Time-limited demands are one of the few tools that level the field between an injured person and an insurance company after a crash. Used well, they can push a reluctant insurer to pay policy limits without a lawsuit. Used poorly, they can backfire, delay fair compensation, or even jeopardize a later bad faith claim. I have seen both outcomes, and the difference almost always comes down to timing, clarity, and proof.

This piece unpacks what a time-limited demand is, how it works, and the judgment calls that matter. I will share what typically persuades adjusters, where lawyers misstep, and how real people with real injuries can protect themselves.

What a time-limited demand actually is

At its core, a time-limited demand is a formal, written settlement offer you send to the at-fault driver's insurer with a firm expiration date. The message is simple: pay a specific amount within a specific time, under specific conditions, or face the risk of a later lawsuit and, in some states, potential bad faith exposure. The deadline is not a gimmick. Courts in several jurisdictions recognize that insurers must act reasonably and with due care when given a fair chance to settle within limits.

The rules are not identical across the country. Texas has the Stowers doctrine. Georgia recognizes "Holt" demands after Southern General v. Holt. Florida courts scrutinize how reasonably an insurer responds when presented with a clear chance to settle, and Harvey v. GEICO reminded carriers that they must act with the same urgency an ordinary person would in the insured's shoes. The themes repeat: clarity, reasonableness, and proof.

Why insurers take these demands seriously

Insurance companies do not like surprises, especially not the kind that turn a $25,000 policy into a seven-figure verdict with bad faith allegations. When a demand package shows liability is clear and damages exceed the policy limits, the carrier's safest move is often to tender those limits before the deadline. If they do not, and a jury later awards more than the policy, some states allow the insured to pursue the insurer for the excess based on bad faith. That risk changes the conversation.

A typical example from my files: a client with $68,000 in hospital charges after a T-bone crash caused by a red-light runner. The at-fault driver carried a $50,000 per person limit. We prepared a 30-day time-limited demand that included the police report, black box data showing speed, full medical records, billing, imaging, photos, and wage loss proof. We offered a standard bodily injury release limited to the at-fault driver and insured the lienholders would be paid. The insurer paid within 18 days. The demand did not bully, it simply made the risk unmistakable.

Timing is a strategic choice

Send a demand too early and the insurer can say it lacked the information to evaluate the claim. Wait too long and you might miss leverage or a statute of limitations. I usually target one of two windows:

- When the injury is clearly catastrophic and immediate bills already eclipse the policy limits. In those cases, even short treatment histories can justify an early policy limits demand.
- After a client reaches maximum medical improvement, or at least has a stable treatment plan and documented prognosis. This avoids the "we need more records" dodge and shores up future medical needs with doctor opinions.

For soft tissue cases with disputed mechanisms or long treatment gaps, patience helps. Insurers pounce on missing records, missed appointments, or unaddressed preexisting issues. A rushed demand is easy for an adjuster to dismiss as incomplete, and judges later tend to agree.

The anatomy of a strong demand package

Think of your demand as a self-contained proof file. Adjusters are trained to ask three questions: Who is at fault, what are the injuries, and do the numbers justify the payment requested. A clear package that answers those questions leaves little room for delay.

Here is the short checklist I use when assembling a policy limits demand:

- Precise settlement offer and a reasonable deadline set out on page one
- Liability proof, including the police report, witness statements, and any scene photos or data
- Complete, organized medical records and bills with dates, providers, and charge summaries
- Wage loss documentation and any employer verification if claiming lost earnings
- A proposed release limited to the tortfeasor, plus instructions on payment and lien handling

Clarity matters more than adjectives. I avoid superlatives and stick to facts, images, and numbers. I also explain any issues the insurer is certain to spot, such as a prior back injury. Owning the hard facts builds credibility and prevents the carrier from claiming surprise later.

The deadline: how long is long enough

The right time limit depends on the case and the jurisdiction. Ten days can work where liability is obvious and the policy limit is low. Thirty days is common and usually perceived as reasonable. Sixty days may be appropriate in complicated cases, especially if you are requesting documents from the insurer like a certified declarations page or coverage affidavits.

What matters is whether the time frame gives the insurer a fair chance to gather the file, evaluate liability, and get authority. Include the claim number, the policy number if you have it, and the names of any adjusters who have worked the file. If you know the insurer’s internal escalation process, copy a supervisor. Every practical step that reduces their excuses becomes part of the reasonableness equation if a judge later looks at the timeline.

What to ask the insurer to provide

Good demands are not one-way streets. I often ask for a certified copy of the declarations page, confirmation of any excess or umbrella coverage, the insured’s full name and address, and whether any other policies may apply, such as a resident relative policy. If the insurer cannot or will not provide these, that refusal may matter later. Requests should be tight and realistic. A two-page questionnaire with 15 ambiguous coverage demands is a gift to the adjuster who wants to run out your clock.

Releases and landmines you should spot early

Release language can make or break a settlement. Overbroad releases that try to wipe out property damage, unknown claims, or even claims by other household members can derail a deal. So can surprise indemnity clauses that shift lien liability back onto the injured person. I attach a proposed release with specific terms: settlement of bodily injury claims only, for the incident on a particular date, no confidentiality, and no indemnity for the insurer’s negligence. If the insurer wants to add terms, they should propose them within the time limit.

Medicare, Medicaid, and ERISA plans add complexity. If Medicare is involved, the insurer will worry about conditional payment recovery. Address it up front. State that you will protect and resolve Medicare's interests and that the settlement is not contingent on a final letter from the Benefits Coordination and Recovery Center. For ERISA plans, be ready to discuss lien negotiations and have the plan documents on hand. When you show a plan to get everyone paid correctly, adjusters tend to move quicker.

Common reasons insurers refuse or ignore demands

When a demand fails, there is usually a paper trail explaining why. The frequent culprits are familiar:

- The demand did not include all medical records or bills, or the records were out of order and hard to follow.
- Liability was not clearly established, often because the police report was inconclusive or witness statements were missing.
- The deadline was unreasonably short, especially around holidays or when prior adjusters had just rotated off the file.
- The release was overreaching, or the claimant refused to clarify lien handling or tax identification details for the check.
- The demand created ambiguity about whether all claimants were included, such as multiple injured passengers or derivative consortium claims.

I have also seen good demands lost to simple logistics. A letter mailed to a P.O. Box without tracking that sat in an intake bin. An email with a 70-megabyte attachment quarantined by the insurer's system. The cure is redundancy. Send the demand by certified mail, email with read receipts, and fax if the carrier uses it. Note each method in the letter.

When a time-limited demand should not be your first move

Not every case is a candidate. If your medical picture is still developing and the policy is large, a hard deadline can motivate the insurer to tender too little, too soon, in exchange for a broad release you later regret. If liability is murky, the carrier may welcome the chance to let your demand expire so it can lock in a defense posture.

I once advised a client with a spinal disc herniation to delay a limits demand for six weeks. Physical therapy had plateaued. A consult with a spine surgeon produced a recommendation for an injection series with a fair chance of a microdiscectomy later. We updated the demand with the surgeon's report and CPT codes. The insurer that had previously dangled $18,000 on a $25,000 policy tendered the full limits within the new 30-day window, citing the objective change in risk.

Bad faith exposure is a shield, not a sword

It is tempting to threaten bad faith at every turn. Resist that urge. The clearest path to bad faith is not bluster. It is a paper trail showing the insurer had a fair chance to pay within limits and failed, without a reasonable basis. Judges read tone. So do juries. A reasonable, fact-driven demand helps you later if the case matures into an excess verdict.

Different states treat bad faith differently. Some require proof that the insurer acted without a reasonable basis. Others use a negligence-like standard focused on whether the carrier acted as a prudent insurer would under the circumstances. No single magic phrase flips the switch. Conduct and clarity matter.

Practical steps for injured people who are not yet represented

I meet many people who send their own demands before hiring a lawyer. Some do fine. Many get tripped up by technicalities. If you are not yet working with a car accident lawyer, keep your first communication simple and accurate. Focus on liability facts, medical documentation, and the policy limit if you know it. Avoid agreeing to releases you do not understand. Do not exaggerate. Insurance adjusters are trained to test credibility with small inconsistencies.

If you later hire counsel, bring everything: envelopes with postmarks, delivery receipts, email read notices, and any voicemail logs. Those small details sometimes decide close calls about whether an insurer acted promptly.

How I present numbers without overplaying the hand

Adjusters are skeptical of medical billing totals. A $60,000 hospital charge might be reduced to $12,000 after contractual write-offs. I do not hide that reality. Instead, I present both the face amount and the expected payment amounts, then explain liens and subrogation rights. I include ICD and CPT codes when available and summarize treatment chronologically with dates and providers. When future care is likely, I ask treating physicians for short, practical outlines and use conservative cost ranges tied to local charges. Precision leads to faster, cleaner outcomes than inflated wish lists.

Managing multiple claimants and limited policies

Pileups and multi-passenger crashes create race-to-the-limit problems. If three people are hurt and the at-fault driver has a $50,000 per occurrence limit, timing turns critical. I notify the insurer early that multiple claimants exist, then demand that the carrier secure a global settlement conference or initiate an interpleader if they cannot allocate fairly. If my client’s injuries dwarf the others, I still propose a partial resolution with documentation explaining why a policy tender to my client makes sense. Some carriers will tender to the most severely injured and negotiate hold harmless language regarding other claims.

Uninsured and underinsured motorist demands

UM and UIM time-limited demands require a slightly different touch. Your own insurer plays the adverse role, but your policy imposes duties of cooperation and proof. I provide the same comprehensive package, plus proof that the at-fault driver’s policy has been exhausted or is insufficient, along with any required permission to settle language. I am careful about releases here. The UM carrier often wants a credit or offset for any liability settlement, which is fine, but it should not expand beyond the policy math.

The role of photographs, data, and small details

Photographs of airbags, crushed frame rails, and intrusion into the passenger compartment move numbers because they make risk tangible to claims committees. Traffic camera clips or event data recorder downloads can erase disputes about speed or braking. I include property damage appraisals and, when available, scene measurements or simple diagrams. Even with clear liability, these details anchor causation and link mechanism to injury. When an adjuster can tell a clean story at a roundtable, the file tends to resolve.

Medical narratives that carry weight

The most persuasive medical narratives read like focused memos, not novels. I ask treating doctors to state diagnosis, causation in probability terms, treatment rendered, response to care, and likely future needs. If prior similar injuries exist, address them directly. “Symptomatic before” is different from “aggravated by.” Adjusters know that difference and will exploit silence. When therapists or chiropractors have the bulk of the records, I pair them with at least one MD’s opinion to stabilize the medical theory.

A grounded approach to liens and net recovery

Clients want to know what reaches their pocket after attorney fees, costs, and liens. If a policy limit is modest and liens are heavy, a demand should signal how each will be resolved. Hospital lien statutes vary, but most carriers respond faster when they see a plan. Include contact information for lienholders and note whether reductions have been requested. Insurers do not require that liens be resolved before they cut a check, but they do prefer clean files with reduced post-settlement surprises.

How to send the demand so it lands, not lingers

Even the best demand fails if it disappears in the intake abyss. I use a short cover letter on firm letterhead, then a table of contents, then the body of the demand, then exhibits with clear labels. I send the package three ways and log everything.

A simple, effective process looks like this:

- Email a PDF under 25 MB to the assigned adjuster and a general claims inbox, request a read receipt, and ask for written acknowledgement within two business days
- Overnight a hard copy with a USB drive containing the PDF and exhibits, signature required
- Fax a copy if the carrier still uses a dedicated claims fax line
- Document delivery dates and who signed for the package, then calendar the expiration date and a reminder one week before
- Follow up if you do not receive acknowledgement within 72 hours, and note that follow-up in your file

These steps are not busywork. They close the door on later arguments that the insurer did not have the materials in time.

Examples from the trenches

Two quick contrasts show how small choices change outcomes.

First, a rear-end crash with $25,000 limits. The client had a concussion and cervical strain. We waited six weeks to collect neurology notes and vestibular therapy records, then sent a 20-day demand with a narrow release and a lien plan for a modest ERISA claim. The adjuster acknowledged receipt the next day and paid in full on day 12. The completeness and modest tone accident lawyer compensation help did more work than any fiery language could have.

Second, an early demand in a sideswipe with shared fault allegations. The prior lawyer set a 10-day deadline with no police report and only two chiropractic visits. The carrier ignored it. When I took over, we rebuilt the file: obtained dashcam footage from a rideshare nearby, secured a supplemental report from the investigating officer, and added four months of medical records. A new 30-day demand produced a settlement at 85 percent of the $50,000 limit based on comparative fault apportionment. The first attempt failed because it was not ready.

Ethics and professionalism still matter

A time-limited demand is not a trap. If an adjuster asks a fair question within the deadline that would not change the settlement amount but would clarify a term, I try to answer. If they request an extra week for a legitimate reason, I consider it and confirm any extension in writing. Professionalism does not weaken your client’s position. It strengthens the argument that you acted reasonably while the insurer dawdled, if that is what happens.

When to bring in a car accident lawyer

If your injuries are significant, the policy limits are low, or the liability picture is complex, a car accident lawyer can add real value. We know how carriers evaluate files, what documents trigger roundtable authority, and how to structure releases and lien resolutions so money moves. More importantly, we recognize when a case should not settle within limits because the long-term needs or the bad faith posture justify a different course. Good counsel pays for itself through avoided mistakes as much as through headline numbers.

Final thoughts from years of doing this work

The best time-limited demands feel inevitable, not aggressive. They present a fair settlement path and a predictable consequence if the insurer declines. They are anchored in facts, organized so a busy adjuster can navigate them, and timed to allow a real decision. They do not pretend small cases are large, and they do not sandbag weak spots.

After a crash, people want stability and dignity back. A strong demand letter is a practical step toward both. It replaces guesswork with evidence, fear with a timeline, and posturing with a plan. Whether you handle it yourself for a straightforward claim or partner with a lawyer for something more complex, focus on clarity and proof. That is what moves the file, and it is what ultimately moves the needle for you.