CAIIA Status Report

AUGUST 2006

Insurance Law Update

Submitted by Sedgwick, Detert, Moran & Arnold, LLP

California Supreme Court Holds That Cost-Shifting Provisions Apply to An Uninsured Motorist Arbitration and That An Arbitration Award, Combined With Costs, May Exceed Insurer's Policy Limits

By Laura Goodman, Sedgwick San Francisco

July 14, 2006

In *Pilimai v. Farmers Insurance Exchange Co.*, 06 C.D.O.S. 6237 (Cal.S.Ct. July 13, 2006), a unanimous California Supreme court held that the cost-shifting provisions of California Code of Civil Procedure section 998 apply to an uninsured motorist arbitration conducted under Insurance Code section 11580.2 and that the award of such costs, together with the arbitration award, can permissibly exceed an insurer's "maximum liability" (the policy limits) under Insurance code section 11580.2(p). The court also held that plaintiff could not recover prejudgment interest from his insurer under Civil Code section 3291 in an uninsured motorist arbitration.

Plaintiff was injured in an accident with an uninsured driver and filed a petition to compel arbitration with his insurance carrier pursuant to the uninsured motorist provisions of his insurance policy, which had a limit of $250,000. Prior to the arbitration, plaintiff served a settlement demand pursuant to Civil Code section 998 on his insurer, offering to settle for $85,000. The offer was refused. The arbitrator found that plaintiff was entitled to recover damages in the amount of $556,972, less a $15,000 credit due to the insurer. Both parties filed petitions to confirm the award in which they acknowledged that the damages were limited to the $250,000 policy limit, but took different positions on the recovery of costs. The insurer argued that plaintiff could not recover more than the policy limits, even if costs were included. Plaintiff, on the other hand, argued that he was entitled to recover costs and prejudgment interest even if that amount, coupled with his damages, exceeded the policy limits. The trial court agreed with the insurer and plaintiff appealed.

The appellate court reversed and the Supreme Court granted review. The court, relying on its prior decisions, expressly held that "an uninsured motorist arbitration pursuant to Insurance Code section 11580.2 is an 'arbitration' within the

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■ PRESIDENT'S MESSAGE

As we are in the middle of these crazy, lazy days of summer, I thought about some of the crazy claims that have come before my attention.

A few issues ago I related the story of a businessman who presented the claim for the theft of his employees' tools. While I was relatively sure of the outcome, because of the insured's conduct all rules were properly followed. While the insured was upset that the tools would not be covered, at least no legal action resulted.

I remembered, many years ago there was a lady that turned a claim for a cigarette burn in her carpet. When I arrived at her home, I realized what the problem was. On each side of her recliner were several cigarette burns. She answered my question that she had lived there nine years and that the first cigarette burn appeared approximately seven years earlier. I leaned down and started counting, "One hundred dollars, two hundred dollars, three hundred dollars, four hundred dollars." She then stopped me and asked what I was doing. I replied that I was counting her deductibles. I then stated that the last cigarette burn did not detract from the overall appearance of her carpet. Of course, being the sharp person that she was, she stated then that she was claiming the first burn and not the last burn. I then reviewed her policy information and advised her that this carrier had only insured her for two years and that she would have to back to the carrier that insured her seven years earlier. She became very upset as I exited the home with a smile on my face.

I recalled a fire at a tenant occupied dwelling. I represented the carrier that insured the home. The fire started in the tenant's car and her sole concern was that her brand new child's restraint seat, the one she had recently purchased at a yard sale. Of course, there was no liability on the part of the homeowner, but she kept insisting. I then advised her that I would not engage in a game of verbal volleyball with someone who did not bring all the equipment. She looked at me, smiled and said, "I agree with you a hundred percent." And, with that, she walked away.

Finally, there was man who had a fire. He would not allow his personal property to be examined. The damages to the dwelling were taken care of but the personal property claim was not resolved. Subsequently, the man sued in Small Claims Court. After all testimony, we asked the Judge if we could direct a question to the Plaintiff. The question we posed was, "Why wouldn't you allow the insurance company to examine your personal property?" His reply was that he was protecting his lawsuit. The Judge just smiled, realizing that from the first day this man planned to sue, and found for the insurance company.

I am sure that many of you have similar stories and if you would like to have them considered to be printed in the Status Report, please do not hesitate to mail, fax, or e-mail to my attention.

I must also point out that the three claims I just wrote about all occurred prior to the Fair Claims Practice Regulations being enacted.

The Claims Conference of Northern California is going to be held September 21 – 22 at the Hyatt Regency in Sacramento. You can call Corby Schmautz at (916) 361-6616 for registration. Looking forward to seeing you at the CCNC.

Have fun doing your job!

STEVE WAKEFIELD
President - CAIIA 2005-2006

When You Need to Know What Really Happened

Submitted by Garrett Engineers, Inc. - Forensic Division

Evaluating Stairway Falls:

Let's face it, stairways are a common hazard, but one we reasonably accept as necessary to get from one elevation to another. Still, many injuries occur from stairway falls.

Almost all serious stairway falls happen while the victim is descending the stairway; typically they report that they "slipped" on a step. However, the actual cause of the fall is usually not a "slip", but a "mis-step", and mis-steps are often caused by irregular out-of-code rise and run dimensions of the as-built stairway.

"Rise" is defined as the vertical change in height of two adjacent steps, measured from nose to nose; and "run" is defined as the horizontal distance from the nose of one step to the nose of an adjacent step. Special tools and techniques are necessary to correctly measure rise and run.

Over the years, the building code requirements for rise and run have changed. Currently in commercial and public structures, the rise must be between four and seven inches, while the run must not be less than eleven inches. However, much more importantly, the variation of both rise and run must not exceed three eights of an inch (3/8 inch) for the entire stairway.

Handrails are also an important safety feature; they must be firmly mounted, easily grasped, and at a proper height (again, code requirements for handrails have changed over the years). For most public locations, a handrail is required on both sides of the stairway.

Other factors such as lighting, visual patterns, and nose markings might be involved in a stairway fall, and the expert evaluating the stairway should be prepared to address those issues as well.

If the construction of the stairway is up to code, it is reasonable to ask why did this one person fall when ten thousand others passed by without a problem? This brings in the additional level of complexity of the human factors. Here are some of the questions that need to be answered when evaluating those factors to fairly assess causation:

- What was the claimant doing just prior to the accident? In what direction was the claimant going? Was the claimant carrying something or talking to somebody? Was the claimant turning or running? Which foot was initially involved? Security cameras have been very helpful in helping to answer some of these questions.
- Was the claimant visually or physically limited? How about obesity, arthritis or color blindness? What medications were taken?
- Exactly where did the accident happen? On what step of the stairway and on which side? On which particular surface, if it varies?
- What were the environmental factors? Were the steps wet? Were there contaminants or debris (spilled drinks, leaves, sand)? What was the lighting like (dark, bright, too bright)?
- Are the steps loose or broken? Are they painted or carpeted? Is the carpeting tight? Are defects significant or trivial?
- Is the claimant's footwear a factor? Did the footwear fit securely? Are they slippery on the walkway surface? How slippery? Are they new or old or worn?
- How slippery are the steps? What is the appropriate method to measure the slipperiness of the steps?

Experts qualified to evaluate environmental conditions, code requirements, human factors and biomechanics must consider all of these factors.

Insurance Law Update

Submitted by Sedgwick, Detert, Moran & Arnold, LLP

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meaning of Code of Civil Procedure section 998 and subject to the latter statute's cost-shifting provisions. "The court further held that the provisions of Insurance Code section 11580.2(p)(4), which provide: "When bodily injury is caused by one or more motor vehicles, whether insured, underinsured, or uninsured, the maximum liability of the insurer providing the uninsured motorist coverage shall not exceed the insured's underinsured motorist coverage limits, less the amount paid to the insured by or for any person or organization that may be held legally liable for the injury," do not preclude an award of costs pursuant to Code of Civil Procedure section 998, even if the costs, in addition tot he damage award, exceed the insurance policy's limits.

The Court, however, rejected plaintiff's claim that he was entitled to recover prejudgment interest under Civil Code section 3291 which provides, in relevant part: "If an action brought to recover damages for personal injury sustained by any person resulting or occasioned by the tort of any other person . . . it is lawful for the plaintiff in the complaint to claim interest on the damages alleged as provided in this section. If the plaintiff makes an offer pursuant to Section 998 of the Code of Civil Procedure which the defendant does not accept prior to trial or within 30 days, whichever occurs first, and the plaintiff obtains a more favorable judgment, the judgment shall bear interest at the legal rate of 10 percent per annum . . ." It held that an action against an insurance company to recover policy benefits is not an action to recover "damages for personal injury" but rather damages for breach of contract, even if that contract is to provide compensation for personal injury. Therefore, prejudgment interest is not recoverable.

Insurance Commissioner John Garamendi's Office to Announce Major Indictment of 25 Suspects for Insurance Fraud

One year probe by the California Department of Insurance's Urban Organized Auto Fraud Task Force nets 25 suspects who created 22 "'phantom" auto accidents

SANTA CLARA – Insurance Commissioner John Garamendi announced today the indictment of 25 suspects in connection with a major insurance fraud investigation dubbed "Operation Cashout." As of early this morning, 20 suspects were arrested. Five suspects remain outstanding.

The Urban Organized Auto Fraud Task Force consists of investigators from the California Department of Insurance's Fraud Division, the Santa Clara County District Attorney's Office and the California Highway Patrol. All 25 suspects were charged with felony insurance fraud. Khai Van Nhin, 39, of San Jose, the main suspect and orchestrator of the scheme, was charged with 14 felony counts of insurance fraud and two felony counts of forgery. Many of the suspects have been arrested this morning by task force investigators.

"Operation Cashout" involved a ring of suspects who conspired to report auto accidents that never occurred in order to file false insurance claims. The suspects would typically claim they were driving on a freeway when another vehicle changed lanes striking the suspect's car, forcing him or her into a guard rail. Both vehicles reportedly involved in the claim were usually owned and driven by the ring members. They would file false vehicle damage claims and "cash out" the settlement, thereby taking the money but not repairing the vehicle. They would then use the same damaged vehicle to make repetitive false claims with different insurance companies. Often the driver and passengers would also submit false bodily injury claims as part of the phantom accidents in order to obtain additional insurance proceeds.

"All of us pay a penalty for insurance fraud because the costs are passed along to policyholders," said Insurance Commissioner John Garamendi. "That's why I've made fighting insurance fraud a top priority of my Department."

The felony charges stem from 22 phantom accidents involving 12 cars. Various insurance companies became suspicious after noting some suspects were using the same addresses and vehicles in claims dating from 2000 through August 2005. This fraud ring was brought to the attention of the task force by Farmers Insurance, State Farm and Safeco Insurance companies. The charged claims involved approximately $400,000 in insurance payments.

The indictment was returned by the grand jury after the presentation of over 50 witnesses including individuals from the Special Investigative Units (SIUs) of several insurance companies and attorneys. Warrants remain outstanding for Khai Van Nhin and Mason Son Trans, 38, of San Jose, the other primary suspect. Nhin's bail was set at $1,000,000. Bail for Trans was set at $75,000. Anyone with information concerning the whereabouts of suspect Nhin and Trans should contact the Department of Insurance's Fraud Division at 408-779-7200.

"The efforts of this Department's Auto Fraud Task Force—in addition to the tip received from the insurance companies—helped to save California consumers millions of dollars that would have lined the pockets of these criminals," said Commissioner Garamendi. "Here is a message to all con artists seeking to scam the system: You can not hide from us – we will catch you, prosecute you and put you behind bars."

Also providing information were the SIUs of State Farm, Progressive, AAA, Hudson, Farmers, Safeco, Qestrel, David Morse and Associates, 21st Century, Western General and Western United Insurance Companies. The Santa Clara County District Attorney's office is prosecuting the case.

If convicted, Nhin faces a maximum sentence of 18 years in state prison. The other suspects face maximum prison terms ranging from 5 to 10 years.

20 SUSPECTS ARRESTED TODAY, JUNE 29, 2006

* CHAU BICH NGUYEN, 37
* HUE THI NGUYEN, 55
* RICHARD BUI, 66
* GIANG THI PHAM, 45
* HA NGOC NGUYEN, 46
* KIEUDIEM THI NGUYEN, 23
* LISA HONG NGUYEN, 43
* TUOI THI VU, 37
* NAM VINH CHUNG, 37
* DUNG HUNG LE, 57
* THANH TAN LE, 35
* PHUONG THI HUYNH, 48
* LONG KIM NGUYEN, 30
* JOHN MINH TRAN, 26
* TIGER HUYNH, 42
* HELEN FONG, 28
* ANNIE BUI, 55
* MAI NHIN, 30
* NHUNG THI NGUYEN, 46
* THUTHUY THI NGUYEN, 25

CAIIA *Calendar*

Claims Conference of Northern California
September 21-22, 2006
Contact F. Michael Sowerwine at
(510) 740-0377

CAIIA Annual Convention
October 11-13, 2006
Sheraton Grand Hotel, Sacramento
Contact Sharon Glenn at 925-277-9320

Weekly Law Resume

Prepared by Low, Ball & Lynch, Attorneys at Law

Property Insurance - Appraisals - Coverage

Jeff Kacha v. Allstate Insurance Company, Court of Appeal, Division One - June 1, 2006

Appraisals are normally limited to determination of the value of the item insured. This case discusses the issue of whether an appraiser's jurisdiction is exceeded where determinations of coverage are made by the appraiser along with his valuation.

Jeff Kacha and his wife suffered damage to their home and personal property in a fire. Allstate Insurance Company insured the Kacha residence. Allstate evaluated the claim and made payment. Kacha then hired a public adjuster and demanded an appraisal. He contended he was owed an additional $600,000. This included cleaning and repair or replacement of property. Kacha petitioned the Superior Court to compel an appraisal and appoint an umpire. The motion was granted by the court and a retired Judge was appointed as umpire. Each side appointed their own appraiser to work with the umpire.

Thereafter, an inspection of the property occurred with the appraisers and umpire. The matter was briefed by the parties and Allstate contended that certain claimed damages were unrelated to the fire. Kacha objected to this, stating that this was outside the scope of the appraisal. The panel made an award of $163,792 in replacement cost value and $155,993 in actual cash value. Some items were marked zero. Allstate paid the amount of the award. Kacha applied to the appraisal panel to correct the award, arguing that the determination of zero dollars for certain items was a coverage determination. When the panel refused to change the award, he petitioned the Superior Court to vacate it. The court denied Kacha's petition and confirmed the award. A judgment was entered in conformance with the award. Kacha appealed.

The Court of Appeal reversed. It ordered the appraisal award vacated. An appraisal is to determine only the amount of loss. It is to determine the amount of the actual cash value and loss. It is not to resolve questions of coverage or interpret policy provisions. When an appraisal panel exceeds its powers by deciding coverage issues, the decision must be vacated. Thus, the trial court erred by denying Kacha's petition to vacate the appraisal award.

It was clear from the evidence that some items for which a zero sum was awarded had suffered damage. The question was the source of that damage. By awarding zero, the appraisal panel made coverage determinations, thus exceeding its authority.

Finally, the court held that there was no waiver of the right to challenge the award because Kacha accepted and retained Allstate's payment of the award. Here, Kacha immediately applied to the appraisal panel for reconsideration and then petitioned the Superior Court for an order vacating the award. Allstate sent the drafts unsolicited and they had not yet been cashed. Thus, Kacha was apparently holding the drafts pending resolution of the appeal. There was no voluntary acceptance of benefits which would justify a dismissal of the appeal.

Based on the foregoing, the court directed the trial court to reverse the judgment and enter an order granting Kacha's petition, vacating the appraisal award.

COMMENT

Appraisals must strictly comply with the provisions of Insurance Code §2071 or the parties must stipulate to expand the powers of an appraiser. This case shows that failure to do so will result in a vacation of an award where the appraisers make coverage determination.

Coverage - Contribution Action - Burden of Proof

Safeco Insurance Company of America v. Superior Court, Court of Appeal, Second District - June 22, 2006

When an action for equitable contribution is brought by a settling insurer against a non-participating insurer, the issue arises as to what must be proven in order to prevail. This case answers that question.

This case arose out of a construction defect lawsuit. Thirteen construction companies had purchased commercial general liability policies from Safeco Insurance Company of America or American States Insurance Company and later purchased policies from Century Surety Company. All policies were primary for the relevant time and provided coverage for property damage that occurred within the policy period and was in the scope of the contractors' work. In seventeen separate lawsuits, the insureds were sued for property damage allegedly arising from their work during the periods of time they were covered by the relevant policies. In each case after tender Safeco and American State accepted and defended but Century rejected all tenders. Century relied on an "other insurance" clause to contend it was excess to other coverage. Century alleged that since it provided only excess coverage it had no duty to defend or indemnify.

Safeco and American States sued Century for equitable contribution alleging breach of the duty to defend and indemnify. By way of summary adjudication motion, the trial court determined the other insurance clause did not make Century excess to other coverage. Safeco then moved for a summary judgment on the remainder of the case. The trial court denied the motion holding that Safeco had a duty to prove coverage by Century.

Safeco filed a petition for a writ of mandate in the Court of Appeal challenging the court ruling. The Court granted the petition in part and denied it in part. The Court stated a defending insurer seeking equitable contribution from a non-participating co-insurer need only establish a potential for coverage un-

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der the non-participating insurer's policy in order to obtain contribution for the cost of defense. The court also held that once a prima facie case is made of coverage the participating carrier has met its burden of proof and the burden then shifts to the non-participating insurer to prove an absence of actual coverage.

The reasoning of the court was that once a duty to defend is shown a non-participating insurer is presumptively liable for both the costs of defense and settlement. By refusing to participate, the non-participating insurer waived its right to challenge the reasonableness of defense costs and amount paid in settlement. The settlement is therefore presumptive evidence of the insurer's liability and the amount thereof. This presumption can only be overcome by proof to the contrary. Coverage defenses become affirmative defenses to the contribution action. As affirmative defenses, they became part of the burden of proof that rest with the non-participating insurer. Thus, while Century only had a duty to participate in settlements where it had coverage, once its duty to defend was established, and where by law the settlements were presumptively reasonable, the burden was on Century to establish there was in fact no coverage.

The court held that in an action for equitable contribution by a settling insurer against a non-participating insurer, the settling insurer has met its burden of proof by making a prima facie showing of coverage under the non-insurer's policy and then the burden of proof shifts to the non-participating insurer to prove the absence of actual coverage. Thus, the petition was granted holding that Safeco and American States had met their burden of proof in each of these cases. The burden then shifted to Century to prove the absence of actual coverage.

COMMENT

This decision makes sense in light of the principles cited by the court regarding equitable contribution. It will ease the ability of carriers to obtain such contributions by easing their burden of proof

Coverage - Damages - Administrative Order Response Costs

CDM Investors v. Travelers Casualty and Surety Company, Court of Appeal, Sixth District - May 26, 2006

This case is another in a series following from the Supreme Court rulings regarding whether costs incurred pursuant to an administrative order are covered under an insurance policy. In this case, the administrative order concerned property environmental cleanup.

CDM Investors owned property that they leased to tenants. They were ordered by the California Water Quality Control Board ("CWQCB")to test the property for pollutants after it was concluded they were suspected of discharging pollutants into the soil. CDM notified their insurers of the Board's order and claimed insurance coverage for the costs to respond. The insurers denied coverage.

CDM hired a company and spent approximately $230,000 to comply with the order of the CWQCB. The matter was eventually closed with the Board taking no further action. CDM then filed this action, seeking coverage and reimbursement for its legal expenses. The trial court sustained the demurrer to the complaint.

On appeal to the Court of Appeal, the judgment was affirmed. The Court noted that the Supreme Court had held that policies providing coverage for sums for which the insured became "legally obligated to pay" as damages provide indemnity only for money judgments ordered by a court. This is to be distinguished from "expenses," such as ordered by an administrative agency. The Court held that the duty to indemnify for damages did not extend to any expenses required by an administrative agency, pursuant to an environmental statute. Similarly, the duty to defend a suit seeking damages was restricted to civil proceedings prosecuted in a court.

In this case, the relevant insurance policies, although worded slightly differently, all provided coverage for sums for which the insured became legally obligated to pay as damages. Thus, there was no obligation to pay for the expenses incurred because of the order to comply with the decision of the CWQCB order.

The Court distinguished the policies in question from ones that have been found to encompass such expenses. Those policies provide coverage for "ultimate net loss," which was defined to include sums the insured was obligated to pay through adjudication or compromise, and sums paid for litigation, settlement, adjustment, investigation, and expenses. Policies containing such provisions have been held by the California Supreme Court to encompass the costs incurred pursuant to an administrative order.

The Court also rejected without merit CDM's contention that the insurers had a duty to defend it against affirmative defenses raised by its tenants when it sued those tenants in Federal Court to recover those response costs. The Court stated that an insurer has no duty to defend an affirmative defense asserted against the insured in an insured initiated action.

The judgment of the trial court was therefore affirmed.

COMMENT

This decision reaffirms the rule established by the California Supreme Court that there is no obligation to defend or indemnify the insured for administrative proceedings, absent language broader than the standard comprehensive general liability policy.

California Connects Workers to Insurance Careers

July 7, 2006

A coalition of insurance companies, community colleges and workforce development specialists have started a statewide insurance education program, called the California Insurance Careers Program, aimed at preparing community college students for work in the insurance field. Solano Community College is taking the lead in managing the program with colleges from throughout California.

"The insurance industry provides outstanding career opportunities for today's community college students because of the abundance and diversity of jobs available," said Paul White, CEO of Vantage Insurance Services, and originator of the program. "Insurance is prevalent in our society whether you drive a car, own or rent a home, have a small business, or manage a Fortune 500 company. The skills learned through this program will benefit both the individual and the insurance industry as a whole."

However, the coalition said that misperceptions about the insurance industry, combined with a lack of formal training, are allowing community college students to overlook a high-paying, highly flexible career in the insurance industry. In the next two years, 36,200 entry level positions in the insurance industry in California will go unfilled if a pool of highly-skilled workers is not made available, according to research conducted as part of the program.

Actively involved partners include 17 community colleges, 9 Workforce Investment Boards, 30 businesses (including several of California's largest insurance companies), and employer associations representing over 4,500 businesses statewide with extensive linkages to national networks.

"This unique program incorporates centralized curriculum development, coordinated professional development, and student learning resources that combine to meet the workforce needs of the insurance industry," said Mike Wilson, program manager and principal at Rockridge Partners, a workforce development firm. "This model reduces recruiting expenses for employers, expands education programs at community colleges, and prepares students for work in California's $1.06 billion insurance industry. Everyone wins," he said.

The California Insurance Careers Program has been designed in response to industry demand for qualified entry level workers. Industry experts, including the Insurance Educational Association, have helped shape the insurance specialization curriculum under which students will be required to take six courses that complement a Business Associate of Arts degree. Basic requirements such as industry knowledge, and computer and communication skills are the foundation of the initiative.

CA-ICP is a statewide initiative that unites community colleges, workforce investment boards, businesses, and the K-12 system to prepare students for careers in the insurance industry. The program is funded in part by a grant awarded under the President's Community-Based Job Training Grants, as implemented by the U.S. Department of Labor's Employment & Training Administration. More information about the California Insurance Careers Program can be found at www.ca-icp.com.

Insurance Commissioner John Garamendi Announces The Arrest of Bay Area Chiropractor For Alleged Insurance Fraud

Bay Area chiropractor allegedly submitted fraudulent billing statements for eight patients – She was booked into the Contra Costa County Jail on $100,000 bail

SACRAMENTO – Insurance Commissioner John Garamendi announced today the arrest of Dr. Linda Fang, a Bay Area chiropractor, for insurance fraud. Dr. Fang was charged with eight counts of presenting fraudulent claims; eight counts of false statements in support of insurance claims; and eight counts of grand theft. She was booked into the Contra Costa County Main Jail with bail set at $100,000.

According to the San Mateo County District Attorney's Bureau of Investigations, Dr. Fang, who was arrested on April 21, submitted billing statements to four different insurance companies for treatment and services she did not render to eight of her San Mateo patients. The patients came to her for treatment due to various injuries resulting from automobile accidents. Dr. Fang has one office in San Mateo and another in Walnut Creek.

The San Mateo County District Attorney's Office is prosecuting the case. The Department of Insurance's Fraud Division assisted in the investigation.

If anyone has any information or concerns about treatment and services rendered by Dr. Fang, please contact San Mateo County District Attorney Inspector Samson Gee at (650) 363-4773.

Funnie(?). A frog goes into a bank and approaches the teller. He can see from her nameplate that her name is Patricia Whack. "Miss Whack, I'd like to get a $30,000 loan to take a holiday."

Patty looks at the frog in disbelief and asks his name. The frog says his name is Kermit Jagger, his dad is Mick Jagger, and that it's okay, he knows the bank manager.

Patty explains that he will need to secure the loan with some collateral.

The frog says, "Sure, I have this," and produces a tiny porcelain elephant, about an inch tall, bright pink and perfectly formed.

Very confused, Patty explains that she'll have to consult with the bank manager and disappears into a back office. She finds the manager and says, "There's a frog called Kermit Jagger out there who claims to know you and wants to borrow $30,000, and he want to use this as collateral." She holds up the tiny pink elephant. "I mean, what in the world is this?"

The bank manager looks back at her and says . . . "It's a knickknack, Patty Whack. Give the frog a loan. His old man's a Rolling Stone" (Bryan Simmons, KOST)