IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ALABAMA
CENTRAL DIVISION

QBE INSURANCE CORPORATION,	)	
	)	
Petitioner,	)	
	)	
v.	)	**CASE NO.: 08-PWG-2347-S**
	)	
BLOUNT MEDICAL CENTER PARTNERS c/o TOM HACKNEY,	)	
	)	
Respondent.	)	

TABLE OF CONTENTS TO PETITIONER QBE INSURANCE CORPORATIONS'S MEMORANDUM OF LAW IN SUPPORT OF ITS MOTION FOR SUMMARY JUDGMENT

I. Narrative of Undisputed Facts 1

a. The Underlying Facts 1-14

II. Motion for Summary Judgment Standard of Review 14-16

III. Argument 16

A. Applicable Law 16-19

1. Insured's Failure to Cooperate Standard of Review 17
2. Alabama State Cases 19-23
3. 11th Circuit and Other Federal Jurisdictions 23-32

B. QBE has no Duty to Pay Blount Medical Because Blount Medical's Failures to Meet Conditions Precedent to Payment Under the Policy's Terms and Conditions were Material and Substantial to QBE's Prejudice 32-42

IV. Conclusion 42

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Table of Authorities

Adickes v. S. H. Kress & Co., 398 U.S. 144 (1970) 14

Akpan v. Farmers Ins. Exchange, Inc., 961 So. 2d 865, 872 (Ala. Civ. App. 2007) 22

Ala. Farm Bureau Mut. Cas. Ins. Co. v. Teague, 110 So. 2d 290, 294 (Ala. 1959) 18

Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247-248 (U.S. 1986) 15

Auto-Owners Ins. Co., Inc. v. Rodgers, 360 So. 2d 716, 718 (Ala. 1978) 18

Brooks v. U.S. Express, Inc., 2008 WL 1756494 (S.D. Ala.) 17, 29, 31, 32

Brown v. Commonwealth Life Ins. Co., 22 F. Supp. 2d 1325, 1332 (M.D. Ala. 1998) 32

Celotex Corp. v. Catrett, 477 U.S. 317 (1986) 14, 15, 16

Colorado Casualty Ins. Co. v. The Kirby Company, et al, 2008 WL 149996 (M.D. Ala. 2008) 18

Dawkins v. Witt, 318 F.3d 606 (4th Cir. 2003) 32

Earley v. Champion Int'l Corp., 907 F. 2d 1077, 1081 (11th Cir. 1990) 15

Employers Ins. Co. v. Ala. v. Crook, 160 So. 2d 463, 465 (Ala. 1964 18

Equitable Life Assurance Society v. Dorriety, 229 Ala. 352, 157 So. 59 (1934) . 29

Ex parte Clark, 728 So.2d 135 (Ala. 1998) 18

Flick v. Liberty Mut. Fire Ins. Co., 205 F.3d 386 (9th Cir. 2000) 32

Grigsby v. Reynolds Metals Co., 821 F.2d 590 (11th Cir. 1987) 15

Givahn v. Electronic Engineers, Inc., 4 F. Supp. 2d 1331, 1335 (M.D. Ala. 1998) 14

Gowland v. Aetna, 143 F.3d 951 (5th Cir. 1998) 32

Hall v. Liberty Mut. Fire Ins. Co., 2009 WL 235640 (11th Cir.) . . . 17, 26, 28, 31, ... 32, 41, 42

Home Indem. Co. v. Reed Equip. Co., Inc., 381 So. 2d 45, 48 (Ala. 1980) 18

Jenkins v. United States Dept. of Housing and Urban Dev., 780 F.2d 1549 (11th Cir. 1986) 23, 25, 31, 32

Lee v. Prudential Ins. Co., 812 F.2d 1344, 1346 (11th Cir. 1987) 29

Mancini v. Redland Ins. Co., 248 F.3d 729 (8th Cir. 2001) 32

Mordecai v. Blue Cross-Blue Shield of Ala., 474 So. 2d 95, 98 (Ala. 1985) . . . 21

Nationwide Ins. Co. v. Nilsen, 745 So. 2d 264, 267 (Ala. 1998) . . . 17, 19, 21, 22, ... 27, 32

Payne v. Nationwide Mut. Ins. Co., 456 So. 2d 34, 37 (Ala. 1984) 21

Phelps v. Fed. Emergency Mgmt. Agency, 785 F.2d 13 (1st Cir. 1986) 21, 32

Sanz v. U.S. Sec. Ins. Co., 328 F.3d 1314 (11th Cir. 2003) 31

Shalimar Contractors, Inc. v. Am. States Ins. Co., 975 F. Supp. 1450 (M.D. Ala. 1997) 14

State Farm Fire & Cas. Ins. Co. v. Richardson, 2008 WL 4531765(S.D. Ala., October 9, 2008) 31

State Farm Mut. Auto. Ins. Co. v. Hanna, 166 So. 2d 872, 877 (Ala. 1964) . . . 18

Turner v. Liberty Nat'l Fire Ins. Co. 681 So. 2d 589 (Ala. 1996) 17, 22, 27

United Ins. Co. of America v. Cope, 630 So. 2d 407, 411 (Ala. 1993) 17, 19, 21, 32

United States Fire Ins. Co. v. Watts, 370 F.2d 405 (5th Cir. 1966) 17, 18

United States v. Four Parcels of Real Property, 941 F.2d 1428, 1438 (11th Cir. 1991) 16

West v. Founders Life Assurance Co. of Florida, 547 So. 2d 870, 871 (Ala. 1989) 16

Williams v. Ala. Farm Bureau Mut. Cas. Ins. Co., 416 So. 2d 744, 746 (Ala. 1982) 18

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QBE INSURANCE CORPORATIONS'S MEMORANDUM OF LAW IN SUPPORT OF ITS MOTION FOR SUMMARY JUDGMENT

COMES NOW Petitioner QBE Insurance Corporation (hereinafter referred to as "QBE") and submits the following Memorandum of Law in Support of its Motion for Summary Judgment filed in the above-styled action:

I. Narrative Statement of Undisputed Facts

a. The Underlying Facts

1. On April 19, 2006, Blount's facility located at 201 Shirley Street in Oneonta, Alabama 35121 sustained hail and wind damage as a result of high winds. [See Affidavit of William E. Barrett, Sr., attached hereto as Exhibit A, ¶1; See First Report from Fountain Keats & Sanders ("FKS"), attached hereto as part of Exhibit B].

2. On April 27, 2006, Blount notified Anchor of the loss. On the same date, Anchor retained Fountain Keat and Sanders Insurance Adjusters d/b/a/ FKS to

investigate the loss. On the following day, Anchor sent coverage information to FKS. [Exhibit A, ¶2; See Affidavit of Jim Keats, attached hereto as Exhibit C, ¶2].

3. Overall, FKS submitted thirty-two (32) reports to Anchor concerning this loss. [Exhibit A, ¶3; Exhibit C, ¶3].

4. FKS' first report was authored on May 10, 2006. The first report provided photographs of the risk and its damage and a roof diagram. It confirmed the retention of ServPro and the fact ServPro was on site on April 28, 2006. The first report also confirmed a meeting of the FKS' adjuster with the Insured on the Monday following the retention of FKS and FKS' efforts to locate a roofer. The report confirmed Alabama Roofing General Contractors out of Anniston, Alabama was retained and the fact the Insured agreed with cost of the roof repairs. According to the report, the repairs were scheduled to start on or before May 12, 2006. The report confirmed that once all of the initial extraction was completed and debris removed, there was very little more that could be damaged. The report confirms that the contents in the building were antiquated and were left in the building for storage. Finally, the report confirms FKS informed the Insured that the QBE Policy was an ACV policy. [Exhibit A, ¶4; Exhibit B, FKS' First Report].

5. FKS' second report, dated May 19, 2006, included adjusters' estimate for roof damages; direction of payment form from ServPro; an audited ServPro Invoice;

and confirmation that since the last report FKS worked with Alabama Roofing Company to determine the extent of damages to the roof so that the interior repairs could begin in the near future. The second report also provided that the roof estimate had a replacement cost of $61,084.74; however, after applying depreciation of $15,271.21, the ACV for the roof was $45,813.53. Further the amount due was to be reduced by a $1000 deductible. The adjuster requested a check made payable to the Insured in the amount of $44,813.53 and a check made payable to ServPro in the amount of $71,947.52. Finally, the second report noted the Insured was not trying to obtain a roofing contractor. [Exhibit A, ¶5; Exhibit B, FKS' Second Report].

6. On May 25, 2006, QBE issued a check in the amount of $44,813.53 made payable to the Insured for the roof replacement and sent the same to FKS for delivery to the Insured. [Exhibit A, ¶6].

7. Also on May 25, 2006, QBE issued a check made payable to ServPro in the amount of $71,947.52. [Exhibit A, ¶7].

8. FKS noted on June 22, 2006 in its third report that FKS had completed the Proof of Loss and forwarded it to Blount. [Exhibit A, ¶8; Exhibit B, FKS' Third Report; Exhibit C, ¶4].

9. Also, on June 22, 2006, Blount Medical executed a partial, incomplete Proof of Loss to QBE which only covered the damages to the roof for which Blount

Medical received the first check from QBE in the amount of $44,813.53. [Exhibit C, ¶¶ 4-5; Partial Proof of Loss, Attached hereto as Exibit D].

10. According to FKS' fourth report dated July 25, 2006, the roof had been secured. This fourth report from FKS noted that additional portions of the building had to be removed from the building by ServPro and it noted that FKS received quotes from subcontractors to complete an estimate of repairs for the interior damages. [Exhibit A, ¶9; Exhibit B, FKS' Fourth Report].

11. On July 26, 2006, QBE paid an additional ServPro bill in the amount of $8,196.20. [Exhibit A, ¶10].

12. On August 24, 2006, FKS reported that since their last report, FKS had received the partial Proof of Loss for the roof repairs and ServPro figures, less deductible. FKS also received electrical estimates from a subcontractor. FKS' estimate of repairs was in the amount of $120,180.57 on a replacement cost basis to which depreciation is applied in the amount of $22,602.91 for an ACV loss and a claim of $97,577.66 (no deductible taken because applied on earlier payment). [Exhibit A, ¶11; Exhibit B, FKS' Fifth Report; Exhibit C, ¶6].

13. On August 28, 2006, QBE prepared a check made payable to the Insured in the amount of $97,577.66 and sent it to FKS for delivery to the Insured with return of a completed and signed Proof of Loss. [Exhibit A, ¶12; Exhibit C, ¶8].

14. The Sixth Report, dated September 26, 2006, noted that FKS was waiting on the Insured to return the Proof of Loss with regard to the building and waiting on the Insured to provide documentation for the damaged contents. [Exhibit A, ¶13; Exhibit B, FKS' Sixth Report; Exhibit C, ¶9].

15. The seventh report authored on or about October 27, 2006 confirmed FKS still had not received the Proof of Loss and the fact the Insured had not returned FKS' calls and had not identified nor furnished documentation for the damaged contents. [Exhibit A, ¶14; Exhibit B, FKS' Seventh Report Exhibit C, ¶10].

16. On November 30, 2006, FKS issued its eighth report concerning this loss. That report confirmed FKS had made numerous phone calls to the Insured and sent the Insured correspondence. The report confirmed that all of FKS' efforts went without response. [Exhibit A, ¶15; Exhibit B, FKS' Eighth Report; Exhibit C, ¶11].

17. In its ninth report, dated January 2, 2007, FKS confirmed it made numerous contact attempts by phone with the Insured, and that the Insured's cellular telephone mailbox was full; however, FKS left messages at other contact numbers provided which went unanswered. [Exhibit A, ¶16; Exhibit B, FKS' Ninth Report; Exhibit C, ¶12].

18. FKS again confirmed in its tenth report on or about February 2, 2007, that it had no response from the Insured, that FKS continued to receive a message that

the Insured's cell phone messaging center was full; however, FKS left messages at the Insured's office and home. According to the tenth report, those messages went unanswered. [Exhibit A, ¶17; Exhibit B, FKS' Tenth Report; Exhibit C, ¶13].

19. According to FKS' eleventh report authored on or about February 27, 2007, FKS sent correspondence to the Insured via certified mail notifying the Insured that the previously issued check had gone stale, and that FKS would request re-issuance once the Insured contacted FKS. The certified correspondence also confirmed that FKS had no response to its previously issued correspondence and phone calls, that FKS never received Proof of Loss from the Insured nor did it receive a damaged contents inventory. [Exhibit A, ¶18; Exhibit B, FKS' Eleventh Report; Exhibit C, ¶14].

20. On March 27, 2007, FKS confirmed in its twelfth report that the correspondence sent to the Insured by certified mail was received by the Insured on March 9, 2007 and that as of March 27, 2007, the Insured had failed to respond. [Exhibit A, ¶19; Exhibit B, FKS' Twelfth Report; Exhibit C, ¶15].

21. On April 26, 2007, FKS issued its thirteenth report to QBE indicating that the Insured's representative, Tom Hackney, contacted FKS on April 9, 2007. According to FKS' report, Mr. Hackney stated that he could not find any of his paperwork, including the previously provided Proof of Loss. The thirteenth report

confirmed that FKS sent Mr. Hackney on April 9, 2007 another complete copy of the paperwork including the Proof of Loss, FKS' estimate, and contents inventory worksheet and notified the Insured that it will need proof of its value (such as replacement quotes, catalog pages and/or photos) for any content item over $500. [Exhibit A, ¶20; Exhibit B, FKS' Thirteenth Report; Exhibit C, ¶16].

22. On May 24, 2007, FKS again updated QBE. FKS reported in its fourteenth report that the Insured had not responded to voice messages or FKS' previous April 9, 2007 correspondence. [Exhibit A, ¶21; Exhibit B, FKS' Fourteenth Report; Exhibit C, ¶17].

23. On June 26, 2007, FKS submitted their fifteenth report. FKS reported that since the previous report, they still not had yet received from the Insured the Content Inventory or signed Proof of Loss. [Exhibit A, ¶22; Exhibit B, FKS' Fifteenth Report; Exhibit C, ¶18].

24. On July 25, 2007, FKS authored its sixteenth report. This report noted that the Insured called FKS on July 24, 2007 and left a message asking FKS to fax to him a copy of the Proof of Loss to the Birmingham office location. According to the report, FKS attempted to return the Insured's call on numbers provided. FKS left a recorded message on the Insured's Georgia phone number provided as the Insured's cell phone mailbox was full. In this report, FKS confirmed that ServPro's construction

division approved FKS' estimate. [Exhibit A, ¶23; Exhibit B, FKS' Sixteenth Report; Exhibit C, ¶19].

25. Pursuant to Mr. Hackney's phone message on July 24, 2007, FKS faxed another copy of the Proof of Loss and other documentation to be filled out and returned. [Exhibit C, ¶20].

26. On September 26, 2007, FKS' eighteenth report confirmed the Insured failed to return any calls. [Exhibit A, ¶24; Exhibit B, FKS' Eighteenth Report; Exhibit C, ¶21].

27. On October 16, 2007, FKS confirmed that the Insured, during previous conversations, stated that the problem was the Insured's own procrastination and not a reflection of QBE's handling of this claim. [Exhibit A, ¶25; Exhibit C, ¶22].

28. On October 24, 2007, FKS authored an additional report also confirming that the Insured had failed to return any phone calls. This report also confirmed that the Insured did limited roof work because he was considering framing it and putting a metal roof on it. As set forth in the report, FKS advised the Insured that if he did not make the repairs that no further interior damages would be considered in the future. The Insured confirmed his understanding of the fact no further interior damages would be considered in light of the Insured's failure to complete the roof repairs. [Exhibit A, ¶26; Exhibit B, FKS' Nineteenth Report; Exhibit C, ¶23].

29. On November 26, 2007, FKS again reported that it continued to have no contact with the Insured despite repeated attempts. [Exhibit A, ¶27; Exhibit B, FKS' Twentieth Report; Exhibit C, ¶24].

30. On January 2, 2008, QBE issued a reservation of rights to the Insured notifying the Insured of its violation of policy requirements. QBE notified the Insured it would close its file within thirty (30) days. [Exhibit A, ¶28; Letter from William Barrett to Tom Hackney, attached hereto as Exhibit E].

31. On January 4, 2008, Counsel Givhan confirmed an extension in writing. [Exhibit A, ¶29; See Letter from Marcus Givhan to William Barrett, attached hereto as Exhibit F].

32. On February 6, 2008, FKS submitted its twenty-second report. This report reflected that FKS was contacted by Caroline Lenderman at Cade CPA in Birmingham. Ms. Lenderman informed FKS that they would assist FKS in obtaining Proof of Loss from the Insured. According to the report, FKS' last contact with Ms. Lenderman was on January 8, 2008. FKS forwarded another Proof of Loss with supporting documentation to Ms. Lenderman. Nearly one month later, neither the Insured, nor its counsel, nor its accountant had produced the executed Proof of Loss. [Exhibit A, ¶30; See Exhibit B, FKS' Twenty-Second Report; Exhibit C, ¶ 25].

33. In its March 3, 2008 report, FKS confirmed that Ms. Lenderman acknowledged the difficulty she was having in obtaining the Proof of Loss from the Insured. [Exhibit A, ¶31; Exhibit B, FKS' Twenty-Third Report; Exhibit C, ¶26].

34. On March 5, 2008, the Insured's counsel, Gina Pearson-Hinds, sent correspondence to QBE enclosing a revised (unsigned) Proof of Loss for an amount claimed of $645,300. Further, Mrs. Pearson-Hinds did not include any documentation supporting this unsigned Proof of Loss, as Blount Medical admits in its Answer. [Exhibit A, ¶32; See Correspondence from Gina Pearson-Hinds and Unsigned Proof of Loss, attached hereto as Exhibit G; See Blount Medical's Answer to QBE's Complaint for Declaratory Judgment, attached hereto as Exhibit H, ¶36].

35. On March 16, 2008, QBE provided FKS with a copy of Mrs. Pearson-Hinds correspondence. QBE asked FKS to contact the Insured's counsel to schedule a time to meet in order to have the Insured identify and support all items of damage and make available all items for inspection. [Exhibit A, ¶33; Exhibit C, ¶27].

36. On March 26, 2008, QBE again reserved all rights under the Policy when it notified Mrs. Pearson-Hinds of the Insured's lack of cooperation and necessity of an investigation into the revised (unsigned) Proof of Loss she presented. [Exhibit A, ¶34; Correspondence from William Barrett to Ms. Pearson-Hinds, attached hereto as Exhibit I].

37. In its twenty-fourth report, issued on April 2, 2008, FKS reported that they called Mrs. Pearson-Hinds requesting a meeting with the Insured in Birmingham. FKS informed her that it was imperative they meet at the scene and at that time review all events and previously issued Proofs of Loss, FKS noted that the Insured always appeared to be in agreement with the FKS' figures. FKS further noted in this report that in a recent drive-by of the subject building, the building was unsecured and appeared to have been unsecured for sometime. FKS noted that there was a partial roof that has been placed on the building that appeared to be new; however, FKS noted from the flashing area around the rear of the building that no roof was in place and that the old flashing had been removed causing damages to the bricks in the process. The report also noted that the building suffered more extensive damage since the loss due to the negligence of the Insured. Included within FKS' twenty-fourth report was the April 2, 2008 correspondence from FKS to Gina Pearson-Hinds confirming the prior conduct of the Insured, the previous agreement from Insured with FKS' estimate, and the current unsecured condition of building. [Exhibit A, ¶35; Exhibit B, FKS' Twenty-Fourth Report; Exhibit C, ¶28-29].

38. On May 5, 2008, FKS submitted its twenty-fifth report confirming FKS received a request from the Insured's counsel of the insurance carrier's estimate on April 22, 2008. The report noted that QBE's estimate was provided to Mrs. Pearson-

Hinds on April 23, 2008. [Exhibit A, ¶36; Exhibit B, FKS' Twenty-Fifth Report; Exhibit C, ¶30].

39. On June 3, 2008, in its twenty-sixth report, FKS reported that it had not heard from the Insured's counsel concerning FKS' correspondence of April 23, 2008. [Exhibit A, ¶37; Exhibit B, FKS' Twenty-Sixth Report; Exhibit C, ¶31].

40. On June 30, 2008, FKS submitted its twenty-seventh report again confirming there had been no communication with the Insured and/or the Insured's counsel. [Exhibit A, ¶38; Exhibit B, FKS' Twenty-Seventh Report; Exhibit C, ¶32].

41. In its twenty-eighth report, submitted on or about July 31, 2008, FKS confirmed it sent the Insured's counsel additional correspondence since there had been no word from her in 60 days. [Exhibit A, ¶39; Exhibit B, FKS' Twenty-Eighth Report; Exhibit C, ¶33].

42. On September 2, 2008, FKS confirmed in its twenty-ninth report that it had received no response from the Insured and/or its attorney. [Exhibit A, ¶40; Exhibit B, FKS' Twenty Ninth Report; Exhibit C, ¶34].

43. The Policy is a Commercial Property Policy issued to Blount Medical Center Partners c/o Tom Hackney. [Exhibit A, ¶41].

44. The Declaration Pages indicate that the named Insured is Blount Medical Center Partners c/o Tom Hackney. The Declarations also confirm a Policy period, in relevant part, from 5/11/05 to 5/11/06. [Exhibit A, ¶42].

45. The Policy, in relevant part, is set forth below:[1]

> 3. Duties In the Event of Loss or Damage
>
> A. You must see that the following are done in the event of loss or damage to Covered Property:
>
> ...
>
> (4) Take all reasonable steps to protect the Covered Property from further damage, and keep a record of your expenses necessary to protect the Covered Property, for consideration in the settlement of the claim. This will not increase the Limit of Insurance. However, we will not pay for any subsequent loss or damage resulting from a cause of loss that is not a Covered Cause of Loss. Also, if feasible, set the damaged property aside and in the best possible order for examination.
>
> (5) At our request, give us complete inventories of the damaged and undamaged property. Include quantities, costs, values, and amount of loss claimed.
>
> (7) Send us a signed, sworn Proof of Loss containing the information we request to investigate the claim. You must do this within 60 days after our request. We will supply you with the necessary forms.
>
> (8) Cooperate with us in the investigation or settlement of the claim.
>
> ...
>
> 4. Loss Payment

[1] QBE reserves any and all rights it has under the Policy and does not waive any right to rely upon any provision within the Policy whether or not said language is set forth herein. QBE adopts the Policy in its entirety as if fully set forth herein.

g. We will pay for covered loss or damage within 30 days after we receive the sworn proof of loss, if you have complied with all of the terms of this Coverage Part and:
(1) We have reached agreement with you on the amount of the loss; or
(2) An appraisal award has been made.

[See QBE Insurance Policy issued to Blount Medical, attached hereto as Exhibit J].

II. Motion for Summary Judgment Standard of Review

Summary judgment is proper if there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Ala. R. Civ. P. 56(c); *See also Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986); *Shalimar Contractors, Inc. v. American States Ins. Co.*, 975 F. Supp. 1450 (M.D. Ala. 1997). The court must construe the evidence and factual inferences in the light most favorable to the non-moving party. *Givahn v. Electronic Engineers, Inc.*, 4 F. Supp. 2d 1331, 1335 (M.D. Ala. 1998) (*citing Adickes v. S.H. Kress & Co.*, 398 U.S. 144 (1970)). The party seeking summary judgment has the burden to establish there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law. *Celotex*, 477 U.S. at 323. In cases where the non-moving party will bear the burden of proof at trial, the moving party may either submit affirmative evidence negating an essential element of the non-moving party's claim, or demonstrate that the non-

moving party's evidence is insufficient to establish an essential element of his claim. *Celotex*, 477 U.S. at 322.

When the moving party makes out a prima facie case that no genuine issue of material fact exists, the burden shifts to the non-moving party to rebut the showing by presenting substantial evidence of the existence of a genuine issue of material fact. *Celotex*, 477 U.S. at 323. "[T]he mere existence of ***some*** alleged factual dispute between the parties will not defeat an otherwise properly supported motion for summary judgment; the requirement is that there be no ***genuine*** issue of ***material*** fact." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-248 (U.S. 1986) (emphasis in original). Further, 'the plain language of Rule 56 (c) mandates the entry of summary judgment . . . against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Celotex*, 477 U.S. at 322-23. Indeed, "in such a situation, there can be 'no genuine issue as to any material fact,' since the complete failure of proof concerning an essential element of the non-moving party's case necessarily renders all other facts immaterial." *Id.*

Neither unsubstantiated assertions nor conclusory allegations are sufficient to satisfy the non-moving party's burden. *Earley v. Champion Int'l Corp.*, 907 F. 2d 1077, 1081 (11th Cir. 1990); *Grigsby v. Reynolds Metals Co.*, 821 F.2d 590 (11th Cir.

1987). Courts have defined "substantial evidence" as "evidence of such weight and quality that fair-minded persons in the exercise of impartial judgment can reasonably infer the existence of the fact sought to be proved." *West v. Founders Life Assurance Co. of Florida*, 547 So. 2d 870, 871 (Ala. 1989); *see also United States v. Four Parcels of Real Property*, 941 F.2d 1428, 1438 (11th Cir. 1991). The non-moving party must go beyond the pleadings, and by affidavits or other evidence, he must show that there is a genuine issue for trial. *Celotex*, 477 U.S. at 323; *see also* Fed. R. Civ. P. 56(e). In meeting this burden, the nonmoving party must do more than simply show that there is a metaphysical doubt as to the material facts. The non-moving party must demonstrate there is a genuine issue for trial. *Celotex*, 477 U.S. at 323.

III. Argument

A. Applicable Law

In QBE's Complaint for Declaratory Judgment, QBE asserts that "the Insured is not due any recovery for this loss in light of the Insured's failure to comply with the terms of the Policy." [See Complaint, attached hereto as Exhibit K, ¶ 54]. Specifically, QBE asks this Court to, among other things, "[d]eclare and decree that the QBE Policy issued to Blount does not afford coverage to the Insured for this loss based upon the Insured's failure to cooperate, failure to submit a signed Proof of Loss, failure to submit documentation of this loss, failure to adequately protect the building

and its contents from further damage, and failure to otherwise comply with the requirements under the Policy." [*Id.* at p. 14, ¶ A].

There are a multitude of cases where the courts have granted summary judgment for insurer's when their insureds, who have failed to comply with the post-loss duties included in their respective policies, have been deemed uncooperative and therefore were not entitled to the proceeds of the policies. The following sections include both citation to and discussion of multiple cases from both Alabama and the Eleventh Circuit Courts which hold the same based on the circumstances of each individual case.

1. Insured's Failure to Cooperate Standard of Review

Under Alabama law, 'an insurer's obligation to pay or to evaluate the validity of an insured's claim does not arise until the insured has complied with the terms of the contract with respect to submitting claims.' *Brooks v. U.S. Express, Inc.*, 2008 WL 1756494 (S.D. Ala.) (*quoting Nationwide Ins. Co. v. Nilsen*, 745 So. 2d 264, 267 (Ala. 1998). *See also Turner v. Liberty Nat'l Fire Ins. Co.* 681 So. 2d 589 (Ala. 1996); *United Ins. Co. of America v. Cope*, 630 So. 2d 407, 411 (Ala. 1993). As a precondition to recovery, an insurer can require its insured to adhere to the terms of the policy and cooperate with the insurer's investigation of the loss. *Hall v. Liberty Mut. Fire Ins. Co.*, 2009 WL 235640 (11th Cir., February 3, 2009).

The insurer holds the burden for establishing non-cooperation. *Colorado Casualty Ins. Co. v. The Kirby Company, et al*, 2008 WL 149996, *4 (M.D. Ala., January 14, 2008) (*quoting Employers Ins. Co. of Ala. v. Crook*, 160 So. 2d 463, 465 (Ala. 1964) *citing Ex parte Clarke*, 728 So. 2d 135, 141 (Ala. 1998); *State Farm Mut. Auto. Ins. Co. v. Hanna*, 166 So. 2d 872, 877 (Ala. 1964) ("Lack of cooperation being an affirmative defense, the burden was upon the insurer to establish such a defense."). In order for non-cooperation to constitute a breach of insurance coverage, the lack of cooperation must be material and substantial. *Colorado Casualty*, 2008 WL at *4 (*citing Clarke*, 728 So. 2d at 141; *Williams v. Ala. Farm Bureau Mut. Cas. Ins. Co.*, 416 So. 2d 744, 746 (Ala. 1982); *Home Indem. Co. v. Reed Equip. Co., Inc.*, 381 So. 2d 45, 48 (Ala. 1980); *Auto-Owners Ins. Co., Inc. v. Rodgers*, 360 So. 2d 716, 718 (Ala. 1978); *Ala. Farm Bureau Mut. Cas. Ins. Co. v. Teague*, 110 So. 2d 290, 294 (Ala. 1959)). In order to satisfy the material and substantial elements, an insurer must show prejudice. *Colorado Casualty* 2008 WL at *4; (*citing Williams*, 416 So. 2d at 746.) Non-cooperation is deemed prejudicial if the failure to cooperate "negates the only evidence the insurer could offer in defense," or if the insurer is deprived of the opportunity to conduct an investigation and mount a defense. Determining whether the non-cooperation is prejudicial is usually a question for the trier of fact. *See Colorado Casualty*, 2008 WL at *4; *Williams,* 416 So. 2d at 746; *see also*, *United*

States Fire Ins. Co. v. Watts, 370 F.2d 405 (5th Cir. 1966); *Clarke*, 728 So. 2d at 141; *Crook*, 160 So. 2d at 465.

2. Alabama State Cases

Alabama has consistently and vigorously enforced an insured's post-loss duties under policies of insurance, holding: " . . . [N]o case from this Court places on an insurance company an obligation to either investigate or pay a claim until the insured has complied with all of the terms of the contract with respect to submitting claims for payment." *Cope*, 630 So. 2d at 412 (reversing judgment for insured who failed to provide written proof of loss.) In a case of particular importance, *Nilsen, supra*, perhaps the "bellcow" case from Alabama on an insured's post-loss obligations, the Alabama Supreme Court considered an action brought by an insured against his homeowners' insurer to recover for a fire loss and additional expenses. 745 So. 2d at 265. On July 4, 1994 the insured's home was destroyed by fire. The next day the insured contacted his insurer to notify it of the fire and the day after that he met with an adjuster. *Id.* Initially, the insurer forwarded $5000 to the insured to cover additional living expenses as a result of the loss, but on July 29, 1994, the adjuster notified the insured that his loss was still under investigation and no further advances for living expenses would be made until this investigation was completed. *Id.* Later on in the fall of 1994, the insurer requested that the insured appear for an examination

under oath as was required under the insurance contract. Rather than submit to this examination immediately, the insured hired an attorney. *Id.* The insurer scheduled and rescheduled the examination multiple times in order to accommodate the insured and his attorneys, but before any examination could be done the insured hired a different attorney and filed suit against the insurer on March 10, 1995. *Id.*

The insured's homeowners' policy contained several provisions outlining his duties after a loss. In pertinent part, the provisions stipulated that after a loss, the insured had a duty to "submit to an examination under oath," and to "submit to us, within 60 days after we request, your signed, sworn proof of loss which sets forth, to the best of your knowledge and belief: . . . (5) detailed estimates for repair of damage . . . (6) a list of damaged personal property described in 2c . . . (7) receipts for additional living expenses and records supporting the fair rental value loss." *Id.* at 266. The insurer argued that these provisions established conditions precedent to coverage under the insurance contract and that the insured had failed to comply with these conditions by failing to appear for an examination under oath and by also failing to respond to the insurer's requests for documents and records. *Id.* at 267.

Citing established Alabama law that an insurance company is entitled to require an insured to submit to an under oath examination pursuant to its claims investigation process, and that an insurer's obligation to pay or investigate a claim is not triggered

until the insured has complied with the conditions of the contract with respect to the claims filing process, the Court agreed with the insurer that the insured had not met its post-loss obligations and had therefore breached the contract. *Id. See Payne v. Nationwide Mut. Ins. Co.*, 456 So. 2d 34, 37 (Ala. 1984); *Cope*, 630 So. 2d at 411. The insured's policy required him to submit to an examination under oath if he wished to recover under the contract, and because it was undisputed that he had not done so prior to filing his lawsuit, the Court concluded that he had failed to meet a condition precedent to recovering under the insurance policy. *Id.* at 269.

Regarding the sworn proof of loss and requested documents condition precedent, the insured argued that he had submitted a sworn proof of loss. However, the Court noted that in conjunction with that sworn proof of loss, supporting documents such as receipts for additional living expenses and records were to be submitted along with the proof of loss. Because it was undisputed that no such documents were attached to the proof of loss, the Court held that the insured had failed to meet this condition precedent to recovery under the contract as well and the insurer was not obligated to pay. *Id.* at 268.

In addition to *Cope, Nilsen* and *Payne* as cited above, other Alabama cases have held similarly in situations where an insured has failed to comply with post-loss policy requirements. *See Mordecai v. Blue Cross-Blue Shield of Ala.*, 474 So. 2d 95, 98

(Ala. 1985) (upholding requirement that insured submit documents supporting a claim in form and manner required by policy); *Akpan v. Farmers Ins. Exchange, Inc.*, 961 So. 2d 865, 872 (Ala. Civ. App. 2007) (Murdock, J.) (*citing Nilsen*, *supra*); *Turner v. Liberty Nat. Life Ins. Co.*, 681 So. 2d 589, 592 (Ala. Civ. App. 1996) (holding that insured's failure to cooperate and to provide insurer with documents required by the policy supplied insurer with legal and factual defense to claim).

Based on the holding in *Nilsen* and the facts of the instant case, QBE asserts that Blount Medical has failed to meet the conditions precedent to recovery under the insurance contract. As did the Insured in *Nilsen*, Blount Medical has failed to meet the Policy requirements for submitting a signed, sworn Proof of Loss and supporting documentation. Even were this Honorable Court to view the partial proof of loss submitted by Blount Medical on June 22, 2006 as valid, the fact that no supporting documentation was submitted in conjunction with it as was required by QBE under the Policy means that this condition precedent was not met. Not only was the documentation not submitted with that partial Proof of Loss, but it was not submitted with the unsigned Proof of Loss submitted nearly two years later either, as Blount Medical admitted in its Answer.

As the Insured had in *Nilsen*, the Insured in the instant case has breached multiple other conditions precedent to recovery in addition to the proof of loss

requirement. Those breaches include the failure to prevent further damage to the building, failure to submit detailed content inventories when provided with the proper forms and the failure to cooperate in general by not returning phone calls and letters so that the claim could be investigated and settled.

3. 11th Circuit and Other Federal Jurisdictions

In a case perhaps the most factually similar to the case at bar, *Jenkins v. United States Department of Housing and Urban Development*, 780 F.2d 1549 (11th Cir. 1986), the Eleventh Circuit Court of Appeals considered a case where an insured failed to submit a signed proof of loss in compliance with his flood insurance policy which required him to file a signed proof of loss within 60 days of the loss else coverage would be denied. The sequence of events in that case was as follows.

The loss occurred on September 12, 1979 and was reported to the insurer on November 5, 1979. *Id.* at 1551. The adjuster on the claim made three visits to the property between November 5, 1979 and January 25, 1980. At that point, more than four months after the loss, no proof of loss had been signed and submitted to the insurer and the insured refused to discuss the loss with the adjuster. *Id.* On March 24, 1980, the adjuster prepared and presented to the insured a proof of loss with an amount the insurer was prepared to pay, accompanied by worksheets with the calculations, but the insured would not sign the proof of loss or discuss the matter

further. *Id.* More than a year later, on September 15, 1981, an attorney representing the insured wrote to the adjusting firm requesting information on the insured's claim. The adjusting firm responded to the insured's attorney on September 22, 1981, and then again on December 14, 1981, having received permission from the insurer to forward another proof of loss for the insured to sign and return. *Id.* The adjusters sent another proof of loss to the insured on December 14, 1981, but as of January 7, 1982 had not received the signed proof of loss in return, prompting another written request for the signed and returned proof of loss from the insured. *Id.* Corollary to this written request, and in that same month, the insurer granted a 15-day extension to the insured in which he could submit the signed proof of loss. *Id.* Again however, the insured failed to so. Rather, the next correspondence in the case came four and a half months later, on June 18, 1982, when the insured's attorney contacted the insurer saying that the adjusting firm's estimate was unreasonable and checking the status of the claim. *Id.* Finally, on March 9, 1983, the insured's attorney was notified that the claim had been denied for failure to comply with the policy's terms and conditions. *Id.*

In reviewing the U.S. District Court's granting of summary judgment in favor of the insurer, the Court of Appeals addressed the insured's argument that the insurer had waived its requirement of a signed proof of loss as a condition precedent to payment. The Court noted that a proof of loss was tendered to the insured in 1980,

then again in January of 1982, and then a 15-day extension was granted by the insurer in an effort to again obtain a signed proof of loss by the insured, even though under the terms of the policy the proof of loss was over two years overdue. *Id.* In the Court's eyes, this was certainly not a waiver of the signed proof of loss requirement, but rather an insistence upon it. *Id.* Based on the insurer's conduct and the fact that a signed proof of loss was never submitted by the insured, the Court affirmed the District Court's grant of summary judgment in favor of the insurer. *Id.*

Certainly, the facts in the instant case are very similar to those in *Jenkins*. In *Jenkins*, the insured was given proof of loss documents on two separate occasions, and then was granted a 15-day extension more than two years after the original 60-day deadline in which to send in the required proof of loss, but still failed to do so. In this case, the Insured or a representative of the Insured was given proof of loss documents on at least five separate occasions, and was granted a 30-day extension by QBE more than a year and a half after the original 60-day deadline in which to send in the required proof of loss, yet failed to do so. As in *Jenkins*, in this case there has been no waiver of the proof of loss requirement, rather QBE has insisted upon it, and as the Court granted summary judgment for the insurer in *Jenkins*, this Court should hold likewise, that the Insured's conduct coupled with its failure to submit the signed proof of loss makes such a holding necessary.

In a second case, a 2009 Eleventh Circuit decision, the Court of Appeals reviewed summary judgment which had been entered by the District Court for an insurer on the grounds that its insured had failed to meet its obligations under the terms of the policy regarding the filing of claims. In that case, *Hall*, *supra*, an insured filed suit against his homeowners' insurer for failure to pay a claim arising out of a house fire on August 1, 2005. 2009 WL at *1. Following the fire, the insured promptly filed a claim with the insurer and was interviewed by an investigator hired by the insurer. On September 25, 2005, the insurer sent him a letter requesting a completed proof of loss form. Under the terms of the policy in effect at the time of the loss, the insured was required to send in a signed, sworn proof of loss within 60 days of the insurer's request as a condition precedent to payment of the claim. *Id.* The insured did not reply to that request nor did he comply with three subsequent requests, the last of which was sent to his attorney on May 8, 2006. *Id.* Aside from those requests, the insurer had also made seven written requests between November of 2005 and May of 2006 to obtain documents and conduct examinations under oath, but the information was not provided by the insured. *Id.* As a result, the insurer set a meeting to be held on June 15, 2006 to which the insured or his attorney was to bring the requested documentation. However, the insured's attorney still did not submit a completed proof of loss form or any of the other requested documents. *Id.* at *2.

Further as of the date the suit was filed, none of the documentation had been provided and none of the examinations under oath had been conducted. *Id.*

Based on this course of events, the insurer filed a motion for summary judgment on the grounds that the insured had not met his contractual obligations that were conditions precedent to his filing of a lawsuit under the policy terms and that he had failed to cooperate with its investigation of the loss. *Id.* The District Court agreed with the insurer, granting its motion for summary judgment, to which the insured appealed to the Court of Appeals, arguing that though there were express conditions precedent to suit which he failed to meet, he still made "a good faith effort to provide the requested information." *Id.* at *3.

Because this was a case originating from the District Courts in Georgia, the Eleventh Circuit first noted that under Georgia law, an insurer was within its contractual rights to require its insured to comply with the terms and conditions of his policy and cooperate in its investigation as preconditions to his recovery under the policy.[2] *Id.* With this in mind, the Court reviewed the circumstances and evidence presented in the case, noting that the insured had a contractual right to gather documents and conduct examinations under oath in the year succeeding the fire loss. *Id.* Further, the insurer had been "patient and reasonable," sending nine letters over

[2] Alabama substantive law is the same as Georgia law on this issue. *See Nationwide Ins. Co. v. Nilsen*, 745 So. 2d 264, 267 (Ala. 1998); *Turner v. Liberty Nat'l Fire Ins. Co.* 681 So. 2d 589 (Ala. 1996); *United Ins. Co. of America v. Cope*, 630 So. 2d 407, 411 (Ala. 1993).

a span of eight months to the insured's attorney in an attempt to get the requested information. *Id.* Despite the fact that the insurer was essentially ignored, it continued to reach out to the insured to try get the information it was contractually obligated to. Still, the insured did not provide the information to the insurer. *Id.* Based on these facts, the Court affirmed the District Court's summary judgment in favor of the insurer based on the insured's failure to satisfy conditions precedent to the suit. *Id.* at *4.

Again, QBE points to the close parallels between the factual scenario in *Hall*, in which the Court granted summary judgment for the insurer, and the facts of the instant case in asserting that Blount Medical has breached the conditions precedent to its recovery under the insurance contract and therefore is entitled to nothing. As the insurer did with the insured in *Hall*, QBE continually reached out to Blount Medical through FKS via calls and letters. However, FKS' calls and letters went unanswered without explanation, no signed, sworn Proof of Loss was sent, the building was left unsecured and unrepaired, and no content inventories or other supporting documents were forwarded. Indeed, it seems the only difference between *Hall* and the instant case is that QBE, through FKS, made many more attempts to contact the Insured over a much longer period of time and Blount Medical's conduct was much more egregious. Certainly, QBE has been more than "patient and reasonable," with Blount Medical.

QBE is at a loss to know what else it could have done to try to get Blount Medical to comply with its post-loss duties.

In a third case, *Brooks*, *supra*, the United States District Court for the Southern District of Alabama considered a case where an insurer would be obligated to pay temporary disability benefits to the employee of its insured when it received acceptable proof that the disability resulted from an injury while the employee was performing the duties of his occupation. *Brooks*, 2008 WL at *9. Under the policy terms, the insurer's obligation to pay was conditioned upon its receipt of 'written Proof of Loss that is acceptable to Us." Quoting the Eleventh Circuit Court of Appeals in *Lee v. Prudential Ins. Co.*, 812 F.2d 1344, 1346 (11th Cir. 1987), the *Brooks* Court summarized the law in Alabama regarding an insurer's requirement of "due proof of loss" as a condition precedent to payment:

> It is clear that under Alabama law, [due proof of loss] is a legitimate condition precedent to the insurer's duty to pay benefits. The purpose of requiring such proof is to allow the insurer to form an intelligent estimate of its rights and liabilities, to afford it an opportunity for investigation, and to prevent fraud. No liability attaches unless proof is furnished or unless the provision is waived. Equitable Life Assurance Society v. Dorriety, 229 Ala. 352, 157 So. 59 (1934).

Id. at *10.

In *Brooks*, the insurer argued that the insured had not provided it with "due proof of loss" because he had not returned certain Attending Physician's Statements

which would have allowed the insurer to determine whether he had been under the care of a doctor for his alleged disability, whether the alleged disability may be permanent, and whether there was any preexisting condition that may have contributed to the disability. *Id.* at 11. Specifically, after receiving the insured's initial notification that a claim may be forthcoming, the insurer wrote to the insured asking him to complete a Statement of Facts form, an authorization to obtain medical records, and a copy of a Physician's Report to be filled out by his primary treating physician. Further, the insured was asked to submit copies of physician's notes, a settlement deduction sheet, a copy of any accident reports, and all medical bills in his possession. *Id.* Despite these requests and two follow-up letters, the insured never responded to the insurer with the requested information, prompting the insurer to send him a letter several months later notifying him that it was closing its file. *Id.*

The insurer did not hear from the insured again until three years later, when it received notice of a second possible claim as a result of a second accident in which the insured was allegedly injured on the job. *Id.* Again, the insurer contacted the insured requesting the same documents and similar information that it had requested under the insured's first claim. Again, the insurer did not hear from the insured with the requested information, and sent a letter to him stating that its file would be closed if it did not receive said information. *Id.* at *11-12. A few months later, the insured

sent a fax to the insurer including some of the requested information but still omitting most of it. The insurer sent him a letter asking him to supplement this fax, but the insured never responded. *Id.* at *12.

Upon review of these facts, the Court held that the insured's failure to complete and submit the requested forms and documents that the insurer had sent to him regarding both of his claims, though he had had ample opportunity to so, was a failure to provide the insurer with "due proof of loss."[3] *Id.* at *13. Therefore, summary judgment was due to be granted for the insurer as the insured had failed to comply with the terms of the policy regarding the claims making process and no duty to pay was triggered.

Other cases arising in the Eleventh Circuit and other jurisdictions have held similarly to *Jenkins*, *Hall*, and *Brooks* when examining strict compliance with terms and conditions in insurance policies and the failure to file an appropriate proof of loss, as have courts from other circuits. *See e.g. Sanz v. U.S. Sec. Ins. Co.*, 328 F.3d 1314 (11th Cir. 2003); *State Farm Fire & Cas. Ins. Co. v. Richardson*, 2008 WL 4531765

[3] While the provision regarding the requirement of proof of loss is different in the instant case under the subject QBE policy, the application is the same regarding the fact that a condition precedent was not met. In the *Brooks* case, the Court dealt with language regarding "due proof of loss" and what exactly that meant when not specifically enumerated in the policy. In the case at bar, what is required to satisfy the proof of loss condition precedent to payment is specifically enumerated, therefore this Court need not try to determine what may or may not satisfy this term. Under the Policy, the policy language requires "a signed, sworn Proof of Loss containing the information we request to investigate the claim. You must do this within 60 days after our request." There is no ambiguity in this term which leaves it open for interpretation as to how the insured must meet its obligation.

**5-7 (S.D. Ala., October 9, 2008) (granting summary judgment to insurer due to insured's failure and refusal to comply with duties after loss, including giving statements, submitting to examination under oath, and producing documents as requested by the insurer); *Brown v. Commonwealth Life Ins. Co.*, 22 F. Supp. 2d 1325, 1332 (M.D. Ala. 1998) (*citing Cope*, *supra*); *Dawkins v. Witt*, 318 F.3d 606 (4th Cir. 2003); *Mancini v. Redland Ins. Co.*, 248 F.3d 729 (8th Cir. 2001); *Flick v. Liberty Mut. Fire Ins. Co.*, 205 F.3d 386 (9th Cir. 2000); *Gowland v. Aetna*, 143 F.3d 951 (5th Cir. 1998); *Phelps v. Fed. Emergency Mgmt. Agency*, 785 F.2d 13 (1st Cir. 1986).

B. QBE has no Duty to Pay Blount Medical Because Blount Medical's Failures to Meet Conditions Precedent to Payment Under the Policy's Terms and Conditions were Material and Substantial to QBE's Prejudice.

Based upon the facts and case law outlined above from both the Alabama Supreme Court and the Eleventh Circuit, QBE asserts that because Blount Medical failed to meet its contractual post-loss duties regarding the filing of claims arising out of the loss on April 19, 2006 in which the Blount Medical Center Facility was damaged, summary judgment is due to be granted for QBE regarding its duty to pay the claim. The facts of the instant case are comparable to those in *Nilsen*, *Jenkins*, *Hall*, and *Brooks* among others, all cases where summary judgment was granted for the insurer.

In this case, under the language of the insurance contract between QBE and Blount Medical, QBE agreed to pay for a covered loss within 30 days of receipt of a signed, sworn Proof of Loss as long as the insured complied with all of the terms under the Policy. Blount Medical had certain duties in the event of a loss or damage with which it must have complied in order for QBE's duty to pay within 30 days of the loss to be triggered. Four such duties included: (1) to take reasonable steps to protect the Covered Property from further damage, (2) to give QBE complete inventories of damaged and undamaged property including quantities, costs, values and amount of loss claimed, (3) to send QBE a signed, sworn proof of loss containing all of the information QBE requested to investigate the claim within 60 days of the loss, and (4) to cooperate with QBE in the investigation of the claim.

Though coverage for Blount Medical would be voided if it had breached only one of these requirements under the insurance contract, as the following facts show, Blount Medical has failed to meet its obligation to QBE on all four of these conditions precedent to QBE's duty to pay. For example, it is absolutely undisputed that Blount Medical never sent QBE a complete signed, sworn proof of loss in this case, despite being provided with at least five separate Proof of Loss documents by FKS. Blount Medical admits this much in its Answer. [See Exhibit H, ¶52]. FKS first prepared a Proof of Loss and presented it to Blount Medical in June of 2006. [Exhibit C, ¶4]. On

June 22, 2006 Blount Medical representative Tom Hackney executed a "partial" Proof of Loss pertaining to the roof damage alone, for which Blount Medical received payment of $44,813.53, and returned it to FKS. [Exhibit D]. In its June 22, 2006 report, FKS noted that it was still awaiting building content inventories to be provided by Blount Medical. [Exhibit B, FKS' Third Report]. By August 24, 2006 FKS had prepared an additional estimate for damage to the building in addition to the roof damage for which Blount had already been paid. [Exhibit B, FKS's Fifth Report]. FKS forwarded a Proof of Loss to be signed and returned by Blount Medical for that damage. [Exhibit C, ¶7]. At that time, FKS again noted that Blount Medical had not provided the requested documentation regarding the damaged contents of the building. [Exhibit B, FKS's Fifth Report]. As of September 26, 2006, no signed Proof of Loss had been returned to FKS by Blount Medical, nor had Blount Medical provided FKS with any documentation for the damaged contents. [Exhibit B, FKS's Sixth Report]. Likewise, as of March 27, 2007, despite repeated phone calls, messages and correspondence, including correspondence sent via certified mail which was confirmed received by the insured on March 9, 2007, Blount Medical had not responded to FKS in any way. [Exhibit B, FKS's Twelfth Report]. Finally, on April 9, 2007, Tom Hackney, Blount Medical's representative, contacted FKS stating that he could not find any of his paperwork, including the previously provided Proof of

Loss. [Exhibit B, FKS's Thirteenth Report]. As a result of that conversation, FKS prepared another complete copy of the paperwork including a Proof of Loss, FKS' estimate, and contents inventory worksheet and sent them to Blount Medical. [Exhibit B, FKS's Thirteenth Report].

More than two months later, FKS had still not received the signed Proof of Loss or any of the damaged contents inventory documents that it had requested. [Exhibit B, FKS's Fifteenth Report]. On July 24, 2007, Tom Hackney called and left a message asking FKS to fax a fourth Proof of Loss to its Birmingham office. [Exhibit B, FKS's Sixteenth Report]. FKS attempted to return this phone call on a couple of different phone numbers, but it could not reach the Insured and left a message asking the Insured to call back. [Exhibit B, FKS's Sixteenth Report]. However, FKS did fax the documentation to the number left by Mr. Hackney in the message. [Exhibit C, ¶20]. On October 24, 2007, FKS reported to QBE that Blount Medical had still failed to return any phone calls, but confirmed to QBE that the Insured had still not repaired the roof from the original loss and that FKS had advised the Insured that no further damages would be considered in the future. [Exhibit B, FKS's Nineteenth Report]. Tom Hackney confirmed that he understood that in light of Blount Medical's failure to complete the roof repairs that no further interior damages would be considered. [Exhibit B, FKS's Nineteenth Report]

On January 2, 2008, having not heard further from the Insured, QBE issued a Reservation of Rights to Blount Medical notifying it of its violation of the Policy terms and that it would be closing its file within 30 days. [Exhibit E]. Subsequently, on January 4, 2008 Chester Hix, a representative of Anchor/QBE, was contacted by Marcus Givhan, counsel for Blount Medical, and granted the Insured a 30-day extension in which it could send in the signed, sworn Proof of Loss. [Exhibit F]. Subsequent to that, FKS was contacted by Blount Medical's CPA, Caroline Lenderman, and forwarded to her a Proof of Loss to have the insured sign and return. [Exhibit B, FKS's Twenty-second Report, Exhibit C, ¶25]. No Proof of Loss was forwarded to QBE until March 5, 2008, when counsel for the Insured sent an **unsigned** Proof of Loss for an amount of $645,300. [Exhibit H, ¶36, Exhibit G]. None of the supporting documentation regarding the damaged contents of the building requested by QBE was included with the unsigned Proof of Loss, only a document containing broad categorizations of content damages and grossly excessive lump sum figures. [Exhibit G].

QBE again reserved its rights under the policy terms in correspondence to the Insured's counsel, indicating that Blount Medical had not cooperated with QBE in the investigation of the claim and stressing the necessity of an investigation into the unsigned Proof of Loss and the damage claims contained therein. [Exhibit I]. On April

2, 2008, FKS noted that it had tried to contact on two occasions the Insured's counsel requesting a meeting at the scene of the loss to review all events and previously issued Proofs of Loss with Tom Hackney and his contractor. [Exhibit B, FKS's Twenty-fourth Report]. FKS noted that in a recent drive-by of the subject building, the building was unsecured and appeared to have been unsecured for some time. Also, the roof had not been repaired and there was more extensive damage since the loss as a result of this. [Exhibit B, FKS's Twenty-fourth Report]. On April 23, 2008, more than two full years after the loss, FKS sent Blount Medical's counsel a copy of QBE's estimate at their request. [Exhibit B, FKS's Twenty-fifth Report]. Subsequent to that correspondence, as of approximately three months later, FKS had not heard from Blount Medical or its counsel despite attempts to contact them. [Exhibit B, FKS's Twenty-eighth Report].

As these facts show, Blount Medical failed to meet four of its post-loss obligations under the insurance contract provisions. In the order in which they appear in the policy, first, Blount Medical failed to take all reasonable steps to protect the Covered Property from further damage. The insured left the premises unsecured for an extended period of time and failed for two years after the loss to repair the roof to prevent further damage. The insured did this despite being notified by FKS even as

late as October 24, 2007 that there would be no coverage for further damage to the building, a fact which Tom Hackney acknowledged.

Blount Medical also failed to meet a second post-loss obligation, its duty to give QBE complete inventories of damaged and undamaged property including quantities, costs, values and amount of loss claimed. It is clear the insured was non-cooperative with QBE's investigation regarding the damaged contents of the building. Blount Medical failed to give QBE complete inventories of the damaged and undamaged property, instead only sending a very general lump sum breakdown of its alleged damages by category nearly two years after the loss as attached to an unsigned Proof of Loss. None of the alleged damaged contents were ever made available for QBE's inspection despite QBE's request through FKS, nor were any supporting documents provided QBE such that it could even remotely assess the accuracy of Blount Medical's claims for damaged contents.

Third, Blount Medical failed to send QBE a signed, sworn proof of loss containing all of the information QBE requested to investigate the claim within 60 days of the loss. As the facts show, FKS first presented Blount Medical with a Proof of Loss in June of 2006 which Blount Medical marked as "partial" and returned incomplete to QBE on June 22, 2006. FKS then presented another Proof of Loss to Blount Medical in August of 2006 for the remaining damages to the building, but

Blount Medical never signed and returned it. Instead, Tom Hackney allegedly lost the documentation several times such that FKS had to resend the Proof of Loss and other documentation to Blount Medical or a Blount Medical representative at least three more times, once to Tom Hackney on April 7, 2007, once again to Tom Hackney on July 24, 2007 and again to Blount Medical's CPA, Caroline Lenderman at Cade CPA in Birmingham, in early January of 2008. The only attempt made by Blount Medical to send the Proof of Loss was the return of an unsigned Proof of Loss for $645,300.00 in March 2008. According to the strict language of the QBE Policy, this is not sufficient for Blount Medical to satisfy its obligation.

Fourth, Blount Medical failed to cooperate with QBE in the investigation and settlement of the claim in general. The insured failed to cooperate due to the fact that phone calls and correspondence were never returned, the Insured misplaced the documents forwarded to it several times, and was negligent in general toward the entire claims filing process to the prejudice of QBE. QBE was extremely "patient and reasonable" with Blount Medical, reaching out to Blount Medical repeatedly through FKS for well over two years, sending multiple copies of the documentation, working with Blount Medical's counsel, and working with Blount Medical's CPA. Still, Blount Medical did not comply with the Policy's requirements and QBE was prejudiced to the point that it had to reserve its rights and deny further coverage.

These failures by the insured were material and substantial, and prejudiced QBE substantially. As of the filing of this motion, QBE has never received a complete, signed Proof of Loss from the Insured, nor has it received any documentation which would adequately support its claims for damaged contents. Further, QBE was never allowed any investigation of the damaged contents claimed by Blount Medical despite its requests for that opportunity, thus QBE was not able to do a thorough and accurate examination of the contents of the building in order to determine the extent of the loss. There is no evidence, other than Tom Hackney's word, that any of the damaged contents claimed ever even existed as far as QBE is concerned. To allow any consideration of damaged contents would likely perpetrate a fraud on QBE.

QBE has been further prejudiced because the insured's failure to repair the roof on the building for over two years has led to further damage to a greater extent than was caused by the original loss. Further, at times the building has been left unsecured which has most assuredly led to damage in excess of that caused by the original loss. QBE can no longer get an accurate assessment of the damage done to the building itself[4] or the contents of the building as a result of the original loss, and the Insured

[4]QBE stands behind the accuracy of the original estimate done at the time of the loss by FKS. However, Blount Medical has filed with this Honorable Court an expert report from someone who has apparently visited the building site just within the last few months to assess the damage as the building sits now. QBE asserts that the Court should completely disregard this report not only because the condition of the building at this point does not relate to any coverage issue before this Court regarding Blount Medical's compliance with its post-loss obligations, but also because the report must be completely inaccurate due to the fact that the building was left for so long unsecured and unrepaired exposed to the weather conditions and potential vandalism.

never provided QBE with the requested documents outlining and supporting those damages despite repeated attempts to get the insured to forward them. As the case law above requires of QBE, QBE has proven through the facts of this case that it has been deprived of the opportunity to conduct an investigation and to mount a defense to the claims made by Blount Medical because "the only evidence QBE could offer in defense" has been negated by Blount Medical's non-cooperation.

In anticipation of an argument by Blount Medical that it made a good faith attempt to forward the requested Proof of Loss and supporting materials as suggested in its Answer[5], QBE points this Court to the Court's analysis and decision regarding this very argument in *Hall*. Again, in that case, the Court looked at all of the circumstances presented in the case, and held that the insured had a contractual right to gather documents and conduct examinations as the policy language allowed. Further, the insurer had been "patient and reasonable," due to the fact that it had made multiple efforts to contact both the insured and the insured's attorney in an attempt to get the requested information. Further, despite being ignored by the insured, it continued to reach out to the insured to try to get the information to which it was contractually entitled. Still, the insured did not provide the information to the insurer in that case. Based on those facts, the Court affirmed the District Court's summary

[5] See Exhibit H, ¶52, P. 5, Seventh Defense].

judgment in favor of the insurer because of the insured's failure to satisfy conditions precedent under the policy language.

A similar situation is presented in this case as was presented in *Hall*. The only difference is that QBE has gone even further and allowed a much longer period of time for the Insured to meet its obligations under the policy. QBE gave Blount Medical multiple copies of the completed Proof of Loss forms, QBE's adjusters tried to contact Blount Medical in order to obtain the Proof of Loss over and over again, and QBE gave Blount Medical a 30-day extension more than a year and a half after the Proof of Loss was due, yet still the Insured did not comply. The only thing that Blount Medical finally did was send in an unsigned Proof of Loss form with no supporting documentation as was requested by QBE and required under the Policy terms. QBE contends that there was no such good faith as it were, and even if there was, this would still fail under the strict conditions in the Policy language.

IV. Conclusion

The case law from the Supreme Court of Alabama and Eleventh Circuit Court of Appeals is clear that contractual conditions precedent to an insurer's duty to pay a claim are to be strictly complied with, else there will be no coverage for the claim. This is especially true in the claims filing process.

Under the QBE Policy in effect on April 19, 2006 at the time of the loss, QBE contracted with Blount Medical to pay for the Covered Loss within 30 days as long as certain post-loss duties were carried out, and Blount Medical contracted with QBE to assume those post-loss duties which were conditions precedent to QBE's duty to pay. Four of these duties were: to (1) to take reasonable steps to protect the Covered Property from further damage, (2) to give QBE complete inventories of damaged and undamaged property including quantities, costs, values and amount of loss claimed, (3) to send QBE a signed, sworn proof of loss containing all of the information QBE requested to investigate the claim within 60 days of the loss, and (4) to cooperate with QBE in the investigation of the claim. As the facts and arguments above clearly show, Blount Medical did not do any of these things.

WHEREFORE, ABOVE PREMISES CONSIDERED, QBE requests that this Honorable Court grant its Motion for Summary Judgment and declare that it has no duty to pay the claim.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that I have served the foregoing document upon the following by causing a true and complete copy of same via United States Mail, sufficient first class postage prepaid, on this the 5th day of October 2009, addressed as follows:

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