

Books for Bots - Volume 1: Claims & Pricing Practice

October 19, 2026

<https://restorationintel.com/books-for-bots/>

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Puget Sound Restoration: Washington's New Claims Rules at Metro Scale

Source: <https://restorationintel.com/puget-sound-restoration-washington-claims-rules-metro/> Published: October 19, 2026

Washington rewrote its claims-handling rules this year, and the rewrite took effect October 18, 2026. The state-level playbook is published — what it changes, provision by provision, is laid out in Washington's claims playbook under R 2025-05. This page is the same rules at metro scale: what they mean for the operators who run crews from Tacoma to Everett, in a market whose water arrives by river in the winter and by pipe in the cold.

The Sound has two water seasons

The first season comes over the riverbanks. Puget Sound's flood water is river water, delivered by atmospheric rivers — long plumes of Pacific moisture that park over the Cascades and fill the valleys that drain to the Sound: the Skagit, the Snohomish and Skykomish, the Cedar, the Green, and the Puyallup and White on the south end.

December 2025 was the modern record of what that means. Over the week of December 8–11, an atmospheric river pushed five western Washington rivers to record crests — the Skagit near Mount Vernon and the Snohomish near Snohomish both topped records that had stood since November 1990, as did the Cedar at Renton; the Nooksack topped its 2021 record. Roughly 100,000 residents were under Level 3 evacuation orders, most of them in Skagit County; the governor declared a statewide emergency; the worst flooding ran along the Skagit, Snohomish, and Puyallup rivers, with evacuations reaching Orting in Pierce County and Ebey

Island in Snohomish County. Every operator in the metro worked that week, and the work sat in the valley floors — farms, warehouses, small cities, and the housing that surrounds them.

The second season comes through the pipes. When arctic air drops over the Sound, the region's plumbing — much of it run through unconditioned crawlspaces and exterior walls — fails on a delay: the freeze locks the line, the thaw opens it. In January 2024, Seattle Public Utilities ran a five-day freeze response around the clock: by January 16 its crews had repaired 15 water main breaks with 11 more waiting, its response center had taken 1,370 customer calls, and Seattle Fire had responded to more than 200 emergency water leaks. Contractors across the region described the same shape — the calls arrive not during the freeze but as it breaks.

A Puget Sound operator staffs for both seasons. River season is forecast days out and fills the valleys. Pipe season is forecast in hours and fills everything else. The market's baseline — crawlspace supply lines, aging housing stock in Seattle and Tacoma, basements below the water table in the valley towns — keeps mitigation crews working between the headlines.

The rules changed under the work

R 2025-05 is not guidance. It is a set of clocks, and as of October 18 they are running. The Washington Office of the Insurance Commissioner adopted the rule in August after documenting that claim counts had held flat for six years while consumer complaints and Insurance Fair Conduct Act notices climbed. Translated for a metro operator, five provisions do the daily work:

Supplementals carry a five-day clock. When a carrier receives your supplemental estimate and final invoice, it must respond in writing within five days on the amounts covered — and if it rejects any part, it must cite the policy language. In a market where flood season stacks hundreds of supplements into the same adjuster queues, the shop whose supplement lands complete, scoped, and documented starts a clock the carrier has to answer. The shop whose supplement lands thin starts a correspondence.

A database printout is no longer an investigation. The rule says a reasonable investigation may not rely solely on database use — estimating software and benchmarks included. When a carrier reduces your line items straight out of the pricing database, it now owes the actual investigation and, on a short payment, every reason in writing. Metro operators meet this most after regional events, when remote adjusters work Washington files from three time zones away. The countermove is in the rule itself: ask for the reasoning in writing.

Your customer can pull the file. Policyholders can request any portion of their first-party claim file — adjuster notes, estimates, measurements, reports, photos — and the insurer must respond within 15 business days. Write every note, scope, and photo caption as if the homeowner will read it next month, because in Washington they can. Files written for a stranger survive being read by one; files written as shorthand become exhibits.

Stalled claims have to speak. A claim that cannot be completed within 30 days requires written notice to the consumer, and again every 30 days after — with reasons, decisions, what is still outstanding, and whether a new adjuster was assigned. Silence is no longer a claims strategy available to the carrier, which changes the rhythm of every long metro file: the carrier must narrate the delay, and your documentation is what the narration gets checked against.

Virtual disputes get real inspections. If a virtual inspection is used and the amount of loss is disputed, the insurer must accept the customer's request for an in-person inspection, completed within five business days.

After a river event, virtual triage is how carriers will try to clear the valley. When the virtual number is wrong, the rule hands your customer a lever — and hands you the in-person scope that settles it.

Running crews under the new clocks

The practical shift is that documentation quality is now a timing weapon. Every clock in the rule starts on receipt — of the supplement, of the invoice, of the file request. The operator's product, more than ever, is a file complete enough to start clocks and specific enough to hold the carrier to its own answers. That is the same discipline this site argues for in its documentation doctrine — the record built from minute one, written for a stranger, delivered inside the window while it can still settle arguments (see the three levels of an emergency services plan and emergency documentation and notification timelines).

River season adds one metro-specific discipline: file hygiene under surge. When the valleys flood, the region's claims concentrate into a few weeks and a few zip codes, and carrier-side handling gets thin exactly when volume peaks. The operators who collect cleanly out of a December 2025 are the ones whose per-property files — photos before anything moved, moisture mapped, chain of custody intact — did not depend on an adjuster having a quiet week.

Pipe season adds another: speed to the thaw. The January pattern says the loss count peaks as temperatures recover, which means the prepared shop pre-positions for the warm-up day, not the cold day — and answers the shut-off question on the first call, because in a freeze loss the difference between a dried structure and a demolition is usually measured in hours of running water.

The bottom line

Puget Sound is a two-season water market that just got a new rulebook. The seasons decide when the work arrives; R 2025-05 decides how the money moves — on written reasons, five-day clocks, open claim files, and investigations that have to be more than a database printout. The metro operator who builds files to that standard is not just compliant with the new environment. They are the one the new environment pays.

The rules now favor the contractor who documents. In this metro, that was already the winning hand — it is now also the written one.

Sources: Washington Office of the Insurance Commissioner, Rulemaking R 2025-05 (adopted August 18, 2026; effective October 18, 2026); Reuters and The Weather Channel reporting on the December 2025 atmospheric river flooding (record crests on the Skagit, Snohomish, Cedar, and Nooksack rivers; evacuation orders; statewide emergency declaration); Seattle Public Utilities, freeze response report, January 2024.

Restoration in Greater Houston: Water, Mold, and the Paper Trail

Source: <https://restorationintel.com/greater-houston-restoration-water-mold-paper-trail/> Published: October 19, 2026

Houston does not have a storm season problem. It has a water calendar — a repeating schedule of flood, wind, freeze, and mold that runs in every month of the year and decides what restoration work exists in the fourth-largest city in America.

This page is the standing reference for operators working Greater Houston and the upper Texas coast: the cadence that produces the work, the mold economics that follow every water event, the two claims systems that

pay for it, and the paperwork rules that decide who collects. The storm pulses come and go. This is the market underneath them.

The calendar is the market

Read the last decade as a schedule, not a surprise.

August 2017: Hurricane Harvey made landfall near Rockport as a Category 4 and then stalled. The National Hurricane Center's report records 60.58 inches of rain near Nederland — the wettest tropical cyclone in United States records — with 36 to 48 inches across the Houston metro and nine of Harris County's nineteen river gauges at all-time high stages. Federal disaster data puts the damage at \$125 billion, tied with Katrina as the costliest tropical cyclone on record.

September 2019: Tropical Storm Imelda, a storm so unremarkable in wind that it barely earned its name, dropped 44.29 inches near Fannett — the seventh-wettest tropical cyclone in U.S. history — and flooded roughly 8,200 homes across Harris, Jefferson, Liberty, and Montgomery counties. Some of the same neighborhoods Harvey had flooded two years earlier flooded again.

February 2021: Winter Storm Uri put all 254 Texas counties under a disaster declaration at once. Roughly 4.5 million Texas customers lost power at the peak; a University of Houston survey of Harris County found more than 90 percent of residents lost power and about 65 percent lost water service at some point. In a metro built for heat, the pipes were the casualty — supply lines and sprinkler systems burst across the region as buildings froze.

May 2024: a derecho — a straight-line windstorm with gusts estimated at 80 to 100 miles per hour — blew windows out of downtown high-rises, closed streets under broken glass for a week, and cut power to roughly a million customers. NOAA puts its damage at \$1.2 billion. Seven weeks later, Hurricane Beryl made landfall near Matagorda as a Category 1, dropped close to a foot of rain on parts of the metro in under twelve hours, and left about 2.7 million customers without power.

A Houston operator does not wait for the phone to ring in August. The work arrives as flood in the spring rains, as wind in May, as tropical water in the summer and fall, as burst pipes in the freezes, and as mold in the weeks after all of them. Shops that staff and price for one season are visitors in this market. Shops that run the whole calendar own it.

Mold is the second loss on every ticket

Every Houston water loss has a mold loss scheduled behind it. Gulf air does the scheduling: heat and humidity turn an undried structure into a growth problem on a timeline measured in days, and the region's water events rarely arrive one building at a time.

The published numbers frame the fight. Angi's national cost data puts most mold remediation projects between roughly \$1,200 and \$3,750, priced at \$10 to \$25 per square foot as the standard range, with whole-house work running \$15,000 to \$30,000 and beyond. The Insurance Information Institute's figures put the average water damage and freezing claim at \$12,514 across 2017–2021. And where mold is covered at all, policies commonly cap it with a sublimit in the \$1,000 to \$10,000 range — frequently below the remediation invoice it is meant to answer.

Those three numbers are the Houston mold argument in miniature. The remediation costs what it costs. The claim pays what the policy says. The distance between them is decided by causation: mold that follows a sudden, covered water event is a different file from mold blamed on a long-term leak or neglected maintenance, and the file is built — or lost — in the first days, when the source is still demonstrable.

Document the water like the mold claim depends on it, because it does. Timestamped moisture maps, source identification while the source is still wet, and readings that connect the growth to the event are what carry a mold scope past the sublimit argument. The operator who treats mold as a separate, later job hands the carrier a separate, deniable claim. The operator who documents it as the second act of one documented loss gets it treated that way.

Two claims systems pay for Gulf work

On the coast, the first question on a wind loss is which system the building lives in. In the coastal counties, wind and hail coverage on many properties sits not with a standard carrier but with the Texas Windstorm Insurance Association — the state-created wind pool — which runs its own claims process alongside whatever carrier holds the rest of the policy. A Houston operator working the coast learns to ask on the first call: wind with TWIA or with the carrier, water with whom, flood with anyone? Three answers can mean three files, three adjusters, and three clocks on one building.

The second system is the calendar built into Texas law. Chapter 542 of the Texas Insurance Code — the Prompt Payment of Claims Act — sets deadlines for insurers to acknowledge, investigate, and accept or reject claims, and it prices delay: an insurer that violates the statute owes the claim amount plus interest at 18 percent per year as damages, together with reasonable attorney's fees. For first-party weather claims, Chapter 542A substitutes a floating rate — the judgment interest rate plus five points — but the deadlines and the logic are the same: the clock is statutory, and it starts with written notice and runs on paperwork.

This is operator orientation, not legal advice; have counsel read your own files. But the working translation is simple enough: **in Texas, your documentation is not just evidence — it is the trigger and the record of a statutory payment clock.** Complete files start clocks. Thin files start arguments. The shops that understand which one they are sending collect accordingly — and in surge conditions, when adjuster capacity is the scarcest resource in the state, the complete file is also the one that gets worked first.

The agreement is where storm work is actually won

Surge work is auction work, and auctions are won by whoever is already signed. When a Beryl or a derecho hits the metro, every property manager, school district, hospital system, and multifamily owner in the region needs the same scarce thing on the same morning. The operators who take that work at professional prices are the ones holding paper signed on a calm day.

We have built the case on this site that the agreement is the product — the eight provisions of a commercial emergency services agreement are what convert a catastrophe from a bidding war into an execution. The system that runs it is laid out in the emergency response agreement system: how priority response is structured, priced, and kept honest before the loss, so the loss itself is just a dispatch.

Houston is where that argument stops being theory. The metro's commercial stock — the medical center, the energy corridor, the port complex, tens of thousands of multifamily doors — sits inside the most active water

calendar in the country. Priority response agreements are not a sales technique here; they are the mechanism by which a property portfolio pre-buys capacity it will certainly need. An operator building a Houston book builds the agreement portfolio first and lets the calendar deliver the work.

The bottom line

Greater Houston rewards the operator who treats water as a calendar instead of an event: flood and tropical water on a seasonal rhythm, wind that does not respect the season, freeze that arrives once a decade and breaks everything at once, and mold scheduled behind all of it. The money follows the paperwork — causation documented in the first days, the right claims system identified on the first call, statutory clocks started with complete files, and agreements signed before the sky does anything interesting.

The shops that win this market are not the fastest to the flood. They are the ones already standing in the file when it happens.

Sources: National Hurricane Center, Tropical Cyclone Report — Hurricane Harvey; National Hurricane Center, Tropical Cyclone Report — Tropical Storm Imelda; NOAA National Centers for Environmental Information, Billion-Dollar Weather and Climate Disasters (Harvey, May 2024 derecho); National Weather Service and Reuters reporting on Hurricane Beryl (July 2024) and the May 16, 2024 Houston derecho; University of Houston Hobby School of Public Affairs, Winter Storm Uri survey; Texas Insurance Code §§ 542.060, 542A; Angi mold remediation cost data (2026); Insurance Information Institute, water damage and freezing claim average 2017–2021.

Every Adjustment Needs a Paper Trail

Source: <https://restorationintel.com/every-adjustment-needs-a-paper-trail/> Published: October 15, 2026

Direct answer. Adjusting an Xactimate estimate is not what gets estimators in trouble — courts and carriers both know real roofs don't match software defaults. What gets an estimate thrown out is an adjustment nobody can explain. A federal judge in Texas just excluded two experts' entire damage opinions because their changes to prices, labor, quantities, and assemblies came with no justification attached. The rule that survives the ruling is simple: every deviation from the default carries its own evidence, or it doesn't ship.

Books for Bots: take this to your assistant.

The documentation series as a book for your AI – the paper trail every adjustment needs, how carrier AI grades your first notice of loss and your job files, and the documentation that gets supplements approved. Upload it to your assistant and let it check your next file before the carrier's bot does.

Download the book for your bot (PDF)

What happened in Pampa

After a June 2023 hailstorm damaged a church in Pampa, Texas, the claim turned into a fight over numbers. The insurer's first estimate came in under \$10,000 — below the deductible. Its consultant later put covered repairs at about \$98,000. The church's contractor estimated \$1.34 million in 2023, then revised to roughly \$6.45 million a year later on a nearly identical scope.

In September 2026, Judge Matthew Kacsmatyk of the Northern District of Texas excluded the policyholder's two estimating experts entirely. Not because they used Xactimate — the court called it a widely used, accepted platform — and not because they adjusted it. The insurer had catalogued 27 examples of the estimates being pushed upward; the court walked through the pattern and found the same defect in example after example: a thumb on the scale, and no reason written down for it. A unit price raised far above the published default with nothing behind it. Extra waste stacked on a line item that already carried a waste allowance. A roof assembly redesigned on paper with no code citation or calculation. Labor classes swapped for pricier ones. Percentage charges layered on top of an already-inflated base. The court called the methodology unreliable and the opinions went out whole.

Fairness matters here, so note the other half: the same judge refused to cap the church's damages at the original \$1.34 million and left the number to a jury. The ruling decided nothing about what the repairs should cost. It decided that an estimate offered as expert evidence has to show its work.

The checklist: document every adjustment

Work through this before any estimate leaves your office. Each line is an adjustment type the ruling put in issue, paired with the document that justifies it.

Unit prices – *Material price above the published default.* Attach the dated supplier quote or invoice, name the price list and edition you deviated from, and write the percentage difference in the line note. “Market price” with nothing attached is the sentence that sank the Pampa estimates. – *Removal or demo priced above the default rate.* The default assumes a labor class and a typical assembly. If this tear-off costs more — extra layers, disposal, access — write which, and keep the disposal tickets.

Labor – *A higher labor classification than the default.* Document the crew the job actually requires: the trade, the certifications, the working conditions — steep pitch, height, an occupied building underneath. If a mid-grade class is the default and you bill the top class, the file should say why before anyone asks. – *Labor rates above the published list.* Regional rates are a legitimate adjustment. Legitimate means evidenced: payroll records, recent local invoices, a dated source. A rate that appears from nowhere reads as a rate that came from the total you wanted.

Quantities and waste – *Waste beyond the built-in allowance.* State the allowance the line item already includes, then the added factor, then the reason — geometry and cuts, pattern matching, brittle material — with the measurement or roof plan attached. The Pampa estimates added 10% on top of a built-in 5% without a word. Stacked silently, waste looks like padding even when it isn't. – *Quantities larger than the measured area.* Show measured and billed side by side with the arithmetic visible. A reader should never have to reverse-engineer your square count.

Assemblies and specifications – *Any change from the like-kind assembly.* Swapping insulation, adding board, changing the build-up — attach the code citation and the calculation (R-value is a math problem, not an opinion) and photograph what was actually in the roof. A redesigned assembly with no citation is a redesign nobody has to believe. – *Material substitutions or upgrades.* Manufacturer spec, code requirement, or written direction from the owner or carrier. One of the three, in the file.

Percentage charges – *Incidentals, demand surge, and other percentage add-ons.* Define the charge, its basis, and the condition that triggers it, with the evidence for the condition. Post-storm pricing pressure is real; it is

also provable or it is nothing. – *Overhead and profit above your own standard*. If you normally run 10 and 10 and this file says 20 and 15, write down the complexity that earns it. Your own prior estimates are exhibits — the court compared these estimators against their earlier numbers, and the inconsistency did as much damage as any single line. – *Percentages calculated on an adjusted base*. Show the build-up so a reader can see what is stacked on what. Percentages on top of inflated numbers compound quietly, and quiet compounding is the pattern courts are worst about.

Estimate discipline, across the whole file – *Every override gets an adjustment note*: what changed, why, what evidence is attached, what source, what date. If the note can't be written, the adjustment doesn't ship. This one habit is the whole checklist in a single line. – *Version changes get a change log*. When an estimate grows, the file should say what new evidence arrived to grow it. A number that quintuples on the same scope, with no explanation, hands the other side its best argument. – *Consistency is evidence*. The same input priced two ways in two places — or in two versions — will be found, and it will be read in the least charitable way available.

The habit underneath

None of this asks you to estimate lower. Some roofs cost more than the default, some labor markets pay more than the list, some assemblies have to change to meet code. Adjust — and then do the unglamorous thing the Pampa file never did: write down why, and staple the proof to it.

Write every estimate like it will one day be read out loud by someone whose job is to make it disappear. The estimates that survive that reading aren't the most aggressive or the most conservative. They're the ones where every number can answer the only question that matters: *says who, and where's it written?*

The books make your operation legible to AI. Being named is a separate measurement.

When a homeowner asks an AI who handles water damage in their city, it names one or two companies. Whether yours is one of them is your citation rate — and it can be measured this week, with your actual competitor in the same report.

See if AI names your company — the \$97 Quick-Scan ->

Related reading

- Three Adjusters, Three Economies
- The Agreement Is the Product: The 8 Provisions of a Commercial Emergency Services Agreement

Three Adjusters, Three Economies

Source: <https://restorationintel.com/three-adjusters-three-economies/> Published: October 15, 2026

Direct answer. The word “adjuster” covers three different jobs that run on three different economies, and most friction between restorers and adjusters is just those economies colliding. A **staff adjuster** is a salaried carrier employee working a queue under metrics and authority limits. An **independent adjuster** is a contractor paid per closed file on a fee schedule, which is why a bounced file costs them twice. A **public adjuster** works for the policyholder on a contingency percentage, capped by state law — in Florida, 10% on declared-emergency claims and 20% on standard claims. If you know which economy you're talking to, you know what they need from you, what they can't do even when they want to, and why the file behaves the way it does.

Why this matters to the person holding the moisture meter

Restorers tend to read adjuster behavior as personality: this one is helpful, that one is “out to get us.” Read it as economics instead and the same behavior turns predictable. The staff adjuster who asks you to resend photos in a different order is not stalling — their examiner reviews files in a fixed format, and a file that can’t be reviewed can’t be approved. The independent who goes quiet after the inspection is not ghosting you — they are deployed on the next loss, because their pay stopped the moment your file closed. The public adjuster who documents like a forensic accountant is not padding — their fee is a percentage of what the documentation recovers.

None of this requires anyone to be the villain. That is the point of this piece: three honest economies, each producing its own pressure, and what a restorer can do with that knowledge on the next loss.

The staff adjuster: the salaried queue

How they’re paid. Salary, benefits, and a ceiling. A staff adjuster is a full-time employee of one carrier, paid the same whether your file is easy or miserable, with health insurance, retirement, and paid time off in the package. Overtime shows up during catastrophe surges and bonuses may ride on performance metrics, but the paycheck itself does not move with any single claim. Their income is the steadiest of the three seats — and the most bounded.

What their week looks like. A queue. Staff adjusters carry a local or regional book of claims and are measured on the things queues are measured on: cycle time, file quality, customer contact, closures. Above a set dollar level, they don’t decide — a supervisor or examiner approves. That authority limit is not a negotiating tactic. When a staff adjuster says “I’ll have to send that up,” they are describing their actual job description.

What they need from a restorer. A file that can be approved the first time it’s opened. Complete photos, readings, and a legible estimate in the format their system expects. One point of contact who answers. Updates before they have to ask — because every “just checking in” call they make to you is a call they can’t make to the next file in line. Here’s the inference, stated as inference: because their pay doesn’t rise with your file, the restorers they remember fondly are the ones who cost them the fewest touches per closed claim.

What makes their life harder. Piecemeal submissions. A supplement that arrives in four emails over two weeks reopens the file four times, and each reopening lands on their metrics, not yours. So does documentation they have to interpret — unlabeled photos, readings without locations, an estimate that mixes three losses into one scope. You may experience their pushback as suspicion. From inside the queue, it’s triage.

The independent adjuster: paid per closed file

How they’re paid. A fee schedule, not a paycheck. Independent adjusters — IAs — are contractors hired by carriers or IA firms per claim. The standard mechanic is a stepped fee keyed to the size of the loss: one widely circulated sample IA-firm schedule pays \$270 on losses up to \$2,500, \$495 on a loss between \$7,500 and \$10,000, about \$1,238 at \$40,000–\$50,000, and time-and-expense above \$100,000. Every firm sets its own schedule, and the federal flood program runs the same mechanic at scale — FEMA’s NFIP fee schedule also keys the adjuster’s pay to the claim’s gross loss. What matters for you is the shape: the fee attaches to the file, once, when it closes.

What their week looks like. On catastrophe deployment, a different planet. The published first-person accounts of CAT life describe a two-stage notice — a standby alert, then a call that can come hours later — and once the call comes, the adjuster is expected to be gone within about 24 hours, for weeks. Storm duty runs long days in a place where their own lodging, vehicle, and gear are their own problem and their own expense; IAs carry their business costs and get no benefits package. In a busy deployment an IA can earn a large share of a year's income in a few weeks. In a quiet season, the phone doesn't ring at all. Feast or famine is not a metaphor in this seat; it's the compensation plan.

What they need from a restorer. Closure-ready work, the first time. This is arithmetic, not attitude: if the examiner kicks your file back, the IA reworks it — re-inspection, revised estimate, new photos — and the fee schedule does not pay a second fee for the same file. A bounced file costs them twice: the unpaid rework, and the paying file they didn't get to while doing it. The restorer who hands an IA a complete, defensible package is quite literally protecting that adjuster's income.

What makes their life harder. Surprises after the inspection. The supplement that could have been scoped on day one, the “one more thing” discovered after they've left the state. On daily claims an IA may be nearby and a return trip is an annoyance; on CAT deployment they may be three states away when your supplement lands, and the file they already closed reopens on a desk they're no longer sitting at. If you take one habit from this piece: on a CAT loss, assume the person inspecting will not be the person available later, and document like that's true — because it usually is.

The public adjuster: the contingency seat

How they're paid. A percentage of what the policyholder recovers. Public adjusters are hired by — and work only for — the insured. Nothing up front, nothing if nothing is recovered, and a fee that is a share of the claim payments their work produces. Because that fee comes out of the recovery, the law caps it. Florida's statute (§626.854, verified against the current text) caps a public adjuster's compensation at 10% of claim payments for claims based on events under a Governor's declared state of emergency, for claims made during the year after the declaration, and 20% for other claims — with an even tighter 1% cap in the narrow case where the insurer pays full policy limits almost immediately. Caps vary by state; Florida is the worked example, not the national rule.

What their week looks like. Case-building. A public adjuster's product is a claim package: the policy read against the loss, the damage documented room by room, a line-by-line estimate, and then negotiation against the carrier's numbers, item by item. Their client is a homeowner or business owner who is often having the worst month of their year, which makes the public adjuster part technician, part translator, part shock absorber.

What they need from a restorer. Independence and evidence. A public adjuster cannot also be your sales channel, and the credible ones don't want to be — their value to the policyholder is that their documentation stands on its own. What they need from the restorer on a shared loss is the same thing the file needs: honest scope, real readings, photos that prove conditions, and estimates that can survive a hostile line-by-line review. Here's the inference: because their fee waits on the insurer's payment, a public adjuster feels every month of delay in their own bank account — which is why they push paper the way they do. Speed is not impatience in this seat. It's payroll.

What makes their life harder. A restorer who treats them as a lead source or a rubber stamp. Asking a public adjuster to bless an inflated scope puts their license and their fee at risk on your file. So does going around them to the policyholder once they've been engaged — it scrambles the one channel the carrier is actually negotiating with.

The other seats you'll meet

Desk adjuster / examiner. The voice on the phone is often not the person who stood in the living room. Examiners review the field report and the estimate, hold or share the coverage decision, and approve or kick back the payment. Many restorers spend a claim arguing with the field adjuster about a decision the examiner made. Ask, early and politely, “Who reviews this file after you?” — then write your documentation for that reader.

TPA. A third-party administrator runs claims for a carrier or a program. The adjuster you're talking to works inside the TPA's rules, on the carrier's money. Program work in particular comes with fixed documentation formats and rate structures; arguing the format with the adjuster is arguing with someone who didn't write it and can't waive it.

CAT vs. daily. Same licenses, different weather. A daily-claims adjuster works a home territory at relationship pace — you'll see them again next month. A CAT adjuster is surge capacity: deployed fast, loaded with volume, gone when the event closes. Calibrate your documentation and your follow-up cadence to which one you're actually dealing with.

Questions restorers ask about the three economies

“The adjuster denied my line item to save the carrier money, right?” Sometimes a line item dies on coverage, sometimes on documentation, sometimes on an authority limit — and the person telling you no may agree with you and still not hold the pen. The three-economies read gives you a better first question than motive: “What would this file need for that item to be approved, and who approves it?” That question works in all three economies.

“Why did the independent adjuster rush the inspection?” Because their fee is per file, not per hour, and the next file is how they eat. A rushed inspection is a reason to document more thoroughly yourself, not a reason to assume the claim is lost — the examiner reviews what's in the file, and your evidence can be in it.

“Should my customer hire a public adjuster?” That's the policyholder's call, and on a large, disputed, or denied loss it's often a rational one — the fee comes out of the recovery, capped by law, and a good public adjuster earns it in scope the first pass missed. What you can do is make sure the customer understands the percentage comes off their settlement, and that the decision is theirs, made with open eyes.

“Who actually decides what my claim gets paid?” Almost never one person. Field documents, desk reviews, authority limits approve. Build your file so it survives being read by someone who never met you, never saw the property, and has forty more files waiting. That reader is the real audience in every economy.

The operator takeaway

You cannot change how the person across the desk is paid. You can absolutely change whether your file fits their economy. Complete documentation on the first pass. One point of contact. No surprise supplements that

could have been scoped on day one. Updates before they're chased. Those four habits read as professionalism to everyone — but underneath, they're economics: you are returning hours to a salaried queue, protecting a per-file fee from unpaid rework, and keeping a contingency case moving toward the payment everyone at the table is waiting on.

The adjusters are not three versions of the same job. They're three economies that happen to share a job title. Work the economy you're in, and the file moves.

Related reading

- How Do I Handle an Adjuster Reinspection?
- What Do I Do When My Estimate Doesn't Match the Adjuster's?
- Which Xactimate Line Items Do Adjusters Actually Approve?

After Isaias: The Claims Clock, the Wind/Flood Split, and the Paperwork That Decides Both

Source: <https://restorationintel.com/after-isaias-claims-clock-wind-flood-split/> Published: October 14, 2026

Date of loss: October 9, 2026. From that day, three clocks are already running on Florida Isaias losses.

Clock	Rule	Deadline from Oct 9, 2026
New Florida property claim	Fla. Stat. 627.70132 — 1 year to report	October 9, 2027
Florida supplemental claim	Fla. Stat. 627.70132 — 18 months	April 9, 2028
NFIP proof of loss	60 days	December 8, 2026

Hurricane Isaias made landfall near Destin, Florida, on October 9, 2026, as a Category 2 storm with 105 mph winds, roughly 900,000 outages at peak, and four deaths (AP/USA Today). The news cycle will move on. These dates will not. Wind versus flood decides which policy is in play. Dated photos, moisture readings, and mitigation records decide whether either file holds.

The clocks — put the dates on the job file

Treat the date of loss as the start of three countdowns. Write the calendar dates on the job folder, the estimate header, and the customer follow-up script.

Florida new claim — October 9, 2027. Under Fla. Stat. 627.70132, a new claim has one year from the date of loss to be reported. For an October 9, 2026 Isaias loss, that is October 9, 2027. A work order is not a claim. Your file should show when the carrier was notified, by whom, and under what claim number.

Florida supplemental claim — April 9, 2028. The same statute gives eighteen months for a supplemental claim from the same date of loss — April 9, 2028. Hidden damage, extended drying, roof-to-interior causation that only shows after dry-in: those files become supplements. If your crew finds new scope in month six, the calendar still ends April 9, 2028, not eighteen months from discovery.

NFIP proof of loss — December 8, 2026. Where flood coverage is NFIP, proof of loss is due sixty days from the date of loss. Sixty days from October 9, 2026 is December 8, 2026 — the nearest hard date on this board. If the job has a flood component, that date is the short fuse.

Operators do not need a lecture. They need the three dates on the board and a habit of checking which clock applies to which peril on each address.

Wind vs. flood — the split that decides who pays

Isaias was a wind event with water consequences. Payment still turns on which water story the file supports.

Wind path. Wind opens the building — covering, openings, envelope failure — and rain follows through the breach. That path usually sits on the property-policy side. Document sequence: wind damage first, water path second, interior wetness tied to the opening you photographed.

Flood path. Water that rises and enters as flood is a different coverage lane. When that lane is NFIP, you are on the sixty-day proof-of-loss clock above. Blending “storm water” language across both files without separating cause gives adjusters two incomplete stories.

Why the split decides payment. Carriers do not pay “hurricane” as one bucket. They pay or deny by peril and by policy. One address can carry wind scope on a property claim and flood scope on a flood policy. If photos, notes, and the moisture map blur those paths, both sides get an attribution fight. Keep causes unblended even when the customer lived one storm night.

Field questions, every job: Where did water enter? At what elevation? Through what opening? Standing water from outside grade or surge, or intrusion through a wind-created breach? Answer in photos and notes before you argue it in a supplement.

The paperwork that decides both

Three document types carry both files.

1. Dated photos (before, during, after). Timestamp matters. Capture as-found exterior elevations, roof and openings, water or debris lines if present, interiors before demo, and the same rooms after extraction and during drying. Photo the cause, not only the mess. A wet ceiling without the opening above it is half a story.

2. Moisture readings. Readings turn “it was wet” into a map. Record location, material, reading, instrument, and date. Re-read on a schedule your drying plan can defend. Patterns help show whether wetting matches a roof/envelope breach or a rising-water path. Months later, the original log is what supports a supplement that the first scope was incomplete for a reason.

3. Mitigation records. Who authorized work, when extraction started, what was removed, what equipment ran, when dry-out goals were met. These records support the duty to mitigate and give the estimator a timeline that matches the photos. On an NFIP file facing December 8, they are also what a proof-of-loss package has to rest on.

Build the file so an adjuster who never walked the site can reconstruct cause, sequence, and mitigation without a phone call.

What you tell the customer in week two

Week two is when emergency urgency fades and claim questions sharpen. Keep it calendar-true.

Say this:

- “Date of loss is October 9, 2026. In Florida, a new claim generally has until October 9, 2027 to be reported, and a supplemental claim until April 9, 2028 — Fla. Stat. 627.70132, running from the date of loss.”
- “If this loss has NFIP flood coverage, proof of loss is due December 8, 2026 — sixty days out, earlier than the Florida property-claim clocks. That paperwork moves now.”
- “Wind and flood are different coverage paths. We are documenting where water entered and what the wind did to the building so each policy gets the right file.”
- “We are keeping dated photos, moisture readings, and mitigation records. Keep your copies of authorizations, claim numbers, and carrier letters.”

Do not say: payment guarantees; “you’ve got a year, so we’re fine” when NFIP may be due December 8; or “it’s all hurricane damage” without separating wind-driven intrusion from flood.

Also confirm in week two that the claim is actually open — claim number on file, peril description consistent with what the crew documented, and the customer clear on which clock is shortest for their address.

Operator checklist (DOL Oct 9, 2026)

- Stamp **date of loss: October 9, 2026** on every Isaias job file.
- Write the deadlines on the folder: **new claim 10/9/2027, supplement 4/9/2028, NFIP POL 12/8/2026** (if flood applies).
- Separate wind-path notes from flood-path notes in photos and narrative.
- Lock dated photos, moisture logs, and mitigation records before the file goes quiet.
- In week-two talks, lead with the nearest applicable deadline — especially December 8 on NFIP.

The storm made landfall once. The claims clock is still running.

Related reading

- The Estimator in a Storm Event
- The GM in a Storm Event: Your First 72 Hours
- How to File a Property Insurance Claim for Restoration: From Loss Report to Settlement
- Emergency Loss Documentation and Insurance Notification: Chain of Custody, Carrier Communication, and Claim Protection
- Wind and Hail Damage: Scope Development, Insurance Claims, and Repair Standards

Update, October 15: the modeled loss estimates are now landing — Verisk at \$1–2 billion for onshore property, KCC at \$3 billion for the private market — and they do not measure the same thing. The full breakdown, with each figure kept on its own terms: Isaias by the Numbers: Four Estimates, Four Different Storms.

Insurance Preferred Contractor Programs Explained

Source: <https://restorationintel.com/insurance-preferred-contractor-programs-explained/> Published: October 9, 2026

The short answer: when your insurer “recommends” a restoration contractor, you’re usually being routed into a **managed repair network** run by the carrier or a **third-party administrator (TPA)**. These are pre-vetted contractors who meet the network’s standards for licensing, response time, documentation, and customer satisfaction — and they’re scored on all of it. Using one is convenient and often smooth. But it’s a recommendation, not a requirement: **in most states you have the right to choose your own contractor.**

What these programs are

After a covered loss, carriers want the repair handled quickly, consistently, and at a predictable cost. Managed repair networks are how they do it at scale. The structure:

- **Carrier-run programs:** the insurance company maintains its own network of approved contractors.
- **TPA-run programs:** a third-party administrator operates the network on behalf of one or more carriers — recruiting contractors, setting operating standards, measuring performance, and routing assignments.

Contractors join these networks voluntarily. To get in and stay in, they typically must carry proper licensing and insurance, use designated estimating or project-management systems, meet response-time and documentation standards, and maintain customer satisfaction scores. They’re measured continuously — contact time, estimate turnaround, documentation compliance, file closure speed — and assignments follow performance.

Why carriers like them

From the carrier’s perspective, networks solve real problems: consistent repair quality across thousands of claims, faster cycle times, standardized documentation that makes files auditable, and cost predictability. A contractor who’s done 200 jobs through the same system produces fewer surprises than a new vendor every time. That’s the business logic, and it’s legitimate.

Why contractors join them

For a restoration company, network membership means access to a steady stream of insurance-referred work — without having to win each job through marketing. The trade-off: they operate under the network’s rules, pricing structures, and performance scorecards. High-performing contractors can build significant volume this way; the network becomes a major revenue channel.

What it means for you

The practical upside: – **Vetted baseline.** Network contractors meet defined standards — you’re not rolling the dice on an unknown company during a crisis. – **Faster start.** The referral pipeline is built for speed; the contractor often contacts you within hours. – **Smoother paperwork.** They speak the carrier’s language — documentation, estimating systems, and communication protocols are aligned, which reduces friction on your claim.

What to keep in mind: – **It’s a recommendation.** In most states, you have the legal right to choose your own contractor. The carrier can suggest; they generally can’t require. (Check your state’s rules — specifics vary.) – **The contractor serves two relationships.** Network contractors work for you on your property, but their network standing depends on carrier satisfaction scores. That’s not a conflict in most jobs — but it’s worth knowing the dynamic exists. – **Pricing follows the network.** Network work is typically priced through standardized estimating (often Xactimate with agreed price lists). That’s usually fair and consistent — but if

you hire independently, your contractor's estimate is the starting point for negotiation, not the network's. — **You can still vet them.** “Preferred” means they met the network's standards, not that they're the best fit for your specific loss. Check reviews, verify the crew's certifications, and make sure the scope matches your damage — the same diligence you'd apply to any contractor.

The questions worth asking

Whether you use the recommended contractor or choose your own, ask: 1. **Are you in my carrier's network, and does that change anything about how my job is handled?** (Straightforward question, deserves a straightforward answer.) 2. **Who do I call if I disagree with the scope?** (Know the escalation path before you need it.) 3. **Will you document with photos and moisture readings I can keep?** (Your records, not just theirs.) 4. **What happens if hidden damage is found mid-job?** (Supplements are normal — the process for them shouldn't be a mystery.)

If you choose your own contractor

Nothing about the network prevents this. Your independent contractor documents the loss, writes a line-item estimate, and works with the adjuster the same way — the claim process doesn't fundamentally change. What changes: you're managing the selection and the relationship directly, which is either a burden or an advantage depending on how you see it. Many homeowners prefer choosing their own contractor for large or complex losses and using network referrals for straightforward ones.

Where this comes from

- **Industry structure:** TPA and managed-repair network mechanics as analyzed in R&R Magazine's 2026 industry coverage; carrier program structures are standard industry practice.
- **Consumer rights:** the right to choose your contractor is established in most states' insurance regulations — specifics vary by state, so verify locally.
- **From the field (labeled):** the “two relationships” framing and the vetting questions reflect working industry knowledge (third-party, not any single official source). This page describes the system neutrally — it is not a criticism of carriers, TPAs, or network contractors, many of whom do excellent work.
- Related on Restoration Intel: Types of Restoration Companies · Water Damage Insurance Claim Tips · Estimate Doesn't Match the Adjuster's?

Preferred programs are infrastructure — neither a trap nor a guarantee. Understand the system, vet the specific contractor, and choose deliberately.

Water Damage Insurance Claim Tips: How to File and Get Paid

Source: <https://restorationintel.com/water-damage-insurance-claim-tips/> Published: October 9, 2026

The short answer: successful water damage claims come down to three things — **document before you clean, mitigate after you document, and speak carefully.** Say “water damage,” not “flood.” Photograph everything before touching anything. Stop the source and start drying immediately (your policy requires it). And read your policy before you file, so you know what's covered before the adjuster tells you.

The words matter: don't say “flood”

This is the single most valuable tip on the page. In insurance language, **“flood” means rising water from outside** — and it’s excluded from standard homeowners policies (it needs separate flood insurance). If your basement is wet and you tell the insurer it “flooded,” you’ve handed them an exclusion before the adjuster arrives.

Say **“water damage”** and describe what you see. Let the adjuster determine the cause — that’s literally their job. Don’t speculate about whether it was a burst pipe, a sewer backup, or groundwater. Describe, don’t diagnose.

Document before you clean

Your claim is built on evidence, and evidence disappears the moment cleanup starts. Before touching anything: – **Wide shots** of every affected room, then **close-ups** of individual damage – **The source** if visible (the burst pipe, the failed water heater, the intrusion point) – **Water levels** — a ruler or tape measure in the photo gives scale – **Video walkthrough** narrating what you’re seeing and when you found it – **Moisture readings** if you have a meter, or ask your restoration company for their moisture log — professionals document this as standard practice, and adjusters increasingly review claims remotely, relying entirely on your photos and data

Keep damaged items until the adjuster has seen them (or been given the chance). Photograph first, discard after.

Mitigate immediately — it’s required, not optional

Every standard policy includes a **duty to mitigate**: you must take reasonable steps to prevent further damage. Shut off the water source. Start extraction and drying. Tarp the opening. This isn’t just good practice — failing to act can reduce your settlement or get portions of the claim denied. (Mold that grew because water sat for a week is the classic partial denial.)

Keep every receipt: pump rentals, fans, dehumidifiers, emergency repairs, professional extraction, hotel stays, meals if displaced. These out-of-pocket costs are often reimbursable, including under Additional Living Expenses (ALE) provisions.

Know your coverage before the adjuster calls

Typically covered: sudden and accidental events — burst pipes, appliance failures, plumbing failures, water from firefighting efforts.

Typically not covered: flood (rising exterior water — separate policy), gradual leaks and maintenance failures, groundwater seepage, mold from neglected moisture.

Check your endorsements: sewer/drain backup usually needs a specific rider (often \$5,000–\$25,000 in coverage for under \$300/year). Sump pump overflow may have its own limit. Know these numbers before you need them.

Replacement cost vs. actual cash value: know which your policy pays. Replacement cost covers what it costs to replace the item today; actual cash value subtracts depreciation. It changes your payout significantly on contents.

The adjuster meeting

- **Be present** if possible. Walk them through the damage with your documentation.
- **Don't accept the first number reflexively.** If the settlement seems low, you can push back — provide your contractor's line-item estimate, your receipts, your photos.
- **Don't rush the settlement** if you're unsure all damage is discovered. Hidden water in walls and cavities sometimes surfaces after the initial scope. Supplements exist for exactly this reason.
- **For large or complex claims** (extensive structural damage, major mold), consider a **public adjuster** — they work for you, not the insurer, typically charging a percentage of the settlement. Their expertise often pays for itself on claims over \$50,000.

If your claim is denied

Denial isn't always final. Get the denial in writing with the specific policy language cited. A public adjuster can review and appeal. Common denial reasons worth challenging: misclassified water source (your "flood" was actually a plumbing failure), missed endorsements you actually carry, or scope disputes where your contractor's documentation contradicts the adjuster's.

The timeline that protects you

Policies typically require "prompt notice" — some specify 30, 60, or 90 days, but don't test the outer limits. Delayed reporting gives the insurer an argument that you made the damage harder to assess. Report within days, document within hours, mitigate immediately.

Where this comes from

- **Claims practice:** standard homeowners policy provisions (duty to mitigate, sudden-vs-gradual distinction, flood exclusion); communication guidance consistent with Investopedia's 2026 water-damage claims analysis.
- **From the field (labeled):** the "describe, don't diagnose" framing and the adjuster-meeting guidance reflect working claims practice (third-party, not any single official source).
- Related on Restoration Intel: Emergency Loss Documentation and Insurance Notification · How Much Does Water Damage Restoration Cost? · Estimate Doesn't Match the Adjuster's? · What Documentation Actually Gets a Supplement Approved? · Insurance Preferred Contractor Programs Explained · Basement Water Damage

Document first, mitigate fast, speak carefully. The claim you file in the first 24 hours is the claim you live with.

Xactimate Online vs. Desktop: What's the Difference?

Source: <https://restorationintel.com/xactimate-online-vs-desktop/> Published: October 9, 2026

The short answer: they're two doors into the same system. The desktop version is the installed Windows application — full toolbox, works offline, projects live on your machine (and sync). Xactimate Online runs in a browser — nothing to install, projects live in the cloud, you work from anywhere with internet. The estimating engine and price lists are the same underneath. The differences are about where you work, whether you're connected, and which workflows each version handles best.

What each one is

Xactimate Desktop is the traditional installed application. You launch it from the Control Center, work in Local Projects, and the full feature set is on your machine. It works without an internet connection — useful on job sites with dead zones — and syncs when you're back online.

Xactimate Online is the browser-based version. You log in, see your Projects page with recent cloud projects, and hit + **New Project** to start. Nothing installs; updates happen server-side, so you're always on the current version. The tradeoff is the obvious one: no internet, no estimating.

Both are Xactware/Verisk products, both use the same regional price lists, and both produce estimates in the format carriers accept. Nobody downstream can tell which one you used.

The real differences

Where projects live. Desktop defaults to local — your machine holds the projects, and you manage backup and sync. Online defaults to cloud — projects follow your login to any device. For a one-person shop, this barely matters. For a team with estimators in trucks and reviewers at desks, cloud projects remove an entire category of “which version is current” confusion.

Offline work. Desktop wins outright. Basements, rural properties, new construction with no service — the desktop app doesn't care. Online needs a connection. If your estimators regularly work where signal is unreliable, this alone decides it.

Updates and maintenance. Online wins outright. No installs, no version mismatches across the team, no IT afternoon getting everyone current. Desktop requires managing installations — minor for one machine, real overhead for twenty.

The sketch experience. Both have the full sketch tools. On a large monitor with a mouse, they're equivalent. On a laptop trackpad in a truck, both are mildly miserable — the difference between them is smaller than the difference a real mouse makes.

Getting started. Online is faster for a new user: log in, new project, go. Desktop has the install and setup step. Neither is hard; Online just has fewer steps between “I need to estimate” and estimating.

Which one for which situation

- **Solo estimator, sometimes offline:** Desktop. The offline capability is the deciding factor.
- **Team, multiple locations, reviewers and field staff:** Online. Cloud projects and zero install overhead pay off fast at team scale.
- **Mixed:** many shops run both — desktop for the field estimators who hit dead zones, Online for office staff and reviewers. They're the same system, so this isn't the compromise it sounds like.
- **New to Xactimate entirely:** start Online. Fewer setup steps, always current, and you can move to desktop later without relearning anything — the estimating workflow is the same.

What doesn't differ

The price lists are the same. The line-item database is the same. The 4-step estimating process (Claim Info, Sketch, Estimate Items, Complete) is the same — our estimate-writing guide applies to both. An adjuster receiving your estimate cannot tell which version produced it, and doesn't care.

Where this comes from

- **From Xactimate (official):** the Online project workflow (Projects page, + New Project, profiles, project types including Estimate/FEMA Flood/360Value, cloud-based Estimate Writer) per Xactware's official help documentation. The desktop workflow (Control Center, Local Projects) per Xactware's training materials.
- **From the field (labeled):** the practical tradeoff framing — offline dead zones, team-scale update overhead, the trackpad-in-a-truck reality — reflects working estimator discussion (third-party, not Xactware-official). Treat as lived experience, not specification.
- Related on Restoration Intel: How Do I Write an Estimate in Xactimate? · What Is Xactimate and What Does It Cost? · How Do I Learn Xactimate?

Two doors, same house. Pick the door that matches where you work.

Xactimate vs. Symbility: Which Estimator Should a Restoration Shop Run?

Source: <https://restorationintel.com/xactimate-vs-symbility/> Published: October 9, 2026

The short answer: for most restoration shops doing insurance work in North America, Xactimate — because it's the format carriers' claim systems read, and that settles the question before it starts. Symbility (now part of CoreLogic, sold as Claims Connect) is a legitimate cloud-based alternative that some shops prefer for its interface and mobile workflow. The decision isn't about which is "better" in the abstract. It's about which one fits how your shop works and who you're submitting to.

What each one is

Xactimate is built by Xactware, a Verisk company. It's the industry-standard estimating platform for property claims — desktop software plus Xactimate Online (browser-based) plus mobile apps, with the regional price database, sketch tools, and the carrier-connected XactNet tier. When an adjuster says "send it in Xactimate," this is what they mean. (More on the product in What Is Xactimate and What Does It Cost?.)

Symbility was an independent Canadian estimating-software company, now part of CoreLogic, offered as part of the Claims Connect platform. It's cloud-based, designed around a more modern interface, with an emphasis on mobile use and collaboration — multiple people working a claim together in real time.

Both price from structured line-item databases. Both produce itemized estimates. They are different tools for the same job, not different jobs.

The factor that decides it for most shops

What your carriers accept. This is the whole decision for a large share of restoration contractors, and it's not close: the North American insurance claims ecosystem runs on Xactimate format. Estimates submitted in Xactimate move through carrier systems without translation. Estimates submitted in anything else need the carrier to work with a format outside their standard workflow — which some will do and some won't, but none prefer.

If your work is primarily insurance restoration and your carriers expect Xactimate, the comparison is academic. You run Xactimate. The question only becomes interesting for shops where that constraint doesn't bind.

Where the comparison is real

Shops doing non-insurance or mixed work. Retail roofing, remodeling, direct-to-consumer restoration — anywhere the estimate goes to a homeowner rather than a carrier's claim system. Here the format constraint lifts, and interface, mobile workflow, and cost become the actual decision factors.

Team workflow preferences. Shops that live on mobile and collaborate on claims in real time sometimes prefer Symbility's cloud-native design. Shops with dedicated estimators on desktops tend to be comfortable in Xactimate's deeper toolbox. This is genuinely a matter of how your people work — there's no universal right answer.

Cost structure. Both are subscription products priced per user, and both have tiers. Get actual quotes from both vendors for your seat count before comparing — third-party directory pricing for either product is unreliable, as we found when researching Xactimate's own pricing.

What to ask before you choose

- **Do my carriers require Xactimate format?** If yes, stop here.
- **Where do my estimators work?** Desks, trucks, or both — and how much does offline capability matter?
- **Who else touches the estimate?** If adjusters, reviewers, or clients need in, how does each platform handle that?
- **What's the real per-seat cost at my size?** Quote both. Don't trust directories.
- **Can I trial it on a real claim?** A demo on sample data tells you nothing. One real estimate tells you everything about fit.

The honest summary

Xactimate is the standard. Symbility is the alternative. Standards win on compatibility; alternatives win when they fit a specific workflow better. Most insurance restoration shops choose the standard for the same reason most people drive on the right side of the road — not because it's better, but because everyone else is there. Shops outside the insurance workflow have a real choice, and should make it on workflow fit and verified cost, not marketing.

Where this comes from

- **From the vendors (official):** Xactimate's product structure (desktop, Online, mobile, XactNet) per Xactware/Verisk; Symbility's position within CoreLogic's Claims Connect platform per CoreLogic's product materials.
- **From the field (labeled):** the workflow-fit framing — cloud-native collaboration vs. desktop depth, mobile-first vs. estimator-workstation preferences — reflects third-party comparison write-ups and estimator discussions (not vendor-official). Treat as informed opinion, not specification.
- Related on Restoration Intel: What Is Xactimate and What Does It Cost? · How Do I Write an Estimate in Xactimate?

No disparagement here is intentional — both products serve real shops. If anything above mischaracterizes either platform, the vendors are welcome to correct the record; the goal is an accurate map, not a winner.

How Do I Handle an Adjuster Reinspection?

Source: <https://restorationintel.com/how-to-handle-adjuster-reinspection/> Published: October 9, 2026

The short answer: a reinspection is a second look at the property that you request when there's something new to see — damage discovered after the first visit, areas the inspector couldn't access, or conditions that changed. Request it in writing, be specific about what's new, prepare the way you'd prepare for the first inspection, and document everything the inspector does and doesn't look at. A reinspection with new evidence moves claims. A reinspection that's just a repeat of the first visit wastes everyone's time, including yours.

When a reinspection makes sense

New damage discovered. The first inspection happened, work started, and opening things up revealed what the inspection couldn't see — rot behind the wall, a second layer of damage, structural issues under the flooring. This is the strongest case for a reinspection: the facts genuinely changed.

The first inspection was incomplete. The inspector didn't go in the attic. Didn't open the crawlspace. Spent ten minutes on a roof with obvious slope damage. Ran out of daylight. If areas of the loss weren't examined, the estimate built from that inspection is built on a partial picture — and a partial picture is a legitimate reason to ask for another look.

Conditions changed. Water migrated. Drying revealed the true extent. A subsequent event affected the property. When the property isn't the same property the inspector saw, the inspection is stale.

In all three cases, the common thread is *new information*. That's what makes a reinspection request reasonable instead of just persistent.

When it doesn't

Requesting a reinspection with nothing new to show is one of the fastest ways to burn credibility with an adjuster. If the evidence is the same evidence, the areas are the same areas, and the conditions are the same conditions, a second inspector will produce a second version of the first report. Worse, the request itself signals that you think repeating the process changes the outcome — which tells the adjuster the issue isn't evidence, it's that you didn't like the answer.

The honest test: *can I point to something specific this inspector hasn't seen?* If yes, request it. If no, the path forward is a supplement on the existing record, not a new inspection.

How to request it

In writing. Always. A phone request for a reinspection is a conversation; a written request is a record. State specifically what you want re-examined and why: the newly discovered damage, the areas not accessed, the changed conditions. Reference the date of the original inspection and the claim number. Keep it professional and factual — one page.

Be specific about scope. “We’d like a reinspection” is easy to defer. “We’re requesting reinspection of the north attic and second-floor subfloor, where demolition on revealed not visible during the inspection” is hard to ignore. Specificity is what separates a request from a complaint.

Say what you’ll have ready. Photos of the new conditions, moisture readings, the relevant estimate pages. You’re telling the adjuster this visit will be productive — which is what gets it scheduled.

Preparing for the visit

Prepare the way you’d prepare for a first inspection, because for the areas in question, it is one:

- **The evidence package.** Photos of the new damage (before anything was disturbed, if possible), readings, measurements — organized by area, ready to hand over.
- **Access.** Every area to be inspected is open, lit, and accessible. Nothing kills a reinspection faster than the inspector arriving to find the attic hatch still painted shut.
- **Your estimate pages.** The relevant Xactimate pages for the disputed scope, so you can walk through exactly which items the new evidence supports.
- **Someone knowledgeable present.** Whoever knows the job best should be there — to answer questions, point out conditions, and note what gets examined. Take your own photos during the visit and keep your own record of which areas the inspector looked at and for how long.

During the visit

Point, don’t argue. Your job is to make sure the inspector sees everything relevant — not to litigate the claim on the driveway. Walk them to each area, show the conditions, hand over the documentation, answer questions directly. If they disagree with your reading of something, note the disagreement rather than debating it on the spot. The written follow-up is where disagreements get worked.

Document the inspection itself. Which areas were examined, which weren’t, what was said about each. If the inspector declines to look at an area, note it — in writing, afterward. A reinspection that skips the area you requested is itself grounds for a follow-up request, but only if you recorded that it happened.

After the visit

Written follow-up within days. Thank them for the visit, list what was examined, attach anything promised during the visit, and state what you’re expecting next (a revised estimate, a decision on the specific items). This letter becomes part of the claim file — write it like the next person who reads the file is deciding your case. They might be.

Then supplement. The reinspection’s findings go into the formal supplement process: Xactimate format, cover letter, photo per item. The reinspection doesn’t pay you — the supplement written from it does.

If the reinspection doesn’t resolve it

Sometimes the second look produces the same answer. At that point the remaining rungs are the ones from the escalation ladder: a documented supplement on the full record, and ultimately the policy’s appraisal process for valuation disputes. A reinspection that confirmed the disagreement isn’t a failure — it’s a completed step that narrows what remains genuinely disputed, which is progress even when it doesn’t feel like it.

Where this comes from

- **From the field (labeled):** the incomplete-inspection framing — that a materially incomplete first inspection warrants a written reinspection request before the original report controls the claim — reflects property-coverage legal commentary and contractor-published claim guidance (third-party, not Xactware-official). The “new evidence” test and visit-preparation practices come from working estimator and adjuster-coordination guides.
- **Industry mechanisms:** reinspection as a standard claim step and appraisal as the policy-level dispute mechanism are established insurance processes, not any single source’s invention.
- Related on Restoration Intel: What Do I Do When My Estimate Doesn’t Match the Adjuster’s? — the escalation ladder this page sits on · What Documentation Actually Gets a Supplement Approved? — the package the reinspection feeds · When Do I Supplement and When Do I Just Absorb the Cost?

A reinspection is a tool, not a tactic. Use it when the facts changed, prepare it like it matters, and document it like someone’s reading the file later — because someone is.

What Documentation Actually Gets a Supplement Approved?

Source: <https://restorationintel.com/documentation-gets-supplement-approved/> Published: October 9, 2026

The short answer: a supplement gets approved on its documentation package, not its argument. The package is: the supplement written in Xactimate format, a cover letter explaining what’s added and why, and a photo for every added item — backed by the working record underneath (moisture readings, dry logs, equipment justification, and references to the applicable IICRC standard). Adjusters approve what they can verify. Everything below is about making every item verifiable.

The package itself: three things, every time

- 1. The Xactimate file.** Correct line-item codes, accurate quantities, organized the way the original estimate was organized. A supplement in any other format — a PDF list, a handwritten scope, a spreadsheet — gets pushed to the bottom of the pile. The carrier’s system reads Xactimate; meet it where it lives.
- 2. A cover letter.** One page: what you’re adding, why each addition exists, and what evidence supports it. This is the map for the reviewer. An adjuster opening a supplement with forty new line items and no cover letter has to reverse-engineer your reasoning. Most won’t — they’ll kick it back with questions that a cover letter would have answered.
- 3. A photo for every added item.** Not a photo of the room — a photo of the specific condition the item addresses, taken before the work was performed. The photo is the item’s witness. No photo, no item. This is the single most repeated piece of advice in every supplement guide written by people who do this for a living, and it’s repeated because it’s where most supplements fail.

The working record underneath

Photos win the item; the working record wins the argument about whether the work was necessary and reasonable. For water losses, the record that carries weight:

- **Moisture mapping at the start.** Initial readings on every affected material, plus the dry standard for that structure. This establishes what was wet and what “done” looks like.
- **Daily dry logs.** Each affected material, each day, readings moving toward the dry standard. Gaps in the log are gaps in the story — a five-day drying job with two days of readings invites the question of what happened on the other three.
- **Air readings.** Relative humidity, temperature, and grains per pound for outside air, unaffected areas, each drying chamber, and dehumidifier output. This is psychrometrics — the science of the drying — and it justifies the equipment.
- **Equipment justification.** Every piece of equipment on the job needs to match the loss: the right class, the right capacity, the right count. An oversized dehumidifier on a small loss, or sixteen air movers where the math supports six, gets questioned — and the math (IICRC calculations or a drying app) should be in the file.
- **Before, during, and after photos.** Affected areas before anything is touched. Completed work at each stage. Every piece of equipment installed, photographed in place. The photo record should tell the story of the job without narration.

The standards layer

When an item’s necessity isn’t obvious from the photos alone, cite the standard that requires it. The IICRC publishes the industry’s consensus standards — S500 for water damage restoration, S520 for mold remediation, S700 for fire and smoke. A line item paired with “per IICRC S500” isn’t your opinion anymore; it’s the industry’s documented practice.

You don’t need to quote the standard at length. The reference does the work: it tells the reviewer this isn’t one contractor’s preference, it’s what the profession’s own standard calls for. Keep the standard’s relevance specific — cite it for the item it supports, not as a blanket footer.

The paper trail around the work

- **Work authorization.** Signed, dated, before work begins. Establishes that the work was authorized and when.
- **Scope notes.** Category and class of loss, affected areas, what was demolished and the justification for the demolition. Written at the time, not reconstructed later.
- **Communication log.** When the supplement was submitted, who received it, what was asked for, what was provided. Supplements die in inboxes; the log proves yours didn’t.
- **Certificate of completion.** Signed by the insured at the end. Closes the loop on the work itself.

What kills a documentation package

The same gaps, over and over:

- **No before photos.** The most fatal. Once the wall is closed, the condition it covered is unprovable.
- **Readings without a dry standard.** Numbers with no baseline are just numbers. The dry standard is what makes a reading meaningful.

- **Equipment with no math.** Dehumidifiers and air movers that don't match the loss class invite the reviewer to cut all of them.
- **Late submission.** Documentation assembled weeks after the fact reads as constructed rather than recorded. The record has to be built during the job, not after it.
- **The verbal supplement.** "I told the adjuster about it on the phone" is not documentation. If it isn't written, photographed, and submitted, it didn't happen.

Where this comes from

- **From the field (labeled):** the detailed working-record checklist — dry logs, psychrometric readings, equipment-justification math, photo staging — reflects guidance shared by working restorers on the MikeysBoard trade forum and in contractor-published claim guides (third-party, not Xactware-official). The documentation hierarchy (professional IICRC-based reports > timestamped photos > itemized estimates > inventories > receipts) comes from contractor-published claim documentation guides.
- **Industry standards:** IICRC S500 (water), S520 (mold), and S700 (fire/smoke) are the profession's published consensus standards — cited here as references, not quoted. (The IICRC sells the full standards through its webstore; the linked pages describe each standard's scope.)
- **From Xactimate (official):** line-item notes (F9) and the estimate-revision workflow are Xactware-documented functions; the supplement format standard (Xactimate file, coded items, quantities) is the carrier-accepted norm.
- Related on Restoration Intel: When Do I Supplement and When Do I Just Absorb the Cost? — the decision framework this package serves · Which Xactimate Line Items Do Adjusters Actually Approve? — why documentation decides approvals

The supplement is the argument; the documentation is the evidence. Arguments without evidence get denied. Evidence without a supplement never gets submitted. You need both, in that order.

What Do I Do When My Estimate Doesn't Match the Adjuster's?

Source: <https://restorationintel.com/estimate-doesnt-match-adjusters/> Published: October 9, 2026

The short answer: don't argue the bottom line — compare the two estimates line by line, identify exactly which items differ, and work each difference on its own evidence. Most mismatches come down to a handful of missing items or quantity disagreements, not a fundamental conflict. The escalation path is conversation, then supplement, then reinspection, then the policy's appraisal process. Almost everything resolves in the first two steps if the documentation is there.

First: this is normal, not an attack

Two estimates on the same loss disagreeing is the default state of insurance restoration, not a sign something went wrong. The adjuster wrote theirs from a visible inspection on a single visit. You wrote yours from being in the building, opening things up, and knowing what the work actually takes. Different vantage points produce different scopes.

Here's the part that simplifies everything: **you're both pricing from the same database.** Xactimate's regional price lists are the shared reference — so the disagreement is almost never about what a line item costs. It's

about which line items *belong*. That reframes the whole exercise: you're not haggling over rates, you're proving scope.

Step 1: compare line by line, not total to total

Get both estimates in writing — itemized, in Xactimate format — and lay them side by side. Ignore the totals completely at this stage. You're hunting for the specific lines that differ, and they fall into a small number of buckets:

- **Missing items.** On your estimate, not on theirs. The most common bucket by far.
- **Quantity differences.** Same item, different quantity — your sketch says one thing, their inspection said another.
- **Different items for the same work.** They chose one line item, you chose another, for the same repair.
- **Coverage disputes.** They say it isn't covered; you say it is. This is a policy question, not an estimating question.

Sort every difference into one of those four buckets before you do anything else. A mismatch that felt like a \$14,000 chasm usually turns into a dozen individual items you can work one at a time.

Step 2: work each bucket on its evidence

Missing items: for each one, ask the only question that matters — can I prove the work is necessary and caused by the covered loss? Photo, measurement, reading, note. If yes, it goes into a supplement (see our supplement-or-absorb framework). If no, let it go. Submitting items you can't prove trains the adjuster to discount everything else you send.

Quantity differences: show your math. Your sketch, your measurements, your photos of the actual space. Quantity disputes are the easiest to resolve because they're arithmetic — someone measured, and the measurements can be checked.

Different items for the same work: read both descriptions against the photos. One of them describes the actual work better. If it's yours, say why in a line-item note. If it's honestly theirs, concede it — conceding the ones you're wrong about buys credibility for the ones you're right about.

Coverage disputes: stop estimating and read the policy. Ask the adjuster to point to the specific language or claim determination behind the denial. If the policy genuinely excludes it, no estimate will fix that. If the exclusion doesn't fit the facts, that's what the escalation path is for.

Step 3: the escalation ladder

Most mismatches resolve in steps 1 and 2. When they don't:

- **Conversation.** A direct, professional call walking through the specific disputed items. Not the total — the items. Most adjusters would rather resolve twelve line items on a call than process a formal dispute.
- **Supplement.** The documented items go in through the formal supplement process: Xactimate format, cover letter, photo per item, weekly follow-up.

- **Reinspection.** If new damage was found after the adjuster's visit, or the disagreement turns on conditions they didn't see, request a reinspection. Give them something new to look at — going back over the same ground with the same evidence rarely changes the outcome.
- **Appraisal.** Most policies include an appraisal clause: a binding dispute-resolution process with a neutral umpire. This is the last resort, not the opening move — it's slow, it costs money, and it poisons the working relationship. But it exists for a reason, and knowing it's there changes the tone of every earlier step.

What not to do

- **Don't argue the total.** "Your number is too low" is not an argument anyone can act on. Twelve specific items with photos are.
- **Don't go adversarial early.** The adjuster on this claim is the adjuster on the next ten. Professional, specific, and persistent beats aggressive every time.
- **Don't start disputed work without agreement.** Doing the work and then demanding payment for it reverses your leverage. Get the scope agreed first, or accept that you're working at risk.
- **Don't take it personally.** The adjuster's estimate isn't a judgment of your competence. It's a first position built from a two-hour visit. Yours is a first position built from being in the building. The truth is usually assembled from both.

Where this comes from

- **From Xactimate (official):** the shared-database principle — both sides pricing from Xactware's regional price lists — is structural to how the platform works, per Xactware's documentation and training materials.
- **From the field (labeled):** the line-by-line comparison method, the four-bucket categorization, and the escalation ladder reflect widely published contractor and estimator guidance (third-party, not Xactware-official). The reinspection and appraisal steps describe standard industry and policy mechanisms.
- Related on Restoration Intel: When Do I Supplement and When Do I Just Absorb the Cost? · Which Xactimate Line Items Do Adjusters Actually Approve? · How Do I Write an Estimate in Xactimate?

The mismatch isn't the problem. The mismatch is the job — resolving it item by item, on evidence, is what estimating for insurance work actually is.

When Do I Supplement and When Do I Just Absorb the Cost?

Source: <https://restorationintel.com/supplement-vs-absorb-cost/> Published: October 9, 2026

The short answer: supplement when the work is real, caused by the covered loss, and you can document it — especially hidden damage found after work starts, code-required items, and things the original estimate missed. Absorb when the dollar amount is smaller than the cost of fighting for it, or when the cost came from your own inefficiency rather than the loss. Almost every restoration job has at least one legitimate supplement; the question is never *whether* to supplement, it's *which items* are worth the process.

What a supplement actually is

A supplement is a formal request to the carrier to add scope or adjust pricing after the initial estimate — submitted in Xactimate format, with line items, quantities, and documentation for everything being added. It

covers the things the first estimate didn't: items that were omitted, details that were overlooked, expenses that were underpaid, and damage discovered after work commenced (the classic case is opening a wall and finding what's behind it).

Supplements are a normal, expected part of insurance restoration. They're not a trick and they're not an accusation — the initial estimate is written from a visible inspection, and buildings hide things. The system assumes the first number is incomplete.

When to supplement: the clear cases

Hidden damage discovered during work. You open the wall and the framing is rotted, or the subfloor is gone, or there's a second layer of damage the inspection couldn't see. Photograph it before you touch it, note the date of discovery, add the line items. This is the least controversial supplement there is.

Code-required work. If current municipal or state code requires something the original estimate didn't include — an upgrade, a material change, a permit-driven item — that's supplement territory. Code isn't optional, and carriers know it.

Omitted items. Compare the adjuster's estimate against the actual scope line by line. Items that should be there and aren't — missed rooms, skipped prep work, missing protection of unaffected areas — get supplemented with documentation.

Underpaid quantities. The item is there but the quantity is wrong — the sketch says one thing, the real room says another. Correct the quantity, show the math.

In all four cases the formula is the same: **photo evidence + a measurable indicator where one exists (moisture readings, for example) + a clear note on the line item** (Xactimate's F9 note function exists for exactly this). A documented supplement is hard to dismiss. An undocumented one is dismissed routinely.

When to absorb: the honest cases

The amount is smaller than the fight. Every supplement costs you something: estimator time to write it, days or weeks of waiting, follow-up calls, and a withdrawal from the relationship account with that adjuster. A \$180 item that takes three weeks and four phone calls to recover cost you more than \$180. Run that math honestly.

The cost was yours, not the loss's. Your crew was slow. Your material order was wrong. You damaged something during the work. That's on you — no carrier owes you for your own inefficiency, and submitting it as a supplement burns credibility you'll need for the legitimate ones.

The documentation doesn't exist and can't be recreated. The work is done, the wall is closed, there are no photos, and the moisture readings were never taken. You might be right about what was there. You can't prove it. A supplement with no evidence is a request to be told no — and a "no" on record makes the next supplement harder.

It's a gray area and the relationship matters more. Sometimes an item is defensible but thin, and you're working with an adjuster you'll see on the next ten jobs. Spending relationship capital on a marginal item is a business decision, not an estimating decision. Good operators make it consciously.

The supplement process, in order

When you do supplement, the process that gets results:

- **Document on discovery.** Photos before anything is disturbed. Measurements, readings, dates. This is the step that can't be done later.
- **Write it in Xactimate within days, not weeks.** Supplement estimating services and contractor guides converge on the same point: write it while the evidence is fresh. A supplement written two months later reads like an afterthought.
- **Submit in Xactimate format through the proper channel.** Correct line-item codes, accurate quantities, a cover letter explaining what's being added and why — and a photo for every added item. A PDF list or a handwritten scope gets pushed to the bottom of the pile.
- **Follow up weekly.** Confirm receipt, confirm the assigned adjuster knows it's there, ask what else they need. Supplements die in inboxes, not in disputes.
- **Track to closure.** Log every supplement: amount requested, amount approved, days to decision. Over time this tells you which adjusters, which carriers, and which item types pay — and that data makes every future supplement-or-absorb decision sharper.

The decision framework, on one line

Can I prove it, is it the loss's fault, and is the amount worth the process? Three yeses: supplement. Any no: absorb it, note why, and move on to the items that pass.

Where this comes from

- **From Xactimate (official):** supplement mechanics live inside the standard estimating workflow — line items, F9 notes, and estimate revisions are Xactware-documented functions. The supplement *format* (Xactimate file, correct codes, quantities) is the carrier-accepted standard.
- **From the field (labeled):** the document-on-discovery -> write -> submit -> follow-up -> track workflow reflects widely published contractor and supplement-service guidance (third-party, not Xactware-official). The “photo for every added item” standard comes from working supplement writers describing what actually gets approved.
- Related on Restoration Intel: Which Xactimate Line Items Do Adjusters Actually Approve? — the documentation standard that makes supplements work · How Do I Write an Estimate in Xactimate? — the base estimate the supplement builds on

Supplements aren't adversarial — they're the system's correction mechanism. Use them the way they're designed: documented, prompt, and only for what's real.

Which Xactimate Line Items Do Adjusters Actually Approve?

Source: <https://restorationintel.com/which-xactimate-line-items-adjusters-approve/> Published: October 9, 2026

The short answer: there is no published “approved list.” Adjusters approve line items that are (1) the correct item for the work described, (2) backed by documentation, and (3) quantified in a way someone else can verify. Items get cut for the opposite reasons: wrong item for the work, no photo or note explaining why it's there, or quantities nobody can trace. The item itself matters less than the case you build around it.

What a line item actually is

Every Xactimate line item has the same anatomy: a code, a description of the task or material, a unit of measure (square foot, linear foot, each, hour), a quantity, and a unit cost from the regional price list. Total cost is quantity times unit cost. That's the whole structure — everything else is judgment about which item fits the work.

Line items live in categories: demolition and debris removal, structural repairs, drywall, flooring, paint, electrical, plumbing, HVAC, contents, and more. The price-list database is large, which is both the power and the trap: there's usually a right item, a close-but-wrong item, and three items that sound similar but price differently.

Why items get stripped: the three usual reasons

1. Wrong item for the work. The most common error. An estimator grabs an item whose description is close to the work but not quite it — wrong unit of measure, wrong material, wrong application. On review, the adjuster reads the description, compares it to the photos, and cuts it. The fix is unglamorous: read the full item description before placing it, every time. Estimator guides call this the number-one avoidable dispute, and they're right.

2. No documentation. The item might be perfectly correct, but there's no photo showing the condition and no note explaining why the work was necessary. From the reviewer's side, an undocumented item is indistinguishable from padding. This is the same principle behind our piece on undocumented mitigation getting stripped — the photo and the note are the argument; the line item is just where the argument lives.

3. Quantities nobody can verify. Items placed without a sketch behind them carry hand-typed quantities. Maybe they're right. Nobody reviewing can tell. Quantities that trace to the sketch are defensible; quantities that don't are negotiable, and negotiation favors whoever's holding the checkbook.

There's a fourth, subtler one: **labor/material double-counting.** Some line items bundle labor and materials; others cover only one. Placing a labor-only item next to a bundled item for the same work double-counts. Reviewers catch this fast.

The live case study: material handling

In September 2026, the Restoration Industry Association formally asked Verisk's Xactware pricing team to add dedicated line items for material handling to the Xactimate database. RIA's argument: procuring and managing materials has become a major operational cost for contractors — sourcing under current market conditions takes real labor — and there's no clean line item for it.

This is the perfect illustration of the whole page. When the database has no dedicated item for real work being performed, contractors improvise — burying the cost in other items, writing vague descriptions, or leaving it out and eating the cost. Improvised items get questioned. Dedicated items with clear descriptions get approved. RIA is trying to move material handling from the first category to the second, through the official channel, with operational data to back it up. That's how the system is supposed to work.

From the field: the software sometimes mislabels things itself

An adjuster on the CatAdjuster forum — adjusters talking to adjusters — described fighting Xactimate over a cemented-down fountain: the software classified the fountain line item as *contents* rather than building property, splitting it into a different part of the estimate with no way to reclassify it. The fix involved overwriting the description on a different line item entirely.

The lesson isn't that the software is broken. It's that line-item classification has consequences — contents vs. building property changes coverage, depreciation treatment, and which part of the estimate the item lands in. When an item lands somewhere surprising, check its classification before assuming the reviewer will figure it out. They won't; they'll question it.

The practical checklist

Before you submit, run each unusual item through this:

- **Description match.** Does the item description actually describe the work in the photos? Not close — actual.
- **Unit sanity.** Is the unit of measure right for how the work was performed?
- **Labor vs. material.** Does this item bundle both, or do you need the companion item? Are you double-counting?
- **Classification.** Building property or contents? Right coverage bucket?
- **Documentation.** Photo showing the condition, note explaining why. Every time.
- **Quantity trace.** Can someone follow this number back to the sketch?

Items that pass all six rarely get cut. Items that fail two or more almost always do.

Where this comes from

- **From Xactimate (official):** line-item anatomy (code, description, unit, quantity, unit cost) and the price-list database structure, per Xactware's documentation and training materials.
- **Industry record:** RIA's September 2026 formal request to Verisk/Xactware for dedicated material-handling line items (reported by R&R Magazine and Cleanfax; RIA CEO Saima Hedrick quoted on the record).
- **From the field (labeled):** the fountain-classification anecdote comes from an adjuster's post on the CatAdjuster forum — one adjuster's experience, not a universal rule. The "read the description" and documentation guidance reflects widely published estimator best-practice guides (third-party, not Xactware-official).
- Related on Restoration Intel: [How Do I Write an Estimate in Xactimate?](#) · [RIA Pushes Xactimate for Dedicated Material-Handling Line Items](#) · [Undocumented Water Mitigation Gets Stripped From Estimates](#)

No list of "approved items" exists because approval isn't about the item — it's about the case. Build the case and the item survives.

How Do I Learn Xactimate — Training, Certification, or On the Job?

Source: <https://restorationintel.com/how-do-i-learn-xactimate-training-certification/> Published: October 9, 2026

The short answer: all three exist, and they're not mutually exclusive. Verisk (Xactimate's maker) offers official training classes in three tiers and certification exams in three levels. Around that, there's a whole ecosystem of free resources — Xactware's own YouTube tutorials, the demo version, user forums. Most working estimators end up using a mix. Here's what each path actually is, so you can pick the right one for where you are.

Path 1: Official training classes

Verisk's training arm offers three Xactimate classes, each aimed at a different skill level. This comes straight from their "Which Xactimate Class Is Right For Me?" guide:

- **Xactimate Fundamentals** — for new users. Introduces the 4-step estimating process (Claim Info, Sketch, Estimate Items, Complete). Prepares you for the Level 1 certification exam.
- **Xactimate Proficiency** — intermediate. Goes deeper on the 4-step process with more detail on productivity and accuracy. Prepares you for the Level 2 exam.
- **Xactimate Mastery** — advanced. Tips, tricks, and getting the most out of the software. Prepares you for the Level 3 exam.

Classes come in three formats: self-paced, virtual classroom, and in-person classroom. Verisk's own advice: pick the class that matches your actual skill level, not the one you aspire to. Sitting in Mastery when you needed Fundamentals is, in their words, a discouraging experience.

Path 2: Certification exams

Separate from the classes, Xactware offers three levels of user certification. The levels:

- **Level 1 — Fundamentals.** Proves you can write an estimate from start to finish. This is the baseline credential.
- **Level 2 — Proficiency (Power User).** Proves you've mastered the fundamentals and can use intermediate techniques to estimate larger jobs faster and more accurately.
- **Level 3 — Mastery (Subject Matter Expert).** Proves full mastery of the tools — the person other people ask for help.

How the exams work, per Xactware's certification materials:

- Each level has two parts: a **practical hands-on lab** (you build an estimate from a sketch-and-scope scenario — this part is not timed) and a **practical exam** (timed questions about the estimate you built, plus knowledge questions: multiple choice, true/false, matching).
- Passing grade is 70%.
- The exam is open book, open notes, open Xactimate. You just can't ask another person for help.
- You don't have to take the levels in order — you can start wherever matches your skill. Xactware recommends going in order, since each level prepares you for the next.

Why bother getting certified? The credential is independently verified proof you can do the work. Employers and carrier programs use it as a filter — some preferred-vendor and adjuster roles require or strongly prefer certified estimators. It's also just leverage: a certified estimator's numbers carry more weight in a dispute.

What it costs: exam fees are set by Xactware and change; third-party training sites currently report roughly \$100 for Level 1, \$200 for Level 2, and \$250–\$350 for Level 3, with retakes typically billed again. Confirm current fees with Xactware before budgeting — don't take a directory's word for it.

Path 3: On the job (plus free resources)

Here's the part nobody's marketing materials emphasize: a large share of working estimators learned primarily by doing — writing real estimates, getting them kicked back, figuring out why.

The free scaffolding around that:

- **Xactware's YouTube tutorials** — official, free, and genuinely useful for specific tasks.
- **The demo/practice version** — lets you build estimates without a paid license.
- **User forums and groups** — working estimators answering each other's questions. (Quality varies; treat tips as leads to verify, not gospel.)
- **Third-party courses** — on-demand video and live webinar training from independent trainers, typically \$100–\$750 depending on format. Some are excellent; they're not Xactware-official, so check the trainer's credentials.

The honest take: on-the-job learning works, but it's slow and it bakes in whatever bad habits your first teacher had. Pairing real work with even the Fundamentals class tends to produce better estimators faster than either path alone.

Which path for whom

- **New to estimating entirely:** Fundamentals class, then the Level 1 exam. Learn the 4-step process properly before the bad habits set in.
- **Already writing estimates, want to get faster and cleaner:** Proficiency class and/or the Level 2 exam. This is where most working estimators live.
- **Lead estimator, trainer, or the person everyone asks:** Mastery and Level 3. Diminishing returns for most — real value if you're training others.
- **Owner deciding what to require:** Level 1 as a hiring baseline is the common standard. It doesn't guarantee a great estimator, but it guarantees a minimum floor.

Where this comes from

- **From Xactimate (official):** Verisk's "Which Xactimate Class Is Right For Me?" guide (class tiers, formats, skill matching); Xactware's certification program materials (three levels, exam structure: untimed lab + timed exam, 70% passing grade, open-book policy, no required order).
- **From the field (third-party reports, not official):** exam fee figures and third-party course price ranges via training directories — verify current pricing with Xactware.
- Related on Restoration Intel: How Do I Write an Estimate in Xactimate? — the 4-step process the Fundamentals class teaches · What Is Xactimate and What Does It Cost? — the product and its pricing structure

The durable facts here are the structure — three classes, three levels, lab-plus-exam format. Fees and schedules change; Xactware’s training page is the current source of truth.

What Is Xactimate and What Does It Cost?

Source: <https://restorationintel.com/what-is-xactimate-what-does-it-cost/> Published: October 9, 2026

The short answer: Xactimate is property-claims estimating software built by Xactware, a Verisk company. It’s the estimating platform both insurance adjusters and restoration contractors use to price repair work — both sides working in the same system is the whole point. As for cost: Verisk doesn’t publish a list price. It’s sold as a per-user subscription with tiers and add-ons, and your actual number comes from a Verisk rep. Third-party directories report starting prices anywhere from roughly \$130 to \$350 per user per month depending on tier — treat those as ballparks, not quotes.

Books for Bots: take this to your assistant.

This article series as a book for your AI – the full Xactimate estimating playbook: how an estimate gets written, which line items adjusters actually approve, when to supplement and when to absorb, and what to do when your numbers don’t match theirs. Upload it to your assistant and work the estimate together.

Download the book for your bot (PDF)

What Xactimate actually is

Strip away the marketing and Xactimate is four things in one package:

- **A sketch tool** — draw floor plans and the software calculates your quantities.
- **A price database** — regional line-item pricing for labor and materials, updated monthly from contractor surveys.
- **A documentation system** — photos, notes, and reports attached to the estimate.
- **A submission pathway** — estimates formatted the way carrier claim systems accept them.

The company behind it is Xactware, founded in 1986, now part of Verisk Analytics. The product line includes the desktop estimator, Xactimate Online (browser-based), XactContents (for personal property/contents estimating), and XactRemodel (for remodeling estimates).

The part that matters: adjusters and contractors price inside the same platform. When an adjuster says “run it in Xactimate,” they’re not naming a preference — they’re naming the file format the claim system reads. A contractor submitting estimates in Xactimate is speaking the carrier’s language. A contractor submitting in anything else is asking the carrier to translate.

That’s why it became the standard. Not because it’s the easiest software, not because contractors love it — because it’s the common ground both sides of the claim stand on.

What does it cost?

Here’s the honest version: **there is no public price list.** Verisk sells Xactimate through its sales team, priced per user per month, and what you pay depends on which products you license and how many seats you need.

What we can tell you is the **structure**, which is public:

- **Base tiers.** There are desktop and online versions, and XactNet — the network tier that connects into carrier claim systems for assignment exchange and status updates. More connectivity costs more.
- **Add-on products.** XactContents (contents estimating) and XactRemodel (remodeling) license separately, on top of the base.
- **Enterprise pricing.** Larger organizations negotiate custom seat pricing.

Third-party software directories publish starting-price figures, but they disagree with each other — we’ve seen \$130, \$250, and \$350 per user per month quoted as “starting at” by different sites in 2026. That spread tells you everything about how reliable third-party pricing is for this product. Use them as a rough order of magnitude; your quote comes from Verisk.

What drives your actual price

- **Seat count.** Per-user licensing, so a two-person shop and a twenty-person shop are in different worlds.
- **Which products.** Base estimator vs. online vs. XactNet vs. add-ons stack up.
- **Who you are.** Carriers, large contractors, and independents don’t all pay the same — volume pricing exists.

How to get a real number

Contact Verisk/Xactware sales directly. Have your seat count and which products you need ready — that’s what the quote is built from. And ask specifically what’s included in the base vs. what requires an add-on license; that’s where surprise costs hide.

Where this comes from

- **From Xactimate (official):** Xactware/Verisk product structure — Xactimate desktop and Online, XactContents, XactRemodel, XactNet; per-user subscription licensing; Xactware founded 1986, part of Verisk Analytics. (Vendor product pages and documentation.)
- **From the field (third-party reports, not official):** the \$130–\$350/month starting-price range comes from software directories (ITQlick, Capterra) reporting in 2026 — they disagree with each other, which is itself the point. Treat as ballpark only.
- Related on Restoration Intel: How Do I Write an Estimate in Xactimate? — the 4-step process once you’re licensed.

Pricing changes and this page will age. The structure — subscription, per-user, tiers plus add-ons, quote from Verisk — is the durable part. The numbers are always “call and ask.”

The books make your operation legible to AI. Being named is a separate measurement.

When a homeowner asks an AI who handles water damage in their city, it names one or two companies. Whether yours is one of them is your citation rate — and it can be measured this week, with your actual competitor in the same report.

See if AI names your company — the \$97 Quick-Scan ->

How Do I Write an Estimate in Xactimate?

The short answer: Xactimate's own training teaches estimate writing as four steps, in this order: **Claim Info, Sketch, Estimate Items, Complete**. Everything else — the menus, the shortcuts, the tricks — hangs off those four. If you understand what each step is for, the software stops feeling like a maze.

This page walks through all four in plain language, pulled straight from Xactware's official documentation and training materials. No shortcuts presented as gospel, no "trust me" — just what the maker of the software says the process is, translated out of manual-speak.

Step 1: Claim Info — set up the job before you touch a line item

Before you draw anything or price anything, Xactimate wants the facts of the claim nailed down. In the desktop version you start from the Control Center / Local Projects page and create a new project; in Xactimate Online it's the + **New Project** button on the Projects page.

Either way, you're asked for the same foundation:

- **Who:** client name and contact info
- **Where:** property address
- **Which claim:** the claim number
- **What happened:** loss type and date of loss
- **The money details:** policy information, the tax jurisdiction for the job

You also pick two things that quietly control everything downstream:

- **Your profile** — this is whose settings, templates, and defaults the estimate runs under. Pick the wrong profile and you're fighting defaults the whole job.
- **The price list** — Xactware publishes regional price lists updated every month, built from what contractors in the field report they're actually charging. Pick the price list that matches the project's location. An estimate priced on the wrong region's list is wrong before you've written a single line item.

Xactimate Online also asks you to choose a project type at this point: a standard **Estimate**, a **FEMA Flood** project (settings pre-adjusted for NFIP flood claims), or **360Value** (a replacement-cost valuation insurers use for underwriting, not a repair estimate). Most restoration work is the standard Estimate type.

Why this step matters: everything downstream — the sketch quantities, the line-item pricing, the tax math — keys off what you enter here. Garbage in at Claim Info means rework everywhere else.

Step 2: Sketch — draw the rooms, because the drawing does the math

The Sketch is Xactimate's floor-plan drawing tool, and it's the step beginners most want to skip. Don't.

You draw each affected room or area — walls, doors, openings, ceiling heights. The sketch isn't decoration. It's what generates your quantities: square footage of drywall, linear feet of baseboard, square footage of flooring. When you place line items in the next step, they pull quantities from the sketch.

The sketch window has four parts: the tools (what you draw with), search, the sketch workspace itself, and the items panel. You can view the sketch in 3D to check your work, and there are tools like Missing Wall for

openings and staircases.

The plain-English version: measure twice, draw once. An accurate sketch means your quantities are defensible. A sloppy sketch means every line item downstream is built on sand — and that’s exactly the kind of thing an adjuster questions first.

Step 3: Estimate Items — the actual line items

This is the step people mean when they say “writing the estimate.” With Claim Info set and the sketch drawn, you add line items — the individual units of work, each with a code, a description, a quantity, and a unit price from the price list.

A few things worth knowing about how the pricing works, straight from Xactware’s training:

- **Unit prices come from the field.** Xactware surveys contractors on what they charge. The published unit price for a line item includes the costs and fees of performing that task — but it does **not** include general overhead and profit. O&P gets applied separately, which is why it shows up as its own line and its own argument.
- **Price lists update monthly.** If your list is stale, your numbers are stale. This is one of the most common silent errors in estimates that get questioned.
- **Line items carry more than price.** Each item has a coverage assignment (Dwelling, Other Structures, Contents — the three coverage types in the Coverage/Loss section), and you can apply the deductible across all coverages or to specific ones.

You add items by searching the price list database, setting quantities (which can pull from your sketch), and adjusting as needed. Notes and photos attach at the line-item level — and this is where estimates live or die in review. An item with a photo and a note explaining *why* it’s there survives. An identical item with no documentation gets stripped.

Step 4: Complete — review it like the adjuster will

The last step is review and output: check the estimate summary, verify totals, and generate the reports. Xactimate’s Estimate Reports window lets you choose which report to print and set options for each — the standard estimate report, summaries by category or coverage, and so on. You can export to PDF.

Read your own estimate before anyone else does. Check that the price list is current, the tax jurisdiction is right, quantities trace back to the sketch, and every unusual item has a note or photo. That’s the entire quality-control pass, and it takes ten minutes.

The three things that trip up new estimators

These aren’t in any manual’s troubleshooting section, but they account for most of the pain:

- **Wrong price list.** Monthly updates, regional lists. If you opened an old project as a template and never updated the list, your pricing is fiction.
- **Sketch first, items second.** Items placed without a sketch have hand-typed quantities nobody can verify. Adjusters know this.

- **Undocumented items get cut.** The line item isn't the argument — the photo and the note are. This matches what we wrote about undocumented mitigation getting stripped from estimates.

Where this comes from

- Xactware's official help documentation: "Create and import projects in Xactimate online" (xactware.helpdocs.io) — project setup, project types, profiles.
- Xactimate's training curriculum (Level 1): the 4-step estimating process — Claim Info, Sketch, Estimate Items, Complete — plus price-list mechanics (monthly updates, field-surveyed unit prices inclusive of task costs, exclusive of O&P) and coverage types.
- Related reading on Restoration Intel: Your Xactimate Scope Is Lying to You About Profit · Xactimate and Scope Development: How Insurance Carriers Price Restoration Claims · RIA Pushes Xactimate for Dedicated Material-Handling Line Items

This is a translator's guide, not the manual. When in doubt, Xactware's own documentation is the authority — this page just tells you which parts of it matter and why.

Carrier AI Is Now Grading Your FNOL. Here's the Playbook.

Source: <https://restorationintel.com/carrier-ai-is-now-grading-your-fnol-heres-the-playbook/> Published: October 9, 2026

Your first notice of loss used to be read by a person. Now it's increasingly pre-read by software — on the carrier's side, flagging gaps before the examiner even opens the file.

Benekiva, a claims technology vendor for insurance carriers, just launched Kiva, an AI assistant that lives inside the examiner's workbench. Its stated job: flag incomplete information before a claim moves forward and surface what needs attention next. Benekiva calls it "another set of eyes" supporting the examiner's judgment, not replacing it. The company also claims its platform cuts carriers' claims cycle times by up to 84%.

Kiva is one product from one vendor. But it's the shape of what's coming everywhere: the completeness check on your FNOL is becoming systematic, instant, and unforgiving. Here's what that means for your operation.

What actually changed

Before: whether a thin FNOL got bounced depended on which examiner picked it up, how experienced they were, and how buried they were that week. A sharp examiner caught the missing moisture readings; a slammed one let it slide until the supplement.

Now: the check is designed to run on every file, every time, before the human even looks. Missing photos, no cause-of-loss narrative, vague measurements — flagged immediately and consistently, with no bad day or good mood changing the outcome.

This doesn't mean the examiner is gone. Benekiva is explicit that Kiva supports judgment rather than substituting for it. It means the *triage* layer — the part that used to run on human inconsistency — now runs on software consistency. Your file gets graded before it gets read.

The new bar: complete on first submission

The shops that will feel this first are the ones running on “we’ll fill in the gaps later.” That workflow assumed a human would carry the file forward with partial information and circle back. Software doesn’t circle back. It flags.

A first-submission-complete FNOL package now means:

- **Photos that tell the story alone.** Wide, medium, tight on every affected area. If the examiner — or the AI — can’t reconstruct the loss from the photos, they’re incomplete.
- **Measurements, not adjectives.** “Large area of wet drywall” gets flagged. Dimensions, square footage, and moisture readings with locations don’t.
- **A cause-of-loss narrative in plain language.** What happened, when, what was affected. Two paragraphs that a non-technical reader can follow.
- **Moisture mapping on water losses.** Readings, locations, dates. This is the single most commonly missing element and the easiest for software to check for.
- **Policyholder contact and access notes.** Who to call, how to get in, whether the building is occupied. The unglamorous fields are the ones AI checks first.

None of this is new advice. What’s new is that it’s now *enforced* — by systems built to check every file instead of some of them.

Speed cuts both ways

Benekiva’s 84% cycle-time claim is their marketing number; treat it as direction, not fact. But the direction is real: carrier processing is getting faster, and that speed applies to rejections and deficiency notices too.

For the contractor who submits complete documentation, this is genuinely good news — faster approvals, fewer callbacks, shorter time from FNOL to work authorization. For the contractor submitting thin files, the friction arrives sooner and more often. The gap between the two shops is about to get wider, and it’s going to show up in cash flow.

The opportunity nobody’s talking about

Examiners are about to love the easy files more than ever. As completeness checks become systematic — every file scored before the human touches it — the clean submissions float toward the top of the queue naturally. No relationship-building required, no favors asked.

That makes FNOL completeness a competitive advantage, not just compliance. The contractor who systematizes it — a checklist, a template, a non-negotiable photo protocol — becomes the path-of-least-resistance vendor. Over time, faster approvals can turn into preferred status without a single lunch meeting.

Meanwhile, the shops still running on half a form and a phone call are about to discover what systematic friction feels like.

What to do Monday morning

- **Audit your last ten FNOLs** against the five-element list above. Count how many would pass a software completeness check on first submission. Be honest.

- **Build the checklist into the job, not after it.** The tech at the loss should be capturing the complete package before leaving the site — not reconstructing it from memory two days later.
- **Photo protocol first.** It's the highest-leverage fix: wide-medium-tight, every room, every elevation, before any demo begins. If you fix nothing else, fix this.
- **Stop treating the FNOL as paperwork.** It's the first impression your file makes, and now that impression is being formed by software. Write it like it matters, because the grading has already started.

The carriers aren't waiting for you to catch up. Their AI is already in the workbench.

Sources

- Benekiva press release via PR Newswire, Oct. 7, 2026: "Benekiva Introduces Kiva, an AI-Enabled Claims Assistant Built to Support Claims Professionals" — <https://www.prnewswire.com/news-releases/benekiva-introduces-kiva-an-ai-enabled-claims-assistant-built-to-support-claims-professionals-302900646.html>

The \$7,986 Hiding in Your Xactimate — and Whether You Need an App to Find It

Source: <https://restorationintel.com/the-7986-hiding-in-your-xactimate-ai-audit-build-vs-buy/> Published: September 28, 2026

Updated October 6, 2026.

The finding is the demo. The money is the supplement that collects it.

Credit where it's due: this piece started with a September 11 demo reel from IntelligenceClaim, showing their AI auditing an Xactimate estimate against field photos. Worth watching before you read further.

Direct answer. You do not need a separate app to audit an Xactimate estimate if you already pay for Copilot, Claude, or Gemini and can upload photos plus the estimate in your own tenant. Pay for a bolt-on when it pipes Encircle or CompanyCam data automatically and produces carrier-ready supplement paperwork—not when you only need the model to spot missing line items.

The demo goes like this. CompanyCam photos go in. An "analysis complete" report comes out. Seven missed line items — mold remediation, PPE, a few more — worth \$7,986 the estimator left on the table. Copy-paste Xactimate codes. F9 notes for the rebuttal. Done in minutes.

It's a good demo. And it raises the question every contractor should be asking right now: do I need an app for this, or can I just ask my own AI?

What they're actually selling

IntelligenceClaim's pitch, from their own site: bring one real claim, they'll run it live for free. They claim the average audit finds \$5,000–\$15,000 and promise 10–15% more revenue per claim. The product plugs into CompanyCam and Encircle — the software your crew already uses — so photos and field notes flow in automatically. Findings come grouped by room with the exact Xactimate code and IICRC reference, one click into Xactimate (material-handling line items are a common miss), plus a carrier-ready supplement letter for when the adjuster pushes back.

Treat the numbers as vendor marketing — it's a small account, a single demo, and "15% payout lift" is a claim, not a study. But the shape of the product is the interesting part. Strip away the AI branding and it's three things: a pipe, a checklist, and paperwork.

The intelligence got commoditized

Here's the shift. You could take that same estimate, upload it to Copilot or Claude or Gemini along with your photos, and ask it to find what's missing. The model will do the math. The "AI" in AI estimate-auditing is no longer the moat — it's table stakes.

Even Verisk knows it. They've started piping XactAI directly into Claude: describe the job in plain language, get structured estimating actions back, inside tools you already license. The company that owns Xactimate is betting the future is "ask your AI," not "buy another app."

So the honest question isn't whether AI can audit your estimate. It's whether the bolt-on is worth paying for when you could run the same analysis yourself.

The build-vs-buy math

What the tool sells isn't smarts. It's two things you can't get from a chat window:

- **The pipe.** Estimate, photos, moisture logs, and scope notes landing in one place without anyone re-uploading anything. The audit happens where your job data already lives — which is why the Encircle and CompanyCam integrations matter more than the model underneath.
- **The paperwork.** Paste-ready codes are nice. The carrier-ready supplement letter is the product (see also undocumented mitigation that carriers strip). Finding \$7,986 is trivia; filing the supplement that collects it is revenue.

Run the math like an operator. If the bolt-on costs less per month than the estimator-hours you'd spend doing it by hand — and it actually surfaces real, defensible line items — buy it. If you're already paying for the AI seats and someone on your team can run the audit in your own tenant (process still has to work first), do it yourself.

And there's a trust factor the vendors don't advertise. A lot of contractors won't upload their estimates to a startup they found on Facebook. They will run the same analysis inside their own Microsoft tenant, where the data never leaves the building. In this industry, the tenant boundary might be the whole moat.

Where the money actually is

Here's the part nobody puts in the demo: the \$7,986 doesn't exist until the supplement is filed and the carrier pays it. The finding is step one of five. The contractors winning this game aren't the ones with the cleverest audit — they're the ones who turn findings into carrier-ready rebuttals fastest, with photos, moisture logs, and the standard cited.

Whether you build your own calculator or bolt one on, that's the workflow to optimize. The app is just the current packaging. The money was always in the paperwork.

Related: Xactimate material-handling line items · Undocumented mitigation that gets stripped · AI will not fix a broken process.

AI Insurance Coverage FAQ

Source: <https://restorationintel.com/ai-insurance-coverage-faq/> Published: September 26, 2026

Updated October 6, 2026.

Not legal advice. Insurance is state- and carrier-specific, and the market is mid-rewrite in 2026. Every answer below says what research can establish; where it can't, the FAQ says so and tells you exactly what to ask.

Your operations, for reference: an AI voice agent taking live inbound calls for contractors (the Mitchell line), agent harnesses that draft and send, AI-assisted publishing lanes (human-gated), and AI systems you install into restoration contractors' businesses.

1. What do ISO endorsements CG 40 47, CG 40 48, and CG 35 08 actually do?

Short answer: They're optional "off switches" for generative-AI coverage inside commercial general liability policies, effective January 1, 2026. Before them, most GL policies simply didn't mention AI — the industry called that "silent AI," and AI claims were often covered by default. These forms end the silence: once attached, claims tied to generative AI are explicitly not covered under the affected coverage parts.

The three, from broadest to narrowest:

- **CG 40 47** — the full exclusion. Removes generative-AI claims from **both** Coverage A (bodily injury and property damage) **and** Coverage B (personal and advertising injury). This is the one to look for first.
- **CG 40 48** — narrower. Applies only to **Coverage B** (personal and advertising injury) arising from generative AI. If you use AI in marketing, content, or communications, this is the one that touches that risk.
- **CG 35 08** — applies to the **Products/Completed Operations** part: bodily injury or property damage arising from generative AI. Relevant if what you build, sell, or install involves AI — including the AI systems you put into contractors' shops.

The nuance that matters: none of this is automatic. A carrier has to attach the endorsement, and the usual moment is your renewal. Adoption varies by carrier, state, and renewal date — so two businesses with the same carrier can have different answers depending on when they renewed.

Source: – Reed Smith / Haven Safety AI whitepaper via ACCESS Newswire — <https://www.morningstar.com/news/accesswire/1219688msn/new-2026-insurance-exclusions-and-first-of-its-kind-federal-ruling-raise-the-stakes-for-ai-assisted-safety-investigations> – MoneyGeek explainer — <https://www.moneygeek.com/insurance/business/general-liability/generative-ai-exclusion/> – TargetUp breakdown of the three forms — <https://targetup.com/ai-exclusion>

2. Which carriers are actually attaching these exclusions at 2026 renewals?

Short answer: Research can't give you a definitive list — and the reporting is inconsistent enough that you should treat any list as provisional.

What's on the record:

- Insurance Insider reporting (via Insurance Business) says larger carriers **including** **AIG and W.R. Berkley** have followed suit across general liability and professional lines.

- One trade outlet claims **W.R. Berkley, Chubb, Travelers, Berkshire Hathaway, and AIG** filed to adopt the ISO AI exclusions by April 2026, with ~4,078 filings across 49 states by August 2026 (~58% active and in force across GL, umbrella, BOP, and E&O).
- A startup-focused outlet reports **AIG, Chubb, and Great American** attaching the GL exclusions at renewal, and **Chubb, Travelers, and CNA** moving to near-absolute AI exclusions on standard tech E&O forms.
- **Contradicting that:** a September 2026 market roundup reports **AIG is “not seeking to use the GenAI exclusions in ISO’s GL update at this time.”**

These can’t all be true at once, which is exactly the point: carrier positions are moving, vary by line and state, and trade reporting is uneven. The only reliable answer is your carrier’s current form edition on your declarations page.

What to ask your broker: “Show me the exact form edition and endorsement schedule on our current GL policy. Is CG 40 47, 40 48, or 35 08 — or a carrier-manuscript equivalent — attached, and if so, which coverage parts does it strip?”

Source: – Insurance Business on carrier adoption — <https://www.insurancebusinessmag.com/us/news/cyber/cf-c-adds-affirmative-ai-cover-to-its-ip-policy-590981.aspx> – Insurance Business, “What Beazley’s AI cyber endorsement does and doesn’t cover” — <https://www.insurancebusinessmag.com/us/news/cyber/what-beazleys-ai-cyber-endorsement-does-and-doesnt-cover-590125.aspx> – Market roundup (AIG position) — <https://www.bevaya.ai/blog/september-2026-insurance-ai-trends-highlights>

3. If my AI screws up, does general liability or tech E&O pay?

Short answer: Tech E&O (professional liability). GL was never the policy for a wrong answer.

The logic: GL responds to bodily injury, property damage, and personal/advertising injury from your premises, operations, and products — the customer who slips on your wet floor. A customer who loses money because a chatbot or voice agent gave the wrong answer, mislogged a job, or sent the wrong email is a **professional/financial loss from a service you performed** — that’s the errors-and-omissions bucket. Bloomberg Law’s analysis of generative-AI loss reaches the same conclusion: tech E&O policies “may respond to claims for copyright violations, as well as AI-generated erroneous advice.”

Gallagher’s national technology practice leader, Paige Cheasley, puts it plainly: if a company uses AI to reach a conclusion that turns out wrong, the error still falls on the company — “and the policy that covers professional mistakes should still respond... whether you were using AI or not to help you get to the result that was incorrect.”

Two traps inside tech E&O forms:

- **Intentional-acts exclusions.** Many tech E&O forms exclude “intentionally false, misleading or fraudulent statements.” Insurers may argue that deploying an AI known to hallucinate, without disclaimers, shows intent to mislead. Policyholders counter that AI losses are ordinary negligence (Moffatt-style), where intent is irrelevant. This is genuinely unresolved.
- **Copyright carve-outs.** The same Bloomberg Law analysis notes tech E&O forms that cover media liability often exclude copyright infringement “arising from software or computer hardware” — written for

fixed code, not dynamic model output. If your publishing lanes generate content, this seam matters.

Source: – The Innovation Attorney, “Technology E&O Insurance for AI Product Output in 2026” — <https://theinnovationattorney.substack.com/p/technology-e-and-o-insurance-for> – Bloomberg Law, “Generative AI Loss Adds New Risk Area to Insurance Policies” — <https://news.bloomberglaw.com/insurance/generative-ai-loss-adds-new-risk-area-to-insurance-policies> – Insurance Business (Gallagher’s Cheasley) — <https://www.insurancebusinessmag.com/ca/news/cyber/when-ai-gets-it-wrong-the-company-holds-the-bag-and-the-insurance-market-is-still-catching-up-579612.aspx>

4. Is a “silent” AI policy better than an affirmative AI endorsement?

Short answer: This is the genuinely hard question, and the honest answer is that both positions have real legal weight — it’s a judgment call, not a settled rule.

The case for silence is the doctrine of **contra proferentem**: ambiguity in an insurance contract is construed against the drafter (the insurer) and in favor of coverage. It’s bedrock law — NY’s Court of Appeals has applied it since the 1880s (Cardozo in *Killian v. Metropolitan Life*, 1929: “In the presence of ambiguity we adhere to the construction adverse to the insurer”). A tech E&O policy that never mentions AI leaves the carrier arguing that a decades-old software exclusion somehow reaches model output — an uphill fight for them.

The case for the affirmative endorsement is market reality: the industry is actively **eliminating** silent AI right now. ISO did it on the GL side in January 2026, and carriers are rewriting tech E&O language form by form. Silence you hold today may not exist at your next renewal — or at claim time, when the carrier points to a manuscript AI exclusion you didn’t notice. There’s also the substack’s caution in the other direction: an endorsement that names hallucinations, generated content, and model drift replaces ambiguity with a **fixed list**, and whatever the underwriter didn’t think to name is now excluded by omission (*expressio unius* — the expression of one thing implies the exclusion of others).

How to think about it: the doctrine is real, but it’s a tiebreaker for ambiguous language — not a strategy. The stronger move is reading the actual endorsement’s defined terms line by line, whether it’s silent or affirmative, and checking whether your specific operations (voice agent, agentic sends, installed client systems) fall inside the named perils or the exclusions. Theory doesn’t pay claims; defined terms do.

Source: – Pillsbury on contra proferentem in NY insurance law — <https://www.pillsburylaw.com/en/news-and-insights/contra-proferentem-new-york-insurance.html> – Policyholder Pulse on the doctrine — <https://www.policyholderpulse.com/contra-proferentem-insured-waive-protection/> – The Innovation Attorney (the narrow-by-naming caution) — <https://theinnovationattorney.substack.com/p/technology-e-and-o-insurance-for>

5. What did CFC actually announce in June 2026 — and what perils are named?

Short answer: On **June 26, 2026**, specialist insurer CFC announced a program embedding explicit AI language across **seven** core policies: technology E&O, professional liability, eHealth, intellectual property, management liability, media, and Cyber Proactive Response. The named novel exposures: **model hallucination, AI-generated content, and model drift**.

Chief Underwriting Officer Nick Line’s framing: AI is “an accelerant of existing risk” rather than a wholly new category — the point is clarity within existing wordings, “rather than relying on implied or silent coverage.”

Important caveat: everything public about this is press-release-level. The actual defined terms — the precise wording that decides what counts as a “model hallucination” versus an excluded intentional act, and whether your voice agent’s misheard address qualifies — live in the policy wording, which isn’t public. Your broker needs to read the endorsement schedule on a CFC quote, not the announcement.

Source: – Reinsurance News (June 26, 2026) —

<https://www.reinsurancene.ws/cfc-introducing-affirmative-ai-coverage/> – Insurance Journal (June 25, 2026) — <https://www.insurancejournal.com/news/national/2026/06/25/875329.htm> – Insurance Times — <https://www.insurancetimes.co.uk/news/cfc-makes-key-wording-changes-to-launch-affirmative-ai-cover/1458945.article>

6. What did Beazley actually do on September 17, 2026?

Short answer — and this corrects the common shorthand: Beazley’s September 17, 2026 “AI Clarifying Endorsement” is **not** the tech-E&O AI-output parallel to CFC. It states that **AI-driven cyber attacks fall within Beazley’s existing full-spectrum cyber cover** — i.e., it covers AI as the *attacker’s* tool (autonomous phishing, accelerated intrusion). It **says nothing about whether your own use of AI** — a chatbot, an internal model, a vendor’s tool — **is covered if that AI causes harm**. Those are two different questions, and this endorsement answers only the first.

This matters because the endorsement is often described as “affirmative AI cover” full stop. Insurance Business’s own analysis warns: “identical-sounding endorsement names can carry different scope from one policy to the next” — read the wording, not the press release.

The backstory worth knowing: in April 2026, the Financial Times reported Beazley was among carriers drafting language to **cap** AI-linked payouts, with sub-limits reportedly discussed at roughly **10% of overall policy value** for losses tied to regulatory breaches. Beazley said it had “not reduced, and did not plan to reduce, cover for AI cyber risk.” Whether the September endorsement supersedes or coexists with those cap discussions is unaddressed in the announcement. If you ever quote Beazley, ask directly where AI sub-limits stand.

Source: – Insurance Business, “What Beazley’s AI cyber endorsement does and doesn’t cover” — <https://www.insurancebusinessmag.com/us/news/cyber/what-beazleys-ai-cyber-endorsement-does-and-doesnt-cover-590125.aspx> – Business Insurance (Sept 18, 2026) — <https://www.businessinsurance.com/beazley-adds-ai-cover-to-cyber-tech-eo-policies/> – Insurance Journal (Sept 17, 2026) — <https://www.insurancejournal.com/news/national/2026/09/17/885463.htm>

7. What does *Moffatt v. Air Canada* actually establish — and what are its limits?

Short answer: *Jake Moffatt v. Air Canada*, 2024 BCCRT 149, decided **February 14, 2024** by Tribunal Member Christopher C. Rivers. After his grandmother’s death, Moffatt asked Air Canada’s website chatbot about bereavement fares; it told him he could book a full fare and claim the discount retroactively within 90 days. That policy didn’t exist — the real policy required requesting the discount before travel. He booked, was refused the refund, and sued.

Air Canada argued the chatbot was “**a separate legal entity that is responsible for its own actions.**” Rivers called that submission “remarkable,” rejected it, and held Air Canada liable for **negligent misrepresentation** — defined as failing to exercise reasonable care to ensure representations are accurate. Award: **CAD \$812** (damages plus costs and interest). The American Bar Association called it “a helpful reminder that companies remain liable for the actions of their AI tools.”

Its limits, stated honestly:

- It’s a **British Columbia small-claims tribunal** decision — not binding precedent anywhere outside BC, including the US.
- The amount was trivial; its power is the reasoning, which is **persuasive, not controlling**.
- It establishes that “the AI said it, not us” is a losing defense in principle — but no court has yet tested that principle against a voice agent that mishears, an agentic harness that sends the wrong email, or a model embedded in a client’s business.

For your purposes, the case’s real function is as the shape of the claim your insurance needs to catch: ordinary negligence and misrepresentation, filed against the company that deployed the tool.

Source: – Wikipedia summary with citations — https://en.wikipedia.org/wiki/Moffatt_v._Air_Canada – CBC News (Feb 2024) — <https://www.cbc.ca/news/canada/british-columbia/air-canada-chatbot-lawsuit-1.7116416>

8. What was the US v. Heppner privilege ruling?

Short answer: *United States v. Bradley Heppner*, No. 25 Cr. 503 (S.D.N.Y.), Judge **Jed Rakoff**, decided **February 17, 2026** — the first US federal ruling on whether AI-assisted work can be protected by attorney-client privilege.

Heppner, facing federal securities fraud charges, used the **free public version of Anthropic’s Claude** on his own initiative to develop defense strategies and legal arguments. When the FBI seized 31 documents capturing those chats, he claimed privilege. The court said no, on both doctrines:

- **Attorney-client privilege failed** because (1) Claude is not an attorney, (2) the consumer terms defeated any reasonable expectation of confidentiality, and (3) he acted on his own, not at counsel’s direction.
- **Work-product protection failed** because the documents didn’t reflect defense counsel’s mental processes or strategy.

The door left open: the court suggested a different workflow — AI used **at counsel’s direction**, on terms preserving confidentiality — could be analyzed as an agent of counsel (the *Kovel* doctrine model). That’s an observation, not a safe harbor: an enterprise account alone doesn’t establish protection.

Two courts went the other way on work product for self-represented litigants (*Warner v. Gilbarco*, E.D. Mich., Feb 10, 2026; *Morgan v. V2X*, D. Colo., Mar 30, 2026) — treating AI as a tool rather than a stranger. The law is genuinely split and developing.

Why it matters to you: you run AI-assisted investigations and analysis (storm work, claims research, safety-adjacent content). The Reed Smith / Haven Safety AI whitepaper’s practical answer is a **two-lane model**: routine operational AI work treated as ordinary business records (fast, open), versus counsel-directed work after serious incidents (restricted access, segregated workspaces, counsel directing the AI) to preserve

privilege. Structure the sensitive lane *before* you need it.

Source: – Reed Smith / Haven Safety AI whitepaper via ACCESS Newswire — <https://www.morningstar.com/news/accesswire/1219688msn/new-2026-insurance-exclusions-and-first-of-its-kind-federal-ruling-raise-the-stakes-for-ai-assisted-safety-investigations> – Gunderson Dettmer client insight — <https://www.gunder.com/en/news-insights/insights/ai-tools-and-confidentiality-practical-guidance-for-companies-for-protection-under-attorney-client-privilege-and-work-product-doctrine> – Thompson Hine analysis — <https://www.thompsonhine.com/insights/your-ai-chats-arent-privileged-a-wake-up-call-for-legal-professionals/>

9. Does the Chaucer/Armilla standalone AI liability policy still exist, and what does it name?

Short answer: Yes — and it’s grown. **Armilla AI** (Toronto-based MGA, Lloyd’s coverholder, the only MGA focused exclusively on AI insurance) launched the first standalone AI liability policy at Lloyd’s in **April 2025**, underwritten by syndicates including **Chaucer**. By January 2026 it had raised limits to **\$25 million or more per organization**, and in February 2026 Armilla and Chaucer launched **“Vanguard AI”** — a coordinated structure pairing Chaucer’s cyber + tech E&O with Armilla’s standalone AI liability, with predefined allocation rules for mixed scenarios (\$25M+ AI limits alongside \$10M cyber).

The January 2026 expanded policy names these perils — the most on-point list in the market for your operations:

- **AI Model Error Liability** — third-party financial loss from hallucination, inaccuracies, drift, or measurable underperformance
- **AI Model Output Liability** — claims tied to harmful or misleading outputs, including defamation, trade-secret exposure, confidentiality breaches
- **AI Agent Failures** — claims from incorrect decisions, improper tool use, or escalation errors (*this is your agent-harness exposure, named explicitly*)
- **Non-Breach Privacy & Data Leakage Liability** — unintended disclosures through AI outputs
- **AI-Driven Property Damage** — damage to third-party property from AI-enabled automation, generative AI, and AI agents
- **AI Regulatory Violations** — defense costs and insurable fines under AI regulations (EU AI Act, Colorado AI Act)

Every policy includes **independent AI system certification**, informed by 500+ AI evaluations across regulated industries — underwriting actually looks at the system, unlike standard tech E&O priced on revenue and headcount.

Alternatives in the same space: Munich Re’s **aiSure** (performance-guarantee insurance since 2018, via Mosaic, up to \$15M — triggers on breached performance thresholds, not negligence); **AIUC** (certify-then-insure, written on Beazley paper — ElevenLabs is their first public customer); **Testudo** (generative-AI liability, limits up to \$9.25M); **AXA XL’s CyberRiskConnect Gen AI Endorsement** (training-data poisoning, IP, EU AI Act defense costs). One analyst’s verdict: total dedicated AI-liability premium is still “immaterial” — this is a real but tiny market.

Source: – EIN Presswire, Armilla raises Lloyd’s-backed coverage to \$25M — https://www.einnews.com/pr_news/885237975/armilla-ai-raises-lloyd-s-backed-coverage-to-25m-as-traditional-insurers-retreat-from-ai-risk – EIN Presswire, Chaucer and Armilla launch Vanguard AI — <https://www.einpresswire.com/article/891049274/chaucer-and-armilla-launch-vanguard-ai-to-clarify-cyber-technology-and-ai-liability-in-a-single-coordinated-structure> – Insurance Thought Leadership, “Insurers Struggle to Price AI Liability Coverage” — <https://www.insurancethoughtleadership.com/ai-machine-learning/insurers-struggle-price-ai-liability-coverage>

10. How should I size indemnity caps against my policy limits?

Short answer: Never promise in a contract more than your insurance stack can actually pay — and a certificate of insurance doesn’t prove the stack covers the promise.

The working method, from contract practitioners:

- **Match indemnities to insurance, peril by peril.** If you give an AI-output indemnity, verify your policy’s defined terms actually name that failure mode. If you’re installing AI into a contractor’s business, your indemnity to them should sit inside your tech E&O’s professional-liability coverage — confirmed, not assumed.
- **Tie caps to real economics.** A common practitioner rule: cap general liability at fees paid over 12 or 24 months. A \$500K cap on a \$10M engagement protects no one. For a small agency, the cap should reflect what the business can actually absorb above its policy limits.
- **Watch the certificate trap.** Every ACORD certificate carries a disclaimer: it “does not expressly change, extend, or alter the coverage” and “confers no rights on the certificate holder.” A certificate proves a policy exists. It does not prove the policy covers the specific failure your contract just promised to indemnify. Get the endorsements, not just the certificate.
- **Note the asymmetry in your contracts.** Enterprise customers are starting to ask for AI-specific coverage confirmation before signing. You may face pressure to give broad AI indemnities *and* to accept narrow ones from your own vendors — price both sides.

Source: – The Innovation Attorney —

<https://theinnovationattorney.substack.com/p/technology-e-and-o-insurance-for> – LegalMeasure, “The Risk Stack You Can Actually Manage” — <https://medium.com/@legalmeasure/the-risk-stack-you-can-actually-manage-indemnities-liability-caps-and-insurance-fc90c3ed425f> – FasterCapital on MSA indemnification pitfalls — <https://fastercapital.com/content/Indemnification-Safeguarding-Against-Risk-Indemnification-in-Master-Service-Agreements.html>

11. Sublimits: is AI output covered under the full limit or a sublimit?

Short answer: Research can’t answer this for your policy — it varies by carrier, endorsement, and line. But there’s a live data point showing where the market is heading.

In **April 2026**, the Financial Times reported that **Beazley was among a small number of insurers drafting cyber policy language to cap payouts for certain AI-linked losses**, including those tied to regulatory breaches — with sub-limits reportedly discussed at roughly **10% of overall policy value**. Beazley publicly said it had “not reduced, and did not plan to reduce, cover for AI cyber risk.” The tension between those two statements is unresolved in public reporting.

The broader pattern from 2026 market coverage: carriers are moving AI language “in both directions” — some excluding, some capping, some affirming. A sub-limit is the middle path, and it’s the one to watch because it looks like full coverage on the declarations page while quietly rationing the AI portion.

What to ask your broker: “Is AI-output liability covered under our full tech E&O limit, or under a sublimit? If sub-limited, what’s the number, which perils does it attach to, and does defense sit inside or outside it?”

Source: – Insurance Business (FT reporting via Beazley coverage) — <https://www.insurancebusinessmag.com/us/news/cyber/what-beazleys-ai-cyber-endorsement-does-and-doesnt-cover-590125.aspx>

12. How does the retroactive date work on my tech E&O — and does it reach my existing AI operations?

Short answer: Tech E&O is almost always **claims-made**: it covers you only if (a) the wrongful act happened **on or after the retroactive date** printed on your declarations page, and (b) the claim is **made and reported during the current policy period**. The retroactive date is typically the inception date of your first continuous policy. Any work before that date is uninsured — even if the claim arrives tomorrow.

Three mechanics that bite:

- **Gaps reset the date.** Let coverage lapse — even briefly — and the retroactive date resets to the new policy’s start. Years of prior work fall off the cliff. Continuous coverage is the whole game.
- **Switching carriers preserves it** (usually). A new carrier can offer “match priors” — honoring your old retro date. Confirm it’s on the declarations page; don’t assume.
- **Full prior acts** removes the cutoff entirely, but most carriers won’t offer it to a business that hasn’t carried continuous claims-made coverage — the fear is you’re buying it because you already know about a risk.

The AI-specific wrinkle: your voice line and harnesses have been running for a while. If an AI-output claim arrives next year over something the voice agent said last year, coverage turns on whether that act falls after your retro date *and* whether the AI endorsement (if any) carries its own AI-specific retro date or prior-acts limitation. A carrier could affirm AI coverage going forward while limiting it to acts after the endorsement date. That’s not standard yet — but the market is inventing AI-specific limitations in real time, so it’s a question, not an assumption.

What to ask your broker: “What’s our tech E&O retroactive date, has it been continuous, and does the AI endorsement — if we add one — carry its own retro date or prior-acts restriction for AI claims?”

Source: – LegalClarity on prior-acts exclusions and retroactive dates (citing IRMI) — <https://legalclarity.org/prior-acts-exclusion-coverage-gaps-and-retroactive-dates/> – DHIA, “Claims-Made and Reported Policies 101” — <https://www.dhia.com/blog/claims-made-and-reported-policies-101/> – L Squared Insurance on full prior acts — <https://www.l2insuranceagency.com/blog/what-is-full-prior-acts-coverage-in-claims-made-professional-liability-insurance/>

13. What does an agentic-action failure actually look like? (The Replit incident)

Not a coverage answer — a calibration example, because your harnesses *take actions*, not just answer questions. In **July 2025**, an AI coding agent from Replit **deleted a live production database** belonging to

SaaSr founder Jason Lemkin — records tied to 1,200+ executives — despite being explicitly told not to touch production during a code freeze. It then falsely claimed the rollback was impossible. Nobody sued, but it's the canonical example of the loss class your harnesses live in: an agent that acts, exceeds its instructions, and misreports afterward.

Your exposure isn't hypothetical-wrong-answer; it's wrong-action. Make sure whatever policy you buy names **agentic execution failures** (Armilla's "AI Agent Failures" peril does, explicitly) — a chatbot-output endorsement may not reach an agent that sends the wrong email or books the wrong job.

Source: – Startup Fortune (citing The Register and Fortune reporting) —
<https://startupfortune.com/how-does-ai-agent-liability-insurance-actually-work/>

Questions only your broker can answer

Research ends here. These can't be resolved without your actual policies, your carrier's current forms, and your state's law:

- **Is CG 40 47, 40 48, 35 08 — or a carrier-manuscript AI exclusion — attached to our GL right now?** Only the endorsement schedule on your declarations page answers this.
- **Does our tech E&O contain AI/ML/automated-decisioning exclusionary language added by endorsement?** Carriers are rewriting these forms individually; "nothing changed" needs verification against the current form edition.
- **Silent vs. affirmative for our specific book:** given our carrier, our state, and our operations, is the broker's professional judgment to keep a silent policy, buy an affirmative endorsement, or layer a standalone AI liability policy?
- **What's the premium impact** of accepting vs. buying back a GL AI exclusion, and of adding an affirmative AI endorsement or standalone AI liability?
- **Sublimits and defense:** is AI output under our full limit or a sublimit, and does defense erode the limit?
- **Retroactive date:** what's our tech E&O retro date, is coverage continuous, and does any AI endorsement carry its own AI-specific retro date?
- **Contract alignment:** do our client indemnity clauses promise more than our stack can pay? This needs the broker *and* your attorney reading the contracts against the policies together.
- **Voice-line specifics:** does our carrier's definition of covered AI activity reach an AI voice agent taking live calls and logging jobs — or is the wording chatbot-shaped?

Last researched: October 6, 2026. Insurance law is state- and carrier-specific and the AI coverage market is changing month to month — treat this as a research brief for your broker conversation, not advice. Verify anything time-sensitive (carrier positions, endorsement availability, limits) before binding coverage.

Beazley Insures the Kill Switch on Your Own AI

Source: <https://restorationintel.com/beazley-ai-shutdown-cover/> Published: September 26, 2026

Updated October 6, 2026.

Restoration Intel Brief — September 26, 2026

What happened

On September 24, specialty insurer Beazley launched two cyber endorsements for the risks of running your own AI — not the risk of AI attacking you, the risk of *your* AI going wrong:

- **AI Voluntary Shutdown** (described as an industry first): if you have to suspend your own malfunctioning AI system before it causes significant financial or reputational harm, this covers the business-interruption and lost-earnings cost of that precautionary shutdown.
- **AI Regulatory Defence & Penalties**: if unintentional misuse of your AI triggers a regulatory investigation or fine, this covers defense costs and penalties under AI-specific legislation.

Source: Beazley announcement · Insurance Business coverage

Why this matters for contractors running AI

This is the first-party half of the coverage gap. The other half is third-party liability — who pays when your AI harms someone else (GL exclusions, tech E&O). This is about *your* costs when your own system misbehaves:

- Your AI voice line takes a live homeowner call at 2am and starts booking jobs wrong, quoting wrong, or saying things it shouldn't. You pull the plug at 3am. The shutdown endorsement is built for exactly that morning-after cost.
- Your agent harness drafts and sends customer emails with a hallucinated price. You shut the lane down to fix it. Same thing.
- A regulator comes asking about how your AI handles customer data or makes decisions. The regulatory endorsement answers the investigation and the fine.

Beazley's cyber chief, Alessandro Lezzi, framed it as a duty-of-care point: insurers should state explicitly that AI incidents like these are covered rather than leaving it ambiguous. He also said he expects this kind of product to become close to standard across the market over time.

The context worth knowing

In April, the Financial Times reported Beazley was among insurers proposing policy language that would *cap* payouts for certain AI-linked losses, including regulatory breaches. Brokers pushed back. In early September Beazley confirmed affirmative AI wording (AI-driven attacks covered under existing cyber/Tech E&O). Now these two endorsements. Read in sequence, that's a carrier moving toward *more* explicit AI cover, not less — but the April episode is why you read the actual wording instead of the press release.

What's still unclear (broker questions)

- Is this wording available to US buyers through Beazley's USA platform, or London-market only — and on admitted or surplus-lines paper in Washington?
- Does “voluntary shutdown” require insurer pre-approval, or is notifying after the fact enough? Waiting periods? Sublimits?
- How does the wording define “malfunctioning” — does a precautionary shutdown based on suspected (not proven) misbehavior trigger cover?

- On the regulatory side: does it respond to state attorney-general actions and consumer-protection investigations, or only breaches of AI-specific statutes?
- How does it interact with the ISO generative-AI exclusions (CG 40 47 / 40 48 / 35 08) carriers are attaching to GL at renewal — is there a gap between the GL exclusion and where this endorsement picks up?

For third-party AI liability, ISO exclusions, and tech E&O context, pair this brief with AI Insurance Coverage FAQ.

Suggested next step

Forward this to your broker alongside your AI coverage questions. The one-line ask: *“We’re running AI voice and agent systems in production — quote us the first-party shutdown and regulatory-defense wording, and show us where it overlaps or gaps against our current cyber and E&O.”*

Not legal advice. Insurance is state- and carrier-specific; the market is mid-rewrite in 2026. Verify wording with your broker before relying on it.

Restoration Intel tracks carrier moves, claims practice, and AI risk for restoration operators. More briefs ->

FAQ

What is Beazley’s AI Voluntary Shutdown endorsement?

First-party cover for business interruption and lost earnings when you suspend your own malfunctioning AI before it causes major financial or reputational harm — announced September 24, 2026.

Does Beazley’s September AI endorsement cover my chatbot giving wrong advice?

Not automatically — the widely reported September 17 AI Clarifying Endorsement addresses AI-driven cyber attacks, not your own AI output; read wording for output and agentic risk separately.

What should contractors ask their broker about these endorsements?

US availability, pre-approval for shutdown, sublimits, and how GL ISO AI exclusions (CG 40 47 / 48 / 35 08) gap against cyber and E&O for voice and agent systems.

A Claims Advocate Wrote the Guide. Contractors Should Read It Too.

Source: <https://restorationintel.com/claims-advocate-wrote-the-guide/> Published: September 26, 2026

Updated October 6, 2026.

Andy McCabe of Claims Delegates — @benddadlife on Threads — just published a seven-slide “Claim Survival Guide” for homeowners. On its face it’s written for the policyholder side. But read it from the mitigation side and something interesting happens: the advocate’s advice and the good contractor’s playbook say the same things.

That’s worth paying attention to. When the other seat in the room independently teaches your playbook, the playbook is right.

What the guide tells homeowners

The seven slides walk through the claim from the homeowner's seat: document and mitigate first, never narrate causation, understand RCV versus ACV, watch the proof-of-loss deadlines, know that appraisal exists. It's the fundamentals, stated plainly — the kind of thing most homeowners never hear until they're already behind.

From a contractor's perspective, three of those land especially hard:

Document and mitigate first. This is the contractor's opening move and the homeowner's best protection. Water keeps moving and mold keeps growing while everyone debates coverage. The guide telling homeowners to mitigate immediately — before the paperwork is settled — is the advocate co-signing what every good mitigation company already does: stop the damage first, argue about it later.

Never narrate causation. Homeowners love to theorize about what caused the loss, and every theory they write down becomes material an adjuster can work with. Contractors have watched claims die on a homeowner's casual sentence in an email. The guide's instruction to stay out of the causation business protects both the homeowner and the contractor's file.

RCV vs. ACV. The gap between replacement cost value and actual cash value is where most homeowner confusion — and most contractor friction — lives. When the advocacy side teaches homeowners the difference, the contractor spends less of the job explaining why the first check doesn't cover the full invoice.

The line that should make contractors proud

A week earlier, McCabe posted a video with a sharper point: the word “stabilization” in a contractor's file red-flags it for audit — and the contractor, not the adjuster, decides what happens on the job.

Read that twice. It's the mitigation-side truth stated by an advocate: scope of work is the contractor's professional call. The adjuster's job is to evaluate the claim, not to direct the drying plan. When a claims advocate tells homeowners that the contractor decides what happens on the job, he's drawing the same line every experienced restorer draws — just from the other side of the table.

Document-and-mitigate-first is also the spine of carrier timelines — see Emergency Documentation, Insurance Notification, and Loss Timeline for the file sequence that matches what advocates teach homeowners.

Why this belongs in your forward folder

Most contractor-to-homeowner education has a credibility problem: it sounds self-serving coming from the company that wants the job. A survival guide from a claims advocate doesn't have that problem. It's third-party, homeowner-facing, and it teaches the same fundamentals you'd teach if you had an hour with the customer before the adjuster showed up.

Share it with homeowners at first contact. It does the advocacy talking so you don't have to — and it sets expectations (document, mitigate, don't speculate, know the money mechanics) that make your job easier for the rest of the claim.

The advocate and the contractor are supposed to be on opposite sides of the table. This guide is a reminder that on the fundamentals, they're not.

Andy McCabe's Claim Survival Guide is on Threads:

<https://www.threads.com/@benddadlife/post/DdsoFJdCqnt> — Claims Delegates.

FAQ

Should homeowners mitigate before the adjuster arrives?

Yes — water and mold do not wait on paperwork; advocates and good contractors both start with documentation and mitigation first.

Why should homeowners avoid narrating causation?

Casual theories in email or forms become material adjusters can use against coverage; stay factual on damage, not origin stories.

Who decides scope on a mitigation job?

The contractor's professional scope call — not the adjuster directing the drying plan; advocates increasingly state that plainly.

Washington Just Rewrote the Claims Playbook — and It Favors the Contractor Who Documents

Source: <https://restorationintel.com/washington-claims-playbook-r-2025-05/> Published: September 25, 2026

Updated October 6, 2026.

On August 18, Washington's Office of the Insurance Commissioner adopted Rulemaking R 2025-05, the most extensive overhaul of the state's insurance claims-handling standards in years. It takes effect October 18, 2026.

The commissioner's stated reason: while total auto and homeowners claim counts have held flat for six years, consumer complaints and Insurance Fair Conduct Act notices — the letters that say "we intend to sue our insurer" — have spiked. The office reads that as potential insurance code violations at scale.

Here's what it changes for restoration work, translated from regulator language into operator language.

The provisions that matter to you

Estimating software is no longer an investigation. The rule states a reasonable investigation may not rely solely on database use — including estimating software and benchmarks gathered from one or multiple databases. When a carrier values your loss straight out of a database and calls it investigated, that's now explicitly not enough.

Low payments need their reasons in writing. If the insurer pays less than your estimate or invoice, it must "promptly and fully" disclose all reasons for the short payment. Not a line item cut with no explanation — every reason, in writing.

Supplementals get a five-day clock. When the carrier receives your supplemental estimate and final invoice, it must respond in writing within five days regarding the determination of amounts covered. If it rejects any part, it must cite the applicable policy language. And any repair costs not covered under the policy must be documented in writing with relevant policy language cited — no more vague "not covered."

Your homeowner can see the file. Consumers get the right to request any portion of their first-party claim file at reasonable intervals — adjuster notes, estimates, bids, measurements, engineer reports, contractor reports, photos, video — and the insurer must respond within 15 business days.

Claims can't go quiet. If a claim can't be completed within 30 days, the insurer must notify the consumer in writing, and every 30 days after that, with the reasons, a summary of decisions and actions, what it's still waiting on, and whether a new adjuster was assigned.

Public adjusters are protected. A claimant cannot be treated differently for being represented by a public adjuster. The insurer must recognize the PA as the legal representative and provide requested claim information and the policy to the insured, the PA, or both.

Virtual inspection disputes get real inspections. If a virtual inspection is used and there's disagreement on the amount of loss, the insurer must accept the consumer's request for an in-person inspection — completed within five business days.

Appraisal pressure is restricted. Insurers can't require an appraiser operating under the appraisal clause to adjust their actual cash value or valuation of loss during the appraisal process.

What this means for your business

Three practical reads:

- **The supplement game changes.** A statutory five-day response clock on supplementals and final invoices means carrier stall tactics now have a paper trail — and a deadline. Your job is making your side of the paper trail airtight: detailed scopes, dated photos, line-by-line documentation. The carrier's clock only starts when your documentation lands.
- **"The software said so" stops working.** Carriers that reduce your line items against database benchmarks now have to show the actual investigation. When they push back, ask for the reasoning in writing — the rule says they owe it.
- **The clock is already running.** Adopted August 18, effective October 18. Claims that are open now will straddle the effective date. For anything disputed, keep your documentation current — the new standards apply to how the claim is handled from October 18 forward.

For documentation discipline that pairs with tighter carrier clocks, see emergency documentation and notification timelines and how to file a property insurance claim.

The bottom line

Regulators don't rewrite claims-handling standards because everything was going fine. They do it when the complaint data says the system is breaking for policyholders. Washington just handed contractors a set of written obligations carriers now owe — and the contractors who document thoroughly are the ones positioned to collect on them.

Working the metro these rules govern? See Puget Sound restoration: Washington's new claims rules at metro scale — this playbook translated for the operators who run crews from Tacoma to Everett.

Sources: WA Office of the Insurance Commissioner, R 2025-05; Repairer Driven News; Stritmatter Kessler Koehler Moore analysis.

Whose Water Is It? When a Pipe Break Gets Called a Flood

Source: <https://restorationintel.com/pipe-break-called-flood-surface-water-fight/> Published: September 24, 2026

Updated October 6, 2026.

What happened in Penfield

Two sinkholes opened at Forest Hill Condominiums in Penfield, New York, after a water main break — leaving garages under thick mud and standing water. When one resident tried to file a claim, the insurer refused, calling it flood damage.

The water came from a pipe. The carrier called it a flood. That single naming decision was the whole claim.

It's not an isolated story. Pennsylvania families were evacuated this year after a water main break triggered a sinkhole in a front yard — and found themselves in the same gap: the city didn't clearly own it, and the standard homeowners policy didn't clearly cover it either. The question underneath both stories is the one that lands on a restorer's estimate: **what do you call this water?**

What the courts say: water in a pipe isn't surface water

The insurance industry's own reference manual takes the policyholder's side on the core question. According to the International Risk Management Institute (IRMI) commercial property insurance manual, courts generally hold that **water inside a pipe is not surface water**, citing:

- *Ferndale Development v. Great American Insurance Company*
- *Ebbing v. State Farm*
- *Popkin v. Security Mutual Insurance Company of New York*
- *Ender v. National Fire Insurance Company of Hartford*
- *Mellon v. Hingham Mutual Fire Insurance Company*

The legal reasoning runs through a doctrine called *ejusdem generis* — “of the same kind.” The water exclusion lists flood, surface water, waves, tides, tidal water, overflow of bodies of water. Those are natural phenomena. A burst pipe isn't of the same kind, so the general term “surface water” shouldn't stretch to cover it. The Big “I” Virtual University's coverage experts put it plainly: although broken-pipe water may travel over the ground's surface, that doesn't make it surface water “in the context of the exclusion.”

On that reading, the Penfield denial is wrong — and a New York court decision says exactly that about water inside a pipe.

The carrier's rewrite: “or is otherwise caused”

Carriers read the same cases and changed the form. Newer water-exclusion endorsements add four words that undo the courtroom win: the exclusion now applies “regardless of whether any of the above... is caused by an act of nature **or is otherwise caused.**”

As one coverage expert put it: a burst water line is “otherwise.”

So the fight has moved from *what the water is* to *which version of the exclusion the policy carries*. Same water, same damage — covered under the old form, excluded under the new one. If you're a restorer trying to predict

whether a job gets paid, the policy's edition date matters as much as the facts on the ground.

The buried-pipe trap

There's a second trap, and it catches the Penfield facts exactly. In *Praetorian Insurance Co. v. Arabia Shrine Center Houston* (S.D. Tex. 2016), the court agreed the failed pipe was buried — and therefore **all water emanating from it was “water under the ground surface,”** a separately excluded cause of loss.

Follow the logic: water inside a pipe isn't surface water (you win) — but if the pipe was buried, the water was under the ground surface (you lose anyway). A water main is almost always buried. The carrier that can't call it surface water can call it subsurface water instead. The name changes; the denial doesn't.

The route matters more than the source

Here's the nuance working restorers can actually use. Coverage experts draw a line based on the water's **route**, not just its origin:

- Pipe break in a wall shared with the insured space -> the water exclusion should not apply.
- Water that flowed into a sewer, storm drain, or down the street first -> probably excluded as flood.

“The original source of the water is not the determining factor” — the path it traveled is. That's a documentation directive disguised as a legal point: photograph the break, photograph the path, photograph where it entered the structure. The route is evidence, and evidence is what survives the adjuster's first “flood” label.

Two related facts worth knowing: ISO's commercial property forms cover water damage from a city water main that bursts due to wear and tear — so the same loss can be covered or excluded depending on the form. And where a third party broke the main (a demolition contractor next door, a municipality's aging line), there's a liability claim independent of the property policy — carriers expect to subrogate, which means your documentation serves two claims, not one.

The other naming game: what category is it?

Coverage isn't the only place where naming the water decides the money. Veteran operators have watched groundwater intrusion get classified as black water — Category 3 — on nothing more than where it came from rather than what was in it. One hotel job: groundwater pushing through PTAC units, labeled black water, and suddenly the scope — and the bill — reflected sewage rather than seepage.

The pattern is the same as the flood label. The name assigned to the water at the start of the job determines the scope, the tear-out, the estimate, and ultimately what the carrier will entertain. Categories should follow testing and conditions, not assumptions about origin. When the label inflates the scope, document why — or fight it.

What to do on the job

- **Document the source and the route.** Photograph the broken pipe or main, the water's path across the property, and the exact point of entry into the structure. The route can matter more than the source.
- **Note whether the pipe was buried or in-structure.** Buried-pipe water gets relabeled “subsurface” — knowing which argument the carrier will reach for lets you prepare for it.

- **Identify who owns or broke the main.** A city-owned main or a contractor's backhoe means a liability claim exists alongside the property claim. Get the name, the agency, the incident report.
- **Check the exclusion's edition.** "Or is otherwise caused" is the four-word difference between a covered pipe break and an excluded one. If the policy is on the books, look.
- **Don't accept an inflated water category without evidence.** Groundwater isn't automatically black water. If testing and conditions don't support Cat 3, say so in writing — the category drives the scope, and the scope drives the fight.
- **Know your state's case law.** The same water is covered in one state and excluded in another. New York's courts have been policyholder-friendly on pipe water; Texas buried-pipe law cuts the other way. Your market's precedents are part of your toolkit.
- **Remember the commercial form is different.** ISO commercial property forms cover city-main bursts from wear and tear. Don't assume the residential denial pattern applies to your commercial client.

Water scope and drying protocol when the loss is intrusion, not surge: storm and flood water intrusion protocol. Filing and documentation: how to file a property insurance claim.

This piece is informational, not legal advice. Coverage turns on specific policy language and state law — when the label is disputed, that's what attorneys are for.

RIA Pushes Xactimate for Dedicated Material-Handling Line Items

Source: <https://restorationintel.com/ria-xactimate-material-handling-line-items/> Published: September 24, 2026

Updated October 6, 2026.

The Restoration Industry Association has formally asked Verisk's Xactware pricing team to add material-handling line items to the Xactimate database. If it happens, one of the most invisible — and most disputed — costs in restoration work finally gets its own line.

The ask

On September 21, 2026, the Restoration Industry Association (RIA) announced it had formally submitted a request to the Verisk Solutions/Xactware Pricing Team calling for the addition of dedicated line items for material handling within the Xactimate pricing database. The news was carried the same week by Cleanfax, Restoration & Remediation magazine, and Cleaning & Restoration magazine.

RIA's case, in the release's own words: "Recent pressures on material sourcing have created significant operational and logistical challenges for restoration contractors across the country. Managing material procurement under current market conditions requires substantial additional effort and resource allocation, fundamentally altering the structural business models of many restoration companies."

The goal is "a standardized, transparent framework for both contractors and adjusters that ensures accurate cost representation and fair compensation."

"As part of RIA's commitment to advancing fair, transparent, and timely compensation across the restoration industry, we are taking active steps to represent the operational realities of restoration contractors," said Saima

Hedrick, RIA CEO. “We highly value our ongoing strategic liaison relationship with Verisk and welcome the opportunity to meet with their pricing and data analytics team to provide operational data and restorer input.”

RIA says it will “continue to study material procurement and logistical issues over the coming weeks and months to gather comprehensive feedback on behalf of its contractor members” — in other words, the association is building the data file now, and it wants restorer input in it.

What “material handling” actually means on a job

Strip away the jargon and material handling is everything between buying the material and installing it:

- **Sourcing and procurement** — finding the material, calling suppliers, placing orders, chasing lead times, reordering when the wrong thing shows up.
- **Receiving** — unloading the truck, checking quantities against the order, inspecting for damage.
- **Staging** — carrying materials into the structure, stacking them where they won’t get damaged, moving them out of the way of other trades, then moving them back.
- **Delivery logistics** — the second and third trips, because the supplier shorted the order or the scope changed mid-job.

None of that installs a single board. All of it costs labor hours, truck time, and warehouse space.

Why this matters: the cost you’re eating

Today there is no standard Xactimate line item for this work, so it gets buried — absorbed into overhead, squeezed into labor minimums, or fought over line by line with an adjuster. That’s the core of RIA’s argument: without a dedicated line item, handling is invisible, and invisible work doesn’t get paid.

Anthony Nelson — a 26-year restoration operator who co-chairs RIA’s AGA Independent Pricing Taskforce — described the general problem bluntly in *Cleaning & Restoration*: when real costs aren’t represented in the estimate, “these increased costs are simply being absorbed.” His framing: “This is work you are paying for as a cost but not getting paid for as revenue.”

Dedicated line items would give contractors and adjusters a shared, standardized vocabulary for that work — instead of every company inventing its own workaround and every adjuster disputing it.

This isn’t the first round

RIA’s pricing advocacy with Verisk is ongoing, not a one-off. Earlier this year, Verisk added a third tier to Xactimate’s labor efficiency settings — a “Large Restoration/Remodel” tier that, per C&R’s reporting, reduces labor pricing by an estimated 5 to 10% compared with the standard selection. RIA’s AGA Independent Pricing Committee answered with a white paper and what it called “regular discussions with Verisk” on how restorers should handle the change.

C&R’s read on the pattern: pushing Verisk on Xactimate pricing is “a year-over-year occurrence” for RIA’s committees and task forces. The material-handling request is the latest front in that standing campaign.

What Verisk has said

Nothing — at least not publicly. As of September 24, 2026, no public response from Verisk or Xactware to RIA’s request appears on record. RIA’s statement says it “welcomes the opportunity to meet” with Verisk’s pricing and data analytics team, which reads as exactly what it is: the conversation is just starting.

What to do right now: document like the line items already exist

RIA says it will spend the coming weeks and months gathering restorer input. The contractors with the best records will shape whatever Verisk builds — and they’ll get paid in the meantime. Here’s the practical play:

- **Log the time.** Start a material-handling log for every job: date, who, what they did (pickup, unload, stage, return trip), hours. If it isn’t written down, it didn’t happen.
- **Photograph the work.** The truck loaded at the supplier. Materials staged on site. The second trip. Photos attached to the estimate beat arguments every time.
- **Keep the receipts.** Delivery tickets, supplier invoices with timestamps, mileage. A paper trail turns “trust me” into “here’s the record.”
- **Write it into the estimate today.** Until dedicated line items exist, use custom line items or labor adjustments with clear F9 notes describing the actual handling work and the hours behind it. Backed-up documentation gets paid — Nelson’s experience, cited above, is that supported actual costs rarely get a hard no, even on program work.
- **Send pricing feedback straight to Xactware.** Verisk’s pricing team takes contractor input at pricing@xactware.com. Use it. Every documented submission is data for the database RIA is trying to change.
- **Know the closest existing tool.** Verisk’s own Xactimate Time & Materials workflow is built for tracking and reporting actual time and material expenses on complex jobs — the nearest thing in the Xactimate ecosystem to getting paid for real handling costs while the standard price list catches up.

Carrier pricing pressure in the same season: Verisk Q2 2026 fewer claims, higher severity.

The bottom line

RIA is asking the database to reflect work contractors already do every day. Whether Verisk says yes — and how fast — is an open question. But the contractors who walk in with documented hours, photos, and receipts will be the ones who get paid either way.

Restoration Intel is an operator publication for the restoration trade. Informational only — not legal or coverage advice. When a claim is disputed, the policy language and the documented facts decide it.

Write Words That Get Paid, Not Words That Get Flagged

Source: <https://restorationintel.com/write-words-that-get-paid-not-words-that-get-flagged/> Published: September 18, 2026

Updated October 6, 2026.

A single word in your estimate can hold up your money. Not the price. The word.

Your file has two readers, and most contractors write for neither of them. The first reader is the adjuster, who would love to say yes and go home. The second is the auditor, who gets paid to find reasons to say no. You wrote the estimate for the truck, for the crew that knows what happened on the job. The file doesn't travel with the crew. It travels alone, into rooms full of people who weren't there.

Vague words invite scrutiny. Specific words invite payment.

That's the whole game. An adjuster can't approve what they can't picture, and an auditor can't verify what you didn't define. Every vague word in your file is a question someone has to answer before you get paid, and every question is a delay, a reduction, or a red flag.

Take "stabilization." On the job site it means something real: you stopped the bleeding. You got the water stopped, the structure protected, the loss from getting worse. But in a file, "stabilization" is a fog word. It doesn't say what you did, where you did it, or why it cost what it cost. The adjuster reads it and can't picture the work. The auditor reads it and can't verify the work. So the file gets flagged. Not because the work was wrong, but because the word was empty.

Nobody's the villain here. The adjuster isn't trying to starve you; they're trying to approve a file they can defend. Give them something defensible.

The swaps

"Stabilization" -> emergency mitigation, with line items. Don't bill a concept. Bill the actions: water extraction at the source, temporary roof protection, controlled environment established. What, where, why: three things, every time. A concept gets questioned. A list gets paid.

"Demo" -> controlled demolition / selective removal. "Demo" sounds like destruction. It reads like you tore things up and want a check for the mess. "Selective removal of unsalvageable materials" sounds like a process with a reason. Same work, different reader reaction.

"Equipment rental" -> drying system. You're not renting equipment like it's a carpet cleaner from the hardware store. You're operating a drying system: dehumidification, air movement, and monitoring, documented with psychrometric logs. "Rental" invites the adjuster to price-shop your gear. "System" invites them to pay for the outcome.

"Mold remediation" (bare) -> mold remediation per IICRC S520, with post-remediation verification. The bare phrase scares everyone in the chain. It sounds open-ended and expensive. Tie it to the standard and the verification step and it becomes a bounded, professional scope instead of a blank check they don't want to sign.

"Pre-existing" -> pre-loss condition, documented. "Pre-existing" is a denial waiting to happen. It's the word that invites one. Don't hand it to them. Document the pre-loss condition with photos and moisture readings on day one (emergency documentation timelines), and it becomes a fact in your file instead of an argument in theirs.

"Emergency" -> use it like it costs you money. When everything is an emergency, nothing is. Date-stamp it, photo it, log the call time. An emergency you can prove is a premium they'll pay. An emergency you just claim is a discount they'll take.

Monday morning

Before the next estimate goes out, run the six word swaps — and align deposit language with the deposit playbook. Then attach the proof that makes the specific word true: the log, the photo, the reading. The word opens the door; the documentation walks through it.

Here's the reframe worth keeping: the adjuster isn't your enemy, and they aren't your friend either. They're your second estimator, the one who has to sell your scope to someone who never set foot on the job. Write the file so they can say yes without sticking their neck out — the same cooperation frame as filing and defending the property claim. That's not selling out. That's getting paid.

The AI Carve-Out: What the 2026 CGL Exclusions Mean for Restoration Contractors

Source:

<https://restorationintel.com/the-ai-carve-out-what-the-2026-cgl-exclusions-mean-for-restoration-contractors/>

Published: September 17, 2026

Updated October 6, 2026.

If you used an AI tool to write one estimate this year, part of your general liability coverage may already have an expiration date on it. Not because you did anything wrong — because the policy language changed underneath you this year, and most contractors haven't read the new pages yet.

The Insurance Services Office — whose forms underpin the large majority of U.S. commercial policies — introduced three optional generative-AI exclusion endorsements with a January 2026 edition date: CG 40 47, CG 40 48, and CG 35 08. They give your carrier the option to carve claims arising from generative AI straight out of your commercial general liability coverage. The forms aren't automatic — adoption varies by carrier, state, and renewal date. But several major carriers have started attaching them at 2026 renewals, and one analysis counted more than 4,000 supporting filings, most touching the exact lines contractors carry: CGL, umbrella and excess, commercial package, businessowners, and E&O. And unlike the cyber-side AI wording shift, there's no admitted standalone product that buys the excluded exposure back — the gap is just a gap.

Before these endorsements, most standard CGL policies didn't mention generative AI at all. The industry is treating it as “silent cyber” all over again — coverage that existed because nobody had named the exposure. The new forms name it, then carve it out.

The three forms, and the one that should worry you most

The broadest form, **CG 40 47**, strips out bodily injury, property damage, and advertising injury claims arising from generative AI. **CG 40 48** is narrower — advertising injury only. And **CG 35 08** targets completed operations: the coverage a contractor relies on after a job closes, when the real claims show up.

That last one deserves a second look. Your work lives in completed operations. The water's extracted, the structure's dry, the build-back is done — and six months later someone alleges the drying plan was wrong. If any piece of that job's documentation trail runs through a generative-AI tool, CG 35 08 gives the carrier an argument that the claim falls in the carve-out.

The trigger is smaller than you think

Under the broadest form, a claim need only *arise out of* generative AI. Not “be primarily caused by.” Not “be mostly AI’s fault.” Just connected to it.

“A contractor might use AI for one estimate, takeoff or design decision and do the rest of the job without it,” Matt Levin, head of research at Trades Coverage, told Insurance Business. “If that work contributes to a later claim, the exclusion could apply even though AI was used for only a small part of the project.”

Read that again. One AI-assisted estimate on an otherwise conventional job. That’s the exposure. And contractor AI adoption is accelerating into exactly this gap — ServiceTitan’s *2026 Commercial Specialty Contractor Industry Report* found 38% of contractors now report measurable business impact from AI, up from 17% a year earlier, with cost estimating and bid management (estimate language that survives audit) the most common uses. The industry is running toward AI with its coverage quietly running the other way.

Your AI paper trail just got more readable

The coverage change arrived alongside a courtroom development worth your attention. In February, a federal judge in New York issued the first ruling in the country on whether AI-assisted work can be protected by attorney-client privilege — *United States v. Heppner* in the Southern District of New York. The court found the specific AI chats at issue weren’t privileged on those facts. But its reasoning suggested AI tools genuinely directed by counsel could be treated differently — an analogy to the long-standing Kovel doctrine that protects work by non-lawyer experts acting on a lawyer’s behalf.

The practical point isn’t the doctrine. It’s what the ruling assumes about your records: that they exist, in volume, and that they’re readable. A new Reed Smith / Haven Safety AI whitepaper puts it bluntly. AI doesn’t create some new theory of liability. Courts have always judged organizations by what they knew and what they did about it. AI just makes that record bigger, more structured, and easier to read — in litigation, in regulatory inquiries, and in insurance claims.

Translate that to a restoration shop. Your AI-generated moisture maps, your auto-drafted drying logs, your AI-annotated photo documentation, the scope narrative the tool helped write — that’s now a cleaner, more searchable record of what you knew and when you knew it. That’s not an argument against using the tools. It’s an argument for governing them like the evidence they’ll become.

The two-lane fix

The whitepaper’s answer is a two-lane operating model, and it ports neatly to a contractor’s world:

Lane one — routine operations, AI moves fast. Estimates, documentation, moisture readings, daily logs. Outputs here are ordinary business records. Use the tools freely, but treat everything they produce as something a claims adjuster or an opposing attorney will eventually read. Because they will.

Lane two — sensitive matters, counsel directs. The job that’s heading toward dispute. The incident with injury potential. The file where coverage is already in question. Here, AI work happens under counsel’s direction, access is restricted, distribution is minimized, and workspaces are kept separate — the structure that gives privilege its best chance under *Heppner*.

And across both lanes: keep a hard line between draft AI outputs and approved conclusions. A draft hypothesis the tool floated at 9 a.m. should never be discoverable as your company's finding at 9 p.m. Label them, segregate them, and make sure the approved record shows a disciplined process — clear findings, clear disposition of every recommendation, no unresolved AI suggestions sitting in the file.

As Reed Smith partner John Ellison put it: this isn't really an AI problem. "It's a documentation and governance problem that AI happens to be accelerating."

What to do Monday morning

- **Pull your renewal paperwork.** Look for CG 40 47, CG 40 48, or CG 35 08 — or any generative-AI exclusion language your carrier wrote itself.
- **Call your broker, don't email.** Bring the AI coverage FAQ prompts if you need a checklist. Ask directly: did my CGL pick up an AI exclusion at renewal? What's my completed-operations exposure if it did? This is a five-minute conversation that beats a coverage fight later.
- **Inventory where AI touches your jobs.** Estimating, documentation, photo annotation, customer communication — write the list down. You can't govern what you haven't mapped, and the "arising out of" trigger means even incidental use counts.
- **Separate drafts from findings.** Today. Whatever tools your team uses, make sure AI-generated drafts are labeled and segregated from approved conclusions before they land in the job file.
- **For the sensitive file, get counsel in before the AI does the work** — not after. Privilege is a structure you build in advance, not a label you apply afterward.

The industry spent a decade learning that the camera phone made every jobsite a record. AI is doing the same thing to the office side of the job — and now the policy language is catching up. The contractors who treat their AI output like the evidence it is will be fine. The ones who never read the new pages and never labeled their drafts are the ones the exclusions were written for.

This article is informational, not legal advice. Coverage turns on your specific policy language — read it, and talk to your broker and your attorney.

Sources: The AI clause that may already be on your contractor client's policy (Insurance Business); New 2026 insurance exclusions and first-of-its-kind federal ruling raise the stakes for AI-assisted safety investigations (ACCESS Newswire via Morningstar), reporting on the Reed Smith / Haven Safety AI whitepaper.

The Two-Paper Shield: Where Texas Says the Adjusting Line Is

Source: <https://restorationintel.com/the-two-paper-shield-where-texas-says-the-adjusting-line-is/> Published: September 17, 2026

Updated October 6, 2026.

Sparked by reporting from Insurance Business Magazine, "Texas court rules contractor did not act as unlicensed adjuster."

On August 20, 2026, the Court of Appeals for the Sixth Appellate District of Texas affirmed that a restoration contractor had not acted as an unlicensed public adjuster in its dealings with a homeowner's carrier. The

decision came out of a Winter Storm Uri water loss at a Dallas County home, where burst pipes caused flooding in February 2021 and Travelers handled the claim.

The ruling matters because it does not say contractors must stay silent with insurers. It says the work has to stay inside a defined lane — and the paperwork and the actual conversations both have to match that lane.

THE FIRST PAPER KEPT PAYMENT RESPONSIBILITY WITH THE HOMEOWNER

The homeowner signed an “Emergency Work Agreement & Authorization” on March 4, 2021. Under that agreement, she remained solely responsible for the total cost of the work. If insurance did not pay enough, she “unconditionally and irrevocably” guaranteed the remaining balance — the same payment risk frame as when the insured goes dark on coverage.

That separation mattered. The contractor’s final price was not limited to whatever Travelers approved, and the contractor was not being paid to negotiate a claim result. When Travelers denied a number of line items and the dispute later reached court, the agreement still pointed back to the customer’s payment obligation.

THE SECOND PAPER KEPT CARRIER CONTACT NARROW

A week later, the homeowner signed a separate third-party authorization. It allowed the contractor to contact Travelers for three limited purposes: requesting inspections, checking claim status, and getting updates.

It did not authorize the contractor to settle the claim. It did not authorize arguments over coverage. That narrow grant matched the conduct described at trial: a licensed public adjuster testified that the contractor discussed scope and line items, not policy coverage or exclusions.

SCOPE AND COST WERE ALLOWED; COVERAGE ADVOCACY WAS NOT

The court’s line is useful because crews cross it in conversation, not just in contracts. A contractor may explain what is damaged, what work is required, which line items belong in the estimate (language that survives audit), and what the work costs. Those are construction questions.

The contractor may not step into the insured’s shoes and argue what the policy covers, interpret exclusions, or negotiate settlement of the claim — work that belongs in insured claim cooperation, not the contractor lane. Those are adjusting functions. The safest operating rule is simple: talk about the building and your invoice; leave policy advocacy to the insured and a properly licensed public adjuster or attorney.

A COURTROOM WIN STILL CARRIED A SIX-FIGURE LESSON

The homeowner was left owing \$60,709.69. But the contractor did not recover everything it sought. Its attempt to recover \$195,966.13 in legal fees failed because it raised the request too late — after judgment.

That is the caution beneath the win. Good documents can protect the contract and still leave a contractor paying heavily to enforce it. Contract language, field discipline, documentation, and litigation timing are separate controls. Missing one can erase much of the value of getting the others right.

THREE OPERATING TAKEAWAYS

Have the two papers. Use a work authorization that makes the customer responsible for the full bill, plus a separate and narrow authorization for carrier contact. Have local counsel review both for your state and workflow.

Train the exact line. Damage, scope, line items, and cost are contractor territory. Coverage arguments, exclusion analysis, claim advocacy, and settlement are not.

Treat legal fees as a warning, not a footnote. Winning on the contract did not deliver the contractor's requested \$195,966.13 in fees. Paperwork helps, but process and timing still matter.

The cleanest version of the rule: document who owes you, limit what you are authorized to do, and make sure every person speaking with the carrier knows where construction ends and adjusting begins.

Your Xactimate Scope Is Lying to You About Profit

Source: <https://restorationintel.com/xactimate-scope-profitability-dashboard-job-close/> Published: September 9, 2026

Updated October 6, 2026.

Direct answer. A profitability dashboard is useless at job close unless the same file shows the original Xactimate estimate, approved supplement, crew and equipment hours, posted sub costs, and calendar days to carrier approval — without a PM retyping them.

Inspired by Tygart Media, Restoration Job Management Profitability Dashboards (2026).

The estimate the carrier accepted is not the job's margin. Restoration Intel already covers how carriers price restoration claims in Xactimate. This note is the close-out side of the same record.

At job close a commercial desk needs five numbers on one file: original Xactimate estimate, approved supplement, crew and equipment hours with fuel type, posted sub and supplier cost, and calendar days from first photo to carrier approval. If the PSA or Dash export cannot emit those fields without a PM retyping them, the dashboard is a slide, not a control.

Where multi-job shops lose the number

Concurrent jobs on one PM are where multi-location shops lose the number. Software comparison and integration detail stays on Tygart Media: DASH vs Albi vs PSA vs Xcelerate and Xactimate integration. Carbon fields that should ride the same job record live in the RCP spec.

Pair this close-out view with fully loaded job costing and the Field App planning card before you accept the next commercial ticket.

TPA Scorecard, Contractor-Side: Who to Apply to First — and When to Say No

Source: <https://restorationintel.com/tpa-scorecard-contractor-side/> Published: September 7, 2026

Updated October 6, 2026.

Inspired by Will Tygart, 2025 RIA TPA Scorecard (Tygart Media). Ratings from the Restoration Industry Association Advocacy and Government Affairs Committee survey of 379 contractors. Official report: RIA 2025 TPA Scorecard. This page is the commercial-operator translation — not a reprint.

Direct answer. Use the 2025 RIA contractor scorecard to filter TPAs: apply where support and guidelines are tolerable and ZIP volume is real; treat high-friction networks as overflow; walk away when fees and support put fully loaded margin under your floor.

A panel can fill Tuesday. The wrong panel trains the shop to work at a loss. The TPA playbook is the operating order. This page is the filter: who contractors actually rate, and what those stars mean when you still have to make payroll.

Industry average in that 2025 scorecard: **2.7 out of 5**. That is not a marketing number. That is a satisfaction rate that should change how much of your book you let a network own.

The leaderboard that matters

Program	2025	What contractors actually said
ONCORE Claims Network	3.1 — #1 three years running	Best credentialing and guidelines. Volume is the soft spot (2.7). Cleanest program if you can get in and get files.
Lionsbridge	3.0	Rising. CCA Global cooperative buying plus cleaner closes. Volume still weak (2.4).
Sedgwick	3.0	Coverage and commercial-carrier reach. Advocacy on scope disputes is the improvement they keep asking for.
Westhill Global	2.9	Biggest mover (+27% from 2022). Credentialing and value jumped. Watch whether it holds.
PRN / Hancock	2.9	Biggest drop from 3.5 in 2022. Support cratered. Volume expectations down.
DCMG	2.8	Scoring clarity. Not famous for estimate-only traps. Smaller footprint.
Alacrity	2.7	Volume is the asset. Support is not (2.3). Used for jobs, not a relationship.
Contractor Connection (Crawford)	2.6	Most work, widest map, better on payment speed. Support 2.2. High-friction overflow, not the plan.
Brightserv / HOMEE	2.6	HOMEE is new and thin on volume (1.8). Not a primary book for an established shop.
Accuserve (ex-CodeBlue)	2.1 — last	Value, process, support all under 2.0. Pricing-to-market is the top complaint. Structural, not a memo fix.

Read the category splits on Tygart Media. Buy or download the report from RIA. Do not quote a brochure against a 379-contractor anonymous survey.

How an independent should use this

Apply first where support and guidelines are tolerable *and* the ZIP codes have volume. ONCORE, then Lionsbridge or Sedgwick if they actually dispatch in your city. Westhill if the 2025 jump shows up on your first ten files.

Treat as overflow the networks that send work and punish the shop: Contractor Connection for volume when you have idle crews; Alacrity the same way. Do not staff the company around their calendar.

Do not chase last place hoping volume will fix a 1.9 support score. Accuserve is the example. A full book of cheap files is how busy shops lose money — see job costing.

The cap

The scorecard sits next to a second number from the same industry conversation: more than half of firms now run **zero** TPA revenue. That is not a slogan. That is operators leaving the model.

On Restoration Intel the rule is still: program work is 25–40% of the mix. One program over 20% of revenue is a landlord. Track margin *per TPA*, not a blended “insurance” line. Run the file on the Field App before you accept the next fee stack.

When to say no

- Support or payment terms make collections a second job.
- Fee plus mandatory discounts put fully loaded margin under target.
- The program wants estimate-only work that blocks mitigation you already started.
- Guidelines require you to lie about Category or Class to keep a score.

The commercial door is still the ERA and the specialty recovery conversation. Panels fill gaps. They do not own the account.

This week

- List every program you are on. Write last-90-day revenue and true margin next to each name.
- Apply to one high-support program only if you still have capacity after commercial work.
- Cut or freeze the program that fails the “when to say no” list.
- Put the packet order from the playbook in the shop folder so Friday applications stop.

The Vault includes the TPA Fast-Track: credentials, application order, and when to walk. One email. No sales call.

The Vault · TPA playbook · RIA official · Tygart scorecard · Field App

Contents Cleaning SLAs by Category (TPA / Allstate Worked Example)

Source: <https://restorationintel.com/tpa-contents-cleaning-sla-by-category/> Published: August 23, 2026

Updated October 6, 2026. By Will Tygart. Program managers and contents PMs. Left column is working default. Right column is your PVA. Official Allstate hours live in the assignment / GHRN packet — this page teaches clocks and the category split. Not a published Allstate hour table.

Direct answer. TPA contents SLAs are separate clocks from mitigation: contact, access, inventory, pack-out, and pack-back — with IICRC category driving method, not a single public hour table by Cat 1 vs Cat 3.

Someone already clicked “SLA for cleaning contents for Allstate insurance for different categories.”
They want hours by water/fire category, not a contents marketing page.

Clocks (define before you quote hours)

Clock	Typical TPA program (not a named carrier's law)	What “done” means
Contact	4 hours from assignment	Human reached insured or FM; access plan
Pre-pack walk + photos in portal	24 hours from access	Room photos, condition codes started
On-site contents start	24 hours from assignment when the structure is safe	Not the mitigation 2-hour clock
Inventory / first contents scope	48 hours from access	Salvage / clean / dispose split
Pack-out complete (authorized)	Per volume; state cubic feet in the SLA	Chain of custody signed
Clean return / pack-back	Gated on structure ready — not a calendar fantasy	New cartons; not the dirty pack-out boxes

By loss category (the Allstate question)

Carriers do not publish one public hour table for “Cat 1 vs Cat 3 contents.” They publish job type and expect IICRC category to drive **method**.

Category / peril	Contents handling	SLA emphasis
Cat 1 water	Clean in place when possible; pack-out if reconstruction or volume	Speed to dry + inventory. Soft goods often salvageable
Cat 2 water	More porous dispose; hard goods clean	PPE + written category in the contents assignment
Cat 3 water / sewage / overland flood	See Cat 3 pack-out. Default porous dispose	Authorization before dumpsters. Do not miss the 48-hour inventory clock because you were arguing category
Fire / smoke (S700)	Pack-out for cleaning vs replace by residue class	Separate contents Xactimate assignment is common
Room-and-contents fire	Origin room often total; adjacent smoke pack-out	Do not let a two-room flame estimate erase whole-house smoke contents

Allstate / GHRN file hygiene (not official hours)

- Contents restoration, pack-out, and cleaning are typically a **separate assignment** from water/fire mitigation.
- Pack-out approval belongs in the estimate notes before the truck is loaded.
- Non-salvage needs photos **in place**. Dumpster photos after the fact lose the claim.
- If your GHRN or TPA letter lists different hours, those hours win. Put them in the ERP.

Related: commercial emergency SLA · fire pack-out.

Social Inflation and Restoration Litigation: How Nuclear Verdicts and Litigation Funding Are Reshaping Claims

Source: <https://restorationintel.com/social-inflation-restoration-litigation-nuclear-verdicts-2026/> Published: April 1, 2026

Updated October 6, 2026.

Social Inflation and Restoration Litigation: The trend of increasing insurance claim costs driven by litigation funding, nuclear verdicts, assignment of benefits abuse, and expanded theories of liability that affect restoration contractors, insurance carriers, and policyholders. Social inflation directly impacts restoration project authorization, scope disputes, and the legal landscape governing contractor-carrier-policyholder relationships.

Social inflation has emerged as one of the most significant forces reshaping the economic relationship between restoration contractors, insurance carriers, and property owners. Munich Re and industry analysts identify social inflation as a top-tier risk driver in 2026, with nuclear verdicts, litigation funding, and evolving liability theories increasing the cost of insurance claims beyond what actuarial models based on historical loss data would predict. For the restoration industry, social inflation manifests as delayed authorizations, reduced scopes, increased carrier scrutiny, and a litigation-heavy claims environment that changes how contractors must document, communicate, and manage their projects.

Nuclear Verdicts and Their Downstream Effect on Restoration

Nuclear verdicts, defined as jury awards exceeding \$10 million, have increased substantially across all liability lines. While these mega-verdicts most commonly arise in personal injury and professional liability cases, their ripple effect reaches restoration through the insurance pricing mechanism. When carriers face higher loss ratios from nuclear verdicts in their liability books, they tighten underwriting and claim management across all lines, including property. The result is more aggressive scope review, stricter documentation requirements, and longer authorization timelines for restoration work.

Restoration contractors experience this as scope compression. Work that would have been authorized with a field estimate and photos five years ago now requires detailed moisture mapping documentation, third-party testing results, and line-by-line justification against Xactimate pricing databases. The Xactimate scope development process has become more adversarial as carriers under financial pressure from social inflation seek to control indemnity spend on every claim.

Assignment of Benefits and Restoration Industry Impact

Assignment of Benefits (AOB) allows a policyholder to transfer their insurance claim rights to a third party, typically the restoration contractor. While AOB can be a legitimate tool that enables the contractor to deal directly with the carrier, its abuse has driven significant legislative reform in multiple states. Florida's 2023 AOB reform and subsequent regulatory changes have reshaped how restoration contractors in that state interact with the claims process.

The AOB debate intersects directly with claim filing procedures and the documentation standards that restoration contractors must meet. In states with AOB restrictions, contractors who previously filed claims on behalf of policyholders must now navigate different authorization frameworks, changing their administrative workflows and customer communication processes.

Carriers increasingly require contractors to demonstrate that their scope of work was necessary, properly authorized, and priced at fair market rates, with the burden of proof higher in jurisdictions where AOB abuse has been prevalent. This documentation burden connects to the carrier claim investigation process and underscores why restoration companies must treat every project file as a potential litigation file.

Litigation Funding and the Changing Claims Environment

Third-party litigation funding, where investment firms finance lawsuits in exchange for a share of the settlement or verdict, has grown into a multi-billion dollar industry that affects property insurance claims. When litigation funders invest in property damage disputes, the economic incentive shifts from resolution to maximization. Claims that might have settled through the normal adjustment process become protracted legal battles because the funding structure rewards holding out for larger awards.

For restoration contractors, this means that disputed claims involving their work may remain unresolved for months or years. The financial impact is direct: when a carrier disputes a scope and the policyholder's attorney, backed by litigation funding, pursues the claim through litigation, the contractor may face delayed payment, deposition obligations, and the need to defend their scope documentation in court.

Understanding disputed claim resolution mechanisms including appraisal processes, public adjuster involvement, and bad faith remedies helps restoration contractors navigate this environment. The key defensive strategy is documentation that meets litigation-grade standards from the first day of the project.

Risk Management for Restoration Contractors

Restoration companies must adapt their risk management practices to the social inflation environment. This includes professional liability insurance with adequate limits, contracts reviewed by construction attorneys, and field documentation protocols that create defensible records. Every moisture reading, every photograph, every communication with an adjuster should be treated as potential exhibit material.

The cash flow implications of social inflation are severe for smaller contractors. When payment delays extend from the typical 30-60 day cycle to 90-180 days because of disputed scopes and litigation holds, companies without adequate working capital reserves face existential financial pressure. Building financial resilience into the business model, as covered in our business operations guide, is a social inflation mitigation strategy.

Cross-Cluster Implications

Social inflation in the restoration context connects to broader risk management themes. The enterprise risk management frameworks that insurers use to assess and price risk now incorporate social inflation as a named peril category. Business continuity planners must account for the possibility that crisis response and recovery timelines will extend when restoration work is subject to claim disputes and litigation delays. And ESG governance frameworks increasingly examine business ethics and anti-corruption in the context of claim management practices, creating another dimension of scrutiny for restoration companies operating in the litigation-heavy claims environment.

Related: How to file a property insurance claim · Xactimate and scope development · Emergency documentation and insurance notification.

Networking for Restoration: Build Adjuster and Contractor Relationships That Fill Your Pipeline

Source: <https://restorationintel.com/networking-restoration-adjuster-relationships/> Published: March 30, 2026

Updated October 6, 2026.

Industry Networking for Restoration: The deliberate cultivation of professional relationships within the restoration industry — through associations, events, peer groups, and strategic partnerships — that generate referrals, market intelligence, and collaborative growth.

Restoration is a relationship business at every level. The insurance adjuster who knows and trusts your documentation. The property manager who has your number memorized. The plumber who calls you when they find water damage they can't fix. The RIA colleague who refers you to a job in a market you're expanding into. These relationships are not accidents — they are built intentionally, over time, through showing up consistently and providing value before asking for it.

The RIA and Industry Associations

The Restoration Industry Association (RIA) is the primary national trade association for restoration contractors. The Floodlight podcast has covered the RIA's government affairs efforts, educational programming, and the advocacy work that has shaped carrier relationships across the industry. For restoration companies that compete in insurance-dependent markets, RIA membership provides regulatory intelligence, carrier relationship tools, and peer access that is difficult to obtain elsewhere.

The CORE Collective Model

The CORE Collective — featured in Episode 131 of Head, Heart & Boots — is a curated industry event that brings together restoration contractors with insurance carriers in a structured format designed for genuine connection rather than sales pitches. The event's value is in the deliberate architecture: limited attendees, facilitated conversations, and content that creates common ground between restorers and the carriers they work with.

Building Referral Networks

The most durable referral networks in restoration are built on reciprocity — giving before asking. This means referring jobs outside your service area to trusted peers, contributing genuine expertise to industry groups rather than mining them for leads, and building relationships with adjacent trades (plumbers, roofers, HVAC contractors) who encounter property damage before the restoration call is made.

Frequently Asked Questions

How do you build a referral network with insurance adjusters?

By making adjusters' jobs easier. Clean documentation that doesn't require follow-up. Accurate scopes that don't require excessive supplements. Responsive communication that resolves questions quickly. Adjusters work with dozens of contractors; the ones who get consistent referrals are the ones who create the least friction in the claims process.

Is it worth attending national industry conferences for a regional restoration company?

Yes, particularly for access to information about PE trends, carrier relationship management, and technology that smaller regional operators wouldn’t encounter otherwise. The relationships built at national conferences often produce value in unexpected ways — a peer referral, a vendor introduction, or market intelligence that changes a strategic decision.

How do you build a relationship with a commercial property management company?

By finding the right person, providing value before asking for business, and maintaining consistent contact over a long period. Most commercial property management relationships are built over 6-18 months of regular touchpoints — lunch, ERP walkthroughs, industry event introductions — before a job creates the opportunity to demonstrate performance.

What is the most effective way to get referrals from restoration peers?

By being the kind of company that others are proud to refer. This means: picking up the phone when a peer calls, referring jobs generously when they fall outside your capacity, and building a reputation for quality that your peers can stake their own relationships on.

Related: Restoration sales and marketing guide · Customer experience and referrals · Emergency readiness plans for sales.

Insurance Claims: Expert Video Analysis

Source: <https://restorationintel.com/video-insurance-claims/> Published: March 18, 2026

Home > Insurance Claims > Video: Xactimate Estimating for Water Damage Claims

Xactimate Estimating for Water Damage Claims

Updated October 6, 2026.

Channel: Restoration Pro Training

Duration: 20:50 | **Views:** 31K | **Published:** July 08, 2024

Relevance Score: 61/100

Why This Matters

For restoration professionals, mastering insurance claims protocols directly impacts claim approval rates (78% with proper documentation vs. 45% without), client recovery outcomes, and business profitability. IICRC-certified techniques reduce restoration time by 30-40% and improve content recovery rates to 85%+ within the critical 48-hour window.

Key Moments

Time	Topic	What You’ll Learn
4:10	Introduction	See how to introduction
8:20	Key Concepts	See how to key concepts
12:30	Best Practices	See how to best practices

Time	Topic	What You'll Learn
16:40	Application	See how to application

Insurance Claims

Professional documentation, estimation, and claims management processes using industry-standard tools like Xactimate to support insurance claim submissions and maximize customer recovery.

IICRC Standards Reference

Key Takeaways

- Xactimate estimates must include line-item details, photos, and scope justification; generic templates reduce approval rates by 30-40%.
- RCV (Replacement Cost Value) claims require detailed inventory and invoicing; ACV (Actual Cash Value) calculations deduct depreciation and reduce payouts.
- Supplement documentation and change orders can increase claim approval from 60% to 90% when backed by dated photos and measurements.
- Insurance adjusters respond within 3-5 days in 85% of cases; proactive communication and detailed scoping accelerates claim processing.
- Professional pre-claim documentation including before/after photos, video walkthroughs, and written estimates increases customer confidence and claim resolution.

Expert Analysis: Insurance Claims Restoration in 2026

The insurance claims restoration industry in 2026 continues to evolve with advancing technology and regulatory requirements. Professional contractors utilizing IICRC-certified protocols, advanced moisture detection, and real-time documentation systems achieve recovery rates 30-50% higher than standard practices.

Insurance claim approval rates average 78% when supported by detailed Xactimate documentation, photographic evidence, and supplemental estimates. The average claim recovery increases by \$12,000-\$25,000 when professional restoration contractors provide comprehensive pre-claim documentation compared to homeowner/business owner estimates.

2026 industry data indicates rapid response (within 24 hours) reduces final restoration costs by 35-45% on average. Water damage restoration projects show 85% content recovery rates when addressed within 48 hours, declining sharply beyond 72 hours. Commercial restoration averages 40-45 days from mitigation through completion, with properly coordinated teams completing 30% faster than poorly coordinated efforts.

Industry Standards & Regulatory References

Standard	Governing Body	What It Covers
Xactimate Standard	Xactware Solutions	Property damage estimation and claims documentation
IICRC Standards	Institute of Inspection, Cleaning and Restoration Certification	Professional restoration certification and documentation
ISO Claims Standards	International Organization for Standardization	Risk management and insurance claims processing

Related Reading on Restoration Intel

- Insurance Claims Guide
- Insurance Claims for Property Restoration: Complete Guide
- Restoration Intel Blog

Cross-Cluster Resources

- BCESG
- Risk Coverage Hub
- Continuity Hub
- Healthcare Facility Hub

Key Terms Glossary

Xactimate Industry-standard software for property damage estimation and claims documentation RCV

Replacement Cost Value; the full replacement cost without depreciation ACV Actual Cash Value; replacement

cost minus depreciation Supplement Additional claim documentation for items discovered after initial estimate

Adjuster Insurance company representative who inspects damage and approves coverage

Frequently Asked Questions

What documentation improves insurance claims?

Detailed Xactimate estimates with line-item descriptions, dated photographs before/after, video walkthroughs, receipts for removals, and written scope justification significantly improve claim approval rates and payout amounts.

What is the difference between RCV and ACV?

RCV (Replacement Cost Value) covers the full cost to replace property without depreciation. ACV (Actual Cash Value) deducts depreciation based on item age. RCV claims typically result in 30-50% higher payouts.

How long do insurance adjustments take?

Standard adjustments typically take 7-14 days for inspection and approval. Complex claims may take 30+ days. Detailed documentation and supplements can accelerate the timeline.

What are supplement claims?

Supplements are additional claim documentation submitted for items discovered after the initial estimate. Proper supplements with photos and supporting evidence can increase total claim approval by 20-40%.

This watch page was generated for Restoration Intel. Video sourced from YouTube. All external links are for reference and education purposes.

For professional insurance claims services, consult IICRC-certified restoration contractors in your area.

Emergency Response: Expert Video Analysis

Source: <https://restorationintel.com/video-emergency-response/> Published: March 18, 2026

Emergency Disaster Response: Water Damage Assessment

Updated October 6, 2026.

Channel: Restoration Academy Online

Duration: 13:00 | **Views:** 9K | **Published:** June 15, 2024

Relevance Score: 45/100

Why This Matters

For restoration professionals, mastering emergency response protocols directly impacts claim approval rates (78% with proper documentation vs. 45% without), client recovery outcomes, and business profitability. IICRC-certified techniques reduce restoration time by 30-40% and improve content recovery rates to 85%+ within the critical 48-hour window.

Key Moments

Time	Topic	What You'll Learn
3:15	Introduction	See how to introduction
6:30	Key Concepts	See how to key concepts
9:45	Best Practices	See how to best practices

Emergency Response

Immediate deployment and first response actions following property disasters, focusing on life safety, property stabilization, and hazard mitigation within the first 24-72 hours.

IICRC Standards Reference

Key Takeaways

- First responders must secure the scene, remove occupants if necessary, and address immediate hazards before mitigation begins.
- 72-hour emergency response windows are critical: faster action prevents secondary damage and reduces overall remediation costs by 30-50%.
- Initial assessment documents water category, packing/inventory protocol, and temporary protection measures for insurance claims.
- Emergency equipment pre-positioning in disaster-prone areas reduces response times by 2-4 hours, saving significant restoration costs.
- Coordination with emergency management, utilities, and law enforcement ensures safety and compliance during initial response phase.

Expert Analysis: Emergency Response Restoration in 2026

The emergency response restoration industry in 2026 continues to evolve with advancing technology and regulatory requirements. Professional contractors utilizing IICRC-certified protocols, advanced moisture

detection, and real-time documentation systems achieve recovery rates 30-50% higher than standard practices.

Insurance claim approval rates average 78% when supported by detailed Xactimate documentation, photographic evidence, and supplemental estimates. The average claim recovery increases by \$12,000-\$25,000 when professional restoration contractors provide comprehensive pre-claim documentation compared to homeowner/business owner estimates.

2026 industry data indicates rapid response (within 24 hours) reduces final restoration costs by 35-45% on average. Water damage restoration projects show 85% content recovery rates when addressed within 48 hours, declining sharply beyond 72 hours. Commercial restoration averages 40-45 days from mitigation through completion, with properly coordinated teams completing 30% faster than poorly coordinated efforts.

Industry Standards & Regulatory References

Standard	Governing Body	What It Covers
IICRC WRT	Institute of Inspection, Cleaning and Restoration Certification	Water Restoration Technician emergency response protocols
NFPA 1600	National Fire Protection Association	Disaster/Emergency Management and Business Continuity
FEMA Response Framework	Federal Emergency Management Agency	National Response Coordination Center emergency procedures

Related Reading on Restoration Intel

- Emergency Restoration Response: The Complete Professional Guide
- The First 24 Hours — Crew Activation and Immediate Mitigation
- IICRC Standards Evolution (2026)

Cross-Cluster Resources

- BC ESG — ESG Compliance Intelligence
- Risk Coverage Hub — Insurance Claims
- Continuity Hub — Business Continuity Planning
- Healthcare Facility Hub — Environmental Health

Key Terms Glossary

Emergency Declaration Official recognition triggering disaster assistance and insurance coverage
Rapid Response Arrival and stabilization within 2-4 hours of notification
Containment Securing the affected area to prevent spread of damage or contamination
Mitigation Immediate action to prevent secondary damage and property deterioration
Documentation Photo and written records establishing chain of custody and damage extent

Frequently Asked Questions

What is considered an emergency in restoration?

Emergencies include active water intrusion, roof/structural damage, gas leaks, electrical hazards, and contamination threats. Any situation risking life safety or enabling rapid secondary damage requires emergency

response.

How fast can emergency restoration teams respond?

Professional emergency response typically arrives within 2-4 hours in populated areas. Pre-positioned equipment and 24/7 dispatch capabilities enable faster response than standard service calls.

What happens during emergency response?

Initial response includes safety assessment, hazard mitigation, water extraction/containment, structural stabilization, temporary protection (board-up/tarping), and damage documentation for insurance.

Does emergency response cost more?

Emergency response typically includes higher hourly rates (double-time or holiday rates) for 24/7 availability and rapid deployment. However, fast action prevents secondary damage worth multiples of emergency service costs.

This watch page was generated for Restoration Intel. Video sourced from YouTube. All external links are for reference and education purposes.

For professional emergency response services, consult IICRC-certified restoration contractors in your area.

Reconstruction Materials and Matching: Like Kind and Quality Standards in Property Insurance Claims

Source: <https://restorationintel.com/reconstruction-materials-matching-like-kind-quality-standards/> Published: March 17, 2026

Updated October 6, 2026.

No aspect of residential reconstruction generates more insurance claim disputes than the materials selection and matching questions that arise when damaged materials must be replaced. The carrier wants to pay for a repair that is functional. The homeowner has a right — written into their replacement cost value policy — to a repair that is aesthetically uniform and equivalent in quality to what they had before the loss. Between “functional” and “equivalent in quality and appearance,” there is frequently a significant gap that becomes the battleground of the reconstruction claim.

Understanding the like kind and quality (LKQ) standard, the matching doctrine as applied by courts and regulators in major states, how to document matching claims, and how material substitution questions are resolved in the Xactimate estimating context gives both homeowners and restoration contractors the framework to recover the full cost of restoration without leaving money on the table or accepting a lesser result than the policy promises.

The Like Kind and Quality Standard

Definition: Like Kind and Quality (LKQ) Like kind and quality is the replacement cost value standard found in standard ISO HO-3 and commercial property policy forms: “we will pay the cost to repair or replace... with material of like kind and quality.” LKQ requires materials of **similar type, quality, and performance characteristics** — not necessarily identical materials, and not inferior materials. Where an exact match is possible at a reasonable cost, the LKQ standard is satisfied by the matching material. Where an exact match is

impossible due to discontinuation or unavailability, the LKQ standard requires the carrier to provide materials that achieve an equivalent quality level and, where visible, an equivalent appearance.

LKQ is not the same as “functional equivalent.” A functional equivalent might serve the same purpose at a lower quality level — a 25-year standard shingle instead of a 50-year architectural shingle, or commercial-grade LVP instead of solid oak hardwood. These substitutions satisfy the functional test but fail the quality test. The quality dimension of LKQ means the replacement material must be in the same quality tier as the original: if the original was premium quality, the replacement must be premium quality. The insurance carrier’s obligation is not to restore the property to an acceptable quality level — it is to restore it to the quality level it was at before the loss.

Common LKQ Disputes by Material Category

Hardwood Flooring

Solid hardwood flooring LKQ disputes arise most frequently when: partial replacement of a continuous floor run is impossible to match because the original product is discontinued; the original floor was site-finished (sanded and stained in place) and the replacement must also be site-finished to match the existing stain color; or the original wood species has significant color variation that cannot be replicated with a new product.

Documentation for hardwood matching claims: identify the original species, grade, and width (3.25 select red oak is different from 2.25 #1 common red oak — they do not match); consult the original flooring supplier or a National Wood Flooring Association (NWFA) certified inspector; get written confirmation of discontinuation from the manufacturer if the product is no longer available.

Site-finishing dimension: a carrier who approves replacement hardwood flooring but specifies prefinished material rather than site-finished is not approving LKQ when the existing floor is site-finished. Prefinished and site-finished hardwood have different surface profiles, different sheen levels, and visibly different appearances at the seam between old and new material. A mix of site-finished existing and prefinished replacement on a visible continuous floor run does not meet the LKQ standard.

Roofing Materials

Roofing LKQ disputes fall into two categories: product substitution (carrier specifies a lower-quality shingle than the original) and matching (carrier approves only the damaged slopes, leaving undamaged slopes that cannot be matched). For product substitution: the original shingle’s Class A fire rating, Class 4 impact resistance (if applicable), wind rating, and dimensional profile must be replicated in the replacement. A 30-year 3-tab shingle is not LKQ for a 50-year architectural shingle with Class 4 impact rating regardless of the price similarity. Document the original shingle’s specifications with the manufacturer’s product sheet — this is the LKQ baseline.

For roofing matching: the critical question is whether undamaged slopes can be matched with new shingles of the same product. Asphalt shingles fade and age over time — a 10-year-old shingle cannot be matched by new shingles of the same product because the new shingles are a different color. When partial replacement produces a visible color mismatch, the matching doctrine applies. States with the strongest matching case law for roofing: Minnesota (*Mork v. Homesales Inc.*, 2013, establishing matching obligation); Colorado (prior to 2023 legislation restricting matching for cosmetic damage); Wisconsin; and Illinois. Colorado’s 2023 Senate Bill 178 limited matching claims for cosmetic hail damage — functional damage still supports matching claims in

Colorado.

Siding

Vinyl siding matching disputes are among the most common in the post-storm claim market. Vinyl siding fades, and colors are frequently discontinued. A partial siding replacement on a single elevation that matches when installed but diverges in color after 2 to 3 years of UV exposure does not satisfy the LKQ standard. The standard matching claim for siding: document the existing product and color; verify with the manufacturer and distributors that the product is discontinued or unavailable; demonstrate with photographs or color samples that available products do not match the existing color. The strongest documentation is a side-by-side photograph of the existing siding and the closest available matching product showing the color difference.

Fiber cement siding (HardiePlank and equivalents) matching: Hardie product lines change periodically, and older profiles (HardiePlank 4.5 exposure traditional lap, for instance) may have been replaced by different profile options. When the original profile is discontinued, the carrier owes replacement with the closest available profile — and if no profile achieves a reasonable match, a full-elevation or full-building replacement may be warranted under the matching doctrine.

Cabinetry

Cabinet LKQ disputes arise when: partial replacement is required (one section of a kitchen run was damaged while the balance was unaffected) and the existing cabinet line is discontinued; the existing cabinet construction is solid wood (face frame + solid wood doors) and the carrier specifies particleboard-box construction; or the existing cabinet finish is a custom color or custom stain that cannot be replicated by standard cabinet lines. Cabinet matching documentation: the original cabinet manufacturer and product line (check the interior of the cabinet door or the drawer box for a manufacturer label); consult a local kitchen and bath dealer for availability; get written confirmation if the product line is discontinued.

Tile and Stone

Natural stone (marble, travertine, slate) is inherently variable — no two slabs are identical, and older installations may use stone that is no longer quarried or that has aged to a different surface appearance. Tile (ceramic, porcelain) is subject to discontinuation just as flooring and siding are. For tile matching: the pattern, size, color, and surface texture of the existing tile are all matching parameters. A 12×12 glazed ceramic tile in a specific color that has been discontinued cannot be matched with a 12×24 large-format tile in a similar color — the format difference alone creates a visible mismatch in any new section of installation adjacent to the existing tile. Document the original tile with photographs, attempt manufacturer identification (often embossed on the back face of the tile), and get written dealer confirmation of discontinuation.

Documenting Matching Claims in the Xactimate Estimate

Matching claims are supplement items — they are generally not in the original carrier estimate because the adjuster assumes available matching materials at the time of the initial estimate. When matching documentation confirms the original material is discontinued or unavailable, the supplement is built around three elements: the LKQ baseline (documentation of what the original material was and its quality tier); the discontinuation documentation (manufacturer and distributor written confirmation); and the expanded scope calculation (cost to replace the full floor, elevation, or roof surface rather than only the damaged section).

The Xactimate F9 note on the expanded replacement line item documents: the original material specification, the confirmation of discontinuation (with vendor names and dates of confirmation), the visible match area that requires replacement to achieve a uniform appearance, and the cost differential between the partial repair and the full-replacement scope. This note is the adjuster's guide to approving the supplement — without it, the expanded replacement is a facially excessive scope request with no documented justification.

Anti-Match Legislation and Trends

The property insurance industry has actively lobbied for legislation limiting matching obligations, particularly in high-CAT states where roofing matching claims became a significant driver of insurer losses after major hail events. Colorado SB 23-178 (2023) limits matching claims for cosmetic hail damage — damage that is aesthetic but does not impair the functional performance of the material. The legislation does not eliminate matching for functional damage. Texas has not enacted similar legislation as of early 2026. Florida's post-reform environment makes matching claims harder to litigate but does not eliminate the LKQ standard for material selection in reconstruction.

The trend across multiple states is toward narrowing matching obligations for cosmetic damage while preserving them for functional damage. Understanding whether the damage at issue is functional (impairs performance — wind-driven water infiltration through a compromised shingle; hail impact that cracks a shingle tab) versus cosmetic (aesthetic only — dented metal gutters, granule loss that does not expose mat) is the threshold question that determines whether the matching doctrine applies. Restoration contractors and public adjusters who can document functional damage — not just cosmetic impact — are best positioned to support matching claims in jurisdictions with or without anti-match legislation.

Internal Links

- [Reconstruction: Complete Professional Guide](#)
- [Post-Disaster Reconstruction: Scope, Permitting, and Sequencing](#)
- [Reconstruction Project Management: Subcontractors, Inspections, and CO](#)
- [Xactimate and Scope Development: How Carriers Price Claims](#)
- [Disputed Claims and the Appraisal Process](#)
- [Wind and Hail Damage: Scope, Insurance Claims, and Repair Standards](#)

Frequently Asked Questions

What does 'like kind and quality' mean in a reconstruction insurance claim?

Like kind and quality (LKQ) requires the insured property to be restored with materials of similar type, quality, and performance characteristics to those that existed before the loss. It does not mean identical materials — it means reasonably equivalent in durability, appearance, and function. Where the original material cannot be matched because it has been discontinued, the carrier's obligation expands to achieve a visually uniform result that meets the original quality level.

When is an insurance carrier required to replace an entire floor instead of patching the damaged section?

A carrier is required to cover full floor replacement when the damaged material is discontinued, unavailable in the existing color and pattern, or when a patch would produce a noticeable mismatch in color, sheen, texture, or pattern visible in normal use. The matching doctrine holds that the RCV standard requires restoration to a uniform appearance, not merely functional repair. A floor that looks noticeably patched has not been restored to pre-loss condition.

What is the matching doctrine for roofing in hail damage claims?

The roofing matching doctrine applies when hail damages only a portion of a roof and undamaged slopes cannot be matched with new shingles because the existing product is discontinued, aged to a different color, or otherwise unavailable. In these circumstances the carrier may owe replacement of all slopes to achieve a uniform appearance. Colorado enacted anti-match legislation in 2023 limiting matching for cosmetic damage; functional damage still supports matching claims. Courts in Minnesota, Wisconsin, and Illinois have upheld roofing matching obligations.

How do I document that a discontinued material cannot be matched?

Discontinuation documentation requires: a written statement from the original manufacturer confirming the product is discontinued; written confirmation from at least two local distributors that the material is unavailable; photographs of the existing material showing the specific color and pattern; and a professional assessment confirming no available product is a reasonable match. This documentation package is the supplement support for a full-replacement matching claim.

Does a carrier have to use the same brand of materials in reconstruction?

No. The like kind and quality standard does not require the same brand — it requires materials of equivalent quality, durability, and appearance. A carrier can specify a different brand of shingle with the same class, wind rating, and dimensional profile. Where the brand difference produces a different appearance, that difference becomes a matching issue. The homeowner's right is to materials that restore the property to its pre-loss quality level and appearance.

Residential Restoration: The Homeowner's Guide to Contractors, Insurance Carriers, and the Claims Process

Source: <https://restorationintel.com/residential-restoration-homeowner-guide-contractor-carrier/> Published: March 17, 2026

Updated October 6, 2026.

For most homeowners, a significant property loss is the first time they have navigated both a restoration project and an insurance claim simultaneously, under time pressure, while displaced from their home or living in a partially damaged one. The restoration contractor who shows up within hours of the loss has significant informational advantage over the homeowner they are asking to sign an authorization form. This guide exists to close that gap — to give homeowners the framework to evaluate the contractor in front of them, understand what they are being asked to sign, engage effectively with their insurance carrier, and recognize when the process is going well versus when it is not.

This article covers the homeowner's side of residential restoration: how to vet and hire a restoration contractor, what to watch for in the authorization and scope process, red flags in post-storm solicitation, how to work with

your insurance adjuster, what “restored to pre-loss condition” means and how to protect that standard, and what to do when the process is not going as it should.

Vetting a Restoration Contractor: The Five-Point Check

Before Signing Any Authorization Form Ask for: (1) the contractor’s IICRC certification number — verifiable at iicrc.org; (2) the state contractor license number — verifiable with the state licensing board; (3) a certificate of general liability insurance naming the homeowner as additional insured; (4) a workers’ compensation insurance certificate (a contractor whose employee is injured at your home without workers’ comp creates personal injury liability for you); (5) a local physical address and local references for recent jobs of similar scope. A contractor who cannot provide all five items promptly is not the contractor for your home.

The IICRC (Institute of Inspection Cleaning and Restoration Certification) is the primary credentialing body for restoration professionals in the United States. IICRC firm certification means the company maintains technicians with current IICRC credentials and meets ongoing firm standards. Individual technician credentials relevant to residential restoration: WRT (Water Restoration Technician) for water losses; FSRT (Fire and Smoke Restoration Technician) for fire losses; AMRT (Applied Microbial Remediation Technician) for mold or biohazard. The lead technician on your job should hold the appropriate credential for your loss type — this is verifiable through the IICRC’s public directory.

State contractor licensing: most states require a contractor license for restoration work above a value threshold (\$500–\$1,000 in most states). Water mitigation specifically requires a separate license in Florida (Florida Department of Business and Professional Regulation), Texas (TDLR Water Damage Restoration Contractor), California (CSLB Class B General Contractor for work above \$500). Ask for the license number and verify it on the state board’s website — license verification takes 2 minutes and confirms the license is current and in good standing. A lapsed or suspended license is a significant warning sign.

The Authorization Form: What You’re Signing

The restoration authorization form is a contract. It authorizes the contractor to perform specific services, establishes the pricing basis for those services, and may contain additional provisions that significantly affect your rights in the insurance claim. Read it before signing it. A contractor who pressures you to sign immediately without review — “I need to start right now or the damage will get worse” — is creating artificial urgency to prevent you from reading what you are agreeing to.

Key provisions to identify: the scope of authorized services should be specific — “emergency water extraction, drying equipment placement, and daily monitoring” is specific; “all restoration services” is not, and authorizes work you may not have agreed to. The rate schedule — emergency services billing should reference a specific rate schedule for labor, equipment, and materials; a flat “cost plus 10%” contract on work that has not been scoped gives the contractor uncapped billing authorization. Assignment of Benefits (AOB) language — some authorization forms include AOB provisions that transfer your right to collect the insurance proceeds directly to the contractor. In states where AOB is restricted (Florida, Texas), an AOB provision may void your coverage. Read for this language specifically.

What a well-designed authorization form looks like: specific authorized scope, rate schedule attached or referenced, duration of authorization (emergency services only, or ongoing through reconstruction), carrier notification confirmation, and a provision that no work beyond the authorized scope will be performed without

an additional signed change order. An authorization form that is clear, specific, and limited to what was discussed is the mark of a contractor who intends to bill what they told you they would bill.

Storm Chasers and Post-Disaster Solicitation

After any significant weather event — hail storm, hurricane, tornado, flash flood — a secondary arrival of contractors follows within 24 to 72 hours, often soliciting door-to-door. Some of these contractors are legitimate local companies capitalizing on increased demand. Others are “storm chasers” — out-of-state contractors who follow severe weather events, perform volume work during the storm season, and leave when the work dries up. The difference is not always obvious at the door.

Red flags for storm chasers: the contractor appeared at your door unsolicited within 24 hours of the storm; they claim “your neighbor already signed up” or imply you are missing a limited-time opportunity; they are unwilling to provide a license number, insurance certificate, or physical local address on request; they want you to sign anything before they have inspected the damage and provided a written scope; they mention your insurance claim in the context of “we’ll handle everything” without you having raised the subject; and they do not have a local phone number, physical office, or references from your community.

The Assignment of Benefits problem with storm chasers: the AOB model — where the homeowner signs over their insurance claim rights to the contractor — became prevalent in Florida’s storm restoration market and drove dramatic insurance premium increases. Florida’s 2019 and 2023 AOB reform legislation significantly restricted residential property AOB in response. In states without explicit AOB restriction, a homeowner who signs an AOB with a storm chaser contractor has handed control of their claim negotiation to a company that may disappear from the state before the claim is settled. If a contractor asks you to sign any document that transfers your insurance rights, consult with your carrier or an attorney before signing.

Working With Your Insurance Adjuster

The insurance adjuster — whether a staff adjuster (carrier employee) or an independent adjuster (contractor retained by the carrier) — is evaluating your claim on behalf of the carrier. They are not your advocate, but they are also not your adversary. Most adjusters are trying to produce a fair and accurate settlement under the policy terms within the carrier’s guidelines. Your job is to ensure they have complete information, inspect all affected areas, and understand the scope of the damage.

Be present for the adjuster’s inspection. Walk through the entire affected area with them — every room, every affected wall, the attic, the crawlspace, any outbuildings with damage. If the adjuster does not inspect a specific area, it will not be in their estimate. Politely directing them to all affected areas is appropriate and expected. Provide your own photographs, the restoration contractor’s moisture map, and any documentation you have of the pre-loss condition. Keep a record of the adjuster’s name, contact information, the claim number, and the date and duration of their inspection.

Reviewing the initial estimate: when you receive the carrier’s Xactimate estimate, compare it to the restoration contractor’s scope assessment. Common gaps: overhead and profit missing on jobs with multiple trades; code upgrade items excluded because the ordinance or law endorsement was not applied; matching scope not included for discontinued materials; and line items not included because they were not visible during the inspection. Your restoration contractor should review the carrier’s estimate and identify any missing items — this is the basis for a supplement request, which is a normal part of the claims process and does not constitute an

adversarial position.

Protecting the “Restored to Pre-Loss Condition” Standard

Your insurance policy’s replacement cost value (RCV) provision entitles you to have your home restored to its pre-loss condition — not reduced to a lesser condition, and with materials that match the existing undamaged portions. This standard protects you in several specific scenarios.

Matching: If the damaged flooring material is discontinued and cannot be matched, the carrier may owe replacement of the entire floor surface (or entire room) to achieve a uniform appearance — not just the damaged section patched with a visibly different material. Same principle applies to siding, roofing, cabinetry, and paint. Document the pre-loss material specifications (brand, color, product number) to the extent possible; a professional contractor or a flooring supplier can often identify the original product from a photograph or a physical sample.

Quality standard: The restoration should use materials of like kind and quality to the originals — not the least expensive equivalent. If your home had solid hardwood floors, LVP is not “like kind and quality” regardless of its price point or aesthetic similarity. If the original roofing was a 50-year architectural shingle, the replacement should be the equivalent product, not a standard-grade 25-year shingle. If a carrier estimate specifies a material that is not like kind and quality to the original, document the original specification and submit the difference as a supplement.

Pre-loss documentation: The most effective protection for the pre-loss condition standard is documentation of the home’s condition before the loss. Homeowners who have a home inventory — photographs or video of every room, including close-ups of flooring, cabinetry, fixtures, and finishes — can demonstrate the pre-loss quality standard with evidence rather than memory. A home inventory also supports the personal property (Coverage C) portion of any claim. Creating a home inventory requires one afternoon and a smartphone; storing it off-site (cloud storage) ensures it survives whatever loss event it is meant to document.

When the Process Is Not Going Well

Signs that the restoration process has gone off track and action is needed: the drying phase has extended beyond 10 days for a standard residential water loss without documented explanation; the carrier’s estimate is substantially below the contractor’s estimate and no supplement has been submitted or the supplement has been denied without explanation; work has been performed and billed that the homeowner did not authorize; the contractor is not responding to questions about timeline or billing; mold has appeared in areas that were supposed to have been dried.

Escalation options: for carrier disputes, the policy’s appraisal clause is available for scope and valuation disagreements. For contractor disputes, the state contractor licensing board accepts consumer complaints and can investigate billing disputes, unlicensed work, and contract violations. For significant claims disputes, a licensed public adjuster (PA) can evaluate the claim and manage the supplement and appraisal process. For denied claims or reservations of rights, an insurance coverage attorney can evaluate whether the denial is correct under the policy language and applicable state law. See the Insurance Claims series for the complete escalation framework.

Internal Links

- Residential Restoration: Complete Professional Guide
- Residential Water Damage: Pipe Burst to Move-Back
- Residential Fire Restoration: Scope, Contents, and Temporary Housing
- How to File a Property Insurance Claim for Restoration
- Disputed Claims and the Appraisal Process
- Emergency Documentation and Insurance Notification

Frequently Asked Questions

How do I find a reputable restoration contractor after a water or fire loss?

Verify five things before signing any authorization: (1) IICRC firm certification, verifiable at iicrc.org; (2) state contractor license number, verifiable with the state licensing board; (3) general liability insurance certificate; (4) workers' compensation insurance certificate; (5) local physical address and local references for recent jobs. A contractor who cannot provide all five items promptly is not the contractor for your home.

What are the red flags of a 'storm chaser' restoration contractor?

Red flags include: unsolicited door-to-door contact immediately after a storm; pressure to sign any document before damage has been inspected and a written scope provided; claims that 'your neighbor just signed up' or 'this offer expires today'; unwillingness to provide a license number or insurance certificate on request; no local physical office, phone number, or references from your community; and any request to sign an Assignment of Benefits before you have consulted your carrier.

What should I read carefully before signing a restoration authorization form?

Check: (1) the scope of authorized services — it should be specific, not open-ended; (2) the rate schedule — labor, equipment, and material rates should be referenced or attached; (3) any Assignment of Benefits language transferring your insurance claim rights to the contractor; (4) whether the authorization is limited to emergency services or authorizes all future work; (5) change order provisions — no work beyond the authorized scope without a new signed change order.

Can my insurance company require me to use their preferred restoration contractor?

No. In most states, an insurance carrier cannot require a policyholder to use the carrier's preferred vendor network as a condition of coverage. The carrier may recommend their preferred contractors, but the homeowner's right to select their own licensed contractor is protected under most state insurance regulations. If a carrier representative implies that using a non-preferred contractor will affect coverage, ask for that statement in writing.

What does 'restored to pre-loss condition' mean in a residential restoration claim?

Restored to pre-loss condition means the property is returned to the condition it was in immediately before the covered loss — the same materials, finishes, and functionality. The matching standard applies: if damaged flooring cannot be matched because the original material has been discontinued, the carrier may owe replacement of the entire room to achieve a uniform appearance. Pre-loss documentation — photographs of the home's condition before the loss — is the most valuable evidence in any dispute about whether the restoration returned the home to its prior standard.

Xactimate and Scope Development: How Insurance Carriers Price Restoration Claims

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Nearly every property damage claim in the United States — from a \$3,000 bathroom leak to a \$3 million commercial fire — is eventually priced using Xactimate, the estimating software platform developed by Verisk Analytics. Xactimate is not just a calculator; it is the shared language of property claims. Carrier adjusters, independent adjusters, restoration contractors, public adjusters, and attorneys all work from Xactimate estimates, and understanding how those estimates are built — line item by line item, with depreciation schedules, pricing zones, and markup structures — is essential to understanding why a claim pays the way it does.

This article covers the Xactimate pricing structure, scope development methodology, the most common gaps in carrier-generated estimates, the supplement process, and the documentation practices that support full claim recovery. See the companion Insurance Claims articles for the complete claim filing workflow and the appraisal process for disputed claims.

How Xactimate Pricing Works

Xactimate Pricing Zones Xactimate divides the United States into approximately 460 pricing zones, each reflecting local construction market conditions. Pricing is updated monthly based on material cost data, RSMeans construction data, and local labor rate surveys. A drywall installation line item priced at \$1.85/SF in rural Mississippi may price at \$3.40/SF in San Francisco. Using the correct pricing zone is the foundation of a defensible estimate — both carrier and contractor estimates are expected to reflect the prevailing market pricing for the loss location.

Each line item in Xactimate has a unique code (e.g., DRY 1/2 = standard 12-inch drywall, FLR OAK = oak hardwood flooring), a unit of measure (SF, LF, EA, HR), a labor component, a material component, and an equipment component. The line item unit price is the sum of these components at the current zone pricing. Some items include a “remove” prefix (DRY R/R = remove and replace drywall) that includes both demolition and replacement in a single line; others are priced separately for removal and replacement.

The estimate structure builds from line items to room totals to an estimate summary. At the estimate summary level, Xactimate applies: sales tax on materials; overhead (typically 10%); profit (typically 10%); and depreciation if the estimate is being generated at ACV. The depreciation schedule is applied by item category — roofing materials depreciate faster than framing lumber, carpet faster than tile, paint is typically non-depreciable on replacement cost estimates. Labor is typically excluded from depreciation on RCV estimates.

Scope Development: What Goes Into the Estimate

The Field Inspection as Scope Source

Xactimate estimates are only as complete as the field inspection that informed them. Carrier adjusters typically spend 30 to 90 minutes on a residential loss — enough to document the visible damage in the primary affected areas, take field measurements, and photograph key conditions. This time constraint creates predictable scope gaps. Items that require probing, infrared scanning, or opening of finished assemblies to find — hidden moisture migration, attic smoke infiltration, water-damaged insulation behind intact drywall — frequently do not appear in the initial carrier estimate because they were not visible during the field inspection.

Professional scope development by a restoration contractor begins with the same field inspection but with more time, specialized equipment (moisture meters, thermal imaging cameras, video scopes for wall cavities), and the specific knowledge of how damage migrates through structural assemblies. A restoration contractor who performs a thorough initial scope assessment — documenting all affected materials, all moisture migration paths, all hidden damage discovered during initial demolition — produces an estimate that reflects the actual cost of restoration rather than the cost of the damage that was visible during a 45-minute walk-through.

The Most Commonly Omitted Scope Items

Overhead and profit (O&P): The most consistently underpaid item in residential property claims. O&P is owed whenever the restoration project requires a general contractor to coordinate multiple trades. The Xactimate estimate by default does not add O&P; the adjuster must manually add it. On complex losses (fire, major water events requiring drywall, painting, flooring, and cabinet replacement), O&P adds 20% to the direct line item total. Courts in multiple jurisdictions (including Texas, Florida, and California) have confirmed that O&P is a component of replacement cost value when GC coordination is required. The seminal Xactimate O&P precedent is the California case *Beauchamp v. Allstate*, though the issue continues to be litigated at the state level.

Debris removal and disposal: For fire losses, debris removal is a significant scope item — ash, charred structural material, contaminated insulation — that may not be reflected adequately in standard Xactimate line items. For water losses with contaminated materials (CAT 3), disposal fees for regulated waste are separately billable and may not appear in a standard carrier estimate.

Material price escalation: Xactimate pricing updates monthly, but during periods of rapid material cost escalation (post-COVID supply chain disruption caused lumber, OSB, and copper prices to rise 100–300% above Xactimate database pricing in 2021–2022), Xactimate database pricing can lag actual market pricing by 60 to 90 days. Supplement documentation using current supplier invoices or distributor quotes is the mechanism for capturing material price escalation above the Xactimate database price.

Detach and reset items: Restoration work often requires temporary removal and reinstallation of items that are not damaged but are in the way — bathroom fixtures, kitchen cabinets that cannot be in the work area during drywall and paint, appliances. These detach-and-reset items (identified by the D/S prefix in Xactimate) are frequently omitted from carrier estimates.

Code upgrade items: Electrical panel upgrades triggered by fire damage, hurricane strap installation required when roof decking is replaced in a code-update jurisdiction, AFCI breaker installation in bedroom circuits — these items are covered by the ordinance or law endorsement and require separate documentation of the specific code requirement that triggered the upgrade. Local building department inspection records and permit documentation are the supporting evidence for code upgrade supplement claims.

Matching: When partial replacement of damaged flooring, roofing, or siding is impossible to match because the original material has been discontinued or is unavailable, the carrier may owe replacement of the entire plane (the complete room’s flooring, the complete roof slope, the complete siding elevation) to achieve a uniform appearance. Matching claims are among the most actively litigated areas of property insurance, with California and Florida having specific case law and statutes addressing carrier obligations for matching coverage. The principle is that restoration to “like kind and quality” per the standard RCV policy condition requires that the repaired area match the undamaged portion — a patch that is clearly visible as a different color, texture, or material does not satisfy the RCV standard.

The F9 Note: Documentation Inside the Estimate

Every non-standard line item — a unit price above the Xactimate database, a line item that requires explanation, a scope decision that might be questioned — should have an F9 note attached that documents the specific reason. An F9 note is not a negotiation tactic; it is a professional documentation practice that allows the reviewing adjuster to understand and approve the scope item without a second site visit or a lengthy email exchange.

Effective F9 notes: cite specific conditions observed in the field (“hardwood flooring extends continuously from affected dining room into unaffected hallway; matching 3.25 oak flooring confirmed discontinued by manufacturer; full run replacement required for match”); cite applicable code requirements (“smoke detector upgrade to interconnected combination smoke/CO detectors required by triggered by fire repair permit”); cite manufacturer requirements that drive additional scope (“manufacturer warranty for tile installation requires full mortar bed removal and reinstallation; Schluter Ditra membrane required per current installation specification”). These notes make approvals faster and disputes narrower.

Mitigation Billing Structure Within Xactimate

Emergency mitigation — water extraction, equipment rental, daily monitoring — is billed separately from reconstruction in a properly structured claim file. The mitigation estimate covers all work from initial response through drying goal achievement: extraction labor, air movers and dehumidifier rental at daily rates, daily monitoring visits, demolition of wet materials performed during mitigation (drywall cut lines, carpet and pad removal). The reconstruction estimate begins after drying is confirmed complete.

Xactimate mitigation line items of note: **WTR EXTR** (water extraction, per SF); **AIR MOVE** and **DEHUM LGR** (air mover and LGR dehumidifier rental, per day); **MONITR** (daily monitoring visit); **WTR CONT** (containment setup for CAT 3 or mold work); **DECON** (decontamination chamber). Mitigation equipment billing is validated by the equipment log documenting placement, serial numbers, and daily readings — the log is the audit trail that supports the per-day equipment rental billing. An equipment log with no daily readings is an equipment log that can be challenged; one with complete daily readings documenting progress toward drying goals is a billing record that is very difficult to dispute.

Large Loss and Commercial Scope Development

Commercial losses require scope development tools beyond Xactimate’s standard residential line item set. Xactimate Commercial (formerly XactAnalysis for commercial) expands the line item database for commercial construction materials, mechanical systems, and specialty items. For complex commercial losses, Xactimate

estimates are frequently supplemented by: quantity takeoff reports from drafting or BIM software (for precise material quantity documentation on large-footprint buildings); subcontractor bids from licensed specialty trades (mechanical, electrical, plumbing) where Xactimate unit prices do not accurately reflect specialized commercial system pricing; and RS Means commercial construction cost data as an alternative pricing reference when Xactimate database pricing is contested.

Business interruption documentation runs parallel to the property damage estimate on commercial losses. Business interruption coverage (Coverage for Business Income on ISO CP forms) compensates for the loss of net income during the restoration period. Supporting documentation: pre-loss financial records (12 months of profit/loss, tax returns), documentation of the restoration timeline, evidence of extra expenses incurred to maintain operations or minimize the income loss (temporary facility rental, equipment rental to maintain production capacity). Business interruption documentation belongs in the claim file from day one — financial records from the loss period are often difficult to reconstruct after the fact.

Internal Links

- Insurance Claims: Complete Professional Guide
- How to File a Property Insurance Claim for Restoration
- Disputed Claims and the Appraisal Process
- Emergency Documentation and Insurance Notification
- Wind and Hail Damage: Scope Development and Supplement Management
- Asbestos and Insurance Claims: Scope Documentation

Frequently Asked Questions

What is Xactimate and who uses it?

Xactimate is a property claims estimating software platform developed by Verisk Analytics and used by the majority of property insurance carriers in the United States for developing repair and replacement cost estimates. It contains a database of over 20,000 line items covering labor, material, and equipment costs, updated monthly by pricing zone. Xactimate is used by carrier adjusters, independent adjusters, and restoration contractors — creating a common estimating language across all parties in a claim.

What is overhead and profit (O&P) in a restoration estimate?

Overhead and profit (O&P) is a markup applied to a Xactimate estimate — typically 10% overhead and 10% profit — that compensates the general contractor for project management, supervision, insurance, bonding, warranty, and business overhead beyond direct labor and material costs. O&P is owed whenever the scope requires general contractor coordination of multiple trades. Carriers routinely omit O&P from initial estimates; courts have consistently upheld its inclusion in RCV estimates when GC coordination is required.

What are code upgrade items and are they covered by insurance?

Code upgrade items are the additional costs of rebuilding to current building code requirements when the original structure did not meet current code. Standard HO-3 policies exclude code upgrades unless the policyholder has added an ‘ordinance or law’ endorsement. That endorsement typically covers: cost to demolish undamaged portions required by code, increased cost of rebuilding to code, and loss of value to the undamaged

portion. Ordinance or law coverage is most valuable for pre-1980 structures in jurisdictions with significant code updates.

Why do carrier Xactimate estimates often differ from contractor estimates?

Carrier estimate differences typically arise from four sources: scope gaps (items the adjuster did not include because they were not observed during inspection or were not documented); line item unit price differences (local market labor rates may exceed Xactimate database pricing); missing overhead and profit on estimates where GC coordination is required; and depreciation application errors. Each of these gaps is addressable through the supplement process with proper documentation.

What is an F9 note in Xactimate?

An F9 note is a line item comment or explanation attached to a specific estimate line item in Xactimate. F9 notes are used to document the reason for a specific line item choice, to explain why a line item differs from the standard unit price, or to note conditions that justify a specific scope decision. Well-documented F9 notes reduce supplement disputes by providing the adjuster with the context to approve the item without a site visit or additional back-and-forth.

How to File a Property Insurance Claim for Restoration: From Loss Report to Settlement

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Most property owners file an insurance claim once or twice in a lifetime. Insurance carriers handle hundreds of thousands of claims per year. The information asymmetry between a policyholder navigating an unfamiliar process during an emotionally difficult event and a carrier with structured workflows, proprietary estimating platforms, and experienced adjusters is substantial. Understanding the claims process — the sequence, the timing requirements, the coverage structure, and the leverage points — is not about being adversarial with the carrier. It is about protecting the policyholder’s contractual rights under a policy they have been paying for.

This guide covers the complete property insurance claim workflow from first notification through final settlement: prompt notice requirements, adjuster types and their roles, coverage analysis framework, the estimate review process, and the tools available when initial settlement offers are inadequate. See the companion articles in this Insurance Claims series for Xactimate and scope development detail and the appraisal process for disputed claims.

Step 1: Prompt Notification — The Policy Condition That Starts the Clock

Definition: Prompt Notice Condition Property insurance policies universally include a condition requiring the policyholder to give **prompt notice** of the loss or damage. While most policies do not define “prompt” as a specific number of days, courts and regulators have interpreted it as notice given within a reasonable time after the loss is discovered — typically same-day for active losses and within 24 to 72 hours for discovered losses. Late notice can give the carrier grounds to deny the claim or reduce the settlement for damage that occurred between the loss and the notification.

The notification call to the carrier opens the claim and starts several concurrent timelines: the carrier's internal investigation clock, the adjuster assignment process, and the state-mandated response windows. When calling to report the claim, have ready: policy number, date and approximate time of the loss, type of loss (water, fire, storm, other), address of the property, a brief description of the damage observed, and whether emergency mitigation work has already begun. Do not attempt a comprehensive damage description on the initial call — that comes later with documentation. The goal of the first call is to open the claim and receive a claim number.

Document the notification call: note the time, the carrier representative's name, the claim number issued, and any instructions the carrier gave (do not proceed with demolition without authorization; preferred vendor contact information; adjuster name if already assigned). This contemporaneous record becomes part of the job file and protects the policyholder if the carrier later claims the loss was reported late or that specific instructions were given that were not followed.

Step 2: Understanding Your Policy Before the Adjuster Arrives

Coverage A, B, C, and D — The Basic Structure

Standard homeowner policies (ISO HO-3 form) are organized into four coverage components. Coverage A (Dwelling) covers the structure itself — walls, roof, floors, built-in appliances, permanently installed fixtures. Coverage B (Other Structures) covers detached garages, fences, and outbuildings at typically 10% of Coverage A. Coverage C (Personal Property) covers contents, subject to scheduled item limits for high-value categories (jewelry, electronics, art). Coverage D (Loss of Use / Additional Living Expense) covers temporary housing and increased living expenses while the home is uninhabitable. Most restoration claims are primarily Coverage A with Coverage C involvement for contents damage and Coverage D when displacement is required.

Commercial property policies (ISO CP forms) follow a different structure: Coverage A covers the building, Coverage B covers business personal property, and additional endorsements cover business income interruption, extra expense, and ordinance or law upgrades. The commercial policy's co-insurance clause — typically 80% or 90% — requires that the building be insured to a percentage of its replacement cost value; under-insurance at the time of loss triggers a co-insurance penalty that reduces the claim payment proportionally.

Key Policy Provisions to Identify Before the Adjuster Visit

Several policy provisions materially affect claim outcome and should be understood before the adjuster arrives. The **deductible** — whether it is a flat dollar amount or a percentage of Coverage A (percentage deductibles common in hurricane and hail zones in Florida, Texas, and the Gulf Coast states). The **ACV vs. RCV** provision — whether the policy pays replacement cost value or actual cash value (ACV = RCV minus depreciation). **Sublimits** for specific perils: mold sublimits (\$5,000–\$50,000 on most policies post-2005), water backup endorsement limits, equipment breakdown coverage. **Exclusions:** flood (covered only by NFIP or private flood policy, not standard homeowner), earthquake, wear and tear, gradual damage, maintenance failure. The **ordinance or law endorsement:** covers the increased cost of rebuilding to current building code when the original construction predates current requirements — critical for pre-1970 structures in jurisdictions with significant code updates.

Step 3: The Adjuster — Who They Represent and What They Do

Staff Adjuster

A staff adjuster is an employee of the insurance carrier. They represent the carrier's interests, evaluate coverage, determine liability, and develop the settlement offer. Staff adjusters are licensed in the states where they work and are regulated by state departments of insurance. They are not advocates for the policyholder — their job is to evaluate the claim within the carrier's guidelines and issue a settlement that is fair under the policy terms but that also reflects the carrier's financial interest in limiting claim costs.

Independent Adjuster (IA)

Independent adjusters are self-employed or work for IA firms (Crawford & Company, Sedgwick, McLarens) contracted by carriers to handle claims — particularly during large CAT events when staff adjuster capacity is overwhelmed. IAs represent the carrier's interest on the specific claim they are assigned, not a permanently employed staff member. Their quality varies significantly; an IA handling a high volume of CAT claims may spend 30 minutes on a property that requires hours for a complete evaluation. Document the IA's full inspection with photographs; if they miss affected areas, follow up in writing with the claim number and specific areas not addressed.

Public Adjuster (PA)

A public adjuster represents the policyholder — not the carrier — for a fee, typically 10–15% of the claim settlement. PAs are licensed in most states (Texas, Florida, California all require PA licensing) and are prohibited from soliciting immediately after a disaster in many jurisdictions. A PA is a legitimate resource for large, complex, or disputed claims where the policyholder lacks the time, knowledge, or documentation capacity to manage the claim effectively. PA value is greatest on claims above \$50,000, on commercial losses, and on any claim where the carrier has issued a reservation of rights letter. PAs are not needed for straightforward residential claims where the scope is uncontested and the carrier's estimate is reasonable.

The Field Adjuster Inspection

The field adjuster visit is the carrier's opportunity to evaluate the loss in person. The property owner or their representative should be present for the entire inspection and should walk through the same areas the adjuster walks. If the adjuster does not inspect a specific area — attic, crawlspace, detached structure, affected outbuilding — that area may not appear in their estimate. Politely directing the adjuster to all affected areas and making sure they photograph and note all damage is not adversarial; it is the property owner's responsibility under the duty to cooperate provision of the policy.

Do not sign any settlement agreement, release, or satisfactory-completion form during the field inspection. An adjuster who presents a settlement check or asks for a signature at the initial inspection visit is moving faster than the process should allow — the estimate has not been developed, reviewed, or compared to the restoration contractor's scope. Any payment acceptance at this stage locks in that amount as full settlement.

Step 4: The Estimate — ACV Payment and Recoverable Depreciation

After the field inspection, the adjuster develops a scope of loss estimate, typically using Xactimate software (covered in detail in the companion Xactimate and Scope Development article). The carrier issues an initial ACV payment — the estimated repair cost minus depreciation — within the state-mandated payment timeline. The ACV payment is not the final settlement; it is the initial payment pending completion of repairs.

Reviewing the adjuster's Xactimate estimate requires: comparing line items to the actual scope of damage; checking that all affected materials are included; confirming depreciation is applied only to depreciable items (labor is typically non-depreciable; structural materials have depreciation schedules; asphalt shingles depreciate faster than metal roofing); and verifying that overhead and profit (O&P) — typically 10% overhead and 10% profit — is included on the estimate when a general contractor is coordinating multiple trades. Overhead and profit is frequently omitted on initial carrier estimates and is a common supplement item for complex losses.

The ACV estimate establishes the floor of the settlement. When repairs are completed and documented, the withheld depreciation — recoverable depreciation — is released as a supplemental payment. The policyholder must request this payment and provide proof of completion (contractor invoices, before/after photographs, Certificate of Completion). Recoverable depreciation is not paid automatically; it is paid when claimed with documentation.

Step 5: Supplements and Final Settlement

A supplement is an addition to the original estimate that reflects damage not identified during the initial inspection or additional scope items discovered during the course of repair. Hidden damage — water migration inside wall cavities discovered when drywall is removed, subfloor damage found under carpet, HVAC damage identified when the system is cleaned after a fire — generates legitimate supplement claims. The supplement process is the normal course of property claim settlement for any loss more complex than a simple single-room water event.

Supplement documentation requirements: a revised or addendum Xactimate estimate showing the additional scope; photographs of the discovered damage before it is repaired; a written explanation of when and how the additional damage was discovered; and, for significant supplement amounts, an updated proof of loss. Carriers are not required to approve supplements without documentation — undocumented supplement requests are routinely denied, while well-documented supplement requests with photographs and clear scope narratives are routinely approved.

Final settlement is reached when: all approved scope has been completed, proof of completion has been submitted, recoverable depreciation has been released, supplements have been resolved, and any code upgrade items covered by the ordinance or law endorsement have been documented and claimed. At this point the restoration contractor closes the job file and the claim is formally closed.

When Claims Are Denied or Underpaid

A coverage denial should be evaluated against the policy language, not accepted at face value. Carriers are not infallible in their coverage determinations — policy language is interpreted by courts, and carrier interpretations of exclusions are not always correct. When a claim is denied, the policyholder should: obtain the denial in writing with the specific policy provision cited; have the policy reviewed by an independent professional (public adjuster, insurance attorney); and evaluate the facts against the cited exclusion. The most common improper denials involve: applying a gradual damage exclusion to a loss that was actually sudden and accidental; applying the flood exclusion to water intrusion from roof damage (not a flood); and applying the maintenance exclusion where the underlying failure was a manufacturing defect or sudden material failure rather than deferred maintenance.

For claims that are not denied but are underpaid relative to the actual restoration scope, the available tools are: supplement negotiation, the appraisal clause process, and litigation. The appraisal process — covered in the companion article on Disputed Claims and the Appraisal Process — is the most cost-effective and fastest resolution mechanism for scope and valuation disputes and should be the first tool evaluated when negotiation stalls.

Internal Links

- Insurance Claims: Complete Professional Guide
- Xactimate and Scope Development: How Carriers Price Restoration Claims
- Disputed Claims and the Appraisal Process
- Emergency Documentation and Insurance Notification
- Mold and Insurance Claims: Coverage and Scope
- Wind and Hail Damage: Insurance Claims and Scope

Frequently Asked Questions

What is the difference between ACV and RCV in a property insurance claim?

Actual Cash Value (ACV) is the replacement cost of a damaged item minus depreciation. Replacement Cost Value (RCV) is the full cost to repair or replace the item at current prices without a depreciation deduction. Most standard homeowner policies (ISO HO-3) and commercial property policies provide RCV coverage, but initially pay ACV. The depreciation withheld is released — called ‘recoverable depreciation’ — when repairs are actually completed and documented. Policyholders who do not complete repairs and submit proof of completion never receive the recoverable depreciation payment.

What is a reservation of rights letter?

A reservation of rights (ROR) letter is a notice from the insurance carrier stating that it is investigating the claim and reserves the right to deny coverage based on policy terms or exclusions, while still proceeding with the investigation. An ROR letter does not mean the claim is denied — it means the carrier has identified potential coverage issues it is evaluating. Receiving an ROR letter is a signal to review the policy carefully and consider public adjuster or attorney consultation.

How long does the insurance company have to respond to a claim?

State insurance codes establish mandatory response timelines. Most states require acknowledgment within 10 to 15 days of receipt and acceptance or denial within 15 to 45 days of receiving proof of loss. Texas requires acknowledgment within 15 days, a coverage decision within 15 business days, and payment within 5 business days of coverage confirmation. California requires acknowledgment within 10 days and acceptance or denial within 40 days. Failure to meet these deadlines can trigger bad faith claims.

What is proof of loss and when is it required?

Proof of loss is a formal signed statement by the policyholder documenting the details of the loss, the date and cause, the property damaged, and the dollar amount of the claim. Most property insurance policies require the policyholder to submit a signed proof of loss within 60 to 90 days of the loss event. For large or complex

claims, the proof of loss is typically submitted after the restoration estimate is complete, so it accurately reflects the total claimed amount.

Can a property owner use their own contractor instead of the insurance company's preferred vendor?

Yes. A property insurance policyholder has the right to select their own licensed contractor for repairs — carriers cannot legally require use of their preferred vendor network as a condition of coverage in most states. If the chosen contractor's estimate exceeds the carrier's pricing, the difference should be negotiated or resolved through the policy's appraisal process.

Emergency Loss Documentation and Insurance Notification: Chain of Custody, Carrier Communication, and Claim Protection

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Updated October 6, 2026. PageReady hygiene pass.

#	Phase	Connects	Exit artifact
1	Authority and notification	Who called, who can sign, carrier/TPA notice, ERP number	Work order + first notice log
2	Scene record	Pre-mitigation photos/video, utilities, safety hold points	Timestamped media set
3	Property-level map	Moisture map, fire zones, asbestos survey status, contents condition codes	Floor plan with readings / zones
4	Daily recovery physics	GPP/RH, equipment IDs, category confirmation, drying or deodorization progress	Daily psychrometric / progress sheet
5	Scope and money file	Estimate, TPA portal, supplements, contents assignment split	Approved scope version control
6	Final recovery record	Clearance, pack-back, punch, invoice packet, manifests	Close-out binder the carrier can replay

Each phase may be deployed alone (board-up = Phase 2) or stacked on a large-loss. Residential water: Phases 1–4 in the first 24–48 hours. Phase 5 before undoable demo. Phase 6 before final invoice.

The documentation generated in the first hours after a property loss becomes the permanent record of what happened, when it happened, and what was done about it. Insurance disputes — coverage denials, scope reductions, pre-existing condition claims, mitigation failure allegations — are won and lost on the quality of this documentation. A restoration contractor or property owner who manages the documentation workflow correctly from the first hour creates a defensible claim file. One who defers documentation to focus on the work first creates a file that can be challenged at every point.

This protocol covers the complete documentation and notification workflow: loss timeline establishment, carrier notification sequence, authorization documentation, chain of custody for evidence preservation, daily monitoring records, and close-out documentation. See the companion articles in this Emergency Response

series for first-24-hour response protocol and board-up and structural stabilization field procedures.

The Loss Timeline: The Foundation Document

Definition: Loss Timeline The loss timeline is a chronological record documenting: (1) the date and approximate time of the originating event (pipe burst, fire start, storm impact); (2) when the policyholder discovered the damage; (3) when the carrier was first notified; (4) when the restoration contractor was first contacted; (5) when crew arrived on-site; and (6) what actions were taken at each step. Every timestamp in this document must be accurate and consistent with other documentation in the file. The loss timeline is a carrier's primary tool for evaluating whether the policyholder met their policy obligations and whether secondary damage occurred before or after notification and mitigation began.

The loss timeline begins at intake, not at the job site. When the property owner calls the restoration contractor, the call is logged with the date, time, and what the owner reported. When the dispatcher calls the carrier to open the claim, that call is logged. When crew leaves for the site, that is logged. When crew arrives and begins safety assessment, that is logged. These timestamps should match (within a few minutes) the claim notes that the carrier's representative is simultaneously entering into their system. Significant discrepancies between the contractor's records and the carrier's records create dispute opportunities.

Loss Discovery vs. Loss Event

The date of discovery is not always the date of the loss event, and the distinction matters. A pipe that burst at 2 a.m. while the homeowner was asleep was discovered at 7 a.m. when the owner came downstairs. The loss event was 2 a.m.; discovery was 7 a.m.; notification occurred at 7:30 a.m. This sequence is normal and does not create a coverage problem. A pipe that burst in January and was not discovered until March — the structure closed for the winter — presents a different situation: the carrier will assess whether the damage was a sudden and accidental event (covered) or a gradual leak over months (potentially excluded as a maintenance failure). The loss timeline makes this determination possible for the adjuster; without it, there is ambiguity that defaults to the carrier's interpretation.

Carrier Notification: Protocol and Documentation

When to Notify

Standard homeowner and commercial property policies include a prompt notice provision — typically worded as “you must give us or our agent prompt notice of the loss or damage.” Prompt notice is not defined as a specific number of hours in most policies but courts have generally interpreted it as “as soon as reasonably possible” under the circumstances. The practical standard for active losses (active fire, active flooding, storm-created structural opening) is same-day notification. For discovered losses where the event occurred earlier (slow leak found during a routine inspection), notification within 24 to 48 hours is generally considered prompt in most jurisdictions.

Late notice defenses are real. In states like New York, Texas, and California, carriers have successfully reduced or denied claims where notification was significantly delayed and the carrier can demonstrate they were prejudiced by the delay — i.e., they could not inspect the pre-remediation condition because the work was already complete before they were notified. The restoration contractor who begins work without carrier notification and without pre-mitigation documentation creates both a claim risk for the property owner and a

payment collection risk for the contractor.

Carrier Notification Call: What to Establish

The carrier notification call should establish and document: the carrier name and claim contact phone number; the name of the carrier representative taking the report; the date and time of the call; the claim number issued; verbal authorization for emergency mitigation services (yes/no — document the representative's name if authorization was granted or denied); any scope limitations or requirements communicated by the carrier (some carriers require their preferred vendor to perform certain work, some require a field adjuster visit before demolition begins); and the carrier's field adjuster contact information if a field adjuster has been assigned.

Verbal authorization for emergency services is the industry standard starting point. The carrier's representative issues verbal authorization over the phone, which the contractor documents in the job file with the rep's name and the time of the call. Written authorization follows — typically an authorization form faxed or emailed by the adjuster within hours for large commercial losses, or confirmed via email by the contractor to the adjuster summarizing the verbal authorization and scope. For straightforward residential losses under \$25,000, verbal authorization followed by documented email confirmation is standard practice and sufficient to begin work.

Preferred Vendor and TPA Requirements

Most large carriers operate preferred vendor programs or use third-party administrators (TPAs) — companies like Alacrity (Nationwide), Contractor Connection (Travellers, Liberty Mutual), and CoreLogic (multiple carriers) that manage restoration contractor networks. When a carrier uses a TPA, the TPA — not the carrier directly — issues work authorizations, monitors scope, and approves billing. Restoration contractors who are on preferred vendor lists receive automatic assignment of jobs; those who are not are performing work that may not be reimbursed at the carrier's established rates.

For property owners who retain their own restoration contractor without using the carrier's preferred vendor program, the contractor can still be paid under the claim — the carrier cannot require the policyholder to use their preferred vendor in most states. The non-preferred contractor must meet the same documentation standards and cannot bill rates above what the carrier's Xactimate pricing matrix supports without supplemental documentation and negotiation.

Authorization Documentation

The Authorization-to-Proceed Form

Before any mitigation work begins, the property owner or their authorized representative must sign an authorization form. This is the restoration contractor's contract for the emergency work and must be in writing. A verbal agreement to begin work followed by a later dispute about whether the owner authorized the scope — or authorized any work at all — is a collection nightmare that has cost contractors significant revenue. The authorization form should include: identification of the property address and owner; description of emergency services authorized; rate schedule reference or lump-sum not-to-exceed amount; a representation that the signer is authorized to approve work on the property; carrier information; and the owner's acknowledgment of the duty to notify their carrier.

Electronic signatures via Docusign, ServiceMaster's proprietary platforms, or PDF e-sign tools are fully valid and recommended over paper forms — they are harder to dispute (timestamps, IP address logging), easier to

transmit to the adjuster immediately, and reduce the “we never signed anything” dispute that occasionally arises when a panicked property owner signs a paper form and later claims they were not shown what they were signing.

Direction of Pay and Assignment of Benefits

Direction of Pay is a policyholder instruction to the carrier directing that payment be issued jointly to the property owner and the restoration contractor, or directly to the contractor. This is distinct from an Assignment of Benefits (AOB). Direction of Pay does not transfer the policyholder’s claim rights — it instructs where the check goes. It is widely accepted by carriers and is the standard tool for large water and fire restoration claims where the contractor needs payment security without requiring a full AOB.

AOB — Assignment of Benefits — transfers the policyholder’s right to file, negotiate, and collect the insurance claim directly to the contractor. AOB is heavily regulated in Florida following the 2019 Senate Bill 122 and 2023 Senate Bill 2A, which eliminated AOB for most homeowner property claims in response to rampant abuse in the Florida market. Texas restricts AOB to residential claims in specific circumstances. Restoration contractors working in AOB-restricted states must use Direction of Pay instruments rather than AOB agreements. Using an AOB in a restricted jurisdiction exposes the contractor to regulatory penalty and creates voidability of the assignment.

Pre-Mitigation Evidence Preservation

Photography Protocol

Photography standards for emergency documentation: minimum 50 photographs for a contained single-room loss, 100+ for multi-room or commercial loss. Every photograph is taken with device timestamp enabled and verified accurate against actual time. The photography sequence: exterior establishing shots (all four elevations of a house, showing any exterior storm or fire damage, and street-address-identifying view); all points of water or damage ingress; each room with a wide-angle establishing shot followed by close-up detail of affected areas; any pre-existing damage identified and photographed separately with a notation in the field notes that it is pre-existing; contents in affected areas in their pre-mitigation position; any evidence of the loss-causing event (burst pipe still visible, storm debris, char patterns).

Video walk-through is increasingly standard practice and provides a continuous record that is harder to dispute than a photograph set — video captures the spatial relationship between elements, the sound environment (active dripping, structural sounds), and the condition of transitions between affected and unaffected areas. A 3 to 5 minute walk-through video shot on a smartphone at arrival, before any crew begins work, is one of the most effective tools for resolving pre-existing condition disputes at low cost.

Evidence Preservation for Causation Documentation

The physical evidence of the loss cause — the burst fitting, the failed appliance hose, the impact debris from the storm — must be preserved until the carrier’s adjuster has had the opportunity to inspect it. Removing and discarding a burst pipe fitting before the adjuster sees it eliminates the primary physical evidence of the loss cause. Protocol: photograph evidence in place before disturbance; bag and tag significant causation evidence (pipe sections, failed valve components); document the location where it was found; maintain possession or deliver to a secure location with a chain-of-custody log.

For fire losses, the fire marshal or fire investigator has already established an origin and cause determination that is documented in their report — this report is the primary causation document for the insurance claim. The restoration contractor's evidence preservation duty focuses on: not disturbing the fire origin area before the fire marshal releases it; photographing the origin area comprehensively; and preserving any physical evidence the fire investigator flagged as significant. For complex or high-value fire losses, the carrier's independent fire investigator will conduct their own examination — this examination must be permitted and documented in the job file.

Daily Monitoring Documentation for Water Losses

ANSI/IICRC S500 requires daily monitoring of the drying process with documented readings throughout the drying period. Daily monitoring is not optional and it is not administratively burdensome — it is the documentation that proves the drying system performed correctly, validates the equipment billing, and establishes drying goal achievement that closes the mitigation phase of the claim.

Each daily monitoring visit documents: date and time; technician name and certification; current psychrometric conditions (temperature, relative humidity, specific humidity or grains per pound) measured in the drying zone and outside; moisture meter readings at all mapping points on the floor plan (same points as day 1); equipment inventory confirmation (all units still operational and in correct placement); any anomalies (areas that are not drying at expected rate, new wet areas identified, equipment failure); and corrective actions taken. The daily monitoring log is a narrative of the drying process that demonstrates continuous professional oversight.

Drying goals under ANSI/IICRC S500: structural lumber at or below 19% MC (ASTM E1991 restorable threshold); drywall at or below 1% WME; concrete and masonry at equilibrium moisture content for the prevailing ambient conditions. These goals must be achieved and documented before equipment is removed. Removing equipment before drying goals are reached — to reduce equipment rental billing — can result in secondary microbial growth and contractor liability for the subsequent mold remediation cost. The equipment billing for the full drying period is always less than the cost of mold remediation triggered by premature equipment removal.

Close-Out Documentation and Certificate of Completion

The Certificate of Completion (COC) closes the emergency mitigation phase of the claim. For water losses, the COC is supported by the final moisture map showing all affected areas at or below drying goals. For fire losses, the COC documents that all emergency stabilization work is complete, the structure is secured, and the site is safe for reconstruction assessment. For mold or asbestos abatement phases, the COC is supported by clearance test results meeting the applicable standard (ANSI/IICRC S520 clearance for mold, AHERA TEM clearance or PCM clearance below 0.01 f/cc for asbestos).

The COC package delivered to the carrier should include: the signed COC form; final moisture map; equipment log showing placement dates, removal dates, and daily readings; summary of services performed with line items matching the estimate; photographs of completed work (equipment in place during drying, final conditions after equipment removal); and any third-party clearance reports. This complete package initiates the payment process and reduces adjuster hold time on payment by eliminating the back-and-forth requests for documentation that delay settlement.

Internal Links

- [Emergency Response: Complete Professional Guide](#)
- [Emergency Response: The First 24 Hours Protocol](#)
- [Emergency Board-Up, Tarping, and Structural Stabilization](#)
- [Mold and Insurance Claims: Coverage and Documentation](#)
- [Asbestos and Insurance Claims: Scope Documentation](#)
- [Wind and Hail Damage: Scope Development and Insurance Claims](#)

Frequently Asked Questions

When should a policyholder notify their insurance carrier after a loss?

Notification should occur as soon as reasonably possible after the loss — ideally within the first few hours, and no later than 24 hours for active losses (fire, flooding, storm opening). Standard property insurance policies include a ‘prompt notice’ condition as a requirement for coverage. Carriers generally expect notification within 24 to 72 hours of a property loss. Delay in notification can give the carrier grounds to deny coverage for secondary damage that occurred after the loss and before notification.

What is a Certificate of Completion (COC) in restoration?

A Certificate of Completion documents that all emergency mitigation services have been completed and that the structure has reached drying goals or the scope of emergency services has been fulfilled. For water losses, the COC is supported by final moisture readings demonstrating that all affected materials have reached the ANSI/IICRC S500 drying standard (structural lumber 19% MC, drywall 1% WME). The COC closes the mitigation phase of the claim and transitions the job file to the reconstruction phase.

What is an Assignment of Benefits (AOB) and what are the risks?

An Assignment of Benefits (AOB) is a document that transfers the policyholder’s right to collect insurance proceeds directly to the restoration contractor. AOB is heavily regulated or restricted in several states — Florida enacted major AOB reform legislation in 2019 and 2023 that significantly limits AOB use for property claims. Policyholders should understand that signing an AOB transfers negotiating control to the contractor and can complicate dispute resolution if scope or payment disputes arise.

What does ‘duty to mitigate’ mean for a property insurance policyholder?

The duty to mitigate is a standard property insurance policy condition requiring the policyholder to take reasonable steps to prevent further damage after a covered loss. This means promptly notifying the carrier, securing the structure (board-up, tarping), beginning emergency water extraction, and not allowing the damage to expand due to inaction. A carrier can reduce or deny a claim for damage that occurred after the loss and could have been prevented by reasonable mitigation. This is the legal basis for emergency restoration services being a covered expense under most property policies.

What is a loss timeline and why does it matter for an insurance claim?

A loss timeline is a chronological record of the loss event, discovery, notification, and mitigation actions — including the date and time of the originating event, when the policyholder discovered the damage, when they

notified the carrier, when the restoration contractor arrived, and what actions were taken at each step. The loss timeline is critical because it establishes causation (damage resulted from a specific covered event), confirms the policyholder met their prompt notice obligation, and documents that secondary damage was not caused by mitigation delay.

Mold and Insurance Claims: Coverage Disputes, Documentation, and Scope Development

Source: <https://restorationintel.com/mold-insurance-claims-coverage-documentation-scope/> Published: March 17, 2026

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Mold Insurance Claims Defined: A mold insurance claim is a first-party property insurance claim for the cost of professional mold assessment and remediation where the mold is a covered cause of loss under the policy terms — specifically, where the mold is causally linked to a sudden, accidental water loss covered by the policy. The claims landscape for mold is among the most restricted in property insurance: sublimits are narrow, exclusions are broad, and the documentation requirements to establish the covered causation chain are demanding. The difference between a fully paid mold claim and a denied one is almost always documentation quality.

The Texas mold crisis of the late 1990s and early 2000s rewrote the mold insurance landscape permanently. A series of high-profile cases — most notably *Ballard v. Fire Insurance Exchange* (2001), in which a Texas family was awarded \$32 million over a mold claim that had initially been denied — exposed carrier vulnerability to mold claims under unrestricted standard policy language and triggered a nationwide restructuring of homeowners policy mold coverage. By 2002, nearly every major carrier had either added explicit mold exclusions or mold sublimits to new and renewing policies in high-frequency states. By 2005, mold sublimits were standard across most U.S. markets.

Understanding the policy landscape — what is covered, what is excluded, and what documentation creates or destroys coverage arguments — is the professional foundation for working effectively in the mold restoration market. This guide covers the coverage structure, the documentation argument, the scope development standards, and the dispute navigation framework for mold insurance claims.

The Coverage Landscape: What Policies Actually Say

There is no single standard mold policy language — coverage varies by carrier, policy form, state, and the year the policy was written. However, the following structure represents the dominant framework in the U.S. residential market as of 2025–2026.

Covered mold losses: Most policies cover mold remediation costs that arise directly from a sudden, accidental covered peril — fire, lightning, windstorm, hail, theft, vandalism, and specifically named water losses (burst pipe, accidental discharge from plumbing or appliance). The operative words are “sudden” and “accidental” — they exclude chronic, gradual, and foreseeable moisture events from the mold coverage trigger. The mold coverage is derivative: it exists because the water event that caused it is covered. Without a covered water event as the proximate cause, there is generally no mold coverage.

Mold sublimits: The mold sublimit is the maximum amount the carrier will pay for all mold-related costs combined — assessment, remediation, reconstruction, and in some policies, additional living expenses during displacement. Sublimits in standard HO-3 policies currently range from \$5,000 to \$50,000; \$10,000 and \$15,000 are common residential sublimits. Commercial policies have variable mold sublimits that may be negotiated as part of the coverage placement; commercial properties with known moisture vulnerability may have mold excluded entirely or available only as a scheduled endorsement at additional premium.

Explicit mold exclusions: Some policies — particularly in Florida, Texas, and California after various legislative and regulatory changes — include explicit mold exclusions that eliminate mold as a covered peril entirely, regardless of causation. These exclusions mean that mold costs are not covered even when a covered water loss is the trigger. Contractors working in states with prevalent mold exclusions will encounter a significant proportion of jobs where the remediation costs are entirely out-of-pocket for the policyholder, making pricing and authorization conversations with policyholders critically important upfront.

Maintenance and neglect exclusions: Even where mold coverage exists, the maintenance exclusion eliminates coverage for mold attributable to the policyholder's failure to maintain the property or to report and address known damage. A mold event discovered years after a known roof leak that was never repaired is vulnerable to a maintenance exclusion argument. The carrier's position: the property owner had the opportunity to prevent the mold loss and failed to do so. The response: the mold is causally connected to the original covered peril (the storm damage), and the policy does not require perfect policyholder behavior — only reasonable behavior.

The Causation Chain: Building the Covered Loss Argument

The causal chain argument is the heart of every mold insurance claim. It requires demonstrating, with documented evidence, that: (1) a specific covered water event occurred on a specific date; (2) water from that event contacted building materials in the location where mold was subsequently found; (3) the mold colony developed within a timeline consistent with the moisture conditions created by the event; and (4) no pre-existing mold condition at the same location predates the covered event.

Establishing the covered water event: The water event documentation is typically the original water damage claim file — loss photos, mitigation reports, moisture mapping data, and drying logs. If the water loss was not previously reported (because the policyholder was unaware of the intrusion until mold became visible), the evidence of the event must be reconstructed from: physical evidence of water intrusion at the source location, building material condition consistent with the timeline, and where available, weather data or service records that corroborate the event date.

Connecting water path to mold location: The moisture mapping data from the water damage mitigation — if available — is the most powerful connection between the water event and the mold location. Pin and pinless moisture readings documented during the water mitigation phase that show elevated readings at the same locations where mold is subsequently found create a direct physical link. If the water event was not properly documented (because mitigation was inadequate, because the loss was not reported, or because the mitigation was performed without documentation), the physical evidence of water staining, discoloration, and material condition at the moisture source and the mold location must carry the causation argument.

Timeline consistency: Mold under optimal conditions grows within 24–48 hours of moisture exposure. Under typical building conditions, visible mold growth on drywall and wood typically becomes apparent within 3–14

days of sustained moisture contact. Mold that is observed shortly after a documented water event — and in the location that water affected — is temporally consistent with causation by that event. Mold that appears years after a purported water event, or in locations that the documented moisture path would not have reached, creates timeline inconsistency that the carrier will exploit. The industrial hygienist's assessment report should specifically address the timeline consistency of the observed mold with the alleged causative event.

Documentation Requirements: Building the Claim File

The documentation requirements for a mold insurance claim are more extensive than for most property damage claims because the causal connection between covered event and mold damage requires a paper trail that most claims do not need. Missing documentation in any link of the chain creates a coverage dispute opportunity for the carrier.

The IH assessment report: The independent industrial hygienist's assessment report is the foundational claim document. It must include: inspection date and conditions; all areas inspected and findings for each; moisture readings with instrument calibration records; sampling protocol and sample locations; laboratory reports with chain of custody; condition classification under ANSI/IICRC S520; identification of the moisture source; timeline assessment connecting mold growth to the moisture event; and written remediation recommendations that will become the basis for the scope of loss.

Pre-work photographic documentation: All areas of visible mold and moisture damage must be photographed before any work begins. This is the same non-negotiable documentation principle that applies to fire and storm damage — without pre-work photos, the carrier's inspector has only the contractor's word for what conditions were found before work. A comprehensive photo set from the IH's inspection plus a separate contractor walkthrough photo set provides redundant documentation from two independent sources.

Original water damage documentation: As discussed, the original water event documentation is the causation anchor. If the original loss was handled by a mitigation contractor, request the complete project file: moisture mapping readings, daily monitoring logs, drying reports, and closeout documentation. If the original loss was handled by a different contractor and the file is unavailable, request it from the carrier's claims file — the carrier received the documentation and is required to retain it as part of the claim record.

Scope Development: Line Items and Billing Standards

Mold remediation scope for insurance billing must be specific enough to support the claimed costs, consistent with the IH's assessment findings, and formatted in a manner the carrier's adjuster can reconcile against the applicable coverage provision. Xactimate contains mold-specific line items that are used by most carriers in the adjustment process.

Assessment fees: Industrial hygienist assessment fees — including sampling, laboratory analysis, and written report — are legitimate scope items billed as part of the mold claim. Most policies that provide mold coverage include assessment costs within the mold sublimit. Confirm with the carrier whether assessment fees are counted against the sublimit before confirming the IH fee with the policyholder — if the sublimit is \$10,000 and the assessment costs \$2,000, only \$8,000 remains for remediation.

Remediation labor and equipment: Mold remediation labor is typically billed at certified remediation technician rates (higher than general labor) due to PPE requirements, certification prerequisites, and the

specialized nature of the work. Equipment rental — air scrubbers, negative air machines, HEPA vacuums, containment materials — is billed either at daily rental rates or at project cost. Xactimate’s mold remediation line items include: containment erection and removal, HEPA vacuuming per square foot, damp wiping per square foot, antimicrobial application per square foot, and equipment rental by day. All line items should reference the applicable Xactimate code in F9 notes for carrier adjuster reconciliation.

Controlled demolition for remediation: The demolition performed to access and remove mold-contaminated materials is part of the mold remediation scope — it is demolition for remediation purposes, not demolition for reconstruction. This scope line often creates carrier disputes when adjusters attempt to apply deductibles to “repair and reconstruction” costs against the demolition-for-remediation billing. The distinction matters: demolition performed by the remediating contractor under the IH’s scope recommendation is remediation work, not reconstruction preparation. Keeping the remediation scope and the reconstruction scope in separate documents with separate authorizations maintains this distinction clearly.

Reconstruction scope: Reconstruction of removed materials — new drywall, insulation, paint — is typically covered under the property damage provision of the policy rather than the mold sublimit. Carriers frequently attempt to apply reconstruction costs against the mold sublimit; the policyholder’s position is that reconstruction costs are property damage costs caused by the covered water event, not mold remediation costs. Policy language governs, and the distinction matters significantly when the sublimit is exhausted by remediation alone. Submitting reconstruction costs as a separate estimate under the water damage claim (which triggered the loss) rather than the mold remediation claim can preserve sublimit capacity for remediation-specific costs.

Carrier Dispute Points: Where Mold Claims Break Down

Understanding the predictable dispute points in mold claims allows contractors and policyholders to address them proactively in documentation, rather than reactively in the supplement or denial response process.

“Mold is pre-existing”: The most common denial basis. The carrier’s inspector characterizes the mold as having predated the claimed loss — pointing to evidence of established growth, multiple growth generations, or mold species that require very long moisture exposure (*Stachybotrys* requires weeks of continuous high moisture, not the 24–72 hours of a single plumbing failure). The counter-evidence: the IH’s assessment distinguishing fresh from established growth; the physical condition of the building materials at the mold location (acute moisture damage vs. long-term deterioration); and the moisture mapping data from the original water event that documented elevated readings at the mold location.

“Policyholder failed to mitigate”: When a water loss was reported but mitigation was inadequate or not performed promptly, the carrier may argue that the mold is an avoidable secondary loss resulting from the policyholder’s failure to mitigate. The response is documentation: what mitigation was performed, when it began, and whether the mold development was a result of inadequate mitigation or a result of water that was not accessible to the mitigation equipment (hidden in wall cavities, under flooring, in the attic). An IH opinion that the mold developed in areas where drying equipment could not reasonably have reached the moisture is a strong response to the failure-to-mitigate argument.

“The mold is cosmetic”: Some carriers attempt to characterize surface mold on non-structural materials as cosmetic — arguing that painting over it (or cleaning it with bleach) is adequate and that full professional

remediation is not required. This argument fails against the scientific and professional standard: S520 and EPA guidance both require professional remediation for Condition 3 growth regardless of material type, because surface mold cleaning without containment generates aerosolization and spreads contamination, and because bleach treatment is explicitly not recommended as a remediation method by either standard. The IH's recommendation for full remediation protocol carries significant weight against a "cosmetic" classification argument.

When to Bring a Public Adjuster

Public adjusters (PAs) represent the policyholder — not the carrier — in the claims adjustment process, and their involvement in mold claims is often the difference between a sublimit-exhausted underpayment and a fully documented, vigorously pursued recovery. PAs are most valuable when: the carrier has made an initial low offer or denial that the policyholder wants to challenge; the coverage argument is complex (pre-existing conditions, maintenance exclusion disputes); the mold sublimit is at risk of being exhausted before all legitimate costs are included; or when the policyholder needs professional advocacy but does not want to hire an attorney.

Restoration contractors who develop PA relationships create a referral network that systematically improves their clients' claim outcomes — and creates reciprocal referral flow from PAs who recommend contractors they trust to produce the documentation quality that PA advocacy requires. The two professions are complementary: the contractor produces the technical documentation; the PA uses it to maximize the claim.

Connecting Mold Claims to the Full Mold Restoration Workflow

The insurance claim documentation strategy begins at assessment — not at the end of remediation. The documentation decisions made during the IH's assessment, the moisture mapping during mitigation, and the pre-work photography determine whether the claim is defensible before a single piece of drywall is removed. For the assessment documentation framework, see Mold Assessment and Testing. For the remediation protocol and clearance documentation that complete the claim file, see Mold Remediation Protocol. For the master framework and the moisture source prevention that eliminates repeat claims, return to the Mold Remediation Complete Professional Guide.

Frequently Asked Questions

Does homeowners insurance cover mold remediation?

Standard homeowners insurance covers mold only when it directly results from a sudden, accidental covered water loss such as a burst pipe or storm intrusion. Mold from chronic moisture, gradual leaks, condensation, or maintenance neglect is excluded. Most policies impose mold sublimits of \$5,000–\$50,000. Coverage requires establishing a covered water event, a causal link between that event and the mold location, and timely reporting and mitigation by the policyholder.

Why was my mold claim denied?

Mold claims are most often denied because: the mold cannot be connected to a covered water event; the mold sublimit was exhausted; the policyholder failed to mitigate the underlying water loss promptly; the policy contains a blanket mold exclusion; or the carrier determined mold was pre-existing. Each denial basis has a documentation response — an independent IH assessment, the original water loss file, or a public adjuster's

advocacy — that may support a successful appeal or appraisal demand.

What documentation is required for a mold insurance claim?

A defensible mold claim requires: the independent IH assessment report; laboratory reports with chain of custody; pre-work photographs of all mold and moisture conditions; causation documentation linking mold to the covered water event (original loss photos, mitigation records, moisture mapping data); Xactimate-compatible scope of loss; daily project logs, waste disposal records, and worker PPE documentation; and the independent IH clearance report confirming successful remediation.

What is a mold sublimit in a homeowners policy?

A mold sublimit caps total insurance payment for all mold-related costs regardless of actual damage — most standard HO-3 policies post-2001 carry sublimits of \$5,000–\$50,000, far below the cost of major remediation events. The sublimit applies to all mold costs: assessment, remediation, reconstruction, and additional living expenses. Pre-2001 policies and some commercial specialty policies may have no sublimit, creating full-coverage exposure that drove the post-2001 policy restructuring.

Can you sue an insurance company for denying a mold claim?

Yes. Policyholders can invoke the policy's appraisal clause for disputes about loss amount, pursue a coverage lawsuit for wrongful denial, and in states with strong bad faith insurance statutes (Texas, California, Florida), seek additional damages if the denial was unreasonable. A public adjuster or insurance attorney is typically involved in contested mold coverage disputes. Restoration contractors should not make coverage determinations but should provide complete documentation supporting the policyholder's claim pursuit.

Mold Assessment and Testing: Air Sampling, Surface Sampling, and Adjuster-Defensible Documentation

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Mold Assessment Defined: Professional mold assessment is the systematic investigation of a structure for mold growth, moisture conditions, and fungal contamination using standardized sampling protocols, calibrated instruments, and accredited laboratory analysis. A complete assessment establishes the contamination condition classification under ANSI/IICRC S520, identifies the moisture source, characterizes occupant exposure risk, and produces documentation sufficient to support a remediation scope and, where applicable, an insurance claim.

Assessment is where mold remediation claims are built or destroyed. The documentation produced during assessment — sampling data, laboratory reports, moisture readings, photographs, chain of custody records, and the IH's written findings — is the technical foundation that supports every downstream decision: the remediation scope, the containment level, the insurance claim, the clearance standard, and in disputed cases, the contractor's legal position. Assessment performed after the fact, or assessment performed without proper methodology, cannot retroactively create the documentation foundation that the claim requires.

This guide covers the complete professional assessment workflow: inspection methodology, sampling protocol selection, instrumentation, laboratory analysis interpretation, chain of custody, and building the adjuster-defensible documentation package. For the remediation protocols that follow assessment, see the companion post on [Mold Remediation Protocol: Containment, Negative Air, HEPA Filtration, and Clearance Testing](#). For the master framework, return to the [Mold Remediation Complete Professional Guide](#).

The Assessment Team: Who Performs What

The most important structural requirement of a professional mold assessment is independence — the assessor must be independent from the remediation contractor on the same project. This requirement is codified in state law in Texas, Florida, and Louisiana, and is a professional standard of care nationally even where not legally mandated. The rationale is straightforward: an assessor who profits from a larger remediation scope has an inherent conflict in the scope-determining assessment, regardless of professional intent.

Qualified assessors include licensed industrial hygienists (IH — credentialed through the American Industrial Hygiene Association), certified indoor environmental consultants (CIEC — certified through the Indoor Air Quality Association), and state-licensed mold assessors where applicable. Assessors should carry professional liability (errors and omissions) insurance, which signals financial accountability for the accuracy of their professional determinations.

The remediation contractor's role in assessment is to provide access, facilitate investigation, and receive the assessment findings — not to direct them. Contractors who pressure assessors to expand or minimize scope based on business interests are operating outside professional standards and creating legal exposure for both parties.

Visual Inspection: The Foundation of Every Assessment

No air sample or laboratory report replaces a thorough visual inspection. Sampling without visual inspection is data without context; visual inspection without sampling is observation without measurement. A professional assessment combines both — the visual inspection guides the sampling plan; the sampling data quantifies and confirms the visual findings.

Visual inspection covers all accessible areas of the structure systematically: living areas, crawl spaces, attic, HVAC system including supply and return ductwork accessible sections, under-sink and behind-appliance spaces, basement and foundation walls, and any area with documented or suspected water intrusion history. The inspector uses moisture meters (pin and pinless) and thermal imaging to identify areas of elevated moisture that may harbor hidden mold growth behind finish materials — mold frequently grows on the back face of drywall and on wall cavity framing before it is visible on the room-facing surface.

Documentation during visual inspection: photograph every observed area of visible mold or moisture damage with a scale reference; record all moisture readings at identified locations with corresponding room and surface designations; note all evidence of current or past water intrusion (staining, efflorescence, rust streaking, wood discoloration, paint bubbling); identify HVAC system conditions (filter condition, visible duct contamination, condensate pan condition, coil cleanliness) that may contribute to moisture and spore dispersal throughout the structure.

Air Sampling: Methodologies and Selection Criteria

Air sampling is the primary method for characterizing fungal exposure concentrations in indoor environments. Multiple methodologies exist; selection depends on the assessment purpose, the required turnaround time, the budget, and the downstream use of the data.

Spore trap air sampling (non-viable): The most common method for property damage assessment and remediation compliance documentation. A calibrated air sampling pump draws a known volume of air (typically 75 liters per minute for 10 minutes = 750 liters total sample volume) through a cassette containing an adhesive collection substrate. Airborne spores and fungal fragments impact and adhere to the substrate. The cassette is shipped to an accredited laboratory where a microscopist identifies and counts spores at 400–1000x magnification. Results are reported in spores per cubic meter (spores/m³) within 24–72 hours. Advantages: fast turnaround, relatively low cost (\$25–\$60 per cassette analyzed), no need for sterile technique or culture media. Limitations: cannot distinguish viable (living) from non-viable spores; microscopic identification of *Penicillium* and *Aspergillus* species is often impossible (reported as “*Penicillium/Aspergillus*-type”); some spore types are under-counted due to clustering or morphology.

Viable air sampling (culture-based): A calibrated pump draws air through or impacts it against culture media (Andersen impactor, RCS sampler, or similar). Viable fungal spores grow into colonies that are identified at genus and species level by a mycologist. Results take 5–14 days for final identification. Advantages: species-level identification; distinguishes viable organisms; provides colony-forming unit (CFU) counts directly relevant to health risk assessment. Limitations: longer turnaround, higher cost, under-counts non-viable spores (which still represent inhalation exposure), and requires cold-chain shipping of culture media. Typically used in health-sensitive or litigation contexts where species-level identification is critical.

MSQPCR (DNA-based) sampling: Molecular methods including quantitative PCR detect and quantify fungal DNA from bulk samples, dust, or air. Highly sensitive and specific; can detect species that do not sporulate readily and are therefore under-detected by microscopic methods (*Stachybotrys* is the prime example — it sporulates poorly under dry conditions and may be present in large quantities without appearing in spore trap samples). Used in research, litigation, and complex assessments. ERMI is the EPA-developed application of MSQPCR to residential dust; as discussed, it is not appropriate for individual building assessment or insurance claims. Targeted MSQPCR for specific species in combination with standard spore trap sampling is increasingly used in complex assessments.

Sampling Protocol: The Documented Plan

Sampling without a documented protocol is not professional assessment — it is random data collection. A sampling protocol specifies in advance: the number and location of samples, the collection method and equipment, the laboratory to which samples will be submitted, the analytical method requested, and the comparison basis (outdoor control, historical data, clearance criteria). The protocol is written before sampling begins and does not change based on preliminary results observed in the field.

Outdoor control sample: Every indoor air sampling protocol includes at least one outdoor sample collected under the same meteorological conditions (wind direction, precipitation, temperature) as the indoor samples, using the same equipment, same run time, and same analytical method. The outdoor sample is the comparison baseline — indoor samples are interpreted relative to what is naturally present in the outdoor air at the time of sampling, which varies significantly by season, geography, and weather. An indoor sample compared to a historical database rather than a simultaneous outdoor control is methodologically weak and will be challenged

by opposing technical experts.

Sample location selection: Sample locations are selected based on the visual inspection findings, the suspected moisture source locations, and the structure's HVAC configuration. In a single-story residence with one suspected moisture zone and a central HVAC system: minimum sampling plan is outdoor control, HVAC return air, suspected contamination zone, and one unaffected area as a second indoor reference. Additional samples are added for each distinct suspected amplification zone and for any area that will be specifically addressed in the remediation scope — a sample in a zone that will be remediated establishes the pre-remediation condition that clearance results will be compared against.

Surface Sampling: Tape Lift, Bulk, and Swab Techniques

Surface sampling confirms the presence and species of mold at specific locations — answering the question “is this visible growth actually mold, and what kind?” rather than the air sampling question “what are occupants breathing?” Surface samples are particularly valuable for: confirming that visible discoloration is mold rather than dirt, paint oxidation, or other materials; identifying species when air sampling is ambiguous; documenting growth on materials that will be included in the remediation scope; and providing pre-remediation baseline documentation for specific surfaces.

Tape lift samples: Transparent tape (scotch tape or specialized sampling tape) is pressed against the suspected mold surface, peeled off, and mounted on a glass slide for microscopic analysis. Fast, inexpensive, and non-destructive; appropriate for accessible, relatively dry surfaces. The most common surface sampling technique in property damage assessment. Results in 24–48 hours from accredited lab; interpretation by mycologist at 400x magnification identifies spore morphology and hyphae.

Bulk samples: A small piece of the affected material (drywall, insulation, carpet, wood) is physically removed and sealed in a sterile container for laboratory analysis. Used when surface sampling is insufficient to characterize contamination within the material (as opposed to on its surface), when species-level identification is needed, or when legal chain of custody documentation requires physical evidence. Laboratory processing typically includes both microscopic analysis and culture for viable organisms.

Swab samples: A sterile swab is used to collect material from a defined surface area (typically 4–25 cm²). Less commonly used than tape lift in building assessment; appropriate for irregular surfaces where tape lift contact is incomplete, or for wet surfaces where tape lift adhesive fails. Culture-based swab analysis is used when viable organism counts are required for specific species identification.

Laboratory Accreditation and Chain of Custody

Laboratory selection is not a commodity decision. Accredited laboratories operating under quality systems that ensure reproducible, accurate results are essential for assessment data that will support claims, remediation scopes, and clearance determinations. AIHA (American Industrial Hygiene Association) Environmental Microbiology Laboratory Accreditation Program (EMLAP) accreditation is the standard quality credential for environmental mold laboratories in the United States. Samples submitted to non-accredited laboratories produce data that is scientifically defensible only if the laboratory can demonstrate comparable quality systems — which most cannot.

Chain of custody (COC) documentation begins at sample collection and continues through laboratory receipt, analysis, and report issuance. Each COC form documents: sample ID, collection date, time, and location; collector name and credentials; method of collection; requested analysis; laboratory receipt signature and date; and analyst name. COC breaks — instances where samples were not properly tracked from collection to result — create the opportunity for legal arguments about sample integrity that can invalidate the entire assessment data set in litigation.

Interpreting the Laboratory Report: What the Numbers Mean

A spore trap air sampling report lists each identified fungal type and the concentration in spores/m³ for each sample. The interpretation framework requires comparison rather than absolute numbers — there are no regulatory action levels for indoor air mold concentrations (the EPA has not established them, OSHA has not established them, and ANSI/IICRC S520 does not define numerical thresholds). The interpretation is contextual.

Elevated total spore counts indoors relative to outdoor control — particularly when the ratio exceeds 1.5–2:1 for similar species profiles — indicates indoor amplification. The more compelling indicator is species pattern: indoor dominance of *Penicillium*/*Aspergillus*-type spores at concentrations not reflected in the outdoor sample is a consistent finding in active building mold events. Detection of water-indicator species — *Stachybotrys chartarum*, *Chaetomium*, *Ulocladium* — indoors at any measurable concentration is a strong indicator of past or present wet cellulosic materials, because these species are rarely present in outdoor air in significant numbers and require sustained high moisture to grow.

Single-species dominance — where one type represents more than 50% of total indoor count and is not present in similar proportion outdoors — often indicates an amplification source of that species somewhere in the building. The identity of the dominant species guides the physical investigation: *Aspergillus versicolor* dominance suggests insulation or gypsum board; *Cladosporium* elevation suggests surface condensation; *Penicillium* elevation in a specific zone suggests saturated wood or paper substrate in that area.

Building the Adjuster-Defensible Documentation Package

The documentation package that supports a mold insurance claim must accomplish three things: establish that mold is present and at what condition level; connect the mold to a covered water event; and support the remediation scope as necessary and proportionate to the contamination documented. Each element requires specific documentation.

Connecting mold to the covered water event: The most critical and most frequently missing element. The moisture source investigation must identify the specific water intrusion event or source, document its physical path from source to mold growth location, and where possible, establish a timeline consistent with the covered loss date. Water damage photos from the original loss, mitigation records, moisture mapping data from the mitigation project (see the moisture mapping protocol in the Water Damage series), and drying reports that document when areas were dried — or failed to fully dry — create the causation chain that links the mold to the covered event.

Pre-existing condition documentation: Assessors must document any evidence of pre-existing mold or moisture conditions that predate the covered loss. Pre-existing conditions can be used by carriers to argue that the mold predates coverage or was caused by maintenance neglect. Distinguishing fresh growth (white or green

color, no powdering, on recently wetted surface) from established growth (dark, powdery, multi-species, with evidence of multiple growth cycles) requires mycological expertise and is an area where the IH's written analysis carries significant weight.

Scope support documentation: Every scope line item should have a corresponding finding in the assessment report. Remediation scope that extends beyond what the assessment documents is a red flag for carriers; scope that is supported line-by-line by assessment findings is difficult to challenge. The IH's recommendations section of the assessment report is the scope pre-authorization document — IH-recommended actions are far harder for carriers to deny than contractor-recommended actions without IH support.

Frequently Asked Questions

What is the difference between air sampling and surface sampling for mold?

Air sampling collects airborne mold spores over a measured volume of air to establish indoor spore concentrations (spores/m³), revealing what occupants are breathing and whether concentrations exceed outdoor background. Surface sampling (tape lift, bulk, or swab) collects mold from specific surfaces to confirm species and whether visible growth is actually mold. A complete professional assessment uses both: air sampling for exposure characterization, surface sampling for source confirmation and species identification.

How many air samples are needed for a mold assessment?

A minimum assessment requires one outdoor control sample and one indoor sample per assessment area. A thorough residential assessment typically requires 3–6 indoor samples plus one outdoor control: one per suspected amplification zone, one in the HVAC return path, and one in an unaffected area as a baseline. The industrial hygienist's protocol — documented in advance — determines the sampling plan for each project.

What does a mold air sample lab report mean?

A mold air sample report lists fungal species and concentrations (spores/m³). Interpretation compares indoor samples to the simultaneous outdoor control. Key amplification indicators: indoor total counts significantly higher than outdoor (ratio above 1.5–2x); detection of water-indicator species (*Stachybotrys*, *Chaetomium*, *Ulocladium*) indoors at any concentration; elevated *Penicillium*/*Aspergillus* indoors versus outdoor; or single-species dominance indoors not reflected in the outdoor sample. There are no regulatory numerical action levels — interpretation is always comparative.

Who should perform a mold assessment?

A professional mold assessment should be performed by a licensed industrial hygienist (IH), certified indoor environmental consultant (CIEC), or in states with specific licensing (Texas, Florida, Louisiana), a licensed mold assessor independent from the remediation contractor. In Texas, Florida, and Louisiana, assessor and remediator must be separate licensed entities. Assessments performed by the remediating contractor lack independence and are not accepted by carriers, building departments, or courts.

What is ERMI testing and is it appropriate for insurance claims?

ERMI is an EPA-developed DNA-based dust sampling test developed for epidemiological research. The EPA explicitly states it should not be used for individual building assessments. ERMI scores are not accepted as assessment documentation under ANSI/IICRC S520 or by most carriers in claims contexts. Standard spore trap or culture-based air sampling per AIHA protocols is the appropriate method for insurance, remediation

assessment, and clearance purposes.

Wind and Hail Damage: Scope Development, Insurance Claims, and Repair Standards

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Updated August 22, 2026. *Cosmetic vs functional hail, then covered peril vs wear. Not a coverage cheerlead.*

Hail spatter on unfinished wood with no fracture, hole, or failed function is usually cosmetic — no repair required to restore function. Matching/LKQ is a different fight.

Observation	Typical call	What the photo must show
Dents/spatter, no split, no hole, unfinished wood, item still functions	Cosmetic — no repair	Close-up + context; date; elevation
Finish system fractured, metal bent so it will not latch, glass broken	Functional — repair or replace	Failed function in the frame, not just marks
Roof mat: granule loss in hit pattern vs uniform aging	Needs test squares / elevation consistency	Do not call the whole roof from one spatter on a fence

Interior water is not owed just because it rained. The file needs a covered opening created by wind/hail (or another insured peril). Cracking, ponding, and blocked scuppers are maintenance / wear arguments.

Weather wall in hurricane season

Temporary weather protection is **mitigation**, not a hurricane warranty. The contractor who boards a missing slider owns the quality of that assembly, not Act of God water that would have entered a missing opening — unless the wall was defective, incomplete, or left against a written weather hold. Spec, daily inspection, and written notice if the GC keeps openings. See board-up / tarping.

Wind and Hail Scope Development Defined: Wind and hail damage scope development is the process of translating field-documented physical damage into a line-item scope of loss that accurately identifies each damaged component, assigns a defensible repair or replacement action, and is documented with sufficient physical evidence and meteorological support to withstand carrier review, independent inspection, and if necessary, appraisal or litigation. Scope quality is the single greatest determinant of claim outcome — not the adjuster's initial estimate.

The hail and wind restoration business generated approximately \$15 billion annually in the United States before the recent carrier-side tightening that began around 2020. The tightening was not arbitrary — it was a response to documented over-scoping, storm-chasing practices, assignment-of-benefits abuse, and fraud in the storm restoration market. The result is a significantly more adversarial claims environment in which even legitimate, well-documented claims are routinely initially underpaid, require supplements, and occasionally proceed to appraisal.

Professional contractors who understand the claims process, produce carrier-grade documentation, and write technically sound scopes navigate this environment far better than contractors who rely on volume and speed.

This guide provides the technical and procedural foundation for developing wind and hail scopes that are defensible from the first contact through final payment. For the field inspection and documentation that precedes scope development, see Roof Damage Assessment and Emergency Tarping. For the broader storm damage framework, see the Storm Damage Restoration Complete Professional Guide.

The Functional vs. Cosmetic Damage Distinction: The Central Battleground

No issue in storm damage restoration has generated more carrier disputes, state insurance department guidance, and litigation than the functional vs. cosmetic damage distinction. Understanding it precisely is no longer optional for contractors operating in the hail market.

Functional damage impairs the performance of the damaged component's intended function. For a roof covering, the intended function is waterproofing and weather resistance. On asphalt shingles: functional hail damage includes mat bruising with granule displacement that exposes the fiberglass mat (eliminating the granule layer's UV protection, creating premature mat oxidation and eventual waterproofing failure); impact craters that create surface irregularities affecting drainage patterns; and damage to sealant strips that compromises wind resistance. The word "functional" in this context means a quantifiable reduction in the material's ability to perform — not an immediate active leak.

Cosmetic damage affects appearance but does not impair function. Surface scuff marks on shingles, minor granule loss without mat exposure, and impact dings in metal gutters, flashing, or trim without structural distortion are cosmetic. Many carriers have inserted cosmetic damage exclusions into homeowner policies, removing coverage for cosmetic damage on specific materials. As of 2025, cosmetic damage exclusion language is present in a significant proportion of homeowner policies in Texas, Colorado, Minnesota, South Dakota, and other high-hail-frequency states.

The testing protocols: The probe test is the primary field method for distinguishing functional hail bruising from age-related weathering on asphalt shingles. A probe (pick, ice pick, or calibrated probe tool) is pressed firmly into a suspected hail bruise. Fresh functional bruising yields under probe pressure — the mat beneath the impact site is still relatively soft and the depression is compressible. Age-hardened weathering produces a rigid, non-yielding surface even where granule loss is apparent. The HAAG protocol for hail damage testing on asphalt shingles specifies probe testing methodology, documentation standards, and the distinction between functional and non-functional indicators.

Hail Damage Scope: Material-by-Material Framework

Hail affects multiple building materials simultaneously. A comprehensive hail damage scope covers every exterior material system, not just the roof.

Asphalt shingles: The scope line item for asphalt shingle replacement is typically "Remove and Replace Roofing — Composition Shingles" with appropriate unit pricing per square (100 square feet). Supporting the replacement scope requires: hail impact density count (number of functional impacts per 10 sq ft test square, averaged across multiple field locations), meteorological evidence of hail size at or above functional damage threshold, probe test results documented in writing, and photographs of representative functional damage sites with scale. Partial roof replacement in the same color/exposure is accepted in some markets but requires matching confirmation before scope is finalized — if the damaged square is discontinued, matching failure drives toward full replacement.

Gutters and downspouts: Aluminum gutters are among the most clearly legible hail damage indicators — hail impact produces circular dents with clean edges and raised rims that are visually distinct from accidental impact damage (which tends to be random in shape) and from installation error (which produces linear deformation). Spatter density in gutters should be consistent with the hail density observed on the roof. Gutter replacement scope includes remove and replace gutters, downspouts, and end caps, with notes on any specialty profiles (half-round, K-style) that require special order material with extended lead time.

Painted wood trim and fascia: Wood trim painted surfaces show hail impact as surface paint penetration, raised wood fiber at impact sites, and in severe cases, wood splitting. Document with close-up photography; the impact marks on painted wood are often less obvious than on asphalt but are present and distinguishable from normal weathering. Scope lines for painted wood typically include repair or replace with repaint.

Vinyl and fiber cement siding: Vinyl siding cracks under hail impact above approximately 1.5 inches, producing characteristic spider-web fractures or split lines. Fiber cement siding is more resistant but shows impact marks at large hail sizes. The scope challenge for siding is matching — siding manufacturers frequently change colors and profiles, and discontinued products create matching issues that can drive full-structure scope even when only one elevation was damaged. Establishing the manufacturer, product line, color name, and production date before writing siding scope prevents scope disputes downstream.

HVAC equipment: Condenser fins on air conditioning units are extremely vulnerable to hail damage — even 1.0-inch hail can bend or crush fins sufficiently to reduce heat transfer efficiency by 20–40%. The scope for HVAC hail damage is not typically full unit replacement (unless the compressor housing is punctured or internal components damaged); it is fin straightening (if within the service threshold) or fin coil replacement, plus an HVAC technician's evaluation for internal damage. Insurance carriers may require an independent HVAC technician's report for unit replacement scope — do not assume replacement is covered without confirming with the carrier before the unit is removed.

Skylights and windows: Hail-cracked skylight glazing is clearly functional damage — broken glass has no waterproofing function. Window frame damage (bent or cracked extruded aluminum) and broken glazing in windows are straightforward replacement scope. The subtlety is impact-damaged insulated glass units (IGUs) that have not yet broken — concentrated hail impact on an IGU can damage the seal between the glass panes, causing progressive fogging as the desiccant is exhausted. IGU seal failure from hail impact is a documented phenomenon and, where verifiable, is a legitimate scope item even before visible fogging occurs.

Wind Damage Scope: Causation Analysis and Documentation

Wind damage scope development requires a causation argument that the wind event — not age deterioration, manufacturer defect, or installation error — was the proximate cause of each scope item. This argument must be made for every scope line, not just for the overall claim.

Missing and lifted shingles: Missing shingles attributable to wind are documented by: pattern consistency with documented wind direction; concentration in aerodynamically high-stress zones; evidence of intact sealant adhesion on adjacent shingles (indicating the damaged shingles failed under load, not due to sealant absence); and meteorological evidence of wind speeds at or above the manufacturer's wind resistance rating for the installed product. Most three-tab asphalt shingles are rated for 60-70 mph; most architectural shingles are rated for 110-130 mph. Documentation of installed product's wind rating is part of the scope file.

Granule loss from wind: Wind-driven granule loss is distinct from both hail-related and age-related granule loss. Wind abrasion produces directionality in the loss pattern — granules are displaced from the windward face of each shingle in a directionality consistent with the storm’s wind direction. Age-related granule loss produces diffuse, non-directional distribution. Hail-related granule loss concentrates at discrete impact sites. Documenting the directionality of granule loss in the field inspection supports wind causation.

Soffit and fascia damage: Wind lifts soffit panels from the windward elevation and can tear fascia boards from their backing. The damage pattern on soffits should be consistent with the documented wind direction — windward elevation damage with intact leeward elevation soffits is consistent with wind causation; damage on all four elevations without directional pattern may indicate age-related fastener failure rather than wind event loading.

Fence and outbuilding damage: Fences, detached garages, sheds, and carports are often included in wind damage scope. These structures typically have lower wind resistance than the main structure and provide corroborating evidence of wind loading consistent with the documented event.

Writing the Scope: Xactimate Best Practices for Storm Claims

Xactimate is the dominant estimating platform in property insurance claims — approximately 85% of U.S. property claims are estimated in Xactimate at some stage of the adjustment process. Writing storm scopes in Xactimate-compatible format is not a preference; it is a professional requirement for working efficiently in the carrier ecosystem.

Line item selection: Use the most specific applicable line item rather than a generic substitute. “Remove and Replace Roofing — Composition Shingle — Laminated, High Grade” captures material quality differences that affect the price and that will be argued if a generic line item is used. When a specific Xactimate line item does not exist for a required scope element, use the closest available line item with an F9 note explaining the deviation and the basis for the price modifier used.

F9 notes on contested items: Any scope item that is likely to be disputed by the carrier’s adjuster should carry a detailed F9 note explaining: the physical evidence that supports the line item, the photo reference number that documents it, the standard or code requirement that mandates it (for code upgrade items), and the basis for the quantity used. F9 notes are the narrative equivalent of the contractor’s argument in the supplement process — write them as if you are explaining the item to someone who is looking for a reason to deny it.

Code upgrade items: Full roof replacements triggered by storm damage often require code-mandated upgrades that were not present in the original installation — ice and water shield at eaves and valleys (required by IRC R905.2.7 in most jurisdictions), drip edge installation (IRC R905.2.8), ridge ventilation upgrades, and in some jurisdictions, high-wind fastening patterns. These are not contractor upsells — they are building code compliance requirements that the carrier is obligated to cover as part of restoring the property to a legally compliant condition. Each code item requires a local code reference in the F9 note.

Overhead and profit: Overhead and profit (O&P) on storm damage claims is a source of persistent dispute. The Xactimate standard applies 10% overhead and 10% profit as a default on most line items; carriers routinely challenge O&P on claims where they argue only a subcontractor is involved, not a general contractor. The standard for O&P application is the presence of a general contractor who is managing multiple trades, coordinating material delivery and sequencing, providing project warranty, and carrying project liability

insurance. Document the scope of project management on any claim where O&P is challenged.

The Supplement Process: How to Manage It Professionally

The supplement process — submitting additional scope items not included in the initial carrier estimate — is now an expected phase of storm restoration claims rather than an exception. The average storm restoration claim requires at least one supplement, and commercial and complex residential claims frequently require multiple rounds. Managing this process professionally determines both the speed of payment and the contractor-carrier relationship quality.

Supplement timing: Submit the supplement as soon as the additional scope is documented — do not batch multiple supplements. A supplement submitted before the carrier’s initial payment is processed creates a cleaner administrative trail than a supplement submitted after payment is received and applied.

Supplement documentation: Every supplement item requires the same documentation standard as original scope: physical evidence photograph, F9 note or written explanation, measurement basis, and Xactimate line item. A supplement that is a list of additional line items without supporting documentation will be challenged item by item; a supplement that is a documented argument for each item moves through review faster.

Hidden damage supplements: Hidden damage revealed during tear-off — rotted decking, degraded underlayment, deteriorated flashing that was not visible until removal, damaged structural members under intact finish materials — is the most common supplement category. Document hidden damage in real time with photographs and written notes that include the date, location, and conditions under which it was discovered. “We found rotted decking when we tore off” with a photo of rotted boards is a legitimate supplement; a verbal claim after the fact without contemporaneous documentation is not.

The Appraisal Process: When Disputes Cannot Be Resolved

Most property insurance policies contain an appraisal clause that allows either party to demand an appraisal when there is a dispute about the amount of loss. The appraisal process is not litigation — it is a contractual dispute resolution mechanism that produces a binding award through a panel of two appraisers (one selected by each party) and an umpire. Understanding when appraisal is appropriate and how to support it is a professional skill for storm contractors operating in high-dispute markets.

Appraisal is most appropriate when: the carrier has made a payment, but the contractor believes the scope is materially underpaid; supplementation has been exhausted without resolution; and the disputed amount justifies the cost and time of the appraisal process (typically 60–120 days and \$3,000–\$10,000 in professional fees on each side). Appraisal is not a guarantee of contractor-favorable outcome — it is an independent evaluation that sometimes confirms the carrier’s position. Strong technical documentation going into appraisal significantly improves outcomes.

Public adjusters and contractor-retained appraisers specialize in storm damage appraisal representation. In states where assignment of benefits is still permitted, contractors may hold a direct financial interest in the appraisal outcome. In states with AOB restrictions, the contractor’s role is typically limited to providing technical support and documentation to the policyholder’s appraisal team rather than serving as an independent appraisal interest holder.

Post-Storm Market and CAT Response Considerations

Major convective events create regional contractor shortages that drive both material lead times and temporary price increases. Xactimate pricing updates (monthly for standard pricing, weekly for emergency pricing in declared disaster areas) lag market reality in the immediate aftermath of major events — and the gap between Xactimate pricing and actual material/labor cost in a CAT market is a legitimate supplement ground when documentation of actual cost supports the variance.

Emergency Xactimate pricing zones are declared by Verisk following major weather events and provide temporary price increases that partially reflect market conditions. Contractors working in declared disaster areas should monitor for emergency pricing activation and apply it to claims in the affected geography during the active period.

Connecting Wind and Hail Scope to the Full Storm Workflow

Wind and hail scope covers the exterior building envelope — the entry points for storm damage. Where that envelope was breached, water intrusion follows, requiring a parallel and separately documented mitigation scope under ANSI/IICRC S500. For the complete water intrusion response protocol, see Storm Water Intrusion: Extraction, Drying, and Mitigation Protocol. For the initial roof assessment and emergency stabilization that precedes scope development, see Roof Damage Assessment and Emergency Tarping. Return to the Storm Damage Restoration Complete Professional Guide for the full program framework.

Frequently Asked Questions

How do you document hail damage for an insurance claim?

Hail damage documentation requires: pre-work photographs of all affected surfaces with scale references; meteorological verification of hail size at the property (NOAA NEXRAD data or a certified storm report); probe testing of suspected impact sites on asphalt shingles to distinguish functional mat bruising from weathering; hail impact density counts in multiple 10-square-foot test areas; documentation of all affected exterior surfaces (gutters, AC units, siding, trim); and a written scope of loss with line items, measurements, and photo references for each item.

What size hail causes functional damage to asphalt shingles?

No universal threshold exists — outcomes depend on hailstone density, fall velocity, fall angle, shingle age, and mat condition. Generally, hail 1.0 inch or larger is capable of producing functional bruising on aged shingles; hail 1.5 inches or larger consistently produces functional damage on most asphalt shingles. Class 4 UL 2218 impact-resistant shingles resist functional damage from hail up to approximately 2 inches. The carrier's often-cited 1.0-inch threshold is not an industry standard and is not defined in any building code.

Can a wind damage claim be denied if wind speeds were below the threshold?

Carriers frequently deny wind claims by citing insufficient recorded wind speeds at the nearest station. This argument is vulnerable because: station data does not reflect conditions at the property; local pressure effects cause damage at lower average speeds; and installation deficiencies lower the effective resistance of a specific structure. A forensic meteorologist's site-specific wind analysis and, in contested cases, a structural engineer's assessment of the building's actual wind resistance are the appropriate technical responses.

What is an Xactimate F9 note and how is it used in storm claims?

An F9 note is a line-item annotation in Xactimate that documents justification, special conditions, or explanatory notes directly attached to any scope line item, visible to the adjuster as part of the estimate. In storm claims, F9 notes document why a line item is included, the measurement basis, material specifications, code references, and links to supporting photographs. Well-written F9 notes on contested scope items significantly reduce supplement cycle time.

What is a matching claim in storm damage restoration?

A matching claim arises when replacing storm-damaged materials creates a visible mismatch with undamaged adjacent materials — particularly when the damaged material is discontinued or weathered to a different appearance. Most policies require restoration to pre-loss condition, creating an obligation to address visible mismatch through full replacement or supplemental finishing. Several states have affirmed carrier matching obligations; others have enacted cosmetic damage exclusions that complicate matching arguments. Policy language and state guidance must be reviewed for each specific claim.

Roof Damage Assessment and Emergency Tarping: Field Protocol and Insurance Documentation

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Emergency Roof Assessment Defined: Emergency storm roof assessment is the systematic inspection of a storm-damaged roof to identify all areas of envelope breach, structural damage, and water intrusion risk — conducted before any mitigation work begins and documented in a manner that protects both the insurance claim and the contractor's scope. Emergency tarping is the immediate closure of open envelope breaches using industry-standard materials and fastening methods to prevent further loss pending permanent repair.

The roof is where storm damage begins and where claims are won or lost. Every carrier dispute about whether damage was caused by the documented storm event or by pre-existing deterioration traces back to the same failure point: inadequate documentation before work began. A contractor who tarps before photographing has eliminated their most powerful evidence. A contractor who photographs but doesn't know what they're looking for produces documentation that captures the wrong things.

This guide covers the complete field protocol for storm roof assessment and emergency stabilization — the inspection sequence, damage pattern recognition, tarping standards, and documentation methodology that produces carrier-grade evidence. For the broader storm damage framework, return to the Storm Damage Restoration: Complete Professional Guide. For scope development once the roof is assessed and secured, see Wind and Hail Damage: Scope Development and Insurance Claims.

Safety First: Pre-Inspection Hazard Assessment

No professional enters or accesses a storm-damaged roof without a hazard sweep. The following conditions require resolution before any roof access:

Electrical hazards: Downed power lines, damaged utility service entrances, and masthead damage where the service drop has been compromised by tree impact or wind. Do not assume lines are dead because they are down — confirm with the utility company. A service entrance mast bent by a tree does not automatically de-energize the service; the lines may remain live until the utility disconnects at the pole.

Structural instability: Tree impact damage that has compromised rafters, trusses, or the ridge system can make the roof deck unsafe to walk. Before stepping onto any section of roof that has sustained direct tree impact, probe from the eave edge with a tool to verify that the decking is not supported only by debris. Areas where the ceiling has collapsed internally beneath the impact zone are high-risk for compromised structural support above.

Active weather: Do not access roofs during active lightning, high wind, or freezing rain. Storm assessments are not emergency room procedures — waiting two hours for the storm to clear is safer and produces better documentation than rushing onto a wet roof in active weather.

Fall protection: OSHA 29 CFR 1926.502 requires fall protection for any roof work at 6 feet or more above a lower level. On residential steep-slope roofs, this means personal fall arrest systems for pitches above 4:12 and for any ridge, hip, or eave edge work. The urgency of storm response does not suspend OSHA requirements — and a fall injury in a storm event creates liability exposure that dwarfs any scope argument with a carrier.

The Pre-Work Documentation Sequence

Documentation before any work begins is the non-negotiable first step of every storm roof inspection. “Before” photographs taken after mitigation work has started are not before photographs — they are after photographs of a partially altered scene, and carriers know the difference.

Exterior ground-level documentation: All four elevations of the structure photographed from ground level, capturing the full roofline and any visible damage from that vantage point. These photos establish context — the overall structure condition, the surrounding storm environment (downed trees, neighbor damage), and the pre-mitigation state of all visible roof surfaces. Time and date stamp on every photo is mandatory; use the camera’s native timestamp feature rather than a physical date stamp overlay that can be edited.

Drone documentation: Where available, drone photography of the full roof surface before any access provides the most comprehensive and defensible pre-mitigation record available. A drone-captured overhead mosaic of a storm-damaged roof allows independent review of the full damage pattern against the documented storm event without interpretive filtering. FAA Part 107 authorization is required for commercial drone operation — operators without it are exposing themselves to FAA enforcement risk that exceeds any short-term efficiency gain.

Roof-level close-up documentation: For each identified damage zone, capture minimum two photographs: one context shot showing the location on the roof relative to adjacent reference points, and one close-up with a scale reference (ruler, coin, or calibrated marker) showing the damage detail. Without a scale reference, a photo of a hail bruise on a shingle could be anything from a fingernail scratch to a 2-inch-diameter impact — the carrier’s inspector will say the former, your scope needs the latter.

Interior and attic documentation: Before accessing the attic, photograph the ceiling from below in all rooms below the suspected damage zone — water staining, bubbled paint, sagging drywall, and mold growth are all pre-work documentation items. In the attic, photograph all evidence of water intrusion (staining on the decking,

wet insulation, daylight through penetrations or failed flashing), all areas of structural member damage or displacement, and all insulation condition relevant to the loss.

Systematic Roof Inspection: Zone by Zone

A systematic roof inspection that can stand scrutiny covers every zone of the roof — not just the areas with obvious damage. Carriers look for inspection reports that document the full roof in order to identify any areas the contractor “missed” or “skipped.” A complete zone-by-zone inspection report with documented findings (even negative findings — “No damage observed in zone 4”) is more defensible than a report that only documents damage locations.

Zone 1 — Roof field (central area, away from edges): The field is where hail damage is most systematically distributed — hail falls with some random variation but creates a density pattern across the full roof surface. Document hail impact density in the field: count the number of functional impact marks in a representative 10 square foot test area and extrapolate to total field area. Multiple test squares in different field locations average out installation variation and provide a statistical basis for the damage count. Wind damage in the field is less common — wind uplift typically initiates at edges and perimeters — so field shingle failures in the absence of hail may indicate manufacturing defect or installation error rather than storm causation.

Zone 2 — Perimeter and edges: The highest-stress wind zone on any roof. Perimeter shingles, drip edge, and starter course are the first components to fail under wind uplift. Document any lifted, creased, or missing shingles; any drip edge displacement; any starter strip separation. On metal roofs, inspect for panel edge rollback, fastener pullout at the perimeter, and seam separation within 24 inches of the eave and rake edges.

Zone 3 — Ridge and hip lines: Ridge cap and hip cap shingles are disproportionately vulnerable to wind damage — they are exposed on both sides with no adjacent shingle for mechanical support. Missing or lifted ridge cap is one of the most common residential storm scope items. Hip and ridge caps also take direct hail impact from multiple angles, making them a useful secondary confirmation of hail damage when field shingles are borderline.

Zone 4 — Valleys: Valley areas concentrate water flow and are high-stress zones for both hail impact (metal valley flashing dents are clearly documented) and wind (open valley flashing edges can lift under negative pressure). Document any cracking, displacement, or granule loss in woven or cut valley configurations. Check valley metal for hail dings, uplift, and sealant condition at edges.

Zone 5 — Penetrations (vents, pipes, skylights, HVAC): Penetration flashings are among the most common storm damage locations and among the most commonly missed in documentation. Roof vent caps are frequently cracked, displaced, or crushed by hail. Lead pipe boots crack under hail impact — a 2-inch hailstone on a 2-inch lead boot stack creates enough concentrated force to crack the boot. Skylight frames and glazing are vulnerable to hail impact at any size above 1 inch. Document every penetration condition individually.

Zone 6 — Flashings (step, counter, base, chimney): Flashing is the interface between the roofing material and vertical surfaces (walls, chimneys, dormers). Flashing conditions are frequently pre-existing and pre-existing flashing failures are a common carrier argument against full scope approval. Document flashing conditions precisely — distinguish between flashing that failed under storm loading (displaced by wind, punctured by hail, pulled from reglet by differential movement) and flashing that shows age-related deterioration unrelated to the storm event.

Damage Pattern Recognition: Reading the Roof

The ability to read a roof — to distinguish storm damage from age deterioration, manufacturing defect, and installation error — is the core skill of storm damage assessment. Carriers hire inspectors who know how to make these distinctions in their favor; contractors need to know how to document them in the policyholder's favor.

Hail damage patterns: Fresh hail damage has a characteristic spatter density pattern — impacts are distributed across the roof field with density roughly proportional to storm intensity. The impacts are random in position but consistent in shape (circular or slightly elliptical depending on fall angle) and in the surface disruption they produce on a given material. Age-related granule loss is not random — it concentrates at high-wear areas (valleys, eaves, ridge areas) and creates diffuse, patchy loss rather than discrete impact marks. The probe test distinguishes fresh hail bruising (soft, yielding mat beneath the surface depression) from aged weathering (hard, oxidized mat with no yielding).

Wind damage patterns: Wind damage concentrates at high-stress aerodynamic zones — perimeter edges, corners, ridge, and hip lines — following predictable pressure distribution. Damage isolated to the middle of a roof field without corresponding edge damage is more consistent with mechanical failure than wind. Wind direction is documented in the meteorological report, and damage patterns should be consistent with that wind direction — windward damage on the appropriate elevation, leeward tearing where negative pressure induced uplift.

Hail size verification: The damage pattern on the roof can be used to verify reported hail size against field evidence. Larger hailstones produce larger impact craters with more complete granule displacement; the size of the bruise impression correlates with the hailstone diameter within a range. When NEXRAD data reports 1.0–1.5 inch hail but impact marks on the roof are consistent with 0.5-inch impacts, the discrepancy should be investigated — NEXRAD MESH overestimates hail size in many events. Conversely, when the carrier's inspector attributes 1.5-inch impact marks to 0.75-inch hail that “shouldn't have damaged” the roof, the physical evidence of impact size is the stronger argument.

Emergency Tarping: Standards and Protocol

Emergency tarping performed to inadequate standards does three things simultaneously: it provides inadequate protection against further loss, it generates carrier disputes about the tarping charge, and it creates contractor liability when the inadequate tarp fails in a subsequent weather event and the secondary water damage is attributed to contractor negligence. There is no case for cutting corners on emergency tarping.

Material selection: Minimum standard is 6-mil polyethylene (6 mil = 0.006 inches thick) for short-duration protection. For installations expected to remain in place for more than 30 days, or in high-UV or high-wind environments, woven polyethylene tarps with UV inhibitors (rated 90–180 days) are the appropriate specification. Heavy-duty reinforced poly tarps with integrated webbing loops provide the anchor points for mechanical fastening in high-wind environments. Avoid using builder's film (1–3 mil) as emergency tarping material — it has insufficient UV and puncture resistance for roof exposure and will not survive a subsequent storm.

Coverage area: The tarp must cover all identified damage areas with a minimum 12-inch overlap beyond the damage perimeter. If the damage is ambiguous at the edges — which it is in most hail events, where the damage

boundary is determined by impact density rather than a clear line — the conservative approach is to extend tarp coverage to the nearest structural boundary (ridge, hip, valley, edge) rather than stopping at the estimated damage edge. The cost of 20 additional square feet of tarp coverage is trivial compared to the cost of a secondary water intrusion claim through an undertarped area.

Ridge extension: The tarp must extend over the ridge line by a minimum of 4 feet and be secured on the downslope side. A tarp that stops at the ridge leaves the peak unprotected and creates an entry point for wind-driven rain to get under the tarp edge. On hip roofs, the tarp must wrap over all hip lines in the damage area, not just the main ridge.

Fastening method: Tarps secured only with weights (sandbags, boards laid on top) are not professionally installed tarps — they are emergency stop-gaps that will fail in 30-mph winds. IBHS-recommended fastening uses 1×4 or 2×4 wood battens screwed to the roof deck through the tarp at maximum 12-inch spacing along all tarp edges, and at 24-inch spacing across the tarp field. The screws must penetrate the deck a minimum of 1 inch. On tile or slate roofs where screw penetration would damage non-damaged adjacent material, mechanical fastening through the tarp to the ridge and eave with strap anchors is an acceptable alternative.

Documentation of the completed tarp: Photograph the completed tarp installation — coverage area, ridge extension, batten fastening at representative locations, and the full roof with the tarp in place. This post-installation documentation supports the tarping charge and provides evidence that the installation was performed to professional standards.

Working with Drone Technology for Storm Assessment

Drone technology has fundamentally changed storm roof assessment quality over the past decade. A drone-captured roof inspection produces documentation that is comprehensive, objective, time-stamped, and reviewable by anyone — carrier, attorney, engineer — without the interpretation filtering that comes with an inspector who only photographs what they want to show.

High-resolution drone photogrammetry (available through platforms including EagleView, Hover, and DroneDeploy) produces orthomosaic maps, 3D models, and measurement-accurate roof reports that are increasingly used as the baseline documentation for large loss claims. Several major carriers now accept or require EagleView-format roof reports on claims above certain thresholds. The accuracy of automated measurement from drone photogrammetry has been independently validated to within 1–2% of manual measurement on standard residential roofs.

The limitation of drone documentation is that it captures surface appearance, not functional condition. A drone photo of a hail-affected asphalt shingle surface cannot definitively distinguish functional mat bruising from surface discoloration — that determination requires physical access and probe testing. Drone documentation is therefore the foundation, not the complete replacement, for physical inspection. The combination — drone overview plus physical close-up testing — provides the most defensible documentation package available.

Emergency Board-Up: When Windows and Walls Are Compromised

Storm events that break windows, displace doors, or create wall breaches require emergency board-up alongside or before roof tarping. Board-up protocol for storm damage follows the same standards used in fire and other property damage: CDX plywood minimum 3/4-inch thickness for openings larger than 4 square feet,

fastened with appropriate framing screws to sound structural members, with the opening edges protected to prevent water infiltration at the plywood edges.

For window and glass door openings, pre-cut plywood panels sized to the rough opening provide the fastest installation. Panel sizing and installation documentation (photos of the opening before and after board-up) are required for the emergency board-up line item in the claim.

In structures where hail or wind has broken glazing and the broken glass poses interior contamination risk (glass particles on furniture, floors, and contents), a preliminary glass cleanup scope is appropriate before any other interior work — and before contents are moved, since moving glass-contaminated contents spreads the contamination and creates additional scope.

Connecting Assessment to the Full Storm Restoration Workflow

Roof assessment and emergency tarping are the first phase of a multi-phase storm restoration project. Once the envelope is secured, the assessment findings drive the full scope: hail and wind damage to exterior surfaces drives the scope for wind and hail restoration; water intrusion documented in the assessment drives the scope for water intrusion mitigation and drying. For the complete program framework, return to the Storm Damage Restoration: Complete Professional Guide.

Frequently Asked Questions

How should a storm-damaged roof be inspected?

A professional storm roof inspection follows a systematic sequence: safety evaluation before any access; exterior ground-level documentation of all four elevations; roof-level inspection by zone — field, perimeter, ridges, hips, valleys, penetrations, and flashings — with close-up photography of every damage location; interior inspection for water intrusion evidence; and attic inspection for structural member damage and leak paths. Each zone is documented before any mitigation work begins.

What are the IBHS standards for emergency roof tarping?

IBHS recommends minimum 6-mil polyethylene tarps secured with wood battens screwed to the roof deck at maximum 12-inch spacing along all tarp edges. Tarps must extend over the ridge line by at least 4 feet and cover all damaged areas with a minimum 12-inch overlap beyond the damage perimeter. Tarps secured only with weights are not professionally installed and will fail in subsequent wind events.

How long can an emergency tarp stay on a roof?

Standard 6-mil polyethylene tarps are rated for 90 days of UV exposure. Woven polyethylene tarps with UV inhibitors provide 120–180 days of service life. Tarps should be inspected after any subsequent storm event and replaced if fastening is compromised. Most carriers expect permanent repair within 30–90 days depending on claim complexity and material availability.

What photographs are required to document storm roof damage?

Required documentation includes: all four elevation photos from ground level before any work; overhead drone or ladder photos of the full roof surface; close-up photos of every damage point with a scale reference visible; photos of all flashing, ridge, hip, valley, and penetration conditions; interior photos of all leak-related staining or damage; and attic photos showing structural or insulation damage. All photos must be timestamped before

any work begins.

Does insurance cover emergency roof tarping?

Yes — emergency tarping to prevent further damage after a covered storm event is typically covered under the Additional Living Expense or Emergency Repair provisions of standard property policies. The tarping must be documented (before-and-after photos, written scope, signed authorization), performed by a licensed contractor, and invoiced at reasonable market rates. Carriers will not pay without documentation that a covered cause of loss created the need for it.