A Policyholder’s Primer on Insurance

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A Policyholder’s Primer on Insurance
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This primer is intended to give inside corporate counsel background to assist him or her in identifying insurance issues that may arise, participate in substantive insurance discussions relating to those issues, and assist risk managers in maximizing the protection afforded by insurance. This information should not be construed as legal advice or legal opinion on specific facts, or representative of the views of ACC or any of its lawyers, unless so stated. This is not intended as a definitive statement on the subject but a tool, providing practical information for the reader. We hope that you find this material useful. Thank you for contacting the Association of Corporate Counsel.

This material was compiled and updated by the Insurance Coverage practice attorneys of Dickstein Shapiro Morin & Oshinsky LLP (www.DicksteinShapiro.com) at the direction of the Association of Corporate Counsel.
I. Introduction

Insurance is a valuable asset that can protect corporate America from both man-made and natural disasters. The continuing development of mass tort and product liability litigation, Sarbanes-Oxley, the increase in securities class action and derivative claims, and the property damages and business interruption losses caused by the World Trade Center tragedy are all recent examples of circumstances that highlight the importance of a corporation’s insurance program. The role of insurance in responding to natural disasters is a subject of immediate importance in light of Hurricane Katrina. The resulting property damage and business interruption losses will be in excess of $100 billion, and will impact corporations throughout the country, not just in the immediately affected states. Those losses will be insured, at least in part, by various types of policies discussed below. Accordingly, every in-house lawyer should have an understanding of, or at least be able to identify, basic insurance issues so that he or she can assist their risk management department in making sure that the insurance purchased by the corporation is drafted in a way to maximize coverage, and that claims are submitted in a way that will maximize recovery.

Risk managers typically focus on the financial aspects of insurance: the premium and the limits. In-house counsel are trained to focus on other aspects of the transaction that can have significant impact on the asset’s value, such as the legal implications of the language contained in various policy terms, and whether the policyholder should even accept certain provisions, such as those concerning arbitration and choice of law. Counsel can assist in the submission of claims, including adherence to the notice and cooperation provisions in the policy. Counsel also can bring his or her understanding of the underlying liability or loss to insurance recovery so that the claim is described to the insurance company and managed in such a way as to maximize coverage.

This Primer is intended to give inside corporate counsel background so that he or she can identify insurance issues that may arise, participate in substantive insurance discussions relating to those issues, and assist risk managers in maximizing the protection afforded by insurance. It does not address all issues that can be found in an insurance coverage dispute. Rather, it introduces basic insurance concepts to in-house counsel so that he or she can identify those issues and identify the circumstances in which outside insurance coverage counsel may be helpful or necessary.

Section II provides an introduction to the basic structure of an insurance program, the types of insurance policies that are sold, a discussion of the key documents that form an insurance agreement and the principal sections of an insurance policy. Sections III - V provide a more detailed treatment of some of the types of insurance available, as well as current hot insurance issues that are troubling in-house counsel. Sections VI - VIII attempt to provide practical advice to in-house counsel.
II. Insurance Basics

A. Types of Insurance

Insurance policies generally fall into two categories: first-party and third-party policies. First-party policies typically insure against loss of, or damage to, the policyholder’s property. They may also provide coverage for lost business revenue. Examples of first-party coverages are comprehensive business property policies (which can include business interruption coverages), and Fidelity and Crime policies, which insure against loss of the policyholder’s property due to fraud or the dishonesty of an employee.

Third-party policies typically provide insurance for the policyholder’s liability to third parties for alleged injury or damage. The most important example of a third-party policy is the general liability policy, which provides broad insurance for claims against the policyholder alleging bodily injury, property damage, personal injury, and/or advertising injury. Businesses typically purchase general liability insurance in a Comprehensive General Liability or Commercial General Liability policy (“CGL”). Other types of liability insurance policies include Directors and Officers (“D&O”) policies, which protect corporate officers and directors against claims alleging wrongful acts in their capacity as directors and officers; Errors and Omissions (“E&O”) insurance policies, designed to protect the policyholder against claims that it was negligent in providing professional services; Fiduciary Liability insurance, intended to protect against claims that the company’s pension fund has been mismanaged; Employment Practices Liability insurance, intended to protect against various forms of employee claims; and Workers Compensation insurance, intended to protect against workers’ compensation claims brought pursuant to state law.

Businesses generally purchase both first-party and third-party insurance, in varying amounts and layers. The first so-called “layer,” referred to as a deductible or a self-insured retention (“SIR”), is not really insurance, but an amount that the policyholder must pay before an insurance company’s obligation to pay is triggered. Although frequently confused, deductibles and SIRs operate in different ways. If the insurance policy has a deductible, the insurance company pays first-dollar coverage up to the limits of the policy, but the amount of the deductible is billed back to the policyholder for reimbursement to the insurance company. For example, if a $1,000,000 liability policy with a $100,000 deductible is required to pay a claim, the insurance company will pay the injured third party the $1 million policy limit. The policyholder must then reimburse the insurance company for the deductible amount, or $100,000. On the other hand, if the insurance policy with $1,000,000 in limits has a $100,000 SIR, the policyholder is responsible for paying the first $100,000 to the injured party.

After the deductible or SIR, the “primary policy” provides the first real layer of insurance for a covered claim. The primary policy contains the basic coverage provisions that define the scope of the particular type of insurance.

Corporations (and sometimes individuals) purchase layers of “excess insurance” to provide additional insurance in addition to the primary coverage. The “first-layer excess” will pay after the primary has been exhausted. The “second-layer excess” will pay after the first-layer excess policy limits are exhausted, and so on. It is not uncommon for more than one insurance company to share a layer sold to a corporate policyholder. Each company’s percentage is referred to as its "quota share.”

When the first layer of excess insurance contains its own terms and conditions, it is referred to as an “umbrella policy.” An umbrella policy may be broader than the underlying primary policy.
(or policies) and may cover certain types of losses or claims that are not covered by the primary policy. If there is no underlying policy that covers a claim within the insuring provisions of the umbrella policy, then the umbrella policy will pay as if it were a primary policy after the policyholder pays a certain amount toward the claim, referred to as a “retained limit.”

Excess policies in layers above the umbrella policy often do not contain their own terms and conditions, but merely adopt, or “follow form” to, the provisions of the umbrella policy. They also may follow form “with exceptions,” that is, adopt the terms and conditions of underlying policies, except to the extent those terms conflict with specific provisions of the excess policy. Most excess policies provide that they will pay claims only when the limits of the underlying policies have been exhausted through the payment of judgments or settlements. Alternatively, the excess policies can be triggered after a retained limit has been paid for a loss that would be covered by the excess policy, but not covered by the underlying policies.

Problems can, and often do, arise when excess policies do not “follow form” to the underlying umbrella policy, but contain their own terms and conditions. If layers of insurance are to work as intended, all of the policies, at least above the primary, must cover the same risks. Inconsistencies in policy language may create gaps in coverage, which will make it difficult to trigger excess policies. Disputes will then arise as to whether the underlying policy limits, or the retained limit, have been exhausted properly.

Although it is the broker’s obligation to place an insurance program that does not have inconsistent policy provisions in layers of insurance, such errors can and do occur. Indeed, policies even within the same layer can be issued with inconsistent policy provisions if each quota share participant issues its own policy. In-house counsel can help risk managers and provide additional oversight by reviewing policy language for inconsistencies in the policy language between, or within, different layers of coverage. Alternatively, counsel may suggest that the policyholder insist that the broker obtain only true “follow form” excess policies.

### B. Insurance Documents

The “Insurance Binder” is the initial document that evidences that insurance was sold. The binder typically is only a few pages long, and refers in summary fashion to the basic terms of the insurance contract, often by reference to standard policy forms. Often, the formal policy is not prepared until months after the coverage becomes effective, and sometimes may not be delivered until after the policy period has expired. The binder is particularly important because it may be the only documented “contract” that exists during that portion of the policy period. For instance, the litigation over insurance coverage for the billions of dollars in loss and liabilities at the World Trade Center primarily concerns the wording contained in binders because, as of September 11, 2001, the policies had not yet been issued. World Trade Ctr. Props. L.L.C. v. Hartford Fire Ins. Co., 345 F.3d 154 (2d Cir. 2003) (concerning first-party property policies) (“World Trade Center Properties”); In re Sept. 11 Liab. Ins. Coverage Cases, 333 F. Supp. 2d 111 (S.D.N.Y. 2004) (“Sept. 11 Liab. Ins. Coverage Cases”) (concerning third-party liability policies.)

When the formal insurance policy eventually is delivered, it is essential that it be reviewed to determine whether the actual policy is consistent with the terms as outlined in the binder. The formal policy generally consists of: (1) a Declarations Page; (2) a Policy Form; and (3) Endorsements.

The “Declarations Page” provides a summary of the insurance provisions, including the specific type of insurance being sold, the designation of the named insureds, the policy period, and the
amount insured or limits of liability. The Declarations Page may be the only document that is
customized for the individual policyholder and the particular type of insurance.

The “Policy Form” generally is a preprinted document that describes (1) who (or what) is in-
sured; (2) the insuring agreements (and definitions); (3) the exclusions; and (4) the conditions the
policyholder must satisfy in order to be entitled to coverage under the policy. For general liability
policies sold today, this form most frequently has been created by the Insurance Services Organi-
zation, an insurance industry organization commonly referred to as ISO.12 Other types of insur-
ance policies (e.g., D&O, E&O, Fidelity, and property policies) often are written on an insurance
company’s own standard forms,13 which sometimes are customized for a particular industry. For
example, a Bankers Blanket Bond form is a Fidelity policy customized for the financial industry.

The insurance industry uses standard language so that it can set premiums based upon prior
loss experience under the same insurance provisions. Policyholders, therefore, generally have no
opportunity to negotiate the language of the basic insuring provisions in the Policy Form. The
negotiations that do take place concern principally the premiums and limits of coverage. Ac-
cordingly, under general rules of insurance contract construction, ambiguities in standard policy
language are construed against the insurance company on the ground that only the insurance
company could have clarified or eliminated those ambiguities.14

“Endorsements” are modifications to the Policy Form. There are standard, preprinted endorse-
ments, such as nuclear energy, asbestos, or pollution exclusions, and customized endorsements
that list, for example, additional insureds, or exclude an aspect of the policyholder’s business from
coverage. There may be negotiations over the language of endorsements dealing with the scope of
coverage, but most often these “negotiations” are limited to a discussion over which of the insur-
ance company’s various standard endorsements will be used.

In some limited circumstances, insurance policies may be tailored for the particular policyholder.
These policies are referred to as “manuscript” policies. Insurance companies often argue that
policy language is negotiated between the insurance company and the policyholder and, thus,
try to avoid the rules of policy construction that favor policyholders. However, true manuscript
policies, where the language of the insuring agreements is negotiated, are rare. In most cases,
“manuscript” policies merely involve standard insurance company language that is retyped, rather
than presented on a preprinted form. In this case, the pro-policyholder rules of construction still
should apply.15

Finally, some aspects of the insurance relationship, such as how a deductible will operate or how
a retrospective premium will be calculated, may be included in a “side agreement” to the actual
policy.16 A common form of side agreement covers claims-handling and addresses various aspects
of the management of the defense of the underlying claims, including the selection of counsel and
the authorization necessary for a settlement. Claims-handling agreements often are presented to
the policyholder after coverage is bound. Policyholders should ask to see these agreements before
they decide to purchase the insurance, and negotiate changes, if necessary.

Liability insurance companies also may have billing or claims-handling guidelines that they
distribute to defense counsel whom they retained to represent their policyholders in underlying
lawsuits. These guidelines attempt to regulate the conduct of counsel by declaring what defense
costs will be reimbursed by the insurance company. For instance, the guidelines relating to a
liability policy may provide that the insurance company will not pay for: (i) more than one at-
torney to attend a court conference or deposition; (ii) any internal conferences between defense
counsel; (iii) any research, unless prior approval is obtained from the insurance company; and
(iv) the filing of any motions or discovery unless prior approval is obtained from the insurance
company.17 In recent years, courts, bar associations, and state legislators have begun to question
the ethics behind the use of claims-handling guidelines18.
C. Sections of the Policy Form

1. Who (Or What) Is Covered?

Liability policies provide insurance for specifically described persons and entities. Typically, there is a “named insured,” which will be the corporate entity. In a provision entitled “Who is an Insured” the policy may describe other persons (such as employees or shareholders) or entities (such as vendors) who will be considered “insureds” under the policy. D&O policies, for example, will typically include former, as well as current, directors and officers of the corporation as individuals who are “insureds.”

Liability policies also may extend coverage to other parties, generally listed in an endorsement. Often these “additional insureds” will include corporate affiliates of the “named insured,” or persons or entities with whom the named insured has a close commercial relationship, or to whom the named insured is contractually bound to provide insurance.

The equivalent provision in first-party property policies is the “Covered Property” provision, which describes the property covered by the policy. This description may list the type of property covered (e.g., inventory, goods in transit, elevators, or art) or identify property at certain defined locations. The “Covered Property” provision also may specifically identify property that is not covered by the policy.

2. Insuring Agreements and Definitions

The insuring agreement defines the type of risk covered by the particular policy. Each type of insurance policy has different types of insuring agreements. For instance, a CGL policy will have an insuring agreement that obligates the insurance company not only to pay the liability imposed on the policyholder (the duty to indemnify), but also to provide counsel and/or to pay the costs of litigation associated with claims that may be covered under the policy (the duty to defend). A first-party property policy will provide that it covers a loss of property from “all risks” or from a specifically identified risk, such as fire or flood.

A policyholder cannot understand the scope of the insurance provided without reading the insuring agreement in conjunction with the Definitions section of the policy. Indeed, much of the litigation surrounding the scope of insurance coverage involves disputes over the definition of key words, such as “Loss,” “Suit,” “Wrongful Act,” “Occurrence,” “Property,” and “Property Damage.”

a. The Duty To Indemnify or To Pay on Behalf of the Policyholder

In a general liability policy, the insurance company typically agrees:

to pay those sums that the insured becomes legally obligated to pay as damages because of “bodily injury” or “property damage” to which this insurance applies. . . . This insurance applies only to bodily injury and property damage which occurs during the policy period. The “bodily injury” or “property damage” must be caused by an “occurrence.” The “occurrence” must take place in the “coverage territory.”

A general liability policy also may have separate insuring agreements for “personal injury” and “advertising injury.” Personal injury generally is defined to cover such claims as false arrest or
detention, malicious prosecution, slander, libel, and violation of the right of privacy. Advertising injury generally is defined to include such claims as infringement of copyright, title, or slogan; misappropriation of advertising ideas or style of doing business; or publication of material that slanders a person or organization, or a person’s or organization’s goods, products, or services.

A typical insuring agreement for a D&O policy provides that the insurance company will reimburse the insured for all “Loss” that arises out of claims alleging “Wrongful Acts” committed by a director or officer in his or her capacity as a director or officer.

Property policies generally provide that the insurance company will “pay for direct physical loss of or damage to Covered Property at the premises described in the Declarations caused by or resulting from any Covered Cause of Loss.” The definitions of the terms “Covered Property” and “Covered Cause of Loss” provide then the real substance of the insuring agreement. Such policies come in two general categories: “All Risk” and “Named Peril” policies. An All Risk policy provides insurance for “all risk of direct physical loss or damage to property” owned, leased, or under the control of the insured. “Risk” refers generally to the cause of the loss. In an “All Risk” policy, numerous risks are then weeded out of the insurance by exclusions. A Named Peril policy insures against a particular risk, such as fire, flood, or tornado. Fidelity policies, which insure against the risk of loss from employee dishonesty, are a form of Named Peril policies. Government-backed insurance policies for loss caused by terrorist acts is another form of a Named Peril policy.

b. The Duty To Defend and To Pay Defense Costs

The insuring agreements of a primary general liability policy typically provide that “[the insurance company] will have the right and duty to defend any `suit’ seeking damages [covered by the indemnity provisions of the policy].” Standard form general liability policies also contain provisions that require the policyholder to cooperate with the insurance company in a defense of the underlying claims. Those same policies prohibit the policyholder from settling a covered claim, or otherwise making a “voluntary” payment, without the insurance company’s consent.

For those policies with a separate duty to defend, such as primary general liability policies, the defense obligation is broader than the duty to indemnify for a claim. This means that the insurance company must defend, or reimburse for the costs of defense, even if the claim is only potentially covered by the policy. Moreover, an insurance company typically must defend the entire action, even if only some of the claims are covered.

In most primary general liability policies, the costs of defense are payable in addition to, or “outside of,” the indemnity limits of the policy. The obligation to defend terminates only if and when the primary insurance company pays judgments or settlements in an amount sufficient to exhaust the policy limits. As a result, the amount the insurance company pays under its defense obligation often far exceeds the policy limits. Primary general liability insurance is thus sometimes referred to as “litigation insurance.” Litigation insurance is particularly valuable where the underlying actions involve mass torts or related product liability claims, where defense costs often equal or exceed the amount of any ultimate liability.

Most excess general liability policies, as well as other forms of liability policies, such as Fiduciary, D&O, and E&O policies, agree to pay defense costs “within” limits. Under such policies, each dollar paid in defense costs “erodes” the policy limit, reducing the amount available to pay any eventual judgment or settlement. The contractual basis for the reimbursement for defense costs under these policies often is found in the definition of a covered “Loss,” which includes the costs of defense.
Moreover, in most specialized liability policies (e.g., Fiduciary, D&O, and E&O policies), the insurance company has no “duty to defend,” but, rather, has a duty to reimburse for the costs of defending a covered claim. In these types of coverages, the scope of the duty to reimburse for defense costs may be coextensive with, not broader than, the duty to indemnify.²⁷

A defense obligation generally is irrelevant to first-party coverage. However, first-party policies may contain a liability component.

### 3. Exclusions

The insuring provisions must be read, not only in conjunction with the definitions section of the policy, but also in conjunction with any exclusions to coverage. Indeed, it is not unusual to find an insuring provision that is a simple one-sentence declaration of coverage, followed by four pages of exclusions.

Standard exclusions vary depending upon the type of coverage involved. General liability policies, for example, typically include exclusions for, among others, property owned, operated, and leased by the policyholder; business risks; and pollution. D&O policies may exclude coverage for, inter alia, illegal personal gain, short swing profits, and claims that should be covered by other available insurance policies. First-party property policies that include business interruption coverage may exclude losses caused by, among other things, lease cancellations, interference by strikers, consequential losses, and interruption of utility services.

Many types of policies also exclude insurance coverage for losses arising out of intentionally harmful conduct. D&O policies, for example, may exclude coverage for loss arising out of the directors’ and officers’ fraud or self-dealing, but only if the wrongful conduct is proved “in fact.” Thus, the policy provides reimbursement for the defense of such claims, but not for a judgment based upon a finding of liability for fraud or self-dealing.²⁸

Similarly, general liability policies often contain an exclusion if the “bodily injury” or “property damage” was expected or intended by the policyholder. Although insurance companies try to argue that this exclusion applies whenever the policyholder’s conduct is intentional, this position has been uniformly rejected. Instead, courts have held that such exclusionary language applies only when the policyholder expected or intended the harm that resulted from its intentional conduct.²⁹ In the case of a corporate insured, the intent typically must be the intent of senior management.³⁰

This “expected or intended” exclusion may align an insurance company with the plaintiff asserting an underlying claim against the policyholder. For instance, the facts that may establish a claim against the policyholder for punitive damages are the same facts on which an insurance company could deny insurance, based upon the expected or intended exclusion. This can lead to a conflict of interest and will impact upon whether the insurance company can control, or even participate in, the defense.³¹

Often, exclusions are written in response to an increase in a certain type of litigation. For instance, exclusions for liability caused by asbestos, pollution, lead, or mold claims now are common in general liability policies. Similarly, in the wake of September 11th, many first-party property insurance companies began to add exclusions for damage arising from terrorist acts. There also can be exclusions specific to the policyholder. For instance, a pharmaceutical company may not have coverage for claims arising out of specific drugs “lasered” or excluded from coverage; exclusions for claims arising out of DES, for example, are common.
In some instances, insurance companies have argued for what amounts to policy exclusions based on the supposed “inherent nature” of insurance. Two of the more common examples are insurance company refusals to provide coverage based on “known loss” (sometimes inaccurately referred to as “known risk”) and “lack of fortuity.” These “exclusions” are not contained in the policy; rather, insurance companies allege that they arise out of the supposed basic nature of insurance. For the most part, these fictional “exclusions” have been rejected by the courts.

The news on exclusions is not all bad. Sometimes insurance can be “revealed” through an exclusion, usually as an exception. For instance, in general liability policies, there is a standard exclusion for liability assumed by contract. However, that exclusion has an exception for “insured contracts.” This exception to an exclusion is often relied upon as a grant of coverage.

Finally, even if an exclusion applies to one theory of liability or loss, there may be theories of liability or loss that are not excluded. This is sometimes referred to as the “concurrent cause” doctrine. As long as one theory of liability (in a third-party policy) or one type of peril (in a first-party policy) is covered, the resulting loss also should be covered. Thus, a legal analysis of the potential underlying liability or loss is necessary if a policyholder is to maximize recovery under an insurance policy.

4. Conditions

Most insurance policies have a Conditions section, which sets forth various duties of the policyholder and the insurance company. The most frequently litigated condition relates to the policyholder’s obligation to provide prompt notice of a claim made against the policyholder, or of an occurrence that might give rise to a loss or a claim under the policy. Liability insurance policies generally provide, with regard to notice:

In the event of an occurrence, written notice containing particulars sufficient to identify the insured and also reasonably obtainable information with respect to the time, place and circumstances thereof, and the names and addresses of the injured and of available witnesses, shall be given by or for the insured to the company or any of its authorized agents as soon as practicable. (Emphasis added). The policies also may require the policyholder to forward immediately a copy of any underlying complaints that have been filed. Closely related to this notice condition is the requirement that a policyholder cooperate with its liability insurance company in the investigation of a loss or a claim under the policy or the defense of a third-party claim.

Notice requirements are particularly important to “claims-made” liability policies, such as D&O and E&O policies. These types of policies generally respond only to claims made against the policyholder and reported to the insurance company during the policy period. However, even under an “occurrence” policy - which responds to claims filed against the policyholder at any time, as long as the alleged bodily injury or property damage took place during the policy period - late notice can result in the insurance company’s being able to avoid payment.

First-party policies have a requirement that a proof of loss must be filed within a specified time after notice of the loss. A failure to provide prompt notice, to file a proof of loss, or to cooperate with your insurance company can result in a forfeiture of coverage.

5. Limits of Liability

The liability limits of the policy set a maximum that the insurance company will pay under certain specified circumstances. Policy limits generally are stated on the Declarations Page. Insurance policies can have many types of limits. An aggregate limit sets the most that the policy will
pay under any circumstances, regardless of how many claims are submitted. Some policies do not have aggregate limits. A per occurrence limit provides the total that the policy will pay per occurrence, or cause of the loss. There also can be limits for certain types of coverages, such as a specific limit for product liability or completed operations coverages.

In the WTC Properties case, there were no aggregate limits in the first-party property policies, only a per occurrence limit. Thus, a key dispute in the litigation over the loss of the World Trade Center was whether the insurance companies must pay a single limit because there was one occurrence (one terrorist conspiracy), or two limits because there were two occurrences (two planes that hit two buildings). Similarly, in the area of environmental insurance coverage, there typically are only per occurrence limits that apply to the premises operations insurance that responds to that type of claim. Thus, a key question for a pollution claim is how to determine the number of occurrences - each polluting release or event? Each type of polluting operation? Each site?

Insurance companies also can use limits as a form of an exclusion. For instance, extensive litigation has surrounded the meaning and scope of various versions of the pollution exclusion. When insurance companies were frustrated in their efforts to exclude such claims, in part due to rules of contract construction, which require that exclusions be interpreted narrowly and ambiguities construed against the insurance company, some insurance companies have responded by placing a low sub-limit on coverage for pollution claims.

D. Rules of Construction

The first rule in understanding a policyholder’s rights under an insurance policy is to read the policy. The second rule is to read the policy again. This may seem too obvious to mention, but the fact is that, too often, policyholders simply assume that they know what the policy says without reading the details.

Despite the importance of insurance contracts and the value of the asset which they represent, insurance policies often are poorly written and ambiguous. The rules of policy construction are generally helpful to policyholders and are fairly uniform across the country. The rules may be summarized as follows:

1. The language in insurance policies will be given its plain meaning if it is reasonably possible to do so;

2. Extrinsic evidence may be considered to interpret an ambiguous provision, but it must be evidence of the parties’ objective intent communicated prior to or at the time that the contract is entered into. An insurance company’s testimony of its subjective understanding may not be admissible when offered by the insurance company;

3. Insurance policy language should be construed to protect the reasonable expectations of the insured. If there is an ambiguity in an insurance policy, it should be resolved against the insurance carrier;

4. If a term is not defined, it may be considered ambiguous and interpreted in favor of the policyholder;

5. Exceptions, limitations, and exclusions to coverage should be interpreted narrowly; and

6. The insurance company has the burden of proving that an exclusion applies to a claim.
III. Comprehensive General Liability Policies

A. Basics of the Insuring Agreement

For businesses, the most common type of liability insurance is comprehensive or commercial general liability (CGL) insurance coverage. In the late 1940’s, the “comprehensive” general liability policy was introduced. This policy was intended to insure all risks not specifically excluded.53 One court has described the coverage as follows:

The primary purpose of a comprehensive general liability policy is to provide broad comprehensive insurance. Obviously, the very name of the policy suggests the expectation of maximum coverage. Consequently the comprehensive policy has been one of the most preferred by businesses and governmental entities over the years because that policy has provided the broadest coverage available. All risks not expressly excluded are covered, including those not contemplated by either party.


Over the years, the forms for CGL policies largely have been standardized by various insurance industry organizations, including, as already mentioned, the Insurance Services Office, Inc. (ISO).45 Until 1966, standard form CGL policies typically provided coverage for claims alleging two types of damage or injury - “bodily injury” and “property damage.” After 1966, it became common to find CGL policies that also provided coverage for “personal injury” and “advertising injury.” Indeed, since at least the early 1980’s, standard form CGL policies have included coverage for all four types of injury.

As already mentioned, a typical CGL policy obligates the insurance company to pay those sums that the policyholder becomes legally obligated to pay as damages because of bodily injury or property damage to which the policy applies. It also typically obligates the insurance company to defend any “suit” seeking those damages. CGL policies are, by far, the most important form of insurance available to most policyholders. It is also the type of insurance that has generated the most extensive coverage disputes. Some of the key issues raised by those disputes are discussed in the following sections.

B. Managing an Insurance Company’s Defense Obligation

The most frequently litigated issues in cases arising out of complex insurance claims involve how the policy works when claims are submitted. Often, these issues of policy administration have a higher dollar value than issues surrounding the scope of coverage. In cases involving third-party liability policies, often the first area of dispute is the management of an insurance company’s defense obligation.

1. The Scope of the Duty To Defend

The duty to defend is recognized as one of the most important duties under an insurance policy.46 It is well established nationally that an insurance carrier’s duty to defend exists as to any suit that
“potentially seeks damages within the coverage of the policy.” In fact, courts have recognized that the duty to defend arises whenever the insurance company “is informed of [an] accident and learns of even the potential for liability under its policy.” If there is doubt about the existence of a duty to defend, that doubt should be resolved in the policyholder’s favor. Furthermore, as long as one claim in a suit is potentially covered, the insurance company typically has a duty to defend the entire action. The insurance company’s duty to defend applies even to suits where the allegations are groundless, false, or fraudulent.

One question often raised about the duty to defend is whether it can be evaluated based upon anything other than the allegations in a complaint. Most courts recognize that even if the allegations of a complaint do not trigger the duty to defend, the duty can be triggered by information outside of the complaint that is reasonably available to the insurance company. However, by comparison, when the allegations of the complaint indicate that there is a potential for coverage, most states do not permit an insurance company to escape its duty to defend by pointing to extrinsic evidence showing that the allegations in the complaint are untrue.

2. The Impact on the Duty To Defend When There Is a Conflict of Interest Between the Policyholder and the Insurance Company

General liability policies provide that the insurance company has the “right and duty to defend.” Thus, the insurance company will argue that it has the right to control the defense. This is not a problem when the insurance company has accepted coverage. When the underlying claim is fully covered, the insurance company will bear the entire consequence if judgment is obtained against the policyholder. As a consequence, the insurance company is motivated to provide a sufficient defense and the policyholder is fully protected if it does not.

Unfortunately, there are many circumstances where the entire risk of an adverse result in the underlying claim has not been shifted to the insurance company. In these circumstances, policyholders and their insurance companies often find themselves in conflict on any number of issues regarding management of the defense. Although this conflict will arise with respect to areas in which the insurance company has reserved its rights, there are additional sources of conflict.

For example, a policyholder and its insurance company may have a very different view of the quality of the defense that is appropriate. Insurance companies may want to hire an “insurance defense” firm - a firm that has a long-standing relationship with the insurance company from whom it receives a significant portion, or sometimes all, of its business. The insurance defense firm’s handling of the underlying claims can be characterized as economical and efficient, or inadequate, depending upon one’s standards and perspective. A defense firm recommended by the insurance company can be very good. Policyholders, on the other hand, generally want “the best defense that money can buy,” particularly when the costs of that defense are borne by the insurance company. These differing views as to the quality of the defense often arise when there are non-insurable consequences from the underlying action, such as damage to reputation, or interference with future business prospects.

These differences can lead to numerous disagreements, particularly when an insurance company rejects defense expenditures that the policyholder believes are necessary to protect its interests, or the insurance company imposes limitations on the work defense counsel can do, which the policyholder believes will negatively affect the quality of the defense. For example, the policyholder facing a series of lawsuits in different jurisdictions - such as mass tort or products liability suits - may believe that national defense counsel is necessary to ensure that the positions and strategies undertaken in each individual action are consistent, and to determine the overall strategy of defense to be followed in those actions. Insurance companies may object to the added expense of
hiring national defense counsel.

The unlimited defense obligation contained in many general liability policies also can create a conflict between the interests of the insurance company and those of the policyholder in the outcome of the underlying claim. It may be in the financial interest of the insurance company to reach early settlements, or even suffer early losses, so that the policy’s indemnity limits can be exhausted and the insurance company’s defense obligation extinguished. However, the insurance company’s interest in promoting quick “nuisance settlements” can be devastating to the policyholder’s interests in many ways. Not only may there be a portion of the loss not covered by the insurance (e.g., damage to reputation), but word of quick settlements in a few early actions can lead to the filing of many more claims against the policyholder, as well as increasing the “war chest” available to underlying plaintiffs’ counsel to fund additional claims. Thus, the insurance company’s financial interest in exhausting its indemnity limits and exiting the case quickly, may be in direct conflict with the policyholder’s interests in vigorously defending each underlying claim.

For example, in Emons Industries, Inc. v. Liberty Mutual Insurance Co.,55 the policyholder was sued in numerous underlying actions relating to its manufacture and sale of the drug DES. The court found that there were “substantial conflicts of interest” between the policyholder and the insurance company, because the insurance company had “a strong interest in reducing the defense costs it must pay by quickly settling these cases irrespective of whether they are reasonable or are within the per claim limit,” while it was in the policyholder’s best interest to vigorously defend these suits and obtain the smallest possible settlement or judgment. In the face of that conflict, the court enjoined the insurance company from interfering with the policyholder’s choice of counsel.

Insurance companies often respond to notice of an underlying action by agreeing to defend under a reservation of rights. A letter from an insurance company in which it agrees to defend while setting forth various defenses to indemnity coverage is referred to as an ROR letter. Often the strength of the insurance company’s defenses to coverage will depend upon the facts developed in the underlying action. Sometimes the ROR letter also will attempt to preserve the insurance company’s right to recoup any money spent in defense of the action if the insurance company is successful in establishing that there was no indemnity coverage.

The insurance company may take a position in the ROR letter that is similar to the position taken by the underlying plaintiffs asserting claims against the policyholder. As already mentioned, the insurance company may reserve its right to deny coverage on the ground that the policyholder expected or intended to cause bodily injury or property damage. Based upon those facts, the insurance company will argue that there is no occurrence, or that the claim arose out of a “known loss.” These insurance defenses are based upon an alleged factual premise that is similar, if not identical, to what the underlying plaintiffs allege against the policyholder to support their claims for an intentional tort or for punitive damages. If the insurance company seeks to deny coverage based upon a factual argument that is similar to what is asserted against the policyholder in the underlying claims, there is a conflict of interest between the policyholder and insurance company in the defense of that claim.

It is also typical for an underlying action to involve both covered and non-covered claims. For example, many product liability claims are based upon negligence (covered), but also include intentional or punitive damage claims, or contract and warranty claims (generally not covered). An insurance company’s defense obligation is triggered whenever the underlying complaint contains allegations that are arguably within the policy coverage. In most states, the law requires that the insurance company must defend the entire action as long as even one potentially covered claim is at issue. This creates a conflict, as the insurance company’s primary interest is in defeating only the potentially covered claim, and thereby ending its duty to defend, while the policyholder’s
interest is in defeating all claims filed against it.

In Lockwood International, B.V. v. Volm Bag Co.,56 after spending four years defending its policyholder, the insurance company entered into a settlement agreement with the underlying plaintiff in which the insurance company paid the underlying plaintiff to file an amended complaint that pled only non-covered claims. The appellate court, reversing the trial court’s entry of final judgment dismissing the covered claims, recognized that the insurance company’s actions arose directly from the conflict of interest created when the insurance company controlled the defense of both covered and not covered claims.57

The law provides policyholders with certain protections when there is a conflict between the interests of the insurance company and those of the policyholder.58 For instance, the ethical rules governing an attorney’s conduct require that the defense counsel’s sole loyalty is to the policyholder client, rather than the insurance company that is paying the legal bills.59 Insurance companies contend that this ethical rule solves the problems that arise when there is a conflict of interest between the insurance company and the policyholder.

This “protection,” however, may be insufficient. First, such ethical rules are binding only on the attorney, not on the insurance company. They may not, for example, prevent the insurance company from attempting to interfere with the management of the case through enforcement of its claims-handling guidelines or through a dispute over what is reimbursable under the billing guidelines. Moreover, the defense counsel’s ethical rules do not prevent the insurance company from initiating settlement discussions directly with an underlying plaintiff despite the policyholder’s objections.

Second, insurance companies often do not agree that, when there is a conflict, the right to control the defense shifts to the policyholder.

Third, whatever the rules formally state about the loyalty required of defense counsel, that loyalty can be sorely tested when a significant portion of the attorney’s practice depends upon receiving continued defense assignments from the insurance company’s claims handlers.

Because of the inadequacy of the one-client rule, the vast majority of courts addressing the conflict issue have held that, when a conflict of interest exists, the policyholder must be allowed to select defense counsel and to manage the defense of an underlying action, even in the face of policy provisions clearly and unambiguously granting such management to the insurance company. For example, in Mundry v. Great American Insurance Co.,60 the Second Circuit held that under both Connecticut and New York law, an insurance company must notify its policyholder if it disputes insurance coverage, in order to allow the policyholder to exercise its right to “retain independent counsel and to take over the defense, and either settle the case or conduct the defense more vigorously than the insurance company would after announcing an intention to disclaim.” Cases in other jurisdictions routinely hold that the insurance company must pay for independent counsel chosen by the policyholder, when there is a conflict between the interests of the insurance company and those of its policyholder.61

As a leading authority on insurance coverage states: “Where the insurance company lacks an economic motive for vigorous defense of the insured, or the insurance company and insured have conflicting interests, the insurance company may not compel the insured to surrender control of the litigation.”62 Neither the theoretical “sole-client” rule nor the policy provision that the insurance company has the “right and duty to defend” the policyholder justifies exposing the policyholder to the risk that the insurance company will advance its own interests at the expense of the defense to which the policyholder is entitled.
C. The Controversy over Trigger of Coverage

“Trigger of coverage” refers to the event that must take place during the policy period that requires the policy to respond. For example, as noted, a “claims-made” policy must respond if the claim is made against the policyholder during the policy period. Many claims-made policies also require that the claim must be reported to the insurance company during the policy period. These are sometimes referred to as “double-anchor” policies. Other types of policies, or specific coverages, contain specific triggering provisions. For instance, personal injury and advertising liability coverages in general liability policies provide that the policy must respond if the alleged wrongful act took place during the policy period.

By far, the greatest degree of controversy concerns the trigger of coverage in “latent” injury claims that are submitted under the bodily injury or property damage occurrence coverages provided by general liability policies. Under these coverages, the policy is triggered if the alleged bodily injury or property damage takes place during the policy period. An example of “latent” claims is environmental property damage claims. These typically involve a single claimant, usually a governmental entity. However, environmental damage is usually widespread and not detected until years after the activity that caused the problem. Perhaps the most important characteristic of latent injury claims is that, in addition to being typically difficult to evaluate, they usually involve a lot of money.

In the standard general liability policies, the policy language that provides the trigger of coverage is generally found in the definitions of bodily injury and property damage. Typical definitions provide that:

“bodily injury” means bodily injury, sickness or disease sustained by any person which occurs during the policy period, including death at any time resulting therefrom;

“property damage” means (1) physical injury to or destruction of tangible property which occurs during the policy period including the loss of use thereof at any time resulting therefrom, or (2) loss of use of tangible property which has not been physically injured or destroyed provided such loss of use is caused by an occurrence during the policy period.

In the late 1970s and early 1980s, there was significant coverage litigation concerning asbestos-related bodily injury claims. Insurance companies took different positions on trigger of coverage, arguing that: (1) only policies on the risk at the time when the claimant was exposed to asbestos were triggered; or (2) only policies on the risk on the date of first exposure was triggered; or (3) only policies on the risk at manifestation or discovery of the asbestos disease was triggered; or (4) only policies on the risk when the injury could have been discovered was triggered. Not surprisingly, the trigger position advocated by each insurance company tended to minimize its exposure, either in the context of the particular claim presented or in the context of the insurance company’s entire book of business.

These coverage-limiting theories were rejected in Keene Corp. v. Insurance Co. of North America, which held that all policies on the risk from first asbestos exposure to manifestation of the disease were triggered, because the asbestos caused bodily injury in each policy year during that period. The Keene theory is referred to as the “continuous trigger.” It imposes a legal presumption that latent injury claims involve continuous injury, but allows the insurance company to prove, as a matter of fact, that injury or damage did not take place during any particular policy period.

Closely related to the Keene decision is the “injury-in-fact trigger” adopted by American Home Products Corp. v. Liberty Mutual Insurance Co. Under this theory, the policyholder has the burden of proving, as a matter of fact, that injury or damage took place during each policy period.

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The injury-in-fact and continuous trigger theories often lead to the same result, particularly in toxic tort cases; all policies from first exposure to manifestation are triggered. The difference is one of burden of proof: whether the policyholder has the burden of proving injury during each policy period (“injury-in-fact trigger”), or whether the burden shifts to the insurance company to disprove injury in its particular year or years (“continuous trigger”). Although most jurisdictions appear to be moving towards either an injury-in-fact or continuous trigger of coverage, there still are exceptions, and some courts apply an exposure or manifestation trigger to certain types of claims.

One area relating to trigger of coverage that currently is causing disputes in coverage litigation is how the factual issues surrounding trigger of coverage are litigated in the mass tort context, where coverage often is sought for thousands, or tens of thousands, of claims. To require a factual inquiry into each claim has the practical effect of denying coverage because of the procedural difficulties of proof. Accordingly, courts have allowed the factual issues surrounding trigger of coverage to be resolved using exemplar claims, a statistical sample, the testimony of a series of independent experts that provides an opinion of a particular fact, or summary testimony of a fact witness who has reviewed all or a statistically valid sample of the universe of claims. In-house counsel, who are involved both with defending underlying claims as well as pursuing coverage, should, at an early stage, begin to gather the facts on the timing of injury or damage so that the policyholder can establish this element of its insurance claim.

Another issue of recent interest relating to the trigger of coverage involves the question of whether policies can be triggered when there has been no determination in the underlying case of the existence, much less the timing, of bodily injury or property damage. This is an issue of particular significance in underlying mass tort litigation because the policyholder often contends that no bodily injury or property damage actually occurred. If the underlying case is settled, there may be no factual determination as to whether, much less when, bodily injury or property damage actually took place. In many jurisdictions, the policyholder need establish only that it had potential liability based upon the facts known at the time of the settlement, and that the settlement was reasonable.

The case of Dow Corning Corp. v. Continental Casualty Co., which concerned insurance coverage for breast implants, demonstrates this point. All of the parties in the coverage litigation, including the court, believed that the implants did not cause bodily injury. Dow Corning settled the underlying claims because, regardless of the medical evidence, Dow Corning believed it could lose its case on the underlying claims if it were tried by a jury. Nonetheless, the court held that, despite the absence of actual bodily injury, the underlying implant claims still could trigger coverage.

D. The Debate over Number of Occurrences

The insuring agreements in general liability, umbrella, and excess policies generally provide coverage for bodily injury and property damage resulting from an “occurrence.” Generally, that term is defined as follows:

“Occurrence” means an accident, including continuous or repeated exposure to conditions, which results in personal injury, property damage or advertising injury neither expected nor intended from the standpoint of the insured.

That standard definition of “occurrence” was introduced in 1966. Prior to that time, liability insurance policies typically provided coverage for liabilities arising from “accidents” during the
policy period. The change in the standard policy language from “accident” to “occurrence” required that the term “occurrence” be interpreted “from the standpoint of the insured,” not from the standpoint of the injured person. Insurance provided by other forms of coverage, such as first-party property policies, also can be provided on an occurrence basis.

The number of occurrences involved in underlying litigation may affect: (i) the number of deductibles or SIRs the policyholder must pay; (ii) the number of per occurrence limits the policy must pay; and (iii) whether the loss will be borne principally by the primary layer of coverage (in the case of multiple occurrences) or shifted to the excess layers (in the case of one occurrence). The number of occurrences also may impact whether it is appropriate to allocate the entire loss over many years (if occurrence is considered synonymous with loss) and whether a “non-cumulation clause” (present in some policies) applies, requiring that all loss be paid from a single policy. Accordingly, a determination of the number of occurrences can have an enormous impact on which layer of insurance responds to a claim and for how much.

Because the number-of-occurrences issue affects many aspects of how the policy works, and often affects how the loss is spread among multiple insurance companies, it is an issue on which insurance companies and policyholders take different positions, depending upon how their interests are affected in a particular case. It is also an intensely factual issue that must be determined on a case-by-case basis. This allows for creativity in the dispute over the number of occurrences, and diversity (or inconsistency) in the results.

The “number of occurrence” issue is also an example of an area in which counsel should identify the facts in the underlying case that may impact on the amount of coverage. At an early stage, counsel must determine whether the policyholder is benefited by a single or multiple occurrence finding, and present the facts to an insurance company in a way that will maximize coverage.

The vast majority of courts hold that a determination of the number of occurrences requires reference “to the cause or causes of damage, rather than to the number of individual claims or injuries.” Cases that have considered the change from accident-based, to occurrence-based, coverage have recognized that, in determining the “cause” of the loss, the analysis must focus on the policyholder’s conduct and not the resulting individual injury. A minority of cases look to the effect, or resulting injury, to determine the number of occurrences. Courts applying the cause test may, depending upon the circumstances of the particular case, reach different conclusions on the number of occurrences. In Metropolitan Life Insurance Co. v. Aetna Casualty & Surety Co., for example, the issue was the number of occurrences that were involved in thousands of asbestos claims arising out of an alleged failure to warn of asbestos dangers. Although the court adopted a cause test, it found that the cause of the alleged bodily injury was each claimant’s exposure to asbestos, not the alleged conduct of the policyholder. Thus, it held that each claim presented a separate occurrence. A Third Circuit case declined to follow the reasoning in Metropolitan Life, and held that the asbestos liabilities arose out of multiple occurrences. Liberty Mut. Ins. Co. v. Treesdale Inc., No. 04-4172 (3d Cir., Aug. 15, 2005); see also Appalachian Ins. Co. v. Gen. Elec. Co., Index No. 122807/96 (N.Y. Sup. Ct. Apr. 7, 2003).

In Uniroyal, Inc. v. Home Insurance Co., in contrast, the court held that hundreds of thousands of Vietnam veterans’ exposures to Agent Orange, as a result of numerous sprayings, all arose from a single occurrence. The single occurrence was the policyholder’s delivery of Agent Orange to the military. The Uniroyal court rejected the insurance company’s argument that the number of occurrences should be determined “by reference to the time and place of the ultimate injury,” and instead looked at the underlying conduct for which the policyholder was being held liable.

An interesting example of a court’s wrestling with the number-of-occurrences issue is presented
by two decisions involving claims against Dow Chemical Company. In Dow Chemical Co. v. Associated Indemnity Corp., 88 a federal court in Michigan held that multiple claims based upon the sale of a building product should be treated as multiple occurrences. The same court a few years later, interpreting the same policies, held in a subsequent case, Associated Indemnity Corp. v. Dow Chemical Co., 89 that the sale of defective resin used to make pipes that failed, resulting in multiple claims of property damage, constituted a single occurrence. The only way to harmonize these apparently conflicting decisions is through the court’s belief that the policy language was ambiguous. Accordingly, in each case, the court interpreted the language in a manner that favored Dow Chemical for that particular claim.

An issue related to the number of occurrences involves interpretation of the so-called “batch” clause, which some policies also include in their definition of “occurrence.” Such a provision may (there are different versions) provide:

For purposes of determining the limit of the company’s liability and the retained limit, all bodily injury and property damage arising out of continuous or repeated exposure to substantially the same general conditions shall be considered as arising out of one occurrence.

This type of provision generally is referred to as a batch clause because it is intended to combine, or “batch,” all related claims emanating from substantially the same conduct into a single occurrence.

Disputes over the meaning of a batch clause may arise with respect to the interpretation of the phrase “exposure to substantially the same general conditions.” Parties have argued that claims should be “batched”: (i) only when multiple exposures are suffered by the same injured party; (ii) only when similar exposures are suffered by multiple bodily injury claimants (e.g., in the case of asbestos); (iii) when multiple dumpings of wastes at a single environmental site cause property damage; (iv) when multiple claims arise out of the sale of the same product; or (v) when multiple claims arise out of a similar course of conduct.

Albeit in the context of a first-party claim, the Second Circuit’s decision on the number-of-occurrences issue in World Trade Center Properties LLC v. Hartford Fire Insurance Co. et al., 345 F.2d 154 (2d Cir. 2003), was instructive. The issue was whether the two planes colliding into the two towers of the World Trade Center constitute one or two occurrences under various definitions of the term “occurrence.” The issue determined whether Silverstein, the lessee of the World Trade Center, was entitled to receive $3.5 billion, $7 billion, or some amount in between. The opinion of the Second Circuit addressed related issues, such as whether the determination of the number of occurrences is an issue of fact for the jury to decide, or an issue for the Court. The Court held that, with respect to the language in certain policies, the terrorist attack was a single occurrence. With respect to other policies where the definition of occurrence was ambiguous, the appellate court remanded for a jury trial. The jury subsequently found two occurrences with respect to many of the policies at issue. Thus, the number-of-occurrences issue was resolved independently for each layer of the tower of insurance.
E. Allocation in General Liability Insurance Policies

The issue of allocation refers generally to whether a loss will be spread horizontally over multiple triggered policies or will be assigned to a single triggered policy year.¹⁴ Again, traditional general liability policy language defines an insurance company’s obligation as follows:

“[The insurance companies will pay] on behalf of the insured all sums which the insured shall become legally obligated to pay as damages . . . .”

Policyholders argue that, once a policy year is “triggered” by injury or property damage during the policy period, each of the individual insurance policies in that year must indemnify the policyholder for “all sums” for which the policyholder becomes liable, subject to each policy’s limits, regardless of when the bodily injury or property damage occurred. “All sums” allocation divides the loss among policies “vertically.” Each triggered policy is jointly and severally liable for “all sums” until the policy’s limits are exhausted, and then the policies that sit above the exhausted policy are called upon in the same manner. Each of the paying insurance companies then can pursue its contribution claims against the other insurance companies whose policies are triggered in different policy years.

Insurance companies, in contrast, generally argue for “pro rata allocation” or “pro rata by time on the risk allocation,” which refers to dividing a loss “horizontally” among all triggered policy periods, with each insurance company paying only a share of the policyholder’s total damages. When courts adopt proration, they tend to rely upon general principles of equity, rather than policy language, ruling that, given the facts in a particular case, it is fair to spread the loss over the several years.⁹⁵

Cases at the level of state supreme courts are fairly evenly divided between these two theories of allocation. The highest courts of California, Delaware, Indiana, Illinois, Ohio, Pennsylvania, and Washington,⁹⁶ as well as numerous federal courts,⁹⁷ have refused to imply a pro rata limitation in policies where no express limitation exists. For example, the Washington Supreme Court, in American National Fire Insurance Co. v. B & L Trucking & Construction Co.,⁹⁸ rejected an insurance company’s argument for proration based upon “fairness” considerations, emphasizing that the policy language controls.

Other state supreme or appellate courts have adopted pro rata allocation.⁹⁹ These cases reached their results based upon considerations of the particular equities in their cases, not upon the policy language. Thus, if a court is to adopt pro rata allocation, it must weigh the particular equitable factors in its case before deciding to what time period or periods a loss should be assigned.

For instance, in Stonewall Insurance Co. v. Asbestos Claims Management Corp.,¹⁰⁰ the Second Circuit, applying a pro rata allocation to injuries from asbestos, refused to allocate to years beyond 1985, although injuries continued after that date, because of the factual finding that the policyholder had not voluntarily assumed the risk of asbestos liability after 1985, when no coverage for asbestos liability was available in the marketplace.¹⁰¹ Stonewall thus held that proration to the policyholder was appropriate only if there was a finding (i) that liability insurance was available and (ii) that the policyholder consciously decided to underinsure for that period.

The “all sums” theory of allocation is also supported by the language related to the issue of exhaustion of underlying policies. Excess policies contain a “Schedule of Underlying Insurance” specifying the particular policies that must be satisfied before the relevant policy must pay. The Schedule typically refers only to the policies directly “underneath” the excess policy for that particular policy year. The “Schedule of Underlying Insurance” does not require that all other available insurance across all horizontal policy periods be exhausted before an excess policy must respond. It requires only vertical exhaustion.¹⁰²
F. Other Issues Under CGL Policies

1. Coverage for Consequential Damages Because of Bodily Injury or Property Damage

General liability policies provide insurance for claims seeking damages “because of" bodily injury or property damage. Insurance companies may argue that the damages sought in the underlying case are not in direct compensation for the bodily injuries or property damage but, rather, are compensation for economic loss that is not covered. There is no exclusion in general liability policies for economic loss. Policyholders should object when the insurance companies seek to deny coverage on this basis. The only question is whether the damages sought are “because of" bodily injury or property damage.

First, whether damages are “because of" bodily injury or property damage is a question of causation, traditionally a question of fact, which should be resolved by the jury or the finder of fact at trial.

Moreover, courts have held that economic losses that flow from bodily injury or property damage can be covered under a standard form comprehensive general liability policy. See, e.g., Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp., 73 F.3d 1178, 1194, 1208-09 (2d Cir. 1995) (rejecting insurance company assertion that underlying asbestos claims asserted non-covered “economic loss”; “[s]uch claims are for ‘property damage,’ not economic loss.”); Indep. Petrochemical Corp. v. Aetna Cas. & Sur. Co., 654 F. Supp. 1334, 1359 (D.D.C. 1986). For example, in Reinsurance Association of Minnesota v. Timmer, 641 N.W.2d 302 (Minn. App. 2002), aff’d, 944 F.2d 940 (D.C. Cir. 1991), the court held that, although lost profits or other consequential damages do not constitute property damage, the insurance company in question was obligated to defend and indemnify its policyholder against claims for lost profits based upon physical injuries to the cows of the underlying plaintiff farmer. Thus, the district court concluded, coverage is not limited to property damage, but includes other damages that flow from property damage.

In Aetna Cas. & Sur. Co. v. Pintrail Corp., 948 F.2d 1507, 1515 (9th Cir. 1991), the Ninth Circuit held that costs incurred to clean up environmental contamination were covered under a liability policy, as those costs were “imposed ‘because of . . . property damage.’” 948 F.2d at 1515. The court expressly rejected the argument that cleanup costs were not recoverable under the policy because they did not compensate directly for the property damage. The environmental contamination itself constituted the property damage that triggered coverage under the policies. The court looked to the “plain meaning” of the policies and found that “cleanup costs constitute damages incurred ‘because of . . . property damage’ as that term is used in the policies.” Id. at 1515.

In Charles F. Evans Co. v. Zurich Insurance Co., 731 N.E.2d 1109, 1110 (N.Y. 2000), a contractor was sued by a building owner, after a subcontractor built a roof that leaked. The leaks caused the building owner’s employees to suffer bodily injuries when they slipped and fell on the wet floor. The claims in the underlying action were not brought by the employees but by the building owner who suffered economic losses arising from lost employee time at work and the costs of workers’ compensation claims. The court concluded that allegations of “consequential” harm resulting from bodily injury triggered coverage because the policy’s insuring agreement was broadly written to cover liability for all damages awarded “because of” bodily injury. 731 N.E.2d at 1110.

In Marley Orchard Corp. v. Travelers Indemnity Co., 750 P.2d 1294 (Wash. Ct. App. 1988), the policyholder installed an irrigation system in the underlying claimant’s orchard that failed. The property damage was the stress to the claimant’s trees. In the insurance coverage action, the court found that the “policy language covers consequential damages, i.e., damages caus-
ally related to the property damage.” Id. at 1297. Because the costs of modifying the irrigation system were reasonably related to the stressed trees, i.e., the property damage, those consequential damages were covered by the policy as damages because of property damage. Id. at 1298.


A recent line of cases, which arises from litigation by municipalities against handgun manufacturers, provides further support for broad reach of the “because of” language. In Scottsdale Insurance Co. v. National Shooting Sports Foundation, No. 99-90 (J3), slip op. at 2 (E.D. La. Sept. 15, 1999), aff’d, No. 99-31046 (5th Cir. July 11, 2000), municipalities alleged that they suffered damages, such as increased costs of police and emergency medical care, arising out of National Shooting Sports Foundation’s (“NSSF”) marketing of handguns. NSSF’s insurance company brought a declaratory judgment action against NSSF, seeking a declaration that the underlying claims were not covered because they did “not allege damages ‘because of’ an injury to body or property.” Id. at 4. The court rejected that argument and stated:

The complaint alleges that, because of the bodily injuries to its citizens, the City of New Orleans had to incur additional costs. This allegation is arguably covered by the policies. We reject Scottsdale’s contention that the “because of bodily injury” provision requires the plaintiff seeking damages to be the one who suffered the bodily injury. At best, the provision is ambiguous and should be construed against Scottsdale. Scottsdale could have explicitly limited coverage to “claims for damages incurred because of bodily injury to the plaintiff seeking damages,” but it did not.


2. **Issues Concerning Coverage for Environmental Liabilities**

Environmental claims present some of the most complex insurance coverage issues. Many of the areas of difficulty already discussed in this Primer will be involved when an environmental claim is presented. For instance, because environmental property damage takes place over time, policies in many policy years will be triggered. Because many years are triggered, the problems associated with allocating a loss over multiple years also will be implicated. There also may be a dispute over how to determine the number of occurrences presented by an environmental property damage claim. All contamination at a given site may be considered a single occurrence giving rise to insurance under a single per occurrence limit. Alternatively, the contamination at a single site may be found to arise from multiple occurrences, providing the policyholder with multiple occurrence limits in insurance. For instance, contamination arising out of each operation at a site, or contamination resulting from each release of contaminants may be considered a separate occurrence. This will greatly affect the amount of insurance dollars that are available to clean up the environmental property damage.

However, there are also numerous insurance disputes that are unique to environmental property damage claims. As can be seen from the following discussion, the law on these issues varies by jurisdiction, and also will impact a policyholder’s recovery.
a. Whether a “PRP” Letter Is a “Suit”

As already explained, standard CGL policies require a primary insurance company to defend any “suit” seeking “damages.” Environmental proceedings commenced by the federal Environmental Protection Agency under CERCLA, or by a state agency under an equivalent state statute, often are commenced when the agency sends a potentially responsible party (“PRP”) letter to a party, advising them that they may be liable to investigate and remediate a contaminated site.

A threshold issue is whether a PRP letter is the equivalent of a “suit.” A minority of courts have held that, since a PRP letter does not commence a judicial proceeding, it is not a suit implicating the duty to defend.\(^{107}\)

The majority of courts, however -- including recently the Supreme Court of Connecticut, in R.T. Vanderbilt Co. v. Continental Casualty Co., 870 A.2d 1048 (Conn. 2005) -- have used a functional, less rigid definition of suit to find that a PRP letter constitutes a suit.\(^{108}\) These courts have emphasized that a PRP letter commences an administrative action, that a PRP’s actual liability is established at this stage, and that judicial review of the administrative proceedings is appellate in nature, and greatly circumscribed.

b. Are Cleanup Costs “Damages”?

A related issue is whether the costs of remediating contaminated property -- “cleanup costs” -- are “damages” within the meaning both of the duty to defend and the duty to indemnify. A minority of courts, relying primarily on traditional distinctions between actions at law and actions at equity, have held that remedial costs are equitable in nature, and thus are not “damages.”\(^{109}\) Most courts, however, view damages from the perspective of a lay policyholder, and hold that the costs of cleaning up a contaminated site constitute “damages” within the meaning of a CGL policy.\(^{110}\)

c. Categorization of Investigation Costs

Primary CGL policies typically provide that defense costs that are paid are in addition to, and thus do not erode, policy limits of liability. Prior to the cleanup of an environmental site, a policyholder typically investigates a site in phases. In the initial phase, which may involve multiple investigations, the extent of contamination is defined. This investigation often is termed a “remedial investigation.” In the second phase, the plan of remediation is determined. This phase typically is called a “feasibility study.” Whether a remedial investigation or a feasibility study is considered a “defense cost” or “indemnity” under the insurance policy determines whether those payments reduce, or even exhaust, policy limits, or must be paid by the primary insurance company in addition to limits.

Courts are divided on this issue. For example, the Northern District of New York has held that remedial investigation costs are defense costs, while feasibility studies are considered indemnity. Endicott Johnson Corp. v. Liberty Mut. Ins. Co., 928 F. Supp. 176 (N.D.N.Y. 1996). In American Bumper & Mfg. Co. v. Hartford Fire Insurance Co., 550 N.W.2d 475 (Mich. 1996), in contrast, the Michigan Supreme Court held that investigation costs related to remediation or making a party whole are indemnity, and costs related to a determination of who was liable are defense expenses.

d. The Pollution Exclusion
Beginning in 1970, the insurance industry adopted a pollution exclusion that precluded coverage for environmental contamination, unless the discharge of pollutants was “sudden and accidental.”

By far the most significant litigated issue that the exclusion has raised is whether “sudden” only means “abrupt,” -- and thus excludes gradual pollution from insurance under the policy, as the insurance companies argue -- or whether, as policyholders argue, “sudden” also can mean “unexpected,” in which case unexpected gradual contamination is not excluded. The insurance companies’ argument focuses on the “common meaning” of sudden, while policyholders rely both on alternative dictionary definitions and representations about the exclusion’s meaning that the insurance industry made to state regulators when seeking approval for the exclusion. Courts have split fairly evenly on this issue.

In response to this conflicting case law, beginning in the mid-1980’s, the insurance industry developed the following so-called “absolute” pollution exclusion, which precludes coverage for contamination, with a narrow, “hostile fire” exception.

This insurance does not apply to:

1. “Bodily injury” or “property damage” arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of “pollutants”:
   a. At or from any premises, site or location which is or was at any time owned or occupied by, or rented or loaned to, any insured. However, this subparagraph does not apply to:
   1. “Bodily injury” or “property damage” arising out of heat, smoke or fumes from a “hostile fire.”

A new battleground issue has begun to emerge with the advent of the “absolute” pollution exclusion: What constitutes a “pollution” claim subject to the exclusion? Insurance companies, for example, have attempted to extend the exclusion’s reach beyond traditional environmental pollution claims to such areas as injuries from carbon monoxide fumes inside a residence, lead paint exposure, and worker exposure to chemicals or fumes in the workplace.

While some courts have held that the absolute pollution exclusion bars coverage for such claims, increasingly, courts have refused to expand the reach of the exclusion beyond “traditional” environmental claims. In large measure, that refusal is based on the breadth of the exclusion’s wording; as the Seventh Circuit noted in one oft-cited case, “without some limiting principle, the pollution exclusion would extend far beyond its intended scope, and lead to absurd results.” In addition, courts have recognized that both the drafting history of the pollution exclusion, and its use of environmental “terms of art” such as “discharge, dispersal, release or escape” - terms and phrases drawn directly from environmental legislation and regulations - demonstrate that “the industry’s intention was to exclude only environmental pollution from coverage.”

e. The Owned Property Exclusion

The owned property exclusion precludes coverage for damage to the policyholder’s own property, which presumably would be covered by first-party coverage. This exclusion generally provides that:
This insurance does not apply to:

1. Property owned or occupied by or rented to the insured;

2. Property used by the insured; or

3. Property in the care, custody or control of the insured or as to which the insured is for any purpose exercising physical control.

The exclusion raises two significant issues. Since environmental contamination often affects groundwater, one issue is whether the property owner or the state owns the groundwater under the contaminated property. In many states, the state owns groundwater, and, thus, groundwater contamination is not implicated by the exclusion. See, e.g., N. States Power Co. v. Fid. & Cas. Co., 504 N.W.2d 240 (Minn. Ct. App. 1993), aff’d as modified, 523 N.W.2d 657 (Minn. 1994). In Massachusetts, where the property owner owns the groundwater, courts have recognized that groundwater flows off site, and have not enforced the exclusion when groundwater is contaminated. Rubenstein v. Royal Ins. Co. of Am., 694 N.E.2d 381, 389 (Mass. App. Ct.), review granted, 707 N.E.2d 367 (Mass. 1998) (Table), aff’d, 708 N.E.2d 639 (Mass 1999).

The second issue is whether remedial action by a policyholder on its own property to prevent imminent contamination to offsite property is subject to the exclusion. Many courts have held that such activity is not subject to the exclusion. See, e.g., Aetna Ins. Co. v. Aaron, 685 A.2d 858 (Md. Ct. Spec. App. 1996). New Jersey courts agree, but only if contamination already has occurred to offsite property. State v. Signo Trading Int’l, Inc., 612 A.2d 932 (N.J. 1992).

f. Exclusion for Intentional Damage

Insurance covers the unintended results of intentional conduct. The language embodying this concept generally is found in the definition of “occurrence” included in liability insurance policies at least since 1966. That exclusion provides that “occurrence” means:

An accident including injurious exposure to conditions which results, during the policy period, in bodily injury neither expected nor intended from the standpoint of the insured.119

Most courts essentially ignore the “expected” language in the definition of occurrence, and preclude coverage only if the resulting damage is intentional. Thus, there should be insurance, even when the act causing the damage is intentional, provided that the resulting damage is not intentional.

Two major issues arise from the “occurrence” question. The first is whether the issue is analyzed from an objective, “reasonable person” standard, in which case industry-wide knowledge is relevant, or whether the issue is judged only from the policyholder’s subjective intent. Not surprisingly, insurance companies typically prefer the objective test, while policyholders prefer the subjective test. Most courts have applied a subjective test, see, e.g., Capano Mgmt. Co. v. Transcontinental Insurance Co., 78 F. Supp. 2d 320 (D. Del. 1999); Nationwide Mutual Insurance Co. v. Grady, 502 S.E.2d 648 (N.C. Ct. App. 1998), particularly those that have based their decision on the “from the standpoint of the insured” language in the definition of “occurrence.” See, e.g., Lane v. Worcester Mut. Ins. Co., 430 N.E.2d 874, 875 (Mass. App. Ct. 1982).

The second issue is which party bears the burden of proof on whether the damages are “expected or intended.” Since the policy language serves to exclude coverage, many
courts treat the language like an exclusion -- even though it is part of the definition of “occurrence” found in the policy’s sections granting coverage -- and place the burden of proof on the insurance company. Other courts place the burden of proof on the policyholder.

**g. The Choice of Law Is Critical in a Coverage Dispute over Environmental Claims**

As can be determined from the above discussion, the law on several key issues varies by jurisdiction. Thus, the choice of law that will be applied is critical in determining whether the policyholder will be able to obtain insurance. Although most courts will apply the law of the jurisdiction where the environmental site is located to the insurance issues, the choice of forum in which the dispute is resolved also will influence what law is applied. Compounding this complexity is the fact that often policyholders seek, at the same time, insurance for multiple environmental sites located in different states.

Thus, the first steps for counsel, when faced with a potential environmental claim, include determining: 1) whether the corporation’s overall environmental exposure involves sites in multiple jurisdictions; 2) what the law is with respect to the key issues in each of these jurisdictions; and 3) what the facts are with respect to each of the sites on each of the key issues. Only after “profiles” of each site are prepared, containing this information, will counsel be able to assess the likelihood of insurance recovery, and to develop a strategy that will maximize that recovery.

**3. Coverage for Advertising Liability and Its Application to Intellectual Property Claims**

For at least the last three decades, CGL policies typically have covered suits against insureds alleging “advertising injury” or “advertising liability.” In 1986, ISO revised the definition of “advertising liability” in its standards forms. In particular, it replaced the prior advertising offenses of “unfair competition” and “piracy” with “misappropriation of advertising ideas or style of doing business.” Therefore, the definition of “advertising injury” was changed to include injury “arising out of” various “offenses,” including: “Misappropriation of advertising ideas or style of doing business” and “Infringement of copyright, title or slogan.”

As a result of the changes in definition of “advertising injury” in the 1986 ISO form, much litigation has been directed towards the intended effect of these changes. A majority of the courts that have decided the issue have held that “misappropriation of advertising ideas or style of doing business” includes “a wrongful taking of the way another promotes its business” and have held that “trademark and trade dress infringement allegations [fall] within this definition of ‘advertising injury.’”

In 1997, the standard form of advertising injury coverage was modified again. The definition of “advertising injury” was combined with the definition of “personal injury” and changed to read as follows:

“Personal and advertising injury” means injury...arising out of one or more of the following offenses:

F. the use of another’s advertising idea in your “advertisement;” or

G. Infringing upon another's copyright, trade dress or slogan in your “advertisement.”
a. Coverage for “Infringement of Copyright, Title, or Slogan”

Courts have held that there is coverage for trademark infringement under the covered offense “infringement of copyright, title or slogan.” For example, in J.A. Brundage Plumbing & Roto-Rooter, Inc. v. Massachusetts Bay Insurance Co., the court found coverage under the “infringement of copyright, title or slogan” provision for allegations of trademark infringement involving use of the trademark “Roto-Rooter” in connection with the advertising and sale of sewer, drain and pipe cleaning services. The J.A. Brundage court explained that infringement of both “title” and “slogan” can encompass trademark or trade name infringement. Similarly, in Clary Corp. v. Union Standard Insurance Co., the court determined that “infringement of title” can include trademark or trade name infringement.

Other cases likewise have found coverage for trademark infringement of “slogans.” For example, in Energex System Corp. v. Fireman’s Fund Insurance Co., the court found that “[w]hile an injury defined as infringement of title may not cover all trademark infringement claims, the language clearly suggests coverage of claims where there are allegations of infringing a company’s mark or slogan.” Indeed, a slogan is defined as “a brief attention-getting phrase used in advertising or promotion.” In A Touch of Class Imports, Ltd. v. Aetna Casualty & Surety Co., the court took judicial notice of several slogans, including “You’re in good hands with Allstate” and “Good to the Last Drop.” Similarly, in Union Insurance Co. v. Knife Co., the court explained that a slogan’s use in advertising as an identifier of a product, service, or company results in coverage for trademark infringement claims under the “infringement of slogan” offense.

b. Coverage Under “Misappropriation of Advertising Ideas and Style of Doing Business”

While coverage for trademark or trade name infringement typically is found under the enumerated offense of “infringement of copyright, title, or slogan,” coverage for trade dress claims most often is found under the “misappropriation of advertising ideas and style of doing business” offense. The majority of courts have held that “misappropriation of...style of doing business” or “piracy” and “unfair competition” are synonymous with “trade dress” and “trademarks.” In Lebas Fashion Imports of USA, Inc. v. ITT Hartford Insurance Group, the court determined:

The misappropriation of an “advertising idea” certainly would include the theft of an advertising plan...it is also reasonable to apply it to wrongful taking of the manner or means by which another advertises its goods or services.... [O]ne of the basic functions of a trademark is to advertise the product or service of the registrant. For the same reason, a trademark could reasonably be considered an integral part of an entity's style of doing business.

Other courts similarly have held that “claim[s]...for trademark and trade dress infringement constitute...‘advertising injury,’ under the enumerated definition ‘misappropriation of advertising ideas or style of doing business.’” Indeed, several courts have found that the phrase “misappropriation of style of doing business” is analogous to trade dress infringement and trademark infringement.

The courts that have determined that the “advertising injury” provision covers trademark and trade dress infringement have done so primarily based on the plain and ordinary meaning of the terms in the policy and the reasonable expectations of the insured. These jurisdictions have
determined that the types of claims covered by the advertising injury coverage must be based on the reasonable expectations of the insured and that it is objectively reasonable for an insured to expect that the definition of “advertising injury” includes claims of trade dress and trademark infringement.\footnote{138}

c. The Requirement of “Advertising” or “Advertising Activity”

Advertising injury coverage typically requires that “advertising” or “advertising activity” be involved and that there is a causal connection between the alleged infringement and the advertising activity. Commercial general liability policies do not define “advertising activity.” The majority of published opinions define “advertising” to mean “widespread promotional activities directed to the public at large.”\footnote{139} Not all courts, however, have required that the “advertising” encompass widespread promotional activities. For example, in New Hampshire Insurance Co. v. Foxfire, Inc.,\footnote{140} the court found that solicitations to a target audience constitute “advertising.” The Foxfire court explained that “because the term [advertising] is used within the context of the insuring provisions and not within an exclusion, the term should be interpreted broadly, with any doubts as to coverage resolved in favor of the insured.”\footnote{141} Similarly, in John Deere Insurance Co. v. Shamrock Industries, Inc.,\footnote{142} the court found that a single solicitation coupled with a demonstration of the item for sale met the definition of “advertising.”\footnote{143} Therefore, even though some courts favor limiting “advertising” to widespread promotional activities, marketing and attempts to sell to even one potential buyer can constitute advertising activity.

d. The Causal Nexus Between the Advertising and the Alleged Injury

The Ninth Circuit Court of Appeals has explained that in order “[t]o compel an insurance company to defend under the advertising injury provision, the insured must demonstrate a causal connection between the plaintiff’s claim in the underlying action and the defendant-insured’s advertising.”\footnote{144} However, the advertising activities do not have to be the only cause of the alleged injury. Rather, the case law merely requires that the advertising activities be a substantial factor in contributing to the injury.\footnote{145}

Courts have made clear that allegations involving trade dress infringement that result in false designation of origin or confusion that takes place, at least in part, through advertising, satisfies the nexus requirement.\footnote{146}

In Poof Toy, the policyholder allegedly copied foam material toys known as “bath stickers” and “fuzzles” and sold them in Target and Wal-Mart stores. Id. at 1230. The court found that trade dress infringement related to the “entire product’s appearance and packaging, [which is] a form of advertising.” Id. at 1236. Therefore, the claims for trade dress infringement against the policyholder “arguably fall within the course of advertising the insured’s goods and thus, within the coverage of the policy.” Id; see also Dogloo, Inc. v. N. Ins. Co., 907 F. Supp. at 1391 (finding that claim for trademark infringement constitutes “advertising injury” because “[section 43(a) of the Lanham Act provides a remedy for ‘a false designation of origin, or any false description or representation,’” a claim which “necessarily involves advertising.”).

Courts have made clear that allegations involving trade dress infringement that result in false designation of origin or confusion that take place, at least in part, through advertising, satisfy the nexus requirement. For example, in Energex Systems Corp. v. Fireman’s Fund Insurance Co.,\footnote{147} the court found the requisite causal nexus, given that the underlying complaint “alleged that ‘the total visual effect of Plaintiff’s product’ would cause confusion...and that [the insured] has provided ‘false representations or descriptions’ of their goods.... [The insured] advertised its...services by mailing brochures and price lists to potential customers.”\footnote{148}
Several courts have found a clear causal nexus between an alleged injury and the advertising activity. For example, in Massachusetts Bay Insurance Co. v. Preville, Inc., the policyholder sought coverage for a lawsuit filed against it alleging, among other things, trade dress infringement. The underlying lawsuit was based on allegations that plaintiff’s jewelry designs were being duplicated by the policyholder. The claim of trade dress infringement was premised on the contention that the jewelry designs were distinctive and had acquired secondary meaning indicating the source for the jewelry to the trade and to purchasers and to the public at large. The court rejected the insurance carrier’s argument that there was no causal connection between the injury and the advertising activity, finding that the underlying “complaint [made] numerous references to [the insured’s] marketing activities and efforts to promote the sale of imitation...pieces.”

Likewise, in Bay Electric Supply, Inc. v. Travelers Lloyds Insurance Co., the court found that the causal nexus between the advertising injury and advertising activity was established because the plaintiff in the underlying complaint:

specifically alleged “importation, marketing, and/or sale of circuit breakers bearing the infringing reproductions . . . [which] constitutes the use of false designations of origin . . . which is likely to confuse or deceive the public as to the source, sponsorship and/or approval of Defendants' circuit breakers.”

Courts also have held that allegations of trademark infringement relating to the use of names or logos satisfy the requisite causal nexus.

Some courts have determined that advertising activity is inherent in trademark and trade dress infringement and, therefore, the causal nexus automatically is met. As succinctly stated by the court in Poof Toy,

“allegations of trademark/trade dress infringement inherently involve advertising activity. In other words, there can be no trademark/trade dress infringement without advertising having occurred. This conclusion results from a required element in every...trade dress case, that the...dress is likely to cause confusion to the consumer or deceive the consumer as to the origin or manufacturer of the goods.”

In fact, it is unlikely that there can be trademark infringement without advertising of a product, because without advertising of the product, it is questionable whether there can exist the likelihood of confusion. Indeed a “trade-mark is but a species of advertising, its purpose being to fix the identity of the article and the name of the producer in the minds of the people who see the advertisement, so that they may afterward use the knowledge themselves and carry it to others having like desires and needs for such article.”

4. Coverage for Personal Injury

In 1966, the concept of “personal injury” was added to the coverage traditionally provided for “bodily injury” and “property damage.” Before then, personal injury coverage was not provided on a standard form basis.

When the standard form personal injury provision was added by the National Bureau of Casualty Underwriters as a standard endorsement, it provided coverage for three groups of offenses - false arrest, detention or imprisonment, or malicious prosecution (Group A), publication or utterance of libel or slander or of any defamatory or disparaging material, or publication or utterance in violation of an individual’s right of privacy (Group B), and “wrongful entry or eviction, or other invasion of the right of private occupancy.” (Group C). Coverage for “Group A and B” offenses
is fairly straightforward. Courts that have examined the scope of coverage afforded for “Group C” offenses have concluded that the coverage applies to a variety of claims alleging interference with interest attending to the possession or enjoyment of real property.159

Courts also have recognized that insurance carriers must defend and indemnify their policyholders against claims alleging interference with the use or enjoyment of property. A physical invasion of real property is not necessary to trigger coverage - any alleged interference with real property rights is covered under the “personal injury” provisions of the policies. In Town of Goshen v. Grange Mutual Insurance Co.,160 for example, the underlying complaint alleged that the town’s planning board had “for over two years delayed and obfuscated the attempts made by the plaintiff to gain subdivision approval” for his real property and demonstrated an “intent...to deny the plaintiff...his right to the free enjoyment of his property....”161 The insurance carrier argued that there was no coverage because there were no allegations of invasion, intrusion, or interference by any person or thing upon plaintiff’s land. This argument was rejected by the New Hampshire Supreme Court, which ruled that the carrier had a duty to defend. The court stated:

We cannot accept [the insurance carrier’s] argument that an appreciable and tangible interference with the physical property itself is necessary to constitute an “invasion of the right of private occupancy.”162

Other courts have reached similar conclusions.163

5. Additional Insured Coverage - Other Insurance Provision and Order of Payments

a. Purpose of Additional Insured Coverage

There are numerous situations where a third party is entitled to coverage under an insurance policy it did not purchase. Under a general liability policy, those situations most commonly involve: a contractor who is added as an “additional insured” under a policy bought by a subcontractor; a lessor or owner of property who is added as an “additional insured” under a policy bought by a tenant or store owner; or a vendor who is added as an “additional insured” under a policy bought by the manufacturer of goods, a shareholder, or partner or joint venturer of the named insured.

The additional insured generally is added through an endorsement that amends the “Who Is an Insured” section of the policy to include as an insured the additional entity, but only for a limited purpose, depending upon the nature of the relationship between the named insured and the added party.

Often, these policy endorsements are added in situations where the “additional insured” also is entitled to indemnification by the named insured as a result of their underlying business relationship. Thus, the endorsement to the named insured’s policy reinforces the risk transfer reflected in the non-insurance indemnity agreements by providing the additional insured with direct rights under the named insured’s policy. As a result, the additional insured is entitled to an immediate defense under the policy, rather than being indemnified for defense costs at a later date by the named insured. Defense costs also should be paid to the “additional insured” in addition to, and not out of, the policy limits.

Additional insured coverage should not be confused with the contractual liability coverage afforded the named insured to help fund its contractual obligation to indemnify a third party.164 Contractual liability coverage protects the named insured. Additional insured coverage protects the third party, and allows that third party a direct right under the insurance policy. Those rights
are governed by the terms of the policy, not by the terms of the underlying contract.

For example, a landlord leases premises to the tenant. In the lease, the tenant agrees to indemnify the landlord for any liabilities arising out of the leased premises. To help fund the tenant’s indemnification obligation, the lease is defined as an “insured contract” that will fall within the exception to the contractual liability exclusion. As a result, the insurance company will pay on behalf of the named insured tenant the monies owed to the landlord under the indemnification agreement contained in the lease. In addition, the landlord can be named as an “additional insured” under the tenant’s insurance policy so that, in the event that the landlord is sued because of an injury on the premises, the landlord can obtain a defense and indemnity directly from the tenant’s policy.

b. The Scope of Additional Insured Coverage

An issue that frequently arises is the scope of additional insured coverage. The insurance companies will argue that it covers only vicarious liability, which the additional insured may have for the negligence of the named insured. For instance, a recent case, Raymond Corp. v. National Union Fire Insurance Co., No. 3, 95, 2005 WL 1523565 (N.Y. June 29, 2005), held that a vendor’s endorsement did not extend coverage for the additional insured’s negligence. Two other cases, however, reached a result directly contrary to Raymond: Pep Boys v. Cigna Indemnity Insurance Co., 692 A.2d 546 (N.J. Super. App. Div. 1997) and Sportmart, Inc. v. Daisy Manufacturing Co., 645 N.E.2d 360 (Ill. App. Ct. 1994). Some new additional insured endorsements will limit coverage only “with respect to liability...caused in whole or in part by [the named insured’s] acts or omissions or the acts or omissions of those acting on behalf [of the named insured] in the performance of the ongoing operations [of the named insured] for the additional insured.” ISO Form CG 20100704. The new language tries to limit the additional insured’s coverage to vicarious liability and may not provide insurance when the additional insured’s independent act of negligence is the sole cause of the loss.

Where an additional insured endorsement extends coverage only in certain circumstances, ambiguities concerning the right to coverage can arise. For example, endorsements adding a shareholder of the named insured as an additional insured under the policy typically limit the extension of coverage to liabilities arising out of the additional insured’s status as a shareholder. Courts have reached different conclusions as to the nature of the relationship and the liability necessary to trigger such coverage. For example, in Certainteed Corp. v. Federal Insurance Co., 913 F. Supp. 351 (E.D. Pa. 1995), the court held that only a direct shareholder of the policyholder would be covered by a named insured provision extending coverage to the policyholder’s shareholders; thus, the ultimate parent company of the policyholder, which owned the company that held the policyholder’s stock, would not be included as an additional insured. In Turner & Newall, P.C. v. American Mutual Liability Insurance Co., No. Civ. A. 82-1339, 1985 WL 8056 (D.D.C. Aug. 1, 1985), in contrast, the court held that such an “indirect” shareholder would be entitled to coverage, but only for those claims that specifically alleged that the parent was being sued in its capacity as a shareholder of the policyholder.

A related scope issue, in addition to the question of coverage for the additional insureds’ own negligence, is whether restrictions in the named insured’s indemnity obligation, which may be contained in the underlying contracts, limit the insurance available to the additional insured. The answer should be no. The terms of the policy, not the underlying contracts, control the scope of the additional insured coverage. See Donald S. Malecki, The Additional Insured Book (5th Edition) (2004) at 266; see also Valentine v. Aetna Ins. Co., 564 F.2d 292, 296 (9th Cir. 1977); Old Republic Ins. Co. v. Comcast, Inc., 588 F. Supp. 616 (S.D.N.Y. 1984).
c. The Order of Payments

Situations where additional insured coverage is implicated almost inevitably involve multiple lines of coverage because the additional insured is likely to have its own insurance policies where it is the named insured. When faced with a problem of concurrent and overlapping insurance, a court first will look to the “other insured” provisions in the competing policies to determine which respond first.

When, which is often the case, the competing “other insurance” clauses cancel each other out, a court generally requires each insurance policy, or each line of insurance, to share the liability on a proportional basis. Allstate Ins. Co. v. Farmers Ins. Group, 488 N.Y.S.2d 703, 704 (App. Div. 1985). Alternatively, a court may hold that the later-issued policy should pay first, on the assumption that the insurance companies who sold the later policy were in a position to make their insurance excess of earlier policies, if that was intended. Argonaut Ins. Co. v. U.S. Fire Ins. Co., 728 F. Supp. 298, 303 (S.D.N.Y. 1990); United Nat’l Ins. Co. v. Lumbermens Mut. Cas. Co., No. 89 Civ. 3869 (SWK) 1994 WL 259820, at *6 (S.D.N.Y. June 8, 1994), aff’d, 48 F.3d 1212 (2d Cir. 1994). If the purpose of additional insured coverage is considered, a court may find it reasonable to require the policy or policies containing such insurance to pay first.

After all, one of the reasons for requesting additional insured status is to obtain a certain amount of primary protection as the first recourse under the liability policy of the named insured. However, when the named insured’s insurance company raises the other insurance issue, it has the tendency to defeat one of the very purposes for being an additional insured.


This confusion can be reduced if the additional insured agrees with its own line of insurance to attach a specific “other insurance” clause providing that those policies will apply in excess of other insurance available to the named insured as an additional insured under another policy. However, there is not a wide body of case law on this issue and, like many insurance issues, it will be resolved based on the particular facts of each case, including the policy language, and the jurisdiction whose laws will govern.

IV. Other Types of Liability Policies

A. Directors and Officers Liability Insurance Policies

Concern over the liability exposure faced by directors and officers has never been higher. Their responsibilities have increased; the fluctuations in the market has given rise to many unhappy investors eager to obtain redress through litigation; corporate scandals suggest that there is wrongdoing in the corporate boardroom to be discovered; and the Sarbanes-Oxley Act of 2002 (“Sarbanes-Oxley”) has not only imposed new responsibilities on directors and officers, but has required corporations to generate the kind of paper trail that may make it easier for plaintiffs to prove their case.

Given the present environment, it is difficult for corporations to attract and keep outside directors, particularly those asked to serve on the Audit Committee. Such positions carry with them increased responsibilities to supervise not only the business performance of the company, but also
the company’s outside auditors, and other consultants who provide non-audit services. Outside directors and Audit Committee members also may be required to implement the whistle-blowing requirements imposed under Sarbanes-Oxley.

One of the few protections available to directors and officers in this hostile environment is Directors and Officers ("D&O") insurance. However, D&O insurance premiums have increased dramatically, at the same time that D&O insurance companies are cutting back on the coverage afforded under their policies. Deductibles, retentions, co-insurance, and premiums have increased, as have the number and scope of exclusions. Thus, the extent of insurance coverage provided under the standard D&O policy, and the availability of limits, have decreased. Accordingly, buying D&O insurance that provides the protection directors and officers demand and require has become increasingly difficult.

1. Basics of D&O Insurance - The Insuring Agreements

D&O insurance is not sold on a common form used by the insurance industry as a whole. Rather, each insurance company has developed its own set of forms. Although policyholders are not in a very strong bargaining position, they should be aware of certain key issues relevant to the purchase of D&O insurance so that they can negotiate the most favorable language possible.

a. Side A, Direct or Liability Insurance

Under a traditional D&O insurance policy, the insurance company agrees to indemnify, or to pay on behalf of, the individual directors or officers for all “Loss” that those individuals become legally obligated to pay arising out of a “Wrongful Act” committed in their capacity as a director or officer.

“Wrongful Acts” are defined in the policy and generally include “any act, error, misstatement or omissions, neglect or breach of duty” committed by the individual in his or her capacity as an officer or director. Although some insurance companies argue that intentional conduct is not a “wrongful act” covered by the policy, this argument generally has been rejected. See PepsiCo, Inc. v. Cont’l Cas. Co., 640 F. Supp. 656, 659 (S.D.N.Y. 1986) (“PepsiCo”). However, this issue can and does arise in connection with the various “conduct exclusions” discussed infra.

“Loss” generally is defined to include amounts that the policyholder is legally obligated to pay, including damages, settlements, and defense costs. The question of whether fines and penalties are “losses” under D&O policies often is disputed in coverage cases, with insured officers and directors contending that the fines or penalties are in lieu of more traditional damages. In some instances, the insureds may also argue that, since the fines and penalties are insurable as a matter of law (i.e., that state law allows for corporate indemnification thereof), they also are covered under a D&O policy. Some policies explicitly provide that punitive and exemplary damages are included within the definition of “Loss.”

Whether restitution or disgorgement of ill-gotten gain is recoverable under a D&O policy is not well settled. In Level 3 Communications, Inc. v. Fed. Ins. Co., 272 F.3d 908, 911 (7th Cir. 2001), the court denied coverage, stating: “An insured incurs no loss within the meaning of the insurance contract by being compelled to return property that it had stolen, even if a more polite word than ‘stolen’ is used to characterize the claim for the property’s return.” However, in a recent non-insurance case, Pereira v. Farace, Dock. No. 03-5053 (2d Cir. decided June 30, 2005), the defendants had been denied a jury trial on the grounds that the remedy sought on the breach of fiduciary claims -- restitution -- was equitable. The Second Circuit reversed, holding that, be-
cause the plaintiff sought to recover funds attributable to plaintiff’s loss, and not the defendant’s unjust gain, the claim was for compensatory damages. Pereira would appear to require an analysis of the actual nature of the relief sought, and may allow for insurance on claims that otherwise would be foreclosed under Level 3.

Generally, the individuals covered under a D&O policy include past, present, and future directors and officers. The individuals are covered only for claims that allege wrongdoing performed by the director or officer while acting in his or her capacity as a director or officer. Where the acts of misconduct were not performed in such a capacity, claims under the D&O policy will be denied. E.g., Berenson v. World Jai-Alai, Inc., 374 So. 2d 35 (Fla. Ct. App. 3d Dist. 1979); accord Bowie v. Home Ins. Co., 923 F.2d 705, 709 (9th Cir. 1991). The policy also generally covers individuals who serve as outside directors of other corporations at the request of their corporate employer.

Side A Coverage provides insurance to pay the directors’ and officers’ liabilities for which the corporation either cannot or will not provide indemnification. For example, corporations may refuse to indemnify directors and officers after a change in corporate control, especially in the case of a hostile takeover. They also may refuse, as a matter of policy, to indemnify certain types of claims (e.g., SEC violations). In addition, the corporation may be unable to indemnify its directors or officers because of corporate bankruptcy. Side A coverage protects only the individual directors and officers for claims made against them. It does not provide insurance for claims against the corporate policyholder.

b. Side B, Reimbursement or Indemnity Insurance

Under Side B Coverage, referred to also as “reimbursement” or “indemnity” coverage, the insurance company agrees to reimburse the corporate entity for all “Loss” for which the company is required to indemnify, or has legally indemnified, the directors or officers for a claim alleging a Wrongful Act. As with Coverage A, Coverage B does not provide insurance for claims asserted directly against the corporate policyholder. It merely reimburses the corporation for monies spent to protect the individual directors and officers.

State indemnification laws typically delineate the types of liabilities for which indemnification by the corporate employer to its directors and officers is permitted. Many state statutes permit full indemnification for judgments, fines, settlement costs, and expenses in third-party actions where the director or officer (a) acted in good faith, (b) in a manner that reasonably could be construed to have been in the best interests of the corporation, and (c) where there was “no reasonable cause to believe his conduct was unlawful.” E.g., Del. Gen. Corp. Law § 145(a).

Where, however, the officer or director causes loss because of willful misconduct or has been found guilty of acts of deliberate dishonesty, state statutes may prohibit corporate indemnification. See, e.g., N.Y. Bus. Corp. Law § 726(b)(1) (McKinney 2003) (precludes indemnification for final adjudication of deliberate dishonesty); Cal. Ins. Code § 533 (2003) (insurance company not liable for “loss caused by the willful act of the insured”).

c. Side C or Entity Coverage Insurance

Many, if not most, lawsuits filed against the individual directors and officers, such as securities claims, also are filed against the corporation. As a result, in the 1990s, there were numerous disputes over how to allocate the costs of defense, and any resulting settlements or judgments, between the insured claims against individuals and the uninsured claims against the corporate entity. See, e.g., Nordstrom, Inc. v. Chubb & Son, Inc., 54 F.3d 1424 (9th Cir. 1995) (“Nordstrom”).
In partial response to this allocation dispute, the insurance industry developed and sold Coverage C, or “entity” coverage. Under “entity” coverage, the insurance company agrees to reimburse the corporate policyholder for liability arising out of a defined group of claims filed directly against the corporation. The scope of entity coverage for a publicly held company often is limited to securities claims. Particularly for private or nonprofit corporations, the policy may extend entity coverage to employee claims, although such claims may be the subject of separate Employment Practices Liability Insurance. A typical provision which combines entity coverage (Side C) with reimbursement coverage (Side B) states as follows:

This policy shall pay the Loss of the Company arising from a: (i) Securities Claim first made against the Company, or (ii) Claim first made against the Directors or Officers during the Policy Period or the Discovery Period (if applicable) and reported to the Insurance company pursuant to the terms of this policy for any actual or alleged Wrongful Act, but, in the case of (ii) above, only when and to the extent that the Company has indemnified the Directors and Officers for such Loss pursuant to law, common or statutory, or contract, or the Charter or By-laws of the Company duly effective under such law which determines and defines such rights of indemnity. The Insurance company shall, in accordance with and subject to Clause 8, advance Defense Costs of such Claim prior to its final disposition.

If “entity” coverage exists for a particular claim, there is no need to allocate defense costs or indemnity payment between the individual and corporate defendants because the claim against both is covered by the policy.

2. The Allocation Dispute Between Insured and Uninsured Liability

When an action is brought against a director or officer, the corporate entity almost always is also named as a defendant. Unless all of the claims fall within the scope of entity coverage, a dispute over allocation may still arise. Moreover, D&O claims are often the subject of parallel proceedings. For instance, the same conduct, allegedly in violation of the federal securities laws, can give rise not only to shareholder lawsuits, but also to grand jury investigations, investigations by the Securities and Exchange Commission (“SEC”), and Congressional inquiries. D&O claims not involving violations of the securities laws (such as the sale of a defective product, infringement of intellectual property rights, or unfair trade practices) also can be the subject of governmental investigation or otherwise require a response to a regulatory agency.

As a result, even with the presence of entity coverage, the same alleged wrongful conduct can generate many claims, some covered by the insurance policy and others not. The defense of these parallel claims is often common or, at least, overlapping. These circumstances still may lead to a dispute over allocation - what percentage of the “Loss,” is attributable to a covered claim and should be reimbursed by the insurance company. There are two primary approaches that courts will use in determining allocation of losses for D&O policies: the larger settlement test and the relative exposure test.

Under the “larger settlement” test, “allocation is permitted to the extent that any settlement was made larger by the wrongful actions of uninsured persons.” When directors and officers and a corporate entity are joined as co-defendants, indemnity and defense costs may be allocated between covered and non-covered parties if “there is some amount of corporate liability that is both independent of and not duplicated by liability against the directors and officers.”

Under the “relative exposure” test, allocation is “based on a measure of proportional fault,” Nordstrom, 54 F.3d at 1432 (citing Smith v. Mulvaney, 827 F.2d 558, 561 (9th Cir. 1987)). Under this test, then, “the court allocates the amount at issue according to the degree to which the re-
spective parties contributed to the injuries in the underlying litigation.” 2 Ostrager & Newman, § 20.03[a][2], at 1116-17; see also Mathias § 6.04(3)[a], at 6-44 - 6-45; Kalis § 11-06[C][1], at 11-21; Caterpillar, 62 F.3d at 961. This rule is said to “envision[] a somewhat elaborate inquiry into what happened in a settlement and who really paid for what relief.” Caterpillar, 62 F.3d at 961.

Some policies include a provision requiring that the parties will use their “best efforts” to allocate between covered and non-covered claims. The result of such a provision is to frustrate the “larger settlement” test, which frequently resulted in no allocation to uninsured claims. Other policies may have a provision that contains a pre-set allocation percentage. Thus, if and when a dispute arises over what portion of the loss is covered, that dispute will be resolved according to a fixed percentage.

The broader the coverage and the narrower the exclusions, the less likely that a dispute over allocation will arise. The addition of entity coverage has significantly reduced the frequency of allocation disputes. One way to reduce further the allocation disputes arising out of parallel proceedings is to obtain the broadest possible definition of “Claim” in the D&O policy. That term can, and often is, defined to include investigations by the SEC and the Department of Justice. Whether by fixed allocation, or by settlement of a coverage dispute, the most common resolution of the allocation issue is to have the insurance company accept two-thirds of the loss as covered by the D&O policy.

3. The Allocation Dispute Between Insureds

Because D&O policies generally contain a single aggregate limit, any payment by the insurance company, whether under liability (Coverage A), reimbursement (Coverage B), or entity (Coverage C) coverage, reduces, and can ultimately exhaust, the limits of the policy. As a result, the corporation may be in conflict with the individual directors and officers, and the individual directors and officers may be in conflict among themselves, over the limits of the policy. For example, it is not uncommon for the outside “innocent” directors to be able to settle shareholder claims against them at an early stage in the litigation. They will demand that the insurance companies fund that settlement. That payment, however, may significantly deplete, or even exhaust, the D&O policy, leaving the inside directors with little or no insurance to pay for their ongoing defense.

The issue of allocating fixed limits among multiple covered parties can arise with any form of insurance policy, but arises with particular frequency with D&O insurance. In general, an insurance company must act in good faith and cannot pay its entire limits to some insureds while leaving other insureds without any protection.169

A number of cases have addressed the problem of allocation of fixed D&O limits when the corporation is in bankruptcy.170 These decisions suggest that, particularly when the D&O insurance policy provides entity coverage, both the policy and its proceeds will be considered an asset of the bankruptcy estate and may not be available to fund the defense of lawsuits brought against the individual directors and officers.

In two recent cases, the impact of entity coverage has been at issue when the individual insureds sought reimbursement of the costs of their defense while the corporation was in bankruptcy. In both cases, the court held that the insurance policy, as well as the policy proceeds, were assets of the estate. In In re CyberMedica, Inc., 280 B.R. 12 (Bankr. D. Mass. 2002), the bankruptcy court allowed payment of the individual defense costs of the directors and officers after it found it unlikely that securities claims would be brought against the corporate debtor that would fall within the entity coverage of the policies. In In re Adelphia Communications Corp., 285 B.R. 580 (Bankr. S.D.N.Y. 2002), vacated, 298 B.R. 49 (S.D.N.Y. 2003), the bankruptcy court found that because claims against the corporate debtor were within the scope of entity coverage, the
limits of the D&O policies had to be preserved as an important asset of the estate. The bankruptcy court, however, allowed limited payment of the individual’s defense cost out of the policies’ limits - the insurance companies were allowed to pay $300,000 per insured for the individual’s defense out of total aggregate D&O limits of $50 million. Thus, the existence of entity coverage will, at a minimum, delay payments for the benefit of the individual insureds. Moreover, the extent of such payments will be up to the discretion of the bankruptcy judge.

One option is to include language in the insurance policy that specifically deals with how the limits of the policy will be paid to competing insureds, particularly if the entity declares bankruptcy. For instance, a policy can contain an “order of payments” provision, which specifically provides that, if individual directors and officers and the entity are competing for the limits of the policy, the individual directors and officers are paid first. There is insufficient case law to give an individual director or officer comfort as to how a bankruptcy court, which tends to be pro-debtor, will apply such language. The issue was addressed in In re Enron Corp., No. 01-16034 (AJG), 2002 WL 1008240 (Bankr. S.D.N.Y. May 17, 2002). In that case, the court allowed payment of substantial sums for the individual directors’ and officers’ defense costs under a D&O policy with an order of payments provision.

A second option is to provide separate sublimits for the corporation on the one hand, and the directors and officers on the other hand. However, even with sublimits, if the insured entity is subject to bankruptcy proceedings, the individual directors and officers can be adversely affected by substantial delays if the trustee or creditors contend that the policy or its proceeds are property of the debtor’s estate. Moreover, insurance companies now regularly seek bankruptcy approval for payments to directors and officers if they perceive any risk that the D&O policy or its proceeds will be considered property of the debtor’s estate.

A third option is to remove entity coverage entirely from the D&O insurance policy, or to purchase policies that provide excess insurance only for Coverage A, the insurance designed for the individual directors and officers. The proceeds of a D&O policy that insures only individuals should not be treated as property of the debtor’s estate, as there should be no competition with the corporation over the allocation of a limited fund. The elimination of entity coverage does not, however, eliminate the competition among individual insureds over the fixed limits of the policy. The safest option is for each individual director or officer to have his or her own policy or designated limits within a single policy.

4. Trigger of Coverage and Definition of a Claim

D&O coverage is written on a “claims-made” basis, which requires that, to “trigger” or cause the policy to respond, the claim must be made against the insureds during the policy period. Most D&O policies are “claims made and reported” policies, meaning that not only must the claim be made against the insured during the policy period, but the claim also must be reported to the insurance company during the policy period, or during a short extended reporting period, usually 60 days after the policy terminates. These are sometimes referred to as “double trigger” or “double anchor” D&O policies, since they require both the claim and notice to take place during the policy period. Some policies may include a “retroactive date,” which means that the claim must arise out of conduct subsequent to that specified date and also require the wrongful act to take place during the policy period. These policies are referred to as “triple trigger” or “triple anchor” D&O policies.

One question that often arises regarding the trigger of the claims-made policy is what constitutes a “claim.” Where the policy does not define the term, courts generally have followed the dictionary definition in Black’s Law Dictionary 247 (6th ed. 1990), that a “claim” is “[t]o demand as
one’s own or as one’s right, to assert; to urge; to insist. A cause of action.”


In civil cases, courts have found the existence of a claim, for example, when the underlying plaintiffs file suit, e.g., MGIC Indem. Corp. v. Cent. Bank, 838 F.2d 1382, 1388 (5th Cir. 1988); Employers Reinsurance Corp. v. Sarris, 746 F. Supp. 560, 563 (E.D. Pa. 1990); when a client asked its attorney to work without pay to correct errors in legal work (i.e., when insured was aware that work was inadequate), e.g., Phoenix, 186 Cal. Rptr. at 515; when the policyholder “first learned of an event that could reasonably be expected to result in the eventual filing of a claim,” e.g., Nat’l Union Fire Ins. Co. v. Baker & McKenzie, 997 F.2d 305, 307 (7th Cir. 1993); where the Federal Home Loan Bank Board sent a further letter directive imposing severe operating restrictions on a bank “‘for the protection of the Federal Savings and Loan Insurance Corporation [FSLIC],’” e.g., Mt. Hawley Ins. Co. v. FSLIC, 695 F. Supp. 469, 479 (C.D. Cal. 1987) ("Mt. Hawley"); when the FSLIC conducted an investigation and entered a Supervisory Agreement with the directors and officers of a defunct savings and loan business, e.g., Burns v. Int’l Ins. Co., 709 F. Supp. 187, 189 (N.D. Cal. 1989), aff’d, 929 F.2d 1422 (9th Cir. 1991); where a policyholder became aware of potential liability to the state under its environmental protection laws, e.g., Cent. Ill. Pub. Serv. Co. v. Am. Empire Surplus Lines Ins. Co., 642 N.E.2d 723, 725 (Ill. 1994); when demand was made on an employer to restore an employee’s insurance coverage, e.g., Katz Drug Co. v. Commercial Standard Ins. Co., 647 S.W.2d 831, 836 (Mo. Ct. App. 1983); when subpoenas and other demands were made in an antitrust investigation, Bendis v. Fed. Ins. Co., 958 F.2d 960, 962 (10th Cir. 1991); and when a policyholder received an E.E.O.C. notice of charge of discrimination, e.g., Specialty Food Sys., Inc. v. Reliance Ins. Co., 45 F. Supp. 2d 541 (E.D. La. 1999) (employment practices liability policy), aff’d, 200 F.3d 816 (5th Cir. 1999).

Courts also have found that no claim existed where a demand did not “necessarily result [] in a loss.” E.g., FDIC v. Booth, 82 F.3d 670, 676-77 (5th Cir. 1996) (letter from Federal Deposit Insurance Corporation (FDIC) suggesting that charges against directors may be filed in the future, if they failed to comply with regulations was “too tenuous to constitute a claim”); FDIC v. Mijalis, 15 F.3d 1314, 1333-34 (5th Cir. 1994) (FDIC’s general demands for regulatory compliance are not “claims”); Nat’l Union Fire Ins. Co. v. Ambassador Group, Inc. (In re Ambassador Group, Inc. Litig.), 830 F. Supp. 147, 155 (E.D.N.Y. 1993) (letters from Vermont Commission of Banking regarding possible wrongful acts by directors and officers was merely notice of an occurrence, not of a claim, because they did not demand specific or full relief from the directors and officers for some particular wrongful act); Klein v. Fid. & Deposit Co. of Am., 700 A.2d 262, 271 (Md. Ct. Spec. App.1997) (letters threatening litigation were not a claim).

5. Extended Reporting Period Coverage

Most claims-made policies, including D&O policies, contain a provision requiring the insurance company to sell the policyholder extended reporting period (“ERP”) coverage if the insurance company does not renew the policy. Such coverage extends the life of the policy so that it will continue to cover claims made and reported during the extended reporting period, but only if the claims arise out of wrongful acts which occurred prior to the original termination date of the policy.
The availability of extended reporting coverage is a critical aspect of claims-made coverage. The New York Insurance Department has recognized that “claims-made coverage tends to provide less protection,” and is “a more complicated and confusing method of coverage,” than traditional “occurrence”-based coverage, which generally “protect[s] against injury or damage that occurs during the policy period” without regard to the timing of the claim against the policyholder. 11 N.Y.C.R.R. § 73.0(a), (c).

Equally to the point - and as the Insurance Department also has recognized - claims-made coverage poses a clear potential for “coverage gaps.” Id. § 73.0(c). ERP coverage is intended to avoid these coverage gaps.

An important recent issue with claims-made coverage in general, and D&O coverage in particular, is whether the insurance company has refused to renew the policy and, thus, is required to sell extended reporting period coverage. Whether a particular bundle of terms constitutes a “renewal” or a refusal to renew is likely to be a litigated issue.

Exercise of the extended reporting option should be considered whenever a new policy provides narrower coverage than an existing policy that is about to expire, or when a corporation changes D&O insurance companies. The new policy, particularly one sold by a different insurance company, generally will not retain the retroactive date used in the previous policy. Under these circumstances, the purchase of extended reporting period coverage for the original policy will allow the directors and officers to report new claims under the old policy arising out of conduct going back to the old retroactive date.

6. **The Insurance Company’s Defense Obligation**

Under most D&O policies, the insurance company does not have a duty to defend.174 Rather, the insurance company is required to reimburse for the costs of a defense. As already noted, the defense costs are included within the definition of “loss” as used in the insuring agreement. Thus, defense costs are paid by the insurance company out of the limits of the policy. Under a D&O policy, the costs of defense are not in addition to the limits of that policy.

Another consequence of the way such policies are structured is that the duty to reimburse for defense costs may be co-extensive with the scope of the insurance company’s indemnity obligation. D&O policies are unlike general liability policies, where the duty to defend is explicitly broader than the duty to indemnify. Under a general liability policy, the duty to defend applies even if the underlying claim is only potentially covered. Under many D&O policies, the insurance company has a duty to reimburse for defense costs only if the claim is covered. This gives rise to a timing issue, i.e., when must the insurance company reimburse for defense costs?

Under old forms of D&O insurance, the insurance company was obligated to indemnify the policyholder only when the claim was resolved, and a final determination of coverage could be made. Insurance companies are now required to “advance” defense costs, at least for Coverage A, and sometimes under all of the coverages. Most courts require an insurance company to advance defense costs, even though the insurance company has brought an action to declare that there is no coverage.175 However, if the claims ultimately are found not to be covered by the D&O policy, the insurance company may seek recoupment of any monies that have been advanced.

As already noted, an insurance company will have the obligation to reimburse only for the costs of defending covered claims. Thus, there can arise an allocation dispute when the litigation involves both covered and uncovered claims. It is well settled that an insurance company is obligated to pay all defense costs that are “reasonably related to the defense of the covered claims,”
whether or not those costs also are related to non-covered claims or events. Cont’l Cas. Co. v. Bd. of Educ., 489 A.2d 536, 545 (1985) (“So long as an item of service or expense is reasonably related to defense of a covered claim, it may be apportioned wholly to the covered claim.”); accord Safeway Stores, Inc. v. Nat’l Union Fire Ins. Co., 64 F.3d 1282, 1289 (9th Cir. 1995); Raychem Corp. v. Fed. Ins. Co., 853 F. Supp. 1170, 1182 (N.D. Cal. 1994) (insurance company obligated to pay all costs “reasonably related” to a covered claim); Nordstrom, Inc. v. Chubb & Son, Inc., 820 F. Supp. 530, 536 (W.D. Wash 1992) (“No right of allocation exists for the defense of non-covered claims that are ‘reasonably related’ to the defense of covered claims.”), aff’d, 54 F.3d 1424 (9th Cir. 1995); Fed. Realty Inv. Trust v. Pac. Ins. Co., 760 F. Supp. 533, 536-37 (D. Md. 1991) (insurance company is not entitled to allocation of defense costs when legal services benefited the defense of both covered and non-covered claims); Nodaway Valley Bank v. Cont’l Cas. Co., 715 F. Supp. 1458, 1465 (W.D. Mo. 1989), aff’d, 916 F.2d 1362 (8th Cir. 1990); see also Har-ristown Dev. Corp. v. Int’l Ins. Co., No. CIV.A. 87-1380, 1988 WL 123149, at *12-*13 (M.D. Pa. Nov. 15, 1988) (costs and expenses for items that were of use in defense of an insured director are recoverable from the insurance company even though they also may have been useful in the defense of an uninsured corporation); City of Burlington v. Ass’n of Gas & Elec. Ins. Servs., Ltd., 751 A.2d 284, 293 (Vt. 2000) (insured “entitled to the $359,413 in fees because it would have incurred those fees even if the noncovered claims had not existed”).

Because the policyholder has the duty to defend, it has the right to select defense counsel. However, this right often is limited by requiring the policyholder to select an attorney pre-approved by the insurance company, referred to as the “Panel Counsel.” If there are outside counsel that the insured entity or directors and officers believe they want to use, they should negotiate at the time the policy is issued for those attorneys to be on the Panel Counsel list.

7. Exclusions

a. Conduct Exclusions

D&O policies include exclusions for liability that arises from a director’s or officer’s fraud, self-dealing, or otherwise intentional wrongful conduct. Typically, those provisions exclude coverage for loss arising out of:

a. illegal personal gain (although such exclusion may not apply if the insured’s dishonesty has not been clearly established);

b. illegal or unauthorized remuneration;

c. short swing profits gained in violation of Section 16(b) of the Securities Exchange Act of 1934, or similar state statutory provisions;

d. final adjudication of fraudulent or dishonest acts.

Usually, these provisions require a final judicial determination of intentional wrongdoing for these exclusions to apply. Other policies exclude coverage for dishonesty, but only where the allegations are adjudicated against the officer or director, and the wrongful conduct was determined to be deliberate and material. The insurance company must advance defense costs until a determination of fraud or dishonesty is made. Moreover, given that most claims are settled, the insurance company is obligated to fund a reasonable settlement despite the possible application of these exclusions, provided there has been no finding of wrongdoing.

In recent years, some insurance companies have begun to remove from standard policies the “fi-
nal adjudication” requirement prior to application of these exclusions. Particularly in the present market, policyholders must carefully scrutinize the language of the exclusions being offered.

The “innocent” director who did not participate in the wrongdoing should not be precluded from obtaining coverage under the policy. D&O policies may explicitly limit the applicability of the conduct exclusions in order to protect “innocent directors” with a severability clause. Such clauses typically provide that “the Wrongful Act of an Insured shall not be imputed to any other Insured for the purposes of determining the applicability of relevant exclusions.” See discussion of severability infra.

b. “Insured vs. Insured” Exclusion

The “insured vs. insured” exclusion was designed by insurance companies to exclude so-called “family disputes” arising between officers and directors of an institution and to address claims brought, for example, against former management where there has been a change in corporate control. Some courts have questioned whether the “insured v. insured” exclusion violates the reasonable expectations of the policyholder and have refused to enforce it.\textsuperscript{178}

In bankruptcy, the insurance company may argue that a claim brought by the trustee in bankruptcy against a director or officer is not covered by the policy because the trustee stands in the shoes of the corporation. Whether a claim against the directors and officers by a bankruptcy trustee, creditors committee, or debtor in possession falls within the “insured v. insured” exclusion is an issue about which the courts have disagreed.\textsuperscript{179} Directors and officers obviously will be better off if the D&O policy explicitly provides that a trustee in bankruptcy is not deemed to be the corporation for the purpose of this exclusion.

c. Regulatory Exclusions

A “regulatory exclusion” typically precludes coverage for claims brought against directors and officers by regulatory agencies (particularly, in earlier versions, relating to the banking industry). The exclusion began appearing in the 1980’s when many financial institutions encountered serious financial difficulties, and federal banking regulators (i.e., the FDIC and FSLIC) began taking legal action against failed financial institutions and their officers and directors.

Some courts have found the exclusion to be ambiguous and have refused to enforce it on public policy grounds.\textsuperscript{180} In Branning v. CNA Insurance Cos., 721 F. Supp. 1180, 1184 (W.D. Wash. 1989), for example, the court specifically refused to enforce the exclusion, concluding that the regulatory exclusion substantially hindered the FSLIC’s exercise of its federal powers and, therefore, was contrary to public policy. Similarly, in American Casualty Co. v. FSLIC, 704 F. Supp. 898 (E.D. Ark. 1989), another court explained its rationale for refusing to enforce the regulatory exclusion as follows:

It is preposterous to suggest that any institution would pay a substantial premium for a policy to insure against loss resulting from breach of fiduciary duty, but which at the same time excludes coverage for claims resulting from conduct inconsistent with the fiduciary standard. Id. at 903.\textsuperscript{181}

d. Other Exclusions

D&O policies typically exclude coverage for claims that generally are covered, or could be cov-
ered, under other forms of insurance. For instance, claims for bodily injury, property damage, libel, and slander will be excluded because such claims are covered under typical general liability policies. Claims for violations of ERISA are excluded because coverage is available under a Fiduciary Liability Policy. Other exclusions may deny coverage for, among other things, (1) failure to maintain insurance, (2) punitive damages, and (3) terrorist acts.

8. Misrepresentation/Rescission

D&O insurance companies require applications for insurance that enable the insurance company to evaluate the potential risks of insuring a particular business. With increasing frequency, D&O insurance companies are trying to avoid liability for a claim based on the allegation that there was a material misrepresentation on the application. Indeed, some policies provide that the policy is void if there are material misrepresentations in the application or other materials submitted. For instance, given that the companies’ financials generally are incorporated into the application, an underlying claim based upon a financial restatement likely will be denied on the grounds of rescission.

D&O policies have been rescinded where the policyholder failed to disclose the extent of its precarious financial position, or where the policyholder failed to disclose a distinction between nonprofit and for-profit affiliates. Indeed, most of the recent financial scandals have resulted in efforts by the insurance industry to rescind D&O policies.

An issue is presented where one corporate director or officer makes a misrepresentation on the policy application and another so-called “innocent” director, who had no knowledge of the misrepresentation, brings a claim under the D&O policy. Some cases hold that neither knowledge of the misrepresentation nor an intent to misrepresent on the part of the policyholder are elements that the insurance company must prove to support a defense of misrepresentation. Thus, an innocent director may be denied coverage because of a misrepresentation on the application by the corporate officer or director who signs the insurance application.

As with most issues related to insurance, the question of which state’s law will apply to the elements of a misrepresentation and rescission claim is critical to whether or not an insurance company will be allowed to rescind.

9. Severability

Because of the growing frequency of rescission claims, severability is a current key issue with D&O insurance. The severability issue refers to whether, and in what circumstances, the wrongdoing or false statements of one director or officer can be imputed to the other directors or officers, or to the corporation. A severability provision will limit the ability of the insurance company to deny coverage under one of the conduct exclusions, or to rescind an entire policy solely on the basis of false statements or intentional wrongful act committed by a single insured.

The issue of severability typically arises in two circumstances. The first circumstance is when statements made in the insurance application are false. In such event, the insurance company may try to rescind the entire policy on the grounds of misrepresentation. If the responsibility for the statements in the application is severable, the insurance company can rescind the policy only as to the individual director or officer who signed the application or was aware of the false statement. Typical severability clauses preclude an insurance company from rescinding the entire policy solely on the basis of misrepresentations by a single insured.

The second circumstance where severability becomes important is in the application of the “conduct” exclusions. For instance, an insurance company may seek to deny insurance based on
the fraud exclusion if the president of the company pleads guilty or is convicted of fraud, arguing that the wrongdoing of the president is imputable to the corporation. Many policies have a non-imputation clause which provides: The Wrongful Acts of a Director or Officer shall not be imputed to any other Director or Officer for the purpose of determining the applicability of [intentional act exclusions].

The term “Director and Officer” can be defined to include the corporate entity. Thus, a policy with a non-imputation clause specifically provides that the wrongful acts of a director or officer may not be imputed to either individuals or to the corporation for purposes of determining the applicability of the intentional act exclusions. In such a case, the wrongdoing of each insured must be looked at separately.

In SEC v. Credit Bancorp, Ltd., 147 F. Supp. 2d 238, 265-66 (S.D.N.Y. 2001), a case involving a Bankers’ Blanket Bond, the court held that a policy’s exclusion for losses arising out of dishonesty did not apply to persons other than the individual dishonest actor, and that barring coverage for other insureds for losses arising out of related but non-dishonest conduct would render the non-imputation clause meaningless. In Alstrin v. St. Paul Mercury Insurance Co., 179 F. Supp. 2d 376, 378 (D. Del. 2002), executives sued the corporation’s D&O liability insurance company, seeking coverage for both a securities fraud class action and a bankruptcy adversary proceeding. The insurance company sought to exclude coverage to all insureds, under a provision that excluded coverage for claims arising out of profit or advantage to which an insured was not legally entitled. The court held that in order to exclude coverage based on illegal profit or gain, the insurance company must prove guilt separately for each insured. Id. at 398.

Finally, in Shapiro v. American Home Assurance Co., 616 F. Supp. 900, 903 (D. Mass. 1984), the insurance companies argued that the policies were void ab initio as to all officers and directors, because the insurance was procured by means of fraudulent financial statements. The court disagreed:

I interpret the policy to mean that each insured must be treated separately with respect to a defense of fraud as well as in other respects. If the insured making the particular claim of coverage willfully defrauded, then the exclusion applies and coverage for that insured is defeated. But if only some other insured willfully defrauded, the exclusion and severability clauses taken together plainly say the insured who is not guilty of the willful fraud is covered. The exclusion clause itself indicates that each insured must be treated separately.

Id. at 904 (emphasis added).

Accordingly, policy provisions requiring severability, both for statements made in the application and for conduct which falls within the exclusion, are critical to the purchase of D&O insurance, particularly for outside directors.

10. Protection of the Outside Director

Outside directors who are most concerned about exposing their assets to liability based upon the conduct of the inside management team should consider requiring their corporation to obtain non-rescindable “Side A” excess policies that insure only their own liability. The purchase of these policies will resolve many of the problems mentioned in this paper. This insurance can be written to cover the independent directors when the underlying primary D&O policy is rescinded or commuted or has its limits exhausted. This policy is not cancelable (except for non-payment of premiums), defines “securities claim” to include claims brought by a bankruptcy trustee, and does not exclude coverage due to a financial reporting restatement or insider wrongdoing.
“Side A” coverage for outside directors can be written to provide that the insurance company will respond if the insured corporation itself does not honor its indemnification obligations, particularly for defense costs, within a defined period of time after the outside director has made a written demand on the corporation (or debtor in possession or bankruptcy trustee). Although this coverage will increase premium expense, it does address one of the problems presented in the new world of Sarbanes-Oxley - the reluctance of independent outside individuals to join the board of directors and sit on the Audit Committee.

B. Employment Practices Liability Coverage

1. Scope of Coverage

Employment Practices Liability (“EPL”) insurance covers traditional employment-related claims, such as those alleging “sexual harassment,” “discrimination,” and “wrongful termination.” It provides insurance on a claims-made basis. However, many EPL policies have broader coverage that applies to “workplace torts,” “employment practices violations,” or similar catch-all terms. These terms typically are defined to include a laundry list of possible theories. For example, one policy defines “Employment Practices Violation(s)” to include:

1. Wrongful dismissal, discharge or termination (either actual or constructive) of employment, including breach of implied contract;

2. Discrimination (including but not limited to discrimination based upon age, gender, race, color, national origin, religion, sexual orientation preference, pregnancy, or disability);

3. Retaliation (including lockouts);

4. Employment-related misrepresentation(s) to employee or applicant for employment;

5. Wrongful failure to employ or promote;

6. Wrongful deprivation of career opportunity, wrongfull demotion or negligent employee evaluation, including giving of negative or defamatory statements in connection with an employee reference;

7. Wrongful discipline;

8. Failure to provide or enforce adequate or consistent corporate policies and procedures relating to any Employment Practices Violation.


EPL insurance also typically protects insureds from a broader range of monetary awards or judgments than CGL policies. For example, while CGL policies typically obligate an insurance company to pay for “damages” that an insured is legally obligated to pay, EPL insurance typically obligates the insurance company to pay all “loss” that an insured is legally obligated to pay. “Loss” is not limited to simply damages, but rather is more broadly defined to mean the total amount which any Insured becomes legally obligated to pay on account of each Claim...
against them for Wrongful Acts for which this coverage applies, including, but not limited to, damages, judgments, settlements, costs and Defense Costs.

Chubb Executive Protection Policy, Employment Practices Liability Form, ¶16 (Form 14-02-0953 (Rev. 8/96)). See also AIG American International Companies Employment Practices Liability Insurance Policy, ¶2(l) (4/97)).

2. **Coverage for Wage-Hour Class Action Lawsuits**

Over the past few years, many purported class action lawsuits have been filed against employers regarding an alleged failure to pay overtime. Some of these lawsuits are premised on the federal Fair Labor Standards Act. Most are premised on state wage-hour laws that have a different method for determining when employees are exempt from overtime requirements. These lawsuits present a potential exposure of hundreds of thousands, or even tens of millions, of dollars for an employer. Protection for employers may be found in EPL insurance policies.

Many so-called “wage-hour” or “overtime” lawsuits contain allegations that may fall within the ambit of such terms. Even if there is a question as to whether a wage-hour lawsuit gives rise to coverage under one of the above provisions, there should be a strong argument that coverage is implicated in most wage-hour suits because of the very nature of the lawsuits. Many of these lawsuits allege that employers misclassified or improperly designated the status of their employees as “exempt” from overtime laws, failed to enforce adequate wage-hour policies, or coerced employees into working excessive hours. In fact, many “wage-and-hour” lawsuits allege that employees were told that they were “exempt” from overtime requirements when they were, in fact, not exempt.

Such allegations should constitute “misrepresentations” covered by an EPL policy. “Misrepresentation” has been defined as “[a]ny manifestation by words or other conduct by one person to another that, under the circumstances, amounts to an assertion not in accordance with the facts.” A.P. Landis, Inc. v. Mellinger, 175 A. 745, 746 (Pa. Super Ct. 1934); see also Webster’s New Collegiate Dictionary 724 (1980) (“misrepresent” defined as “to give a false or misleading representation of [usually] with an intent to deceive or be unfair”). A “misrepresentation” also can involve the concealment of the truth. United States v. Sterling Salt Co., 200 F. 593, 597 (D.N.Y. 1912). The Black’s Law Dictionary definition of “misrepresentation” shows the broad scope of the term:

> A misrepresentation, being a false assertion of fact, commonly takes the form of spoken or written words. Whether a statement is false depends on the meaning of the words in all the circumstances, including what may fairly be inferred from them. An assertion may also be inferred from conduct other than words. Concealments or even non-disclosure may have the effect of a misrepresentation . . . [A]n assertion need not be fraudulent to be a misrepresentation. Thus a statement intended to be truthful may be a misrepresentation because of ignorance or carelessness, as when the word “not” is inadvertently omitted or when inaccurate language is used.


Given this breadth, it is not surprising that courts have recognized that a misclassification of employees can constitute a “misrepresentation.” Thus, the term “misrepresentation” in an EPL policy reasonably can be interpreted to include a representation contrary to fact, or a concealment, relating to the nature of an employee’s job, such as whether the employee is “exempt” from overtime requirements.

Coverage also should be triggered when an EPL policy applies to claims for breaches of express
or implied contracts. Courts have recognized that employment contracts “must be held to . . . incorporate[] the provisions of existing law. Hence, upon violation of [a Labor Code] section, an employee has a right of action for damages for breach of his employment contract.” Lockheed Aircraft Corp. v. Super. Ct., 171 P.2d 21-25 (Cal. 1946). Therefore, because wage-hour actions often allege a failure to comply with state labor laws, such a claim may be a breach of implied contract covered by EPL provisions.

C. Errors and Omissions and Professional Liability Coverages

Errors and Omissions (“E&O”) coverage is intended to insure against liability arising out of an act, error, or omission of the named insured in rendering or failing to render services. Professional Liability Insurance is a form of E&O insurance designed to protect the professional activities of those who possess specialized knowledge and skills through special education and experience in a particular field. The professions that typically fall within this category are accountants, architects, attorneys, engineers, physicians, and veterinarians. This type of insurance often is referred to as malpractice insurance.

E&O policies, however, are not limited to those specialized professions. They can apply to “non-professionals” who require coverage for the mistakes they make that cause harm to others. Insurance agents, brokers, consultants, real estate agents, and stockbrokers are examples of individuals in less-specialized fields who often purchase E&O insurance. Indeed, any company that provides a service may seek to purchase E&O insurance.

Although E&O and Professional Liability policies used to be considered two separate lines of insurance, over time the distinctions have blurred. What is more common is for policy wording to be developed by each insurance company tailored for whatever business area the insurance company decides to underwrite. The form developed for each business area will tailor the terms and conditions to that business.

A few points are obvious from the standard insuring agreement. First, E&O coverage is sold on a claims-made basis. The Claim must be made against the insured and reported to the insurance company during the policy period. Second, defense costs (Claim Expenses) are within limits.

E&O policies cover only “Damages,” which usually are defined to exclude the return or reimbursement of fees, costs, and expenses to the Insured for Professional Services. Thus, if a client sues the policyholder for the return of fees, that lawsuit is not covered. If the client sues for damages, and the claim is settled by the return of fees, the insurance company may pay defense costs, but not the settlement amount. If the policyholder sues the client for non-payment of fees, and is met with a counterclaim based on the policyholder’s negligent performance of services, the defense of the counterclaim may not be covered.

The insuring provision may or may not require that the “act, error or omission” be “negligent.” Thus, intentional acts which lead to damages may be covered, provided they are not excluded elsewhere in the policy. It is also critical to check the definition of Professional Services in the policy. The policyholder must be careful to make sure that the definition is sufficient to cover the conduct that could give rise to a claim.

E&O policies typically contain many exclusions. Some of these exclusions are intended to exclude those liabilities that should be covered by the CGL policy. Obviously, it is important to verify that there are no gaps between the two lines of insurance, leaving areas of liability unprotected.
V. First-Party Policies

First-party policies are designed to provide insurance for a direct loss to the policyholder’s property. Examples of personal first-party policies include automobile and homeowners’ policies. Commercial first-party policies protect a business’ place of operations and inventory.

Traditionally, the issues under commercial first-party insurance were ones of quantification, and to a lesser extent, causation. Adjusters were, and to a great extent still are, the first professionals called when such a loss occurs. However, recent events, particularly the fear of Y2K losses, and the terrorist attacks of September 11, 2001, have given rise to an increase in litigation over the scope of first-party property coverage. Indeed, one of the most followed insurance coverage case in recent years involved first-party property coverage for the World Trade Center. World Trade Center Properties LLC v. Hartford Fire Insurance Co., 345 F.3d 154 (2d Cir. 2003).

The scope of loss caused by Hurricane Katrina presently is unknown. However, the financial damages are estimated to be in excess of $100 billion, with at least $25 billion covered by insurance. In addition to direct property damage, Katrina has resulted in loss from business closures of oil fields and refineries, stores and casinos. There have been extensive power losses, some of which are expected to last for weeks. Forced evacuation of directly affected areas, including the City of New Orleans, has been ordered by civil authorities. The states directly impacted include Alabama, Georgia, Mississippi and Louisiana, but the financial impact will spread beyond those states’ borders. For instance, farmers in the Midwest may have difficulty getting their crops to market because of the disruption of the Port of New Orleans. Moreover, the costs of relocation during the period of dislocation also may be covered by insurance as an expense incurred to mitigate loss. All of these circumstances will give rise to issues that will impact whether there is insurance coverage and, if so, the amount.

Insurance adjusters already are on the scene attempting to quantify the loss caused by Katrina. Given that many first-party property policies contain exclusions for flood damage, engineers will be needed to determine whether a particular loss was caused by flood, by hurricane winds, or by some other factor. Thus, the issue of causation will be a key factor in any insurance recovery. Other factual and legal issues raised by Katrina will be the subject of intense scrutiny during the coming months and may result in litigation over the next several years.

Basic issues surrounding first-party insurance are discussed below. However, a first-party policy is often a combination of various different but overlapping coverages, and with both common and distinct definitions, conditions and exclusions. Its application to any particular loss is very fact-intensive.

A. Property Policies

Commercial property insurance generally falls into one of two categories: “named perils” and “all risk.” Named-perils insurance covers losses to property, only if they result from one of the specific causes, or perils, listed in the policy. Typical named perils include fire, lightning, windstorms, and hail. All-risk insurance, on the other hand, covers losses from all causes, other than those expressly excluded. Courts are liberal in interpreting the losses that all-risk policies cover.191

1. What Type of Property Is Covered

First-party property policies generally provide insurance for “direct physical loss or damage to
property. Traditional losses under first-party property policies involve tangible property: buildings, machinery, or inventory. Such insurance generally is held to exclude losses that are intangible. Accordingly, claims alleging a harmful economic impact that does not arise out of physical injury to property generally will not result in coverage under a property policy. However, there are some cases that hold that if the property is rendered unusable, for instance through the presence of contaminants, recovery under a property policy may exist.

Assuming physical damage to property, the analysis is straightforward. Disputes arise primarily over issues of valuation. However, when the loss is of intangible property, such as information or computer software, a dispute may arise over the definition of property covered by the policy. This issue arose several years ago in the context of the concern over potential Y2K losses, and what type of property is covered. Although Y2K losses did not materialize, the dispute sparked a debate over whether the loss of or damage to intangible property is covered by insurance policies.

The simplest way to resolve this dispute is to explicitly provide for such coverage through an amendment to the policy. Some first-party property policies contain endorsements that specifically expand coverage to include loss of or damage to “electronic data processing or electronically controlled equipment” or “storage mediums,” “data stored on such medium,” or “records on mediums.” However, without these clarifications of coverage, the policyholder may be faced with the issue of whether the loss of information or software is insurable under its first-party property policy. This issue can arise both under first-party and third-party liability policies, and the analysis as to whether “property damage” includes intangible property is similar.

In Seagate Technology, Inc. v. St. Paul Fire & Marine Insurance Co., the insured manufactured allegedly defective disk drives, which were incorporated into the claimant’s computers, causing them to malfunction. The court held that the failure of the computers was not physical damage to tangible property and, thus, did not constitute “property damage” under the terms of the third-party liability insurance policy. Seagate based its reasoning upon the fact that the disk drives were not inherently dangerous products and, therefore, their failure did not cause physical property damage to the whole computer.

Two Minnesota cases also address whether lost data constitutes property damage under a general liability policy. In Retail Systems, Inc. v. CNA Insurance Cos., the policyholder lost a computer tape that contained its client’s data. The policyholder submitted the resulting claim to its insurance company, which denied coverage on the ground that the lost data was not property damage within the definition of the policy - physical damage to tangible property. The court ruled that because the data had been integrated into, and was located only on, the lost tape, there was “tangible property damage” under the policy.

In St. Paul Fire & Marine Insurance Co. v. National Computer Systems, Inc., the policyholder’s employees had taken proprietary data in binders from a previous employer when they changed jobs. The court found that there was no property damage, and no coverage.

Given the likely future magnitude of claims involving intangible property, these few cases are hardly indicative of how the law will evolve on the issue of whether lost information or the breakdown in a computer system constitutes property damage. In-house counsel should help risk managers evaluate the corporation’s insurance needs and, if necessary, obtain endorsements that expand the meaning of the term “property damage,” as used in the insurance policy.

2. Business Interruption Policy Issues

The area that has received the most recent attention under first-party policies is the coverage provided for Business Interruption claims, particularly Contingent Business Interruption claims.
Business interruption (“BI”) insurance most often is found not in a separate policy, but as an additional endorsement that supplements the policyholder’s first-party property insurance.

In general terms, the first-party property policy indemnifies the policyholder for the value of the covered property that has been lost or damaged. The BI coverage indemnifies the policyholder for the income that is lost when, as a result of the lost or damaged property, there is a disruption to the policyholder’s business. Recovery is limited to the income lost while the property is being repaired or replaced. Contingent Business Interruption (“CBI”) is the loss that results when loss or damage to the property of another causes an interruption in the policyholder’s business.

The aftermath of 9/11 has focused the attention of the business community on the availability and potential benefits of BI and CBI insurance. Zurich American Insurance Co. v. ABM Industries Inc., 397 F.3d 158 (2d Cir. 2005) is a recent case that arose out of the September 11th terrorist attack, and addresses the scope of business interruption and contingent business interruption insurance. The policyholder, ABM, provided janitorial, lighting, and engineering services at the World Trade Center. ABM serviced the common areas of the complex, had office space and storage space in the complex, and had access to janitorial closets and slop sinks located on every floor.

Its policy covered loss or damage to property “owned, controlled, used, leased or intended for use by” ABM (Insurable Interest provision). The policy provided BI insurance against “loss resulting directly from the necessary interruption of business caused by direct physical loss or damage, not otherwise excluded, to insured property at an insured location.” The policy also provided CBI insurance “due to the necessary interruption of business as a result of the direct physical loss or damage...to properties not operated by the Insured which...wholly or partially prevents any direct receiver of goods and/or services for the Insured from accepting the Insured’s goods and/or services.” The CBI coverage had a $10 million sublimit.

The District Court granted Zurich’s motion declaring that ABM was not entitled to BI insurance on the grounds that the common areas and tenants’ premises serviced by ABM, but not owned or leased by ABM, were not “Insured Property,” as that term was defined in the policy. The Second Circuit reversed, holding that ABM “used” the WTC in its business, thus creating an insurable interest in the property. 397 F.3d at 165-67. The court also held that, because ABM effectively operated the WTC, the CBI did apply. 397 F.2d 169-70.

Given the variations in the language in the basic insuring agreement, each BI claim can present its own set of issues. Whether or not there will be coverage for that claim will depend not only upon the underlying facts, but also upon the particular bundle of provisions and endorsements that make up the insuring agreement. However, the following five elements typically contribute to a business interruption claim:

(1) there must be a covered peril;
(2) the covered peril must result in a loss of covered property;
(3) the loss of covered property must result in an interruption of the policyholder’s business operations;
(4) the business interruption must result in a covered loss; and
(5) the covered loss must occur during the “period of restoration,” while the lost or damaged property is restored or replaced.

As should be evident from the above, it is not sufficient that the policyholder prove that the above elements are present. The policyholder also must prove a causal connection among those elements...
in order to recover on a business interruption claim.

a. Covered Peril

The policyholder must prove that the risk falls within the “peril” for which the insurance policy provides protection. If the insurance is provided under an “All Risk” policy, the insurance company will have the burden of showing that one or more of the exclusions applies.

For instance, after 9/11, there was significant discussion as to whether the “war risk” exclusion found in many first-party policies excluded the losses that resulted from the destruction of the World Trade Center. Insurance companies concluded that the terms of the “war risk” exclusion did not apply because the exclusion required that the act of war be committed by a hostile government. There is now a separate terrorist exclusion to insert into future “All Risk” policies, along with a separate “Named Peril” policy that provides coverage for a loss caused specifically by a terrorist act.

An example of coverage that has drawn particular attention since 9/11 is coverage that applies when ingress or egress to a business has been prohibited by a civil authority. This form of coverage can be found under “all risk” language or grafted onto a business interruption insurance policy through a separate endorsement. Thus, if a governmental entity orders an area closed, or otherwise denies access to the premises, the business interruption coverage could be triggered. Some of the civil authority or ingress/egress coverages still require physical damage to the premises of the policyholder or at adjacent locations, but others do not.

There are many other forms of “named peril” coverages that may be relevant to business interruption claims. For instance, there is “service interruption” coverage, which specifically indemnifies the policyholder for a loss to the policyholder’s business that results from an interruption of utility service such as electricity, gas, or sewer services, or telecommunications services. These “service interruption” policies also may be viewed as a form of “contingent business interruption” insurance.

b. Loss of Covered Property

“Covered Property” typically is defined to include all property at certain specified locations (or premises), or within a certain number of feet of the listed locations. For instance, typical “All Risk” policy language provides insurance “against all risks of direct physical loss or damage to the property described in Paragraph 1 from any external cause.”

The issue of the need to show actual physical damage to the policyholder’s property may be obviated if the policy contains “contingent business interruption” coverage. As already noted, CBI insurance explicitly covers the policyholder for losses that arise in its operations because of damage to the property of another business or individual upon which the policyholder depends. In the case of CBI coverage, the third-party property generally is referred to as “contributing” or “dependent” property.

Generally, the third-party property is specifically described on a schedule annexed to the policy.

“Dependent property” generally is limited to property at the following four types of businesses:

(1) a business that provides goods or services needed for the policyholder’s operations;

(2) a business that purchases the policyholder’s goods or services;
(3) a business that manufactures products that the policyholder sells; and

(4) a business that attracts customers to the policyholder’s business.

Some CBI policies can be broader in scope and can extend to the interruption of business “caused by damage to or destruction of real or personal property . . . of any supplier of goods or services which results in the inability of such supplier to supply an insured locations [sic].” For instance, in Archer-Daniels-Midland Co. v. Phoenix Assurance Co., the court held that there was CBI coverage when a flood of the Mississippi River disrupted transportation on the river, requiring the policyholder to obtain substitute transportation and supplies for its farm product manufacturing operation. However, when, as in Archer-Daniels-Midland, the policy contains the more generalized reference to “dependent property,” there is likely to be a dispute over whether the particular loss triggers coverage.

c. **Interruption of Policyholder’s Business Operations**

Demonstrating that the covered peril interrupted the policyholder’s business operations often presents two issues for resolution. The first issue is one of causation - did the damage to covered property actually cause the business interruption? The facts in Harry’s Cadillac-Pontiac-GMC Truck Co. v. Motors Insurance Corp. illustrate how this issue can arise. In Harry’s Cadillac, a snowstorm caused the roof of the automobile dealership to collapse. The storm also blocked access to the dealership for one week. The damage to the roof was covered by the first-party property policy. The dealership sought coverage for the week of lost sales under the business interruption provisions of the policy. The court held that the property damage, the collapsed roof, did not cause the lost sales. Rather, the lost sales were due solely to the storm. Accordingly, the court held that the policy did not cover the loss.

The second significant issue that arises in connection with this element is whether the level of interruption to the business has been sufficient under the policy language. Business interruption insurance commonly uses the phrase “necessary suspension of operations.” The issue is whether a significant slowdown in operations is sufficient, or whether the policy requires a total shutdown in operations. For instance, in Home Indemnity Co. v. Hyplains Beef, L.C., the court held that the “common understanding of the term ‘suspension’ [is] a temporary, but complete, cessation of activity.”

As a result, policyholders should submit their claims in a form that maximizes the chance of recovery. A “slowdown,” or a reduction in productivity, might accurately be described as a partial “shutdown” of some of the operations. Moreover, a policyholder has a duty to mitigate damages by resuming operations at the covered location or elsewhere. Performance of this duty to mitigate, by resuming some operations when possible, should not be used to void coverage.

d. **Covered Loss**

The policyholder must establish that, but for the suspension of its operations, it would have earned income. This element requires a showing not just that there were lost sales, but that those sales would have resulted in a profit. If the interruption is to an ongoing business, with a history of sales and profits, then the calculation of loss may be straightforward. However, the marketplace is not static. New products appear, demand for existing products changes, and the prices of materials fluctuate. The event that caused the loss (for instance, a natural disaster like a hurricane, or the 9/11 tragedy) may impact on the economy generally. The insurance company may use volatile economic factors to argue that the lost income under a business interruption
policy is much less than the policyholder contends. The problems of calculating lost income, a somewhat speculative activity, require the early intervention of an accounting expert.

A significant and common endorsement to business interruption coverage that will affect the scope of the insurable loss is “extra expense” coverage. This endorsement extends coverage to those expenses necessary to continue operating the business while the property is being repaired and the operations’ capacity is brought back to normal. The most obvious example of these mitigation costs would be the costs of renting alternative space.

e. Period of Restoration

The “period of restoration” is the period that it takes to repair the damaged property and return the business back to its normal level of operation. Generally, only losses incurred during the period of restoration are reimbursable under a business interruption policy.

Two issues often arise regarding calculation of the period of restoration. Property or premises destroyed often are not replaced as they were, but in a modernized or improved form. Thus, there often is a dispute over whether the actual time of restoration includes additional time to improve or modernize the facility. The insurance company will contend that some portion of the lost income is attributable to the additional time period and is not reimbursable.

The second issue arises when loss, otherwise covered by the policy, takes place after the period of restoration. For instance, if, during the period of restoration, the policyholder makes sales out of inventory, the depleted inventory may result in reduced sales after the period of restoration, when the business is operational. Courts have reached different results as to whether losses incurred in the post-restoration period are covered.

Some of these problems can be resolved through the purchase of an extended business interruption coverage. This provision allows coverage for losses that occur after the period of restoration. However, the losses still must be caused by the initial business interruption.

3. Specialized Types of First-Party Property Coverage

a. Computer Insurance

Businesses that rely heavily on computer software and data processing may purchase computer-related insurance that covers the widespread loss or corruption of their electronic data due to bugs or viruses. Computer equipment insurance provides all-risk coverage for direct physical damage to computer hardware, including repair, upgrade, and replacement costs. Certain types of computer insurance include coverage for damage to software. Other policies provide insurance for lost data, computer programs, and media. For purposes of this coverage, “data” is defined as “facts, concepts, or instructions in a form usable for communications, interpretation, or processing by automatic means”; whereas “media” coverage pays the cost of replacing or reproducing lost programs or data (unless backup files exist). Certain computer insurance policies even cover direct and consequential damage arising out of mechanical or electrical breakdown. These policies define electrical breakdown to include “any accidental erasure of data caused by electrical or magnetic injury, or operator or programmer error.”

Most of these policies exclude losses arising from “latent defects,” “programming errors,” or “design errors, faulty materials, or damage during service or repair, unless loss results from an otherwise covered peril.” Thus, the critical issue will be whether or not a particular bug is a “design
error,” “programming error,” or “latent defect.” Nonetheless, even if such coverage is excluded as a “latent defect” or “programming error,” or is not included in the policy, ensuing losses may be covered.

During the last decade, certain new insurance products have emerged to protect the insured from specialized computer-related perils. Generally, these specialized perils focus on two broad areas: (1) security of data, programs, and proprietary information; and (2) computer crime, including viruses, fraud, destruction, corruption, or extortion from threatened computer crime.

Computer information and data security policies insure against loss incurred because the insured utilized or relied upon programs or data which, unknown to the insured, were in fact fraudulent. To the extent that the insured transfers, pays, or delivers monies, securities, or property, or establishes credit, or gives any value as a result of the fraudulent input of electronic data into the insured’s computer system, the loss would be covered. Similarly, the policy covers such losses from the fraudulent preparation of electronic computer programs.

Although the coverages clearly overlap, computer crime policies extend to cover losses from an unauthorized intrusion, illegitimate or unauthorized use, viruses and other attacks on the system or Internet. Under these policies, computer crime includes intentional destruction or corruption of data and computer systems, and also extortion by means of a threat to cause injury to the computer system. Losses covered include the lost data, lost money, and lost securities, as well as other property. In the case of lost data, the policy covers the cost to restore, recover, or recreate such data. If the lost data cannot be restored, recovered, or recreated, the policy covers all costs incurred to make that determination.

b. “Sue and Labor” Coverage

In response to the potential damage from the Y2K bug, policyholders expended extraordinary sums to repair their systems, or replace defective system components. Traditional property insurance policies not only cover such preventive measures, but expect the policyholder to take such measures to avoid imminent loss. Recovery of expenses under “sue and labor” provisions has been one of the most actively litigated areas of insurance coverage for computer code defects.

Until recently, the sue and labor clause was considered an archaic policy provision not frequently discussed amongst insureds and insurance companies. However, this provision continues to be included in property policies today. The insurance essentially applies when policyholders spend money to protect otherwise covered property from damage or destruction by a covered peril. By encouraging policyholders to protect threatened property, insurance companies hope to protect themselves from the far greater liability they would incur under their policies, if the covered property were damaged or destroyed. For example, in the context of a hurricane threatening to destroy a policyholder’s place of business, the expenses incurred by the policyholder to place sandbags around the structure of the business should be covered as costs necessary to safeguard the business from destruction. Were the policyholder not to engage in these efforts, the insurance company could be obligated to pay for reconstruction for the building and replacement of its contents, rather than paying only for the cost of the sandbags.

It has been widely observed that the sue and labor clause is a separate contract of insurance. In White Star Steamship Co. v. North British & Mercantile Insurance Co., the court explained the supplementary and independent character of the sue and labor clause:

The law is well settled that the sue and labor clause is a separate insurance and is supplementary to the contract of the underwriter to pay a particular sum in respect to damage sustained by the
subject matter of the insurance. Its purpose is to encourage and bind the assured to take steps to prevent a threatened loss for which the underwriter would be liable if it occurred, and when a loss does occur, to take steps to diminish the amount of the loss. Under this clause, the assured recovers the whole of the sue and labor expense which he has incurred, subject to the expense having been proper and reasonable in amount under all the circumstances, and without regard to the amount of the loss or whether there has been a loss or whether there is salvage, and even though the underwriter may have paid a total loss under the main policy.

As a separate contract of insurance, the exclusions applicable to other coverages do not apply to prevent payment under the sue and labor provisions. Were it otherwise, the insured would be forced to act at its peril unless: (1) the loss was not totally averted; and (2) the peril giving rise to the loss, regardless of what was anticipated, must in fact be a covered peril. The only way for the “sue and labor” clause to work is as a separate coverage whose provisions are triggered by the reasonable anticipation of a potentially covered cause of loss.

In Witcher Construction Co. v. Saint Paul Fire & Marine Insurance Co., the court construed policy language that was similar to a “sue and labor clause.” The court found that the provision was a separate coverage, not subject to exclusions which, in effect, merely stated an implied duty to mitigate damage. The court emphasized that, as long as the steps are reasonable and calculated to mitigate, the insurance company should be held accountable for its share of such costs.

c. Fidelity Coverage

Financial institutions bonds and commercial fidelity insurance are purchased by employers to protect against loss arising out of the dishonesty of its employees. Often these policies contain a number of related coverages, such as forgery. Whether a person is an employee depends upon whether he or she is compensated in the form of wages or salary, and whether the individual is subject to the direction and control of the insured. Fidelity insurance generally does not extend to the dishonesty of independent contractors. The employee generally must act with an intent to benefit him or herself, or to cause the employer harm.

d. Other Forms of First-Party Property Coverage

Additional coverage often contained in a first-party property policy include: 1) “Extra Expense” coverage for the costs of running a business over and above the total cost in running the business if the loss or damage to property had not occurred; 2) Leader coverage - loss arising out of damage to property not owned or operated by the Insured, but in the same vicinity as the Insured, which attracts business to the Insured; and 3) Civil Authority coverage - for the loss that results when access to real or personal property is impaired by order or action of civil or military authority.

In addition, there are specific types of policies designed to cover a particular type of property, such as Boiler and Machinery insurance and Aircraft or Watercraft insurance. There also are several types of insurance designed to protect the property of the policyholder when it is in the hands of a third person, often in transit. These types of policies are sometimes referred to as “Inland Marine” policies. Marine insurance was the first type of insurance designed to protect goods in transit. However, this coverage ended when the ship landed. Inland Marine insurance was developed to protect goods while they continued their journey “inland,” thus, the generic reference to “Inland Marine” for transit insurance.
VI. What To Do When a Claim Comes in

A. Before a Claim Comes in, Gather and Maintain Policies

Even before a claim is made, in-house counsel should review the corporation’s document retention policy to make sure that it requires the preservation of all insurance policies. As already discussed, occurrence CGL policies sold decades ago can provide valuable insurance for “long tail claims” where the bodily injury or property damage is the result of a process that did not manifest or become discoverable until years after the initial exposure. Policies sold 20 or 30 years ago may apply to a claim that is made against the corporation tomorrow, and may be worth tens or hundreds of millions of dollars.218

In-house counsel should gather the historical record on insurance purchased by the company by reviewing documents in files, contacting insurance brokers historically used by the company, and exploring any registry that might be helpful. Acquisition or Merger documents also should be reviewed, since they often recite insurance that was available at the time of the corporate transaction. There are professional “insurance archeologists” that can help with reconstructing a historical picture of the insurance available to the policyholder. Once the material is gathered, the corporation should consider creating a coverage chart, which provides a visual picture of the company’s historical insurance assets.

B. Which Insurance Companies To Notify

One of the most important contributions that inside counsel can make in the area of insurance is to guarantee that notice of a loss, claim, or occurrence is prompt and otherwise meets the requirements of the insurance policy. The first step is to determine which types of insurance might be triggered by a claim or a loss, and which insurance companies within an insurance program should be noticed.

A single event can trigger several types of coverage. An explosion at a plant may involve first-party property, business interruption, and Workers’ Compensation insurance. The explosion may also damage third-party property or cause inhalation claims by neighbors, thus triggering general liability coverage. A product defect could cause third-party claims, triggering general liability policies, but also lead to a drop in stock values and securities claims, triggering D&O coverage. If the stock is held by the company’s pension fund, the drop in stock value could lead to claims under the Fiduciary Liability policy.

Policies written on a claims-made basis can provide their own set of issues. Particularly in the area of product liability, if notice of a claim already has been sent under a previous policy, the policyholder may have to decide whether a new claim arises out of related “wrongful acts” so that the second claim should be covered by the policy in the previous year because it is related to the first claim, or whether notice should be given under the policies currently on the risk. Attention also must be given to the amount of the potential exposure and whether excess insurance companies should be notified.

The general rule is that notices should be given under all possible policies that might be triggered - regardless of type, year, or layer.
C. Prompt Notice of a Claim, an Occurrence or a Loss

Regardless of what type of insurance policy is at issue, a policyholder should provide prompt notice as soon as it learns of a claim or loss, or an occurrence that might give rise to a claim or a loss potentially covered by the policy. Unfortunately, it is all too common for policyholders to be late in giving notice. This delay may provide the insurance company the ability to deny coverage. If inside counsel work properly with Risk Management, the insurance companies can be denied the opportunity to raise this common defense.

The consequences of late notice differ, depending upon the type of policy and the jurisdiction. In many jurisdictions, the insurance company has the burden to show that it was prejudiced as a result of late notice under occurrence-based policies. For instance, it must show that evidence was lost, or there were steps that it would have taken to reduce the exposure, had it been given notice of the claim earlier. In other jurisdictions, the policyholder has the burden of showing that the insurance company was not prejudiced. In New York, it may not matter whether or not the insurance company was prejudiced. Late notice alone can result in a loss of insurance.

The notice provisions in insurance policies also may provide specific guidelines as to how, and in what form, notice should be given. E.g., Resolution Trust Corp. v. Artley, 24 F.3d 1363, 1367-68 (11th Cir. 1994). The policies typically identify to whom notice should be addressed, and request a statement regarding all the particulars of the underlying claims.

Insurance companies have argued, and some courts have held, that notice was not adequate when it did not conform to the specific requirements in the policy. For instance, if the notice of possible claims were in materials submitted with a policy’s renewal application, that may be insufficient. E.g., FDIC v. Mijalis, 15 F.3d 1314, 1333-37; (5th Cir. 1994); LaForge v. Am. Cas. Co., 37 F.3d 580, 583 (10th Cir. 1994); Am. Cas. Co. v. Continisio, 17 F.3d 62, 69 (3d Cir. 1994); Am. Cas. Co. v. RTC, 845 F. Supp. 318, 322 (D. Md. 1993). One court also has held that even when the insurance company might be aware of claims because of submissions made by the policyholder during the policy period, the policyholder nonetheless must provide the notice as required under the insurance policy. E.g., FDIC v. Booth, 82 F.3d 670, 676-77 (5th Cir. 1996) (transmittal of general financial and regulatory material from FDIC to the insurance company during time of coverage did not constitute notice of a claim against bank directors for breach of duty in managing loans).

Every form of insurance requires that notice be given promptly, but with claims-made and reported coverages, such as policies intended to protect the Directors and Officers, prompt notice is more than a condition of the contract. A claims-made policy typically will provide, as part of the insuring agreement, that the policy applies only to claims made against the policyholder and reported to the insurance company during the policy period. D&O policies also generally state that written notice should be given “as soon as practicable” or when the policyholder becomes “aware of any circumstances which may reasonably be expected to give rise to a claim being made [against the policyholder].” Notice beyond the policy period is generally fatal to claims-made coverage, regardless of the jurisdiction.

Several courts have found that the purpose of notice in a claims-made policy is not merely to prevent prejudice to the insurance company and that, therefore, late notice under such policies will void coverage even without a showing that the insurance company has been prejudiced. A recent and thorough discussion of the importance of prompt notice in the context of a claims-made policy can be found in Root v. American Equity Specialty Insurance Co., G033818 (Cal. Ct. June 28, 2005). In Root, the policyholder, an attorney, received a telephone call from a legal publication asking about his reaction to a malpractice claim that allegedly had been filed against him. Root thought the call was a possible prank and left the next day, Saturday, February 27th, for a long weekend. His claims-made malpractice policy expired on February 28th. Root
returned to his office on Tuesday, March 2nd, read an article about the malpractice claim and notified his malpractice carrier the same day. The insurance company denied coverage because the claim had not been reported during the policy period. In the subsequent coverage action, the insurance company won summary judgment in the trial court.

On appeal, the court discussed at length the history of claims-made coverage, and the reasons why the notice/prejudice rule applicable to occurrence policies did not apply.\(^\text{223}\) The court ultimately reversed, holding that, under the facts in this case, the reporting requirement could be equitably excused. Op. at 2. The court specifically cited the refusal of the insurance company to offer an extended reporting period to the policyholder. Such an endorsement usually provides an extra 60 days in which a policyholder can report a claim after the policy period has expired.

Where underlying liability is uncertain or appears to be minimal, some policyholders may delay giving notice, fearing that the insurance company will raise their premium at renewal, or refuse to renew altogether. However, by waiting, policyholders open themselves up to insurance company defenses of late notice if litigation later ensues. As a general rule, the policyholder should send notice as soon as becoming aware of an underlying problem or claim that may require insurance coverage, and especially before taking any remedial steps that insurance companies later could argue impeded their ability to investigate the underlying claim adequately. If the policyholder is at the point where it is asking whether notice should be given, the answer is yes.

First-party property policies contain additional “notice-like” requirements. Such policies typically will require that the policyholder file a “proof of loss” within a set period after discovery of the loss. The late filing of a “proof of loss” in a property policy may defeat coverage. While insurance companies may agree to waive proof-of-loss requirements in connection with widespread losses from a common cause, such as the September 11 attacks, or may agree to extend the filing period, a policyholder must get any extension agreement in writing.

D. Presentation of a Claim or Loss in a Manner That Will Maximize Coverage

After a loss or claim has occurred, the attorney should assist the risk manager in presenting the claim in a way that will maximize coverage. This Primer has addressed a number of issues, such as trigger of coverage, number of occurrences, and allocation, that can significantly affect the existence or amount of recovery under a policy. Moreover, certain causes of loss or liability may be excluded from coverage, while others are not. These are not simple issues and require a level of legal sophistication to be understood and applied to the facts of a particular case. Resolution may depend not only on the law of a particular state that will be applied, and the facts presented by a claim, but also on the way in which the facts are developed in the underlying action, and presented to the insurance company or, ultimately, to a court, if insurance litigation is necessary. A lawyer is needed to analyze how the resolution of these issues will impact on the policyholder’s insurance recovery, and to help the company describe its claim in a way that will maximize its protection under the insurance program in light of the coverage issues.

The original notice letter may be responded to with a request for information. Such requests may seek to have the policyholder characterize its claim in a way that will limit coverage. Before the policyholder engages in any such exchange with its insurance company, the policyholder should know what legal issues are likely to arise, and how best to describe its claim so as to maximize coverage.
E. Response to an Insurance Company’s Denial of Coverage or Reservation of Rights Letter

An insurance company must eventually respond to notice with a statement of its coverage position. A denial letter simply states the insurance companies’ position that there is no insurance for the submitted claim. As already mentioned, a reservation of rights (“ROR”) letter is sent when the insurance company believes that it has a defense obligation, but does not want to waive its rights to later deny coverage if the facts in the underlying claim eventually establish that no coverage exists. To preserve its rights, the insurance company in its ROR letter is required to state each and every basis on which it believes that there might not be coverage.

Such letters are common and are often misconstrued as a denial of coverage and the end of the insurance discussion. Rather, ROR letters should be viewed as the first step in recovery under an insurance policy. They assist in defining the issues on which the policyholder must focus in order to obtain insurance for the claim. At the very least, an ROR or a denial letter should be responded to with a simple “The Company does not agree with the positions on insurance coverage expressed in your letter of X date.”

What the company decides to do next depends upon the size of the potential liability and the basis on which the insurance company has denied or reserved its rights. Some coverage disputes can be resolved by showing the insurance company that its assumption of facts or the law is incorrect. However, if the potential liability is large, it is highly likely that the matter will not be resolved without mediation, arbitration, or litigation.

As can be seen by the earlier discussion of issues in this Primer, the law with respect to many insurance issues varies by jurisdiction. The jurisdiction in which a coverage action is filed may impact on what law is applied. Many insurance companies know this and, therefore, when a coverage dispute is presented that has a potentially large exposure, the insurance company may bring a declaratory judgment action against its policyholder in a jurisdiction that is favorable to the insurance company. Thus, it is important for in-house counsel to assess the possibility that the policyholder might be sued by its insurance company. If that possibility exists, then the company should either file first in a favorable jurisdiction, have a complaint drafted so that it can file immediately if it is “jumped” by its insurance company (that is, sued in a jurisdiction with less favorable law), or enter into a stay agreement with its insurance company providing that both sides agree not to file while the parties seek to resolve their differences.

F. The Policyholder’s Duty To Cooperate

A policyholder has an obligation to cooperate in the defense of the underlying claim. Cooperation clauses were historically interpreted to mean that the policyholder had to provide information to the insurance company about the alleged occurrence by making underlying documents available, agreeing to be interviewed, and appearing at depositions and trial. In other words, to cooperate in the insurance company’s defense of the claim. There should be no objection to this form of cooperation, and the policyholder should comply with these types of requests.

Even when the insurance company is not actively participating in the defense, it still has legitimate reasons for asking for information. It needs to set appropriate reserves and keep its reinsurers informed of potential liability. It could, although it rarely does, provide assistance in the defense of the claims. Moreover, if the policyholder ever hopes to bring the insurance company into a settlement of the underlying claims, or to resolve the insurance dispute, it needs to keep the insurance company informed. Finally, a policyholder does not want to give its
Accordingly, the policyholder should comply with the insurance company’s reasonable request for public information, or for documents that have been disclosed to the underlying claimants. Failure to provide this type of information to the insurance company can lead to a loss of coverage.

Counsel, however, must make sure that the insurance company does not abuse the cooperation clause by turning it into a sword to use against its policyholder in the dispute over coverage. Insurance companies may use the cooperation provision to try to compel the policyholder to produce material related to areas on which they denied insurance or reserved their rights. This is a misuse of the cooperation clause, creates a conflict of interest between the insurance company and the policyholder, and should be opposed. Where there is a conflict between the interests of the policyholder and those of its insurance company with respect to the defense of the underlying claims, a policyholder should resist providing the insurance company with privileged and work product information that relate to the disputed coverage issues.

 Disclosure of attorney-client or work product documents that may contain defense counsel’s analysis of issues in the case, particularly if it also relates to an uncovered claim or an area of dispute in the coverage case, also could result in a finding that the policyholder has waived the attorney-client privilege.

There are many practical solutions to these problems that have been agreed to by insurance companies. At a minimum, the disclosures should be made pursuant to a confidentiality agreement. If possible, that confidentiality agreement should be “so ordered” by a court, and provide that the disclosure does not affect a broader waiver of the attorney-client or work product privileges. The confidentiality agreement and order also should provide that the documents are to be used by the insurance company solely for purposes of assisting in the defense of the underlying case, setting reserves, and keeping reinsurance companies informed, and not against the policyholder in the insurance dispute.

Some insurance companies maintain a wall between those persons designated to assist in the defense of the case and those that handle the coverage dispute. In such a case, the insurance company should agree that the confidential information will not be viewed by those persons involved in the insurance coverage dispute.

Instead of the disclosure of sensitive documents, the insurance companies may be satisfied by meetings with defense counsel. In such situations, the defense counsel can be asked not to discuss areas related to disputed insurance issues. In-house counsel or outside coverage counsel should attend those meetings to further guarantee that the insurance companies do not misuse the cooperation clause to obtain information for use against the policyholder.

**G. Selection of Defense Counsel**

The insurance company’s duty to defend under a liability policy generally gives it the right and obligation to select defense counsel, provided that it has not reserved its rights. Even if some policies do not contain a duty to defend, the policyholder may have to select defense counsel from a panel approved by the insurance company, or the insurance company may reserve the right to approve defense counsel selected by the policyholder. If the policyholder knows at the time of purchase that it is likely to want to use a particular counsel, it should add an endorsement to the policy allowing it to make that selection.
The defense mounted by the insurance company may be perfectly appropriate for the circumstances. However, the policyholder should resist the inclination to assume that if the insurance company has accepted the defense “everything is under control.” In-house counsel should receive status reports regularly, as well as copies of all pleadings, discovery demands, and correspondence with the underlying plaintiffs’ counsel. The policyholder also should receive copies of all communications defense counsel have with the insurance company regarding the matter. If the stakes are high enough, the policyholder may consider employing “shadow counsel,” a separate law firm that can monitor the conduct of defense counsel and warn the policyholder if it appears that the defense is being adversely affected by the insurance company’s protection of its own interests.

If there is a conflict between the interests of the insurance company and the policyholder in the defense of the claim, and the policyholder has not contractually secured the right to control the defense in the policy or the claims-handling agreement, the policyholder still may be able to control the defense, and select defense counsel, under the law that exists in most jurisdictions.

Separate from any dispute over the policyholder’s right to select defense counsel, the insurance company may contend that the defense costs incurred by counsel selected by the policyholder are not “reasonable and necessary.” As part of the claims-handling agreement, the policyholder should seek the insurance company’s consent that non-disputed items will be paid immediately, so that the dispute over the reasonableness of some fees will not be used as an excuse to withhold payment on the entire bill. Moreover, the parties should agree to a mechanism to resolve fee disputes promptly, such as through submission to a third-party arbitrator.

Many defense counsel are used to complying with insurance companies’ claims handling and billing guidelines. In-house counsel should determine the familiarity of defense counsel with those guidelines when defense counsel is hired, and monitor defense counsel to make sure that counsel comply with those guidelines.

H. Protecting Your Liability Insurance Assets When You Settle the Underlying Claim

Policyholders always should keep their insurance companies notified of settlement negotiations and invite them to participate. If there is a hearing to approve a settlement, such as when the underlying case is a class action, the insurance company must be notified in sufficient time to attend and to voice any objection. The policyholder also should be mindful that the documents generated in connection with an underlying settlement, to the extent they describe the nature of the claim being settled, should be reviewed by insurance coverage counsel so that coverage for the underlying claim and, thus, the settlement, is not adversely affected.

The reasons for keeping the insurance company informed are three-fold. First, policies generally give the insurance company a right to participate in settlement negotiations and, ultimately, to approve settlement. Failure to provide insurance companies with the opportunity to exercise that contractual right may lead to a loss of insurance. Second, the insurance companies may be helpful in the settlement negotiations, particularly in these days of structured settlements.

Third, notice and the opportunity to participate in settlement discussions prevents the insurance company from later claiming that the settlement was voluntary or unreasonable. The insurance company is not likely to object to the terms of the settlement at the time it is being negotiated. The most common insurance company response to a notice of a settlement meeting or a proposed settlement is either silence or advice to the policyholder that it should do what it believes is appropriate. Most courts will hold that, in those circumstances, the insurance company has waived the right to later object to the reasonableness of the settlement.
VII. Dispute Resolution

A. Dispute Resolution Provisions in Insurance Policies

It is common for insurance companies to try to limit the dispute resolution options available to policyholders by inserting various provisions in an insurance policy that require arbitration, select a venue, or select the appropriate law to be applied. When possible, these efforts should be resisted.

Arbitration, generally, is not a favorable forum for policyholders. The pro-policyholder rules of policy interpretation, and the option of raising a bad faith claim, generally, are less available in arbitration. A jury is generally a more favorable fact-finder for a policyholder than an arbitrator. The belief that arbitrations are a more expeditious and less costly alternative to litigation is not always well deserved, and is totally inaccurate if the requirement is arbitration in London, a favorite venue for many insurance companies, particularly those in the London, European, or Bermuda markets. Similarly, insurance companies often suggest a choice-of-law provision designating New York or English law. Those jurisdictions have law that is favorable to insurance companies.

Policyholders are better off if the policy is silent on these issues. If and when a dispute arises, a policyholder can always agree to arbitrate if it feels that is desirable under the circumstances. Policyholders should not give up their right to bring an action in the jurisdiction of their choice, subject to applicable jurisdictional and venue requirements. At that point, each side can argue what law should govern the insurance claim.

B. Bringing an Action Against the Insurance Company

The law with respect to the issues surrounding a policyholder’s right to insurance varies by jurisdiction. Although it should not matter in what jurisdiction an action is filed, it does. A court is most likely to apply, or be influenced by, the laws of the forum. Accordingly, the forum in which the insurance coverage action is filed can be outcome-determinative. Therefore, if a dispute arises with an insurance company, the first step is to identify the key legal issues that will arise and research the law in the various possible jurisdictions to determine which forum is most favorable to the policyholder.

The insurance company will be doing the same analysis. If there is a significant difference in the law of the potentially applicable jurisdictions, some insurance companies, part of whose business is litigation, will file a preemptive law suit against the policyholder, seeking a declaration of no coverage. Accordingly, the policyholder may want to consider filing a coverage action first in the appropriate forum, or have a complaint ready to file in case the insurance company commences an action, making both actions essentially simultaneous. In that case, the first round of motions will concern transfer, dismissal, or stay on the grounds of forum non conveniens.

An alternative is to negotiate a standstill agreement with the insurance company, whereby both sides agree not to file a lawsuit during settlement discussions. Since merely asking an insurance company for a standstill agreement can trigger the filing of a lawsuit, it is possible for outside counsel to contact the insurance company on behalf of a non-disclosed policyholder client and obtain a standstill agreement without revealing the client’s name. Once the standstill agreement is in place, the policyholder is protected and settlement discussions can take place without fear of being sued.
C. Litigation, Mediation, or Arbitration with the Insurance Company

Although litigation with the insurance company is not an option that most policyholders like, it may be the only way to protect a policyholder’s rights. Trying an insurance coverage case requires the same skills as trying any other civil matter. However, a few items are worth noting:

Always ask for, and try to obtain at the earliest possible date, a jury trial.

- Be a plaintiff’s lawyer, not a defense lawyer. Corporate policyholders are used to being defendants. By disposition and habit, they bring their desire for delay to insurance coverage litigation. Change your posture. Be aggressive. Move the case. Get a firm trial date from the judge as soon as possible, and do not, through a delay in discovery, give the insurance companies an excuse to delay the trial.
- Try the insurance case, not the underlying liability case. The tactic of the insurance company is to put its policyholder on trial, and seek to prove that its policyholder acted maliciously, intentionally, fraudulently or whatever standard of conduct will exclude coverage. The policyholder must focus on the insurance company’s promise to pay, and its wrongful refusal to do so. Do not let the jury’s attention be distracted from the insurance company’s conduct.
- The insurance company has a fiduciary duty to its policyholder; it has a duty to act in good faith, to look for coverage, rather than look for ways to avoid coverage. More than likely, if a need for litigation has arisen, the insurance company has failed in these duties. Become familiar with the state’s unfair claims handling statutes and regulations, and the other statutory and industry guidelines that articulate the standards insurance companies are supposed to meet in handling a claim. Hold the insurance company to those standards in prosecuting your case.
- Become familiar with the state’s bad faith law and use it when appropriate.
- Keep it simple. Juries can understand that your client paid money in return only for the insurance company’s promise that it would defend and protect their policyholder when a claim is made. Emphasize the special nature of the insurance relationship. Unlike other transactions, where you get a product or immediate service, when a policyholder pays a premium, all it gets is a promise. When the policyholder needs that insurance company to keep its promise, the insurance company may run “for cover, rather than coverage” or, worse, turn on its policyholder and open a second front at a time when its policyholder needs help.
- Insurance companies say the darnedest things. Check their website, where they promote their efficient and fair claims handling (for everyone, it seems, except you). Check their Form 10-K and other filings to find out what they are telling regulators about claims against them by other policyholders like you.
- As a general matter, if the underlying case is still pending, try to stay the coverage litigation with respect to a determination of indemnity until the underlying case is resolved. It is difficult to fight a battle on two fronts at the same time.
- If the insurance company has a duty to defend (or to reimburse for defense costs) move early for summary judgment on the duty to defend. On that motion, the insurance company has the heavy burden to prove that there is no possibility of coverage.
- Mediation is merely a structured settlement negotiation with a third-party mediator serving as a go-between. Many courts require mediation, with mediators appointed by the court. There also are numerous private organizations which supply mediators, who often are retired judges.
- Mediation is not, necessarily, an alternative to litigation, but is a method of dispute resolution that may be run in conjunction with litigation. It will be effective only if both sides want to settle. It also can be particularly helpful if the problem on one or both sides is the adversary posture or even antagonism between counsel. Mediations also can be helpful if the realities of each side’s strengths and weaknesses are not reaching the client(s) because they are being filtered by counsel. Principals, who generally must be present at the mediation, may be able to find a business resolution of the dispute when litigation counsel cannot. Even if the mediation...
does not result in a settlement, the process can be a useful mechanism to learn the strengths and weaknesses of the other side’s case.

- Arbitration is a form of private litigation, a trial outside of the public court system. Discovery and the rules of evidence may or may not be available, depending upon the agreement of the parties. A key factor is the selection of the arbitrator(s). Some organizations, like the American Arbitration Association, will appoint an arbitrator or, what is preferable, the parties can agree upon their own. One common practice is for each side to pick an arbitrator (the “Party Arbitrators”), and for the Party Arbitrators to pick a third neutral arbitrator.

As previously mentioned, in the insurance coverage context, arbitration often is not the quick and inexpensive method of dispute resolution that it is reputed to be. The negotiations with respect to the procedure to be used in the arbitration, and the selection of the arbitrator(s), can be time-consuming. Because the arbitration sessions must accommodate the schedule of the parties, witnesses, and arbitrators, an arbitration often takes place over many months, if not years, with the trial days not consecutive. Once the arbitrators reach a decision, it is generally final, and cannot be challenged or appealed, except on very limited grounds, such as fraud.

D. Settling with Your Insurance Company

An insurance settlement can take many forms. There are at least three general categories. First, a settlement can be limited to an individual claim for a fixed amount, either with a single payment by the insurance company or a structured payment over time. Such a settlement does not affect the availability of the policy(ies) for other claims, except through the reduction in limits and a release of the specific claim. Such settlements are common with claims-made coverages. By the time of settlement negotiations, the policy period is usually over, so there is little risk that unknown, future claims covered by the policy would arise.

Second, a settlement can result in a full or partial buyout of the policy(ies), where the policyholder gives up the right to submit all or a defined set of future claims under the settled coverage. Such buyouts often are limited to a certain type of coverage provided by the policy(ies). For instance, such buyouts can exhaust only the bodily injury coverage, or the product liability coverage. Such partial buyouts are particularly common in settlements under general liability policies, which often contain many types of coverage with separate limits (e.g., product liability, premises operations, completed operations).

If the parties are unable to agree to the amount of the settlement, sometimes they can agree to a coverage-in-place agreement. This third type of settlement is particularly applicable to occurrence policies that provide insurance for repeated types of claims (e.g., asbestos, product liability claims). In such a settlement, the insurance company agrees to accept coverage for a defined set of claims, but will do so based upon a reduced percentage of the liability or under reduced limits.

There are numerous variations in the above three general categories. However, in negotiating with insurance companies, it is helpful to know what kinds of settlements a particular insurance company has agreed to in the past. It also is necessary to be aware of a number of side issues that are important to the settlement. For instance, although an insurance company will require a release from the policyholder, the policyholder also should require a release from an insurance company. This will prevent the unfortunate surprise which may occur when an insurance company tries to bill back to the policyholder a portion of the settlement as a deductible or retrospective premium.
Assignment of the loss is another issue that policyholders often overlook. In the situation where the settlement affects multiple policies sold by the same insurance company, the policyholder may have an interest in deciding to what policy, or to what types of coverage, the loss is assigned. This impacts on exhaustion and is particularly important if the policy remains available for other claims.

Insurance companies also will want the policyholder to indemnify them for any claims arising out of the settled loss. If policyholders cannot prevent such a provision they should be careful to limit any such indemnity as much as possible. For instance, the indemnity should be limited to only: 1) direct action claims by underlying claimants; and 2) claims or cross-claims for contribution by other specific insurance companies on the policyholder’s program. The indemnity should be further limited to claims arising out of the subject of the settlement. The indemnity provisions also should include, if possible:

1. A limitation of the policyholder’s indemnification obligation to a dollar amount, often the amount that the insurance company pays in settlement.

2. Exclusions to the indemnity provision, including: Claims of bad faith against the settling insurance company, or claims for punitive or exemplary damages, fines, sanctions, and similar awards.

3. Exclusions for claims relating to disputes with the settling insurance companies’ reinsurance companies.

4. The Settlement Agreement should provide that any claim for which indemnity is not specifically granted should be excluded.

5. The conditions governing defense of indemnity claims should be spelled out. A settling policyholder will want the same type of terms that an insurance company requires in an insurance policy with respect to a claim covered by the indemnity, such as: notice, cooperation, the right to control or participate in the defense, the selection or approval of counsel, and consent to settlement.

Once a settlement is reached, and the settlement price agreed to, the insurance company will draft the papers to make the settlement as broad as possible. Similarly, the policyholder should seek to narrow the scope of the settlement. Following are a few additional matters that should be considered:

1. Limit the definition of the parties to the Agreement. Insurance companies often will seek to broaden those definitions to all affiliates. A policyholder who is not careful may inadvertently release policies sold by an affiliate of the settling insurance company, or release policies purchased from the settling insurance company by one of its subsidiaries.

2. Limit the definition of policies being released. Consistent with the concerns expressed above, it is prudent to have the settlement cover only the policies listed on an exhibit to the settlement, not all policies sold by the insurance company or its affiliates. A less desirable alternative is to have the insurance company warrant that it knows only of the policies listed on an exhibit to the agreement as the subject of the settlement.

3. Narrow the definition of the type of claims being released. Generally, “released claims” should be limited to the specific claims noticed to the insurance company, or to the underlying claims at issue in the coverage action. To eliminate ambiguity, a
policyholder may want to specify in an appendix what claims, or types of claims, are not being released.

4. The release, which runs in favor of the policyholder, should be broad enough to include any claim brought by the settling insurance company, or its affiliates, for: additional premiums, such as retrospective premiums; reimbursement of deductibles or self-insured retentions; any reinsurance obligations; liability for misrepresentation or material omissions in the underwriting; and liability for reverse bad faith, improper claims handling, or fraud.

5. Be specific on the time, place, and manner of the settling insurance company's payment.

6. If the insurance company is required to make payments over time, yet requires dismissal of the coverage action before all payments are made, the policyholder should request that the terms of the settlement be incorporated into a consent judgment.

7. The settling insurance company should waive its right of contribution, indemnity, and subrogation with respect to the monies it has paid in settlement, particularly its claim against other insurance companies that sold insurance to the policyholder. The settling insurance company also should give a warranty that it has not already transferred its rights of contribution, indemnity and subrogation.

8. Both sides may want confidentiality, but the insurance company probably will want it more. The Settlement Agreement must allow the policyholder to disclose the settlements to its accountants and to regulatory authorities, such as the SEC. The policyholder may want to specifically prohibit the insurance company from disclosing the amount of the settlement to other insurance companies with whom the policyholder seeks to settle.

9. Settlement with the London Market, both Underwriters at Lloyd’s and London Market Companies, has its own set of issues, given the manner in which their policies are subscribed to by multiple syndicates and companies. Hiring a specialist in such settlements, who is familiar with the workings of the London Market is recommend-

E. Impact of Settlement on the Claims Against Other Insurance Policies

As already discussed, a single claim can trigger: 1) various layers of insurance, if the amount of the claim exceeds the limits of the primary insurance company; 2) concurrent policies, if more than one type of insurance, or more than one line of insurance, is implicated; or 3) consecutive policies spanning several years. A settlement of one policy, or with one insurance company, will give rise to issues regarding the policyholder’s ability to access other triggered policies.

1. Impact on Excess Policies

Most settlements are for less than the limits of that policy. This gives rise to the claim by excess policies that the settled underlying policies have not been properly exhausted and, therefore, the excess policies never will have to pay. The law in most jurisdictions is that an excess insurance
A policyholder's duty to indemnify the policyholder for an otherwise covered loss arises when that covered loss exceeds the underlying limits, regardless of whether the primary insurance company has actually paid its entire limits toward the claim. Such a rule would deter settlements which, almost by definition, are below limits. Insurance companies have a legitimate interest in not being required to pay for indemnity that does not reach the attachment point of their policies. They have no legitimate interest in how those underlying limits are exhausted.

2. **Impact on Consecutive or Concurrent Policies**

When there are many policies that respond to a loss, and that provide concurrent or consecutive coverage, a settlement with one insurance company can impact recovery against the others. The non-settling insurance companies likely will argue that they are entitled to either contribution from the settling insurance company or a set-off from their liability equal to an amount of the settling insurance companies' allocated share. For instance, if 10 years of CGL coverage are triggered for a $100 million environmental loss, and the policyholder settles for $2 million with the insurance company that sold one year of insurance, the non-settling insurance companies will contend either: 1) that they have an $8 million contribution against the settling insurance company (which probably must be indemnified by the policyholder as part of its settlement agreement), or 2) that the claim against the non-settling insurance companies must be reduced by the settling insurance companies' $10 million share, not the $2 million that the policyholder actually received in settlement. Non-settling insurance companies will rely, primarily, on Koppers Co. v. Aetna Casualty & Surety Co., 98 F.3d 1440 (3d Cir. 1996), but also may cite Olin Corp. v. Insurance Co. of North America, 221 F.3d 307 (2d Cir. 2000), and Keene Corp. v. Insurance Co. of North America, 667 F.2d 1034 (D.D.C. 1981) in support of their contribution and set-off claims. The situation usually is complicated by the fact that most settlements in complex coverage disputes are not for an isolated claim, but are in the form of buyouts where the settlement payment is for the release of several known, but also other unknown, future claims.

In jurisdictions that have imposed liability on an insurance company based upon an “all sums” or “joint and several” method of allocation, any right to contribution or a set-off or credit against monies owed to the policyholder should be limited to the extent necessary to prevent the policyholder from recovering more than its total loss. In the above example, a set-off would be allowed only for the $2 million actually received by the policyholder, provided that the $2 million was in settlement of the disputed claim, as opposed to additional or future claims.

First, public policy in all jurisdictions favors settlement and repose, and disfavors continuation of the coverage dispute through contribution claims against insurance companies who have reached earlier settlements. Second, true “all sums” allocation, which does not allocate damages to an insured for periods where no collectible insurance is available, should preclude the insurance companies from shifting responsibility through contribution claims to policies that have been extinguished through settlement, or back to the policyholder through set-off. Third, both parties to a settlement, both the policyholder and settling insurance company, want finality. That finality cannot be achieved if either the policyholder or settling insurance companies are forced to submit to subsequent litigation with the non-settling insurance company regarding the settlement.

Case law supports finality and rejects the reallocation efforts of the non-settling insurance companies. In Eli Lilly & Co. v. Aetna Casualty & Surety Co., No. 49D12 0102 CP 000243 (Ind. Super. Ct. Marion County July 15, 2002), the policyholder facing an environmental liability settled with some, but not all, of its insurance companies. In the insurance coverage action, when faced with the non-settling insurance companies’ argument regarding reallocation to other years of coverage, the court phrased the issue as follows: “can [Lexington] by a contribution action against settling insurance companies obtain ‘pro rata’ reallocation where that would leave the policyholder with less than a full recovery for its losses.” Id. slip op. at 3.
The court, relying on Indiana “all sums” decisions, rejected Lexington’s argument that Eli Lilly’s claim should be spread across all years triggered by the environmental property damage. Id. Additionally, the court relied on the public policy arguments that Lexington’s contribution theory would discourage settlements. Id. at 4. Policyholders and insurance companies would have little incentive to settle if they could be forced to pay more or contribute a pro-rata share in response to a contribution claim by a non-settling insurance company. Id. at 4. Additionally, the court reasoned that no contribution rights even existed against a settled policy. Id.

Similarly, courts generally have limited the non-settling insurance companies’ claim of set-off to an amount that was actually paid on the disputed claim. The purpose is to prevent the policyholder from recovering more than its actual loss. Indeed, a set-off may not be allowed where there is uncertainty as to whether all or a portion of the prior settlement is attributed to the disputed claim, or to a bundle of existing and future claims.

For instance, in Weyerhaeuser Co. v. Commercial Union Insurance Co., 15 P.3d 115, 126 (Wash. 2001), the policyholder faced liabilities and incurred damages at 42 environmental sites. It sought insurance coverage from its insurance companies, and ultimately settled with all but one. After a judicial determination that the non-settling insurance company owed $8 million, the non-settling insurance company argued that it was entitled to a set-off equal to the amount of the prior settlements. The court disagreed. Id. at 125-27. The Weyerhaeuser court emphasized that “the insured must first be fully compensated for its loss before any setoff is allowed.” Id. at 125. It determined that, since the policyholder’s past environmental costs greatly exceeded the amounts of earlier policy settlements, there was no evidence of a double recovery. The court noted that the prior settlements were for “far more than a simple release of liability at specific sites.” Id. at 126.

Like the policyholder in Weyerhaeuser, the policyholder in Insurance Co. of North America v. Kayser-Roth Corp., 770 A.2d 403, 413-14 (R.I. 2001), faced damages arising out of environmental contamination. In the insurance coverage action, after the policyholder settled with several carriers, it obtained a $9 million judgment against First State Insurance Company. In support of a motion to amend the judgment to reflect the amounts received in the prior settlements, First State attempted to subpoena the confidential settlement agreements, arguing that it was entitled to discovery to support its claim for a set-off. The trial court quashed the subpoena. Id. at 413. The Rhode Island Supreme Court affirmed, relying heavily on public policy: “[A]lthough public policy mitigates against [the policyholder] receiving a windfall, public policy mitigates more strongly against [the non-settling insurance company] receiving a windfall.” Id. (quoting trial court decision). The Kayser-Roth court also reviewed the settlement agreements in camera and found that “the settlements were so generalized that the court could not discern how the parties came to the settlement amounts or whether they intended to allocate any particular dollar [amount] paid in settlement toward the EPA loss.” Id. Considering equitable principles favoring settlements, and against an insurance company paying less than the limits of its triggered policy, the court concluded that, unless it was likely that the policyholder would receive a double recovery, First State was not entitled to a set-off. Id. at 414.

In Pederson’s Fryer Farms, Inc. v. Transamerica Insurance Co., 922 P.2d 126 (Wash. Ct. App. 1996), after settling with one of its insurance companies, the policyholder sued another insurance company, seeking coverage for environmental property damages. Ultimately, it settled with two insurance companies. After a judgment was entered against the non-settling insurance company for the full amount of the policyholder’s environmental liability, that company sought a set-off for the amount the policyholder had obtained in the prior settlement. The court concluded that the earlier settlement agreement was not a “mere payment for [the policyholder’s] clean-up costs; it was in exchange for a release of liability for all past, present and future environmental claims.” Id. at 139. Because the settlement agreement was not attributable to cleanup costs at a particular
site, there was no showing of a double recovery. No set-off was allowed. Id.

A policyholder must be aware of these issues when it decides to settle with some, but not all, of its insurance companies. In jurisdictions that adopt a pro-rata allocation, a policyholder probably will have to absorb the difference between the settlement amount and the settling insurance companies’ pro-rata share of the loss. In a jurisdiction which applies an “all sums” or “joint and several” allocation, a non-settling insurance company’s right of contribution or set-off may be limited only to the extent that the policyholder would recover more than its insured loss. The language used to release the settling insurance company may be a factor in determining whether and to what extent contribution or a set-off will be allowed.

VIII. Additional Practical Considerations for Corporate Counsel

A. Corporate Roles Vis-à-Vis Insurance

Insurance policies are commercial contracts that create valuable corporate assets, but frequently receive little or no attention from the corporate legal departments until a time of crisis, generally when the insurance company denies coverage for a claim. Risk managers generally are part of the finance department and report to the treasurer. They focus on the economics of the transaction, the limits provided, and the costs of the insurance (i.e., premiums). Moreover, risk managers sometimes are not comfortable in pursuing a claim, because of their belief that it may make renewal, or the acquisition of new policies, more difficult or expensive. They also too often accept the representation of the insurance company or the broker that a given claim should not be pursued because it is not covered, rather than making an independent determination of the claim and the policy coverage.

In-house counsel always can be of assistance to the risk management department in the purchase of insurance. They can provide valuable help in evaluating alternative policy language and the implications that language will have when and if a claim is made under that policy or a coverage dispute arises. For example, a lawyer may be in the best position to evaluate whether a policyholder should accept certain dispute resolution provisions, such as a choice of law or a mandatory arbitration clause. Similarly, a lawyer may be more likely than a risk manager to check the actual policy language against the outline of coverage contained in the initial insurance binder, and to insist that inconsistencies be corrected.

Counsel particularly should be involved in the purchase of D&O insurance. An attorney may be helpful in understanding the conflict of interest between the inside individual directors and officers, the outside directors, and the corporate entity, particularly when the D&O policy contains entity coverage. Each insured is in competition with the others for the protection afforded by the policy. What may be in the interest of one, may be contrary to the interests of the others. An attorney can be alert to these conflicts and better able to put the parties on notice.
B. Managing Relationships with the Broker

The broker occupies the middle space between the policyholder and the insurance company. Although the facts in any particular situation may differ, the broker generally fulfills many roles: agent for the policyholder for some purposes; agent for the insurance company for other purposes; or a principal in the transaction, particularly when the broker is an owner or participates in one of the entities providing insurance or has put together the policy or the facility that provides the insurance. This means that the broker may have many interests, some of which may conflict with the interests of the policyholder.

Risk managers often treat the broker as part of the “in-house” team. The broker is not an employee of the policyholder and should not be treated as such. This mistake manifests itself frequently in the dispute over the confidentiality of the broker’s files. Simply, a policyholder should assume that the broker’s files may not be confidential. Any communication to the broker may be discoverable by the insurance company. In this world of e-mails, it is common and unfortunate for a risk manager to forward an opinion of counsel on coverage and ask the broker for comments. Privileged documents may become discoverable when sent to the broker. It is also common for a risk manager to ask the broker for a written opinion on coverage. This also should be avoided. That opinion may become public, and whether or not it is correct, the insurance company will argue that the broker’s opinion limits the policyholder. In-house counsel can help alert risk managers that a broker must be treated as an independent third party.

Finally, an important role that the broker can fulfill is to make sure that communications are sent to all interested insurance companies. In the initial notification of loss, claim, or occurrence, it is the broker’s job to determine all possibly implicated coverages and make sure that notice is provided to all relevant insurance companies. The broker also is responsible for keeping all potentially implicated insurance companies informed of developments in the underlying litigation or in the investigation of the loss. The broker also can make sure that excess insurance companies are notified of side agreements between the primary insurance company and the policyholder, or any other act that the excess insurance companies later could claim impacts their risk, allowing them to avoid coverage.

IX. Conclusion

Insurance is one of the most important assets of the corporate policyholder. In-house counsel should assist the risk management department in the acquisition, maintenance, and use of this asset to help maximize the corporation’s recovery.
X. Additional Resources:

**ACC Docket Articles**


**Practice Profile**


**Program Material**


**Amicus Brief**


**Webcast**


**Other Resources**


Fred T. Podolsky and Susanne Mast Murray,

**Other Insurance Resources**

**Treatises**

Appleman on Insurance Law & Practice by John A. Appleman (57 vols. LEXIS Law Pub.) or Couch Cyclopedia of Insurance Law by George J. Couch and Ronald A. Anderson (2d ed. Rochester, N.Y. Lawyer’s Cooperative Pub. 1959). These are multi-volume collections. Although expensive, they can be useful in helping both lawyers and lay people understand the basics of insurance law for any number of different types of insurance policies.

Insurance Claims and Disputes by Allan D. Windt (3d ed. Colorado Springs, CO, Shepard’s/McGraw-Hill, 1995). This two-volume treatise provides a good substantive overview of insurance coverage issues. It has a particularly useful index.

Handbook on Insurance Coverage Disputes by Barry R. Ostrager and Thomas R. Newman (9th ed. Aspen Law & Business). This one-volume treatise has many helpful charts that provide state-by-state overviews of the law on specific coverage issues. A new edition is published every other year. Policyholder counsel should be aware, however, that the authors represent insurance companies in their private practice, and that this treatise, not surprisingly, tends to have a pro-insurance company slant.

Practitioner’s Guide to Litigating Insurance Coverage Actions by Jerold Oshinsky and Theodore Howard (2d ed. Aspen Law & Business). This two-volume treatise focuses on the nuts and bolts of litigating a coverage case. It includes both substantive information and practical advice for those litigating a coverage action. The set also includes forms drawn from pleadings filed in coverage cases nationwide. It was co-written by a policyholder-side attorney and an insurance-side attorney.

**Other Research Books**


Best’s Insurance Reports: Property/Casualty. Best’s Insurance Reports is considered the “Bible” of the insurance industry. It provides background information on insurance companies, including their principal place of business, state of incorporation, corporate history, and references to determine a company’s solvency.

Dictionary of Insurance Terms by Harvey Rubin (3d ed. Hauppauge, N.Y. Barron’s 1995). This is a basic insurance dictionary, which defines more than 3,000 terms. It includes a separate list of abbreviations and acronyms.

**Periodicals**

Business Insurance. BI provides up-to-date coverage of insurance issues from both a legal and a risk management perspective.

Mealey’s Litigation Reports - Insurance. Mealey’s is a good weekly loose-leaf service. Mealey’s tracks insurance coverage actions and publishes the most recent decisions (in slip opinion form) and pleadings in coverage cases nationwide. Mealey’s also offers a myriad of specialty publications on various other subject.

**The Internet**

There are innumerable insurance-related sites. For example, trade associations, insurance companies, state insurance commissioners, and publishers are all on the Internet. You also can subscribe to one of the legal services providers, LEXIS/NEXIS or WESTLAW, to aid with legal research. These services include major insurance trade publications, reported and unpublished court decisions, statutes, regulations, jury verdicts, settlements, law reviews, and insurance law texts.

**XI. About Dickstein Shapiro Morin & Oshinsky LLP**

Dickstein Shapiro Morin & Oshinsky LLP, founded in 1953, is a multi-service law firm with more than 375 attorneys in offices in Washington, DC; New York City;
and Los Angeles, representing clients in diverse industries with a wide variety of requirements. While Dickstein Shapiro’s work generally originates from a client’s need for legal representation, the Firm is mindful that legal service is but one ingredient in achieving a client’s strategic business goals. The Firm prides itself on learning and understanding client objectives and partnering with clients to generate genuine business value.

Dickstein Shapiro’s clients range from Fortune 500 companies to start-up ventures and entrepreneurs, from multinational corporations and leading financial institutions to charitable organizations and government officials in high-profile investigations. The Firm provides comprehensive representation to clients through the multiple resources available in its five core groups: Corporate & Finance, Energy, Intellectual Property, Legislative & Regulatory Affairs, and Litigation & Dispute Resolution, which involve the Firm in virtually every major form of counseling, litigation, and advocacy.

The Insurance Coverage Practice

Dickstein Shapiro Morin & Oshinsky LLP is a national law firm with a premier Insurance Coverage practice that represents policyholders around the country in disputes with insurance carriers. Of the Firm’s 375 attorneys in Washington, D.C., New York, and Los Angeles, more than 70 devote the majority of their time to insurance coverage matters. Attorneys at all levels are involved in the Insurance Coverage practice, including attorneys with extensive settlement and litigation experience at the trial and appellate level. Firm attorneys have a reputation for legal excellence, technical expertise, and exceptional responsiveness, as well as for developing and implementing creative approaches and solutions to complex business disputes. Our insurance coverage practice is nationally recognized as one of the premier insurance coverage practices. In fact, many of the Firm’s Insurance Coverage attorneys are nationally recognized as pioneers and leaders in insurance recovery, and are uniformly rated as among the country’s leading lawyers. Furthermore, unlike some firms that “walk both sides of the street,” Dickstein Shapiro exclusively represents insureds in coverage disputes.

Partners at Dickstein Shapiro Morin & Oshinsky LLP have 25 years of successfully negotiating, litigating, and settling all manner of insurance coverage disputes around the country. It has particular experience in successfully negotiating disputes with the London insurance market. The Firm provides advice in structuring an insurance program, submitting claims, and litigating and arbitrating insurance disputes. It litigates or arbitrates in courts and other tribunals throughout the United States and England. Over the years, it has negotiated and structured complex settlements on behalf of policyholders, many with multiple parties, which have resulted in recoveries of more than $3 billion for its clients. The only limitation in scope of insurance-related service it provides is that it does not represent insurance companies, except when they are themselves policyholders.

About The Authors

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David L. Elkind is a partner in the Washington, D.C. office of Dickstein Shapiro Morin & Oshinsky LLP. Mr. Elkind has represented policyholders in a wide variety of insurance coverage disputes, with particular expertise in representing energy and utility companies.
in the recovery of insurance dollars for environmental liability. He also has represented several companies in private cost recovery actions under CERCLA. He also practices anti-trust law, concentrating on merger analysis and compliance. His direct number is (202) 955-6603.

Endnotes

1 This Primer was finalized shortly after Katrina struck the United States. DSMO has written about, and will continue to address, insurance issues arising out of that disaster. If you have insurance questions specifically arising out of Katrina, please contact one of the authors directly.

2 An insurance policy is a form of commercial contract. Although the general statements in this Primer should be helpful to an understanding of the policyholder’s rights and the insurance company’s obligations, the specific language of the individual policy at issue is the most important factor to consider.


4 Coverage for products liability claims generally is included within CGL policies.

5 In recent years, D&O insurance often has been expanded to protect the corporation against claims based on the federal securities laws.

6 E&O insurance is particularly important for those corporations that sell services, as opposed to products. Professional malpractice insurance is a form of E&O coverage.

7 This practice is particularly common for insurance bought in the London insurance market.

8 A loss that falls within that layer is borne by the insurance companies according to their quota share.

9 It is possible for the policies in each layer of an excess insurance program to have their own distinct terms and conditions rather than following form. This can easily result in problems when the terms and conditions in each layer are not identical.

10 Some policies have “drop-down” language under which the excess insurance company must pay, even without the payment of the entire limits in the underlying coverages. This is particularly important if the underlying coverage is unavailable because the underlying insurance company is insolvent.

11 For insurance sold in the London insurance market, the initial contracting document is called a “Slip,” and serves the same function as a binder for U.S.-based insurance companies. The Slip outlines the coverage to be provided, and each syndicate or London market company is bound to insure its quota share of the risk when its underwriter subscribes to, or signs onto, the Slip.

12 For additional discussion regarding the development of standard-form language in CGL policies, see discussion in American Home Products Corp. v. Liberty Mutual Insurance Co., 565 F. Supp. 1485, 1500-02 (S.D.N.Y. 1983), aff’d as modified, 748 F.2d 760 (2d Cir. 1984).

13 See www.royalsunalliance-usa.com, which allows a user to search policy forms by state in Management Assurance Portfolio section; www.kemperinsurance.com and www.cnapro.com allow a user to view or download sample policy forms such as Directors and Officers and employment practices liability.


16 Where a retrospective premium exists, the cost of the insurance, the premium, is not fixed, but, rather, is adjusted to reflect losses paid under the insurance policy. Thus, many policyholders are surprised when, after they collect insurance for a claim, all or a portion of that payment is billed back to them as part of the retrospectively rated premium.
Insurance-imposed guidelines can vary in the extent to which they seek to control the management of the defense, or impose unreasonable restrictions on defense counsel. One commonly used set of guidelines has been drafted by the Defense Research Institute ("DRI"), an organization of defense trial lawyers and insurance companies. Its "Recommended Case Handling Guidelines for Insurance companies" are available at http://www.dri.org/dri/committees/pdf/ILC_guidelines.pdf. Although not ideal, the DRI guidelines are, from a policyholder's perspective, less onerous than many of the insurance company's own guidelines.

Often policyholders are unaware of these guidelines until a claim is made. Inside counsel should review these “guidelines” before the insurance is purchased so that they can compare guidelines used by different insurance companies or obtain modifications.

See generally Michael F. Aylward, The American Law Institute, Insurance Ethics: The Future of the Tripartite Relationship, SG004 ALI-ABA 217, 220 (2001). Some guidelines have been held to violate court rules regarding the conduct of litigation. See Frederick v. UNUM Life Ins. Co. of Am., 180 F.R.D. 384, 385 (D. Mont. 1998) ("The problem as I see it is that UNUM's bottomline GUIDE is in conflict, not only with the local rules of practice, but also with the Federal Rules of Civil Procedure. The GUIDE hamstrings the lawyer charged with defending the claim.").


The words in quotation marks are separately defined.

Mathias et al., Insurance Coverage Disputes § 11.01, at 11-3 (quoting standard grant of coverage policy provision).


See Gillette, 476 N.E.2d at 275.


See, e.g., Avondale Indus., Inc. v. Travelers Indem. Co., 887 F.2d 1200, 1204 (2d Cir. 1989); City of West Haven v. Liberty Mut. Ins. Co., 639 F. Supp. 1012, 1020 (D. Conn. 1986) (stating that one of the "basic purposes of the defense provision is protection of the insured from the expenses of litigation").


Moreover, the test is a subjective one. It is not sufficient that a reasonable person should have expected

30 See, e.g., Dart Indus., Inc. v. Liberty Mut. Ins. Co., 484 F.2d 1295 (9th Cir. 1973) (coverage for damages in a libel action was not barred by statutory intentional conduct exclusion, even though the libel was the result of the willful act of the corporate president, because there was no showing that the board of directors or other senior management either authorized or ratified the libelous acts).

31 See Discussion at Section III.B., infra.


34 See generally Francis J. MacLaughlin, Brief, Third-Party Liability Policies: The Concurrent Causation Doctrine And Pollution Exclusions, 24-SPG Brief 20 (Spring 1995) (discussing the doctrine and providing a state survey of cases addressing the doctrine).

35 See a more detailed discussion of notice requirements at Section VI, C., infra.

36 345 F.3d 154. The Second Circuit ruled that the definition with respect to certain policies required a single occurrence as a matter of law. With respect to the language of other policies the Court found ambiguous, the number of occurrences issue was resolved by a jury.

37AIU Ins. Co. v. Super. Ct., 799 P.2d 1253 (Cal. 1990); First Ins. Co. of Haw., Inc. v. State, 665 P.2d 648, 655 (Haw. 1983) (“AIU Ins.”) insurance policy terms "should be interpreted according to their plain, ordinary, and accepted sense in common speech.")

38 WTC Properties, 345 F.3d at 170; Sept. 11 Liab. Ins. Coverage Cases, 333 F. Supp. 2d at 122. However, a policyholder should be able to offer standards of the insurance company (for instance, in manuals or in claims handling guidelines) against the insurance company as an admission under Rule 801(d)(2), Fed. R. Evid., and similar state rules of evidence.

39 Int’l Bus. Machs. Corp. v. Liberty Mut. Fire Ins. Co., 303 F.3d 419, 424 (2d Cir. 2002) (“It is well settled that ‘[w]here there is ambiguity as to the existence of coverage, doubt is to be resolved in favor of the insured and against the insurance company.’” (quoting Handelsman v. Sea Ins. Co., 647 N.E.2d 1258, 1260 (N.Y. 1994))); Penn Mut. Life Ins. Co. v. Ogelsby, 695 A.2d 1146, 1149-50 (Del. 1997); Ace Wire & Cable Co. v. Aetna Cas. & Sur. Co., 457 N.E.2d 761, 764, (N.Y. 1983) (“The ambiguities in an insurance policy are, moreover, to be construed against the insurance company, particularly when found in an exclusionary clause.”); Royal Coll. Shop, Inc. v. N. Ins. Co., 895 F.2d 670, 674 (10th Cir. 1990); AIU Ins., 799 P.2d 1253; Bank of the West v. Super. Ct., 833 P.2d 545, 552 (Cal. 1992) (“If the terms of a promise are in any respect ambiguous or uncertain, it must be interpreted in the sense in which the promisor believed, at the time of making it, that the promisee understood it.’ . . Only if this rule does not resolve the ambiguity do we then resolve it against the insurance company.”); see also cases in Footnote 12.

40 See cases in Footnote 19.


42 Garvey, 770 P.2d at 710; Diamond Shamrock Chems. Co. v. Aetna Cas. & Sur. Co., 609 A.2d 440,

43 See J.M. Campbell, Specific Policies on the Way Out-Comprehensive Takes Over, The Local Agent 16 (Mar. 1949) (“Today we have come to the point when separate coverages must give way to . . . comprehensive policies for all industrial and mercantile risks.”).

44 814 S.W.2d 273, 278 (Ky. 1991).

45 ISO and the role it plays with respect to CGL policies have been described as follows:

ISO is a nonprofit trade association that provides rating, statistical, and actuarial policy forms and related drafting services to approximately 3,000 nationwide property or casualty insurance companies. Policy forms developed by ISO are approved by its constituent insurance carriers and then submitted to state agencies for review. Most carriers use the basic ISO forms, at least as the starting point for their general liability policies.


46 As the California Supreme Court has explained:

[I]mposition of an immediate duty to defend is necessary to afford the insured what it is entitled to: the full protection of a defense on its behalf.... The insured’s desire to secure the right to call on the insurance company’s superior resources for the defense of third party claims is, in all likelihood, typically as significant a motive for the purchase of insurance as is the wish to obtain indemnity for possible liability. As a consequence, California courts have been consistently solicitous of insureds’ expectations on this score.


47 Gray v. Zurich Ins. Co., 419 P.2d 168, 176 (Cal. 1966) (“Gray”). Accord McCostis v. Home Ins. Co., 31 F.3d 110, 112 (2d Cir. 1994) (New York law) (“an insurance company can escape the duty to defend only if there is no legal or factual basis in the complaint upon which the insurance company might eventually have to indemnify the insured”); Ross v. Briggs & Mor-
Mr. Windt further states: 

Qui tam action. See, e.g., Reese v. Travelers Ins. Co., 129 F.3d 1056, 1061 (9th Cir. 1997) (“The question is not whether the allegations of the underlying complaint are meritorious, but rather whether [the insurance company’s] policy terms require it to provide a defense against such claims... [The insurance company] has a ‘duty to defend . . . as long as the complaint contains language creating the potential of liability under an insurance policy.’” Thus, we must determine whether the underlying complaint alleges a covered claim, not whether the facts alleged in the complaint are true.” (citations omitted)); Aemco Ins. Co. v. Acer Enters., Inc., 796 F. Supp. 343, 346 (N.D. Ill. 1992) (“The duty to defend hinges on a liberal reading of the underlying complaint: to the extent that a single cause of action is potentially within the policy coverage, the duty to defend is triggered, even if the insurance company discovers that the allegations are groundless, false or fraudulent.”); Gray, 419 P.2d at 174 (recognizing that carrier must defend insured against groundless, false, or fraudulent claims, the nature and kind covered by the policy, because the policy language “would lead the insured reasonably to expect defense of any suit regardless of merit or cause.”); Barbara B., 846 P.2d at 799, (“An insured buys liability insurance in large part to secure a defense against all claims potentially within policy coverage, even frivolous claims unjustly brought . . . If [the claimant’s] claims were indeed so insubstantial as to not warrant any damages, [the carrier] should have raised that defense in the underlying action for [the insured’s] benefit, rather than in this declaratory relief action to his detriment”); A-H Plating, Inc. v. Am. Nat’l Fire Ins. Co., 67 Cal. Rptr. 2d 113, 121 ( Ct. App. 1997) (“The duty to defend does not evaporate simply because the insurance company has decided that the insured will ultimately be exonerated (or because evidence supporting that conclusion has been introduced in a declaratory relief action over coverage). Indeed, the duty of defense, as expressly described in the insurance policy, covers third party claims that are ‘groundless, false or fraudulent.’” Thus [the insurance company’s] unilateral determination that the third party claims are ‘groundless, false or fraudulent’ did not relieve it of the duty to provide a defense.”). As one commentator has explained: “Insurance companies, as a general rule, are not allowed to refuse to defend on the grounds that they are in possession of information establishing that the allegations of the complaint giving rise to coverage are untrue.” Allan Windt, Insurance Claims & Disputes, § 4.4, at 291 (4th ed. 2001). As Mr. Windt further states:

For the same reason, therefore, an insurance company cannot avoid its duty to defend by obtaining a declaratory judgment that the plaintiff’s allegations against the insured, insofar as they are encompassed by the policy, are without merit. That they are without merit does not alter the fact that the insured is being sued based on those allegations and that, as a result, the insured is entitled to have the insurance company prove their invalidity in the context of defending the insured. There have been a few cases which have held to the contrary, but they are clearly bad law.

Id. at 293 (note omitted).

52 See Am. Motorists Ins. Co. v. SW. Greyhound Lines, 283 F.2d 648, 649 (10th Cir. 1960) (Oklahoma law); Barbara B., 846 P.2d at 796, (duty to defend may be deemed to exist based on allegations in the complaint or on facts extrinsic to the complaint that “reveal a possibility that the claim may be covered by the policy”); Associated Indem. Co. v. Ins. Co. of N. Am., 386 N.E.2d 529, 536 (Ill. App. Ct. 1979).


54 Frequently, these firms agree to charge the insurance company a below-market rate for their services, and agree to abide by all aspects of the insurance company’s billing or claims-handling guidelines.


56 273 F.3d 741, 744 (7th Cir. 2001).

57 Id.

58 The relationship among the policyholder, the insurance company, and the defense counsel is often referred to as the triangular, or tripartite relationship.


60 369 F.2d 678, 681-82 (2d Cir. 1966).


However, in a small minority of jurisdictions, the courts hold that, as long as the insurance company hires independent counsel, the fact that counsel’s loyalty is to the policyholder provides sufficient protection. See Finley v. Home Ins. Co., 975 P.2d 1145, 1151-53 (Haw. 1998).


63 A “latent injury claim” or “long tail claim” refers to a claim where the bodily injury or property damage goes on for many years while remaining undetected.


70 Eagle-Picher Indus., Inc. v. Liberty Mut. Ins. Co., 682 F.2d 12 (1st Cir. 1982).


74 See Fed. R. Evid. 1006.

75 Moreover, often there are additional underlying claims on the horizon, so that if the policyholder were required to prove its own liability in order to obtain insurance, that would invite more underlying tort claims to be filed.

76 See Luria Bros. & Co. v. Alliance Assurance Co., 780 F.2d 1082, 1091 (2d Cir. 1986).
Insurance companies that principally write primary coverage are likely to argue that multiple claims arise from a single occurrence. If this argument is accepted, the insurance company can confine its payments to a single occurrence limit and cut off its duty to pay defense costs. Insurance companies that principally write excess coverage tend to argue that each claim is a separate occurrence, in an attempt to confine the loss to the primary layer. Insurance companies that write both primary and excess coverage may take inconsistent positions depending upon their exposure on a particular claim. Knowledgeable policyholders, and their counsel, can and should exploit these differences, arguing that the language is imprecise and, therefore, ambiguous.

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84 765 A.2d 891 (Conn. 2001). Several courts in New York have adopted an “unfortunate events” test, which looks to the “unfortunate event” from which the claim or claims arose to determine the number of occurrences. Under this test, there may be more than one cause for purposes of determining the number of occurrences. See, e.g., Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp., 73 F.3d 1178, 1213 (2d Cir. 1995), modified on other grounds on reh’g, 85 F.3d 49 (2d Cir. 1996); DiCola v. Am. S.S. Owners Mut. Prot. & Indem. Ass’n (In re Prudential Lines Inc.), 158 F.3d 65, 81 (2d Cir. 1998); see also Consol. Edison Co. of N.Y., Inc. v. Employers Ins., No. 96 Civ. 6235 (MBM), 1997 WL 727486, at *3 (S.D.N.Y. Nov. 21, 1997).


86 Id. at 1382.

87 Id. at 1380.


90 Numerous courts have held that multiple claims resulting from exposure to asbestos must be considered a single occurrence under liability insurance policies containing a batch clause. Air Prods. & Chems., 707 F. Supp. at 772-73; Owens-Illinois, Inc. v. Aetna Cas. & Sur. Co., 597 F. Supp. 1515, 1527-28 (D.D.C. 1984);


93 See, e.g., Chemstar, Inc. v. Liberty Mut. Ins. Co., 797 F. Supp. 1541, 1545-48 (C.D. Cal. 1992) (involving underlying allegations of a policyholder’s “failure to warn” over an extended period), aff’d, 41 F.3d 429 (9th Cir. 1994).


97 Whether an “all sums” or “pro-rata” allocation will be applied can impact a policyholder’s settlement strategy. See Section VII.E.2., infra.

98 951 P.2d 250, 257 (Wash. 1998) (footnote omitted) (rejecting the argument that an insurance company on the risk for a short period would be unfairly burdened by having joint and several liability imposed on it for the indemnification of expenses to remediate pollution spanning several years).


100 73 F.3d 1178 (2d Cir. 1995), modified on other grounds on denial of reh’g, 85 F.3d 49 (2d Cir. 1996).

101 Id. at 1203-04.

102 This Fifth Circuit opinion is not published. According to Fifth Circuit Rule 47.5.1, the Fifth Circuit does not publish opinions that “merely decide particular cases on the basis of well-settled principles of law.” Further, Fifth Circuit Rule 47.5.4 provides that unpublished opinions “are not precedent, except under the doctrine of res judicata, collateral estoppel or law of the case.” The rule further provides that “[a]n unpublished opinion may, however, be persuasive.”

103 See Section III.C., supra.
105 See Section III.E., supra.
106 See Section III.D., supra.


115 Nat’l Elec. Mfrs., 162 F.3d at 825; Assicurazioni Generali, 160 F.3d at 1000.


118 Sullins, 667 A.2d at 622-23; see also Jabar, 188 F.3d at 30.

119 The same concept arises under older liability policies that require that the property damage be caused by an “accident,” which often is undefined.


Merriam Webster’s Collegiate Dictionary (10th ed. 1994).


Id.


See also Knife, 897 F. Supp. at 1215-16 (“‘passing off’ and trademark infringement constitute ‘misappropriation of advertising ideas or style of doing business.’”).

50 Cal. App. 4th at 562-63.


See e.g., Knife, 897 F. Supp. at 1215-16; Ekco
Group Inc. v. Travelers Indem. Co., No. Civ. 99-239-JD 2000 WL 1752829 (D.N.H. Nov. 29, 2000) (claims of Lanham Act violations, trademark and trade dress infringement are consonant with misappropriation of style of doing business); J.A. Brundage, 818 F. Supp. at 557 (“one’s mark and name is an integral part of any entity’s ‘style of doing business.’ Such misappropriation of ‘style of doing business’ would include trademark, trade name or service mark infringement.”).

See e.g., Lebas, 50 Cal. App. 4th at 562-63 (to resolve ambiguity in policy language “we must look to the objectively reasonable expectation of [the insured].”); Reboans, 900 F. Supp. At 1246, 1253 (N.D. Cal. 1994) (“A court that is faced with an argument for coverage based on assertedly ambiguous policy language must first attempt to determine whether coverage is consistent with the insured’s objectively reasonable expectations.”); Allou Health & Beauty Care, Inc. v. Aetna Cas. & Sur. Co., 703 N.Y.S.2d 253 (2000) (“Allou”) (based on reasonable expectation of the insured “misappropriation of advertising ideas or style of doing business encompasses the wrongful taking of the manner by which another advertises its goods or services, including the misuse of another’s trademark.”).

Reboans, 1994; Allou, 703 N.Y.S.2d 253.

Bank of the West v. Superior Court, 2 Cal. 4th 1254, 1276 n.9 (1992) (“Bank of the West”).


Id. at 494 (internal quotation marks and citation omitted).


Id. at 440; see also Sentex Sys., Inc. v. Hartford Accident & Indem. Co., 882 F. Supp. 930, 939 (C.D. Cal. 1995), aff’d, 93 F.3d 578 (9th Cir. 1996) (“Sentex Sys.”); Amer. States Ins. Co. v. Canyon Creek, 786 F. Supp. 821, 828 (N.D. Cal. 1991) (“even one-on-one oral representations have been found to constitute advertising.”).


See Sentex, 882 F. Supp. at 945; see also Bank of the West, 2 Cal. 4th at 1276.


Id. at *1.


Id. at * 22.

61 F. Supp. 2d 611 (S.D. Tex. (1999)).

Id. at 619. See also Dogloo, 907 F. Supp. at 1391 (finding lawsuit alleging misappropriation of style of doing business by manufacturing, advertising, and selling a dome-shaped doghouse was covered because “nothing . . .to suggest that the alleged injury was not caused, at least in part, by [the insured’s] advertising of a dome-shaped doghouse”); Sentex Sys., 882 F. Supp. at 945 (“the case law . . .does not require the advertising activities to be the only cause of the advertising injuries”).

See e.g., J.A. Brundage, 818 F. Supp. At 553, 558 (allegations of use of name and mark “Roto-Rooter” in connection with the advertising constitutes an infringement of federally registered marks and “alleges that the use of the mark in connection with advertising caused injury to the Plaintiff”), vacated by reason of settlement, 153 F.R.D. 36 (W.D.N.Y. 1994); Nortek, Inc. v. Liberty Mut. Ins. Co., 858 F. Supp. 1231, 1233, 1238 (D.R.I. 1994) (words “circulating,” “advertising materials,” and “marketing” in the underlying action against the insured could be considered “in the course of advertising....a distinctive package could be considered a form of advertising.”).

891 F. Supp. 1228.

Id. at 1235-36.

Northam Warren Corp. v. Universal Cosmetic Co., 18 F.2d 774, 774 (7th Cir. 1927).


See Fragomeno v. Insurance Co. of the West, 255
Cal. Rptr. 111, 114 (Ct. App. 1989) (term "personal injury" obligates an insurance carrier to defend and indemnify the insured for "any act constituting an invasion of the right of private occupancy which incurs tort liability"), overruled on other grounds, Vandenberg v. Super. Ct., 982 P.2d 229, (Cal. 1997); Nichols v. Great Am. Ins. Cos., 215 Cal. Rptr. 416, 421 (Ct. App. 1985) ("the personal injury contemplated by the business liability policies was the 'wrongful entry, eviction or other invasion of the right to private occupancy' relating to some interest in real property"); Cincinnati Ins. Co. v. Davis, 265 S.E.2d 102 (Ga. Ct. App. 1980) (wrongful entry coverage obligated insurance carrier to defend suit for conversion where complaint alleged reposssession was accomplished by insured's technically deficient entry onto premises).

161 424 A.2d at 923-24.
162 Id. at 824.


164 Contractual liability coverage usually refers to the exception to the general exclusion of liabilities assumed by contract. Under such coverage, the insurance company agrees to insure the named insured for the tort liability it otherwise would have, but which it also assumed by contract.

165 The underlying complaint need not state explicitly that the individual sued is an officer or director in order for D&O coverage to apply. Rather, some courts will look to the allegations of the underlying complaint to determine if there is a "connection [between claimed policyholder and corporation] . . . implicit in the allegations" that would bring the underlying action within a policy's coverage. E.g., U.S. Fid. & Guar. Co. v. Executive Ins. Co., 893 F.2d 517, 519 (2d Cir. 1990).

166 State law also may allow for partial indemnification. For example, a provision of the Delaware General Corporation Law, adopted by many states, provides for mandatory indemnification where the director or officer has been "successful [in a criminal action] on the merits or otherwise," see Del. Gen. Corp. Law § 145(c) (emphasis added), while other states may allow indemnification only where the director or officer was "wholly successful on the merits or otherwise." The Delaware statute, therefore, can be read to allow indemnification where an insured is successful on some, but not all, counts in an underlying lawsuit.


171 Most, if not all, D&O policies also provide that, if notice of circumstances that could lead to a claim is given to an insurance company during the policy
period, all related claims that are subsequently brought will fall within that policy’s coverage.

172 In Mt. Hawley Insurance Co. v. FSLIC, 695 F. Supp. 469 (C.D. Cal. 1987), the court stated that a claim “refers to a debt due the claimant,” and noted that a “claim is not a request for an explanation.” Id. at 479 (citation omitted).

173 See also Richardson Elecs., Ltd. v. Fed. Ins. Co., 120 F. Supp. 2d 698, 700-01 (N.D. Ill. 2000) (“A claim is a demand for something due. A demand for money is not required for a claim.”). At least one court has held, in a criminal case, that the return of the indictment by the grand jury which “gives the government the right to seek a judicial remedy” constitutes a claim. Polychron v. Crum & Forster Ins. Cos., 718 F. Supp. 33, 35 (W.D. Ark. 1989), rev’d on other grounds, 916 F.2d 461 (8th Cir. 1990). Where the criminal case has been settled, however, one court has found that no claim existed. See MGIC Indem. Corp. v. Home State Sav. Ass’n, 797 F.2d 285 (6th Cir. 1986).

174 Although unusual, there are D&O policies that do have a duty to defend.


182 Some states have statutes that detail when an insurance company may rescind because of misrepresentation. See Mathias § 6.02[3], at 6-6, 6-7 (citing, inter alia, Fla. Stat. Ann. § 627.409 and 18 Del. Code Ann.
§ 2711).


188 It is well settled that a corporation will be bound by a statement or declaration made by an employee, but only when the statement or declaration is made within the scope of employment and with the authority of the employer. Wight v. Bankamerica Corp., 219 F.3d 79, 87 (2d Cir. 2000) (“Wight”); see also 2A N.Y. Jur. 2d Agency and Independent Contractors § 271 (2003). Conversely, under the so-called “adverse interest” exception, where the corporate officer acts in his own interests and not in the interests of the company, his misconduct should not be imputed to the corporation. See Wight, 219 F.3d at 87.

189 Sometimes EPL insurance is added onto D&O policies. For privately held companies it is not unusual to have entity coverage for EPL claims.


191 See N.W. Airlines, Inc. v. Globe Indem. Co., 225 N.W.2d 831 (Minn. 1975) (holding that a reasonable insured would interpret the policy as a whole to be an all-risk policy and, therefore, the theft of money by a hijacker would be covered, unless that specific risk was expressly excluded); Miller v. Boston Ins. Co., 218 A.2d 275, 278 (Pa. 1966) (“[T]he very nature of the term ‘all risks’ must be given a broad and comprehensive meaning as to covering any loss other than a willful or fraudulent act of the insured.”); Phoenix Ins. Co. v. Branch, 234 So. 2d 396 (Fla. Dist. Ct. App. 1970).


193 Commercial Union Ins. Co. v. Sponholz, 866 F.2d 1162 (9th Cir. 1989).
As already mentioned, there are two general types of first-party policies: (1) an “All Risk” policy, and (2) a “Named Peril” policy.


If the Harry’s Cadillac policy had contained ingress/egress coverage, the loss might have been covered.


is required in a claims-made policy to trigger coverage. Notice in a claims-made policy therefore serves a very different function than prejudice-preventing notice required under an ‘occurrence’ policy.”); DiLuglio v. New England Ins. Co., 959 F.2d 355, 359 (1st Cir. 1992) (malpractice insurance company not required to establish actual prejudice from attorney’s late notification); Nat'l Union Fire Ins. Co. v. Talcott, 931 F.2d 166, 167 n.4 (1st Cir. 1991) (finding that while prejudice is “justly required” in occurrence policies, no showing of prejudice is required with claims-made policies); Harbor Ins. Co. v. Cont'l Bank Corp., 922 F.2d 357, 369 (7th Cir. 1990) (“The insurance company wants to know whether there is a possibility that it will be receiving a claim after the policy period, but of course it also wants to receive notice of that claim when and if it materializes. It can enforce this vital condition without proving that it was harmed by violation of it.”); Esmailzadeh v. Johnson & Speakean, 869 F.2d 422, 425 (8th Cir. 1989); Employers Reinsurance Corp. v. Sarris, 746 F. Supp. at 560-63 (E.D. Pa. 1990) (“a claims-made policy is of such a different nature from an occurrence policy that the notice-prejudice rule . . . should not apply”); MGIC Indem. Co. v. Cent. Bank., 838 F.2d at 1382-88 (5th Cir. 1988) (no coverage because of failure to give notice pursuant to terms of policy regardless of whether policyholder could demonstrate prejudice); Civic Assocs., Inc. v. Sec. Ins. Co., 749 F. Supp. 1076, 1082 (D. Kan. 1990); see also Winkler v. Nat'l Union Fire Ins. Co., 930 F.2d 1364 (9th Cir. 1991); Burns v. Int'l Ins. Co., 929 F.2d 1422 (9th Cir. 1991); Pac. Employers Ins. Co. v. Super. Ct., 270 Cal. Rptr. 779, 784 (Ct. App. 1990). Not all courts agree, however. See, e.g., N.W. Title Sec. Co. v. Flack, 85 Cal. Rptr. 693, 698 (Ct. App. 1970).


Many states have statutes that require a timely response by the insurance company. See Alaska Statutes § 21.36.125; Arizona Statutes § 20–461; Arkansas Statutes § 23-66-206; California Insurance Law § 790.03; Colorado Statutes § 10-3-1104; Connecticut Statutes § 38a-816; Delaware Statutes, Title 18 § 2304; Florida Statutes § 626.9541; Georgia Statutes § 33-6-34; Hawaii Statutes § 431:13-103; Idaho Statutes § 41-1329; Illinois Statutes, CH 215 § 5 /154.6; Indiana Statutes § 27-4-1-4. 5; Iowa Statutes § 507B.4; Kansas Statutes § 40-2404; Kentucky Statutes § 304.12 -230; Louisiana Revised Statutes § 22:1214; Michigan Statutes § 500.2026; Minnesota Statutes § 72A.20; Missouri Statutes § 375.936; Montana Statutes § 33-18- 201; Nevada Statutes § 686A.310; New Jersey Statutes § 17:29B-4; New Mexico Statutes § 59A-16-20; North Carolina Statutes § 58-63-15; Oregon Statutes § 746.230; 40 Pennsylvania Statutes § 1171.5; South Dakota Statutes § 58-33-67; Texas Insurance Art. 21.21; Utah Statutes § 31A-26- 303; Vermont Statutes, Title 8, § 4724; Virginia Statutes § 38.2-510; West Virginia Statutes § 33-11-4; Wyoming Statutes § 26-13-124

A more detailed discussion of managing the defense of a case when there is a conflict of interest with the insurance companies is discussed at Section III.B., supra.

See discussion at Section III.B., supra.

See generally, e.g., Teigen v. Jelco of Wis., 367 N.W.2d 806, 810 (Wis. 1985), in which the court dismissed a settling primary insurance company over an excess insurance company’s objection. The court observed that “[p]artial settlements not only benefit the parties involved, but the justice system as a whole,” and reemphasized its prior statement that “public interest requires that a plaintiff be permitted to settle claims against some of the exposed parties without releasing others.” Id. (quoting Loy v. Bunderson, 320 N.W.2d 175, 189 (Wis. 1982)).

In the leading California case adopting the “all sums” result, the court rejected the notion of contribution claims by non-settling insurance companies against settled insurance companies in other policy periods.


Ultimately, however, the court allowed a set-off equal to “the amount actually paid in the settlement,”
but no more. Id. at 5.

As already mentioned, a choice-of-law provision generally is an attempt by the insurance company to impose the law of a forum that is not favorable to policyholders, such as New York, to insurance coverage disputes. Arbitration is a form of dispute resolution that is less favorable to a policyholder than an action in court.