Mavericks also sought monetary damages under Article 21.55 of the Code.

The trial court granted the Mavericks' motions for partial summary judgment, stating that there was a cause of action potentially covered by the liability insurance policy, and TIG breached its defense obligations. The trial court also ruled that Article 21.55 applied to the Mavericks' claims but held that the penalty ceased to accrue on the date of the judgment against TIG.

HOLDING: Affirmed in part; reversed and rendered in part.

REASONING: For the two suits to fall within the policies' coverage for advertising injury, the advertisements received by plaintiffs must have constituted published material that violated the plaintiffs' rights of privacy. The court ruled that "material" in the policies referred to the content of the publication rather than the physical form of publication. To hold otherwise would render the words "oral or written" in the definition of advertising injury meaningless. The court recognized that Congress limited the protection by the Act to advertising and not other written material. H.R.Rep. No. 102-317 at 2 (1991). Congress saw advertising as a form of written communication that could have a uniquely intrusive quality. The court, therefore, concluded that the suits fell within the policies' coverage for advertising injury.

The court ruled that "material" in the policies referred to the content of the publication rather than the physical form of publication.

The court held that Article 21.55 presumed a tangible, measurable loss suffered by the insured for which he sought payment from the insurance company. Article 21.55 is titled "Prompt Payment of Claims," and a demand for a defense under a liability policy is not a claim for payment. The definition of "claim" requires that the claim be a first party claim that was to be paid directly from the insurance company to the insured or a beneficiary. The Mavericks' claim for reimbursement of attorneys' fees was not a claim under the policies, but a common law claim for breach of contract damages. *Hartman v. St. Paul Fire Ins. Co.*, 55 F.Supp.2d 600, 604 (N.D.Tex. 1998). Article 21.55 applies only to claims that trigger the insurer's duty under the policy to pay the insured. The court noted that the statute's deadlines and the penalties for failing to meet the deadlines both presumed that the insured's claim is one for compensation for a covered loss rather than for a defense.