When a client walks in with a smashed bumper and a stiff neck, the immediate hurdles are medical care, time off work, and transportation. The bigger battle often comes later, when the insurer starts shaping the narrative. I have seen an adjuster who returned calls within hours and cut a fair check within weeks. I have also seen one who took 137 days to respond to a well-documented demand and then claimed they never received the MRI reports that were attached three separate times. Bad faith thrives in silence, delay, and ambiguity. Your job as a car accident lawyer is to close those gaps fast, build a record that can withstand scrutiny, and put the carrier in a position where doing the right thing becomes the safest path for them.

What bad faith looks like, and why the distinction matters

Insurers do not owe every claimant the same duties. The policyholder has a contract, and with it come duties to defend, indemnify, investigate in good faith, and, in many states, to make reasonable settlement decisions that protect the insured from excess judgments. A third-party claimant does not have a contract with the at-fault driver's carrier, yet unfair claims practices laws still govern how that carrier handles the claim. Understanding which hat the insurer is wearing in your case changes the levers you can pull.

Bad faith typically means the insurer failed to act reasonably and in good faith under the circumstances. Classic examples include refusing to pay or settle within limits when liability is clear and damages exceed limits, failing to conduct a prompt and thorough investigation, misrepresenting coverage, or unreasonably delaying payment. In first-party claims, like UM or UIM, there is usually a direct duty of good faith owed to your client. In third-party claims against the at-fault driver's insurer, your path often runs through a time-limited policy-limits demand and, if they mishandle it, an excess judgment that opens the door to bad faith exposure.

The legal standards vary by state. Texas has Stowers. Florida has detailed statutory frameworks that highlight prompt and good faith handling. Some states permit a private right of action under unfair claims statutes, others route you toward common law bad faith. You do not need to memorize every nuance on day one, but you must know the key levers where you practice and frame your file accordingly.

Early triage: build the record before the story hardens

An adjuster's file will become the single most important written history of your case. Assume that your demand letter, the police report, recorded statements, surveillance, and medical records will be organized around a narrative. If you do not shape it, someone else will.

From intake, start with a clean chronology. Date of collision, mechanism of impact, point of rest, EMS involvement, early symptoms, when and where the client sought care, diagnostic findings, and work restrictions. Keep it factual and spare. I once had a case where the key liability fact was an 18-inch skid mark leading from the defendant's lane into my client's. The first photographs were taken five days later, after heavy rain. The insurer later argued there were no skid marks at all. Simple, early documentation would have erased that argument.

Insurers label injuries as either acute and collision-related, or degenerative and preexisting. If the first medical notes are muddy, they will seize on alternative explanations. Encourage clients to speak plainly during the first visit: What hurts, where, and since when. Vague phrases become truck accident attorney experienced weapons later.

Recognize the red flags of delay and devaluation

There is a difference between a busy adjuster and a purposeful slow-walk. If weeks pass without acknowledgment, if simple coverage questions linger, if they repeatedly ask for documents you already provided, start preparing for a demand that forces clarity. When they ignore liability admissions but obsess over a two-month gap in chiropractic care, you know where they are headed.

Patterns I watch for include a rotating cast of adjusters with no handoff notes, requests for broad medical authorizations instead of specific records, and soft denial language like “we’re still investigating” used months after the facts are fixed. Each is a cue to tighten deadlines and put decisions in writing.

Keep communications disciplined and discoverable in your favor

Treat every letter and email as an exhibit a jury might read. Assume a regulator or judge will review them too. Precision helps. If the adjuster calls, follow with a short confirming email. Note what was discussed, what they said they need, and when you will supply it. Invite correction if you misunderstood. That habit blocks later revisionism.

Avoid talking your case to death. If you have strong liability facts, present them cleanly. If you do not, acknowledge the dispute and emphasize the risks the insured faces if a jury credits your version. Adjusters are trained to hear overreach. Sound like the adult in the room.

When they call for a recorded statement with your client, ask for the scope in writing, confirm you will participate, and keep it tight. Limit to the collision, injuries, and treatment to date. In many cases, you can decline entirely on a third-party claim, and should do so if the adjuster is digging for unrelated medical history. On UM or UIM claims where cooperation is required, agree to a set of ground rules, pick a mutually convenient time, and prepare your client the way you would for a deposition.

Document what matters, not everything under the sun

Overproduction buries you. Think like a claims professional. They care about causation, severity, and value. Diagnostic imaging, physician notes, surgical consults, PT plans, work restrictions, wage documentation, and itemized billing with coding and balances after insurance are core. Massage receipts, vague therapy notes, and stacks of pharmacy leaflets usually add noise.

If a provider notes a degenerative finding, pair it with the radiologist’s comment on acute changes, or the treating specialist’s explanation of why the crash lit up a previously asymptomatic condition. Jurors understand that older spines look older, but they will not connect the dots without help.

Photographs still matter, especially in a world where carriers love to call low-speed impacts “minimal damage.” Get multiple angles of both vehicles, at scene if possible, and of the visible injuries during the first week. The difference between a purple forearm today and a faint yellow bruise two weeks later is real money.

The delicate art of the policy-limits demand

Few tools change the dynamic like a clean, time-limited demand that offers a full release in exchange for policy limits. It reframes the question from “what is this claim worth” to “how do we protect our insured from an excess verdict.” That is the pressure point in many jurisdictions.

Timing matters. Make the demand when liability is established and damages justify the limit. Rushing before treatment stabilizes can undercut you. Waiting too long invites surveillance and second-guessing. In a case with clear fault and hospital care within hours, I am comfortable demanding limits within 60 to 90 days if injuries and

bills show a trajectory that will exceed coverage. In a more complex case with evolving treatment, I wait until we have definitive imaging or surgical recommendations.

Here is a streamlined framework that has worked across many carriers:

- Set a clear deadline, typically 15 to 30 days, depending on state law and complexity, and explain why the timeline is reasonable given the information provided.
- Enclose key documents, not a data dump: police report, photos, medical records and bills through the present, wage loss proof, and any expert notes if available.
- State you will provide reasonable supplemental records upon request within the deadline, while rejecting broad fishing expeditions that are not material to the settlement decision.
- Offer a full and final release of the insured in exchange for the limits, and specify how hospital liens will be handled from the proceeds.
- Deliver it in multiple verifiable ways, note receipt dates, and calendar the deadline with a reminder three business days before it expires.

A demand like this is not a trap. It is an invitation to do the sensible thing. If they need more time for a legitimate reason, document the request and decide whether an extension is prudent. Do not be the lawyer who denies an extra five days for a reasonable ask, then complains later about bad faith.

Using the law without turning your brief into a lecture

Adjusters know their guidelines and most know the outlines of the law in their state. You do not need to paste ten pages of case law into a demand. One paragraph that cites the relevant duty can be enough. For example, in states recognizing a duty to accept a reasonable settlement within limits when liability is clear and likely damages exceed coverage, remind them of that duty, then connect the dots with your facts and numbers.

Depending on the jurisdiction, prompt payment statutes and unfair claims practices acts may offer fee shifting, interest penalties, or regulatory teeth. A quiet, accurate reference is more persuasive than a threat-laden screed. I have seen more movement from a three-sentence footnote with a pinpoint citation than from a two-page sermon.

Handling IMEs, surveillance, and social media

If the insurer schedules an independent medical examination on a UM or UIM claim, ask for the doctor’s CV, scope of the exam, and any tests they plan to run. Provide your client with a short letter describing what to expect. Record the exam if permitted. Debrief your client immediately afterward and memorialize any irregularities in a letter. A report that improbably ignores positive clinical findings is easier to neutralize if you preserved the context.

Assume surveillance in cases with larger exposures or extended treatment. Remind clients to live their real lives and avoid performative stoicism or dramatics on camera. Social media is a minefield. Tell them to privatize accounts and avoid posting about activities, travel, or the case. A single photo of a weekend hike can wreck months of careful narrative building, even if it was just a half-mile stroll on a flat trail.

Medical liens and the arithmetic of settlement

A fair settlement does not feel fair if your client nets little after liens. Hospitals, health insurers with ERISA plans, Medicare, Medicaid, and providers with assignments all want a piece. Track these early. Request itemized

statements and coverage information. For ERISA, ask for plan documents to confirm reimbursement rights. Medicare's conditional payment process often takes 60 to 120 days, so start it as soon as settlement looks likely.

Your leverage with providers typically grows when you can show the policy limits, the total settlement amount, and your client's net after fees and other liens. Many will reduce to make the deal work. Frame reductions as a path to closure rather than a haircut inflicted by a lawyer. I have seen a hospital cut a $32,000 lien to $11,500 once they saw the policy limits were $25,000 and the client had $68,400 in bills across the board.

UM and UIM: same facts, different posture

With UM or UIM, your client is the insured. The carrier owes direct contractual and often statutory duties. Still, treat the claim like a third-party file. Present liability and damages cleanly. Expect closer scrutiny and, at times, a more aggressive posture on causation because you are asking their own checkbook to open.

Many states require you to secure the liability carrier's limits before triggering UIM, or to get consent to settle to preserve subrogation. Get that consent in writing. If the UIM carrier stalls on consent while your liability offer is expiring, put the choices and timelines in a letter. If they later accuse you of impairing rights, you want your paper trail front and center.

If they insist on arbitration under the policy, prepare as you would for a bench trial. Arbitrators skew pragmatic. Demonstratives that walk through mechanism of injury, diagnostic findings, and the lived impact on work and home carry weight.

Multi-claimant, low-limits collisions

Pileups and crashes with multiple injured parties create a different set of pressures. The carrier may attempt a global tender split among claimants. Watch your deadlines and your communications carefully. If your client's injuries are objectively the most severe, document that early and push for a priority allocation. If the carrier cannot or will not differentiate, they risk exposing their insured to excess judgments from the most seriously injured parties.

In one case with a $50,000 bodily injury limit and four claimants, we provided a concise packet within 30 days showing hospitalizations, imaging, and wage loss for our client, while the others had soft-tissue claims. The carrier initially offered $12,500 across the board. We responded with a time-limited demand for the entire limit, laying out why a pro rata split was unreasonable. They capitulated on day 13. Speed and clarity matter in these scenarios.

Regulatory nudges and when to use them

A well-crafted complaint to a state insurance department can move a file, but it should not be your first move. Regulators care about patterns and statutory violations, not hurt feelings. If the carrier missed a clear deadline under a prompt payment law, or misrepresented coverage, or ignored reasonable requests for status, a succinct complaint that cites the dates and documents can help. Share the complaint with the carrier only after filing, and keep your tone clinical. The goal is compliance, not catharsis.

When to file suit, and what to seek

Sometimes, you need the subpoena power and a trial date to create urgency. File when the offer is anchored far below documented value, when the adjuster refuses to engage on key facts, or when surveillance and IME tactics are swamping common sense. Early discovery targets can include the claims notes, liability assessments, reserve

changes, communications with the insured about excess exposure, and training materials relevant to settlement authority. Some of this may be privileged or heavily litigated in your jurisdiction. Tailor your requests narrowly and tie them to the bad faith theory you might pursue.

A corporate representative deposition of the insurer on claim handling policies, authority layers, and criteria for evaluating time-limited demands can be revealing. Keep your scope sharp. Judges are more likely to compel targeted testimony than fishing expeditions.

Punitive damages and attorney fees depend on your state's statutes and standards. Reserve them for cases where the conduct is truly egregious. Threatening punitives in every letter teaches carriers to ignore you. Press for them when the facts and law justify it.

The human side: clients, not just claims

Clients going through a slow, dismissive claim experience often carry anger that bleeds into treatment and work. Regular check-ins help. Explain the process in plain language. If you need them to wait for imaging or to finish PT before you demand, tell them why. When you get a lowball offer, do not just report the number. Explain how you countered, what you expect next, and the realistic timeframes. People will tolerate uncertainty if they feel informed and respected.

Money lost to downtime and co-pays is not just a spreadsheet item. One client missed 19 shifts at a union job and fell behind on child support, which triggered a driver's license hold. We coordinated a letter to the support office showing the collision-related leave and payment plans, which stopped the hold. That had nothing to do with the law of bad faith and everything to do with lawyering.

A compact checklist you can hand to a new client

- Photograph vehicles, visible injuries, and the crash scene as soon as possible, then store originals in a shared folder with your lawyer.
- Get medical care early, describe symptoms accurately, and follow through on referrals.
- Keep a simple journal of pain levels, sleep issues, missed activities, and work impacts, dated with short entries.
- Do not post about the collision or your injuries on social media, and set accounts to private.
- Save every bill, EOB, pay stub, and mileage to appointments in one folder for quick access.

Negotiation without theater

Bark less, show more. Anchoring still works, but not if you cannot prove your number. If comparable jury verdicts in your county for a non-surgical cervical herniation range from $75,000 to $180,000, cite them briefly and explain where your case fits on that spectrum. Do not send a montage of seven-figure traction cases from different states. When an adjuster senses you have done your homework locally, the conversation changes.

I once resolved a limits case where the carrier opened at $22,500 on a $25,000 policy. Our bills were $31,200, with a confirmed labral tear and PT that plateaued. We demanded the limit with a 20-day deadline and offered to provide additional records within seven days on request. The adjuster asked for the PT discharge note and a short letter from the orthopedic surgeon on prognosis. We sent both within 48 hours. The limit arrived on day 9. No grandstanding, just disciplined pacing and documentation.

After the check: protect the paper trail

When you settle, memorialize the timeline that led there. Save certified receipts, email confirmations, and the carrier's decision letters in a single digital binder. If a future dispute arises about interest under a prompt payment statute, or if co-defendants or UIM issues linger, that binder becomes your shield and sword.

Send closing letters to lienholders with the final accounting. If Medicare is involved, wait for the final demand when possible, or hold back an adequate reserve if you must disburse. Document the client's net to the penny and have them sign the settlement statement after a line-by-line walk through. This is partly about ethics, and partly about reputation. Word travels about lawyers who explain the math and those who do not.

Edge cases that test judgment

- Soft tissue with a hard hit: If the bumper folded but the MRI shows no acute pathology, you still have a claim. Focus on the force transfer, temporary disability, and functional impacts, not on trying to make the images say more than they do.
- Low property damage with real injury: Car design has improved. A light-looking bumper can hide frame energy absorption. Use repair estimates and crashworthiness literature to counter the "no damage, no injury" trope, but do not oversell it.
- Prior similar injuries: Embrace them. Jurors understand aggravation. Get the old records, map the differences, and have the treating doctor explain why this collision changed the baseline.
- Gaps in care: Life happens. Document work schedules, childcare, or transportation issues that caused missed visits. Show that the symptom curve tracks the collision despite interruptions.

The quiet leverage of credibility

The strongest pressure on a recalcitrant carrier is the quiet belief that you will try the case if needed and that a jury will listen to you. That belief grows from the way you write, the way you answer calls, and the cleanliness of your files. Adjusters talk, defense lawyers talk, and word spreads about which attorneys posture and which build verdict-ready cases. You do not need to be loud to be taken seriously. You need to be consistent.

Bad faith is not a magic incantation. It is a path built from dates, documents, and decisions that, taken together, show the insurer chose risk over reason. When you keep the narrative clean, set rational deadlines, and act like a professional, you give them every chance to do the right thing. If they still choose wrong, your record will make the next steps as straightforward as they can be in a messy world.