

AN ANNOTATED LAWYERS PROFESSIONAL LIABILITY POLICY

Written Materials Produced by:

David A. Grossbaum, Esq.
Partner
Hinshaw & Culbertson LLP
Boston, Massachusetts
Providence, Rhode Island
(617) 213-7003
dgrossbaum@hinshawlaw.com

Along with updates by:

Duana J. Grage, Esq.
Partner
Hinshaw & Culbertson LLP
Minneapolis, Minnesota
612-333-3434
dgrage@hinshawlaw.com

and

Michelle D. Mitchell, Esq.
Partner
Hinshaw & Culbertson LLP
Minneapolis, Minnesota
612-333-3434
mmitchell@hinshawlaw.com

Reproduced with permission from the authors and **Hinshaw & Culbertson LLP**
Further reproduction is prohibited, and is to be used only for the personal use of the reader.
Copyright © 2008 **Hinshaw & Culbertson LLP**

David Grossbaum's practice focuses on the defense of professional liability cases and on insurance coverage matters. He is a past chair and present member of the New England Steering Committee of the Professional Liability Underwriting Society (PLUS). Additionally, he is a member of the PLUS Communications Committee. He is also a former chair of the American Bar Association's Professionals', Officers' and Directors' Liability Committee. He graduated from the University of Vermont *cum laude* in 1981 and received his law degree *magna cum laude* in 1985 from Boston College Law School.

TABLE OF CONTENTS

	<i>Page</i>
I. THE INSURING AGREEMENT	1
A. The Basic Grant of Coverage.....	1
1. Legally Obligated to Pay	1
2. Claim First Made and Reported Requirement.....	2
3. Negligent Act, Error or Omission.....	4
4. Rendering Professional Services.....	4
a. Coverage for Business Torts.....	5
b. Coverage for Fee Disputes	6
c. Claims Between Members of Same Firm.....	7
d. Professionals Acting in Dual Capacities	7
e. Coverage for Sex With Clients.....	8
f. Must Be Rendering Services for "Others"	8
B. Limitations on Coverage	8
1. Retroactive Dates.....	9
2. Prior Knowledge.....	9
a. Objective vs. Subjective Standard	10
b. Innocent Insureds	11
c. Lack of Mitigating Factors	11
3. Prior Insurance.....	12
II. THE DUTY TO DEFEND	12
A. Tender of the Defense	13
B. Facts the Insurer Can or Must Rely on to Determine Its Defense Obligations.....	13
1. Pleadings	13
2. Extrinsic Facts.....	15
3. Scope of Duty to Defend	15

C.	Termination of the Defense.....	16
1.	Amendment or Partial Dismissal.....	16
2.	Exhaustion of Policy Limits.....	16
D.	Selection and Payment of Counsel Where Insurer Reserves Rights	16
III.	THE INSURED'S CONSENT TO SETTLE CLAUSE	17
IV.	MULTIPLE INSUREDS, CLAIMS, AND CLAIMANTS	18
A.	Claims Made Issue.....	19
B.	Impact on the Number of Deductibles	20
C.	Impact on Policy Limits.....	21
D.	The Framework for Determining Relatedness	21
1.	Acts Were Related	22
2.	Acts Were Not Related	23
V.	EXCLUSIONS.....	24
A.	Business Pursuits Exclusion.....	24
1.	The Rationale for the Exclusion	25
2.	Mixed Allegations of Legal Malpractice and Business Claims	25
3.	Timing, Nature and Extent of Ownership	26
4.	Proximate Cause of Loss.....	27
B.	Intentional Acts Exclusion	27
1.	Generally.....	27
2.	Public Policy and State Statutes Prohibiting Insurance Coverage for Intentional Conduct	28
3.	Recklessness or Constructive Fraud	29
4.	Coverage of Negligence Claims Arising out of or Based on Excluded Conduct	29
C.	Bodily Injury/Property Damage Exclusion	30
1.	Bodily Injury	30
2.	Property Damage	31
D.	Insured v. Insured Exclusion.....	32

VI.	DEFINITIONS	33
	A. "Claim"	33
	B. "Damages"	34
	1. Return of Fees or Restitution of Monies Received by the Insured	35
	2. Sanctions, Fines and Penalties	36
	3. Punitive Damages	36
	4. Non-Monetary Awards	37
	5. Multiplied Damages	37
	C. "Predecessor Firm"	37
VII.	ASSISTANCE AND COOPERATION AND VOLUNTARY PAYMENTS PROVISION.....	38
	A. The Insured's Duty to Cooperate in the Defense of the Matter	39
	B. Duty to Cooperate With Insurer's Coverage Investigation	40
	C. Prohibition Against Insured Making Voluntary Payments.....	41
VIII.	NOTICE OF CLAIM PROVISION	42
IX.	WAIVER OF EXCLUSION AND BREACH OF CONDITIONS.....	43
X.	ASSIGNMENT	45
XI.	OTHER INSURANCE	47
XII.	SUBROGATION	48
XIII.	DECLARATIONS IN APPLICATIONS	50
	A. Objective v. Subjective Standard	50
	B. The Insured's Intent in Making the Misrepresentation.....	51
	C. Rescission As to Innocent Insureds	51
	D. Materiality of Misrepresentation	52
XIV.	DISCOVERY CLAUSE	53
XV.	SEVERABILITY CLAUSE	53
XVI.	MISCELLANEOUS COVERAGE CONSIDERATIONS	54
	A. Choice of Law	54
	B. Burden of Proof.....	54

C. Overlapping/Inconsistent Exclusions..... 55

I. THE INSURING AGREEMENT

A. The Basic Grant of Coverage

The Company will pay on behalf of the Insured all sums which the Insured shall become legally obligated to pay as Damages for Claims first made against the Insured and reported to the Company during the Policy Period or Extended Reporting Period, arising out of any negligent act, error or omission in the rendering of or failure to render professional services for others in the Insured's capacity as a lawyer . . .

Services provided by the Insured as an administrator, conservator, receiver, executor, guardian, trustee or in any similar fiduciary capacity shall be deemed to be professional services covered hereby. Services performed in an attorney-client relationship are deemed to be professional services even if these services could have been performed by a non-lawyer.

There are a number of issues that arise under the insuring agreement, including: (1) the meaning of the phrase "legally obligated to pay"; (2) the "claims made and reported" requirement; (3) the scope of coverage under the phrase "negligent, act, error or omission"; and (4) the requirement that the claim arise out of the insured's "rendering of or failing to render professional services."

1. Legally Obligated to Pay

This issue has rarely come up under lawyers professional liability (LPL) or other professional liability policies. But there has been a great deal of litigation about it in the context of commercial general liability (CGL) policies, the insuring agreement of which only applies to amounts the insured "is legally obligated to pay as damages." This phrase limits coverage in two respects; it has been interpreted to limit coverage to tort damages, rather than contractual ones, and it also precludes an insured from making voluntary payments. See *Coil Anodizers v. Wolverine Ins.*, 120 Mich. App. 118, 327 N.W.2d 416 (1982) (this phrase requires "either a judicial determination of liability or a settlement between the insurer, insured and the claimant . . ."); *Data Specialties, Inc. v. Transcontinental Ins. Co.*, 125 F.3d 909 (5th Cir. 1997) (CGL policy language "legally obligated to pay as damages" applies only to tort-based obligations); *Action Ads, Inc. v. Great American Ins. Co.*, 685 P.2d 42 (Wyo. 1984) (finding that "[t]he phrase 'legally obligated to pay as damages' as used in the liability policy, is synonymous with damages for a liability imposed in law. That latter phrase has been uniformly interpreted as referring to liability ex delicto as distinguished from ex contractu"); *Indiana Ins. Co. v. Hydra Corp.*, 245 Ill. App. 3d 926, 615 N.E.2d 70 (1993) (the provision "legally obligated to pay as damages" "does not provide coverage for damages resulting from breach of contractual obligations"); *Redevelopment Auth. of Cambria County v. Int'l Ins. Co.*, 454 Pa. Super. 374, 685 A.2d 581 (1996) (phrase means "liability sounding in tort, not in contract"); *Olympic, Inc. v. Providence Washington Ins. Co. of Alaska*, 648 P.2d 1008 (Alaska 1982) ("The term 'legally obligated to pay as damages . . . ' refers to liability imposed by law for torts, and not to damages for breach of contract, except contracts for indemnity"); *Nationwide Mut. Ins. Co. v. Regional Electric Contractors, Inc.*, 111 Md. App. 80, 680 A.2d 547 (1995).

However, in *Vandenberg v. The Superior Court of Sacramento County*, 21 Cal 4th 815, 982 P.2d 229 (1999), the Supreme Court of California disapproved of several earlier cases that found the phrase "legally obligated to pay as damages" to refer to tort damages only. In *Vandenberg*, the Court found that "the coverage phrase 'legally obligated to pay as damages,' as used in a CGL Insurance policy, may provide an insured defendant with coverage for losses pleaded as contractual damages . . . Thus, [the] determination of coverage must be made individually by considering 'the nature of the property, the injury, and the risk that caused the injury, in light of the particular provisions of each applicable insurance policy.'" *Id.* at 820. Moreover, the Court stated that it rejected the *ex contractu/ex delicto* distinction.

2. Claim First Made and Reported Requirement

Claims made and reported policies only provide coverage if: (1) a claim is made against the insured, or the insured discovers a potential claim that must be reported, during the policy period; *and* (2) the event is reported to the insurer during *the same policy period*. Claims made coverage can be contrasted with "occurrence" policies, which provide coverage for any event that *occurs* during the policy period, even if a claim is brought years, or even decades, later.

The perceived problem with occurrence coverage in the professional liability area is that the insurer cannot know what the cost of claims adjusting will be in the distant future and, thus, cannot accurately calculate the premium. *Charles T. Main, Inc. v. Firemen's Fund Ins. Co.*, 406 Mass. 862, 551 N.E.2d 28 (1990). Claims made policies remedy the rate-setting problem because the claim that is covered must be made during the policy period, which is usually a one-year period, and the insurer can more accurately predict the costs of defense and indemnity. *Id.*; *FDIC v. St. Paul Fire and Marine Ins. Co.*, 993 F.2d 155, 158 (8th Cir. 1993) ("Notice in a 'claims made' policy provides the insurer with the knowledge that after a certain date the insurer is no longer liable under the policy, and accordingly allows the insurer to more accurately fix its reserves for future liabilities and compute premiums with greater certainty.") Thus, a claims made insurer can charge lower premiums. *Id.*; *Pantropic Power Prod., Inc. v. Fireman's Fund Ins. Co.*, 141 F. Supp. 2d 1366, 1369 (S.D. Fla. 2001), *aff'd*, 34 Fed. App'x. 968 (11th Cir. 2002) ("With a claims-made insurance policy, the insurer undertakes a more limited risk than an insurer who issues an occurrences policy; insurers typically charge higher premiums for occurrence policies to compensate for their exposure to indefinite future liability."); *DiLuglio v. New England Ins. Co.*, 959 F.2d 355 (1st Cir. 1992) (applying Rhode Island law) ("The premiums on 'claims-made' policies can be set appreciably lower than comparable 'occurrence' policy premiums. By limiting the maximum 'tail' period to one year under a 'claims-made' policy, an insurer avoids the increased risks associated with future inflation, the prospect of increasing jury awards, and unanticipated changes in the substantive law of professional liability").

The basic claims made form provides coverage regardless of when the act or omission occurs, as long as the claim is both made against the insured and reported to the insurer during the policy period. *Nat'l Union Fire Ins. Co. of Pittsburgh, PA v. Willis*, 296 F.3d 336, 339 (5th Cir. 2002) (citations omitted) (to invoke claims made coverage, a claim must be made against the insured during the coverage period of the policy and the insured must notify the insurer of the claim during the same period). However, insurers sometimes place on policies retroactive date endorsements, which state that any claims arising out of acts or omissions occurring before the retroactive date are *not* covered. This results in a still lower premium. (SEE "LIMITATIONS ON COVERAGE - RETROACTIVE DATES").

The majority of courts hold that the insured must report the claim prior to the expiration of the policy period, even in the absence of a showing of prejudice by the insurer. *See Janjer Enterprises, Inc. v. Executive Risk Indem., Inc.*, 97 Fed. App'x. 410, (4th Cir. 2004 (Md.)) ("In construing and applying [Md. Code Ann. Ins.] Section 19-110, Maryland courts have held that 'claims made and reporting' policies, which require that a claim be both made against the insured and reported to the insurer during the policy period, are not subject to its prejudice requirement."); *Continental Cas. Co. v. Maxwell*, 799 S.W. 2d 882 (Mo. App. 1990) (claim reported after policy period was not covered and insurer was not required to prove prejudice in order to avoid coverage); *Slater v. Lawyers' Mut. Ins. Co.*, 227 Cal. App. 3d 1415, 278 Cal. Rptr. 479 (2d Dist. 1991) ("notice –prejudice" rule did not operate to bar an insurer from denying coverage under a claims made policy where the insured did not report the claim to the insurer until after the policy period); *Nat'l Union Fire Ins. Co. v. Talcott*, 931 F.2d 166, 166-68 (1st Cir. 1991) (applying Massachusetts law) (attorney failed to notify insurer of litigation until after expiration of claims made policy, and a showing of prejudice need not be made); *Oregon Sch. Activities Ass'n v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 2005 WL 2600444 (D. Or. 2005) (finding that Oregon courts would conclude that the notice-prejudice rule does not apply to a claims made policy). *But see Lexington Ins. Co. v. Rugg & Knopp, Inc.*, 165 F.3d 1087 (7th Cir. 1999) (applying Wisconsin law) (Wisconsin statute requiring insurer to show prejudice from late notice applies to "claims made" policies); *Sherlock v. Perry*, 605 F. Supp. 1001, 1004-05 (E.D. Mich. 1985) (if notice is given within reasonable time, and insurer suffers no prejudice by delay, coverage under claims made policy exists); *Pizzini v. American Int'l Specialty Lines Ins. Co.*, 210 F. Supp. 2d 658 (E.D.

Pa. 2002) ("insurer providing liability coverage under a 'claims made' policy need not show it was prejudiced by an insured's failure to provide timely notice of a claim in order to deny coverage on that ground"); *Coregis Ins. Co. v. Caruso*, 2006 WL 3762026 (E.D. Pa. 2006) (finding that under the law of either Pennsylvania or New Jersey the notice-prejudice rule does not apply to claims made policies).

Courts have routinely held that the strict requirement for timely notice under claims made and reported policies does not violate public policy. *Janjer v. Executive Risk*, 2004 WL 1011004 (4th Cir. 2004) (applying Maryland law); *DiLuglio v. New England Ins. Co.*, 959 F.2d 355 (1st Cir. 1992) (applying Rhode Island law); *Nat'l Union Fire Ins. Co. v. Talcott*, 931 F.2d 166 (1st Cir. 1991) (applying Massachusetts law); *The Home Ins. Co. v. ADCO*, 154 F.3d 739 (7th Cir. 1998) (applying Illinois law); *Merrill & Seeley, Inc. v. Admiral Ins. Co.*, 225 Cal. App. 3d 624, 275 Cal. Rptr. 280 (1st Dist. 1990); *Gulf Ins. v. Dolan, Fertig & Curtis*, 433 So. 2d 512 (Fla. 1983).

The claims made and reported policy requires that a claim presented to the insured must be reported to the insurer in the same policy year, even if the policy is later renewed. A claim made against the insured during one policy period, but not reported until the following renewal policy period may not be covered. *DiLuglio*, 959 F.2d at 360; *Talcott*, 931 F.2d at 168; *Nat'l Union Ins. Co. of Pittsburgh, Pa. v. Baker & McKenzie*, 997 F.2d 306, 307-309 (7th Cir. 1993). In other words, even if the insured has the same insurer for two consecutive one-year policy periods, there may be no coverage if a claim is made against the insured during the first policy period, but not reported until the second policy period. The plaintiff's amendment of the Complaint to add a new claim does not give the insured the right to report the new claim and get coverage for it if the insured never gave notice of the original claim against the insured in the original complaint. *Nat'l Union Fire Ins. Co. v. Willis*, 2002 WL 1369092 (5th Cir. 2002).

Some courts have, however, held that if the policy language indicates that the parties expected coverage to be continuous if renewed, then claims can be reported under the renewal policy. In *Oliver v. Coregis Ins. Co.*, 2002 WL 1478530 (9th Cir. 2002) (unpublished decision), the court determined that notice of claim first made during one policy period but given to the insurer during the term of the policy renewal was covered. In that case, the indication that the parties intended for the coverage to be continuous was found in an exclusion that applied only to claims known to the insured prior to the inception of the first policy issued by the insurer. This created an ambiguity as to when a claim had to be reported if the claim was first known to the insured *after the first policy*.

In *Helberg v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 102 Ohio App. 3d 679, 657 N.E.2d 832, 833-835 (1995), the court came to the same conclusion based on the same language, and based on language allowing claims to be reported during the policy period or during the extended policy period that the insured could *purchase* in the event of cancellation or non-renewal. The court held that this could mean that the extended reporting period was available *automatically* and for free if the policy was renewed. *Accord General Ins. Co. of America v. Rhodes*, 196 F.R.D. 620 (D.N.M. 2000).

Similarly, in *Cast Steel Products, Inc. v. Admiral Ins. Co.*, 348 F.3d 1298 (3d Cir. 2003) (applying Florida law), the court took pains to avoid a situation in which the insured would lose coverage where the claim was made during the policy period, but was not reported until hours after the policy expired and a renewal policy incepted. The insured timely reported the claim to its broker well within the policy period, but the broker did not immediately report the claim. The court grappled with the policy language that there was an automatic extended reporting period of 30 days if the policy was cancelled or non-renewed, but there was no extension if the policy were renewed. The court found this language ambiguous and troublesome because it left a gap in coverage even where coverage was continuous. In following *Helberg*, the court held that the 30-day extended reporting period applied in the event of renewal.

Where public policy concerns have arisen about insureds losing coverage for failing to report a claim before the policy expires, these concerns have generally been resolved by statutory extensions of the reporting periods by 60 or 90 days after termination of the policy. Other courts have, however, upheld the strict claims made and reported language even when the claim was made against the insured on the last day of the policy period or the last day of the extended reporting period, thus, making it difficult to

notify the insurer before the policy or reporting period expired. *United Nat'l Ins. Co. v. Jacobs*, 754 F. Supp. 865 (M.D. Fla. 1990); *Gulf Ins. Co. v. Dolan, Fertig & Curtis*, 433 So. 2d 512 (Fla. 1983).

3. Negligent Act, Error or Omission

Intentional acts or breach of contract claims may not be covered where an insurance policy contains an insuring agreement limited to "negligent acts, errors, or omissions." As the court in an unpublished federal district court opinion held:

Courts in other jurisdictions that have explicitly addressed the issue have almost uniformly held that "negligent act, error or omission" means "negligent act, negligent error, or negligent omission." These courts reasoned that it would be self-defeating for the insurers who draft these contracts to limit coverage for intentional acts, while at the same time covering intentional errors and omissions. *See, e.g., Employer's Reinsurance Corp. v. Teague*, 972 F.2d 339 (4th Cir.1992); *U.S. Fid. & Guar. Co. v. Fireman's Fund Ins. Co.*, 896 F.2d 200, 203 (6th Cir.1990); *Group Voyagers, Inc. v. Employers Ins. of Wausau*, C 01-0400, 2002 WL 356653 (N.D. Cal. March 4, 2002); *TIG Ins. Co. v. Joe Rizza Lincoln-Mercury, Inc.*, 00 C 5182, 2002 WL 406982, at *9 (N.D. Ill. March 14, 2002); *City of Dillingham v. CH2M Hill N.W., Inc.*, 873 P.2d 1271, 1275 (Alaska 1994); *Golf Course Superintendents Ass'n v. Underwriters at Lloyd's, London*, 761 F. Supp. 1485, 1490 (D. Kan.1991). *Cf. Connecticut Indem. Co. v. DER Travel Serv., Inc.*, 328 F.3d 347 (7th Cir. 2003) (assuming that the clause applies only to negligence) . . . The court is inclined to adopt the majority view that the adjective "negligent" unambiguously modifies "act," "error," and "omission" for the reason stated above.

Acordia Northeast, Inc. v. Thesseus Int'l Asset Fund NV, 2003 WL 22057003, *2 (S.D.N.Y. 2003). However, some courts have concluded that where the policy covers "any negligent act, error or omission or breach of duty," the term "negligent" does not necessarily modify all of the succeeding terms, thereby finding coverage for non-negligent "errors or omissions," such as RICO or breach of contract claims. *Volney Residence, Inc. v. Atlantic Mut. Ins. Co.*, 195 A.D.2d 434, 600 N.Y.S.2d 707 (1st Dep't 1993); *USM Corp. v. First State Ins. Co.*, 420 Mass. 865, 652 N.E.2d 613 (1995); *Continental Cas. Co. v. Cole*, 809 F.2d 891, 896-897 (D.C. Cir. 1987); *Employer's Reinsurance Co. v. Mut. Med. Plans, Inc.*, 504 N.W.2d 885 (Iowa 1993) (holding that "negligent" does not modify "error" or "omission"); *Aitchison v. Founders Ins. Co.*, 166 Cal. App. 2d 432, 333 P.2d 178 (Cal. Ct. App. 1958) (assuming that the policy language covered "errors" without addressing the issue of whether the errors need be negligent).

4. Rendering Professional Services

Unlike other broader types of insurance coverage, professional liability policies only cover claims "arising out of the rendering or failure to render services for others" in the insured's capacity as a professional within his or her particular specialty. Professional liability insurance, thus, provides limited coverage as a supplement to a comprehensive general liability policy. *Medical Records Assocs. v. American Empire Surplus Lines Ins. Co.*, 142 F.3d 512, 517 n.4 (1st Cir. 1998).

Courts throughout the country have stated that the test for "professional services" is as follows:

[W]hen a Court is determining the coverage of a professional liability insurance policy, it must examine the nature of the act performed, rather than the title or professional character of the actor [citations omitted]. Stated another way, a question of professional liability coverage is determined not by the professional status of the actor, but by the nature of the tortious act.

Niedzielski v. St. Paul Fire & Marine Ins. Co., 134 N.H. 141, 144, 589 A.2d 130, 131-32 (1991); *Marx v. Hartford Accident and Indem. Co.*, 183 Neb. 12, 157 N.W.2d 870 (1968) ("[i]n determining whether a particular act is of a professional nature or a 'professional service' we must look not to the title or character of the party performing the act, but to the act itself."); *see also Garland, Samuel & Loeb, P.C. v. American Safety Cas. Ins. Co.*, 2007 WL 2305475 (Ga. App. 2007) (citation omitted) ("[i]n determining what types of actions by an insured constitute the providing of 'professional services,' a court looks to the nature of the act the insured performed, rather than the title or status of the insured"). Thus, coverage requires more than just that the act occurred during business hours or at a place of business:

[S]omething more than an act flowing from mere employment or vocation is essential: a professional act or service arising out of a vocation, calling, occupation or employment involving specialized knowledge, labor, or skill that is predominantly mental or intellectual, rather than physical or manual.

Marx v. Hartford Accident & Indem. Co., 183 Neb. 12, 14, 157 N.W.2d 870, 872 (1968); *Roe v. Federal Ins. Co.*, 412 Mass. 43, 48-49, 587 N.E.2d 214, 217 (1992); *Atlantic Lloyd's Ins. Co. of Texas v. Susman Godfrey, LLP*, 982 S.W.2d 472 (Tex. App. 1998) (tasks performed by lawyers are not considered "professional services" if they are ordinary activities that can be completed by those lacking legal knowledge and skill); *Visiting Nurse Ass'n of Greater Phila. v. St. Paul Fire & Marine Ins. Co.*, 65 F.3d 1097, 1101 (3d Cir. 1995) (citation omitted) ("A 'professional' act or service is one arising out of a vocation, calling, occupation, or employment involving specialized knowledge, labor, or skill."); *Medical Records Assocs., Inc. v. Am. Empire Surplus Lines Ins. Co.*, 142 F.3d 512, 514-17 (1st Cir. 1998) (applying Massachusetts law) ("[P]rofessional services' . . . embrace those activities that distinguish a particular occupation from other occupations--as evidenced by the need for specialized learning or training--and from the ordinary activities of life and business."); *Noyes Supervision, Inc. v. Canadian Indem. Co.*, 487 F. Supp. 433 (D.C. Colo. 1980) (citation omitted) ("[t]raditionally, professional services has meant 'work requiring knowledge of an advanced type in a field of learning or science customarily acquired by a prolonged course of study of specialized intellectual instruction as distinguished from training in the performance of routine, manual, or physical processes'").

The definition of "professional services" allows the court to look at the specific activity undertaken by the lawyer, as opposed to imposing his or her status as an attorney upon normal business activities or other ministerial acts and creating professional services out of acts that do not require the specialized knowledge of a lawyer.

Courts thus recognize that acts performed in the course of a profession must be divided between those that are professional and those that are commercial, the latter not being covered by professional liability insurance. *Harrad v. Aetna Cas. & Sur. Co.*, 839 F.2d 979 (3d Cir. 1988); *see also Fanaras Enterprises, Inc. v. Roger Allen Doane*, 423 Mass. 121, 666 N.E.2d 1003 (1996) (borrowing money from client did not involve the rendering or failing to render professional services because an attorney-client relationship did not exist as to this loan); *Krasner v. Professionals Prototype I Ins. Co. Ltd.*, 983 F.2d 1076 (9th Cir. 1992) (the claim against attorneys for participation in a scheme to defraud insurance companies by creating new lawsuits and infiltrating existing ones is not "professional services" because attorney was not acting in his capacity as an attorney and claim did not involve allegations of professional malpractice).

a. Coverage for Business Torts

The most prevalent issue is whether an attorney's business pursuits constitute professional services when the business involves clients. Such activities are also often excluded under "business pursuits" exclusions. (SEE "EXCLUSIONS-BUSINESS PURSUIITS"). Most courts have held that these unrelated business pursuits do not constitute professional services. *See, e.g., General Acc. Ins. Co. v. Namesnik*, 790 F.2d 1397 (9th Cir. 1986) (applying Arizona law) (tax attorney was acting as business agent rather than attorney in soliciting clients' investments in corporations or partnerships formed and operated by attorney, and thus was not rendering professional services); *Cohen v. Empire Cas. Co.*, 771 P.2d 29, 31 (Colo. App. 1989) (dispute as to whether one attorney owed fees to another attorney for services rendered on behalf of client did not arise from rendering of professional services).

Courts in some cases have found coverage for business-related claims that were not traditional malpractice claims because there was a direct connection to the insured's rendering of professional services. *Westport Ins. Corp. v. Bayer*, 284 F.3d 489 (3d Cir. 2002) (fraudulent scheme); *Napoli, Kaiser Bern, LLP v. Westport Ins. Co.*, 295 F. Supp. 2d 335 (S.D.N.Y. 2003) (suit by referring law firms against working firms based on allocation of settlement amounts). These holdings sometimes provide that the issue of coverage comes down to the language in the policy and distinguish between policies that cover claims "caused by" or that "result from" errors in the rendering of professional services, and those policies that cover all claims "arising out of" professional services. Obviously, coverage under the latter policies is broader. See, e.g., *Jefferson - Pilot Fire & Cas. Co. v. Boothe, Prichard & Dudley*, 638 F.2d 670, 674-675 (4th Cir. 1980) (insurer had duty to defend insured law firm against an anti-trust suit brought by a client alleging that a bank and the firm had colluded to require that bank customers go to the firm; this could be construed as "arising out of" professional services); *American Motorists Ins. Co. v. Republic Ins. Co.*, 830 P.2d 785 (Alaska 1982) (allegations by competitor that insured architects made misrepresentations in their bid package were covered under policy covering acts "arising out of a vocation, calling, occupation or employment . . ."); *Sachs v. St. Paul Fire & Marine Ins. Co.*, 303 F. Supp. 1339 (D.D.C. 1969) (policy providing coverage for claims "arising out of the performance of professional services" covered claim by one attorney against another attorney for stealing a client).

However, courts in many cases have declined to find the necessary connection to "professional services," particularly where the policy is limited to claims that were "caused by" or that "resulted from" professional services. *Visiting Nurse Ass'n v. St. Paul Fire & Marine Ins. Co.*, 65 F.3d 1097 (3d Cir. 1995) (claims by competitor against health care company for anti-trust, RICO, and interference with contractual relations did not "result from" professional services: "when the claim is one asserted by the client, i.e., the user of the professional services, it would most likely follow that the claim will be covered by a professional services policy"); *Central Dakota Radiologists v. Continental Cas. Co.*, 769 F. Supp. 323 (D. N.D. 1991) (tort claims brought by competitor were not "caused by" the failure to provide professional services); *Albert J. Schiff Associates, Inc. v. Flack*, 425 N.Y.S.2d 612, 73 A.D.2d 329 (1980) (professional liability policy did not provide indemnity to actuary that was sued for unfair competition); *Attorneys' Title Guarantee Fund v. Maryland Cas. Co.*, 1991 WL 171339 (N.D. Ill. Aug. 23, 1991) (claim against title company for unfair competition and business torts arising from insured's luring clients away from competitors may have alleged acts committed during the course of rendering professional services, but was not a malpractice claim involving the issuance of title opinions that contained errors, omissions or mistakes); *Potomac Ins. Co. v. McIntosh*, 167 Ariz. 30, 804 P.2d. 759 (1991) (claim against attorney was for losses proximately caused by insured's involvement as partner in business, and not as a result of the rendering of legal services); *Crum & Forster Managers Corp. v. Resolution Trust Corp.*, 620 N.E.2d 1073 (Ill. 1993) (professional liability insurer had no obligation to defend claims against real estate agent by former agency for business torts and unfair competition as this was not a claim made against the insured "by reason of" an act or omission in professional services; policy required that there be a "direct causal relationship").

b. Coverage for Fee Disputes

Fee disputes between the professional and the client are not generally covered. *Gregg & Valby, L.L.P. v. Great American Ins. Co.*, 316 F. Supp. 2d 505 (S.D. Tex. 2004) (billing and setting fees are not acts constituting "professional services"); *Nat'l Union Fire Ins. Co. v. Shane & Shane Co., L.P.A.*, 78 Ohio App. 3d 765, 605 N.E.2d 1325 (1992) (a claim by a client alleging that the attorney took a greater percentage of the settlement than appropriate did not constitute a claim "arising out of any act, error or omission of the insured in rendering or failing to render professional services . . ." because a fee dispute was not the same as the rendering of professional services); *Medical Records Assocs., Inc.*, 142 F.3d at 517 n.4. (cases finding coverage for fee disputes were under policies providing coverage for claims "arising out of" professional services, as opposed to the policy at issue in the present case which provided coverage for claims "by reason of" acts or omissions in the rendering of professional services); *Reliance Nat'l v. Sears, Roebuck & Co.*, 58 Mass. App. Ct. 645, 792 N.E.2d 145 (2003) (claim of fraudulent billing not "professional services").

Courts in other cases have found coverage for fee disputes between lawyers at different firms and for disputes about stealing clients. *Sachs v. St. Paul Fire & Marine Ins. Co.*, 303 F. Supp. 1339 (D.D.C. 1969) (policy providing coverage for claims "arising out of the performance of professional services" covered claim by one attorney against another attorney for stealing a client); *Lyons v. American Home Ins. Co.*, 354 N.W. 2d 892 (Minn. Ct. App. 1985) (attorney-client fee agreement is an integral part of the professional relationship); *Continental Cas. Co. v. Cole*, 809 F.2d 891 (D.C. Cir. 1987). (SEE "DEFINITIONS-DAMAGES").

c. Claims Between Members of Same Firm

Disputes between partners or other members of a professional firm are usually not covered. *Roberts v. Fla. Lawyers Mut. Ins. Co.*, 839 S.2d 843, 846 (Fla. Ct. App. 2003) (fee dispute between former partners did not arise from law firm's rendering of professional services); *Blumberg v. Guar. Ins. Co.*, 192 Cal. App. 3d 1286, 238 Cal. Rptr. 36 (1987) (disputes between law partners that did not involve actual or potential clients was not covered by a professional liability policy); *Trans-American Ins. Co. v. Sayble*, 193 Cal. App. 3d 1562, 239 Cal. Rptr. 201 (1987) (same); *Roberts v. Florida Lawyers Mut. Ins. Co.*, 839 So. 2d 843 (Fla. App. 2003) (dispute between former partners on how to divide fee was not covered). *Contrast Biborosch v. TransAmerican Ins. Co.*, 412 Pa. Super. 505, 603 A.2d 1050 (1992) (professional liability insurer of insurance agency was required to defend wrongful discharge and related tort claims against the insured by former employee because the policy did not define the term "professional services," which could include alleged tortious conduct).

d. Professionals Acting in Dual Capacities

It has been held that a professional performing some services that did not involve the insured's profession, along with those that did, has coverage under a professional liability policy. *Jensen v. Snellings*, 841 F.2d 600, 613 (5th Cir. 1988) (insured was acting as attorney and investment advisor); *Niagara Fire Ins. Co. v. Pepicelli, Pepicelli, Watts & Youngs, P.C.*, 821 F.2d 216, 221 (3d Cir. 1987) (law firm submitted an erroneous proof of loss for client under a fire insurance policy); *Regas v. Continental Cas. Co.*, 487 N.E.2d 105, 109 (Ill. 1985) (lawyer wrote a check on law firm's escrow account to assist in closing a real estate deal); *Malikoff, Wasserman & Pecker, P.C. v. American Home Ins. Co.*, (Nassau County, Jan. 19, 1993) (accountant was negligent in dual role as member of insured accounting firm and as member of uninsured company); *Toms v. Lawyers Mut. Liab. Ins. Co.*, 104 N.C. App. 88 408 S.E.2d 206 (1991) (there were genuine issues of material fact as to whether attorney's failure to obtain liability insurance for aircraft was within the scope of his professional services to the client); *Continental Cas. Co. v. Burton*, 795 F.2d 1187, 1188-1189 (4th Cir. 1986) (attorney was covered where he represented clients in settling their spouses' estates and then investing the money); *Westport Ins. Corp. v. Bayer*, 284 F.3d 489 (3d Cir. 2002) (policy was ambiguous as to whether it excluded claim that attorney was hired to set up a commission agreement between an investor and a fraudulent mortgage investment company and became heavily invested in the fraudulent company and allowed future investments to be made at his law office, prepared installment notes, and transferred money invested).

There are, however, cases in which courts have found no coverage in these situations. *Smith v. Travelers Indem. Co.*, 343 F. Supp. 605, 609 (M.D. N.C. 1972) (no coverage where plaintiff gave an attorney \$15,000 to invest for him and brought suit after the attorney failed to make interest payments: "[t]he controlling test should be whether the attorney was engaged in legal services or for work which is not inherently the practice of law, and if it is the latter, it is non-legal services even if his knowledge of the law came into play during the transaction") (citing *Ellenstein v. Herman Body Co.*, 23 N.J. 348 (1957)); *General Accident Ins. Co. v. Namesnik*, 790 F.2d 1397, 1399 (9th Cir. 1986) (where attorney recommended investments to clients and formed partnerships for them which resulted in large financial losses, attorney was acting as a business agent and not as an attorney for purposes of the attorney's professional liability policy).

e. Coverage for Sex With Clients

There are cases in which it is alleged that a consensual or non-consensual sexual relationship between a client and a professional was tortious. When lawyers, doctors, dentists or other professionals are involved, coverage is usually not provided because the sexual encounter does not arise out of professional services. *See generally Roe v. Federal Ins. Co.*, 412 Mass. 43, 587 N.E.2d 214 (1992) (holding that because a dentist's practice consists of working on teeth and has no relation to the alleged sexual acts, sexual molestation of a patient during office visits did not warrant coverage under a "professional services" insurance policy provision); *Smith v. St. Paul Fire & Marine Ins. Co.*, 353 N.W.2d 130 (Minn. 1984) (finding that general practitioner's sexual abuse of minor patients did not constitute "professional services" because they were independent of medical treatment, and committed merely for the satisfaction of the doctor's own prurient interests).

One relevant exception is where the sex was a *quid pro quo* for the professional services, or the sexual relationship adversely affected the services provided. *Bertagnolli v. Ass'n of Trial Lawyers Assurance*, 934 P.2d 916 (Colo. Ct. App. 1997) (attorney's professional liability insurer correctly denied coverage for rape claim, based in part, on an exclusion for "any claim for bodily injury to . . . any person, or injury arising out of an act of any insured unless it arises out of an act committed in his or her professional capacity as an attorney"). *Cf. Vallinoto v. DiSandro*, 688 A.2d 830 (R.I. 1997) (even if there "were a *quid pro quo* for sexual favors, Vallinoto's claim would still fail because of the complete absence of any competent and relevant probative evidence of damages that resulted to her legal position, or to her legal detriment personally, as a result of DiSandro's inappropriate sexual activities"), *Suppressed v. Suppressed*, 206 Ill. App. 3d 918, 565 N.E.2d 101 (Ill. Ct. App. 1990) (an attorney's seduction of a client while he was representing her in a divorce action did not constitute a breach of fiduciary duty). *Contrast Doe v. Roe*, 224 Ill. Dec. 325, 681 N.E.2d 640 (1997) (attorney who committed numerous acts of professional misconduct against his client in a divorce case, and was involved in a sexual relationship with her, could be found to have breached a fiduciary duty: "if, as alleged, the Defendant declined to pursue the Plaintiff's right to seek reimbursement of her attorney's fees from her former husband out of fear of personal embarrassment and potential professional discipline, he breached his fiduciary duty by placing his personal interests above the interests of his client.")

f. Must Be Rendering Services for "Others"

Coverage is usually provided only for errors when the professional is performing services for "others." *Mendelsohn v. CNA Ins. Co.*, 451 N.E.2d 919 (Ill. 1983) (attorneys conduct in divorce proceeding where he was pro se against his wife does not arise out of the provision of professional services to others and did not trigger coverage under his professional liability policy); *Elliot v. Continental Cas. Co.*, 949 So. 2d 1247 (La. 2007) (claims by attorney against another attorney for referring a case that was barred by the statute of limitations did not arise out of the rendering of professional services because referring attorney was not performing services for working attorney). This does not necessarily mean that the "others" are clients, as opposed to other affiliated professionals, such as where two law firms formed a joint venture and were performing legal services with each other. *Continental Cas. Co. v. Cole*, 809 F.2d 891, 896 (D.C. Cir. 1987).

B. Limitations on Coverage

Provided always that such professional services occur:

1. **during the policy period; or**
2. **prior to the policy period, provided that prior to the effective date of the first Lawyers Professional Liability Insurance Policy issued by this Company to the Named Insured firm and continuously renewed and maintained in effect to the inception of this policy period:**

- a) **The Insured did not give notice to any prior insurer of any such act, error, or omission;**
- b) **The Named Insured, any partner, shareholder, employee, or where appropriate the Named Insured's management committee or any member thereof, had no reasonable basis to believe that the Insured had breached a professional duty or to foresee that a claim would be made against the Insured; and**
- c) **There is no prior policy or policies which provide insurance for such claim, unless the available limits of liability of such prior policy or policies are insufficient to pay any Claim, in which event this policy will be excess over any such prior coverage, subject to this policy's terms, limits of liability, exclusions and conditions.**

The most common coverage issues that occur under these limitations concern whether the policy contains a retroactive date and what its effect is, whether the insured had prior knowledge of a potential claim, and whether there is a prior policy of insurance that might cover the claim.

1. Retroactive Dates

Many claims made policies contain retroactive dates. That is, dates prior to which no acts committed by the insured are covered by the policy. This is a limitation on the basic "claims-made" coverage of a policy, which ordinarily covers claims reported to the carrier during the coverage period regardless of when the acts occur. *Gavic v. American Bankers*, 106 Wis. 2d 770, 318 N.W.2d 25 (Wis. App. 1982) (unpublished) (the retroactive date provision only modifies claims made policies, and it does not expand coverage). When an insured has a retroactive date, there will be no coverage if a claim is based upon or arises out of an act that occurred prior to that date, even though the claim may be made against the insured during the policy period. *Fremont Indem. Co. v. California Nat'l Physician's Ins. Co.*, 954 F. Supp. 1399 (C.D. Cal. 1997). Courts often hold that retroactive dates are valid and not against public policy. *Malmay v. Sherman*, 2003 WL 22077786 (E.D. La. 2003) (retroactive date is not ambiguous even though it carves out an exception to claims made coverage); *James J. Mawn v. Enterprises, Inc. v. Protective Liab. Joint Underwriting Ass'n*, 42 Mass. App. Ct. 417, 677 N.E.2d 1162 (1997) (retroactive date coinciding with effective date of the policy was valid and was not against public policy). *But see Hodge v. Garrett*, 263 N.J. Super 278, 622 A.2d 930 (1993) (the claims made carrier cannot make retroactive date coincide with commencement of policy unless it offers retroactive coverage) (citing *Sparks v. St. Paul Ins. Co.*, 100 N.J. 325, 495 A.2d 406 (1985)).

One issue that often comes up is the question of whether there is coverage for acts that begin prior to the retroactive date, and continue into the period covered by the policy. This analysis can become particularly troublesome where it is alleged that the insured failed to perform some act, and the alleged failure occurred both before and after the retroactive date. *O'Donnell v. Twin City Ins. Co.*, 40 F. Supp. 2d 68 (D.R.I. 1999); *Colip v. Clare*, 26 F.3d 712 (7th Cir. 1994); *Michelle Derrah v. John B. Shorton*, 97-3005-D (Mass. Super. Ct., July 3, 2000); *Coregis v. Frank M. Blancata*, 75 F. Supp. 2d 319 (S.D.N.Y. 1999) (there was no evidence that any wrongful acts occurred after retroactive date and continuing representation of malpractice plaintiff by the insured after the retroactive date did not establish coverage).

2. Prior Knowledge

Courts in many jurisdictions have found that problems in the underlying representation can give an insured a reasonable basis to believe that a claim is forthcoming. This is especially true if the client complains to the insured about the result. To the extent the file or other evidence were to reveal such complaints, the insureds would have a basis to believe they breached the standard of care and/or to

foresee a claim, and coverage would be in jeopardy. Simply losing a case may not be enough "prior knowledge to trigger this coverage limitation." *Westport Ins. Co. v. Lilley*, 2003 WL 22705346 (D. Me. 2003).

No court has expressly rejected the concept of barring coverage for claims of which the insured had prior knowledge. Consequently, most courts have held that prior knowledge clauses are unambiguous and enforceable. See *Phoenix Ins. Co. v. Sukut Constr. Co.*, 136 Cal. App. 3d 673, 677, 186 Cal. Rptr. 513 (1982); *Westport Ins. Co. v. Mirsky*, 2002 WL 31018554 (E.D. Pa. 2002). The definition of "prior knowledge" may be judged by either an objective or a subjective standard, or a combination of both.

a. Objective vs. Subjective Standard

In determining whether the insured could have anticipated a claim, many courts apply an objective test. Using that test, courts look to what an objectively reasonable attorney knew or should have known. *Maynard v. Westport Ins. Corp.*, 208 F. Supp. 2d 568, 576 (D. Md. 2002), *aff'd*, 55 Fed. App'x. 667 (4th Cir. 2003) (looking to what "objectively reasonable attorney knew or should have known"); *Nat'l Union Ins. Co. v. Holmes & Graven*, 23 F. Supp. 2d 1057, 1066 (D. Minn. 1998) (an objective, and not a subjective, standard applies when determining whether the insured knew or could have reasonably foreseen); *Mt. Airy Ins. Co. v. Thomas*, 954 F. Supp. 1073, 1079 (W.D. Pa. 1997), *aff'd*, 149 F.3d 1165 (3d Cir. 1998).

There are also courts that apply a test with both subjective and objective components. This is essentially a two-step approach:

First, it must be shown that the insured knew of certain facts.

Second, in order to determine whether the knowledge actually possessed by the insured was sufficient to create a "basis to believe," it must be determined that a reasonable lawyer in possession of such facts would have had a basis to believe that the insured had breached a professional duty; that the insured denies recognizing such a basis on grounds of ignorance of the law, oversight, psychological difficulties, or other reasons is immaterial.

Selko v. Home Ins. Co., 139 F.3d 146, 152 (3d Cir. 1998); *Coregis Ins. Co. v. Baratta & Fenerty, Ltd.*, 264 F.3d 302 (3d Cir. 2001). *Accord Culver v. Continental Ins. Co.*, 1999 WL 503527 4th Cir. 1999); *Coregis Ins. Co. v. Camico Mut. Ins. Co.*, 959 F. Supp. 1213, 1222-23 (C.D. Cal. 1997); *Mt. Airy Ins. Co. v. Thomas*, 954 F. Supp. 1073, 1077-79 (W.D. Pa. 1997); *Home Indem. Co. of Manchester, N.H. v. Toombs*, 910 F. Supp. 1569, 1573 (N.D. Ga. 1995); *Int'l Ins. Co. v. Peabody Int'l Corp.*, 747 F. Supp. 477 (N.D. Ill. 1990); *Employers' Liab. Assur. Corp. v. Hoechst Celanese Corp.*, 43 Mass. App. Ct. 465, 473-474 & n.9, 684 N.E.2d 600, 606 & n.9 (1997).

Thus, "[t]he insured may not successfully defend on the ground that he was uniquely unaware of ethical and fiduciary principles that all lawyers would know, or that he would not understand the implications of conduct and events that any reasonable lawyer would have grasped." *Selko*, 139 F.3d at 152. Under this test, if the facts actually known to the insured would have generated the apprehension of a claim or suit by an objectively reasonable insured, it is irrelevant that the insured alleges he had no such apprehension. *Mt. Airy v. Thomas*, 954 F. Supp. at 1077-79.

The mixed two-part test addresses the criticism that has been leveled at a purely objective test, namely, that it imputes to an insured knowledge of his or her own legal error at the time he or she made it, if a reasonable insured would have understood the error at that time. Such a test would deprive lawyers of the benefit of the very coverage they buy to protect themselves against their own lack of reasonable care and attentiveness.

Very few courts have applied a subjective test. *See, e.g., Petersen v. TIG Ins. Co.*, 2002 WL 31413808 (D. Neb. 2002) (finding that Nebraska courts would use the subjective standard and determine what the attorney knew). In *Estate of Logan v. Northwestern Cas. Co.*, 424 N.W.2d 179 (Wis. 1988), the court applied what it deemed to be a "subjective test," although it rejected the insured's testimony that he did not subjectively believe he had breached a duty that could lead to a claim.

b. Innocent Insureds

Courts have held that knowledge of a potential claim by *any* employee of a law firm will defeat coverage, even if that knowledge was not disclosed to management or a partner of the firm. Thus, courts have rejected the argument that the waiver of exclusions and conditions clauses for "innocent insureds" preserved coverage in these situations, because those clauses only apply to the intentional acts exclusion or the notice provisions.

In *Ehrgood v. Coregis Ins. Co.*, 59 F. Supp. 2d 438, 445-446 (M.D. Pa. 1998), the policy contained an exclusion, Exclusion B, which barred coverage for acts occurring prior to the policy period if "any INSURED knew or could have foreseen" that the acts "might be expected to be the basis of a claim; . . ." The policy also contained a waiver for "innocent insureds" of the intentional acts exclusion, which was Exclusion A in the Coregis policy. The "innocent insured" partners asserted that this waiver of Exclusion A somehow precluded Exclusion B from being asserted against them. The court rejected this argument on the basis that the policy, by its clear terms, did not waive as to innocent insureds the prior acts exclusion, Exclusion B, and that Exclusion B was the one that was being relied upon by the insurer.

Many courts have found that this limitation, or similarly worded exclusions, are neither against public policy nor ambiguous, and have enforced them against innocent insureds. *Coregis Ins. Co. v. McCollum*, 961 F. Supp. 1572, 1579 (M.D. Fla. 1997); *Westport Ins. Corp. v. Atchley, Russell, Waldrop & Hlavinka, LLP*, 267 F. Supp. 2d 601, 607 (E.D. Tex. 2003); *Coregis Ins. Co. v. Lyford*, 21 F. Supp. 2d 695 (S.D. Tex. 1998) (exclusion is not ambiguous); *Westport Ins. Co. v. Mirsky*, 2002 WL 31018554 (E.D. Pa. 2002) (prior knowledge exclusion applies if "any insured" has knowledge of potential claim), *aff'd*, 2003 WL 23002528 (3d Cir. 2003); *Spezialetti v. Pac. Employers Ins. Co.*, 759 F.2d 1139, 1142 (3d Cir.1985) (stating that exclusion based on acts of "any insured" unambiguously precluded coverage for innocent co-insureds). (SEE "SEVERABILITY CLAUSE").

There are a few more recent cases where the courts have refused to allow a carrier to disclaim based on the prior knowledge of an associate or employee. *In re John Perrone*, 2002 WL 31386028 (Bankr. Mass. Oct. 18, 2002) (bookkeeper); *Chicago Ins. Co. v. Lappin*, 792 N.E.2d 1018 (Mass. App. Ct. 2003); *Fuchsberg & Fuchsberg v. Galizia*, 300 F.3d 105 (2d Cir. 2002) (insurer was barred by collateral estoppel from denying coverage based on associate's prior knowledge, which was not communicated to partners, because a prior decision in a case brought by the same carrier implicitly rejected this argument).

c. Lack of Mitigating Factors

The insured's claim that he or she did not report the matter because he or she did not believe that any claims would be made due to his or her relationship with the client, or that any such claim would be frivolous, has generally not been deemed to excuse the failure to disclose. *See, e.g., Coregis Ins. Co. v. McCollum*, 961 F. Supp. 1572, 1579 (M.D. Fla. 1997) ("In no way does the exclusion [for potential claims known to the insured] require that such a claim have merit or that the insured reasonably believed it to have merit"); *Chicago Ins. Co. v. Halcond*, 49 F. Supp. 2d 312, (S.D.N.Y. 1999) (same); *General Ins. v. Boyd*, 2002 WL 1610998 (S.D. Ind.) (same); *Coregis Ins. Co. v. Wheeler*, 24 F. Supp. 2d 475, 479 (E.D. Pa. 1998) (disputes over "whether the defendant believed, on the basis of his relationship with his client or his impression of that client's reaction to the situation, that the client would not make a claim is not relevant to our analysis"); *Coregis Ins. Co. v. Baratta & Fenerty, Ltd.*, 264 F.3d 302 (3d Cir. 2001) (an attorney "cannot assume that the claim will not be brought because he subjectively believes it . . . lacks merit."); *Brownston & Washko v. Westport Ins. Co.*, 2002 WL 1745910 (E.D. Pa. 2002) (comments by client's new lawyer that prior lawyer was "off the hook" did negate potential claim); *Tewell, Thorpe & Findlay, Inc., P.S. v. Continental Cas. Co.*, 64 Wash. App. 571, 825 P.2d 724 (Wash. App. 1992) ("The

language of the notice provision does not require the prediction of claims with absolute certainty or exactitude. Rather, the focus of the clause is on the underlying 'acts and omissions' that are the subject of a dispute which might give rise to a claim"). *Compare Coregis Ins. Co. v. Goldstein*, 32 F. Supp. 2d 508 (D. Conn. 1998) (insured not obligated to report potential claim as he actually disclosed to the client his failure to file suit and received an ambiguous response that did not indicate that the client intended to sue, and had no reasonable basis to believe that the limitations period had run on his client's claims).

Moreover, the fact that the original claim against the insured firm alleged only intentional conduct, which the insured did not believe was covered, did not excuse the insured from reporting the matter to the carrier because it still satisfied the definition of a "claim." *Nat'l Union Ins. Co. v. Willis*, 296 F.3d 336 (5th Cir. 2002).

3. Prior Insurance

The limitations in the insuring agreement state that the policy will be excess of over any prior policy that applies to the same claim. A "prior policy" has been defined as one with an earlier commencement or inception date. *Fremont Indem. Co. v. New England Reinsurance, Co.*, 168 Ariz. 476, 480 n.4, 815 P.2d 403, 407 n.4 (1991); *Smith v. Neumann*, 289 Ill. App. 3d 1056, 682 N.E.2d 1245 (Ill. App. Ct. 1997). The issue usually comes up when a lawyer changes firms and gets sued while employed by the second firm for an act committed at the first firm. The first firm's policy usually covers "former" partners and associates for acts committed at the firm, and the second firm policy may provide "full prior acts" coverage for its partners and employees, thereby providing coverage for acts committed at prior firms. Standing alone, this limitation would make the policy with the earlier inception date the primary policy, and the later-incepting policy the excess policy.

However, no clause in an insurance policy stands alone. In most cases, that earlier incepting policy will have an "other insurance" clause in the policy's "Conditions" section stating that it will be excess over *any* other insurance policy. Thus, the earlier-incepting policy seeks to be excess over the later one. Unless there is reason to favor one policy's language over the other, there will be mutual repugnance, and both policies will contribute to the loss.

One line of cases holds that the "prior policy" language in the insuring agreement acts as a "trump" over conflicting "other insurance" language in another policy's "Conditions" section. Thus, the earlier-incepting policy will be primary. *Smith*, 289 Ill. App. 3d 1056, 682 N.E.2d 1245; *Evanston Ins. Co. v. Affiliated FM Ins. Co.*, 566 F. Supp. 135 (D. Conn. 1983); *Chamberlin v. Smith*, 72 Cal. App. 3d 835, 140 Cal. Rptr. 493 (1997).

A growing number of cases, however, have determined that regardless of whether the "other insurance" clause is in the insuring agreement or in the "Conditions" section of the policy, the intent of both clauses is to make another policy go first; resulting in a tail-chasing game of draftsmanship akin to "rock paper scissors." In this situation, the policies must both share in the loss. *Fremont Indem. Co.*, 168 Ariz. 476, 815 P.2d 403, *Continental Cas. Co. v. The Home Ins. Co.*, 1992 WL 357153, 980 F.2d 736 (9th Cir. 1992) (applying California law); *The Home Ins. Co. v. St. Paul Ins. Co.*, 229 F.3d 56 (1st Cir. 2000) (applying Maine law).

II. THE DUTY TO DEFEND

The Company shall have the right and duty to defend any suit against the Insured seeking damages to which this insurance applies even if any of the allegations of the suit are groundless, false or fraudulent. In no event shall the Company be obligated to pay Damages or Claim Expenses or to defend, or continue to defend, any suit after the applicable limit of the Company's liability has been exhausted by payments of judgments, settlements, Damages or Claim Expenses, as applicable.

The significant issues raised by this clause are what facts determine the existence of the duty to defend, the scope of the defense, the circumstances under which the insurer may terminate its defense, and the selection of defense counsel.

A. Tender of the Defense

One important threshold point is that the insurer may have no duty to defend unless *the insured* gives notice of the claim to the insurer and specifically requests a defense. An insurer's awareness of a claim (perhaps through notice from the claimant rather than the insured) may not, in and of itself, obligate the insurer to defend where the insured does not specifically request such a defense.

Courts are split on this issue. *Great American Ins. Co. v. Short*, 2001 WL 1264944 (Cal. App. Dist. 2001) (notice from claimant is sufficient to trigger defense); *Mahone v. State Farm Mut. Auto Ins. Co.*, 188 Ga. App. 664, 373 S.E.2d 809, 811 (1988) (notice requirement "satisfied if the insurer receives notice of the suit either from an insured or from a third party"); A. Windt, *Insurance Claims and Disputes*, 4.01, at 128-129 (2d ed. 1988) (no need to make specific tender); *White Mountain Constr. Co. v. Transamerica Ins. Co.*, 137 N.H. 478, 631 A.2d 907 (1993) (same); *Delta Group, Inc. v. DBI*, 204 Wis. 2d 515, 555 N.W.2d 162 (1996) (same); *Cincinnati Cos. v. West American Ins. Co.*, 183 Ill. 2d 317, 701 N.E.2d 499 (1998) (notice from anyone is sufficient, but insurer need not defend if insured knowingly waives insurer's involvement; citing cases going both ways); *Hansen v. Barmore*, 779 P.2d 1360 (Colo. Ct. App. 1989) (proper notice given when plaintiff mailed copy of served complaint to defendant's insurance company); *Wilson v. U.S. Fid. & Guar. Co.*, 633 P.2d 493, 496 (Colo. Ct. App. 1981) (notice by injured party satisfied insured's notice requirement); *Standard Oil Co. of California v. Hawaiian Ins. & Guar. Co., Ltd.*, 65 Haw. 521, 654, P.2d 1345, 1348 n.4 (1982) (notice received from other insured under policy was sufficient); *Bibb v. Dairyland Ins. Co.*, 44 Mich. App. 440, 205 N.W.2d 495, 496 (1973) (notice received from injured party's attorney was sufficient). *But see White v. Transit Ins. Co.*, 402 S.W.2d 212 (Tex. Civ. App. 1966) (notice by claimant is not "on behalf of insured"); *see E&L Chipping Co., Inc. v. Hanover Ins. Co.*, 962 S.W.2d 272 (Texas Ct. App. 1998) (insured must make direct demand for coverage); *Cas. Indem. Exch. Ins. Co. v. Liberty Nat'l Fire Ins. Co.*, 902 F. Supp. 1235, 1239 (D. Mont. 1995) (same); *Unigard Ins. Co. v. Leven*, 983 P.2d 1155 (Wash. App. 1999) (insured must request a defense, but insurer must show prejudice from breach before it can refuse to pay defense costs); *Roofing Consultants, Inc. v. Scottsdale Ins. Co.*, 273 A.D.2d 933, 709 N.Y.S.2d 782, 783 (4th Dep't 2000) ("neither notice provided by another insured nor the insurer's actual knowledge of the claim satisfies the contractual obligation of an insured to give timely notice").

Some states have resolved the issue by statute, specifically allowing claimants to give notice. *See, e.g.*, G.A. Code Ann. 33-7-15(c); Mich. Comp. Laws Ann. 500.3008; New York Ins. Law 3420(a)(3).

B. Facts the Insurer Can or Must Rely on to Determine Its Defense Obligations

For a comprehensive state-by-state survey of the facts to be considered by an insurer in determining its duty to defend, *see* Michael Orlando and Megan Gabel, *The Duty to Defend: What a Difference a State Makes!*, The Brief, at pp. 14-21 (Summer 2000).

1. Pleadings

It is well-established that the insurer's duty to defend is broader than its duty to indemnify. *See Frontier Insulation Contractors, Inc. v. Merchants Mut. Ins. Co.*, 91 N.Y.2d 169, 667 N.Y.S.2d 982 (1997); *Meadowbrook, Inc. v. Tower Ins. Co.*, 559 N.W.2d 411 (Minn. 1997); *Farmers Union Mut. Ins. Co. v. Staples*, 90 P.3d 381 (Mont. 2004). Therefore, an insurer is obligated to defend its insured where the complaint states facts which, if proven true, would bring the alleged injury within coverage, irrespective of the insurer's ultimate liability to indemnify. *Id.*; *Skinner v. Allstate Ins. Co.*, 2005 MT 323, 329 Mont. 511, 127 P.3d 359 (2005) (even when a court concludes that coverage applies such that an insurer must defend the insured, a fact-finder may later reach a decision on the disputed facts and conclude that an insurer has no duty to indemnify). However, it is hornbook law that there is no duty to defend when there

is no indemnity available under the policy. See B. Ostrager & T. Newman, *Handbook on Insurance Coverage Disputes*, § 5.02, at 204-208 (2004) (citing cases).

Under the general "four corners of the complaint" rule, the insurer, in determining its duty to defend, must consider the claims as pleaded in the complaint, even if they are groundless, false or fraudulent. *Mt. Vernon Fire Ins. Co. v. Scottsdale Ins. Co.*, 99 Md. App. 545, 638 A.2d 1196 (1994), *aff'd in relevant part, sub nom.*; *Chantel Assoc. v. Mt. Vernon Fire Ins. Co.*, 338 Md. 131, 656 A.2d 779 (1995); *Mut. Ben. Ins. Co. v. Jordan*, 2001 WL 313880, (4th Cir. 2001) (applying Maryland law); *American Guar. & Liab. Ins. Co. v. The 1906 Co.*, 273 F.3d 605, 610 (5th Cir. 2001) (applying Mississippi law); *Unionamerica Ins. Co., Ltd. v. J.B. Johnson*, 806 A.2d 431 (Pa. Super. 2002); *American Economy Ins. Co. v. Fort Deposit Bank*, 890 F. Supp. 1011 (M.D. Ala. 1995); *Seaboard Sur. Co. v. Gillette Co.*, 64 N.Y.2d 304, 486 N.Y.S.2d 873 (1984). The policy language is usually to the same effect.

The carrier can, nonetheless, be relieved of its duty to defend if it establishes in a declaratory judgment action that the facts, as opposed to the allegations, demonstrate a lack of coverage. *Sterillite Corp. v. Continental Cas. Co.*, 17 Mass. App. Ct. 338, 343, 458 N.E.2d 338 (1983); *Northville Indus. Corp. v. Nat'l Union Fire Ins. Co.*, 89 N.Y.2d 621, 657 N.Y.S.2d 564 (1997).

Conversely, a "patently 'groundless' and 'shot-gun' allegation" in a complaint is insufficient to bring an otherwise uncovered claim within the scope of coverage. *Lionel Freedman, Inc. v. Glens Falls Ins. Co.*, 27 N.Y.2d 364, 318 N.Y.S.2d 303, 306 (1971). Thus, where a complaint sets forth factual allegations of uncovered conduct, the mere recitation of conclusory allegations of negligence, which are inconsistent with the intrinsic nature of the misconduct factually alleged, will not suffice to give rise to a duty to defend. See, e.g., *Creagh v. Tudor Ins. Co.*, 931 F.2d 886, 1991 WL 64945 (4th Cir. 1991) (applying Maryland law) ("This court would be totally ignoring the clear language and fair effect of the watercraft exclusion clause, if it permitted appellants to create a duty to defend by artful pleading"); *Allstate Ins. Co. v. Mugavero*, 79 N.Y.2d 153, 581 N.Y.S.2d 142, 147-48 (1992) (allegations of child abuse is inconsistent with claim of negligence); *Winnacunnet Coop. Sch. Dist. v. Nat'l Union*, 84 F.3d 32 (1st Cir. 1996) (claim based on murder was not negligent); *State Farm Fire & Gas Co. v. Tolmie*, 1998 WL 737981 (E.D. Pa. 1998); *Bagley v. Monticello Ins. Co.*, 430 Mass. 454, 720 N.E.2d 813 (1999); *Continental Cas. Co. v. Richmond*, 763 F.2d 1076, 1081 (9th Cir. 1985); *J.E.M. v. Fidelity & Cas. Co.*, 928 S.W.2d 668, 675 (Tex. App. 1996) (even though plaintiff alleged a cause of action for negligence, the facts alleged a sexual assault, an intentional injury, which was not covered by the policy); *Burlington Ins. Co. v. Mexican Am. Unity Council, Inc.*, 905 S.W.2d 359, 361 (Tex. App. 1995) (even though plaintiff alleged a cause of action for negligence, the facts alleged an assault, which was not covered by the policy).

Similarly, it has been argued that coverage is generally unavailable under a LPL policy where a negligence claim is asserted by a non-client. The theory would be that because an attorney owes no duty to a non-client (except to refrain from fraud, collusion or malicious misconduct), see *Michalic v. Klat*, 128 A.D. 2d 505, 512 N.Y.S.2d 436, 437-38 (2d Dep't 1987), any negligence claim against the attorney (perhaps no matter what facts are alleged) is potentially without merit and therefore insufficient to trigger coverage. See generally, R. Mallen & J. Smith, *Legal Malpractice* § 7.1 (5th Ed. 2000) ("Allowing a duty to a third party encroaches on the essential obligations of undivided loyalty, independent judgment and confidentiality owed to the client."). Some states only allow a nonclient to recover against an attorney in circumstances where the nonclient is an intended third-party beneficiary of the attorney-client relationship. See, e.g., *Ferguson v. Cramer*, 349 Md. 760, 766, 709 A.2d 1279, 1282 (1998). However, many states allow recovery, under limited circumstances, by nonclients. See, e.g., *Flaherty v. Weinberg*, 303 Md. 116, 492 A.2d 618 (1985) (real estate purchasers permitted to bring action against bank's attorney at real estate closing because purchasers relied upon representation of bank's attorney, thereby making the purchasers intended third-party beneficiaries of attorneys' legal services to bank); *Credit Alliance Corp. v. Arthur Andersen & Co.*, 65 N.Y.2d 536, 493 N.Y.S.2d 435 (1985) (allowing certain claims for negligent misrepresentation against professionals based on implied "functional equivalent" of privity).

2. Extrinsic Facts

There is widespread authority for the proposition that even if the "four corners of the complaint" do not state a covered claim, if the insurer has actual knowledge of facts outside the complaint that demonstrate coverage, the insurer must take them into account. *See, e.g., New Hampshire Ins. Co. v. Arpin*, 842 N.E.2d 995 (Mass. App. Ct. 2006) ("The scope of an insurer's duty to defend is 'based not only on the facts alleged in the complaint[] but also on the facts that are known or readily knowable by the insurer.'") (citations omitted); *Elan Pharm. Research Corp. v. Employers Ins. of Wausau*, 144 F.3d 1372 (11th Cir. 1998) (Georgia law does not permit insurer to rely on allegations of complaint to deny coverage when facts that insurer knows or can ascertain show that claim is within coverage of policy); *U.S. Fid. & Guar. Co. v. B & B Oil Well Service, Inc.*, 910 F. Supp. 1172 (S.D. Miss. 1995) (if insurer knows of facts which, if proven, would result in coverage under its policy, then its duty to defend is not discharged merely because facts alleged in underlying lawsuits appear to locate the claims outside of coverage or within an exclusion); *Valley Imp. Ass'n, Inc. v. U.S. Fid. & Guar. Corp.*, 129 F.3d 1108 (10th Cir. 1997) (a duty to defend may arise from unpleaded facts actually known to insurer which arguably bring claim within scope of coverage); *Previews, Inc. v. California Union Ins. Co.*, 640 F.2d 1026, 1028 (9th Cir. 1981); *United States Fid. & Guar. Co. v. Louis A. Roser Co.*, 585 F.2d 932 (8th Cir. 1978); *Aetna Cas. & Sur. Co. v. Freyer*, 89 Ill. App. 3d 617, 411 N.E.2d 1157, 1160 (1st Dist. 1980). Even if those facts conflict with the complaint; if they tend to show coverage, the insurer should provide a defense. *Fitzpatrick v. American Honda Motor Co.*, 78 N.Y.2d 61, 571 N.Y.S.2d 672 (1991).

Issues of late notice, failure to cooperate, prior knowledge and the like are usually not readily ascertained from the complaint. Accordingly, with respect to those grounds, an insurer may reserve its rights, undertake the defense, conduct an investigation, and subsequently disclaim based upon evidence outside of the complaint, without fear of waiver or estoppel problems. *Commercial Union Ins. Co. v. Int'l Flavors & Fragrances, Inc.*, 822 F.2d 267 (2d Cir. 1987).

At least a few courts have held that admissions by the insured to the carrier of facts establishing a lack of coverage may serve as a basis to disclaim. *Senger v. Minn. Lawyers Mut., Ins. Co.*, 415 N.W.2d 364 (Minn. Ct. App. 1988). Other courts have stated that the carrier can rely on facts outside the complaint to deny coverage for a complaint that states a covered claim if the facts are undisputed. *Farm Family Mut. Ins. Co. v. Whelpey*, 54 Mass. App. Ct. 743, 767 N.E.2d 1101 (2002); *Northville Indus. Corp. v. Nat'l Union Fire Ins. Co.*, 89 N.Y.2d 621, 657 N.Y.S.2d 564 (1997); *Fluoroware, Inc. v. Chubb Group of Ins. Cos.*, 545 N.W.2d 678 (Minn. Ct. App. 1996) (complaint does not control when actual facts clearly establish existence or nonexistence of duty to defend); *Salvatierra v. Nat'l Indem. Co.*, 133 Ariz. 16, 648 P.2d 131 (Ariz. App. 1982).

3. Scope of Duty to Defend

If the complaint contains both covered and noncovered claims, the insurer must provide a defense for all claims. *Zurich Ins. Co. v. Principal Mut. Ins. Co.*, 134 Md. App. 643, 761 A.2d 344 (2000); *Commonwealth Lloyds Ins. Co. v. Marshall, Neil & Pauley, Inc.*, 32 F. Supp. 2d 14 (D.D.C. 1998) (applying District of Columbia law); *United States Fid. & Guar. Co. v. Fireman's Fund Ins. Co.*, 896 F.2d 200, 201 (6th Cir. 1990); *Int'l Paper Co. v. Continental Cas. Co.*, 35 N.Y.2d 322, 361 N.Y.S.2d. 873 (1974); *Aetna Cas. & Sur. Co. v. Continental Cas. Co.*, 413 Mass. 730, 732 n.1, 604 N.E.2d 30 (1992); *Franklin v. W. Nat'l Mut. Ins. Co.*, 574 N.W.2d 405 (Minn. 1998) (If a complaint alleges several claims, and any one of them would require the insurer to indemnify, the insurer must provide a defense against all claims). However, if the insurer is defending non-covered claims (i.e., claims as to which there was never any potential coverage), and if it can segregate the costs of defending those claims, it may seek to recover the costs of defending the uncovered claims, as long as it reserves its rights to do so at the commencement of the defense. *Buss v. Superior Court*, 16 Cal. 4th 35, 939 P.2d 766, 65 Cal. Rptr. 2d 366 (1997); Stephen Masciocchi, *The Insurer's Right to Reimbursement of Defense Costs: The Emerging Morass*, Corporate Counsel Committee of TIPS/ABA Newsletter (Summer 1999); Dennis Wall, *Insured's Reimbursement of Insurer's Defense Expenses: Some Practical Steps*, Defense Counsel Journal (January 1998).

As to the scope of any defense, it is limited to defending the insured, not asserting claims on the insured's behalf. Thus, fees incurred in connection with the insured's assertion of counterclaims are not deemed to be covered as part of the defense. A. Windt, *Insurance Coverage Disputes*, at 4.41 (3d Ed. 1995).

C. Termination of the Defense

1. Amendment or Partial Dismissal

If the complaint is subsequently amended or narrowed to omit all covered claims, the insurer is no longer required to defend the insured. *County of Nassau v. Michigan Mut. Ins. Co.*, 276 A.D.2d 578, 714 N.Y.S.2d 886 (N.Y.2d Dep't 2000); *Conway v. Travelers Indem. Co.*, 136 F.3d 210, 213-214 (1st Cir. 1998); see also *Primrose Operating Co. v. Nat'l American Ins. Co.*, 382 F.3d 546 (5th Cir. 2004) (applying Texas law) (as an amended pleading completely supersedes prior pleadings, the duty to defend rests on most recent pleading). The fact that the remaining claims may perfunctorily begin by incorporating the other paragraphs of the complaint as if fully set forth therein does not revive any aspect of the deleted allegations. See *Federal Ins. Co. v. Cablevision Systems Dev. Co.*, 637 F. Supp. 1568 (S.D.N.Y. 1986). The converse appears also to be true; if the complaint is later amended to add a covered claim to a complaint that was not previously covered, the duty to defend will arise. *Terrio v. McDonough*, 16 Mass. App. Ct. 163, 450 N.E.2d 190 (1983).

2. Exhaustion of Policy Limits

In some states, an insurer can terminate its defense of an insured after its policy limits are exhausted provided there is clear policy language allowing it to do so. See *Champagne v. State Farm Mut. Auto. Ins. Co.*, 185 A.D.2d 835, 586 N.Y.S.2d 813 (2d Dep't 1992); *Maryland Cas. Co. v. W.R. Grace & Co.*, 794 F. Supp. 1206 (S.D.N.Y. 1991), *rev'd on other grounds*, 23 F.3d 617 (2d Cir.), *cert. denied*, 513 U.S. 1052 (1994); A. Windt, *Insurance Claims & Disputes* 4.32 (3d Ed. 1995); *Zurich Ins. Co. v. Raymark Indus., Inc.*, 118 Ill. 2d 23, 112 Ill. Dec. 684, 514 N.E.2d 150, 162 (1987); *Allstate Ins. Co. v. Montgomery Trucking Co.*, 328 F. Supp. 415 (N.D. Ga. 1971) (an insurer is relieved of the obligation to defend suits filed subsequent to a judgment equal to or in excess of the policy limits.); *Nat'l Union Ins. Co. v. Phoenix Assurance Co.*, 301 A.2d 222 (D.C. 1973). However, a payment of policy limits which does not release the insured from a pending claim will generally not relieve the insurer of its obligation to provide a defense to the insured. See, e.g., *Pareti v. Sentry Indem. Co.*, 536 So. 2d 417 (La. 1988); *Aetna Cas. & Sur. Co. v. Sullivan*, 33 Mass. App. Ct. 154 (1992); *Anderson v. United States Fidelity & Guar. Co.*, 177 Ga. App. 520 (1986); see *Delaney v. Vardin Paransit, Inc.*, 132 Misc. 2d 397, 504 N.Y.S.2d 70 (Sup. Ct., Schenectady Co. 1986); see generally, B. Ostrager & T. Newman, *Handbook on Insurance Coverage Disputes* 5.03. (2004). (SEE "THE INSURED'S CONSENT TO SETTLE CLAUSE").

D. Selection and Payment of Counsel Where Insurer Reserves Rights

Some courts have held that the insured has the right to select counsel of its own choosing, and at the insurer's expense, whenever the insurer reserves its rights. See, e.g., *Kansas Bankers Sur. Co. v. Lynass*, 920 F.2d 546, 548 (8th Cir.1990) (applying South Dakota law) (quoting *Connolly v. Standard Cas. Co.*, 76 S.D. 95, 101, 73 N.W.2d 119, 122 (1955)) (an "insurer [does] not have the right, without the consent of the insured, to retain control of the defense and at the same time reserve right to disclaim liability.").

Not every reservation of rights necessarily gives the insured the right to select his or her own counsel, however. Courts have declined to force the insurer to pay for independent counsel for the insured. *Finley v. The Home*, 90 Hawaii 25, 975 P.2d 1145 (1998); *Suffolk County Patrolmens Benevolent Ass'n, Inc. v. County of Suffolk*, 595 F. Supp. 1471 (E.D.N.Y.), *aff'd*, 751 F.2d 550 (2d Cir. 1984); *Del Monte v. State Farm*, 90 Hawaii 39, 975 P.2d 1159 (1999); *Driggs Corp. v. Pa. Mfrs. Ass'n Ins. Co.*, 3 F. Supp. 2d 657 (D. Md. 1998) (applying Maryland law) (liability insurer's reservation of rights letter did not give rise to actual conflict of interest, involving counsel chosen by insurer to defend insured, that would require insurer to furnish independent counsel to insured).

Other courts have not dogmatically resolved this issue in favor of either the insurer or the insured, but instead have reached varying results depending upon whether the insurer's reservation of rights and the complaint against the insured resulted in a situation whereby the insurers' and insureds' interests truly conflicted, i.e., where the determination of specific liability issues would be determinative of the coverage issues. *Public Service Mut. Ins. Co. v. Goldfarb*, 53 N.Y.2d 392, 442 N.Y.S.2d 422 (1981); *U.S. Underwriters Ins. Co. v. TNP Trucking, Inc.*, 44 F. Supp. 2d 489 (E.D.N.Y. 1999); *Mut. Serv. Cas. Ins. Co. v. Luetmer*, 474 N.W.2d 365, 368 (Minn. Ct. App. 1991) (before an insured is entitled to counsel of its own choice, an actual conflict of interest must be established); *Bituminous Cas. Corp. v. Zadeck Energy Group, Inc.*, 416 F. Supp. 2d 654 (W.D. Ark. 2005) (when there is a duty to defend under an insurance policy and there is a conflict of interest between the insurer's interest and that of the insured, the insurer must either provide an independent attorney to represent the insured or pay the costs incurred by the insured in hiring counsel of its own choice); *Emons Indus., Inc. v. Liberty Mut. Ins. Co.*, 749 F. Supp. 1289, 1297 (S.D.N.Y. 1990) (citations omitted) (An insured is entitled to select its counsel, whose reasonable fee is to be paid by the insurer, when a conflict of interest between an insurer and its insured arises that places the loyalty of the insured's counsel to that insured in doubt).

Another situation in which the insured can select independent counsel is when there is specific policy language permitting the insurer to select counsel. *New York State Urban Development Corp. v. VSL Corp.*, 738 F.2d 61 (2d Cir. 1984).

It should be noted that if the insurer initially disclaims (i.e., denies not only its duty to indemnify but also its duty to defend) but later retracts the disclaimer and seeks to provide for the insured's defense under a reservation of rights, it may well lose any right it might otherwise have to select counsel for the insured. See *Suffolk County Patrolmens Benevolent Ass'n v. County of Suffolk*, *supra*.

However, even in cases in which the insured was permitted to select his or her own counsel, some courts have held that the insurer was only required to pay such counsel fees at its normal insurance defense rates. *Aquino v. State Farm Ins. Co.*, 349 N.J. Super 402, 793 A.2d 824 (2002); *Vanguard Ins. Co. v. Guagenti*, 157 Misc. 2d 900, 599 N.Y.S.2d 215 (Sup. Ct., Nassau Co. 1993); see also *Curtis v. Nutmeg Ins. Co.*, 256 A.D.2d 758, 681 N.Y.S.2d 620 (3d Dep't 1998) (reducing hourly partner and associate rates from \$295 and \$160 to \$230 and \$140, and allowing hourly paralegal rate of \$60), *S.C., Harrington Haley LLP v. Nutmeg Ins. Co.*, 39 F. Supp. 2d 403 (S.D.N.Y. 1999). Most cases discuss this issue in a more general sense, referring only to the payment of "reasonable" fees. See, e.g., *Smart Style Indus., Inc. v. Pa. Gen. Ins. Co.*, 930 F. Supp. 159 (S.D.N.Y. 1999); *Mut. Serv. Cas. Ins. Co. v. Luetmer*, 474 N.W.2d 365 (Minn. Ct. App. 1991); *Emons Indus., Inc. v. Liberty Mut. Ins. Co.*, 749 F. Supp. 1289, 1297 (S.D.N.Y.1990) (reasonable fee is to be paid by insurer).

Notably, the court in *Belanger v. Gabriel Chemicals*, 787 So. 2d 559 (La. Ct. App. 2001), held that an insurer which wanted to limit the fees paid to independent counsel had to reserve that right in the policy.

III. THE INSURED'S CONSENT TO SETTLE CLAUSE

The Company shall also have the right to investigate any Claim and/or negotiate the settlement thereof, as it deems expedient, but the Company shall not commit the Insured to any settlement without their consent. If the Insured refuses to consent to any settlement recommended by the Company and elects to contest the Claim or continue any legal proceedings in connection with such Claim, then the Company shall be relieved of any further duty to defend the Claim, and the liability of the Company for Damages and Claim Expenses shall not exceed the amount for which the Claim could have been settled, as well as the Claim Expenses incurred by the Company, or with the Company's consent, up to the date of such refusal.

One commentator has noted that:

[t]o avoid capriciousness of an insured, insurance policies often require that the [insured] take some of the financial risk of a refusal to settle. Thus, the policy may provide that, if the insured refuses to consent to a settlement recommended by the insurer, the insurers liability can be limited to the amount of the proposed settlement plus the costs and expenses incurred up to that date.

R. Mallen & J. Smith, *Legal Malpractice* § 33.18; (4th Ed. 1996); A. Windt, *Insurance Claims & Disputes* 5.03 at n.32 (3d Ed. 1995). This clause is sometimes referred to as the "hammer clause".¹

In a relatively recent case, a court upheld the insurers' attempt to invoke its rights pursuant to this clause. See *Cowan v. Codelia*, 2000 WL 1593383 (S.D.N.Y. 2000) *aff'd*, 2002 WL 31478922 (2d.Cir. 2002) (LPL policy). However, in the majority of cases, courts have rejected insurers' attempts to invoke those rights in the specific factual setting presented, while clearly recognizing the applicability of this type of clause under appropriate circumstances. See, e.g., *New York City Housing Auth. v. Housing Auth. Risk Retention Group, Inc.*, 203 F.3d 145 (2d Cir. 2000) (no showing that claimant would have accepted offer); *Security Ins. Co. v. Schipporeit, Inc.*, 69 F.3d 1377 (7th Cir. 1995) (no complete settlement possible); *Clauson v. New England Ins. Co.*, 254 F.3d 331(1st. Cir. 2001) (applying Rhode Island law) (where insured did not unreasonably withhold consent, insurer cannot settle the case over the objection of the insured); *Transit Cas. Co. v. Spink Corp.*, 94 Cal. App. 3d 124, 156 Cal. Rptr. 360 (1979) (clause never actually invoked); *Saucedo v. Winger*, 22 Kan. App. 2d 259, 915 P.2d 129 (1996) (clause not in policy).

Presumably, any such involuntary limitation in the coverage otherwise available under the policy would also be binding upon the claimant, at least where there is no statutory mandate for the maintenance of the particular type of policy at issue. Cf. *Employers-Commercial Union Ins. Cos. v. Buonomo*, 41 A.D.2d 285, 342 N.Y.S.2d 447 (4th Dep't 1973) (failure to cooperate; non-auto claim). See generally *Thrasher v. U.S. Liability Ins. Co.*, 19 N.Y.2d 159, 278 N.Y.S.2d 793 (1967) (failure to cooperate; auto claim).

IV. MULTIPLE INSUREDS, CLAIMS AND CLAIMANTS

The inclusion herein of more than one Insured or the making of claims or the bringing of suits by more than one person or organization shall not operate to increase the Company's limits of liability. Related acts, errors, or omissions shall be considered a single claim. All such Claims whenever made shall be considered first made during the policy period in which the earliest claim arising out of such act, error, or omission was first made and all such claims shall be subject to the same limits of liability.

Related Acts means acts based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving the same or related facts, circumstances, situations, transactions or events or the same or related series or facts, circumstances, situations, transactions or events.

The deductible stated in the declarations shall be paid by the Named Insured and shall be applicable for all damages and claim expenses for each and every claim.

This section of the policy can be very important to insureds as it can determine some if not all of the following aspects of coverage: (1) whether a certain claim will actually be deemed a "claim first made

¹ One commentator has observed that, perhaps, "[t]he paucity of cases on the hammer clause illustrates the reluctance of professional liability insurers to bring the hammer down. If they did so more often, insureds would certainly have taken the matter to court, and more published opinions would exist." Daniel J. Pope, "Hammered by the Hammer Clause: Does It Mean What It Says"? *Defense Counsel Journal* 236 (April 2001)

and reported" during a policy period; (2) the number of deductibles to be charged to the insured; and (3) whether the single or the aggregate limits of the policy will apply.

A. Claims Made Issue

The language in these clauses often reads that all related claims will be deemed to have been *first* made during the policy period in which the *earliest* related claim was made. Consequently, a series of related claims made against an insured over many years, when the insured is covered by a number of different insurers, can create significant coverage issues.

If the claims are related and the policies treat them all as being made when the first one is made, then the carrier which receives notices of the later related claim will argue that the claim is deemed to be one made during a prior policy period when the later carrier was not on the risk. This will provide the later carrier with a basis to disclaim coverage altogether. The insured may be left without any coverage if he or she did not notify his or her prior carrier of that first related claim.

For example, in *United States v. A.C. Strip*, 868 F.2d 181 (6th Cir. 1989), an attorney employed by an insured firm was sued individually before his claims made policy with The Home Insurance Company incepted, and while he was insured by a different carrier. However, he failed to give notice to his prior carrier before that policy expired. After The Home policy had been issued, the claimant amended the Complaint to state a claim against the insured firm. The court found that the claims against the lawyer and the claim against the firm were related, and that the claim against the law firm was, thus, deemed to have been first made when the claim was made against the individual lawyer. The court consequently held that the claim against the law firm was not deemed to be a "claim first made" during The Home policy period and The Home was not obligated to provide coverage. Because the claim against the individual lawyer was not reported to the prior carrier, the insured had no coverage.

Likewise, in *Pizzini v. AISLIC*, 210 F. Supp. 2d 658 (E.D. Pa. 2002), the insured was covered by two policies issued by AISLIC, one for 1995, and one for 1996. In 1995, a group of plaintiffs, called the Pizzini Plaintiffs, sent a demand letter to the insured attorney, and sued him in October 1995. The insured was not served with the Complaint until in January 1996, at which time he notified AISLIC under the second policy. In March 1996, during the second AISLIC policy, the Petit Plaintiffs, another set of plaintiffs who were involved in the same matter, filed suit against the insured. The court found that AISLIC properly disclaimed as to the Pizzini Plaintiffs because the claim (the August 1995 demand letter) had been made against the insured during the first AISLIC policy, but not reported until the second AISLIC policy, a violation of language requiring that the claim be first made against the insured *and* reported to the insurer during a single policy period. As to the Petit Plaintiffs, although this claim was actually first made and reported during the second AISLIC policy, the "related acts" language meant that the claim would be treated as having been first made in August 1995, when the Pizzini Plaintiffs first made their "related" claim. The Petit claim was not covered because it was not first made and reported during a single AISLIC policy period.

In *Kopelowitz v. Home Ins. Co.*, 977 F. Supp. 1179 (S.D. Fla. 1997), the court adopted the reasoning that if the first of the related claims is barred (in this case by an exclusion for potential claims reported on the application), the subsequent related claim is also barred. The court, however, found that the claims were not related. In *Continental Cas. Co. v. Wendt*, 205 F.3d 1258 (11th Cir. 2000), the court held that there was no coverage for the second of two related claims because that claim was treated as made under the policy in effect when the first related claim was made, and that earlier policy had already paid its limits.

On the other hand, there are at least two cases in which courts have found that a claim reported after a policy has expired can *never* be covered, regardless of whether it relates back to a claim made and reported while the policy was still in force. In *Homestead Ins. Co. v. American Empire Surplus Lines Ins. Co.*, 44 Cal. App. 4th 1297 (1996), the court found that a subsequent related claim was not covered by the policy in effect when the first related claim was reported. By the time the second claim was reported, the policy covering the first claim had expired. But that policy contained a definition of "claim"

that included the following: "claims arising out of the same act or out of a series of interrelated acts shall be considered as arising out of one negligent act, error or omission and shall be treated as a single claim." The court said that imposing coverage for the later related claim on a carrier whose policy had expired violated the basic requirement of claims made and reported policies, namely that claims must be reported to the insurer while the policy was still in force. The court further found that the "related acts" clause was designed instead to make sure that related claims reported *during the policy* would not trigger two limits and multiple deductibles.

A similar result was reached by the U.S. District Court for the Eastern District of Pennsylvania in *Lehigh Valley Network v. Executive Risk Indem., Inc.*, 2001 WL 21505 (E.D. Pa. 2001), the same court that decided *Pizzini, supra*. The court said that the "related acts" language in the subject American Continental Insurance Company policy was designed for the purposes of creating a limitation on the limits of liability that might be provided for related claims, rather than to extend coverage for related claims reported after the policy had expired. The court then found that the claims were not related.

Another court found that claims brought against a law firm and its clients for RICO violations were not related to the subsequent cross-claim for malpractice brought by the clients against the law firm. Therefore, the malpractice claim was not treated as having been made during the prior policy when the RICO claim was made against the insured. *Purciogliotti v. Risk Enterprise Mgmt. Ltd.*, 240 A.D. 2d 205, 658 N.Y.S.2d 296 (1997).

In another case, an Ohio court dealt with a situation in which one carrier was on the risk when a claim was made for breach of a settlement agreement that was reached during the prior carrier's policy. *Ohio Bar Liab. Ins. Co. v. INA Underwriters Ins. Co.*, 1990 WL 173456 (Ohio App. 1990). The court held that the prior carrier covered the breach of agreement claim because that claim was a mere continuation of the earlier case that led to the settlement.

In *Attorneys Ins. Mut. of Ala., Inc. v. Smith, Blocker & Lowther, P.C.*, 703 So. 2d 866 (Ala. 1996), the Alabama Supreme Court found that the insured's failure to notify the insurer of the first claim did not bar coverage for an arguably related second claim, notwithstanding the policy's related acts language. The firm was retained to form a corporation, but failed to timely file the Subchapter S election with the IRS. The client ultimately had to pay an additional \$12,600 in income taxes. The firm paid the client for that amount but did not advise its insurer. The law firm also did not obtain a release from the client. Soon thereafter the client demanded that the firm pay \$270,000 due to additional capital gains on the sale of certain property. The law firm reported the demand to the insurer. The Court held that the insurer was compelled to cover the subsequent claim.

B. Impact on the Number of Deductibles

If claims are treated as "related acts," a single deductible will apply with respect to them. However, where claims are treated as separate and distinct, a deductible will be assessed against the insured for each unrelated claim. In the event of serial claims, such as a mistake that is repeated time and time again by the insured, such as a Fair Debt Collection Practices Act violation or class action claims, the insured can be saddled with a staggering number of deductibles and can find himself or herself in a situation in which each individual claim is within the deductible, resulting in the carrier having no obligation to make any defense and/or indemnity payments. *New Hampshire Ins. Co. v. Ridout Roofing*, 68 Cal. App. 4th 495 (1988). In *Atlantic Permanent Federal Savings & Loan Ass'n v. American Cas. Co. of Reading, Pa.*, 839 F.2d 212 (4th Cir. 1988) the court was asked to determine the number of deductibles applicable to a directors and officers liability insurance policy. 839 F.2d at 219. Plaintiffs were loan customers who sued defendant savings and loan (Atlantic), its subsidiary and three of its officers, alleging that they "had engaged in various fraudulent and deceptive sales tactics in connection with Atlantic's home improvement loan program." *Id.* at 213. The court held that "when the claims asserted against the insureds arise out of a series of interrelated acts--here, the planning and carrying out of Atlantic's home improvement program--they should be treated as a single 'loss' for the purposes of calculating the deductible." *Id.* at 219.

C. Impact on Policy Limits

Although the insurer can only charge one deductible if a number of claims are related to one another, the carrier is also only obligated to provide a single limit of liability, rather than the aggregate limit. Considering that the difference between the single claim limit and an aggregate limit can be \$1 million or more, this distinction can be crucial to both the insured and the insurer in terms of the total coverage available. For example, in *FDIC v. Mmahat*, 907 F.2d 546 (5th Cir.1990) an attorney was sued for malpractice for advising a client to make loans in violation of the Federal Home Loan Bank Board regulations. *Id.* at 549. These regulations restricted the amount that a savings and loan could loan any one borrower. *Id.* The attorney instructed the client to "never [to] turn a loan down because it is over our loans to one customer limit[]." The court concluded that the attorney advised accordingly to maximize the fees his law firm could generate on the transactions. The law firm was ultimately found liable for \$35 million in bad loans. But the firm's malpractice policy had a \$1 million limit for single claims and a \$2 million limit for aggregate claims. The insurer argued that the single limit ought to apply because the attorney carried out a "series of related acts" The court disagreed, noting "a single motive does not make a single act." The court found three discrete acts of malpractice regarding the legal advice which "resulted in discrete losses on seven loans." Accordingly, it applied the aggregate limit.

D. The Framework for Determining Relatedness

Two approaches have been used by courts in determining relatedness of claims. One approach defines related acts as those that are "logically or causally connected." Other courts reject the notion of a "logical" connection and focus strictly on whether they are "causally connected negligent acts or omissions." *FDIC v. Mmahat*, 907 F. 2d 546, 553 (5th Cir. 1990), *cert. denied*, 499 U.S. 936 (1991); *Bay Cities Paving and Grading Co. v. Lawyer's Mut. Ins. Co.*, 5 Cal. 4th 854, 873, 21 Cal. Rptr. 2d 691, 855 P. 2d 1263 (1993); *St. Paul Fire and Marine Ins. Co. v. Chong*, 787 F. Supp. 183, 187-188 (D. Kan.), *aff'd*, 979 F.2d 858 (1992); *Arizona Cas. & Property Ins. Guar. Fund v. Helme*, 153 Ariz. 129, 735 P.2d 451, 457 (1987). The "logical connection" is a broader concept, allowing more acts to be treated as related than if a strict causal connection is required, which would treat claims as related only if one negligent act was caused by another. *Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Holmes & Graven*, 23 F. Supp. 2d 1057 (D. Minn. 1998) (court rejected notion that related claims were those that were "logically or causally connected" and adopted a test finding claims related if they are "connected by time, place, opportunity, pattern, and most importantly, method or modus operandi").

The Minnesota Supreme Court, for example, has held that the term "related" encompasses both logical and causal connections. *See American Commerce Ins. Brokers, Inc. v. Minn. Mut. Fire and Cas. Co.*, 551 N.W.2d 224, 228 (Minn. 1996). The Court cautioned that the term "related" does not "encompass every conceivable logical relationship," because claims might be "so attenuated or unusual that an objectively reasonable insured could not have expected that they would be treated as a single claim under the policy." *Id.* at 228. Therefore, the Court advised that the inquiry must take into account several factors in determining whether dishonest acts are related, including "whether the acts are connected by time, place, opportunity, pattern, and, most importantly, method or modus operandi." *Id.* at 231.

Across the nation, courts are also split on whether the "related acts" language is ambiguous and, thus, must be construed against the insurer. *Chong*, 787 F. Supp. at 187 (finding language unambiguous); *Doe vs. Ill. State Med. Interinsurance Exch.*, 234 Ill. App. 3d 129, 599 N.E.2d 983 (1992) (finding the language ambiguous); *Pacific Employer's Ins. Co. of L.A. v. Ott*, 545 So. 2d 462 (Fla. Ct. App. 1989); *Continental Cas. Co. v. Wendt*, No. 99-12520 (11th Cir. Mar. 7, 2000) (same). In *Home Ins. Co. of Ill. (New Hampshire) v. Spectrum Info.*, 930 F. Supp. 825, 848 (E.D.N.Y. 1996) the policy provided that "all claims arising from the same wrongful acts or interrelated, repeated, or continuous wrongful acts of the insured shall constitute a single claim." The court found this policy language, to be "(a)t best . . . ambiguous." In *Gregory v. Home Ins. Co.*, 876 F.2d 602 (7th Cir. 1989), the issue before the U.S. Court of Appeals for the Seventh Circuit was the limits of liability of an insurance policy. The policy provided that the limits of liability were \$500,000 for "Each Claim" and \$1,000,000 in the "Aggregate." The policy also provided that: "[t]wo or more claims arising out of a single act, error, omission or personal injury or a

series of related acts, errors, omissions or personal injuries shall be treated as a single claim." The Court found that there is a common understanding of the term "related" and that it covers a very broad range of connections, both causal and logical. *Id.* at 606. Accordingly, the Court concluded that the term "related" was not ambiguous.

The term "interrelated acts," has been deemed ambiguous by a number of courts and will be construed against the insurer. *McCuen v. American Cas. Co.*, 946 F.2d 1401 (8th Cir. 1991) (U.S. Court of Appeals for the Eighth Circuit held that the terms "interrelated" and "similar" are "so elastic, so lacking in concrete content, that they import into the contract, in our opinion, substantial ambiguities"). In *Sigma Fin. Corp. v. American Int'l Specialty Lines Ins. Co.*, 200 F. Supp. 2d 697 (E.D. Mich. 2001), *reconsideration granted in part on other grounds*, 200 F. Supp. 2d 710 (E.D. Mich. 2002) the policy used the phrase "interrelated wrongful acts." As in the other cases relied on by the *Doe* court, the court in *Sigma* found that the term "interrelated" was ambiguous. *Id.* at 706; *see also American Home Assur. Co. v. Allen*, 814 N.E.2d 662 (Ind. App. 2004) (no common meaning of "interrelated" renders it ambiguous).

In *Stauth v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 185 F.3d 875, 1999 WL 420401 (10th Cir. June 24, 1999) the policy used the term "interrelated" and defined the term "interrelated wrongful acts" as "[a]ll such causally connected errors, statements, acts, omissions, neglects or breaches of duty or other such matters committed or attempted by, allegedly committed or attempted by or claimed against one or more of the Insured Persons shall be deemed interrelated Wrongful Acts." *Id.* at *4. The court noted that the term "causally connected" was "unspecific." After attempting to define the term "causally connected," the court concluded that it was a "judgment call" whether to use a narrow or broad definition for it. As a result, the court held that it would construe the policy against the drafter and that the actions were not causally connected. *Id.* at *10; *see also David v. American Home Assurance Co.*, 1997 WL 160367 (S.D.N.Y. Apr. 3, 1997) (the terms "same," "essentially the same," and "related," are not "unambiguous").

1. Acts Were Related

Where the acts involved could be tied together as part of the same scheme or plan, courts have often found a single claim. One such example occurred where a series of fraudulent sales tactics were perpetrated in connection with one particular scheme. *Atlantic Permanent Fed. Sav. & Loan Assoc. v. American Cas. Co. of Reading*, 839 F.2d 212, 219-220 (4th Cir.), *cert. denied*, 486 U.S. 1056 (1988). Likewise, where the insured's negligent act toward one claimant was repeated against other claimants in the context of a single transaction, courts have found that that constituted a single claim. *Gregory v. Home Ins. Co.*, 876 F.2d 602, 605 (7th Cir. 1989). Similarly, separate acts of malpractice resulting in a violation of a single right of the claimant usually results in a single claim under the policy. Such is the case where two lawyers in the same firm successively handled a case and both made mistakes that resulted in the claimant being improperly imprisoned. *Home Ins. Co. v. Wiener*, 716 F. Supp. 10, 11 (N.D. Ill. 1989).

In *Pioneer Nat'l Title Ins. Co. v. Andrews*, 652 F.2d 439 (5th Cir. 1981), applying Florida law, the court concluded there was one claim resulting from three certificates of title prepared by an attorney, the second and third of which were filed to bring the title up to date. Similarly, in *Continental Cas. Co. v. Brooks*, 698 So. 2d 763 (Ala. 1997), the Alabama Supreme Court found that there was one claim for malpractice stemming from loss of title, even when an attorney was retained to do many acts, including preparing quitclaim deeds and a durable power of attorney. In *Bay Cities Paving & Grading, Inc. v. Lawyers' Mut. Ins. Co.*, 5 Cal. 4th 854, 21 Cal. Rptr. 2d 691, 855 P.2d 1263 (1993) the California Supreme Court found that there was one claim arising out of the client's right to be "free from negligence" in the circumstance where the attorney had filed a lien but failed to file a stop notice and did not file suit to foreclose on the lien. *See also Lipton v. Superior Court*, 56 Cal. Rptr. 2d 341, 48 Cal. App. 4th 1599 (1996) (suit against attorney for multiple but related acts was a single claim); *see also Highwoods Props., Inc. v. Executive Risk Indem., Inc.*, 407 F.3d 917 (8th Cir. 2005) (under claims-made policy insuring corporation's directors and officers against claims made against them, two lawsuits were "related claims" because both suits involved allegedly incomplete and deceptive communications to shareholders in relation to the same merger; both included many of the same factual allegations; and the second lawsuit could best be described as the "successor" to the first suit).

Likewise, courts have rejected a claimant's attempt to make *separate* claims against an insured based on the insured's wrongful act and on his failure to correct or mitigate the error. *Transamerica Ins. Co. v. Keown*, 451 F. Supp. 397, 403 (D.N.J. 1978).

Executive Risk Indem. v. Integral Equity, L.P., 2004 WL 438936 (N.D. Tex. 2004) involved a situation where there was a single client and many defendants, who included the "Art Institute Defendants." Although there were 12 separate claims asserted against a number of defendants, those claims were treated as a single claim under a definition in the subject policy of "related acts." That definition provided that "related acts" were those "based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving the same or related facts, circumstances, situations, transactions or events or the same or related series or facts, circumstances, situations, transactions or events." The court noted that the 12 claims were "all based on related facts, or, at least, a series of facts: the alleged inducement by the Art Institute Defendants of the Art Institute to invest in certain funds, the alleged mishandling of those funds by the Art Institute Defendants, the alleged continuing misrepresentations by the Art Institute Defendants about the performance of those funds, the resultant loss to the Art Institute, and the alleged result in enrichment of the Art Institute Defendants."

2. Acts Were Not Related

In seemingly similar situations, other courts have come to the opposite conclusion. In one case, the court held that a number of different frauds perpetrated in the same scheme were separate acts, even though they caused one result, namely the collapse of a bank. *Eureka Fed. Sav. & Loan v. American Cas. Co. of Reading, Pa.*, 873 F.2d 229, 234-235 (9th Cir. 1989); *FDIC v. Mmahat*, 907 F.2d 546, 554 (5th Cir. 1990), *cert. denied*, 499 U.S. 936 (1991). Courts are likely to find separate acts where various errors or separate fraudulent acts took place without any overarching scheme or plan, even though perpetrated by the same person and in the same fashion. *Okada v. MGIC Indem. Corp.*, 608 F. Supp. 383, 387-388 (D. Haw. 1985), *aff'd on this ground*, 795 F.2d 1450, 1454-1456, *modified on other grounds*, 823 F.2d 276 (9th Cir. 1986). *See also Fed. Sav. & Loan Ins. Co. v. Burdette*, 718 F. Supp. 649, 657-660 (E.D. Tenn. 1989); *North River Ins. Co. v. Huff*, 628 F. Supp. 1129, 1133-1134 (D. Kan. 1985); *see also Nat'l Union Ins. Co. of Pittsburgh, Pa. v. Holmes & Graven*, 23 F. Supp. 2d 1057, 1070 (D. Minn. 1998) (claims held not related because commonalities among them were limited to acts by same attorney in context of a single commercial venture while differences among them included distinct injuries to clients.); *Checkrite, Ltd v. Ill. Nat'l Ins. Co.*, 95 F. Supp. 2d 180 (S.D.N.Y. 2000) (where an amended complaint added new claimants and new claims to a pre-existing class action, such that a "new" claim was presented); *Southridge Capital Mgmt., LLC v. Twin City Fire Ins. Co.*, 2006 WL 2730312 (Conn. Super. Ct. 2006).

The question of whether a common *modus operandi* of defrauding clients was sufficient to make the claims of separate clients a single claim or multiple claims may be a question of fact. *Brown v. Nat'l Union*, 2004 WL 292158 (D. Minn. 2004).

Some courts have even held that an attorney's single mistake of law will result in numerous separate claims if the same mistake is made twice or more with respect to the same client. *Village of Camp Point v. Continental Cas. Co.*, 219 Ill. App. 3d 866, 578 N.E.2d 1363 (1991). Similarly, where an attorney makes the same mistake while jointly representing more than one client, the claims will be treated as separate if both clients sue for malpractice. *St. Paul Fire & Marine Ins. Co. v. Chong*, 787 F. Supp. 183, 187-188 (D. Kan.), *aff'd*, 979 F.2d 858 (1992); *Continental Cas. Co. v. Grossman*, 271 Ill. App. 3d 206, 648 N.E.2d 175 (1995); *Continental Cas. Co. v. First Arlington Inv. Corp.*, 497 So. 2d 726 (Fla. Dist. Ct. 1986) (insured lawyer who was sued by both defendants whom he represented in underlying case faced separate and unrelated claims).

In *Scott v. American Nat'l Fire Ins. Co., Inc.*, 216 F. Supp. 689 (N.D. Ohio 2002), the underlying claim arose out of the insured attorney's involvement in the creation of a corporation formed to manufacture and sell golf equipment. Claims were brought against the insured by three separate clients: the two principal investors and the corporation. The investors' claims were based on the insured's alleged failure to ensure that their personal assets would be protected from claims by the corporation's creditors.

The corporation's claim was based on the insured's failure to ensure that certain intellectual property rights were effectively transferred. The court found that the claims were not sufficiently related because the insured owed separate duties to each client, and each client sustained a discrete harm. *See also Admiral Ins. Co., Inc. v. Briggs*, 264 F. Supp. 2d 460 (N.D. Tex. 2003) (in declaratory judgment action seeking determination that management liability insurer had no duty to defend or indemnify insured corporation or its officers or directors in underlying lawsuits, court found that three lawsuits brought by investors claiming fraud and mismanagement were not a single "claim" within the meaning of the insurance policy because the lawsuits contained "different alleged misstatements, omissions and promises that occurred on different days to different individuals"); *GWR Invs., Inc. v. Executive Risk Specialty Ins. Co.*, 2005 WL 3143186 (D. Neb. 2005).

A similar holding resulted in a Maryland case in which one lawyer represented five siblings in one lead paint case, on which summary judgment was granted to the defendants. The siblings filed the malpractice case, but the court held that their claims were separate, triggering the aggregate limits. *Beale v. American Nat'l Lawyers Ins. Co.*, 379 Md. 643, 843 A.2d 78 (Md. Ct. App. 2004). That decision was based on the notion that attorneys owe jointly represented clients separate and distinct duties of care, and the fact that the siblings' exposure to lead paint was different for each of them.

In *American Auto. Ins. Co. v. Grimes*, 2004 WL 246989 (N.D. Tex. 2004), the insured was alleged to be involved in a scheme in which he advised clients to liquidate relatively secure and stable investments and to purchase customer-owned coin-operated telephones. His sales techniques as to each of the different Claimants was essentially the same. But each claimant sued him separately. In determining that the claims were separate, thereby triggering separate errors and omissions policies, the court noted that there was not "any single general misrepresentation by [defendant] Grimes that can be characterized as an independent action that was equally and to the same extent relied upon by each of the Plaintiffs in the underlying suits, causing their injuries. Rather, the court found that because Grimes rendered separate services to each of them in separate and distinct meetings, he owed each of them a separate duty, and each meeting required Grimes to consider unique circumstances in determining how to advise them regarding their investments."

In *St. Paul Fire & Marine Ins. Co. v. Chong*, 787 F. Supp. 183, 188 (D. Kan. 1992) the court found that three malpractice claims arising from an attorney's multiple representation of three clients in a criminal trial were unrelated. In the underlying case, the attorney had defended all three clients against a kidnapping charge. *See id.* at 186-87. The court reasoned that while the criminal charges arose out of the same set of events and that the malpractice claims all involved the attorney's conduct during the criminal trial, the claims were not related because the attorney owed each client a separate duty. *See id.* at 188. The court used the narrower causal connection definition of "related" but noted that it would reach the same result under the logical connection definition because "[a]lthough the errors and omissions [the attorney] committed grew out of highly similar factual situations, [the attorney] had a separate duty to each client and was rendering separate services to each." *Id.* Therefore, the court found that the attorney committed multiple acts and omissions that "resulted in discrete losses to each of the defendants." *Id.*

In *Continental Cas. Co. v. Grossman*, 271 Ill. App. 3d 206, 207 Ill. Dec. 719, 648 N.E.2d 175 (1995), the court found that three clients' malpractice claims against an attorney were not related even though each claim involved the same investment. This result was supported by a finding that the attorney owed separate duties to each client.

V. EXCLUSIONS

A. Business Pursuits Exclusion

The insurance does not apply to:

- **Liability arising out of the Insured's services and/or capacity as:**

an employee, owner, partner, stockholder, director, officer or trustee of any business, enterprise, charitable organization, or pension, welfare, profit-sharing or investment fund or trust; a public official or employee of a governmental body, subdivision or agency; a fiduciary under ERISA, except if an Insured is deemed to be a fiduciary solely by reason of legal advice rendered with respect to an employee benefit plan;

- **Claims arising out of any negligent act, error, omission in the rendering of or failure to render professional services performed for any organization, corporation, company, partnership, or operation (other than the Named Insured, Predecessor in Business or Successor in Business) while any Insured or their spouse has more than 10% equity position in such entity;**

1. The Rationale for the Exclusion

LPL policies are intended to respond to liability arising out of the rendition (or failure to render) professional services. With this principle in mind, most policies contain "business pursuits" exclusions, such as those detailed above, to preclude coverage for liability arising out of, at least in part, the insured's conduct in other capacities, or where the insured is sued by an entity in which he has a significant ownership or proprietary interest. These exclusions can also be referred to as "business enterprise" exclusions or "ownership" exclusions.

Where lawyers provide legal advice while also acting in a corporate capacity, or advise companies in which they have ownership interests, there is an increased risk of loss under the policy. This increased risk is two-fold: (1) insureds may want to convert business losses into a malpractice claim so that the lawyer and his or her company can reap the benefits of the legal malpractice policy's proceeds; and (2) insureds acting in this dual capacity lack appropriate objective detachment and may suffer from conflicts of interest. *Greenberg & Covitz v. Nat'l Union Ins. Co.*, 312 N.J. Super. 251, 711 A.2d 909 (1998). Business enterprise provisions are generally found not to be ambiguous. *Continental Cas. Co. v. Flomenhoft*, 263 Ill. App. 3d 22, 26, 640 N.E.2d 290, 293 (1994); *Potomac Ins. Co. v. McIntosh*, 167 Ariz. 30, 33-34, 804 P.2d 759, 762-763 (1991) (proximate cause of clients' loss was the failure of partnership in which they invested with attorney, not any negligence of the attorney in warning them of the risks inherent in the partnership, so that exclusion from professional liability policy for claims based on attorney's action as a partner precluded coverage).

A few courts have limited the application of the business pursuits exclusion only to circumstances in which the insurer can prove collusion between the attorney and the claimant. *Granary Assocs., Inc. v. Evanston Ins. Co.*, Civ. No. 99-5154, (E.D. Pa. 12/4/2000), a case involving an architects and engineers liability policy, is instructive. In this case, both the claimant and the insured were owned by the same person. The court therefore found that the insured's ownership/management/control exclusion was "technically implicated." The court refused to enforce the exclusion, however, noting that the purpose of such policy provisions is to prevent collusion between claimant and insured. The court noted the absence in the record of any collusion and denied the insurer's motion for summary judgment.

2. Mixed Allegations of Legal Malpractice and Business Claims

The mere fact of an attorney-client relationship with the claimant, which implies a professional rather than business nexus to the claim, is not sufficient to defeat application of the business pursuits exclusion. Absent such a professional relationship, most claims would fall outside the scope of the insuring clause in the first instance and these exclusions would never be implicated. *See Mt. Airy Ins. Co. v. Greenbaum*, 127 F.3d 15, 20 (1st Cir. 1997); *Potomac Ins. Co. v. McIntosh*, 167 Ariz. 30, 804 P.2d 759 (Ariz. App.1990); *Senger v. Minn. Lawyers Mut. Ins. Co.*, 415 N.W.2d 364, 368 (Minn. Ct. App. 1987); *Home Ins. Co. of Ind. v. Walsh*, 854 F. Supp. 458, 461 (S.D. Tex. 1994) (business pursuits exclusion precluded coverage for claims arising from a loan transaction involving a savings and loan association

owned by the insured lawyers and the exclusion would apply even if the insured lawyers performed legal services for the claimant).

Independently stated causes of action for legal malpractice in a case involving the insured's ownership of an enterprise or his or her corporate capacity do not vitiate the impact of the business pursuits exclusion because the exclusion applies to any claim "arising out of" the insured's non-legal services or ownership. See *Salzman & Salzman v. Home Ins. Co.*, 258 A.D.2d 455, 456, 684 N.Y.S.2d 601, 602 (2d Dep't 1999). Even where an attempt is made to cast the damages sought as solely for legal malpractice (and therefore not directly resulting from the failure of the business enterprise in question), courts have tended to enforce these exclusions. *Home Ins. Co. v. Walsh*, 854 F. Supp. 458 (S.D. Tex. 1994); *Potomac Ins. Co. v. McIntosh*, 167 Ariz. 30, 804 P.2d 759 (Ariz. App. 1990); *Aragona v. St. Paul Fire & Marine Ins. Co.*, 281 Md. 371, 378 A.2d 1346, 1350-51 (1977); *Dukart v. Nat'l Union Fire Ins. Co.*, 1993 WL 331175 (Del. Super. Ct. 1993); *General Accident Ins. Co. v. Namesnik*, 790 F.2d 1397 (9th Cir. 1986).

Where an attorney represents a client in a business transaction and in other matters, courts tend to refuse to enforce the exclusion, however, to bar coverage for the entire claim. *Westport Ins. Corp. v. Bayer*, 284 F.3d 489 (3d Cir. 2002). In *Morris v. Valley Forge Ins. Co.*, 805 S.W.2d 948 (Ark. 1991) the Arkansas Supreme Court found that a transaction in which the attorney's own company sold an encumbered motel to a client's company was not necessarily excluded by the other businesses exclusion because the suing client claimed that he entered into the purchase on the attorney's direct advice in connection with divorce in which the attorney had represented the client. See also *Milgrub v. Continental Cas. Co.*, 2007 WL 625039 (W.D. Pa. 2007) (potential coverage for breach of fiduciary duty claim that was independent of claimed conflict of interest under contractual liability exclusion).

In *Niagara Fire Ins. Co. v. Pepicelli, Pepicelli, Watts and Youngs*, 821 F.2d 216 (3d Cir. 1987), the U.S. Court of Appeals for the Third Circuit held that a claim that the law firm committed malpractice was not excluded by the business pursuit exclusion. The attorney had failed to name the client in fire insurance suit concerning an insurance policy in which the client was a loss payee and failed to timely advise a client that the claim of fraud had been raised by the fire insurer. A major shareholder in the firm was also an owner of the named insured under the fire policy. Regardless, the Court held that the claim was not excluded.

3. Timing, Nature and Extent of Ownership

Courts have upheld business pursuits exclusions in a number of different ownership contexts. *Continental Cas. Co. v. Flomenhoft*, 263 Ill. App. 3d 22, 640 N.E.2d 290 (1994) (insured was a three percent partner in the enterprise); *Home Ins. Co. of Ind. v. Walsh*, 854 F. Supp. 458 (S.D. Tex. 1994) (lawyer as land developer); *Continental Cas. Co. v. Smith*, 243 F. Supp. 2d 576 (E.D. La. 2003) (lawyer as president of corporation).

In *Clauder v. Home Ins. Co.*, 790 F. Supp. 162 (S.D. Ohio 2002), the court held that a legal malpractice insurer was required to defend its insured against a complaint alleging breach of fiduciary duty and legal malpractice. The client sued the attorney in connection with an alleged below market sale of an asset to the client by a company the attorney controlled. The court concluded that the business pursuits exclusion did not plainly apply because the client sued the attorney for breach of an obligation the insured attorney owed to his client rather than to his own companies.

A related issue concerning the application of the ownership exclusion concerns the timing of the interest in question. In *Morris v. Employers Reinsurance Corp.*, 84 Cal. App. 4th 1026, 101 Cal. Rptr. 2d 350 (Cal. App. 4 Dist. 2000), the California Courts of Appeal held that in the context of realtor's errors and omissions insurance, the exclusion did not apply where the insured agent had no ownership interest in the property during the course of the alleged wrongful conduct. In that case, the insured had failed to consummate a real estate transaction for the aggrieved client and then purchased the property herself.

In contrast to the approach taken by the Court in *Morris v. Employers Reinsurance Corp.*, however, is the approach adopted by the court in *Coregis Ins. Co. v. Bartos, Broughal & DeVito, LLP*, 37 F. Supp. 2d 391 (E.D. Pa. 1999). There, the question was the applicability of an ownership exclusion where the insured was a 12.5 percent owner of a corporation through which investors in limited partnerships were solicited. The limited partnerships were not in existence at the time of the alleged malpractice, however. The court held that, notwithstanding the timing issue regarding creation of the limited partnerships, the exclusion applied. *See also Coregis Ins. Co. v. Larocca*, 80 F. Supp. 2d 452 (E.D. Pa. 1999) (applying officer/partner capacity exclusion and ownership interest exclusions to liability arising from business venture).

In *American Guar. & Liab. Ins. Co. v. Keiter*, 360 F.3d 13 (1st Cir. 2004), the U.S. Court of Appeals for the First Circuit found that the business pursuits exclusion was ambiguous because it was framed in the negative: an insured would not be deemed to have a "pecuniary or beneficial interest" unless the named insured or members of his family owned 10 percent of the business. The Court said that that language could be read not as a definition of "pecuniary or beneficial interest," but as a carve-out to the exclusion. Read this way, the carrier had to prove that the insured had a "pecuniary or beneficial interest" and found that no such interest could exist if the insured and his spouse owned less than 10 percent interest in the business.

4. Proximate Cause of Loss

Courts that have denied summary judgment to insurers have gone astray from the broad scope of the exclusionary language ("arising out of") and looked at whether the claimant's losses were caused by the legal services involved, or rather some other independent business failure. *See Clauder, supra; Morris v. Valley Forge Ins. Co., supra; Jeffer v. Nat'l Union*, 306 N.J. Super. 82, 703 A.2d 316 (1997); *Niagara Fire Ins. Co. v. Pepicelli, Pepicelli Watts & Young, P.C., supra*.

B. Intentional Acts Exclusion

A Judgment or final adjudication based upon or arising out of any dishonest, deliberately fraudulent, criminal, malicious, or deliberately wrongful act or omission, or deliberate misrepresentation committed by, at the direction of, or with the knowledge of any Insured;

1. Generally

Intentional acts will not be covered where an insurance policy contains either an insuring agreement limited to negligent acts or an exclusion specifically directed to intentional acts. *See Brooks, Tarlton, Gilbert, Douglas & Kressler v. U.S. Fire Ins. Co.*, 832 F.2d 1358 (5th Cir. Tex. 1987); *St. Paul Fire & Marine Ins. Co. v. Aragona*, 33 Md. App. 499, 365 A.2d 309 (1976), *aff'd*, 281 Md. 371, 378 A.2d 1346 (1977); *Battisti v. Continental Cas. Co.*, 406 F.2d 1318 (5th Cir. Fla. 1969) (overall scheme of the attorney that was alleged to be grossly dishonest fell within exclusion); *St. Paul Fire & Marine Ins. Co. v. Starr*, 651 S.W.2d 517 (Mo. Ct. App. 1983) (judgment against attorney was based solely on attorney's deceitful practices, rather than mere negligence and incompetence); *Seaboard Indus. v. Monaco*, 258 Pa. Super 170, 392 A.2d 738 (Pa. Super. 1978) (dishonest acts excludes precluded coverage for claim based on insured's fraudulent scheme to deprive the plaintiff of its rights); *Humphreys v. Niagara Fire Ins. Co.*, 404 Pa. Super. 347, 590 A.2d 1267 (Pa. Super. 1991) (dishonest acts exclusion relieved insurer of any obligation to defraud or indemnify insured in RICO/Anti-trust action); *but see Volney Residence, Inc. v. Atlantic Mut. Ins. Co.*, 195 A.D.2d 434, 600 N.Y.S.2d 707 (1st Dep't 1993) (adopting minority rule of construction where policy covers "any negligent act, error or omission or breach of duty," the term "negligent" does not necessarily modify all of the succeeding terms; upholding coverage for RICO claims); *USM Corp. v. First State Ins. Co.*, 420 Mass. 865, 652 N.E.2d 613 (1995) (same); *Continental Cas. Co. v. Cole*, 809 F.2d 891, 896-897 (D.C. Cir. 1987) (same). Of course, insurance policies frequently contain "personal injury" coverage which applies to certain intentional acts, such as defamation and malicious prosecution.

The fact that the Complaint contains allegations phrased in the disjunctive, that an insured "knew or should have known" of the consequences of certain conduct, does not necessarily trigger coverage. *See Board of Educ. of East Syracuse-Minoa Central Sch. Dist. v. Continental Ins. Co.*, 198 A.D.2d 816, 604 N.Y.S.2d 399 (4th Dep't 1993); *but cf. Cocchi v. Nat'l Union Fire Ins. Co.*, 156 A.D.2d 535, 548 N.Y.S.2d 804 (2d Dep't 1989) (disjunctive allegation that the insured knew *or* should have known does not exclusively allege willful conduct).

Most such exclusions only apply in the event of "a final judgment or adjudication" and, accordingly, insurers are obligated to defend these claims. *Conner v. Transamerica Ins. Co.*, 496 P.2d 770 (Okla. 1972) (policy provides defense for fraud if allegations are groundless or false); *Admiral Ins. Co. v. Weitz & Luxenberg*, 2002 WL 314 09450 (S.D.N.Y. 2002) (court rejects argument that fraud is not "professional services," and finds a duty to defend); *Lee v. New England Ins. Co.*, 579 So. 2d 1182 (La. Ct. App. 1991) (exclusion applies only if there is a final adjudication of a dishonest, fraudulent, or malicious act); *Pepsico, Inc. v. Continental Cas. Co.*, 640 F. Supp. 656, 659 (S.D.N.Y. 1986), *disagreed with on other grounds by Waltuch v. Conticommodity Services, Inc.*, 88 F.3d 87 (2d Cir. 1996). Some courts have found to the contrary. *See Home Ins. Co. v. Tartaglia*, 240 A.D.2d 396, 658 N.Y.S.2d 388 (1997) (where the only theory of liability requires proof of intentional wrongdoing encompassed by the exclusion, the insurance carrier has no duty to indemnify and is therefore relieved of the obligation to defend); *Davis v. Home Ins. Co.*, 1995 WL 380133 (S.D.N.Y. 1995) (language "which would otherwise require the insurer to defend the action until such time as the insured is adjudged to have acted in a manner bringing him within the exclusion, does not apply when the only theory of the insured's liability requires proof of conduct covered by the exclusion").

2. Public Policy and State Statutes Prohibiting Insurance Coverage for Intentional Conduct

Regardless of the insurance policy's provisions, the public policy of a jurisdiction may dictate that coverage cannot be afforded for an insured's intentional acts which are intended to cause injury. *Compare Allstate Ins. Co. v. Mugavero*, 79 N.Y.2d 153, 581 N.Y.S.2d 142 (1992) (sexual molestation of child is not covered because, among other things, legislative policy reflects public perception that such conduct invariably causes serious harm) with *Public Service Mut. Ins. Co. v. Goldfarb*, 53 N.Y.2d 392, 442 N.Y.S.2d 422 (1981) (sexual abuse of patient by dentist is not barred from coverage by public policy because complaint alleged intentional acts causing intended and unintended injury) and *Dodge v. Legion Ins. Co.*, 102 F. Supp. 2d 144 (S.D.N.Y. 2000) (distinguishing *Goldfarb*); *Mass. Mut. Life Ins. Co. v. Millstein*, 129 F.3d 688 (2d Cir. 1997). There is a question, however, as to whether public policy in this regard also requires that the acts bear criminal consequences in order for coverage to be barred. *See Federal Ins. Co. v. Cablevision Systems Dev. Corp.*, 637 F. Supp. 1568 (E.D.N.Y. 1986); *Litrenta v. Republic Ins.*, 245 A.D.2d 344, 665 N.Y.S.2d 679 (2d Dep't 1997).

Some states have codified this public policy. *See, e.g.,* Mass. Gen. Laws c. 175, § 47 (no coverage for "deliberate or intentional [crime or wrongdoing]"); Cal. Ins. Code § 533 ("an insurer is not liable for a loss caused by the wilful [sic] act of the insured . . ."). The questions that arise from these statutes include whether an insurer is permitted to defend such claims, whether the conduct alleged or proven against the insured comes within the statutory prohibition, and whether a specific grant of coverage for claims (such as defamation and malicious prosecution), which require proof of malice in some circumstances, are enforceable notwithstanding the statutes. *See Downey Venture v. LMI Ins. Co.*, 66 Cal. App. 4th 478, 78 Cal. Rptr. 2d 142 (1998) (coverage for malicious prosecution in policy violated statute, but insurer could provide defense) *Mez Indus., Inc. v. Pacific Nat'l Ins. Co.*, 76 Cal. App. 4th 856, 90 Cal. Rptr. 2d 721 (Cal. App. 1999) (coverage for claim of inducement for patent infringement barred from coverage by Section 533); *Boston Housing Auth. v. Atlanta Int'l Ins. Co.*, 781 F. Supp. 80 (D. Mass. 1992) (statute prohibited insurer from defending racial discrimination claim); *Andover Newton Theological Sch. v. Continental Cas. Co.*, 930 F.2d 89, 95 (1st Cir. 1991), 409 Mass. 350, 352, 566 N.E.2d 1117 (1991) (defense in age discrimination permissible because statute only excludes acts if "an intentionally committed wrongful act was also done deliberately or intentionally, in the sense that the actor knew that the act was wrongful").

3. Recklessness or Constructive Fraud

Questions sometimes arise as to whether reckless conduct or constructive fraud is barred by the exclusion. According to Barron's Law Dictionary, "[t]he word 'reckless' has a wide range of meaning that may vary in color and content according to the circumstances . . ." in which it is used. Some cases hold that the term implies more than carelessness, and in fact reaches the equivalent of "willfulness." Indeed, in the treatise *Law of Torts*, it is noted that "[t]he usual meaning assigned to 'willful,' 'wanton' or 'reckless' . . . is that the actor has intentionally done an act of an unreasonable character in disregard of a risk known to him or so obvious that he must be taken to have been aware of it, and so great as to make it highly probable that harm would follow." Prosser, *Law of Torts* § 34, at 185 (4th ed. 1971). Nevertheless, "there is often no clear distinction at all between such conduct and 'gross' negligence, and the two have tended to merge and take on the same meaning." *Id.*

Some courts have found recklessness to be tantamount to intentional conduct and therefore, uncovered, *FDIC v. Mmahat*, 907 F.2d 546 (5th Cir. 1990), *cert. denied*, 499 U.S. 936 (1991); *Cincinnati Ins. Co. v. Metropolitan Properties, Inc.*, 806 F.2d 1541 (11th Cir. 1986). Other courts have found it to be the functional equivalent of negligence, or at least something less than intentional conduct (and therefore covered). *Cowan v. Codelia*, 1999 WL 1029729 (S.D.N.Y. 1999) (emotional distress claim; LPL policy); *Nat'l Sur. Corp. v. Musgrove*, 310 F.2d 256 (5th Cir. 1962); *Warren v. LeMay*, 144 Ill. App. 3d 107, 494 N.E.2d 206 (1986); *Edwards Dodge, Inc. v. Penn. Mut. Cas. Co.*, 510 So. 2d 225 (Ala. 1987); *Perl v. St. Paul Fire & Marine Ins. Co.*, 345 N.W.2d 209 (Minn. 1984) (claim for constructive fraud is, by definition, not actual fraud but conduct that the law treats as fraud, irrespective of the actor's intent or motive, so damages awarded for constructive fraud are covered); *Brooks Tarlton Gilbert Douglas & Kressler v. U.S. Fire Ins. Co.*, 832 F.2d 1358 (5th Cir. 1987), *clarified on different issue in* 832 F.2d 1378 (5th Cir. 1987) (same).

Courts have found that claims alleging statutory violations requiring proof of malice or deliberate conduct are excluded. *Steadfast Ins. Co. v. Stroock, Stroock & Lavan*, 277 F. Supp. 2d 245 (S.D.N.Y. 2003) (fraudulent conveyance required proof of actual knowledge). *Humphries v. Niagara Fire Ins. Co.*, 404 Pa. Super. 347, 590 A.2d 1267 (1991) (RICO and antitrust); *Nat'l Union Fire Ins. Co. v. AARPO*, 1999 WL 14010 (S.D.N.Y. 1999) (RICO); *but see Jefferson-Pilot Fire & Cas. Co. v. Boothe-Prichard & Dudley*, 638 F.2d 670 (4th Cir. 1980) (antitrust violations are not necessarily excluded). The insured's mental impairment may, however, serve to negate the element of intent or the existence of a "criminal act." *Swift v. Fitchburg Mut. Ins. Co.*, 45 Mass. App. Ct. 617, 700 N.E.2d 288 (1998).

4. Coverage of Negligence Claims Arising out of or Based on Excluded Conduct

Where an exclusion bars coverage of claims "arising out of or based on" intentional conduct, negligence claims which are related to the intentional conduct are barred from coverage as well. *See Mt. Vernon Fire Ins. Co. v. Creative Housing*, 88 N.Y.2d 347, 645 N.Y.S.2d 433 (1996), *answer to certified question conformed to*, 93 F.3d 63 (2d Cir. 1996); *U.S. Underwriters Co. v. Val-Blue*, 85 N.Y.2d 821, 623 N.Y.S.2d 834 (1995). In *Mt. Vernon*, the court stated that exclusionary clauses using "based on" or "arising out of" particular excluded events unambiguously preclude coverage for all claims that would not exist "but for" the excluded events. (SEE "WAIVER OF EXCLUSIONS/BREACH OF CONDITIONS"). If the Complaint presents a claim for "negligence" against the entity which is based on intentional conduct by an agent of the company, some courts impute that conduct to the company to bar coverage. An intentional tort committed by a corporate officer in the course of his or her duties as a managing agent constitutes an intentional tort committed by the corporation. *Seminole Point Hosp. Corp. v. Aetna Cas. & Sur. Co.*, 675 F. Supp. 44 (D.N.H. 1987) (citing *Rochez Bros., Inc. v. Rhoades*, 527 F.2d 880, 884 (3d Cir. 1975)); *see also Aetna Cas. & Sur. Co. v. Shuler*, 72 A.D.2d 591, 421 N.Y.S.2d 87, 88 (1979); S. Speiser, *The American Law of Torts* § 4:51 (1983).

Typically, the situation involves a complaint where passive negligence, such as negligent hiring, training, supervision, or failure to warn, and active intentional or otherwise excluded misconduct are alleged either against the insured alone, multiple insureds, or the insured and one or more third parties. It has been held that an insurer did not have to provide professional liability coverage for negligent hiring or

supervision claims against an employer whose employee committed an excluded intentional act. See *Huey Littleton v. Employers Reinsurance Corp.*, 933 F.2d 337 (5th Cir. 1991) (exclusion for "any dishonest, fraudulent, illegal, criminal, or malicious act, other than malicious prosecution" precluded coverage when liability for loss was based upon employee's embezzlement, irrespective of legal theory through which clients proceeded against adjusting company); *Continental Cas. Co. v. HSI Fin. Services, Inc.*, 266 Ga. 260, 466 S.E.2d 4 (1996), answer to certified question conformed to, 81 F.3d 1087 (11th Cir. 1996) (claims against law partners for negligence and malpractice with respect to alleged failure to supervise and mitigate partner's criminal acts did arise out of dishonest, fraudulent, criminal and malicious conduct of partner, thereby bringing those claims within scope of exclusionary clause); *St. Paul Fire & Marine Ins. Co. v. Aragona*, 281 Md. 371, 378 A.2d 1346 (1977); *Stouffer & Knight v. Continental Cas. Co.*, 982 P.2d 105 (Wash. 1999); *Winnacunnet Coop. Sch. Dist. v. Nat'l Union Fire Ins. Co.*, 84 F.3d 32 (1st Cir. 1996) (applying New Hampshire law) (claims against school district for negligent hiring/supervision of teacher such that she was able to entice claimant students to murder her husband were barred); *Mork Clinic v. Fireman's Fund Ins. Co.*, 575 N.W.2d 598 (Minn. Ct. App. 1998) (no professional liability coverage for negligent supervision claims). Hence, an attorney was not covered for negligently failing to correct his own fraudulent advice to a client. *Deiss v. Nat'l Union Fire Ins. Co.*, 90-0150 (Wis. App. 1999). One court has, nonetheless, found coverage for claims that the insured's negligence allowed his law partner to commit fraud. *Continental Cas. Co. v. McDowell and Colantoni, Ltd.*, 668 N.E.2d 59 (Ill. 1996).

Courts in certain circumstances will reject a claim that an insured entity is liable in negligence when its owner or principal agent is charged with committing an intentional act. In *Walthers v. Gossett*, a patient sued her orthodontist, Gossett, and his corporation for sexual abuse. 941 P.2d 575 (Or. Ct. App. 1997). The orthodontist was the corporation's sole officer and shareholder at the time of the alleged sexual abuse. *Walthers*, 941 P.2d at 579. The Oregon Court of Appeals held that the orthodontist's tortious acts could be imputed to the corporation, stating: "[b]ecause Gossett was defendant's sole officer at the time the corporation scheduled plaintiff's appointments and provided the examination room, he wielded 'the whole executive power of the corporation' and 'participated in and directed all that was planned and done.'" Accordingly, his knowledge that he intended to molest plaintiff, or that he was likely to do so, was imputed to the corporation and the conduct, however characterized in the complaint under any theory, was deemed intentional and not negligent. See also *Coit Drapery Cleaners, Inc. v. Sequoia*, 14 Cal. App. 4th 1595, 18 Cal. Rptr. 2d 692 (1993) (no coverage where perpetrator of assault and harassment was the corporation's founder and president); *Quality Painting, Inc. v. Truck Ins. Exch.*, 988 P.2d 749 (Kan. App. 1999) (where perpetrator was sole owner of the corporation, the corporation could not be regarded as a negligent, nonculpable insured).

C. Bodily Injury/Property Damage Exclusion

Liability for bodily injury, sickness, disease or death of any person, or injury to or destruction of any tangible property or loss of use resulting therefrom.

This exclusion applies to liability resulting from bodily injury to a claimant, and to damage to tangible property.

1. Bodily Injury

With respect to legal malpractice and other professional liability claims, the "bodily injury" exclusion comes up most frequently in the context of whether claims for emotional distress will be covered. Some policies are now specifically including "emotional distress" in the definition of "bodily injury." For those LPL policies that do not broaden the scope of their definition of "bodily injury" to specifically include "emotional distress," such claims may be potentially covered. *Garden State Indem. Co. v. Miller & Pincus*, 304 N.J. Super 148, 773 A.2d 1204 (2001) (emotional distress was not excluded under "bodily injury exclusion") see also *Bertagnolli v. Ass'n of Trial Lawyers Assur.*, 934 P.2d 916 (Colo. Ct. App. 1997) (legal malpractice insurer had no duty to defend the insured against sexual assault claims).

Some courts find that mental distress is "personal injury," but not a "bodily injury." *Allstate Ins. Co. v. Diamant*, 401 Mass. 654, 656, 518 N.E.2d 1154 (1988) (court ruled that coverage for "bodily injury" under a homeowner's policy does not include coverage for emotional distress as "it is well settled in the insurance law that 'bodily injury' and 'personal injury' are not synonymous and that these two phrases have distinct definitions . . . 'bodily injury' . . . is a narrow term and it encompasses only physical injuries to the body and the consequences thereof"). Other courts have found that the term "bodily injury" does, indeed, include injuries in the form of emotional distress. *Nationwide Mut. Fire Ins. Co. v. Charles*, 1996 WL 400433 (D. Me. 1996) ("Maine cases construing [policy language referring to 'bodily harm, sickness or diseases'] consistently have found bodily injury to include emotional distress"); *Maine Bonding & Cas. Co. v. Douglas Dynamics*, 594 A.2d 1079, 1081 (Me. 1991) (same); *Sokolowski v. Aetna Life & Cas. Co.*, 1986 WL 9232 (S.D.N.Y. 1986) ("alleged damages due to emotional distress . . . [are] within exclusion relating to 'bodily injury, sickness, disease or death'"); *Cowan v. Codelia*, 1999 WL 1029729 (S.D.N.Y. 1999) (LPL policy; bodily injury exclusionary language is ambiguous such that there is coverage for purely emotional distress).

Although it is less common in professional liability situations, there have been a number of cases in which a claimant has made a professional liability claim for emotional distress arising from a *physical bodily injury*. These claims have generally been excluded on the basis that all damages flowing from an excluded bodily injury are excluded. For example, the U.S. Court of Appeals for the First Circuit, applying New Hampshire law, held that claims against a school district for negligent hiring and supervision of a high school teacher, who enticed her students (the claimants) to murder her husband, were excluded by the bodily injury exclusion in the policy. The court found that the incarcerated students' claims against the school district for emotional distress, mental instability, loss of education, loss of earnings and earning capacity and mental anguish were all barred because they all arose out of the murder of the husband, an excluded bodily injury. *Winnacunnet v. Nat'l Union Fire Ins. Co.*, 84 F.3d 32 (1st Cir. 1996) (New Hampshire law). Similarly, claims against churches, school districts and other institutions for emotional distress damages arising from sexual assaults have been found to be excluded by bodily injury exclusions in policies. See, e.g., *All American Ins. Co. v. Burns*, 971 F.2d 438, 440 (10th Cir. 1992); *Wayne Township Board of Sch. Comm'rs v. Ind. Ins. Co.*, 650 N.E.2d 1205 (Ind. Ct. App. 1995) (limited, however as follows: "the term 'bodily injury' does not include emotional damage that does not arise from a bodily touching."); see also *Armstrong v. Federated Mut. Ins. Co.*, 785 N.E.2d 284, 293 (Ind. Ct. App. 2003) ("'bodily injury,' as used in certain insurance policies, might include . . . emotional harm . . . but only if said injury was the result of a direct physical impact upon the [party seeking] recovery").

In one case, involving a professional liability claim against a town for causing physical injuries to town residents through negligent pollution of the water supply with the giardia bacteria, all parties conceded that claims seeking recovery only for bodily injury were excluded by virtue of a bodily injury exclusion. *Covington Township v. Pacific Employer's Ins. Co.*, 639 F. Supp. 793 (M.D. Pa. 1986).

2. Property Damage

Property damage, including actual physical injury to property, is only rarely an issue in professional liability cases. In one case involving a legal malpractice policy, the court found that a tangible property exclusion barred coverage for a claim against an attorney for damage caused when his airplane collided with other airplanes, even though the insured was flying with a client on professional business at the time of the accident. *McAlear v. St. Paul Ins. Co.*, 158 Mont. 452, 493 P.2d 331 (1972). In *Coregis v. DeCaro*, 232 F.3d 900 (10th Cir. 2000) (Colorado law), the court found that a claim for damages suffered due to the loss of value of real estate was not excluded. In a case involving coverage for a city's alleged civil rights violations for falsely citing buildings for code violations or declaring them uninhabitable as a conspiracy to drive minorities from the city, the court found that a tangible property exclusion precluded coverage as it applied to all claims "arising out of" damage to property and no claim would have existed "but for" the property damage. *Int'l Ins. Co. v. City of Chicago Heights*, 643 N.E.2d 1305 (Ill. Ct. App. 1994) (and cases cited).

On a related issue, courts are generally hostile to claims by insurers that loss of use of money is a claim arising out of damage to tangible property. *Wash. Public Utility Dists. Utility Sys. v. Public Utility*

Dist. No. 1 of Clallam County, 112 Wash. 2d 1, 771 P.2d 701 (Wash. 1989) (exclusion in policy for loss of tangible property in the care, custody or control of the insured did not bar coverage for the loss of funds, holding "[e]xclusions for intangible property damage and property in the care, custody, or control of the insured are anathema to errors and omissions coverage").

Similarly, there is a long line of cases holding that merely economic losses or damages do not come within an insuring agreement that provides coverage for "property damage." Courts have fairly uniformly held that a loss of an investment, money, or the value of property does not constitute "property damage" for coverage purposes. *First Horizon Ins. Co. v. Int'l Surplus Lines Ins. Co.*, 1989 WL 132856 (E.D. La. 1989); *Smithway Motor Xpress v. Liberty Mut. Ins. Co.*, 484 N.W.2d 192, 195-96 (Iowa 1992); *Safeco Ins. Co. v. Andrews*, 915 F.2d 500, 502 (9th Cir. 1990); *Allstate Ins. Co. v. Miller*, 743 F. Supp. 723 (N.D. Cal. 1990); *Lazzara Oil Co. v. Columbia Cas. Co.*, 683 F. Supp. 777 (M.D. Fla. 1988), *aff'd*, 868 F.2d 1274 (11th Cir. 1989); *Lassen Canyon Nursery, Inc. v. Royal Ins. Co.*, 720 F.2d 1016, 1018 (9th Cir. 1983); *American Contract Bridge League v. Nationwide Mut. Fire Ins. Co.*, 752 F.2d 71, 75 n.1 (3d Cir. 1985); *Lamar Truck Plaza, Inc. v. Sentry Ins.*, 757 P.2d 1143 (Colo. Ct. App. 1988); *see Security State Bank of Kansas City v. Aetna Cas. & Sur.*, 825 F. Supp. 944, 947-48 (D. Kan. 1993) (economic losses caused by breach of contract do not constitute "property damage"); *Lapeka, Inc. v. Security Nat'l Ins. Co., Inc.*, 814 F. Supp. 1540, 1549 (D. Kan. 1993) (same); *see, e.g., Snug Harbour, Ltd. v. Zurich Ins. Co.*, 968 F.2d 538, 545 (5th Cir. 1992) *reh'g denied* (Sept. 21, 1992) (construing Texas law) (holding that alleged misplacement of a petition and resulting default judgment were not covered by a CGL policy because such damages did not constitute "property damage"); *Houston Petroleum v. Highlands Ins.*, 830 S.W.2d 153 (Tex. App. - Houston [1st Dist.] 1990, writ denied) (holding that economic loss, such as loss of investment, subscription funds and profits does not constitute loss of "tangible property"); *Lay v. Aetna Ins. Co.*, 599 S.W.2d 684 (Tex. Civ. App. - Austin 1980, writ *ref'd n.r.e.*) (holding that where the insured misread a survey and drilled a successful oil well on a neighbor's property, and where the lease owner sued for recovery of lost revenues and the cost of the well, there was no damage to "tangible property" of the lease owner); *Selective Ins. Co. v. J.B. Mouton & Sons*, 954 F.2d 1075, *reh'g denied* (Mar. 31, 1992) (5th Cir. 1992) (construing Louisiana law holding that loss of a partnership interest, fraudulent inducement to transfer land and loss of future income do not constitute loss of "tangible property"); *Aetna Cas. & Sur. Co. v. First Security Bank of Bozeman*, 662 F. Supp. 1126 (D. Mont. 1987) (insurer not required to defend against allegations of lost wages and diminished earning capacity in a wrongful termination suit because this did not constitute injury to tangible property); *Oxford Lumber Co. v. Lumbermans Mut. Ins. Co.*, 472 So. 2d 973 (Ala. 1985) (insurer not required to defend against plaintiff's claims that an employer wrongfully allowed a health insurance policy to lapse which caused them to lose benefits and suffer mental distress and bodily injury); *Travelers Indem. Co. v. State*, 680 P.2d 1255 (Ariz. Ct. App. 1984) (CGL insurer not required to defend suits against the state regulators for failure to properly regulate a thrift resulting in plaintiff's loss of deposits and other investments); *L. Ray Packing Co. v. Commercial Union Ins. Co.*, 469 A.2d 832 (Me. 1983) (insurer not required to defend against plaintiff's alleged loss of profits and other financial interests as a result of the insured's alleged anti-trust price-fixing); *Giddings v. Indus. Indem. Co.*, 169 Cal. Rptr. 278 (Cal. Dist. Ct. App. 1980) (insurer not required to defend a group of insureds who were owners, directors, and/or officers of a failed bank against allegations that they wasted and misappropriated funds resulting in the loss of the plaintiff's deposits and other investments).

D. Insured v. Insured Exclusion

Made by an Insured under this policy against any other Insured under this policy, unless such Claim arises solely out of Professional Services performed for that party in a lawyer-client capacity.

The application of this "insured vs. insured" exclusion ordinarily comes up in situations involving internal business disputes between partners in the same firm or claims for employment discrimination or other employment torts between members of the firm. It may also apply in situations in which a partner or employee leaves the firm and then sues the firm for tortious acts committed after the employee or partner has left the firm, such as interfering with the departing lawyer's new practice. Because former partners of

a firm are ordinarily covered by the firm's insurance policy, claims between a former partner or employee and the insured firm trigger this exclusion. Even if not excluded under the insured vs. insured exclusion, many of these claims are not covered because they do not "arise out of the rendering of professional services" as required for coverage under the insuring agreement. (SEE "*INSURING AGREEMENT - RENDERING OF PROFESSIONAL SERVICES*"). There is usually an exception to the exclusion for claims made by one insured against another if the claims arise out of one insured's acting in the capacity as a lawyer for the other insured in a lawyer-client relationship.

The exclusion is designed to bar coverage for "collusive" suits. In fact, the primary intent of the exclusion is to prevent collusive lawsuits in which an insured corporation, by filing an action against its own officers and directors, would compel its insurer to pay for the poor business decisions of the officers and directors. *Township of Ctr. v. First Mercury Syndicate, Inc.*, 117 F.3d 115, 119 (3d Cir. 1997). Insurers have met with mixed success in successfully invoking this exclusion to bar coverage for any suit by the company or one director or officer against another director or officer. *Compare Reliance Ins. Co. v. Weis*, 148 B.R. 575 (Bankr. E.D. Mo. 1992), *aff'd*, 5 F.3d 532 (8th Cir. 1993) and *Level 3 Communications v. Fed. Ins. Co.*, 168 F.3d 956 (7th Cir. 1999) (applied the "insured vs. insured" exclusion to preclude coverage for that part of settlement and other expenses of securities suit allocable to plaintiff who had been director of subsidiary.); with *In re Molten Metal Tech., Inc.*, 271 B.R. 711 (Bankr. D. Mass.), *aff'd*, 2002 WL 923936 (D. Mass. May 6, 2002).

A number of courts have found the exclusion to be ambiguous as found in directors and officers policies and have construed it against the insurer. *Conklin Co. v. Nat'l Union Fire Ins. Co.*, Civ. No. 4-86-860, 1987 WL 108957, *3 (D. Minn. Jan. 28, 1987) (if there is "actual adversity" between the parties, exclusion will not bar coverage); *FDIC v. Am. Cas. Co. of Reading, Pa.*, 814 F. Supp. 1021, 1025 (D. Wyo. 1991) (finding an "insured vs. insured" exclusion to be ambiguous and construing it against the insurer); *St. Paul Fire & Marine Ins. Co. v. FDIC*, 765 F. Supp. 538, 548 (D. Minn. 1991) (construing the "insured vs. insured" exclusion against the insurer where it was ambiguous whether the definition of "insured" encompassed the Federal Deposit Insurance Corporation), *aff'd*, 968 F.2d 695 (8th Cir. 1991); *Continental Cas. Co. v. Allen*, 710 F. Supp. 1088, 1098 (N.D. Tex. 1989) (same); *Rieser v. Baudendistel (In re Buckeye Countrymark, Inc.)*, 251 B.R. 835, 839 (Bankr. S.D. Ohio 2000) (construing an "insured vs. insured" exclusion in terms favorable to the insured).

VI. DEFINITIONS

A. "Claim" means a demand for money or services, or the filing of suit or institution of arbitration proceedings against the insured.

A "claim" is defined in Webster's Third International Dictionary as "a challenging request, a demand of a right, a calling upon another for something due, a demand for benefits or payment, or a title to something in the possession of another." The typical definition of a "claim" in the context of claims made and reported insurance policies is a demand for money or services or some specific remedy. However, the definition of a "claim" can be modified by other provisions of the policy. For example, a policy's notice provisions often affect the definition of a "claim." In *Hoyt v. St. Paul Fire & Marine Ins. Co.*, 607 F.2d 864 (9th Cir. 1979), the policy's notice section required the forwarding of "every demand, notice, summons, or other process received . . ." to the insurer. The court interpreted this provision to modify the term "claim" to mean every demand or notice. A disciplinary complaint was found not to be a "claim" or a "potential claim" because it was not a demand for money or services and such matters were excluded from coverage. *Chicago Ins. Co. v. Lappin*, 799 N.E.2d 1018 (58 Mass. App. Ct. 769, 2003).

Even in cases where the policy did not define the term "claim," courts have routinely held that the term is unambiguous and that the common law will supply the definition. *ITC Invests., Inc. v. Employers Reinsurance Corp.*, 2000 WL 1996233 (Conn. Super. 2000) ("the overwhelming weight of authority holds that such a failure of definition [of the term claim] does not create ambiguity. Why? Because these courts give the word its common meaning."); *Nat'l Cas. Co. v. Great Southwest Fire Ins. Co.*, 833 P.2d 741

(Colo. 1992) (finding that in the absence of a policy definition, the term "claim" means a "demand made to enforce a right."); see *Nat'l State Bank v. American Home Assurance Co.*, 492 F. Supp. 393, 396 (S.D.N.Y. 1980) (concluding that "claim" was not an ambiguous term because it "consistently ... [referred] to an assertion of a legal right by a third-party against the insured" even though it was not defined in policy); *Safeco Title Ins. Co. v. Gannon*, 54 Wash. App. 330, 334, 774 P.2d 30, 33 (1989) (although not defined in policy, "claim" was unambiguous and its plain and ordinary meaning is "a demand for compensation"); *CIPS v. American Empire Surplus Lines*, 267 Ill. App. 3d 1043, 204 Ill. Dec. 822, 642 N.E.2d 723 (Ill. App. 1994) (refusing to find the word claim ambiguous, stating that the absence of a definition does not render a policy term ambiguous); *Ins. Corp. of America v. Dillon, Hardamon & Cohen*, 725 F. Supp. 1461 (N.D. Ind. 1988) (stating that the word claim cannot be considered ambiguous despite the absence of a definition). But see *P. Link & Co. v. Continental Cas. Co.*, 470 F.2d 1133 (9th Cir. 1972) (finding the term "claim" to be ambiguous and construing it against the insurer to provide a more expansive definition for coverage purposes).

Generally, the first question in determining whether a "claim" has been made is whether the claimant has actually demanded money or services. For example, in *Rentmeester v. Wis. Lawyers Mut. Ins. Co.*, 164 Wis. 2d 1, 473 N.W.2d 160 (1991), a new attorney for the insured's former clients expressed dissatisfaction with the insured's loss of the case and indicated an intention to sue if the matter was not reversed on appeal. He requested that the insured "notify [his] professional insurance carrier of this matter." *Id.* at 4-5, 473 N.W.2d at 162. The insured wrote back, indicating that the "potential claim" would be forwarded to his insurance carrier. However, the insured never forwarded it. The court held that "the only reasonable construction of [the successor attorney's] letter was to notify the [insured] and his insurer that the [clients] would hold [the insured] financially responsible in the event their appeal failed." The insured argued that this was not a "claim" because it was contingent upon the loss of the appeal. The court disagreed, noting that "[w]hile not every contingent demand rises to the level of a claim, when the only condition is certain, ascertainable and agreed to by both parties, a demand has been made." See also *Berry v. St. Paul Fire & Marine Ins. Co.*, 70 F.3d 981 (8th Cir. 1995) (letter from attorney reporting "personal injuries and disability [that the client] sustained while using one of your products . . . [and to] please forward this letter to your products liability insurer for proper handling . . ." constituted a claim and court rejected argument that "claim" required a specific monetary demand for payment); *Herron v. Schutz Foss Architects*, 935 P.2d 1104 (Mont. 1997) (a letter from an attorney to the insured requesting that the insured contact his malpractice insurer and desiring to discuss "this claim" with the insurer constituted a "demand for money or services . . ."); *Rentmeester v. Wis. Lawyers Mut.*, *supra*.

On the other hand, some courts have found that letters from disgruntled clients are not claims. *Nat'l Fire Ins. v. Bartolazo*, 27 F.3d 518 (11th Cir. 1994) (lawyers' letter to doctor indicating that they represented patient "in her claim for medical malpractice and other relief against you," did not constitute a "demand for money or services or allege a medical incident," as required under the definition of "claim" in the policy).

In *Gibraltar Cas. Co. v. A. Epstein & Sons*, 206 Ill. App. 3d 272, 562 N.E.2d 1039 (Ill. Ct. App. 1990), for example, the court held that the letter only indicated that a preliminary investigation pointed to the insured's negligence, but did not constitute an actual claim. The court found it significant that the letter did not "specify the alleged negligent acts, the employees involved or the type of damage incurred." See also *Purcigliotti v. Risk Enterprise Mgmt., Ltd.*, 658 N.Y.S.2d 296 (1997) ("a 'claim' as defined in the subject policy, is not merely an awareness of the possibility that some wrongdoing has occurred, but rather a demand for a specific relief that can be defended, settled and paid for by the insurer").

A request for information has also been held not to constitute a claim. *Ins. Corp. of America v. Dillon, Hardamon & Cohen*, 725 F. Supp. 1461 (N.D. Ind. 1988) (claim "does not, standing alone, include a mere request for information or an explanation."); *Hoyt v. St. Paul Fire & Marine Ins. Co.*, 607 F.2d 864, 865-66 (9th Cir.1979) (a letter written by the injured party requesting information or an explanation from the insured attorney is not a demand and does not constitute a claim).

B. "Damages" means compensatory judgments, settlements or awards, but does not include punitive or exemplary damages, sanctions, fines or penalties assessed

directly against any Insured, the return of fees or other consideration paid to the Insured, or that portion of any award or judgment caused by the trebling or multiplication of actual damages under federal or state law.

The term "damages" generally applies to monetary damages sought by the claimant. Professional liability policies typically define "damages," however, in such a way as to exclude certain categories of expense/exposure. The fact that a complaint seeking noncovered damages, such as injunctive relief, may also contain a claim for costs and attorneys fees does not trigger the duty to defend because these are not "damages." *116 Commonwealth Condominium Trust v. Aetna Cas. & Sur. Co.*, 433 Mass. 373, 742 N.E.2d 76 (2001). Moreover, even a policy that provides coverage for "non-monetary" claims does not cover attorneys fees and costs incurred in responding to a subpoena because this did not constitute a "claim." *Center for Blood Research, Inc. v. Coregis*, 305 F.3d 38 (1st Cir. 2002).

1. Return of Fees or Restitution of Monies Received by the Insured

The rationale for the first excluded category - return or restitution of fees - is that exposure to a claim or suit from the client for restitution is essentially a business risk to be borne by the professional, and not a matter subject to professional liability coverage. In addition, the damages sought in such an action are typically of a contractual nature or are based upon an equitable theory of liability (restitution, equitable lien or disgorgement). Some policies specifically mention that this limitation applies to the insured's fees "whether claimed as restitution of specific funds, forfeiture, financial loss, or set-off."

Courts have generally enforced return of fees/restitution exclusions, holding that efforts to seek return or restitution of fees are not covered, regardless of the legal theory under which the claimant proceeds against the attorney. *Continental Cas. Co. v. Kaplan*, 801 N.E.2d 992 (Ill. Ct. App. 2004) (attorney sought to collect fees after bankruptcy filed); *Continental Cas. Co. v. Brady*, 127 Idaho 830, 833, 907 P.2d 807, 810 (1985) (in applying the exclusion, the focus is on the nature of the relief requested, rather than the legal theory pursued by the claimant); *Fred Lowenschuss v. The Home Ins. Co.*, 1990 WL 126110 (E.D. Pa. Aug. 27, 1990); *Nat'l Union Fire Ins. Co. v. Shane & Shane Co., L.P.A.*, 78 Ohio App. 3d 765, 605 N.E.2d 1325 (1992); *Krasner v. Prof'l Prototype I Ins. Co. Ltd.*, 983 F.2d 1076 (9th Cir. 1993). *Compare Weissberger v. Home Ins. Co.*, 76 Ohio App. 3d 391, 601 N.E.2d 660 (1991) (limitation on damages for "restitution of legal fees" meant that policy covered a judgment or settlement against the insured for attorneys fees owed to insured's co-counsel); *In re Estate of Corriea*, 719 A.2d 1234 (D.C. 1998) (disgorgement of profits earned by attorney in connection with transaction constituted damages under liability policy). As noted in *Hofing v. CNA Ins. Cos.*, 247 N.J. Super. 82, 90, 588 A.2d 864, 869 (N.J. Super. 1991): ". . . although the policy covers negligent conduct, when the negligent conduct is alleged in order to recoup fees paid, the exclusion applies by excepting this category of claims." In this case, the court held that underlying claims for excessive billing of an insurer (pleaded in theories of accounting, declaratory relief and quantum meruit) were subject to the exclusion. *Id.* at 91, 588 A.2d at 869. See also *Continental Cas. Co. v. Kaplan*, 801 N.E.2d 992 (Ill. Ct. App. 2004) (claim that attorney failed to seek discharge of his pre-petition fee claim was covered).

There are situations, however, in which the exclusion's terms are not so broad as to exclude coverage in its entirety. For instance, additional fees that the client must incur to retain other counsel to cure the alleged malpractice might fall outside the exclusion. *Hofing*, 247 N.J. Super. at 91, 588 A.2d at 869. See also *Berkeley v. Home Ins. Co.*, 68 F.3d 1409 (D.C. Cir. 1995); *McCotis v. Home Ins. Co.*, 31 F.3d 110, 112 (2d Cir. 1994) (suit by law firm against former partner for fraudulently billing a client was covered to the extent former partner did not receive the fees). This is another way of expressing the concept that while the return of fees itself may not fall within the "damages" concept for coverage purposes, the expense of remedial or curative work undertaken by another attorney could be subject to coverage. The same would, of course, be true for a claimant's compensatory damages arising from the attorney's errors in addition to the restitution of fees requested.

Some exclusions bar coverage for claims that the insured gained a personal profit to which it was not entitled. *Brown & LaCounte v. Westport Ins. Co.*, 307 F.3d 660 (7th Cir.2002).

Regardless of any particular policy exclusion, some courts have held that an insured could not recover from an insurer for excessive fees that were repaid to the client, because these are not within the common definition of "damages." *Friend v. Attorneys Liab. Protection Soc'y*, 131 F.3d 134, 1997 WL 746761 (4th Cir.1997) (applying W. Va. law); *Admiral Ins. v. Weitz & Luxenberg, P.C.*, 2002 WL 31409450 (S.D.N.Y. 2002); *Level 3 Communications v. Federal Ins. Co.*, 272 F.3d 908 (7th Cir. 2001) (applying Illinois law).

2. Sanctions, Fines and Penalties

Similarly, courts have tended to uphold exclusions of coverage for sanctions and penalties awarded against insured attorneys. A typical scenario involves a shifting of the fees of the other party upon a finding of malicious or frivolous litigation activity by the insured. These types of sanctions have been held not to be covered by a legal malpractice policy. *Page Wellcome v. The Home Ins. Co.*, 758 F. Supp. 1375, 1378 n.2 (D. Mont. 1991), (same case), 257 Mont. 354, 849 P.2d 190 (1993) (same case) 993 F.2d 887 (9th Cir. 1993); *Green v. Nat'l Union Ins. Co.*, 924 F.2d 1051 (4th Cir. 1991). See also *Pearne, Gordon, McCoy & Grainger v. American Home Assurance Co.*, 92 Ohio App. 3d 251, 255, 634 N.E.2d 1032, 1035 (1993) (sanctions against the involved partner were excluded under the intentional acts exclusion, but insured firm was entitled to a defense under "innocent insured" clause). This is so even though an argument could be made that the purpose of a fee shifting statute is to compensate the other party. *Dixon v. Home Indem. Co.*, 426 S.E.2d 381 (Ga. App. 1992).

Courts in other cases have held that policy limitations as to lack of coverage for "fines or statutory penalties" do not unambiguously bar coverage for sanctions. *Mitchell A. Kramer & Assocs. v. Robert S. Atkins & Associates*, 1991 WL 2419 (N.D. Ill. 1991) (policy provision ambiguous as to whether exclusion extends to award of sanctions pursuant to Rule 11); *Figari & Davenport, LLP v. Continental Cas. Co.*, 1994 WL 85685 (N.D. Tex. 1994) (sanctions not excluded where limitation only applied to "fine or statutory penalties"); *Bar Plan v. Campbell*, 1991 WL 179443 (Mo. Ct. App. 1991) (same); *O'Connell v. The Home Ins. Co.*, 1990 WL 137386 (D.D.C. 1990) (same).

Another type of damages not covered under such language would be statutory penalties awarded in lieu of, or in addition to, compensatory damages. Examples include those statutory penalties that can be awarded under the Fair Debt Collection Practices Act and RICO.

3. Punitive Damages

The exclusion for punitive or exemplary damages is necessary because: (1) not all jurisdictions will construe punitive amounts to fall outside the general concepts of "damages" or "loss" under a policy; and (2) noncoverage for punitive damages arising from public policy concerns may not always be the prevailing rule for a particular jurisdiction. Many jurisdictions presently hold that punitive damages are uninsurable, while many other jurisdictions hold that they are insurable (although some of these jurisdictions do not allow coverage of punitive damages arising out of intentional torts). Ostrager & Newman, *Insurance Coverage Disputes*, 14.06, at 847-862 (10th ed.); see also Hinshaw & Culbertson LLP's *50-State Survey of the Law of Punitive Damages*. The majority of states also allow coverage for punitive damages imposed upon a defendant based upon principles of vicarious liability. *Id.*

Most LPL policies, such as the one quoted above, contain an express exclusion relating to punitive damages. Because such claims may arise in conjunction with otherwise covered liability theories or may be combined with other covered damage claims, insurers may be in the position of asserting a denial as to payment of any punitive or exemplary damages while defending (and potentially settling) other aspects of the suit. Punitive claims may also be thrown into legal malpractice suits with little or no factual and legal support, solely for the purpose of leveraging a larger settlement. Where this occurs, claims may be settled with little or no "premium" paid for resolution of the punitive damages portion along with other liability or damages theories.

A few states hold that coverage for punitive damages is unavailable (on public policy or statutory grounds) even in the absence of policy language excluding them. *Public Service Mut. Ins. Co. v. Goldfarb*, 53 N.Y.2d 392, 442 N.Y.S.2d 422 (1981). (SEE "EXCLUSIONS INTENTIONAL ACTS - PUBLIC POLICY AND STATE STATUTES PROHIBITING COVERAGE FOR INTENTIONAL CONDUCT"). In addition, other courts have reasoned that unless a policy states that it specifically covers punitive or exemplary damages, coverage would not be granted. *E.g., United L.P. Gas Systems, Inc. v. Int'l Surplus Lines Ins. Co.*, 869 F.2d 1109, 1110 (8th Cir. 1989) (under Missouri law policy covering bodily injury and property damage does not cover punitive damages, "unless other language in the policy provides for payment of punitive damages").

Thus, it is probably not safe for insureds to assume that they have coverage for punitive damages simply due to the absence of an exclusion precluding it. Insurers, for their part, should also not assume that an exclusion for "fines or penalties" will be, by itself, sufficient to include punitive or exemplary damages. See *Collins & Aikman v. Hartford Acc. & Indem.*, 106 N.C. App. 357, 416 S.E.2d 591 (1992).

4. Non-Monetary Awards

Injunctive or declaratory relief generally does not qualify as "damages" because relief awarded under equitable theories is not compensatory. Thus, a suit seeking only a declaration of rights, an accounting, or any form of injunctive relief would not be subject to coverage under most LPL policies. *116 Commonwealth Condominium Trust v. Aetna Cas. & Sur. Co.*, 433 Mass. 373, 742 N.E.2d 76 (2001) (stating that "[t]his Commonwealth defines damages as 'the word which expresses in dollars and cents the injury sustained by the plaintiff'"); *York Golf and Tennis Club v. Tudor Ins. Co.*, 2004 WL 757870 (Me. 2004); *Ladd Constr. Co. v. Ins. Co. of North America*, 73 Ill. App. 3d 43, 46-47, 29 Ill. Dec. 305, 391 N.E.2d 568 (1979) (nuisance action, as equitable remedy, does not constitute action for money damage to property); *Jones v. Farm Bur. Mut. Ins. Co.*, 172 Mich. App. 24, 29, 431 N.W.2d 242 (1988) ("damages" cannot encompass strictly injunctive action). Adding a claim for professional malpractice and seeking other damages would usually trigger the insurer's defense obligations, subject to a reservation of rights on the expense of defending the nonmonetary relief aspects of the suit. (SEE "DUTY TO DEFEND - SCOPE OF DUTY TO DEFEND").

5. Multiplied Damages

The "multiplied portion of awards" language may be an important policy feature in jurisdictions in which multiplied damages are available in legal malpractice actions. Examples of such damages can be found where attorneys are subject to liability under state consumer protection statutes or RICO, which allow a judge to award multiple damages where the conduct is willful or knowing. See, e.g., Massachusetts General Laws G.L. c. 93A. Presumably, in such an action, the multiplied portion of any award against the attorney would be subject to the exclusionary language set forth above.

- C. "Predecessor Firm" means any legal firm which has undergone dissolution and either (a) some or all of such firm's principals, owners, officers or partners have joined the Named Insured, provided such persons were responsible for producing in excess of 50% of the prior firm's annual gross billings and such billings have been assigned or transferred to the Named Insured; or (b) at least 50% of the principals, owners, partners or officers of the prior firm have joined the Named Insured; or (c) at least 50% of the prior firm's financial assets/liabilities have been assumed by the Named Insured.**

The reason that this definition is provided in LPL policies is that the definition of "named insured" ordinarily includes not only the present insured firm, but also any firm that qualifies as a "predecessor firm." By virtue of this language, all of that predecessor firm's lawyers and employees end up being insured under the successor firm's policy. See *Schwelling v. Wis. Lawyers Mut. Ins. Co.*, 192 Wis. 2d 763, 532 N.W.2d 469 (Wis. App. 1995).

LPL policies provide several different variants of this language. But most share the common theme that a predecessor firm will include a firm over which the insured firm assumes a majority interest or majority control. Some definitions focus on billings. Others focus on hiring of a certain percentage of attorneys from the prior firm. Yet others focus on a combination of the two factors, as illustrated by the foregoing provision. Some clauses require that the former firm be dissolved.

An alternative to focusing on the manner in which the prior firm was absorbed into (or taken over by) the named insured is the following: "Predecessor firm' means any entity which has undergone dissolution and is named as such on the Declarations." The above approach to the predecessor firm issue presumes that no prior firms are covered unless specifically endorsed onto the policy. This puts the onus on the insured and the underwriter to ensure that firms merged into the present firm are discussed, and included within the policy's coverage, if necessary. There must be an actual dissolution. *In re: Popkin & Stern*, 2003 WL 21998978 (8th Cir. 2003) (where coverage terminated upon "dissolution" resignation of partners did not dissolve firm).

The problems created for insurers by these provisions are twofold. Specifically, (1) trying to calculate the prior firm's assets and liabilities can be extremely complicated due to valuation issues as to computers, furniture, receivables (collectible/uncollectible), office leases, and equipment leases, and the need to review countless documents to accurately do so; and (2) providing predecessor coverage can result in an insurer picking up the coverage for an entire predecessor firm, resulting in a dramatically increased risk without an ability to underwrite it or collect an appropriate premium, at least until the renewal. Moreover, because the insurer for the named insured may cover *all* former members of the predecessor firm (and the predecessor firm itself) it will be liable for acts committed at the predecessor firm by those members of that firm who did *not* join the named insured. Thus, the insurer never has a chance to accurately underwrite this risk.

Nonetheless, only legal services performed for the named insured or a qualifying "predecessor" firm would be covered. Also, the same limitations on coverage apply to both a predecessor firm and to the named insured, including that: (1) the insured did not give notice to a prior insurer of such claim or act; (2) prior to the inception date of the policy the insured did not have a basis to foresee a claim; and (3) there is no other policy that covers the claim.

VII. ASSISTANCE AND COOPERATION AND VOLUNTARY PAYMENTS PROVISION

The Insured shall cooperate with the Company and, upon the Company's request, submit to examination and interrogation by a representative of the Company, under oath if required, and shall attend hearings and trials and assist in securing and giving evidence and obtaining the attendance of witnesses, as well as in giving written statements to the Company's representatives for the purpose of investigation and/or defense, all without charge to the Company. The Insured shall further assist in enforcing any right of contribution or indemnity against any person or organization who may be liable to the Insured because of Damages with respect to which this Ins. applies. The Insured shall not, except at the Insured's own cost, voluntarily make any payments, admit liability, assume any obligation or incur any expense.

This policy clause involves numerous components including: (1) the insured's obligation to cooperate with the carrier in the defense of the liability claim and assisting the carrier in enforcing rights of contribution or indemnity; (2) the potential that the insured must cooperate with respect to the carrier's coverage investigation; and (3) the insured's obligation to refrain from making any payments, admitting any liability, or assuming any obligation or incurring any expense without the insurer's permission.

A. The Insured's Duty to Cooperate in the Defense of the Matter

There are numerous cases in which courts have held that an insurer may be relieved of its liability under an insurance policy if the insured fails to cooperate with the insurer in the defense of the matter by failing to be available for testimony at trial or a deposition, failing to respond to the carrier's request for information or otherwise making it difficult, if not impossible, for the carrier to defend the insured due to the insured's lack of responsiveness or unavailability. Many states require that the insurer, prior to disclaiming, demonstrate that it acted diligently in attempting to secure the insured's cooperation and that the insured's lack of cooperation was willful. *Thrasher v. U.S. Liab. Ins. Co.*, 19 N.Y.2d 159, 278 N.Y.S.2d 793 (1967); *Hanover Ins. Co. v. Demato*, 143 A.D.2d 807, 533 N.Y.S.2d 138 (1988); *O'Leary v. Lumbermen's Mut. Cas. Co.*, 178 Conn. 32, 420 A.2d 888 (1979).

Courts generally find that "[t]he purpose of a cooperation clause is to protect the insurer's interest and to prevent collusion between the insured, to whose rights the insurer has been subrogated, and the third party tortfeasor." *Paxton Nat'l Ins. Co. v. Brickailik*, 493 A.2d 764 (Pa. Super. Ct. 1985) (citing 8 Appleman *Insurance Law and Practice* § 4771), order rev'd, 522 A.2d 531 (Pa. 1987). A breach of the duty to cooperate will relieve the insurer of liability only where the failure to cooperate is substantial and the insurer has suffered prejudice as a result of the breach. See *Forest City Grant Liberty Assoc. v. Genro II, Inc.*, 652 A.2d 948, 951 (Pa. Super. Ct. 1995). Most jurisdictions require insurers to demonstrate prejudice. *Prudential Prop. and Cas. Co. v. Erie Ins. Co.*, 660 F. Supp. 79 (E.D. Pa. 1986). Examples of breach of the duty to cooperate are: "the insured neglects to disclose information needed by the insurer to prepare a defense, does not aid in securing witnesses, refuses to appear and testify at trial or otherwise fails to 'render all reasonable assistance necessary to the defense of the suit.'" *Forest City*, 652 A.2d at 951-952 (quoting 8 Appleman, *Insurance Law and Practice* § 4774). An insurer might be "precluded from advancing any defenses" without assistance from the insured. *American Int'l Specialty Lines Ins. Co. v. Continental Cas. Ins. Co.*, 142 Cal. App. 4th 1342, 49 Cal. Rptr. 3d 1 (Cal. App. 2 Dist. 2006). "Where an insured violates a cooperation clause, the insurer's performance is excused if its ability to provide a defense has been substantially prejudiced. [Citations.]" *Id.*; see also *Juvland v. Plaisance*, 255 Minn. 262, 96 N.W.2d 537 (1959) (a breach of the cooperation clause must be a substantial and material breach which prejudices the insurer).

Most of the case law regarding the insured's duty to cooperate focuses on the insured's duty to assist the insurer in its own defense. See *San Gabriel Basin Water Quality Auth. v. Aerojet-General Corp.*, 105 F. Supp. 2d 1095 (C.D. Cal. 2000) (insured and *Cumis* counsel must disclose information related to action, but *not* privileged materials relevant to coverage disputes); *Hall v. Travelers Ins. Cos.*, 93 Cal. Rptr. 159 (Cal. Ct. App. 1971) (insured shall assist in effecting settlements, securing and giving evidence and in conduct of suits, and failure to do so when requested constitutes a defense in suit brought against insurer by injured party); *Ford v. Providence Wash. Ins. Co.*, 311 P.2d 930 (Cal. Ct. App. 1957) (insured required to give fair and frank disclosure of information reasonably demanded by insurer to determine if there is a defense or whether insurer should settle); *Standard Accident Ins. Co. of Detroit, Mich. v. Winget*, 197 F.2d 97 (9th Cir. 1952) (concealment and material misrepresentation of facts will violate cooperation clause, but misrepresentation is not material if the false statement is withdrawn before the defense of the insured by the insurer is prejudiced); *Martin v. Travelers Indem. Co.*, 450 F.2d 542, 553 (5th Cir. 1971) (construing Mississippi law, "[c]ooperation clauses are intended to guarantee to insurers the right to prepare adequately their defenses on questions of substantive liability").

In *Metawave Communications Corp. v. St. Paul Fire & Marine Ins. Co.*, 2006 WL 3057746 (Cal. Ct. App. Oct. 27, 2006), the court upheld the jury's finding in favor of St. Paul on the business interruption and extra expense claims where Metawave breached cooperation clause by failing to provide any documentation in support of those claims. *Id.* at *8. Metawave's refusal to provide basic documentation to support its claim and refusal to submit to an examination under oath justified the denial of the claims. *Id.* at *8.

Under New York law, for example, the insurer bears a heavy burden in showing that the insured breached the duty to cooperate. *Underwriters at Lloyd's of London v. 150 Nassau Street Billiards, Inc.*, 2003 WL 22999464 at *10 (S.D.N.Y. Dec. 22, 2003) (citing *Thrasher v. U.S. Liab. Ins. Co.*, 19 N.Y.2d

159, 278 N.Y.S.2d 793, 225 N.E.2d 503, 508 (1967)). The burden on the insurer must be heavy because the defense of lack of cooperation penalizes the claimant for the action of the insured. *Thrasher*, 225 N.E.2d at 508. It is well-settled that to deny coverage for a failure to cooperate, the insurer must show that: (1) it acted diligently in seeking to bring about the insured's cooperation; (2) the efforts employed were reasonably calculated to obtain the insured's cooperation; and (3) after the insured's cooperation was sought, the insured's attitude was one of willful and avowed obstruction. *Id.* (citing *Thrasher*, 225 N.E.2d at 508); see also *U.S. Underwriters Ins. Co. v. 203-211 W. 145th St. Realty Corp.*, 2001 WL 604060 at *7 (S.D.N.Y. May 31, 2001); *Banghaloo-White v. Allstate Ins. Co.*, 270 A.D.2d 296, 704 N.Y.S.2d 131 (App. Div. 2000).

Some courts demonstrate great reluctance to find a breach of the cooperation clause. For example, in *150 Nassau Street, supra*, the court held that the insured landlord's initial failure (prior to filing a claim) to notify the insurer of certain tenant claims alleging only intentional acts did not constitute a breach of the cooperation clause because New York law requires that the insured "willfully and avowedly obstruct[]" the insurer's investigation after the insurer contacted the insured seeking cooperation. *Id.* at *11.

The court in *Nelson Electrical Contracting Corp. v. Transcontinental Ins. Co.*, 231 A.D.2d 207 (N.Y. App. Div. 1997), refused to find a breach of the cooperation clause based upon the decision of the insured's defense counsel not to oppose a co-defendant's motion for summary judgment on its indemnification claims against the insured. *Id.* at 210. The court held that defense counsel's purpose was to safeguard the insured's interests and that finding a breach of the duty to cooperate under such circumstances would effectively enable the insurer to take control of the defense and subordinate the insured's interests to its own. *Id.* at 210. However, in *Nationwide Mut. Ins. Co. v. Graham*, 275 A.D.2d 1012 (N.Y. App. Div. 2000), the court held that where the insured lied about the circumstances of the injury-causing incident, the insurer sustained its "heavy burden" of showing a lack of cooperation by the insured and had no duty to defend or indemnify. *Id.*

Similarly, in *Lewis v. Nationwide Mut. Ins. Co.*, 202 A.D.2d 816 (N.Y. App. Div. 1994), where the insured had lied to the insurer regarding the circumstances of the subject auto accident, the court held that the insured's failure to cooperate and failure to give proper notice entitled the insurer to disclaim any duty to defend. *Id.* at 817.

If the insurer disclaims coverage at the outset, but the disclaimer turns out to be erroneous, the insurer cannot rely on the fact that the insured failed to cooperate after the disclaimer. *Clarke v. Fid. & Cas. Co. of New York*, 55 Misc. 2d 327, 285 N.Y.S.2d 503 (1967); *Matychak v. Security Mut. Ins. Co.*, 181 A.D. 2d 957, 581 N.Y.S.2d 453 (1992). Nonetheless, an agreement for judgment entered into by an insured after the insurer had disclaimed may not be binding on the insurer if it is procured through fraud or collusion. *Matychak*, 181 A.D.2d 957, 581 N.Y.S.2d 453; *Burbach v. Armstrong Rigging and Erecting*, 560 N.W.2d 107 (Minn. Ct. App. 1997); *Black v. Goodwin, Loomis and Britton*, 239 Conn. 144, 681 A.2d 293, 302 (1996); *Campione v. Wilson*, 422 Mass. 185, 661 N.E.2d 658 (1996).

B. Duty to Cooperate With Insurer's Coverage Investigation

The question of whether an insured has a duty to cooperate when the insurer is attempting to investigate coverage is an issue that arises frequently in practice, but in few reported cases. *MetLife Auto & Home v. Cunningham*, 59 Mass. App. Ct. 583, 797 N.E.2d 18 (2003) (insured had duty to cooperate in coverage investigation). Sometimes the policy language makes it clear that the insured must provide cooperation with the insurer as to *any* topic into which the insurer seeks to inquire. Other policies are reasonably susceptible to an interpretation that the cooperation clause is only directed towards cooperation with respect to defense issues. *Compare Saftler v. Government Employees Ins. Co.*, 95 A.D.2d 54, 465 N.Y.S.2d 20 (1983) (insured's duty to cooperate includes the duty to cooperate in coverage investigation); *with Lafarge Corp. v. Hartford Cas. Ins. Co.*, 61 F.3d 389 (5th Cir. 1995) (court refused to allow insurer to disclaim on the basis that an insured had failed to cooperate with coverage investigation since "cooperation clauses are intended to guarantee to insurers the right to prepare adequately their defense on questions of substantive liability," and insurer was arguably prevented from

"even invoking cooperation clause with respect to coverage"); and *Martin v. Travelers Indem. Coverage*, 450 F.2d 542 (5th Cir. 1971) (same). Practically, however, courts recognize that it can be difficult to separate an insurer's need for information for the defense from its need to investigate for coverage purposes. See *General Ins. Co. of America v. Gross*, 1997 WL 230800 (E.D. Pa. 1997) (disagreeing with *Lafarge Corp.*, *supra*). The issue usually comes up in response to the insurer's request for a statement under oath, or for documents with respect to coverage. *Stover v. Aetna Cas. and Sur. Co.*, 658 F. Supp. 156 (S.D. W. Va. 1987) (insurer was justified in disclaiming coverage where insured failed to comply with policy terms commanding that insured submit to an examination under oath) (and cases cited).

Insurers have also used the cooperation clause in the coverage context to compel the insured to produce attorney/client files from an underlying litigation for which the insured sought coverage. *EDO Corp. v. Newark Ins. Co.*, 145 F.R.D. 18 (D. Conn. 1992) (where insured had a duty to cooperate in defense of the matter, it was under a duty to disclose all relevant information to its insurer until it was on notice that coverage would be denied); *Waste Mgmt., Inc. v. Int'l Surplus Lines Ins. Co.*, 144 Ill. 2d 178, 579 N.E.2d 322 (1991) (duty of cooperation includes assisting insurers in determining extent of coverage for claim for which insured is seeking coverage). Other courts, however, have determined that the standard cooperation clause is intended to facilitate cooperation "in the defense of an underlying suit, not to benefit insurers in a coverage dispute" and have decided not to allow the insurer to see the privileged documents from the underlying case. *State v. Hydrite Chemical Co.*, 220 Wis. 2d 51, 582 N.W.2d 411 (1998); *Bituminous Cas. Corp. v. Tonka Corp.*, 140 F.R.D. 381 (D. Minn. 1992) (and cases cited); *North River Ins. Co. v. Phila. Reinsurance Corp.*, 797 F. Supp. 363 (D.N.J. 1992); *Remington Arms Co. v. Liberty Mut. Ins. Co.*, 142 F.R.D. 408 (D. Del. 1992); *Metropolitan Life Ins. Co. v. Aetna Cas. and Sur. Co.*, 249 Conn. 36, 730 A.2d 51 (Conn. 1999) (disclosure of attorney work product developed in the underlying case pursuant to the cooperation clauses possibly could be required only if and when the insurance company participates "in the defense" of underlying cases).

Insureds often contend that their obligation to cooperate is waived once an insurer has contested coverage. In some circumstances, this may be true. But some courts require more. In *Safeco Ins. Co. of America v. Rogers*, 968 S.W.2d 256 (Mo. App. 1998), the insurer first declined coverage, then informed its insured that it would provide a defense to a claim of alleged sexual harassment by an employee of the insured, subject to a reservation of rights. The insured accepted the defense, and the insurer commenced a declaratory judgment action. Three days before trial, the insured partially settled with the employee. The employee amended her claim on the day of trial to allege invasion of privacy. The insurer was not advised of the amended complaint. The Missouri Court of Appeals held that by providing a defense which the insured accepted and when the insured knew of the insurer's position of non-coverage the insurer had not waived the cooperation clause. *Id.* at 258. See also *Steadfast Ins. Co. v. Purdue Frederick Co.*, 2006 WL 1493103 (Conn. Super. 2006) (filing a declaratory judgment, by itself, is not sufficient, as a matter of law, to find a waiver of rights under the cooperation clause occurred).

C. Prohibition Against Insured Making Voluntary Payments, Admitting Liability, or Incurring Expense Without Insurer's Consent

There are cases in which an insured makes a voluntary payment, admits liability, or incurs expenses prior to the time the insured has tendered the claim to the insurer, or before the insurer has an opportunity to decide whether it intends to defend the case. In such cases, the insurer may rely on the "voluntary payments" provision to disclaim with respect to any financial commitment that the insured has made without the insurer's consent. See, e.g., *E & L Chipping Co. v. Hanover Ins. Co.*, 962 S.W.2d 272, 278 (Tex. App. - Beaumont 1998) (as a matter of Texas law, an insurer does not owe an insured a duty to reimburse them for expenses incurred in violation of the voluntary payments clause); *L'Atrium on the Creek I, L.P. v. Nat'l Union Fire Ins. Co.*, 326 F. Supp. 2d 787 (N.D. Tex. 2004) (same); *First American Title Ins. Co. v. Nat'l Union Fire Ins. Co.*, 695 So. 2d 475 (Fla. App. 3 Dist. 1997).

Some courts have placed the burden upon the insurer to demonstrate prejudice from the insured's voluntary payments or admissions and have precluded the insurer from disclaiming if the payments would have been necessary in any case or if the admission of liability was harmless. *Employers' Liab. Assurance Corp., Ltd. v. Hoechst Celanese Corp.*, 43 Mass. App. Ct. 465, 684 N.E.2d

600 (1997) (and cases cited); *Emerson Elec. Co. v. Aetna Cas. and Sur. Co.*, 352 Ill. App. 3d 399, 815 N.E.2d 924 (Ill. App. 1 Dist. 2004) (under Missouri law, insurer must show prejudice). In *American Fire & Cas. Co. v. Kaplan*, 183 A.2d 914 (Mun. Ct. App. D.C. 1962), an attorney agreed to purchase fire insurance for a building on behalf of his clients but failed to do so. The subject building was subsequently destroyed by fire. The court held that the attorney did not violate the voluntary payments provisions in his malpractice policy. On the other hand, some courts have found that an insurer may disclaim on the basis of a voluntary payments clause, without a particularized showing of prejudice, where an insured's conduct "undermined the purpose of the voluntary payment clause -- that of giving the insurer an opportunity to protect its interest" and "[t]here was nothing left for the insurer to do but issue a check." *Atlas Tack Corp. v. Liberty Mut. Ins. Co.*, 48 Mass. App. Ct. 378, 721 N.E.2d 8 (1999) (and cases cited); *Augat, Inc. v. Liberty Mut. Ins. Co.*, 410 Mass. 117, 571 N.E.2d 357 (1991) (and cases cited).

In *Liberty Mut. Ins. Co. v. OSI Indus., Inc.*, 831 N.E.2d 192 (Ind. App. 2005), the Indiana Court of Appeals applied a two-part test to determine whether the insurer was liable for defense fees incurred by the insured prior to tender of the claim to the insured. In the first part of the analysis, the court considers whether the notice was tendered within a "reasonable time." Second, the court considers whether the insurer suffered prejudice. If the notice of the filing of the lawsuit was not tendered within a reasonable time, there is a presumption of prejudice. This presumption may be rebutted by evidence that prejudice did not actually occur. *Id.* at 202 (internal citations omitted).

Once an insurer has denied coverage, an insured is free in some jurisdictions to incur costs to defend and resolve the claim without running afoul of the voluntary payments provision. *Miller v. Shugart*, 316 N.W.2d 729 (Minn. 1982); *Insua v. Scottsdale Ins. Co.*, 104 Cal. App. 4th 737 (2002) (citing *Tradewinds Escrow, Inc. v. Truck Ins. Exch.*, 97 Cal. App. 4th 704, 710 (2002)); *Gribaldo, Jacobs, Jones & Assoc. v. Agrippina Versicherungen A.G.*, 3 Cal. 3d 434, 449 (1970)). If an insurer fails to respond to notices given to the insurer, it may be deemed to have waived any breach of the voluntary payment provision. *Flintkote Co. v. General Acc. Assur. Co. of Canada*, 480 F. Supp. 2d 1167 (N.D. Cal. 2007).

VIII. NOTICE OF CLAIM PROVISION

Upon the Insured becoming aware of any negligent act, error, omission in the rendering of or failure to render Professional Services which could reasonably be expected to be the basis of a Claim covered hereby, written notice shall be given by the Insured, or its representative to the Company together with the fullest information obtainable as soon as practicable. If Claim is made or suit is brought against the Insured, the Insured or its representative shall immediately forward to the Company every demand, notice, summons or other process received by the Insured or the Insured's representative.

As noted above, the claims made and reported policy requires the insured to report the claim in the same policy year as the insured received notice of the claim. As previously stated, notice provisions are strictly construed, and notice to the insurer must be prior to the expiration of the policy. (SEE "INSURING AGREEMENT - CLAIMS MADE AND REPORTED REQUIREMENT; WAIVER OF EXCLUSIONS AND BREACH OF CONDITIONS; AND DISCOVERY CLAUSE").

The notice must be in a manner such that it is clear to the insurer that a claim is being reported. A letter contained within a package of application materials that is not clearly identified as a claim is not proper notice, nor is a cease and desist order or ambiguous audit notes. See *Nat'l Union Fire Ins. Co. v. Baker & McKenzie*, 997 F.2d 305 (7th Cir. 1993); *Employers Ins. of Wausau v. Bodi-Wachs Aviation Ins. Agency, Inc.*, 39 F.3d 138 (7th Cir. 1994); *American Cas. Co. v. Continisio*, 17 F.3d 62 (3d Cir. 1994); *Calif. Union Ins. Co. v. American Divers. Sav. Bank*, 914 F.2d 1271 (9th Cir. 1990); *FDIC v. St. Paul Ins. Co.*, 993 F.2d 155 (8th Cir. 1993); *W.R. Grace & Co., Inc. v. Maryland Cas. Co.*, 33 Mass. App. Ct. 358, 396, 600 N.E.2d 176, 182 (1992) (New York law); *American Cas. Co. v. FDIC*, 944 F.2d 455, 460 (8th Cir. 1991) (holding that a renewal application in which bank officers claimed the bank was in no danger while predicting a \$400,000 loss and reporting a cease-and-desist order was ineffective notice of potential

claims); *California Union Ins. Co. v. American Diversified Sav. Bank*, 914 F.2d 1271, 1278 (9th Cir. 1990) (finding that general financial documents did not constitute constructive notice of a claim when "the principal documents relied upon would not have alerted [the insurer] to anything [the insured] considered to be a potential claim"); *American Cas. Co. v. RTC*, Civ. No. MJG-92-1138, slip op. at 11-14, 1993 WL 655032 (D. Md. Nov. 1, 1993) (finding no notice when the insureds' renewal application claimed compliance with an agreement under which the Federal Home Loan Bank Board would forbear from bringing claims); *American Cas. Co. v. FDIC*, 821 F. Supp. at 663-64 (refusing to rewrite a claims-made policy into an occurrence policy because general information in a renewal application cannot overcome insureds' denials of potential claims); *FDIC v. Continental Cas. Co.*, 796 F. Supp. at 1351-54 (finding that a renewal application reporting general financial troubles and a FDIC cease-and-desist order was ineffective notice when insureds stated on application they were unaware of any occurrence that could subsequently give rise to a claim and the documents were meant to give notice of a potential claim).

Some courts have held that this issue may be an issue of fact, not a matter of law. *Brown Daltas & Assoc. v. General Accid. Ins. Co., Inc.*, 844 F. Supp. 58 (D. Mass. 1994) *rev'd on other grounds* 48 F.3d 30, 66 n.1 (1st Cir. 1995) (appellate court questions whether notice of a claim through a renewal application is insufficient as a matter of law); *United Ass'n Local 38 v. Aetna Cas. & Sur. Co.*, 790 F.2d 1428 (9th Cir. 1986).

If the insured is required to, but fails to, report a *potential* claim, and later reports the matter when the *actual* claim is made, the insured may lose coverage for violation of this notice provision. *Bianco Prof'l Ass'n v. Home Ins. Co.*, 740 A.2d 1051, 1057 (1999).

Even where the insured does report the claim during the same policy period in which he received the claim, these notice provisions require that the notice be given to the carrier either "as soon as practicable" or "immediately." A prejudicially long delay *during* the policy period could jeopardize coverage. *Charles T. Main, Inc. v. Firemen's Fund Ins. Co.*, 406 Mass. 862, 551 N.E.2d 28 (1990); *FDIC v. Barham*, 794 F. Supp. 187, 194 (W.D. La. 1991).

Some courts have held that notice can be made by anyone, as long as the notice clearly informs the insurer of the claim. Other courts require that the insured give notice. (SEE "DUTY TO DEFEND - TENDER OF THE DEFENSE").

Notice to the insurer need not be in writing unless explicitly required under the policy. *Ohio Bar Liab. Ins. Co. v. Hunt*, 152 Ohio App. 3d 224, 787 N.E.2d 82 (2003).

Notice from one claimant does not necessarily constitute notice from all potential claimants. *Nat'l Union Ins. Co. v. Pittsburgh, Pa. v. Holmes & Graven*, 23 F. Supp. 2d 1057 (D. Minn. 1998) *see also Checkrite Ltd., Inc. v. Ill. Nat'l Ins. Co.*, 95 F. Supp. 2d 180 (S.D.N.Y. 2000) (A Second Amended Complaint adding class members to a class action was a "claim made" during the policy period in which it was filed and was not a claim made in the previous policy period even though it was part of the same "judicial proceeding," filed the year before.)

Under California law, where an insurer denies liability under a policy, it waives any claim to failure to give notice. *CNA Cas. of Calif. v. Seaboard Sur. Co.*, 176 Cal. App. 3d 598, 617, 222 Cal. Rptr. 276 (1986).

IX. WAIVER OF EXCLUSION AND BREACH OF CONDITIONS

Whenever coverage under any provision of this policy would be excluded, suspended or lost:

- 1. because of any exclusion relating to any judgment or final adjudication based upon or arising out of any dishonest, deliberately fraudulent, criminal, malicious or deliberately wrongful acts or omissions by any Insured; or**

2. **because of noncompliance with the Notice of Claims provision relating to the giving of notice to the company with respect to which any other Insured shall be in default solely because of the default or concealment of such default by one or more partners or employees responsible for the loss or damage otherwise insured hereunder:**

The Company agrees that such insurance as would otherwise be afforded under this policy shall apply with respect to each and every Insured who did not personally commit or personally participate in committing one or more of the acts, errors, or omissions described in any such exclusion or condition; provided that if the condition be one with which such Insured can comply, after receiving knowledge thereof, the Insured entitled to the benefit of the Waivers of Exclusions and Breach of Conditions shall comply with such conditions promptly after obtaining knowledge of the failure of any other Insured or employee to comply therewith.

With respect to paragraph 1 above, the Company's obligation to pay in the event of such waiver shall be in excess of the deductible and in the excess of the full extent of any assets in the firm of any Insured who is not a beneficiary to the waiver.

The "innocent insured" provision in certain policies provides coverage to insureds who did not personally commit, or remain passive after learning of, conduct that was (1) within an exclusion relating to criminal, dishonest, fraudulent or malicious acts, *Oot v. Home Ins. Co.*, 244 A.D.2d 62, 676 N.Y.S.2d 715 (4th Dep't 1998) (LPL policy), or (2) a violation of the notice condition(s). *deBruyne v. Clay*, 1999 WL 782481 (S.D.N.Y. 1999) (LPL policy). It should be noted that there may be an issue as to whether a firm (as opposed to an individual) can ever qualify as an "innocent insured" since firms can only act through their agents, and at least one such agent was not "innocent." *Compare Mendel v. Home Ins. Co.*, 806 F. Supp. 1206 (E.D. Pa. 1992) (no coverage) and *Sunrise Props., Inc. v. Bacon, Wilson, Ratner, Cohen, Salvage, Fralky & Fitzgerald, P.C.*, 425 Mass. 63, 679 N.E.2d 540 (1997) (same), with *Jensen v. Snellings*, 841 F.2d 600, 617-18 (5th Cir. 1988) (coverage); *deBruyne v. Clay, supra* (same; but no analysis of issue); and *Pearne, Gordon, McCoy & Granger*, 92 Ohio App. 3d 251, 634 N.E.2d 1032 (1993) (same, but no discussion).

Pursuant to this provision, if coverage is provided to an "innocent insured," the policy may provide that the insurer is not obligated to indemnify until the non-innocent insured has exhausted all his or her personal assets or his or her assets in the insured firm. This can be complicated in that it requires the insurer to calculate the wrongdoer's interest in all of the firm's assets, including receivables, hard goods, and leases, and presumably requires a reduction for his share of the liabilities. The insurer sometimes reserves the right to subrogate against the wrongdoer who is not the subject of the waiver of the exclusion. (SEE "SUBROGATION").

There are significant limitations to the protection afforded by this provision. The waiver only applies to the intentional acts exclusion and the notice provision. Thus, an innocent insured can still be deprived of coverage under the prior knowledge limitation in the insuring agreement, or in an exclusion, *Ehrgood v. Coregis Ins. Co.*, 59 F. Supp. 2d 438 (M.D. Pa. 1998); *Coregis Ins. Co. v. McCollum*, 961 F. Supp. 1572, 1579 (M.D. Fla. 1997), *Coregis Ins. Co. v. Lyford*, 21 F. Supp. 2d 695 (S.D. Tex. 1998), based on a misrepresentation on the application, *Home Ins. Co. v. Dunn*, 963 F.2d 1023 (7th Cir. 1992), or because the claim was made against the wrongdoer insured prior to the commencement of the policy, and is not a "claim first made" during the policy period. *Fremont Indem. Co. v. Gienhart*, 560 So. 2d 1223 (Fla. Dist. Ct. App. 1990).

A fairly recent decision by a New York court held that the knowledge of one "partner employee" of a potential claim could not be imputed to his partners. *Rosenberg & Estis v. Chicago Ins. Co.*, Index No. 600938/02 (N.Y. Sup. Ct. July 11, 2003). In *Fidelity Nat. Title Ins. Co. of New York v. OHIC Ins. Co.*, 275 Ga. App. 55, 619 S.E.2d 704 (Ga. App. 2005) the court distinguished the exclusions for claims arising out

of conversion, misappropriation or improper commingling of client funds, and two other exclusions for "dishonest, fraudulent, criminal, malicious or intentionally wrongful acts" and "violations by you of any law or regulation imposing criminal penalties or liability arising out of the violation by others, with your consent, of any law or regulation imposing criminal penalties." The conversion exclusion was broader and excluded coverage for all acts arising out of conversion, misappropriation or improper commingling of funds, such that claims brought against the innocent insured were not covered even if she did not personally participate in any such wrongful acts or if she did not consent to criminal violations by others.

X. ASSIGNMENT

The interest of the Named Insured is not assignable.

There are a few cases finding that such a clause prohibits the insured from assigning its rights to collect under the policy to a claimant who has obtained a judgment against the insured. *Terrell v. Lawyers Mut. Liab. Ins. Co. of N.C.*, 507 S.E.2d 923 (N.C. 1998). In *Terrell*, the insured agreed with the claimant to settle a legal malpractice claim by confessing judgment and assigning his rights against the malpractice insurer to the claimant. This clause was deemed to preclude the claimant from recovering under the malpractice policy. A similar result was reached in *Pennsylvania Millers Mut. Ins. Co. v. Commerce Ins. Co.*, Suffolk County Mass. Super. Ct. Civ. Action No. 95-05572-G (February 23, 1998) (Smith, J.).

Courts around the nation are split as to whether agreements entered into by the insured with a claimant to assign the policy, and/or bad faith and failure to settle claims that the insured may have against the insurer under the policy, are enforceable against the insured. The Tennessee Supreme Court has held that a defendant may not assign causes of action against his or her insurer. *Dillingham v. Tri-State Ins. Co.*, 214 Tenn. 592, 381 S.W.2d 914, 917-919 (1964); *see also Carne v. Maryland Cas. Co.*, 208 Tenn. 403, 346 S.W.2d 259, 261-262 (1961); *Electric Ins. Co. v. Nationwide Mut. Ins. Co.*, 384 F. Supp. 2d 1190 (W.D. Tenn. 2005). The Rhode Island Supreme Court, by allowing only a post-judgment assignment of claims, has suggested that a prejudgment assignment would be invalid. *Mello v. General Ins. Co. of Am.*, 525 A.2d 1304, 1306 (R.I. 1987) *but cf. Thurston v. Continental Cas. Co.*, 567 A.2d 922, 924-925 (Me. 1989); *Medical Mut. Liab. Ins. Soc'y v. Evans*, 330 Md. 1, 622 A.2d 103, 116-118 (1993); *Groce v. Fid. Gen. Ins. Co.*, 252 Or. 296, 448 P.2d 554, 557-559 (1968); *Nichols v. United States Fid. & Guar. Co.*, 37 Wis. 2d 238, 155 N.W.2d 104, 108-110 (1967) (all upholding a post-judgment assignment without discussing validity of prejudgment assignments).

A federal district court in Illinois has found that the "no assignment" clause only prohibits the assignment of the policy to another insured, but does not preclude the assignment of a "accrued cause of action" for bad faith or for coverage to a claimant who has obtained a judgment against the insured. *Hartford Cas. Ins. Co. v. Argonaut-Midwest Ins. Co.*, 664 F. Supp. 373 (N.D. Ill. 1987), *aff'd*, 854 F.2d 279 (7th Cir. 1988), on remand, 1989 WL 8521 (N.D. Ill. Jan. 31, 1989).

In some jurisdictions, an insured is allowed to confess to judgment and assign policy benefits, including extracontractual claims, to the claimant once an insurer has denied coverage or reserved rights to deny coverage. The agreement which contains the assignment is referred to in various jurisdictions as a "Morris agreement," a "Damron agreement," a "Miller-Shugart agreement" a "Coblentz agreement" or a "Gandy agreement." In order to successfully assign claims against an insurer, the insurer has to have been on notice of the claim and either denied coverage or reserved its rights to deny coverage.

Arizona law allows such an assignments. The term "Morris agreement" is generally used to describe a settlement agreement in which an insured defendant admits to liability and assigns to a plaintiff his or her rights against the liability insurer, including any cause of action for bad faith, in exchange for a promise by the plaintiff not to execute the judgment against the insured. *See United Servs. Auto. Ass'n v. Morris*, 154 Ariz. 113, 741 P.2d 246 (1987) (involving an agreement entered into after reservation of rights by insurer); *Ariz. Prop. & Cas. Ins. Guar. Fund v. Helme*, 153 Ariz. 129, 735 P.2d 451 (1987) (involving an agreement entered into after alleged anticipatory breach of insurer's duty to indemnify); *Miel v. State*

Farm Mut. Aut. Ins. Co., 185 Ariz. 104, 912 P.2d 1333 (App. 1995) (involving an agreement entered into after alleged bad faith failure to settle by insurer). An agreement with these same characteristics entered in response to an insurer's refusal to defend the insured is generally referred to as a "Damron agreement." See *Damron v. Sledge*, 105 Ariz. 151, 460 P.2d 997 (1969). The terms "Morris agreement" and "Damron agreement" are sometimes used interchangeably. See *Himes v. Safeway*, 205 Ariz. 31, 34 n.2 ¶ 1, 66 P.3d 74, 77 (App. 2003).

A "Miller-Shugart agreement" allows the claimant to settle a claim with an insured defendant, confess to a specific amount of judgment, and receive an assignment of all benefits under the policy from the insured, and then directly proceed to collect from the insured's liability carrier rather than from the insured. See *Miller v. Shugart*, 316 N.W.2d 729, 733-34 (Minn. 1982). A Miller-Shugart agreement that is reasonable and that is not the product of fraud or collusion is enforceable against an insurer which receives notice of the settlement. See *Brownsdale Co-op. Ass'n v. Home Ins. Co.*, 473 N.W.2d 339, 341 (Minn. Ct. App. 1991), review denied (Minn. Sept. 25, 1991). North Dakota has also recognized the validity Miller-Shugart agreements. *Medd v. Fonder*, 543 N.W.2d 483 (N.D. 1996).

In Florida, such agreements can be referred to as "Coblentz agreements." In *Coblentz v. American Sur. Co. of New York*, 416 F.2d 1059, 1063 (5th Cir. 1969), the court held that an insurer which had "refused to handle" its insured's defense, thereby leaving its insured "to his own resources," was bound by the terms of a negotiated final consent judgment entered against its insured. An insurer will be bound to a settlement agreement/consent judgment negotiated between its insured and a claimant where: (1) the damages are covered by the policy; (2) the insurer wrongfully refuses to defend; and (3) the settlement is reasonable and made in good faith. See *Ahern v. Odyssey Re (London) Ltd.*, 788 So. 2d 369, 372 (Fla. 4th DCA 2001).

In Texas, the agreements are known as "Gandy agreements," named after the Texas Supreme Court decision that established the elements the claimant needs to satisfy to successfully enforce such an agreement. In *State Farm Fire and Cas. Co. v. Gandy*, 925 S.W.2d 696 (Tex. 1996) the Texas Supreme Court held that a defendant's assignment of his or her claims against his or her insurer to a plaintiff is invalid if: (1) it is made prior to an adjudication of the plaintiff's claim against defendant in a fully adversarial trial; (2) the defendant's insurer has tendered a defense; and (3) either: (a) the defendant's insurer has accepted coverage, or (b) the defendant's insurer has made a good faith effort to adjudicate coverage issues prior to the adjudication of the plaintiff's claim.

Other courts have allowed such agreement only when it is proved to be free of collusion between the claimant and the insured. *Steil v. Florida Physicians' Ins. Reciprocal*, 448 So. 2d 589, 592 (Fla. Dist. Ct. App. 1984) (suspicion of collusion and fraud led court to deny effect to settlement and assignment; in addition, court indicated that such an agreement may be upheld where free from taint); *Gainsco Ins. Co. v. Amoco Prod. Co.*, 53 P.3d 1051 (Wyo. 2002) (insurer bears burden of proof on collusion). The courts of last resort in Iowa, Kansas and Pennsylvania have allowed pre-judgment assignments. *Red Giant Oil Co. v. Lawlor*, 528 N.W.2d 524, 531-534 (Iowa 1995); *Glenn v. Fleming*, 247 Kan. 296, 799 P.2d 79 (1990); *Gray v. Nationwide Mut. Ins. Co.*, 422 Pa. 500, 223 A.2d 8, 12-13 (1966). It appears that the New Jersey Supreme Court would also uphold such assignments. *Griggs v. Bertram*, 88 N.J. 347, 443 A.2d 163, 174-175 (1982).

Post-judgment assignments of refusal-to-settle claims were squarely approved by the California Supreme Court in *Comunale v. Traders & General Ins. Co.*, 50 Cal. 2d 654, 328 P.2d 198, 202 (1958); see also *Brown v. Guar. Ins. Co.*, 155 Cal. App. 2d 679, 319 P.2d 69, 77-79 (1957). The Court again enforced such an assignment in *Johansen v. California State Auto. Ass'n Inter-Insurance Bureau*, 15 Cal. 3d 9, 123 Cal. Rptr. 288, 295-296, 538 P.2d 744, 751-752 (1975). As for such assignments in the prejudgment context, in *Wright v. Fireman's Fund Ins. Cos.*, 11 Cal. App. 4th 998, 14 Cal. Rptr. 2d 588 (1992), the court concluded that "[a] judgment on the merits is not always required and insurers have been bound by default and stipulated judgments under certain circumstances." *Id.* at 598. Since *Wright*, California courts' principal concern in these instances appears not to be whether an assignment was valid, but whether a judgment rendered in the absence of adversarial proceedings was fair and reasonable and free of fraud and collusion. The courts in *Roman v. Unigard Ins. Group*, 26 Cal. App. 4th

177, 31 Cal. Rptr. 2d 501, 504-505 (1994), and *Nat'l Union Fire Ins. Co. v. Lynette C.*, 27 Cal. App. 4th 1434, 33 Cal. Rptr. 2d 496, 503-506 (1994), held that an insurer will be liable for an agreed judgment against its insured if the trial court found the judgment to be taken in good faith.

Some courts have allowed the insured to successfully assign the entire policy in a sale to third-party. Under Minnesota law, if a successor corporation establishes that it purchased all of the predecessor's assets, including the insurance policies, and assumed all of the predecessor's liabilities, in a transaction, it qualifies as an insured under the policy. In *Gopher Oil Co. v. American Hardware Mut. Ins. Co.*, 588 N.W.2d 756 (Minn. Ct. App. 1999), the court held that despite the presence of a non-assignment clause in the policy, a successor corporation was an insured because in the purchase agreement, the predecessor agreed to "assign all the assets" to the successor.

XI. OTHER INSURANCE

Except to the extent that a claim is based on acts occurring prior to the Policy Period and is covered by prior insurance, as set forth in the Insuring Agreement, if there is other valid insurance (whether primary, excess, contingent or self-insurance), for a Claim covered by this policy, the insurance provided hereunder shall be deemed excess insurance over and above the applicable limit of all other insurance or self-insurance.

If more than one policy issued by the Company applies to the same claim, the amount paid under this policy shall not exceed the proportion that the limits of this policy bears to the total limits provided by all policies issued by this Company that apply to the same claim, provided that the Company shall in no event pay more than the limit of liability of the largest policy issued by the Company.

Aside from issues of reconciling these "other insurance" clauses in a policy's conditions section and the "prior policy" language in the insuring agreement, courts are sometimes obligated to resolve conflicts between "other insurance" clauses. (SEE "*INSURING AGREEMENT LIMITATIONS ON COVERAGE - PRIOR INSURANCE*").

These provisions generally fall into three categories: (1) "excess" clauses stating that coverage will be *excess* if there is another policy that covers the claim; (2) "escape" clauses stating that *no coverage* claim is provided if there is another applicable primary policy (or "super-escape" clauses which decline all coverage if there is another primary *or excess* policy); and (3) "pro-rata" clauses under which the carrier agrees to share in the loss with any other carrier. See, e.g., *Mission Ins. Co. v. U.S. Fire Ins. Co.*, 401 Mass. 492, 517 N.E.2d 463 (1988); *Lumbermens Mut. Cas. Co. v. Allstate Ins. Co.*, 51 N.Y.2d 651, 655, 435 N.Y.S.2d 953, 417 N.E.2d 66 (1980); *Nat'l Indem. Co. v. Continental Ins. Co.*, 61 Md. App. 575, 578-579, 487 A.2d 1191 (1985).

When two of the same types of clauses appear in the applicable policies, the courts will find an irreconcilable inconsistency (except in the case of two "pro rata" clauses) and declare them mutually repugnant. The court will then impose a sharing formula; such as ordering the carriers to contribute in the proportion that their limits bear to the total limits of all policies; or requiring them to share 50/50 until the smaller of the two policies is exhausted and then placing the remaining risk on the large policy.

If, however, the clauses are of different types, most courts have established a "pecking order" as to which carrier must pay first. Generally, the carrier with the pro rata clause pays first in a contest with "excess" or "escape" clauses, and the "escape" clause is primary in a battle with an "excess" clause. See David P. Knapp, Annotation, *Resolution of Conflicts in Non-Automobile Liability Insurance Policies Between Excess or Pro Rata "Other Insurance" Clauses*, 12 A.L.R. 4th 993 (1982 and 1999 supp.).

In situations where different types of policies obtained by the insured, such as professional liability and CGL policies, are both triggered by allegations in one complaint, some courts resolve "other insurance" clause conflicts by engaging in an analysis to determine which carrier is "closer to the risk." *Nat'l Union Fire Ins. Co. v. Republic Underwriters Ins. Co.*, 429 N.W.2d 695, 697 (Minn. Ct. App. 1988) (in coverage dispute between day-care provider liability insurer and homeowners' insurer, day-care insurer closer to the risk partly because its policy specifically contemplated injury resulting from careless actions of young children in day-care setting, while homeowners' policy did not); *Goeman v. Allstate Ins. Co.*, 725 N.W.2d 375 (Minn. Ct. App. 2006).

Some policies, like the one quoted above, have "anti-stacking" clauses in the event that two or more policies *issued by the same insurer* apply to the same loss. The insurer will not stack both limits, but rather will only pay the highest limit offered by its policies. See *generally* B. Ostrager & T. Newman, *Handbook on Insurance Coverage Disputes* § 9.04(c) (2004) (citing cases). This type of provision benefits the insured that purchased the smaller policy. Another issue is whether the insurer is entitled to collect deductibles under multiple policies. There are a handful of cases which have addressed this matter. In them, the courts have generally provided that where coverage is triggered under multiple policies, if an insured seeks coverage under any of those policies, then the insured must pay the deductible of each policy. See, e.g., *Olin Corp. v. Ins. Co. of North America*, 221 F.3d 307, 327-28 (2d Cir. 2000); *Missouri Pac. R.R. Co. v. Hartford Ins. Co.*, 288 Ill. App. 3d 69, 80-84, 679 N.E.2d 801 (2d Dist.), *appeal denied*, 174 Ill. 2d 567 (1997).

XII. SUBROGATION

In the event of any payment under this policy, the Company shall be subrogated to all the Insured's rights of recovery therefore against any person, organization or entity and the Insured shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Insured shall do nothing after any loss to prejudice such rights.

The Company shall not exercise any such subrogation rights against any persons insured under this policy, except that it reserves the right to exercise such rights against an Insured with respect to any claim brought about or contributed to by the intentional, dishonest, fraudulent, criminal, or malicious act or omission of such insured.

A typical policy provides that in the event of any payment, the insurer shall be subrogated to all of the insured's rights of recovery against any person or entity. Subrogation is a right more often utilized in the first-party context or in construction defect litigation. The right of subrogation is generally subject to the "make whole" rule. That rule prohibits an insurer from recouping anything by way of subrogation or reimbursement until the insured "has been made entirely whole through recovery of all compensatory damages to which he is entitled." *Sunbeam-Oster Co., Inc. Group Benefits Plan v. Whitehurst*, 102 F.3d 1368, 1372 (5th Cir. 1996). Again, this rule has limited application in a third-party liability context.

The subrogation right can include the insurer's right to recover defense costs incurred to defend the legal malpractice claim. *St. Paul Fire & Marine Ins. Co. v. Beirne Maynard & Parson, LLP*, 2002 WL 31771102 (Tex. Ct. App. 2002) (when insured recouped a portion of defense costs funded by insurer from the plaintiffs suing it, insurer allowed to recover from its insured). However, that does not necessarily allow the insurer to bring a subrogation action against its own insured. Under New York law, the anti-subrogation doctrine has been explained as follows:

As a general rule, an insurer has no right of subrogation against its own insured for a claim arising from the very risk for which the insured was covered. Public policy requires this exception to the general rule both to prevent the insurer from passing an incidence of loss to its own insured and to guard against the potential

for conflict of interest that may affect the insurers incentive to provide a vigorous defense for its insured.

McCoy, Cohen and Krajewski, *The Anti-Subrogation Rule*, New York State Bar Association Journal (Torts, Insurance and Compensation Law Section, December 1997); *see also Continental Divide Ins. Co. v. Western Skies Mgmt., Inc.*, 107 P.3d 1145 (Colo. App. 2004); *1700 Lincoln Ltd. v. Denver Marble & Tile Co.*, 741 P.2d 1270, 1271 (Colo. App. 1987); *N. Star Reinsurance Corp. v. Continental Ins. Co.*, 82 N.Y.2d 281, 294-95, 604 N.Y.S.2d 510, 624 N.E.2d 647, 653-54 (1993); *Home Ins. Co. v. Pinski Bros., Inc.*, 160 Mont. 219, 500 P.2d 945 (1972); *Pa. Gen. Ins. Co. v. Austin Powder Co.*, 68 N.Y.2d 465, 471-72, 510 N.Y.S.2d 67, 502 N.E.2d 982, 985-86 (1986).

An issue which sometimes arises is whether the anti-subrogation doctrine precludes the assertion of cross-claims for contribution or indemnification between antagonistic insureds. Generally, pursuant to the anti-subrogation rule, an insurer is not subrogated to its insured's rights against a party who is named as an additional insured in the same policy. This rule applies even when any judgment recovered in a subrogation action would be covered under a policy issued by a different insurer to the additional insured. There are certain exceptions, and whether subrogation in this context is permissible may depend upon whether there are any coverage limitations applicable to either insured. Where there are no such limitations, the anti-subrogation doctrine prevents the assertion of such cross-claims between insureds. The theory is that the insurer, which is the real party in interest, should not be allowed to recover "back from its insured that loss or damage the risk of which the insured had passed along to the insurer under the policy." A. Windt, *Insurance Claims and Disputes* 10.07 (3d Ed. 1995).

Nevertheless, the anti-subrogation doctrine has been held inapplicable, and claims for contribution or indemnification between insureds have been allowed, in cases where coverage was not available to the insured asserting the cross-claim (referred to as the "no coverage exception"), *see, e.g., Chubb Ins. Co. v. DeChambre*, 349 Ill. App. 3d 56, 59, 283 Ill. Dec. 487, 808 N.E.2d 37, 40 (2004); *Rosato v. Karl Koch Erecting Co.*, 865 F. Supp. 104 (E.D.N.Y. 1994); *McGurran v. DiCanio Planned Dev. Corp.*, 216 A.D.2d 538, 628 N.Y.S.2d 773 (2d Dep't 1995); *Zahno v. Urquart*, 213 A.D.2d 1004, 625 N.Y.S.2d 111 (4th Dep't 1995), where excess exposure was involved, *see Fashion Tanning Co. v. Fulton County Elec. Contractors, Inc.*, 142 A.D.2d 465, 536 N.Y.S.2d 866 (3d Dep't 1989), *but see Jones Lang Wootton USA v. LeBoeuf, Lamb, Greene & MacRae*, 243 A.D.2d 168, 674 N.Y.S.2d 280 (1st Dep't 1998) (no claim against insured by its own excess insurer), and where the insured bringing the claim was personally liable for a deductible. *See* A. Windt, *Insurance Claims & Disputes, supra*. There would also be a potential limitation on coverage when the insurer reserves its rights.

The second situation in which subrogation may be available is where there are multiple insurers. It appears that cross-claims for contribution or indemnification will be barred by the anti-subrogation doctrine where the party who could bear vicarious liability and the alleged active wrongdoer are insured under the same policy, even though the latter also maintains a separate policy of his or her own. *Washington v. New York City Indus. Dev. Agency*, 215 A.D.2d 297, 627 N.Y.S.2d 343 (1st Dep't 1995). The opposite result would occur if the additional policy were maintained by the party who could bear vicarious liability. *See Flowers v. K.G. Land New York Corp.*, 219 A.D.2d 579, 631 N.Y.S.2d 177 (2d Dep't 1995); *Apra v. Willets Point Contracting Corp.*, 215 A.D.2d 708, 627 N.Y.S.2d 76 (2d Dep't 1995); *see also Nat'l Union Fire Ins. Co. v. State Ins. Fund*, 222 A.D.2d 369, 636 N.Y.S.2d 31 (1st Dep't 1995).

XIII. DECLARATIONS IN APPLICATIONS

By acceptance of this policy, the Insured agrees that the statements in the Declarations and application are his agreements and representations, and that this policy is issued in reliance upon the truth of such representations and that this policy embodies all agreements existing between himself and the Company or any of its agents relating to this insurance.

Most states allow an insurer to rescind an insurance policy if it was procured through a material misrepresentation by the insured. Often, the remedy of rescission is provided and controlled by statute. See, e.g., Minn. Stat. § 60.08. The issue raised most often when rescission of a professional liability policy is sought is whether the insured was aware of a potential claim that he or she did not disclose in the application or renewal application. This requires consideration of the following: (1) whether the standard for measuring the insured's knowledge of a potential claim is objective or subjective; (2) whether the insured must have intended to make a misrepresentation; (3) whether rescission is affected by whether there are innocent insureds who did not know about the potential claim; and (4) what is the standard for "materiality."

Insurance applications for claims made policies include questions asking whether the insured is aware of any acts, errors, omissions or circumstances that would reasonably be expected to result in a claim during the policy period and to identify each such potential claim. A sample question is as follows:

Having inquired of all partners, officers, owners, or employed lawyers, are there any circumstances which may result in a claim being made against the firm, its predecessors, or any current or past partner, officer or owner?

Insureds are usually required to supplement their application responses if they receive information after submitting the application that makes their prior responses inaccurate. *Minnesota Lawyers Mut. Ins. Co. v. Hahn*, 355 F. Supp. 2d 104 (D.D.C. 2004) (LPL policy rescinded based on failure of firm's principal to notify insurer that he had received letter threatening malpractice litigation in interim between policy application and issuance of policy); *Guardian Life Ins. Co. v. Aaron*, 181 Misc. 2d 393, 40 N.Y.S.2d 687 (Sup. Ct. 1943) (duty to disclose and correct while insurer deliberates as to whether to issue the policy); *Gabbett v. Conn. Life Ins. Co.*, 303 Mass. 433, 436, 21 N.E.2d 950 (1939); *Hanover v. Leeds*, 42 Mass. App. Ct. 54, 57, 674 N.E.2d 1091 (1997); *Borden v. Paul Revere Ins. Co.*, 935 F.2d 370 (1st Cir. 1991); *Metropolitan Life Ins. Co. v. Somers*, 137 N.J. Eq. 419, 45 A.2d 188 (1946); *State Farm Life Ins. Co. v. Lawless*, 586 S.W.2d 468 (Tenn. Ct. App. 1979); *Fid. & Deposit Co. v. Hudson United Bank*, 653 F.2d 766 (3d Cir. 1981); *Carroll v. Preferred Risk Ins. Co.*, 34 Ill. 2d 310, 215 N.E.2d 801 (1966).

A. Objective v. Subjective Standard

In determining whether the insured could have anticipated a claim would be made for the purposes of filling out a truthful, accurate application for insurance, courts usually apply an objective test. See *Pacific Ins. Co. v. Higgins*, 1994 WL 114898 (Del. Ch. 1994), *aff'd*, 648 A.2d 424 (Del. 1994); *Coregis Ins. Co. v. McCollum*, 1997 WL 128132 (M.D. Fla. 1997); *Nat'l Union Ins. Co. of Pittsburgh, Pa. v. Holmes & Graves*, 23 F. Supp. 2d 1057 (D. Minn. 1998) (applying Minnesota law); *Bianco Prof'l Ass'n v. Home Ins. Co.*, 144 N.H. 288, 740 A.2d 1051 (1999); *Home Ins. Co. v. Powell*, 1997 WL 370109 (E.D. Pa. 1997), *aff'd*, 156 F.3d 1224 (3d Cir. 1998) (applying Pennsylvania law); *Evanston Ins. Co. v. Security Assurance Co.*, 715 F. Supp. 1405, 1414 (N.D. Ill. 1989); *Ratcliffe v. Int'l Surplus Lines Ins.*, 194 Ill. App. 3d 18, 141 Ill. Dec. 6, 11, 550 N.E.2d 1052, 1057 (1990). (SEE "PRIOR KNOWLEDGE LIMITATION").

Some courts have used the subjective standard of what the insured was actually aware of, usually relying on the particular language of the application question. *Enserch Corp. v. Shand Morahan & Co., Inc.*, 952 F.2d 1485 (5th Cir. 1992) (Texas law); *General Accident v. Trefts*, 657 F. Supp. 164 (E.D.

Mo. 1987) (lawyer had no knowledge of potential claim until client expresses intent to make the claim); *Fremont Indem. Co. v. Lawton-Byrne-Bruner Ins. Agency Co.*, 701 S.W.2d 737, 742-43 (Mo. App. 1985); *Citizens Bank of Jonesboro v. Western Employers' Ins. Co.*, 865 F.2d 964 (5th Cir. 1989) (Arkansas law); *Shaheen, Cappiello, Stein & Gordon, P.A. v. The Home Ins. Co.*, 719 A.2d 562 (N.H. 1998) (finding the phrase "reasonably be expected" ambiguous and construing against insurer); *Chicago Ins. Co. v. Lappin*, 58 Mass. App. Ct. 769, 792 N.E.2d 1018 (2003); *Estate of Logan by Find. v. Northwestern Nat'l Cas. Co.*, 424 N.W.2d 179 (Wis. 1988) (rejecting objective standard); *Liebling v. Garden State Indem.*, 337 N.J. Super. 447, 767 A.2d 515 (N.J. Super. A.D. 2001); *Westport Ins. Corp. v. Lilley*, 292 F. Supp. 2d 165 (D. Me. 2003) (touchstone is reasonableness, not conceivability).

Other courts have used a mixed subjective and objective standard, finding that an insured has made a material misrepresentation on an application if the insured was subjectively aware of the facts that would lead a reasonable insured to believe that the insured had breached a professional duty. *Selko v. Home Ins. Co.*, 139 F.3d 146 (3d Cir. 1998); *Coregis Ins. Co. v. Baratta & Fenerty, Ltd.*, 264 F.3d 302 (3d Cir. 2001).

B. The Insured's Intent in Making the Misrepresentation

The next issue is the insured's intent when making the misrepresentation. Most courts have held that a material misrepresentation in an insurance application is sufficient to justify rescission even if it is made negligently, without fraudulent intent, finding that it is sufficient that the representation was false. *Evora v. Henry*, 559 A.2d 1038 (R.I. 1989). *Accord Home Ins. Co. v. Dunn*, 963 F.2d 1023 (7th Cir. 1992); *Abulaynain v. N.Y. Merchant's Bankers Mut. Fire. Ins. Co.*, 121 A.D.2d 575, 513 N.Y.S.2d 5 (2d Dep't 1987); *Northwestern Mut. Life Ins. Co. v. Iannochino*, 950 F. Supp. 28, 31 (D. Mass. 1997).

However, some states appear to prohibit rescission if the misrepresentations were made out of ignorance, mistake or negligence. *Mt. Airy v. Millstein*, 928 F. Supp. 171 (D. Conn. 1996); *Pinette v. Assurance Co. of America*, 52 F.3d 407, 409 (2d Cir. 1995) (applying Connecticut law). Still other courts hold that rescission requires an "intent to deceive," but that the intent requirement can be satisfied from proof of circumstances creating a reasonable assumption that the insured recognized the materiality of the misrepresentation. *FDIC v. Duffy*, 835 F. Supp. 307, 314 (E.D. La. 1993), *aff'd*, 47 F.3d 146 (5th Cir. 1995); *compare Coregis Ins. Co. v. Bell*, 1997 WL 335594 (E.D. La. 1997) (applying Louisiana law, finding intent to deceive was a fact issue). These courts do not require a showing of actual fraud.

C. Rescission As to Innocent Insureds

A related question is the effect of a misrepresentation on "innocent" insureds who did not participate in making the misrepresentation, or who signed the application without knowledge of another insured's deception. The majority rule is that the policy is void as to all insureds, innocent or not. *See Dunn*, 963 F.2d at 1026; *Shapiro v. American Home Assur. Corp.*, 584 F. Supp. at 1249-1250; *INA Underwriters Ins. Co. v. D. H. Forde & Co.*, 630 F. Supp. 76 (W.D.N.Y. 1985); *St. Paul Fire Ins. Co. v. Horowitz & Pollock*, No. 406500/96, Slip Op. at 6-8, (Sup. Ct. of New York County, IAS Part 49, Feb. 4, 1998) (knowledge of nonsigning partner sufficient for rescission). This protects the reasonable expectations of insurers, who are also innocent and who are not in as good a position as the "innocent" insured to discover the misrepresentation. *See, e.g., Bird v. Penn Central*, 341 F. Supp. 291, 294 (E.D. Pa. 1972); *D.H. Forde*, 630 F. Supp. at 77; *Mazur v. Gaudet*, 826 F. Supp. 188, 195 (E.D. La. 1988); *Esoldi v. Esoldi*, 930 F. Supp. 1015 (D.N.J. 1996) (policy was reformed even as to the "innocent" insureds, applying New Jersey law). There are, however, cases in which courts have refused to rescind as to innocent partners. *Compare Holloway v. Sacks & Sacks*, 713 N.Y.S.2d 162 (1st Dep't 2000) (knowledge of associate not sufficient for rescission). In a New Jersey Supreme Court case, the Court allowed rescission as to the guilty attorney and the firm, but not as to an innocent partner who worked in a separate office and was unaware of his partner's misdeeds. *First American v. Lawson*, 177 N.J. 125, 827 A.2d 230 (2003). The Court relied in part on the fact that the insurance was to benefit clients and that the insured was a limited liability partnership, designed to protect innocent insureds.

Nonetheless, there are cases in which courts have deviated from this rule where a severability clause in the policy itself states that the insureds are to be treated as separate. (SEE "SEVERABILITY CLAUSE"). *Shapiro v. Home Ins. Corp.*, 616 F. Supp. 900 (D. Mass. 1984) (court found that voiding policy as to innocent insureds who did not participate in misrepresentation was contrary to "the manifested intent of the entire transaction, given the well-understood source and motivation of the initiative for obtaining insurance in this case - the demand of the underwriters for insurance protection").

Many of these severability cases are based on specific policy language stating that the application is to be construed as a separate application for each insured. *Federal Sav. and Loan Ins. Corp. v. Burdette*, 718 F. Supp. 649 (E.D. Tenn. 1989); *Wedtech Corp. v. Federal Ins. Co.*, 740 F. Supp. 214 (S.D.N.Y. 1990); *Atlantic Permanent Fed. Sav. v. American Cas. Co. of Reading, Pa.*, 839 F.2d 212, 215 (4th Cir. 1988). *But see Nat'l Union Fire Ins. v. Sahlen*, 807 F. Supp. 743, 746 (S.D. Fla. 1992) (policy lacked clear indication that application was separate for each insured). Still further, one court held that if there is no severability clause, the court will determine whether the insurer would have agreed to cover innocent insureds had it known of the misrepresentations. *Mazur v. Gaudet*, 826 F. Supp. 188 (E.D. La. 1992) (due to vicarious liability of innocent insureds, insurer would not have covered innocent insured); *FDIC v. Duffy*, 835 F. Supp. 307 (E.D. La. 1993) (same).

This approach has its theoretical flaws. Because a misrepresentation on the application means that the policy is void and never comes into existence, it is inconsistent to use terms contained in the policy to control whether it can be rescinded. Indeed, at least one court has stated as much. *Dunn*, 963 F.2d at 1026 ("because the fraud was committed during the negotiation of the contract, no insurance policy existed....[B]ecause no policy existed, the defendants may not now rely on the waiver provisions in the policy"). *See also Bird v. Penn Central Co.*, 341 F. Supp. 291, 294 (E.D. Pa. 1972); *INA Underwriters v. D.H. Forde*, 630 F. Supp. 76, 77 (W.D.N.Y.); *Esoldi v. Esoldi*, 930 F. Supp. 1015, 1025 (D.N.J. 1996).

D. Materiality of Misrepresentation

Insurers are required to prove that any misrepresentation on an application was "material" before rescission will be allowed. One common definition of a "material fact" is "any fact that would naturally influence the judgment of the underwriter in making the insurance contract, in estimating the degree and character of the risk, or in fixing the rate of premium." *Employers' Liab. Assur. Ltd. v. Vella*, 366 Mass. 651, 655, 321 N.E.2d 910 (1975). *Accord Evora*, 559 A.2d at 1040. An insurer need not always prove, however, that it specifically relied upon the misrepresentation. *Shapiro v. American Home Assur. Corp.*, 584 F. Supp. 1245, 1250 (D. Mass. 1984). Some jurisdictions do require the insurer to prove that if it had known the truth, it would not have issued the policy or it would have issued different coverage.

Courts have also recognized that while certain misrepresentations may be material as a matter of law, others are not. *Bouley v. Continental Cas. Co.*, 454 F.2d 85 (1st Cir. 1972); *Paul Revere Life Ins. Co. v. Fish*, 910 F. Supp. 58 (D.R.I. 1996); *St. Paul Fire & Marine Ins. Co. v. Boston Housing Auth.*, 25 Mass. App. Ct. 9, 13 n.8, 514 N.E.2d 363, 368 n.8 (1987) (misrepresentation was material as a matter of law).

Courts have found that an insured's failure to disclose a potential claim is material as a matter of law. *TIG v. Blacker*, 54 Mass. App. Ct. 683, 767 N.E.2d 598 (2002); *Shapiro v. American Home Assur. Corp.*, 584 F. Supp. 1245, 1249 (D. Mass. 1984) (recognizing general rule that materiality is usually a question of fact, but finding materiality as a matter of law); *Wittner, Poger, Rosenblum & Spewak, P.C. v. The Bar Plan Mut. Ins.*, 1997 WL 597407 (Mo. App. Ct. 1997), *aff'd on other grounds*, 969 S.W.2d 749 (1998) (materiality could be shown without proof that the insurer would have taken further underwriting action had it known of the potential claim); *Nat'l Union Fire Ins. Co. of Pittsburgh, P.A. v. Mason, Perrin & Kanovsky*, 765 F. Supp. 15 (D.D.C. 1991) ("the pendency of the claims alone would appear to supply sufficient evidence of 'materiality'; in other words, National Union's risk of loss has already been substantially enlarged beyond its expectations at the time it issued the policy"); *McColpin v. North Atlantic Cas. & Sur. Ins. Co.*, 1996 WL 636488 (Tenn. App. 1996) (the facts known to the insured constituted at least "circumstances that could result in a professional liability claim" against him and this would be "of sufficient importance to 'naturally and reasonably influence the judgment'" of the insurer); *Duffy*, 835 F. Supp. at 313-314, and n.17 (insured's criminal conduct was material as a matter of law); *St. Paul Fire Ins.*

Co. v. Horowitz & Pollock, No. 406500/96, Slip Op. at 6-8 (Sup. Ct. of New York County, IAS Part 49, Feb. 4, 1998) (N.Y.L.J. Feb. 13, 1998) (same).

XIV. DISCOVERY CLAUSE

If during the policy period, the Insured first becomes aware that the Insured has committed a specific act, error, or omission in the rendering of professional services for which coverage may be provided hereunder, and if the Insured shall give notice to the Company of

- A. The specific act, error, or omission; and**
- B. the injury or damage, which has or may result from such act, error, or omission; and**
- C. and the circumstances by which the insured first became aware of such act, error, or omission.**

Then any claim that may be subsequently made against the Insured arising out of such act, error, or omission shall be deemed for the purposes of this insurance to have been made during the policy period hereunder.

This clause appears to give the insured the *option* of reporting potential claims, thereby triggering coverage for them under the current policy, no matter when the claim is actually made. Careful attention should be paid to the "Notice of Claim" provision to make sure notice of potential claims is not *mandatory*.

The primary issue raised by the discovery clause is whether an insured may provide a "laundry list" of clients and matters in which they have represented such clients, and obtain coverage under the clause should a claim later be asserted after the policy expires. Clearly, under the terms of most discovery clauses, any specific potential claim of which the insured becomes aware during the policy term, and which is timely reported to the carrier, will result in the policy attaching if a claim is later made. However, the laundry list approach typically involves an ambiguous report of the potential for a claim and raises questions of compliance with the policy's terms. The insured's laundry list would not satisfy the language of most discovery provisions as these provisions require that the insured identify particular clients, and particular errors or omissions. *See American Home Assur. Co. v. Abrams*, 69 F. Supp. 2d 339 (D. Conn. 1999) (insured's letter to insurer expressing concern about claim did not trigger coverage because it did not identify circumstances as to why the insured had a reasonable basis for foresee a claim); *Sapp v. Greif*, 961 F. Supp. 243 (D. Kan. 1997) (insured's report of potential claim was too vague to constitute sufficient notice under the discovery clause of a directors and officers policy), *aff'd*, 141 F.3d 1185 (10th Cir. 1998) (table).

The attorney-client privilege is one limitation on the ability to provide information to the insurer before a claim is made. Where the insured anticipates a suit, but the client has not yet sued, the insured must be cognizant of the fact that there may not yet be a waiver of the attorney-client privilege, and therefore no right to inform the insurer or its appointed counsel of attorney-client communications. *REA v. Pardo*, 132 A.D. 2d 442, 522 N.Y.2d 393 (1987).

XV. SEVERABILITY CLAUSE

The insurance afforded hereunder applies separately to each Insured against whom a claim is made or suit is brought, except with respect to the Company's limit of liability.

Insureds have used the severability clause in their attempts to distinguish themselves from other insureds whose coverage has been lost under an exclusion or policy condition or based on a misrepresentation in the application. *See, e.g., Worcester Mut. Ins. Co. v. Marnell*, 398 Mass. 240, 496 N.E.2d 158 (1986) (language of exclusion that applied to "any insured" was held not to apply to "all" insureds due to severability provision, at least under circumstances of the case); *Stewart Title v. Kiefer*, 984 F. Supp. 988 (E.D. La. 1997) (where exclusion refers to "the insured," severability clause mandated coverage for other insureds who did not individually engage in the excluded conduct); *Coregis v. Lyford*, 21 F. Supp. 2d 695 (S.D. Tex. 1998) (citing cases finding that severability provision makes exclusion referring to "any" or "an" insured severable and not joint, but refusing to make policy severable where there is no clause to that effect. (SEE "DECLARATIONS IN APPLICATION- RESCISSION AS TO INNOCENT INSUREDS" and "INSURING AGREEMENT - LIMITATIONS ON COVERAGE - PRIOR KNOWLEDGE - LACK OF MITIGATING FACTORS").

XVI. MISCELLANEOUS COVERAGE CONSIDERATIONS

A. Choice of Law

The first step in any coverage action presenting a potential choice-of-law issue is to determine whether there is an actual conflict between the laws of the jurisdictions involved. *See Allstate Ins. Co. and Stolarz*, 81 N.Y.2d 219, 223, 597 N.Y.S.2d 904, 613 N.E.2d 936 (1993). However, "where application of the laws of two or more jurisdictions with contacts to the litigation reach identical results . . . any potential conflict of laws" is eliminated. *O'Connor v. O'Connor*, 201 Conn. 632, 657 n.18, 519 A.2d 13 (1986). In such a case, the law of the forum state typically applies. *Wilcox v. Wilcox*, 133 N.W.2d 408 (Wis. 1965) ("The law of the forum should presumptively apply."); *see also Dearborn Ins. Co. v. ISLIC*, 719 N.E.2d 1092 (Ill. App. 1999) (in the absence of any conflict between the law of Illinois and any other jurisdiction, the law of the forum state will control).

If there is an actual conflict between two jurisdictions' laws, the court will perform a choice-of-law analysis in the absence of a choice-of-law provision. Courts have applied different tests when asked to perform a choice-of-law analysis. The most common test applied is the "most significant relationship test" detailed in the Restatement of Torts. *See Superior Equip. Co. v. Maryland Cas. Co.*, 986 S.W.2d 477 (Mo. Ct. App. 1999) (Missouri applies a "most significant relationship test" to determine which state's law applies to the interpretation of an insurance policy); *Belland v. Allstate Ins. Co.*, 140 Wis. 2d 391, 397-98, 410 N.W.2d 611, 613-14 (App. 1987) (absent an express choice by the parties, Wisconsin looks to the law of the state that has the most "significant contacts" with the subject matter of the insurance); *Lapham-Hickey Steel Corp. v. Protection Mut. Ins. Co.*, 166 Ill.2d 520, 655 N.E.2d 842 (1995) (Illinois looks to the law of the state that has the most "significant contacts" with the insurance contract).

The significant relationship test requires a balancing of several factors to determine which state has the most significant relationship to the action. *Superior Equip. Co.*, 986 S.W.2d at 480. The factors include: (1) the place of contracting; (1) the place of negotiation of the contract; (3) the place of performance; (4) the location of the subject matter of the contract; and (5) the domicile, residence, nationality, place of incorporation and place of business of the parties. *Id.* The factors generally considered when determining the "significant contacts" include: (1) the place of contracting, (2) the place of negotiation, (3) the place of performance, (4) the location of the subject matter of the contract, and (5) the domicile, residence, nationality, place of incorporation and place of business of the parties. *Superior Equip. Co.*, 986 S.W.2d 480; *Lapham-Hickey Steel Corp. v. Prot. Mut. Ins. Co.*, 166 Ill.2d 520, 655 N.E.2d 842 (1995); *Belland v. Allstate Ins. Co.*, 140 Wis. 2d 391, 397-98, 410 N.W.2d 611, 613-14 (App. 1987).

B. Burden of Proof

With respect to any coverage dispute between an insured and an insurer, the burden of proof may be an important determinative factor. For example, if the burden of proof on a particular issue is on the insured and the facts are insufficient for the insured to carry that burden, the insured may lose the coverage. On the other hand, if the insurer bears the burden and cannot carry it, the insurer may be obligated to provide coverage.

To begin with, the insured bears the burden of proving that the claim for which coverage is sought comes within the insuring agreement, including disproving that certain limitations in the insuring agreement bar coverage. *Brown Daltas & Assocs., Inc. v. General Accident Ins. Co. of America*, 48 F.3d 30, 37 (1st Cir. 1995) (applying Massachusetts law) (and cases cited); *Highlands Ins. Co. v. Aerovox, Inc.*, 424 Mass. 226, 231-32, n.8, 676 N.E.2d 801 (1997) ("where the exclusion is in the same paragraph as the coverage clause, the exclusion is considered part of the coverage clause for purposes of burden of proof, but where the exclusion is in a separate and distinct part of the policy, . . . the burden shifts to the Insurer"); *Edwards v. Lexington Ins. Co.*, 475 F. Supp. 2d 107 (D. Me. 2007) (finding that insured has burden to show that it made a timely claim); *Cyprus Amax Minerals Co. v. Lexington Ins. Co.*, 74 P.3d 294, 301 (Colo. 2003) (The burden is on the insured to prove that the suit arguably comes within the scope of the policy's coverage); *Medill v. Westport Ins. Corp.* 143 Cal. App. 4th 819, 49 Cal. Rptr.3d 570 (Cal. App. 2006) (insureds have the initial burden of proving the claim falls within the scope of coverage). *But see Ehrgood v. Coregis Ins. Co.*, 59 F. Supp. 2d 438 (M.D. Pa. 1998) ("The burden of proving the applicability of any exclusions or limitations on coverage, however, lies with the insurer, as those are affirmative defenses.")

The burden does not shift simply because the insurer is the one that initiates the declaratory judgment action. Also, it has been held that the well-established burdens of proof do not shift based on who took the initiative of filing the coverage litigation. *Camp Dresser & McKee v. The Home Ins. Co.*, 30 Mass. App. Ct. 318, 321, 568 N.E.2d 631 (1991). If the coverage limitation is found in a clearly delineated exclusion, then it is the insurer's burden to prove that the exclusion bars coverage. *Ratner v. Canadian Universal Ins. Co.*, 359 Mass. 375, 269 N.E.2d 227, 230 (1971); *see also Petersen v. TIG Ins. Co.*, 2002 WL 31413808 (D. Neb. 2002) (citation omitted) (the insurer bears the burden of proof on the applicability of any exclusion to coverage under the policy); *Stewart Title Guar. Co. v. Kiefer*, 984 F. Supp. 988 (E.D. La. 1997) (insurer has burden of proving that an exclusion applies). With respect to an insurer which intends to rescind based on a misrepresentation on the application, the insurer must prove all elements of its case. *Hanover Ins. Co. v. Leeds*, 42 Mass. App. Ct. 54, 57, 674 N.E.2d 54 (1997).

C. Overlapping/Inconsistent Exclusions

Occasionally, certain claims will be specifically excepted from one exclusion (making these claims covered), but fall within a separate exclusion which does not contain a similar exception (making the claims uncovered). For example, some legal malpractice policies contain an exclusion for criminal acts, which itself contains an exception with respect to "innocent insureds," as well as an exclusion for misappropriation of funds, which exclusion does not have a similar exception. If a lawyer in the firm steals money, the "innocent insureds" are confronted with the potential loss of coverage if the latter exclusion applies. Generally speaking, courts have held that where conduct comes within *any* exclusion in a policy, it will not be covered, even though there is substantial overlap with another conflicting exclusion. *See, e.g., United Nat'l Ins. v. Waterfront New York Realty Corp.*, 994 F.2d 105, 108 (2d Cir. 1993) (applying New York law) (exclusion for claims arising out of assault and battery precluded coverage for claims arising from a rape, even though a sexual abuse exclusion with respect to persons under sixteen years of age did not apply); *Jasper v. State Farm Mut. Auto. Ins. Co.*, 875 S.W.2d 954, 957 (Mo. App. E.D. 1994) (exclusions that overlapped were not ambiguous); *Hillcrest Educ. Centers, Inc. v. Continental Ins. Co.*, 1995 WL 809961 (Mass. Sup. Ct. Mar. 28, 1995) (same).