October/November 2012

Insurance Coverage Law Report

FC&S LEGAL
The Insurance Coverage Law Information Center

The Insurance Coverage Law Information Center

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Developments and Article Submission:

Submit insurance coverage law decisions, developments, and articles to be considered for use on our Developments page or in the *Insurance Coverage Law Report,* to our Director, Steven A. Meyerowitz, at smeyerowitz@sbmedia.com. Please consult the Editorial Guidelines for the *Insurance Coverage Law Report*.

Industry News and Events Submission:

Submit industry news and events to our Associate Director, Victoria Prussen Spears, at vspears@sbmedia.com. Although we welcome all submissions, selection for publication will be at the discretion of our Directors, and are subject to space limitations.

The Breadth of *Our* Coverage

By Steven A. Meyerowitz

This issue of the *Insurance Coverage Law Report* highlights the breadth of insurance coverage law – and of ***FC&S Legal: The Insurance Coverage Law Information Center***, the new and comprehensive insurance coverage law online portal from Summit Business Media, through its flagship brand, National Underwriter.

In this issue, the *Insurance Coverage Law Report* – the monthly print (and online) publication that complements ***FC&S Legal*** – contains in-depth feature articles exploring how cyber insurance can mitigate losses from cyber attacks, by Rene L. Siemens and David L. Beck, and on state investigations and settlements of unclaimed life insurance benefits, by Mary Jane Wilson-Bilik.

As usual, this issue of the *Insurance Coverage Law Report* also contains selected analysis, explanation, and discussion of insurance coverage law developments and news about our industry from ***FC&S Legal***. The insurance coverage law cases discussed and examined here and in ***FC&S Legal*** – including from federal circuit courts of appeals and the highest state courts – arise under a range of insurance policies and subjects:

- Commercial General Liability;
- Homeowner's Insurance;
- Inland Marine;
- Advertising Injury;
- Automobile Insurance;
- Commercial Auto;
- Life Insurance;
- Bad Faith; and
- Professional Liability Insurance.

We believe that if you are an attorney practicing insurance coverage law who represents policyholders or insurance companies, or if you are an insurance company or corporate executive who wants to keep apprised of the very latest in insurance coverage law, you should read the *Insurance Coverage Law Report* – and you should subscribe to ***FC&S Legal: The Insurance Coverage Law Information Center***.

Enjoy the issue!

Steven A. Meyerowitz, *Editor-in-Chief*
October 2012

Steven A. Meyerowitz, who can be reached at smeyerowitz@sbmedia.com, is the Editor-in-Chief of the Insurance Coverage Law Report and the Director of ***FC&S Legal: The Insurance Coverage Law Information Center***.

Featured Article

How Cyber Insurance Can Mitigate Losses from Cyber Attacks

By Rene L. Siemens and David L. Beck

As with any insurance policy, cyber insurance policies contain many limitations and exclusions. As the authors explain, these exclusions should be read carefully during the initial underwriting process, as many of the limitations of this kind of insurance can be overcome through negotiation before the policy is bound.

Rene L. Siemens

The market is rapidly growing for insurance that is specifically meant to cover losses arising out of cyber attacks and other privacy and data security breaches. These insurance policies are marketed under names like "cyber-liability insurance," "privacy breach insurance" and "network security insurance." Many companies and other institutions that handle legally protected information now view this kind of insurance as an essential part of their coverage programs. There is no standardization of cyber insurance policies. The terms and exclusions can vary dramatically from one insurer to the next. Broadly speaking, however, cyber insurance policies can provide coverage for third party liability, first party losses, or both. A policy typically includes some or all of the following types of coverage.

David L. Beck

Third Party Liabilities

For third party liabilities, a cyber insurance policy may cover costs of mitigating the insured's potential liability from an actual or suspected data security or privacy breach, including:

- Crisis Management Expenses
- Costs of notifying affected parties
- Costs of providing credit monitoring to affected parties
- Costs of public relations consultants
- Forensic investigation costs incurred to determine the existence or cause of a breach
- Regulatory compliance costs
- Costs to pursue indemnity rights
- Costs to analyze the insured's legal response obligations
- Claim Expenses
- Costs of defending lawsuits
- Judgments and settlements
- Regulatory response costs
- Costs of responding to regulatory investigations
- Costs of settling regulatory claims

First Party Coverages

Many policies also provide coverage for a variety of torts, including libel, invasion of privacy, or copyright infringement. First party coverages may include lost revenue due to interruption of data systems resulting from a cyber or denial of service attack and other costs associated with the loss of data collected by the insured, such as:

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- Revenue lost due to interruption of your operations due to, e.g.,
  - Hacking
  - Virus transmission
  - Other security failures
  - Costs of restoring, recreating or recollecting:
  - Lost data
  - Stolen data
  - Damaged data

Some policy forms even include coverage for costs of responding to demands for "ransom" or "E-extortion" threats to prevent a threatened cyber attack.

Market Conditions

The market for cyber insurance in the U.S. grew from less than $100 million in premiums underwritten during 2002 to approximately $800 million in annual premiums by 2011. Many insurers have recently jumped into this market and are competing to establish market share. As a result, the cyber insurance market is "soft": The coverage has actually become less expensive as insurers compete for business. This decrease in price contrasts with the ever-increasing risk for significant cyber-liability exposures. The cyber insurance market may not remain soft for long, but in the meantime policyholders may benefit from a competitive market.

The cost of cyber insurance will vary depending on a variety of factors, including the size and risk factors of the insured organization, the amount and kinds of coverages purchased, and the size of the retentions or deductibles. Average premiums for primary coverage may range from $15,000 to $35,000 per $1 million of limits.

Given the lack of standardization and competitive market, the terms of cyber insurance coverage tend to be highly negotiable. Terms that are initially offered in the form of an apparently standard policy by an insurer may often be customized, through negotiation, in order to respond to a prospective policyholder's unique circumstances. A prospective policyholder may also negotiate changes to policy language that ultimately yield an insurance policy with broader grants of coverage, and narrower (or at least clearer) exclusions and limitations, than those initially offered by an insurer, with no additional premium charge. The result is better coverage, usually for no increased cost.

Insureds that are considering cyber coverage, or are approaching renewal time, should therefore have an experienced insurance coverage attorney review the terms of the policy forms they are being offered, with a view to recommending enhancements that should be requested from the insurer. In short, companies should approach the purchase of a cyber insurance policy the same way they approach the negotiation of any other substantial business contract: They should review the proposed contract carefully and negotiate better terms where possible. Soliciting competitive bids from several insurers may increase one's negotiating power.

Common Coverage Provisions

Cyber insurance policies, like other kinds of insurance policies, usually contain several insuring clauses that cover different types of loss within a single policy.

For third party liability, most cyber insurance forms apply to claims that are brought against the insured by those whose private data has been breached. Costs that are payable typically include the amount of any settlement or judgment, as well as the insured's defense costs. Other covered costs may include expenses incurred to comply with consumer notification provisions contained in privacy laws and regulations, to provide credit monitoring services for those parties whose information has been compromised, to cover investigatory expenses incurred to determine the cause and scope of the data breach, and to pay for retaining a public relations firm to handle the public disclosure of the breach.

For first party losses, coverage may include lost revenues and continuing operating expenses incurred due to a denial of service or other impairment resulting from a cyber attack. Some policies also provide coverage for the cost of restoring or recreating lost or stolen data.

As with any insurance, these coverages are subject to a number of limitations and exclusions that must be reviewed carefully—and renegotiated where appropriate—in order to ensure that important coverages are not omitted and the insured's intent in purchasing the coverage is not obscured or frustrated. Clients frequently ask us to review cyber insurance policies before the underwriting process and advise them on terms, conditions, and exclusions that should be renegotiated.

Conclusion

Cyber insurance can be a valuable tool for mitigating losses from data security breaches. However, as with any insurance policy, cyber insurance policies contain many limitations and exclusions. It is important that these exclusions be read carefully during the initial underwriting process, as many of the limitations of this kind of insurance can be overcome through negotiation before the policy is bound. ■

State Investigations and Settlements of Unclaimed Life Insurance Benefits Continue

By Mary Jane Wilson-Bilik

Examinations and inquiries about unclaimed death benefits are requiring insurers to invest significant resources to gather large amounts of data in response to extensive information requests and interrogatories, in some cases requiring data on policies out-of-force for 20 years, without coordination among regulators.

During 2012, the life insurance industry has continued to see an escalation in the number and intensity of multistate market conduct examinations focused on insurers' practices with regard to unclaimed death benefits. More than forty state insurance regulators have hired Verus Financial LLP to conduct market conduct examinations of certain life insurers' claims practices. At the same time, Verus is performing aggressive unclaimed property audits of the same insurers for a contingency fee on behalf of at least thirty-five state treasurers. ACS Unclaimed Property Clearinghouse and Kelmar Associates, LLC, other contingent fee audit firms are also performing unclaimed property audits of certain life insurers. And Attorneys General in Massachusetts, Minnesota, and New York State have continued their probes of insurers' death claim and escheatment practices, applying different standards and legal constructs to their data requests than Verus. These exams and inquiries are requiring insurers to invest significant resources to gather large amounts of data in response to extensive information requests and interrogatories, in some cases requiring data on policies out-of-force for twenty years, without coordination among regulators.

Mary Jane Wilson-Bilik

Unclaimed Property Laws

The driving theory behind the Verus unclaimed property audits is that, just as unused gift cards must be escheated to the states as unclaimed property if dormant for a certain period of time, death benefits on life insurance and annuity policies that are unclaimed by beneficiaries must be escheated to the states within a dormancy period that is triggered by death – not by notice of death or the filing of a perfected claim. However, the industry believes unclaimed property laws do not support this theory, and it is long established that the state insurance laws and insurance contracts approved by insurance departments require the filing of a claim in good order by a beneficiary before a claim is due and payable.

The regulatory initiatives are attempting to shift the burden to the insurer to determine whether an insured is deceased and benefits are payable by requiring periodic sweeps of an insurer's entire book of business against the U.S. Social Security Administration's Death Master File ("DMF"). In the process, regulators have created significant compliance uncertainty among all life insurers.

Regulatory Settlements

Regulatory settlements by four prominent life insurers have raised numerous questions within the industry about the sudden change in regulators' expectations. On February 2, 2012, seven lead states (California, Florida, Illinois, New Hampshire, North Dakota, Pennsylvania, and New Jersey) announced a $17 million multistate

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regulatory settlement agreement ("RSA") with The Prudential Insurance Company and its life insurance subsidiaries ("Prudential") that requires Prudential to conduct monthly sweeps of the DMF against its life insurance, annuity, and retained asset account blocks of business, with some exceptions, using an algorithm that includes "fuzzy match" criteria.

If Prudential finds that a policyholder has died, the agreement requires Prudential to use "best efforts" to conduct a "thorough search" for beneficiaries, using all contact information in its records and online search and locator tools. If beneficiaries cannot be located, Prudential must turn the proceeds owed to beneficiaries over to the states as required by state unclaimed property laws. Prudential is required to submit quarterly reports to the lead states for a thirty-six-month period and to undergo a second multi-state market conduct exam by Verus within thirty-nine months, with costs borne by Prudential. The RSA terminates ten years after signing. As of this writing, all states, except New York and Minnesota, have signed the Prudential RSA.

The Prudential RSA is in addition to the unclaimed property audit settlement that Prudential signed with Verus in January 2012 on behalf of thirty-six State Treasurers. That Global Resolution Agreement ("GRA") is essentially a work plan for reporting and remitting unclaimed death benefits to the states and requires the aggressive reporting and processing of remittances on 10-15,000 unclaimed death benefits, matured policies, and dormant retained asset accounts per month. Prudential agreed to pay beneficiaries, and if unfound, the states, three percent compounded interest on the value of amounts held from the date of the owner's death or January 1, 1995, if later, and to accelerate turning over unclaimed property to the states.

In April 2012, six insurance commissioners in lead states (Florida, California, Illinois, North Dakota, Pennsylvania, and New Hampshire) announced a $40 million RSA with MetLife, Inc., and its life insurance subsidiaries ("MetLife") that is materially consistent with the Prudential RSA. The MetLife RSA requires MetLife to change its business practices to conduct monthly DMF searches across all lines of business using "fuzzy match" criteria, use "best efforts" to conduct "thorough searches" for beneficiaries, provide quarterly reports to the lead states, and undergo a second market conduct exam within thirty-nine months.

Also in April 2012, it was announced that Verus has entered into a national unclaimed property GRA with MetLife that is materially consistent with the Prudential GRA. Estimates are that MetLife will pay at least $500 million in unpaid life and annuity benefits to beneficiaries and/or escheat the benefits to the states. MetLife agreed to an additional review and remittance of up to 12,000 industrial policies per month (32,000 policies per month in total) beginning within thirty days of the effective date of the GRA.

Similar agreements with Nationwide Financial and AIG have now been signed.

Legislation

Meanwhile, the National Council of Insurance Legislators ("NCOIL") introduced the Model Unclaimed Life Insurance Benefits Act, sponsored by Representative Robert Damron of Kentucky. That bill would require quarterly searches against the DMF of in-force life insurance policies and retained asset accounts, use of "good faith" efforts to locate beneficiaries, and the escheatment of unclaimed benefits to the states. However, the Director of Communications of the Florida Office of Insurance Regulation is reported to have pushed back against the NCOIL model act, citing regulators' concern that insurers will try to use the NCOIL model as a reason why states should not complete their market conduct exams and unclaimed property audits. He reiterated that state insurance regulators intend to reach agreements similar to the Prudential and MetLife RSAs with other insurers that are, or in the future will be, under examination.

As a result of this increased regulatory activity, insurers are looking to understand the full implications of these developments for their business and to develop a comprehensive strategy that will reduce the uncertainty and their exposure from these developments.

New York Implements Unclaimed Death Benefit Requirements

On May 14, 2012, the New York Department of Financial Services (the "NYDFS") announced the emergency promulgation of Insurance Regulation 200. The emergency regulation requires all life insurers doing business in New York to immediately begin to implement significant new procedures to identify unclaimed death benefits and locate beneficiaries so as to make prompt payments of benefits. Regulation 200 became effective June 14, 2012, for ninety days.

In July 2011, the NYDFS issued a letter to insurers pursuant to New York Insurance Law § 308 (the "308 Letter"). The 308 Letter required life insurance companies and fraternal benefit societies doing business in New York to conduct a cross check against the DMF, or another

comparable database, of their entire block of business, using "exact" match criteria. Every life insurance policy and annuity contract and retained asset account issued by a New York domestic insurer or delivered or issued for delivery in New York by an authorized foreign insurer since 1986 was subject to the requirement, with certain exceptions. Insurers were required to pay any unpaid death benefit payments that may have been due under the policies and accounts and to submit monthly reports to the NYDFS on their progress in bucketing, paying, and/or escheating amounts due and payable with regard to valid matches against the DMF.

Regulation 200 has expanded, rather severely and without providing an opportunity for notice and comment, the scope of the procedures that insurers must immediately undertake to identify valid death claims and pay beneficiaries. Regulation 200 also significantly changes the scope of retained asset accounts of foreign insurers that are subject to the regulation from that contained in the 308 Letter (i.e., accounts delivered or issued for delivery in New York) to "any account established under or as a result of" a life insurance policy or annuity contract delivered or issued for delivery in New York. The emergency regulation's key requirements that went into effect on June 14 are as follows:

- Prior to issuing a policy or establishing an account, insurers must request detailed information regarding each owner, annuitant, insured, and/or beneficiary of a policy or account. At a minimum, the insurer shall request names, addresses, social security numbers, and telephone numbers.

- Insurers must conduct quarterly cross checks against the DMF (or a comparable database) of every policy and account using the criteria set forth in the 308 Letter.

- Insurers must implement "reasonable" matching procedures to account for common variations in data that would otherwise preclude an exact match with a death index. In other words, insurers are required to use an algorithm when cross checking the DMF that will generate fuzzy matches. This provision raises significant interpretative and systems issues.

- Insurers must establish "reasonable" procedures to locate beneficiaries and must make prompt payments or distributions of benefits.

- Upon receipt of notification of death or identification of a death using the DMF, insurers must search every policy or account subject to Regulation 200 to determine whether the insurer has any other policy or account for the insured or account holder.

- Upon receipt of notification of death or identification of a death using the DMF, the insurer must also notify each life insurer in their holding company system of the death notice, regardless of the location of the other insurer. This provision raises significant jurisdictional, notice and compliance issues.

- Insurers must respond to requests from the NYDFS Superintendent to search for policies insuring the life of, or owned by, decedents, and to initiate the claims process for any death benefits that may be identified as a result of the requests received through the new Lost Policy Finder system; and

- Insurers must submit a report to the New York Office of the State Comptroller, by February 1 of each year, specifying the number of policies and accounts identified as having unpaid benefits as of December 31 of the prior year.

There are many other aspects to Regulation 200 that present challenges for insurers, including the thirty-day time-frame for implementing most of the procedures required by Regulation 200, such as the requirement to search for multiple policies and accounts. While Regulation 200 gave insurers an additional 150 days from the effective date to implement fuzzy match procedures, the additional time may not be sufficient for insurers that do not have such procedures in place and whose systems currently would not support such searches.

Adding to the regulatory uncertainty is legislation that has passed both houses of the New York State Legislature and, as of this writing, is slated to come before the governor for signature. That legislation, which is supported by the life insurance industry, would require DMF matches but maintain the life insurers' ability to verify that an insured identified by the cross-match is actually deceased by requiring the beneficiary to produce a death certificate. Until this matter is resolved, insurers face the uncertainty of inconsistent regulatory obligations that require significant systems changes with short implementation deadlines. ■

By Steven A. Meyerowitz

Commercial General Liability

New York's Top Court Finds that New Policy Language Eliminates Ambiguity – and Loss Caused by Excavation Now Is Excluded

Three years ago, in *Pioneer Tower Owners Assn. v. State Farm Fire & Cas. Co.*, New York's highest court, the Court of Appeals, held that an "earth movement" exclusion in an insurance policy did not unambiguously apply to excavation. Now, the Court has ruled that loss caused by excavation was excluded from a policy in which a similar exclusion was expressly made applicable to "man made" movement of earth.

The Case

The plaintiff in this case, *Bentoria Holdings, Inc. v. Travelers Indemnity Co.*, alleged that its building suffered cracks as a result of an excavation being conducted on the lot next door. The plaintiff submitted a claim, which the insurer rejected, relying on the earth movement exclusion. The plaintiff sued for breach of the policy. The trial court denied the insurer's motion for summary judgment, an intermediate appellate court affirmed, and the case reached the New York Court of Appeals.

The Policy

The policy in Bentoria Holdings covered "direct physical loss of or damage to" a building in Brooklyn. Under the heading "EXCLUSIONS," the policy said:

> 1. We will not pay for loss or damage caused directly or indirectly by any of the following….
>
> ***
>
> b. Earth Movement
>
> ***
>
> (4) Earth sinking (other than sinkhole collapse), rising or shifting including soil conditions which cause settling, cracking or other disarrangement of foundations or other parts of realty. Soil conditions include contraction, expansion, freezing, thawing, erosion, improperly compacted soil and the action of water under the ground surface;
>
> All whether naturally occurring or due to man made or other artificial causes.

The Court of Appeals Decision

In its ruling in Bentoria Holdings, the Court explained that Pioneer was in most respects virtually identical to the Bentoria Holdings case. The Pioneer policy insured a building against "accidental direct physical loss" and the building suffered cracks and other damage as a result of an excavation on an adjoining lot. The insurer refused to pay, relying on an earth movement exclusion very similar to the one in Bentoria Holdings, with the distinction that the last words of the earth movement exclusion in this case — "All whether naturally occurring or due to man made or other artificial causes" — were absent in Pioneer.

As the Court noted, the plaintiff in Pioneer argued that the policy did not clearly exclude "an excavation — the intentional removal of earth by humans." The Court found that argument to be "reasonable," and therefore held that the earth movement exclusion "did not unambiguously remove" excavation damage from the coverage of the policy.

In Bentoria Holdings, the Court emphasized that the same argument was not available. "By expressly excluding earth movement 'due to man made or artificial causes,' the policy contradicts the idea that 'the intentional removal of earth by humans' is not an excluded event." The Court therefore concluded that the Bentoria Holdings policy could not reasonably be read to cover the damage on which the plaintiff's claim was based.

Accordingly, the Court ruled that the insurer was entitled to summary judgment dismissing the complaint against it.

The case is *Bentoria Holdings, Inc. v. Travelers Indemnity Co.*, No. 160 (N.Y. Oct. 25, 2012). Attorneys involved include Stephen M. Lazare and John V. Decolator. The American Insurance Association filed an amicus brief.

Defective Construction or Workmanship Claims Are Not for 'Property Damage' Caused By 'Occurrence,' Ohio Supreme Court Decides

The Ohio Supreme Court has ruled that claims of defective construction/workmanship brought by a property owner are not claims for "property damage" caused by an "occurrence" under a commercial general liability ("CGL") policy.

The Case

The case arose after Younglove Construction, L.L.C., agreed to construct a feed-manufacturing plant for PSD Development, L.L.C. After PSD allegedly withheld payment, Younglove sued. PSD contended that it had sustained damages as a result of defects in a steel grain bin. The bin had been constructed by a subcontractor, Custom Agri Systems, Inc., which Younglove sued under two general theories: defective construction and consequential damages resulting from the defective construction. Custom asked its CGL insurer, Westfield Insurance Company, to defend and indemnify it, but Westfield argued that none of the claims against Custom sought compensation for "property damage" caused by an "occurrence" and therefore none of the claims were covered under the policy.

In a divided decision, the U.S. Court of Appeals for the Sixth Circuit determined that the question of whether defective construction or workmanship constituted an "occurrence" within the meaning of a CGL policy in Ohio might be determinative of the action, and it certified the questions to the Ohio Supreme Court.

The Policy

The CGL policy provided:

COMMERCIAL GENERAL LIABILITY COVERAGE FORM

* * *

SECTION I—COVERAGES
COVERAGE A BODILY INJURY AND PROPERTY DAMAGE LIABILITY

1. Insuring Agreement
   a. We will pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damage" to which this insurance applies. We will have the right and duty to defend the insured against any "suit" seeking those damages. However, we will have no duty to defend the insured against any "suit" seeking damages for "bodily injury" or "property damage" to which this insurance does not apply. We may, at our discretion, investigate any "occurrence" and settle any claim or "suit" that may result. But:

* * *

(2) Our right and duty to defend end when we have used up the applicable limit of insurance in the payment of judgments or settlements under Coverages A or B or medical expenses under Coverage C.

* * *

   b. This insurance applies to "bodily injury" and "property damage" only if:

(1) The "bodily injury" or "property damage" is caused by an "occurrence" that takes place in the "coverage territory;"

* * *

SECTION V—DEFINITIONS

* * *

3. "Bodily injury" means bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time.

* * *

13. "Occurrence" means an accident, including continuous or repeated exposure to substantially the same general harmful conditions.

* * *

17. "Property damage" means:
   a. Physical injury to tangible property, including all resulting loss of use of that property. All such loss of use shall be deemed to occur at the time of the physical injury that caused it; or
   b. Loss of use of tangible property that is not physically injured. All such loss of use shall be deemed to occur at the time of the "occurrence" that caused it.

The Ohio Supreme Court Decision

In its decision, the Ohio Supreme Court explained that it had to determine whether Custom's alleged defective construction of and workmanship on the steel grain bin constituted property damage caused by an "occurrence." The court noted that the word "occurrence" was defined as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." The court continued by declaring that an accident was something "unexpected, as well as unintended" – something that required "fortuity."

The court then held that claims for faulty workmanship, such as the one in this case, were "not

fortuitous in the context of a CGL policy like the one here." Thus, it concluded, the CGL policy did not provide coverage to Custom for its alleged defective construction of and workmanship on the steel grain bin. [*Westfield Ins. Co. v. Custom Agri Sys., Inc.*, No. 2011–1486 (OH Oct. 16, 2012).]

FC&S Legal Comment

It should be noted that not every state supreme court agrees with the result in the Ohio case. For example, in *Sheehan Constr. Co., Inc. v. Continental Cas. Co.*, 935 N.E.2d 160, 170 (Ind.2010), modified on rehearing, 938 N.E.2d 685 (Ind.2010), the Supreme Court of Indiana established that intent is the key to determining whether a construction defect is accidental:

> Implicit in the meaning of "accident" is the lack of intentionality…. The question presented is whether faulty workmanship is an accident within the meaning of a standard CGL policy. In our view the answer depends on the facts of the case. For example, faulty workmanship that is intentional from the viewpoint of the insured cannot be an "accident" or an "occurrence." [See *Lamar Homes Inc. v. Mid–Continent Cas. Co.*, 242 S.W.3d [1] at 8–9 [(Tex.2007)]. On the other hand if the faulty workmanship is "unexpected" and "without intention or design" and thus not foreseeable from the viewpoint of the insured, then it is an accident within the meaning of a CGL policy.

As is apparent from the Ohio Supreme Court decision, however, the standard enunciated by the Indiana Supreme Court is not universally applied across the country.

Homeowner's Insurance

Divided N.Y. Court of Appeals Finds 'Residence Premises' Ambiguous

A divided New York State Court of Appeals, the state's highest court, has ruled that the term "residence premises" in a homeowner's insurance policy was ambiguous where an insured purchased the policy in advance of a closing but was unable to move in due to the need for major repairs.

The Case

The case arose after Douglas and Joanna Dean entered into a contract to purchase a home in Irvington, New York, in February 2005. The couple acquired a homeowners' insurance policy from the Tower Insurance Company of New York effective as of the closing date, which was delayed until May 20, 2005. After the closing, the insureds discovered extensive termite damage to the house. Mr. Dean, with the help of family and friends, began the process of repairing the damage. Work on the house progressed over the course of the year following the closing, and the policy was renewed in March 2006. The renovations were substantially completed when, on May 15, 2006, a fire completely destroyed the house.

The morning after the fire, the insureds gave notice to Tower. On June 22, 2006, Tower disclaimed coverage on the grounds that: "Our investigation revealed the dwelling was unoccupied at the time of the loss. Accordingly, this dwelling does not qualify as a 'residence premises' [sic] there is no coverage for this claim under your policy." Secondarily, Tower disclaimed coverage on the ground that insureds had engaged in fraud by misrepresenting their intent to live in the premises on the application submitted in advance of acquiring the policy.

The Policy

The Tower policy provided as follows:

> We cover: 1. The Dwelling on the 'residence premises' shown in the Declarations, including structures attached to the dwelling.

In the definitions section, "residence premises" was defined as:

> The one family dwelling ... where you reside.

The term reside was not defined in the policy.

The Lower Court Decisions

The insureds sued Tower for breach of the insurance contract. Following discovery, the trial court granted Tower's summary judgment motion, holding that the term "reside" was clear and unambiguous, and that the insureds had never established residency at the premises and "[a]t best ... established ownership of the house and presence in it to perform renovations, and a stated intent of living there." An intermediate appellate court disagreed. It found that Tower had failed to satisfy its prima facie burden on a motion for summary judgment. In the appellate court's view, the "residence

premises" requirement in the policy failed to define what qualified "as 'resides' for the purpose of attaching coverage" and therefore the "policy [was] ambiguous in the circumstances of this case."

The case reached the New York Court of Appeals.

The Court of Appeals Decision

The majority opinion observed that Mr. Dean claimed that between the date of the closing and the date of the fire he generally was at the property at least five days a week, that he would go there after work between 4:00 and 5:00 p.m. and leave no earlier than 10 p.m., and that he frequently would stay late into the night or early morning. The majority also noted that Mr. Dean declared that he had built a table for eating purposes and would eat at the house every day, sometimes with other workers, and that he slept there on several occasions. In the majority's view, therefore, there were "issues of fact as to whether [his] daily presence in the house, coupled with his intent to eventually move in with his family, [was] sufficient to satisfy the insurance policy's requirements."

The majority also found that because the term "reside" was not defined in the policy, making the term "residence premises" ambiguous, it was "arguable that the reasonable expectations of an average insured" was that occupancy of the premises would satisfy the policy's requirements. Thus, the four judges in the majority concluded, there were issues of fact rendering summary judgment inappropriate in this matter.

The case is *Dean v. Tower Ins. Co. of New York*, No. 173 (N.Y. Oct. 25, 2012). Attorneys involved include Max W. Gershweir and Robert D. Meade.

FC&S Legal Comment

The three dissenters did not have the same problem interpreting the term "reside" as the majority had. In the dissent's view, Mr. Dean's activity fell "short of demonstrating the physical permanence needed to establish that the subject property was their residence."

The dissent found it "[i]nexplicabl[e]" that the majority did not apply the "plain meaning of the term 'reside.'"

The dissenters, however, were outvoted, 4 to 3.

Finding No 'Efficient Proximate Cause Rule' in Arizona, Court Rejects Coverage for Home's Destruction after Wallow Fire

What makes a loss a "direct" loss under a homeowner's policy? A decision by federal district court in Arizona sheds some light on this issue, at least under Arizona law.

The Case

The insureds' home near Alpine, Arizona, was consumed by a mudslide following a wildfire, known as the "Wallow Fire," in the summer of 2011. The fire began on May 29, 2011, and was contained on July 8. The fire consumed the insureds' detached garage on June 13. The residence was destroyed on August 6.

The garage and the residence were insured under a homeowner's policy that provided coverage for "sudden and direct physical loss" caused by fire, but excluded coverage for loss caused by water damage or earth movement, including mudslides. Based on these provisions, the insureds' homeowner's insurer covered the loss of their garage but denied coverage for the loss of the residence. The insureds sued.

The Policy

The homeowner's policy contained the following provisions:

> COVERAGE A—DWELLING AND COVERAGE B—PRIVATE STRUCTURES
>
> We will pay for sudden and accidental direct physical loss or damage to the property described in coverages A and B, except as excluded in Section I—Losses We Do Not Cover.
>
> SECTION I—LOSSES WE DO NOT COVER
>
> 1. We do not insure under any Section I coverage for any loss which would not have happened in the absence of one or more of the following excluded events. We do not insure for any such loss regardless of:
>   (a) the cause of the excluded event;
>   (b) other causes of the loss; or
>   (c) whether such causes acted at the same time or in any other sequence with the excluded event to produce or contribute to the loss.
>
> These exclusions apply whether or not the excluded event results in widespread damage or affects a substantial area. The excluded events are listed below ...
>
> D. Water damage, meaning any loss caused by, resulting from, contributed to or aggravated by:
>   1. flood, surface water, waves, tidal water or overflow of any body of water, or spray from any of these, whether or not driven by wind ...

> E. Earth Movement, meaning any loss caused by, resulting from, contributed to or aggravated by events that include, but are not limited to:
>
> 1. earthquake and earthquake aftershocks;
> 2. volcanic eruption and volcanic effusion;
> 3. sinkhole;
> 4. subsidence;
> 5. mudslide including landslide, mudflow, debris flow, avalanche or sediment;
> 6. erosion or excavation collapse;
> 7. the sinking, rising, shifting, expanding, bulging, cracking, settling or contracting of the earth, soil or land ...
>
> This exclusion applies whether or not the earth movement is combined with water or caused by or results from human or animal forces or any act of nature.

The Court's Decision

The insureds argued that the loss of their residence was directly caused by the Wallow Fire and that under Arizona law, "direct loss," as used in the standard fire policy, meant a loss proximately caused by fire. The court disagreed.

The court reasoned that the insureds' homeowner's policy covered direct loss by fire – adding that that was why the insurer covered the loss of the insureds' garage, which was directly consumed by the Wallow Fire. The court found, however, that the insureds' dwelling "was destroyed by mudslides almost a month after the Wallow Fire was contained" – and that water and earth movement were excluded events under the policy.

The court was not persuaded by the insureds' contention that they were entitled to coverage because the fire was a proximate – and therefore "direct" – cause of their loss, concluding that Arizona does not have a statute mandating coverage for events that are the efficient proximate cause of a loss and has not adopted the efficient proximate cause rule. [*Stankova v. Metropolitan Property and Cas. Ins. Co.*, No. CIV. 12–8016–PCT–PGR (D. Ariz. Oct. 18, 2012).]

FC&S Legal Comment

A different result was reached a number of years ago by a California appellate court. *Howell v. State Farm Fire & Cas. Co.*, 218 Cal.App.3d 1446, 267 Cal.Rptr. 708 (1990). In Howell, a brush fire destroyed vegetation, and subsequent rain triggered a landslide that damaged the insured property. The policy contained earth movement and water damage exclusions, which the insurer applied, along with a concurrent cause provision, to deny coverage for the damage. The California Court of Appeal held that the exclusions were contrary to California statutory law, which made "the insurer liable whenever a covered peril is the 'efficient proximate cause' of the loss, regardless of other contributing causes." Id. at 1452, 267 Cal. Rptr. at 711 (citing Ins. Code, § 530).

The court in Stankova found no such rule in Arizona, and hence it reached a different result than the court in Howell.

Inland Marine

Finding 'Carrier' and 'Entrust' Ambiguous, Court Orders Full Coverage of Theft Loss

A federal district court in Oregon has ruled that terms in an inland marine policy were ambiguous and it therefore decided that theft by fraudulent or imposter carriers was covered by the policy.

The Case

On January 21, 2011, a transportation brokerage company in Oregon agreed to broker a load of LCD monitors from the Industry, California, to Dinuba, California. Following its standard routine regarding brokerage agreements, the brokerage company posted the shipment details on various load-posting websites to find a carrier to transport the load.

On January 31, 2011, a person representing himself to be an employee of a transportation company responded to the posting and provided the brokerage company with a certificate of liability insurance from an insurance agency. After speaking with a supposed representative of the agency, the brokerage company approved the transportation company to transfer the load.

Later that day, an individual who represented himself as a driver for the transportation company picked up the shipment, but the load did not arrive in Dinuba. A subsequent criminal investigation revealed that an imposter had posed as a representative of the transportation company to receive authorization to pick up the shipment, that the insurance agency that had issued the certificate of insurance was not a legitimate

company, and that the certificate insurance had been falsified.

The brokerage company filed a proof of loss with its insurer for $310,172, the estimated value of the LCD monitors. The insurer took the position that the fraudulent or imposter carrier was still a "carrier" under the policy and paid the $50,000 limits for dishonest acts by a carrier. The brokerage company sued, seeking $300,000, plus interest, fees, and costs.

The Policy

The policy in the coverage grant provided as follows:

> COVERAGE
> We cover "loss" to Covered Property from any of the Covered Causes of "Loss."
>
> 1. Covered Property, as used in this Coverage Form, means property of others:
>   (a) For which you have arranged transportation with a "carrier" of the type described in the Declarations; and
>   (b) That you have agreed to insure.
>
> We cover such property while in the due course of transportation.
>
> DEFINITIONS
> 1. "Carrier" means any
>   a. Railroad company;
>   b. Motor transportation company; or
>   c. Air freight company.

The policy in the exclusion section provided as follows:

> We will not pay for "loss" caused by or resulting from any of the following:
>
> a. Delay, loss of use, loss of market, loss of income, interruption of business or any other consequential loss.
> b. Dishonest or criminal acts by any of the following whether or not acting alone or in collusion with other persons or occurring during the hours of employment:
>   (1) You, your employees or authorized representatives;
>   (2) The "carrier" or its employees or authorized representatives; or
>   (3) Anyone else with an interest in, or entrusted with, the property. But this exclusion does not apply to coverage provided by the "carrier" Dishonesty Additional Coverage.

The endorsement in the exclusion section provided as follows:

> "Carrier" Dishonesty
> We will pay up to $50,000 in any one occurrence for loss of or damage to Covered Property caused by or resulting from any fraudulent, dishonest, or criminal act committed by a "carrier." But this Additional Coverage does not apply to any fraudulent, dishonest, or criminal act committed by you.

The Court's Decision

The court first found that the policy did not clearly indicate whether a "carrier" had to be licensed or authorized. The brokerage company contended that it had "arranged transportation with a carrier" as provided in the policy's coverage grant even though it turned out to be a fraudulent or imposter carrier. The insurer argued that this situation was no different than the property being stolen in transit by an unknown third party that was clearly covered under the policy.

The court ruled that the term "carrier" was ambiguous, and interpreted it against the drafter and in favor of the brokerage company. Accordingly, it held, the term "carrier" in the coverage grant was construed in favor of the insured to include fraudulent or imposter carriers.

The court then analyzed whether the loss was excluded by Exclusion (b)(2), which prohibited coverage for dishonest or criminal acts by a carrier or a carrier's employees or representatives or whether the endorsement limited coverage to $50,000 for dishonesty by a carrier. The court declared that because the policy was ambiguous as to whether "carrier" referred to only legitimate carriers or also included fraudulent or imposter carriers, it would interpret the term in favor of the brokerage company. It then held that:

Interpreting the term in [the insured's] favor, "carrier" as used in Exclusion (b)(2) and the endorsement, means "legitimate carrier" and does not include fraudulent carriers. Consequently, neither Exclusion (b)(2) or the endorsement apply to [the insured's] loss.

Finally, the court ruled that coverage for the brokerage company's loss also was not barred by Exclusion (b)(3), which prohibited coverage for anyone with an interest in or "entrusted" with the property being transported. The court pointed out that "entrust" was not defined in the policy, and found that it was ambiguous. The court then interpreted "entrust" in favor of the brokerage company, finding that property could not be entrusted "to a thief"

and that the insured's coverage was not limited by Exclusion (b)(3).

Accordingly, the court granted summary judgment in favor of the brokerage company.

The case is *Intransit, Inc. v. Travelers Property and Cas. Co. of America*, No. 1:11–CV–03146–CL (D.Or. Oct. 22, 2012). Attorneys involved include David B. Paradis, Brophy Schmor Brophy, Paradis, Maddox & Weaver, LLP, Medford, OR; Lloyd Bernstein, Elizabeth A. Eames, Gordon & Polscer, LLP, Portland, OR.

Advertising Injury

Advertising Injury Provision Did Not Require Defense Where Product Was Neither Identified Nor Disparaged

A California appellate court has decided that a liability insurance policy's "advertising injury" provision did not require the insurer to provide a defense for its insured against a claim that the insured company's advertisements disparaged another company's products where the other company's products were neither identified nor disparaged.

The Case

Gary–Michael Dahl, who manufactured and sold the "Multi–Cart," sued Swift Distribution, Inc., dba Ultimate Support Systems, Inc., Michael Belitz, and Robin Slaton (collectively, "Ultimate"), for patent and trademark infringement, unfair competition, dilution of a famous mark, and misleading advertising arising from Ultimate's sale of its product, the "Ulti–Cart."

The complaint alleged that Mr. Dahl owned a U.S.patent to a "convertible transport cart," which he had sold as the "Multi–Cart" collapsible cart since 1997. The Multi–Cart could be manipulated into eight configurations and was used to move music, sound, and video equipment quickly and easily. The U .S. Patent and Trademark Office issued a patent to Mr. Dahl for the "Multi–Cart" mark. The Dahl complaint alleged that Ultimate impermissibly manufactured, marketed, and sold the "Ulti–Cart," which infringed patents and trademarks for Dahl's Multi–Cart and diluted Dahl's trademark. The complaint attached advertisements for the Ulti–Cart, which do not name the Multi–Cart, Dahl, or any other products other than the Ulti–Cart.

Ultimate made three demands upon its insurer, Hartford Casualty Insurance Company, to defend it in the Dahl action. Hartford refused and stated that it had no duty to defend or indemnify Ultimate. Hartford filed a complaint for declaratory relief against Ultimate seeking a declaration that it had no duty to defend or indemnify Ultimate in the Dahlaction.

The trial court granted summary judgment in favor of Hartfordand Ultimate appealed, claiming that the Dahl action alleged facts that constituted the potentially covered offense of disparagement.

The Policy

The liability insurance policy Hartford issued to Ultimate stated:

> We will pay those sums that the insured becomes legally obligated to pay as damages because of ... 'personal and advertising injury' to which this insurance applies. We will have the right and duty to defend the insured against any 'suit' seeking those damages. However, we will have no duty to defend the insured against any 'suit' seeking damages for ... 'personal and advertising injury' to which this insurance does not apply.

The policy defined "personal and advertising injury" in several ways. One definition of "personal and advertising injury" was:

> injury ... arising out of ... [o]ral, written or electronic publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services[.]

The Appellate Court's Decision

The appellate court affirmed, finding that Ultimate's advertisements did not expressly refer to Dahl's Multi–Cart and did not "disparage" Dahl's Multi–Cart product or business.

The appellate court declared that product disparagement was "an injurious falsehood directed at the organization or products, goods, or services of another." The injurious falsehood, the appellate court continued, must specifically

refer to the derogated property, business, goods, product, or services either by express mention or reference by reasonable implication. However, the appellate court continued, Mr. Dahl's complaint, application for a temporary restraining order, and responses to Ultimate's discovery did not allege that Ultimate's advertisements specifically referred to Mr. Dahl by express mention.

Ultimate argued that Mr. Dahl's complaint alleged that Ultimate's use of "Ulti–Cart," a name similar to Mr. Dahl's "Multi–Cart," referred to Mr. Dahl and Mr. Dahl's product by "reasonable implication" and that Dahl's complaint primarily alleged that because of its similarity to Dahl's "Multi–Cart," Ultimate's use of the "Ulti–Cart" name misled the public into believing that Ultimate's products were the same as Mr. Dahl's, were approved by Mr. Dahl, or were affiliated with Mr. Dahl's "Multi–Cart" products. The appellate court was not persuaded, finding that even if the use of "Ulti–Cart" could reasonably imply a reference to "Multi–Cart," Ultimate's advertisement "contained no disparagement of 'Multi–Cart'" and Ultimate's use of a product name (Ulti–Cart) that was very similar to Mr. Dahl's Multi–Cart product was "not disparagement." Because Mr. Dahl did not allege that Ultimate's publication disparaged Mr. Dahl's organization, products, goods, or services, he was precluded from recovery on a disparagement theory, and thus he alleged no claim for injurious false statement or disparagement that was potentially within the scope of the Hartford policy coverage for advertising injury.

The case is *Hartford Cas. Ins. Co. v. Swift Distribution, Inc.*, No. B234234 (Cal.App. 2 Dist. Oct. 29, 2012). Attorneys involved include Little Reid & Karzai, Eric R. Little, M. Catherine Reid and Najwa Tarzi Karzai); and Tressler (David Simantob and Elizabeth L. Musser).

Automobile Insurance

Another Court Rejects Adult Child's Efforts to Be Covered under Parent's Policy

Can an adult child who has his own apartment assert that he is covered by the uninsured motorist ("UM") provisions of his father's auto insurance policy? The issue seems to be coming up with some regularity. The most recent court to consider the matter rejected the child's arguments.

The Case

As the court explained, the plaintiff in this case was the son of Michael and Jeanie Yano. Born in 1979, the plaintiff grew up in his parents' home in Mililani on the island of Oahu. After he married, the plaintiff lived with his first wife in their own place until he was deployed to Iraq with the Army National Guard. By the time the plaintiff returned from Iraq in January 2006, he and his first wife were no longer together, and the plaintiff went back to living at his parents' home. For a few months, the plaintiff commuted from his parents' home to his job in downtown Honolulu. Then, in the spring of 2006, he began renting an apartment closer to work.

The court stated that even after he moved into his apartment, the plaintiff kept a key to his parents' home, where he "came and went freely." His bedroom at his parents' house remained intact, with his bed, stereo, clothes, sports gear, computer, and military gear. The plaintiff visited his parents on most weekends, doing laundry, helping his father with yard work, showering, spending time with his parents, sometimes eating dinner there, and occasionally sleeping there. Most of his "important mail" went to his parents' home, including his voter registration, driver's license, vehicle registration, health insurance, military, and employment information.

On September 24, 2006, the plaintiff was riding his motorcycle when a car hit him. The plaintiff filed a claim with the other driver's insurance company, but the claim was denied because the other driver's policy had lapsed. Thereafter, the plaintiff submitted a claim for UM coverage under his father's insurance policy. The insurer denied the claim, finding that the plaintiff was not a "resident relative" covered by his father's policy. The plaintiff filed suit.

The Policy

The policy listed the plaintiff's father as the named insured and gave the Mililani home as his address. The policy provided:

> Under the Uninsured Motorist coverage, we will pay damages for *bodily injury* caused by accident which the *insured* is legally entitled to recover from the owner or operator of an *uninsured motor vehicle*

or hit-and-run auto arising out of the ownership, maintenance or use of that auto.

The policy defined an "insured" as:

(a) the individual named in the declarations and his spouse if a resident of the same household;
(b) *relatives* of (a) above if residents of his household;
(c) any other person while *occupying* an *owned auto;*
(d) any person who is entitled to recover damages because of *bodily injury* sustained by an insured under (a), (b), and (c) above.

Under the policy, a "relative" included:

any *person,* other than *you,* living in *your* household who is related to you by blood, marriage, or adoption.

The Court's Decision

The court found that the plaintiff was not a resident relative entitled to UM benefits under his father's policy. In its view, what was "paramount" for resident relative purposes was a claimant's "intent to be a member of the named insured's household." Because the plaintiff had submitted no express statement of his own that, at the time of the accident, he intended to return to live with his parents, the court stated that it had to "glean from the circumstances of his life what his intent was."

The court found that the plaintiff was welcome at his parents' home, visited his parents with some frequency, came and went as he pleased, spent time with his parents, ate meals with them, did laundry at their home, and sometimes even slept there. Moreover, the court observed, the plaintiff had declined their offer that he stay at their home to recover from the injuries he sustained in the accident, preferring to stay at his own apartment.

The court also found that the plaintiff was "not just temporarily living on his own" and was not "financially dependent on his parents." It found "no evidence" that the reason the plaintiff's bedroom was unchanged at his parents' home and that he kept many belongings there was that he intended to live in his parents' house. Rather, the court concluded, the plaintiff appeared "to have used his parents' home as a convenient and cost-free storage place for his belongings, not just while renting a small apartment, but even after he himself would be forced to admit he had a separate household."

The court found that the plaintiff's receipt of mail and use of his parents' address did not signify his intent to be part of his parents' household, but rather was a "convenience that freed him from the nuisance of processing address changes while renting an apartment in anticipation of yet another address change when he had saved enough money to buy his own home."

Finally, the court rejected the plaintiff's contention that it should view him as residing simultaneously both at his parents' home and at his apartment, not as having moved out of his parents' home or as needing to show an intent to return there, finding no support in the record for that argument. The court then ruled in favor of the insurer.

The case is *Yano v. Government Employees Ins. Co.*, No. 11–00745 SOM/BMK (D. Hawaii Oct. 17, 2012). Attorneys involved include John Y. Choi, Honolulu, HI, for the plaintiff; J. Patrick Gallagher, Jennifer M. Palmer, Skyler G. Cruz, Gallagher Kane Amai, Honolulu, HI, for the defendants.

Retroactive Rescission of Auto Policy Affecting 'Innocent Third Party Victims' Barred By Connecticut Law

A health care provider sued an auto insurer to recover assigned first-party no-fault benefits assigned to it by passengers allegedly injured in a car accident. In response, the insurer moved to dismiss the complaint on the ground of lack of coverage due to its retroactive rescission of the policy. After the health care provider's motion for summary judgment was granted, the insurer appealed.

The Appellate Ruling

The appellate court, applying Connecticut law, acknowledged that Connecticut law provides for a common law right to retroactively rescind an automobile insurance policy. However, it continued, the Connecticut Supreme Court has held that Connecticut law does not permit an insurer's right of rescission to affect the rights of innocent third party victims – such as allegedly involved in this case.

Therefore, the appellate court concluded, any retroactive rescission of the policy did not affect the rights of the innocent third-party assignors, and it affirmed the lower court ruling in favor of the health care provider. [*W.H.O. Acupuncture, P.C. v. Infinity Ins. Co.*, No. 2011–1975 K C. (N.Y. App. Term 2d Dep't Oct. 16, 2012.]

Insured's Failure to Mention DUI Ticket on Application Leads to Policy's Recission – after Accident

A federal district court in Florida has upheld an insurance company's rescission of an automobile insurance policy after finding that the insured made a material misrepresentation during the application process by failing to disclose that he had received a ticket for Driving under the Influence ("DUI").

The Case

On August 29, 2008, Richard E. Cockram appeared at the State Farm office in LaBelle, Florida, and applied for automobile insurance. When asked about "accidents" and "tickets" he had received in the preceding six years, Mr. Cockram mentioned two accidents and one ticket for making an illegal turn – but he did not disclose that he had been arrested and ticketed for DUI two weeks before. State Farm issued a policy to Mr. Cockram for the policy period of August 29, 2008, to February 28, 2009.

On September 28, 2008, Mr. Cockram was in an automobile accident while driving an automobile covered by the policy. Eric Powers asserted that he suffered severe bodily injury as a result of this accident, and made a claim under the State Farm policy.

State Farm re-examined Mr. Cockram's application, discovered the DUI ticket, and determined that Mr. Cockram had made a material misrepresentation by not disclosing the DUI ticket during the application process. By a letter to Mr. Cockram dated July 29, 2009, State Farm rescinded the insurance policy and returned all monies received in connection with the application. After Mr. Powers sued Mr. Cockram for negligence, State Farm sought a determination of its obligations to defend and potentially indemnify Mr. Cockram under the policy.

The Decision

The court held:

- Cockram made a material misrepresentation to State Farm during his application process for automobile insurance by failing to disclose that he had received a DUI ticket on August 15, 2008;
- State Farm would not have issued the policy if it had known of the misrepresentation regarding the DUI ticket;
- State Farm properly rescinded the policy;
- State Farm did "not owe any duty or obligation to defend or indemnify Richard E. Cockram for any liability and damages that may be assessed or awarded against Richard E. Cockram in the negligence lawsuit filed by Eric Powers"; and
- Messrs. Cockram and Powers were estopped from pursuing a claim, defense and/or indemnity action against State Farm for damages arising from the automobile accident that occurred on September 28, 2008.

The case is *State Farm Mutual Automobile Ins. Co. v. Cockram*, No. 2:11–cv–161–FtM–29DNF (M.D.Fla. Oct. 16, 2012).

Suit against Auto Insurers Alleging Deceptive Acts May Proceed, Appellate Court Rules

A New York consumer protection law, General Business Law § 349, declares unlawful all "[d]eceptive acts or practices in the conduct of any business, trade or commerce or in the furnishing of any service in this state." A New York appellate court has affirmed a lower court decision refusing to dismiss a § 349 action alleging that a number of auto insurers deceived and misled prospective customers, causing auto repair shops a direct economic loss of more than $5 million in lost business sales.

The Case

The defendants in the case – Progressive Insurance Group Company, Progressive Northeast Insurance Company, Progressive Casualty Insurance Company, Progressive Direct Insurance Company, and Progressive Specialty Insurance Company (collectively, the "Progressive defendants") – are involved in underwriting automobile insurance policies in the State of New York. In approximately 2000, the Progressive defendants initiated a direct repair program (the "DRP") by which they contracted with numerous vehicle repair shops regarding rates and terms of repairs for claimants. The plaintiffs, North State Autobahn, Inc., and North State Autobahn, Inc., doing business as North State Custom, operated a vehicle repair shop that was not a member of the DRP.

The plaintiffs alleged that the Progressive defendants violated § 349. Specifically, the complaint alleged that the Progressive defendants engaged in practices that deceived claimants who sought to have their vehicles repaired at the plaintiffs' and other repair shops that did not participate in the DRP by making misrepresentations

as to their workmanship, price, timeliness of service, and character. The plaintiffs also alleged that the Progressive defendants issued damage repair appraisals well below fair market value at about one-half the estimate of the plaintiffs' estimate, and that the Progressive defendants represented to claimants that the defendants would make only partial payments for repairs that would necessarily require claimants who had their vehicles repaired by the plaintiffs or other independent shops to incur out-of-pocket expenses.

The plaintiffs further alleged that the Progressive defendants engaged in these deceptive practices to mislead customers of the plaintiffs and other independent shops to believe that they had to have their vehicles repaired at repair shops that were members of the DRP. The Progressive defendants allegedly failed to inform these claimants that the repair shops that participated in the DRP used inferior aftermarket parts, or were not registered or qualified to work on specific vehicle models. As a result, the plaintiffs alleged that they sustained direct economic loss in the form of more than $5 million in lost business sales, and that the public at large sustained other damages.

The Progressive defendants moved for summary judgment dismissing the § 349 cause of action, which the trial court denied, and they appealed.

The Appellate Decision

An intermediate appellate court affirmed the trial court's decision denying the Progressive defendants' summary judgment motion with respect to § 349.

As the appellate court explained, to successfully assert a § 349 claim, a plaintiff must allege that a defendant has engaged in (1) consumer-oriented conduct that is (2) materially misleading and that (3) the plaintiff suffered injury as a result of the allegedly deceptive act or practice. The appellate court then examined the Progressive defendants' arguments that the alleged conduct at issue was not consumer-oriented and that the plaintiffs failed to adequately allege that they had suffered an injury as a result of the Progressive defendants' allegedly deceptive conduct.

With respect to the first issue, the appellate court noted that the complaint alleged that (i) the Progressive defendants engaged in deceptive conduct that misled customers of the plaintiffs and other independent shops into believing that they must have their vehicles repaired at repair shops that were members of the DRP, and (ii) this conduct was part of an institutionalized program and that it constituted a standard practice that was routinely applied to all claimants who sought to have their vehicles repaired by the plaintiffs or by any other independent repair shop. The appellate court then determined that the complaint adequately alleged conduct that was consumer-oriented inasmuch as it alleged conduct that had a "broad[ ] impact on consumers at large."

Interestingly, the appellate court rejected the Progressive defendants' contention that to show that the alleged conduct had a broad impact on consumers, the plaintiffs had to identify individual consumers who were specifically harmed when they were misled into having repairs done at the DRP shops. The appellate court concluded that that was not necessary to show that the alleged conduct had a broad impact on consumers.

With respect to the second issue, the appellate court rejected the Progressive defendants' contention that the plaintiffs failed to adequately allege that they suffered direct injury as a result of the allegedly deceptive acts or practice. The appellate court noted that the plaintiffs alleged that they were directly injured by the Progressive defendants' allegedly deceptive practices in that customers were misled into taking their vehicles from the plaintiffs to competing repair shops that participated in the DRP. "The allegedly deceptive conduct was specifically targeted at the plaintiffs and other independent shops in an effort to wrest away customers through false and misleading statements," the appellate court declared. It explained that the plaintiffs' alleged injury "did not require a subsequent consumer transaction" but was sustained when customers "were unfairly induced into taking their vehicles from the plaintiffs' shop to a DRP shop regardless of whether the customers ultimately ever suffered pecuniary injury as a result of the Progressive defendants' deception." The appellate court then held that the allegation that the Progressive defendants' deceptive practices diverted the plaintiffs' customers to competing businesses resulting in over $5 million in lost business sales constituted an allegation of a direct injury sufficient to confer standing upon the plaintiffs under § 349.

The case is *North State Autobahn, Inc. v. Progressive Ins. Group Co.*, --- N.Y.S.2d ---- (N.Y. App. Div. 2d Dep't 2012). Attorneys involved include Nelson Levine de Luca & Horst, LLC, New York, N.Y. (Michael R. Nelson, Kymberly Kochis, and Francis X. Nolan IV of counsel); Richard Paul Stone, New York, N.Y. (Anderson, Kill & Olick, P.C. [Finley T. Harckham and Dennis J. Artese of counsel], and Anthony J. Mamo, Jr., PLLC, of counsel).

FC&S Legal Comment

New York General Business Law § 349 is a powerful consumer protection law, and the appellate court ruling in *North State Autobahn* is a very significant decision for auto insurers and insureds. *FC&S Legal* will continue to monitor the case and report on developments as they arise.

Woman in Car Accident Added Collision Coverage While in Ambulance, State Says

A Philadelphia woman has been arrested on allegations that immediately following a car accident she called her insurance company, while in an ambulance, to add comprehensive collision coverage to her insurance policy.

According to the criminal complaint, in October 2011, Regina Whitehead, who did not have comprehensive or collision insurance for her vehicle, was involved in a four vehicle accident.

The charges allege that in an ambulance on the way to the hospital, Ms. Whitehead called her insurance company to add comprehensive, collision, and rental coverage to her auto policy for the vehicle that had just been involved in the accident.

Pennsylvania Attorney General Linda Kelly said that following the accident, Ms. Whitehead allegedly reported a claim to her insurance company in an attempt to have damages to her vehicle paid and lied to the company about when the accident occurred, saying that it happened after she had obtained the additional coverage to her policy.

Ms. Whitehead is charged with one count of insurance fraud and one count of criminal attempt to commit theft by deception.

Commercial Auto

Is Lessor of Motor Vehicle Equipment Covered by MCS-90 Endorsement?

When is a policyholder a "motor carrier" for purposes of triggering the MCS–90 endorsement? A recent decision by the U.S. Court of Appeals for the Tenth Circuit examined that issue.

The Case

The case involved Espenschied Transport, a freight trucking company established in 1982 as an interstate trucking distribution company providing transport and sorting services. In January 2005, Espenschied executed an Asset Purchase/Lease Agreement and an Equipment Lease Agreement, agreeing to lease its fleet of trailers to DATS Trucking, Inc. ("DATS"), a commercial freight trucking company. On January 30, 2005, a dual-wheel assembly came off the axle of an Espenschied trailer that was leased by DATS and attached to a tractor owned and operated by DATS, killing motorist Kimball Herrod. At the time of the accident, Espenschied was insured by Wilshire Insurance Company under a commercial auto liability policy that contained an MCS–90 endorsement. Wilshire disclaimed coverage.

The Herrods brought suit in Utah state court, alleging negligence and other claims, against Espenschied, DATS, and other parties. The Herrods ultimately settled their claims against Espenschied and DATS. As part of the settlement, Espenschied executed a confession of judgment in the amount of $1,292,499.99 that was filed in Utah state court, and judgment was entered against it. The Herrods presented the judgment to Wilshire and demanded payment, but Wilshire refused.

The Herrods then sued Wilshire seeking judgment against it in for the policy limit. The district court held that Wilshire's MCS–90 obligation was triggered because Espenschied was a "motor carrier" for purposes of the MCS–90 endorsement and the confessed judgment against Espenschied constituted a negligence judgment. Wilshire appealed, contending that the district court had erred in concluding that Espenschied was a "motor carrier" for purposes of triggering its MCS–90 endorsement.

The Decision

As the circuit court explained, the financial responsibility requirements of the federal Motor Carrier Act of 1980 ("MCA") apply to "motor carriers," defined as "a person providing motor vehicle transportation for compensation." Federal regulations promulgated pursuant to the MCA and accompanying the MCS–90 endorsement define "motor carrier" as a "for-hire motor carrier or a private motor carrier." In turn, "for-hire carriage" is defined as "the business of transporting, for compensation, the goods or property of another." Finally, the circuit court added, regulations established that the minimum financial responsibility requirements of the MCA apply to "for-hire motor carriers operating motor

vehicles transporting property in interstate or foreign commerce" and for-hire motor carriers transporting hazardous materials.

The Tenth Circuit observed that the district court had decided that Wilshire's MCS–90 obligation was triggered because Espenschied was a registered motor carrier; it owned the trailer and was responsible for its maintenance; the Herrods sued Espenschied for its negligent maintenance of the trailer; and the MCS–90 endorsement required payment for injury "resulting from negligent operation, maintenance, or use of motor vehicles."

However, the Tenth Circuit found, the financial responsibility requirements of the MCA—including the MCS–90 endorsement—applied only to for-hire motor carriers. Accordingly, it continued, to determine whether Wilshire's MCS–90 endorsement applied, it had to be determined initially whether Espenschied was operating as a for-hire motor carrier at the time of the accident. The circuit court then declared that it did not appear that the district court had made such a determination – the fact that the district court ruled that Espenschied was a "registered motor carrier" did not answer the question whether Espenschied was operating as a for-hire motor carrier at the time of the accident.

Accordingly, the circuit court remanded the case for further proceedings.

The case is *Herrod v. Wilshire Ins. Co.*, No. 11–4029 (10th Cir. Oct. 11, 2012). Attorneys involved include L. Rich Humpherys, Kelly H. Macfarlane, Karra J. Porter, Christensen & Jensen, P.C., Salt Lake City, UT; Nelson T. Abbott, Abbott & Associates, P.C., Provo, UT; Robert D. Moseley, Jr., Smith Moore Leatherwood LLP, Greenville, SC; Terry Plant, Jeremy M. Seeley, Plant, Christensen & Kanell, Salt Lake City, UT.

FC&S Legal Comment

The circuit court did not resolve whether Espenschied was entitled to coverage under the MCS–90 endorsement. For that to happen, the district court will have to find that it was in the "business of transporting, *for compensation,* the goods or property of another." That is, it the district court will have to determine what factual predicate of "compensation" was necessary to qualify Espenschied as a for-hire motor carrier. When the district court issues its decision on remand, we will know whether a lessor of motor vehicle equipment acts as a for-hire motor carrier, within the meaning of the MCA and the pertinent regulations, for purposes of triggering an MCS–90 endorsement.

Life Insurance

Kansas Bars Mandated Life Insurance in Divorce

Suppose a divorce court orders an ex-husband to "cooperate" with his ex-wife's attempts to obtain life insurance on his life, at her own expense, and he objects. Is that permitted?

Not in Kansas.

The Case

The dispute arose in the divorce proceeding between Marc and Susan Hall. She asked the court to order him to "cooperate" with her to obtain insurance on his life at her expense. She specified that she wanted the life insurance as security for the payment of any maintenance or child support the court would order him to pay. She clarified that she was not asking him to pay for the life insurance. He objected to her request, arguing that the court lacked jurisdiction to enter the order.

In divorce decree, the divorce court ordered Mr. Hall to pay maintenance and child support. In addition, despite his objection, the court ordered him to "cooperate" with his ex-wife's attempts to obtain insurance on his life at her own expense. The court ruled:

> K.S.A. 60–1610[(a)(1)] states that the court shall make provisions for the support and education of the minor children. The Court finds that a major portion of the current support and education of the minor child is coming from Mr. Hall. That if the child were to lose that financial assistance, it would seriously affect his support and education. Since mother is willing to pay for the cost of life insurance, Court will order that Mr. Hall cooperate in Mrs. Hall's purchase of the life insurance policy to ensure support and education in case he were to pass away. I will grant that request.

An intermediate appellate court affirmed, finding that the lower court's order did not violate public policy. In reaching this holding, the appellate court concluded that the only requirement in Kansas was an "insurable interest" between the party taking out the insurance policy and the party whose life was insured. The appellate

court held that Ms. Hall clearly had an insurable interest in Mr. Hall's life as long as she was entitled to receive maintenance and child support payments. The dispute reached the Kansas Supreme Court.

The Kansas Supreme Court Decision

In its decision, the court noted that Kansas statutory law regarding insurable interest provides:

> Determination of the existence and extent of the insurable interest under any life insurance policy shall be made at the time the contract of insurance becomes effective but need not exist at the time the loss occurs. In the case of life insurance policies issued or renewed for a specific term, an insurable interest shall not exist for any policy term with respect to any person previously insured by the policy who has, in writing, requested the insurer to terminate or nonrenew the insurance applicable to such person's life.

In the court's opinion, under the "plain language" of the statute, if Ms. Hall obtained a life insurance policy on Mr. Hall's life and he then requested, in writing, that the insurer terminate or nonrenew the insurance, she would not have an insurable interest. The court acknowledged that that was "not exactly" the situation in this case because the divorce court ordered Mr. Hall to cooperate in obtaining the insurance.

However, it continued, the lower court's order suffered from two problems. First, it stated, there was the public policy that a life insurance policy could not continue without the insured's consent. Second, it added, although life insurance could possibly be obtained, the order to "cooperate" would be futile because of Mr. Hall's statutory right. By giving Mr. Hall (or others) the right to cancel a policy, the court found that the legislature, in essence, "has required ongoing consent."

The court therefore concluded that in Kansas it would be against public policy to prohibit an insured from expressing his or her objection to a life insurance policy on the insured's life. It thus held that a court order requiring a child support obligor to cooperate with a child support obligee's efforts to obtain insurance on the life of an obligor was against public policy if the obligor objected to the order. Because Mr. Hall objected to the order, the divorce court's order in this case was contrary to public policy and an abuse of its discretion.

The case is *Matter of Marriage of Hall*, No. 101,834 (Kansas Oct. 5, 2012). Attorneys involved include Ronald W. Nelson, Ronald W. Nelson, PA.

FC&S Legal Comment

Generally, courts in other jurisdictions have similarly held that a court cannot issue an order requiring insurance to secure payment of child support if the person whose life is insured does not consent.

For example, in *Davis v. Davis*, 275 Neb. 944, 750 N.W.2d 696 (2008), appellant filed a post-dissolution motion requesting an order directing her ex-husband to submit to a physical examination so that she could obtain, at her own expense, a policy on his life, naming her as beneficiary, as security for his alimony and child support obligations. The Nebraska Supreme Court assumed that appellant had an insurable interest. But because Neb. Rev.Stat. § 44–704 (2004) specifically required an adult insured to consent to an insurance policy on his or her life unless the individual or the individual's spouse was the owner of the policy, the Nebraska Supreme Court ruled that, regardless of an insurable interest, the appellant did not have a right to "own" a policy on her ex-husband's life without his consent.

Similarly, in *Hopkins v. Hopkins*, 328 Md. 263, 614 A.2d 96 (1992), after the appellant was granted a divorce and awarded alimony payments, she filed in the district court a motion to compel her ex-husband to cooperate with her request for insurance on his life. The appellant maintained that she would pay the premiums and all other costs of the policy; all that was required of the ex-husband was a physical examination. The court ruled that the appellant had an insurable interest in her ex-husband's life as long as he owed her alimony. Even so, because Md. Insurance Code, Art. 48A, § 371 (1991) required written consent of the insured, the Maryland court ruled that "[a] court order requiring the proposed insured to cooperate with the efforts of a party with an insurable interest to obtain a policy of insurance on his life cannot effect the consent contemplated by § 371." The court looked to other jurisdictions with similar statutes and noted that the cases in those jurisdictions made it clear that it was against the public policy of the state to permit an individual to insure the life of another without that person's knowledge or consent. See *PHL Variable Ins. Co. v. Price Dawe* 2006 Ins. Trust, 28 A.3d 1059, 1076 (Del.2011) (Delaware statute prohibits policies issued without the consent of the insured except in narrow situations); *Lowe v. Rennert*, 869 S.W.2d 199, 203 (Mo.App.1993) (Missouri statute expressly requires consent except as to children); *Meerwarth v. Meerwarth*, 128 N.J.Super. 285, 289, 319 A.2d 779 (1974) (denying, as a violation of his right to privacy, ex-wife's motion for ex-husband to submit to

physical examination so she could secure life insurance on husband's life as security for alimony); cf. *Cook v. Bankers Life and Cas. Co.*, 329 N.C. 488, 493, 406 S.E.2d 848 (1991) (Although generally the consent of the insured was required even if a person had an insurable interest, the North Carolina statute "allows a married person to insure the life of his or her spouse and it does not provide that such a person must have the consent of the spouse to do so. We do not believe we should add this requirement to the statute.").

Insurers' Failure to Prove Insured Received Cancellation Notice Dooms Their Summary Judgment Motion

The proof needed for a life insurance company to demonstrate that it has effectively canceled a policy was the focus of the New York appellate court decision in *Nocella v. Fort Dearborn Life Ins. Co. of New York*, --- N.Y.S.2d ---- (N.Y.App. Div. 2d Dep't Oct. 17, 2012).

The Case

Bankers American Life Assurance Company and Union Security Life Insurance Company of New York contended that a life insurance policy that had been issued to plaintiff Brian Nocella and his wife by Bankers American had been cancelled in 2000 –prior to the death of the plaintiff's wife in 2006. After the dispute went to court, the trial court granted summary judgment to the insurers. The plaintiff appealed, and the appellate court reversed.

The Appellate Decision

As the appellate court explained, because the insurers relied on the alleged cancellation of the policy as their basis for summary judgment, they had the burden of proving as a matter of law that the policy was canceled prior to the date of the death of the plaintiff's wife. Thus, the insurers were required to prove that the cancellation notice that allegedly was mailed to the plaintiff and his wife was received by them.

In support of their motion for summary judgment, the insurers submitted an affidavit from Susan Budelis in which she asserted that her employer, Minnesota Life, handled the mailing of the cancellation notices on behalf of Bankers American. In addition, Ms. Budelis detailed the standard office practice and procedure that Minnesota Life used to ensure that items were properly addressed and mailed.

The appellate court was not satisfied by those statements. It reasoned that Ms. Budelis failed to state, based on personal knowledge, that such practice and procedure was in place and used at the time Minnesota Life allegedly mailed, to the plaintiff and his wife, the subject cancellation notice or an alleged notice that the policy issued by Bankers American was to be replaced with a policy issued by Northstar Life Insurance Company. Rather, the appellate court continued, in a "carefully worded affidavit," Ms. Budelis stated, "in a vague and conclusory fashion," that "Minnesota Life has utilized the above-described process innumerable times over the years," and that "I have confirmed that these procedures were followed to send the Notice to the Insured Emigrant Customers, including [the plaintiff's wife,] Kathleen Nocella, on April 11, 2000."

However, the appellate court emphasized, "[c]onspicuously absent" from Ms. Budelis' affidavit was any indication that she worked at Minnesota Life at the time of the subject mailing. Moreover, it added, an electronic data entry allegedly recording the receipt of correspondence from the plaintiff's wife regarding a correction to her birth date made "no particular reference to any replacement policy issued by Northstar." Thus, the appellate court found, it could not conclude that the plaintiff or his wife received the notice of cancellation of the Bankers American policy or a certificate of insurance referable to the purported replacement policy issued by Northstar.

Attorneys involved in this case include Kingsley Kingsley & Calkins, Hicksville, N.Y. (Kevin T. Murtagh and Harold M. Kingsley of counsel); Lavin, O'Neil, Ricci, Cedrone & DiSipio, New York, N.Y. (Francis F. Quinn of counsel).

AIG to Pay $300 Million to Resolve Dispute over Unclaimed Life Insurance Benefits

The American International Group has agreed to pay about $300 million to settle a dispute over unclaimed life insurance benefits. The money will be distributed to representatives of 39 states and the District of Columbia. California, for example, will receive between $25 million to $30 million.

AIG also has reached a second multistate agreement relating to the handling of unclaimed property and the use of the Social Security Administration's Death Master File (SSDMF) to identify death claims that have not been submitted to the company in the normal course of business.

First, AIG will pay an $11 million regulatory assessment to various state insurance departments to defray costs of the examination and monitoring. In addition to reserving for

the regulatory assessment, AIG will increase its estimated reserves for policy holder benefit reserve death claims relating to these audits by $55 million in the third quarter for interest and expected acceleration of benefit payments under the settlement, including early payment of policy proceeds under certain older industrial life policies.

In addition, AIG says that it will now take enhanced measures to, among other things, routinely match policyholder records with the SSDMF to determine if its insureds, annuitants, or retained account holders have died and locate beneficiaries when a claim is payable.

Bad Faith

Insured with $1 Million Judgment against Insurer Barred from Bringing Bad Faith Action

Can an insured wait until winning a judgment against his or her insurer to assert a bad faith claim? The U.S. Court of Appeals for the Third Circuit recently found a bad faith claim in these circumstances to have been filed too late.

The Case

The case began on October 1, 1999, when, in the course of his employment, Edward L. Reid, Jr., was involved in a serious automobile accident with a vehicle driven by a third party. Mr. Reid's employer had "Business Auto" coverage that included $1,000,000 of underinsured motorists ("UIM") coverage.

Following a dispute over assignment of subrogation rights, the parties engaged in seven years of litigation in the New Jersey courts regarding the insurer's UIM liability. Mr. Reid ultimately succeeded in his action and obtained a judgment totaling $1,036,650.56, which included $186,650.56 in prejudgment interest. Two years later, he sued the insurer again, this time alleging bad faith failure to negotiate a settlement, bad faith denial of UIM benefits, and bad faith continuation of vexatious litigation.

The trial court granted the insurer's motion for summary judgment and Mr. Reid appealed, arguing that his bad faith claim had not accrued until the arbitration panel had issued a binding award in his favor.

The Circuit Court Ruling

The Third Circuit was not persuaded by Mr. Reid's argument that until the UIM arbitration panel found the insurer liable, he could not have asserted his bad faith claim because "a bad faith claim is contingent upon the success of the underlying claim for breach of the insurance contract." It declared that although Mr. Reid was "correct that the *success* of a bad faith claim may depend upon the success of the underlying litigation, the *assertion* of a bad faith claim does not."

It then concluded that where, as in this case, a plaintiff's bad faith claim was based on first-party UIM litigation, it was more efficient to require the plaintiff to raise the bad faith claim in the same lawsuit in which the plaintiff sought insurance benefits.

The case is *Reid v. Transportation Ins. Co.*, No. 11–4297 (3d Cir. Oct. 19, 2012). Attorneys involved include Mitchell L. Goldfield, Esq., Gibbsboro, NJ; Margaret F. Catalano, Esq., April T. Villaverde, Esq., Carroll, Mcnulty & Kull, Basking Ridge, NJ.

Circuit Rejects Excess Insurer's Bad Faith Claim against Primary Carrier

Kentucky law imposes a three part test for bad faith claims against insurance carriers: (1) the insurer must be obligated to pay the claim under the terms of the policy; (2) the insurer must lack a reasonable basis in law or fact for denying the claim; and (3) it must be shown that the insurer either knew there was no reasonable basis for denying the claim or acted with reckless disregard for whether such a basis existed.

In *National Surety Corp. v. Hartford Casualty Ins. Co.*, No. 11–5965 (6th Cir. Oct. 9, 2012), the U.S. Court of Appeals for the Sixth Circuit applied that standard to a primary insurer's bad faith claim against an excess insurer, upholding a district court decision that the primary insurer had not demonstrated the excess insurer's bad faith.

The Case

The case arose when Tommy Cook was injured while operating a weed trimmer fitted with a trimmer head made by Sufix, Inc. Mr. Cook filed suit against Sufix, and its primary liability carrier, Hartford Casualty Insurance Company, hired an attorney to defend Sufix. During settlement negotiations, Mr. Cook offered to settle his claim for $1 million – the amount of Hartford's policy

limit. Hartford refused, and Mr. Cook's case proceeded to trial.

After pretrial negotiation and mediation with Mr. Cook failed less than a month before trial, Hartford sent an "excess letter" to Sufix, notifying it that a judgment at trial may exceed Hartford's primary policy coverage limits. Sufix's excess liability policy with National Surety Corporation included a provision requiring Sufix to alert National when claims or suits are filed, or when it learned of any occurrence that could precipitate a claim. Despite its knowledge of Cook's pending suit, Sufix failed to notify National; National instead learned of Cook's claim (through a third party) just weeks before the trial date.

The jury returned a verdict against Sufix for $5,783,816.09, comprised of $43,988.81 for past medical expenses, $250,000 for future medical expenses, $463,742 for past and future lost earnings, $2,051,000 for pain and suffering, and $2,975,084.28 in punitive damages. Hartford paid its policy limit – $1 million – and National satisfied the remaining $4.78 million, apparently without raising any defenses it might have against Sufix under the notice provision of the excess policy.

National sued Hartford, contending that Hartford acted in bad faith toward Sufix by exposing "Sufix to an unreasonable risk of an excess verdict." In support, National cited evidence that Hartford:

(1) failed to consider information in its own files;
(2) failed to conduct a diligent investigation into Mr. Cook's claim;
(3) failed to properly respond to Mr. Cook's $1 million demand during settlement negotiations;
(4) failed to timely notify Sufix that a verdict may exceed Sufix's primary policy limits;
(5) relied too heavily on defense counsel;
(6) failed to account for the possibility of a punitive damage award; and
(7) made only "lowball" offers during settlement talks with Mr. Cook.

The district court denied National's bad faith claim, finding that National failed to "present any evidence that Hartford ... engaged in a 'conscious doing of wrong.'" National appealed.

The Appellate Ruling

In its decision, the Sixth Circuit explained that to succeed on its bad faith claim, National had to show that Hartford "either knew there was no reasonable basis for denying the claim or acted with reckless disregard for whether such a basis existed." At most, it ruled, the evidence cited was, at best, evidence of "mere negligence .... [i]nadvertance, sloppiness, or tardiness."

First, the circuit court ruled, National pointed to no evidence that Hartford "lowballed" Mr. Cook because of evil motives or an indifference to Sufix. In hindsight, it acknowledged, settling Mr. Cook's case for less than 20 percent of the final judgment would have been a good decision. It found, however, that National failed to provide evidence that an "evil design" or an indifference to Sufix's rights motivated Hartford's failure to settle for Sufix's policy limits during initial settlement negotiations.

The circuit court also found that National provided no evidence that "evil motives" or "indifference" to Sufix's rights caused Hartford's delay in notifying Sufix. In any event, as the circuit court observed, Sufix – not Hartford – had a contractual duty to notify National of the possibility of an excess verdict.

Finally, the circuit court also rejected National's contention that public policy required that Hartford be held liable for failing to effect a prompt, fair, and equitable settlement of Sufix's claim, given the absence of evidence that Hartford acted maliciously or with reckless indifference toward Sufix.

FC&S Legal Comment

There was evidence that persuaded the Kentucky appeals court to uphold the punitive damages award in this case. But under Kentucky law, insurer bad faith requires more than a punitive damages award or gross negligence on which it is based. National's failure to demonstrate that Hartford's actions constituted "outrageous conduct" that was driven by "evil motives or an indifference" to the insured's rights doomed its case.

Another Court Finds No Private Action under Connecticut's Unfair Insurance Practices Act

Does a private cause of action exist under the Connecticut Unfair Insurance Practices Act ("CUIPA")? Another court has decided that it does not.

The Case

In this case, PHL Variable Insurance Company sued the Bank of Utah, which asserted four counterclaims, including for violation of the CUIPA.

The bank alleged that PHL:

> as part of its general claims handling practices, has: (i) made misrepresentations regarding the facts relating to coverage under the Policy and other policies, including claiming that there were issues regarding the application for insurance and the existence of an insurable interest, where it knew

there were no such issues; (ii) failed to act with reasonable promptness upon communications regarding the Policy and other policies; (iii) failed to adopt and implement reasonable standards for the prompt investigation of claims brought under the Policy and other policies; (iv) refused to pay unquestionably valid claims without conducting a reasonable investigation and despite available information establishing the validity of such claims; (v) failed to affirm or deny coverage of claims within a reasonable time; and (vi) failed to promptly provide a reasonable explanation of the basis for denial of a claim.

The Decision

The court explained that CUIPA claims are handled by the Connecticut Insurance Department, and that the law gives the Commissioner of Insurance broad discretion to investigate potential unfair practices and to enforce its provisions. In the court's view, the legislature intended for the Commissioner to regulate under CUIPA as opposed to allowing private citizens to sue insurance companies directly. Therefore, it concluded, the bank did not have a cognizable stand alone claim under CUIPA.

The case is *PHL Variable Ins. Co. v. Bank of Uta*h, No. 12–1256 ADM/JJK (D. Minn. Oct. 10, 2012). Attorneys involved include Shannon A. Lang, Jarrett E. Ganer, and Thomas F.A. Hetherington, Edison McDowell & Hetherington LLP, Houston, Texas; Adam A. Gillette, and Douglas L. Elsass, Fruth Jamison & Elsass PA, Minneapolis, MN; Stephen G. Foresta, Khai Lequang, Melanie D. Phillips, and Philipp Smaylovsky, Orrick, Herrington & Sutcliffe LLP, New York, N.Y. and Los Angeles, CA; Tim P. Griffin, Leonard Street and Deinard, PA, Minneapolis, MN.

FC&S Legal Comment

Connecticut courts are divided as to whether CUIPA provides a private cause of action, *see W. World Ins. Co. v. Architectural Builders of Westport, LLC,* 520 F.Supp.2d 408, 411 (D.Conn.2007), although the majority have found that there is no private right of action. The U.S. Court of Appeals for the Second Circuit has reached the same conclusion. *See Lander v. Hartford Life & Annuity Ins. Co.,* 251 F.3d 101, 118 (2d Cir. 2001). To date, however, the Connecticut Supreme Court has not directly decided this issue.

Professional Liability Insurance

Professional Liability Insurer Must Defend Civil Conspiracy Claim

A complaint alleged that a certified public accounting and consulting firm and one of its shareholders had "conspired" to commit malicious prosecution, extortion, and abuse of process. The defendants' professional liability insurer argued that conspiracy, as an intentional tort, was not covered by the policy. A federal district court in Florida has rejected the insurer's argument.

The Ruling

The court explained that the tort of civil conspiracy consisted of the following:

(1) an agreement between two or more parties;
(2) to perform an unlawful act or to perform a lawful act by unlawful means;
(3) the doing of some overt act in pursuance of the conspiracy; and
(4) damage to plaintiff as a result of the acts done under the conspiracy.

The court continued by noting that an underlying tort had to exist before a cause of action for civil conspiracy existed.

It then found that because malicious prosecution fell within the coverage of the policy under the facts as alleged in this case, there also was coverage for the conspiracy to commit malicious prosecution. Accordingly, the court held that the insurer owed a duty to defend the insureds on the claim of conspiracy. It concluded by noting that the duty to indemnify could not be resolved until the underlying case was concluded on the facts as developed at trial or otherwise. [*Philadelphia Indem. Ins. Co. v. Hamic*, No. 8:12–cv–829–T–26EAJ (M.D. Fla. Oct. 18, 2012).]

FC&S Legal Comment

The court was not concerned about affording coverage for an intentional tort, explaining that a "professional liability policy covers errors and omissions and the one in this case does not contain an intentional acts exclusion

and provides coverage for some intentional torts though not specifically malicious prosecution or conspiracies." Different policy language leads, once again, to different results.

Excess Carrier May Assert Malpractice Claim against Insured's Attorneys, Mississippi Supreme Court Holds

After the estate of a former resident sued a nursing home for negligent care, the nursing home's primary insurance carrier employed lawyers to defend the suit. Because the lawyers allegedly failed to timely designate an expert witness, the settlement value of the case greatly increased, causing the nursing home's primary carrier to pay its policy limits and its excess insurance carrier to step in, defend the nursing home, and ultimately settle the suit. The excess carrier sued the law firm for professional negligence. The trial court, finding the excess carrier and the lawyers had no direct attorney-client relationship, granted the law firm's motion to dismiss.

The Mississippi Supreme Court's Ruling

The Mississippi Supreme Court rejected that decision, holding that, under the facts as alleged in the complaint, no attorney-client relationship was necessary for the excess insurer to assert a claim of legal malpractice, that the doctrine of equitable subrogation applied, and that the excess carrier could, to the extent of its losses, pursue a claim against the lawyers to the same extent as the insured.

A dissenting justice warned that the "practical effect" of the decision would be to "impose a duty of care toward the excess insurer as well," noting that this had "serious implications for defense counsel's duties of loyalty and confidentiality." The dissenting justice also declared that the ruling would "encourage[] attempts by excess insurers to shift losses to the insured's defense counsel."

The rest of the court was not persuaded, simply declaring that it was not expanding or change the duty owed by counsel to the client. It stated:

> We hold only that, when lawyers breach the duty they owe to their clients, excess insurance carriers, who – on behalf of the clients – pay the damage, may pursue the same claim the client could have pursued.

It should be noted that the court refused to authorize the excess insurer to pursue direct claims of legal malpractice against the insured's lawyers.

The case is *Great American E & S Ins. Co. v. Quintairos, Prieto, Wood & Boyer, P.A.*, No. 2009–CT–01063–SCT (Miss. Oct. 18, 2012). Attorneys involved include Christopher Thomas Graham, Michael A. Heilman, John William Nisbett, David A. Barfield, Steven Lloyd Lacey, and Richard D. Gamblin.

FC&S Legal Comment

The full implications of the ruling remain to be seen, of course. But it is interesting to note that a majority of the courts that have considered the issue have rejected the course taken by the Mississippi Supreme Court. *See, e.g., St. Paul Surplus Lines Inc. v. Remley*, 2009 WL 2070779, *5 (E.D.Mo. July 13, 2009); *State Farm Fire and Cas. Co. v. Weiss*, 194 P.3d 1063 (Colo.Ct.App.2008); *Querrey & Harrow, Ltd. v. Transcont. Ins. Co.*, 861 N.E.2d 719, 723–24 (Ind.Ct.App.2007); *Swiss Reinsurance Am. Corp. v. Roetzel & Andress*, 837 N.E.2d 1215, 1224 (Ohio Ct.App.2005); *Capitol Indem. Corp. v. Fleming*, 58 P.3d 965, 969 (Ariz.Ct.App.2002); *Am. Cont'l Ins. Co. v. Weber & Rose, P.S.C.*, 997 S.W.2d 12, 14 (Ky. Ct.App.1999); *Nat'l Union Fire Ins. Co. v. Salter*, 717 So.2d 141, 143 (Fl.1998); *Fireman's Fund Ins. Co. v. McDonald, Hecht & Solberg*, 36 Ca. Rptr.2d 424, 425 (Cal.Ct.App.1994); *St. Paul Ins. Co. of Bellaire, Texas v. AFIA Worldwide Ins. Co.*, 937 F.2d 274, 279 (5th Cir.1991).

Focus On . . .

By Steven A. Meyerowitz

Can a Crime Insurance Policy's Definition of 'Robbery' Be Ambiguous?

One might think that an ambiguous definition of "robbery" would be unlikely in a crime insurance policy. In a recent insurance coverage dispute, however, the U.S. Court of Appeals for the Second Circuit was faced with that very question.

The Case

VAM Check Cashing Corp., which operated check cashing stores in the New York City area, including Pine Check Cashing in Brooklyn, purchased a crime insurance policy from Federal Insurance Company. During the pendency of the policy, a group of criminals successfully tricked a Pine Check Cashing employee into turning over $120,000 in cash to them. The employee said that:

- she received a phone call from a woman claiming to be the wife of VAM's owner who told her that her husband was opening three new check cashing stores, including one in Manhattan that very day;
- she received a second call from another woman who identified herself as the manager of the newly opened Manhattan store, who said that she needed cash to pay a tax bill and that a man named Windfrey would come to Pine to collect $120,000, and that she would be able to identify him by his use of a code number; and
- a man who identified himself as Windfrey came into the store, offered the pre-arranged code number, took the $120,000 in cash, and left.

The employee said that she "never felt threatened by Mr. Windfrey" and at the time "did not believe he was dangerous or a thief."

Over the course of the afternoon, the employee did not hear anything further from the owner, gradually grew suspicious, and eventually called the police that evening. The police never caught the perpetrators or recovered the money; they advised VAM that the scheme was the work of a sophisticated group of criminals that had perpetrated similar scams across the country.

After the loss, VAM made a claim under the policy, asserting that the crime was covered under the policy's definition of "robbery." Federal denied the claim and VAM sued. The district court granted summary judgment to VAM, and Federal appealed.

The Policy

The policy's "Robbery" clause stated that:

> [Federal] shall be liable for direct losses: ... Within the Premises of Money and other property received from sources other than the sale of Food Stamps but only when such loss is caused by: ... (2) Robbery or attempt thereat.

The policy defined the term:

> "Robbery" means the unlawful taking of insured property from an Insured, a partner, an Employee or any other person authorized by the Insured to have custody of the property by violence, threat of violence or other overt felonious act committed in the presence and cognizance of such person, except any person acting as a watchman, porter or janitor.

The Circuit Court's Decision

In its decision, the circuit court explained that the issue came down to whether the unlawful taking by Windfrey and his associates was an "[1] overt felonious act [2] committed in the presence and cognizance of" VAM's employee.

Federal contended that "overt felonious act" had to be read as a whole. It argued, in effect, that the adjective "overt" should be read to modify the entire phrase "felonious act," such that it covered only a "felonious act" whose felonious character was "overt." On that reading, although Windfrey's taking of the money was a "felonious act," and was "overt" in the sense that it was visible to the employee, it was not an "overt felonious act" because its felonious nature was not "overt," but covert. That is, while the employee knew that she was giving money to Windfrey and observed his taking it, she did not recognize that she was handing the money over to a criminal because the scheme proceeded by trickery.

VAM countered that Federal's interpretation might prevail if the policy read "overtlyfelonious act," in which case the adverb "overtly" would clearly modify the adjective "felonious." But since the policy used two consecutive adjectives, VAM contended, both "overt"

and "felonious" each separately modified the noun "act." Thus, coverage was proper if Windfrey committed an "act" that was both "overt" and "felonious." Here, VAM argued, Windfrey's act was clearly "felonious," since it amounted to larceny by trick. And it was also "overt," since the act of taking the money was "open," "manifest," and "public," even though its true criminal nature was hidden.

The Second Circuit declared that it could not say that either of these two readings was definitive. It noted that English usage was sufficiently flexible to admit Federal's use of an adjective to modify a noun phrase, "even if more careful writers would use an adverb to express the intended meaning." The circuit court then added that VAM's reading was "grammatically more natural," since it did "not require an adjectival word to be read adverbially."

Thus, the Second Circuit held, the meaning of the phrase "overt felonious act" was ambiguous standing alone, and it turned to whether it could be clarified by the second contested phrase, "committed in the presence and cognizance of such person," or by the remaining textual context.

The circuit court observed that the parties agreed that the taking had occurred "in the presence of" the employee, but disagreed on whether it had occurred in her "cognizance." Federal argued that "cognizance" should be "equated with awareness of the criminal nature of the underlying act." On this view, to meet the policy's definition, the employee had to recognize the act "as both overt and felonious." VAM agreed that "cognizance" meant "awareness," but disagreed about the object of that awareness. According to VAM, the employee need only be aware of the act, rather than its felonious character.

In the Second Circuit's view, the key disagreement between the parties about the meaning of the second phrase – "committed in the presence and cognizance of such person" – essentially was identical to their disagreement about the meaning of the first phrase – "overt felonious act": Federal contended that the first phrase meant that the act's criminal character must be possible to observe, and that the second phrase meant the act's criminal character must be actually noticed. VAM argued that the first phrase meant the act must be observable, and that the second phrase meant the act must be in fact observed.

According to the Second Circuit, because the plain text of the policy did not resolve the case, VAM had to prevail if it had provided a reasonable reading permitting recovery. The circuit court decided that it had, and upheld VAM's overall reading of the policy: the insured will recover for "robbery" whenever property is taken from an employee by means of an observable act that amounts to a felony, provided that the act occurs in the presence of the employee and the employee is aware of the act's occurrence, but the employee need not be aware that the act itself is felonious.

The case is *VAM Check Cashing Corp. v. Federal Ins. Co.*, No. 11–2644–cv (2d Cir. Nov. 7, 2012). Attorneys involved include Paul S. Hugel, Clayman & Rosenberg LLP, New York, NY; Arthur N. Lambert (M. Diane Duszak, on the brief), Frenkel Lambert Weiss Weisman & Gordon LLP, New York, NY.

FC&S Legal Comment

The policy's definition of robbery was clearly broader than the definition of robbery under the most common criminal law definitions, which generally limit the crime to larcenies committed by force or threat of force. See, e.g., 3 Wayne R. LaFave, Substantive Criminal Law § 20.3 (2d ed.2003) (common law robbery requires force or threat thereof); Model Penal Code § 222.1 (in addition to theft, robbery conviction requires either actual or threatened infliction of serious bodily injury on another, or actual or threatened commission of another serious felony); 18 U.S.C. § 1951 (under the federal Hobbs Act, "'robbery' means the unlawful taking or obtaining of personal property from the person or in the presence of another, against his will, by means of actual or threatened force, or violence, or fear of injury"). Of course, although the scam accomplished by Windfrey and his group was not a robbery under these definitions, that was not relevant to the interpretation of VAM's insurance policy.

Industry News

By Victoria Prussen Spears

People

American Council of Life Insurers Elects 2013 Board Of Directors

The **American Council of Life Insurers** ("ACLI") elected its 2013 Chairman and Board of Directors at its Annual Conference.

Elected as Chairman was **James T. Morris**, Chairman and CEO of **Pacific Life Insurance Company**. Mr. Morris will serve as Chairman for one year.

"Jim is an exceptional leader and the ideal choice to be ACLI's Chairman this year," said ACLI President and CEO **Dirk Kempthorne**. "He is respected among his peers in the life insurance industry and has a deep understanding of the key issues affecting companies and consumers. These qualities will serve ACLI, the industry, and policyholders well in the coming year."

ACLI also elected **John D. Johns**, Chairman, President and CEO of **Protective Life Corporation**, to its Chairman-Elect position. Mr. Johns will assume the chairmanship in October 2013. ACLI's Chairman-Elect Designate post was awarded to **Roger W. Crandall**, Chairman, President and CEO of **Massachusetts Mutual Life Insurance Company** (MassMutual). Mr. Crandall will take over as ACLI Chairman in October 2014. **Ted Mathas**, Chairman, President and CEO of **New York Life Insurance Company**, will serve as ACLI Immediate Past Chairman in the coming year.

The Chairman and Board of Directors set policy and guide the actions of the association, which represents the life insurance industry in Washington, D.C., the states and internationally.

Serving on ACLI's Board through 2015:

- **Gary C. Bhojwani**, Chairman of the Board, **Allianz Life Insurance Company of North America**;
- **Don Civgin**, President & CEO, **Allstate Financial**;
- **Michael G. DeKoning**, President & CEO, **Munich American Reassurance Company**;
- **Bradford L. Hewitt**, President & CEO, **Thrivent Financial for Lutherans**;
- **Dennis L. Johnson**, President & CEO, **United Heritage Life Insurance Company**;
- **Rodney O. Martin**, Chief Executive Officer, **ING U.S.**;
- **Sherry Martin**, COO & VP, Policyholder Services, Life and Property/Casualty, **Farm Bureau Life Insurance Company of Michigan**;
- **Eileen C. McDonnell**, President & CEO, **The Penn Mutual Life Insurance Company**;
- **Jeffrey Nordstrom**, President, **USAA Life Insurance Company**.

Serving on ACLI's Board through 2014:

- **Craig Bromley**, President, **John Hancock Financial Services**;
- **Steven A. Kandarian**, Chairman, President & CEO, **MetLife, Inc.**;
- **Christopher J. Littlefield**, Chairman, President & CEO, **Aviva USA**;
- **JoAnn M. Martin**, President & CEO, **Ameritas**;
- **Andrew J. McMahon**, President, **AXA Equitable Life Insurance Company**;
- **Deanna Mulligan**, President & CEO, **The Guardian Life Insurance Company of America**;
- **Peter R. Schaefer**, President & CEO, **Hannover Life Reassurance Company of America**;
- **Peter L. Tedone**, President & CEO, **Vantis Life Insurance Company**;
- **Jay S. Wintrob**, President & CEO, **SunAmerica Financial Group**.

Serving on ACLI's Board through 2013:

- **John F. Barrett**, Chairman, President & CEO, **Western & Southern Financial Group**;
- **Roger Ferguson**, Jr., President & CEO, **TIAA-CREF**;
- **Dennis R. Glass**, President & CEO, **Lincoln Financial Group**;
- **Thomas E. Henning**, Chairman, President & CEO, **Assurity Life**;
- **Joseph Monk**, Senior VP, Chief Admin Officer, Life & VP Health & Mutual Funds, **State Farm Insurance Companies**;
- **Mark W. Mullin**, President & CEO, **Transamerica Corporation**;

- **John E. Schlifske**, Chairman & CEO, **The Northwestern Mutual Life Insurance Company**;
- **J. Eric Smith**, President & CEO, **Swiss Re Americas**;
- **Larry D. Zimpleman**, Chairman, President & CEO, **Principal Financial Group**.

Pan-American Life Insurance Announces Five New Appointments

Pan-American Life Insurance Group ("PALIG"), a provider of insurance and financial services throughout the Americas, has announced the appointment of five executives to the Group's finance team:

- **David Demmon** has joined PALIG as Vice President, Controller and Chief Accounting Officer;
- **Alywin Fruge** has come to PALIG as Vice President of Internal Audit;
- **Richard Mabry** as Vice President, Corporate Tax;
- **Michael Douglas** joins PALIG as Second Vice President Field Controller; and
- **Carlos Roberto Aldana** as Vice President Corporate Development.

"The deep industry knowledge and expertise of these five executives further strengthensPan-American Life's finance team, and the Group's commitment to financial security for our policyholders," said **Carlos Mickan**, Executive Vice President, and Chief Financial Officer. "At a time of significant growth for our Group, their collective, vast expertise and insights will guide strategies and reinforce oversight."

David Demmon has more than 20 years of experience in the insurance industry including multinational experience in accounting, financial and management roles, with leadership roles with Aviva North America, Kemper Investors Life Insurance and Zurich Financial Services / Farmers Group Inc. Mr. Demmon received his B.S. in Economics from the University of Oregon and is a licensed Certified Public Accountant and Certified Internal Auditor.

Alywin Fruge has experience in growth strategies and establishing core administrative, quality assurance and general audit methodologies across a variety of Internal Audit capacities. Mr. Fruge earned his B.S. in Management with a focus on Accounting from Tulane University. He is a member of the Information Systems Audit and Control Association ("ISACA") and the New Orleans Chapter of the Institute of Internal Auditors ("IIA").

Richard Mabry has more than 20 years of tax experience, with key roles in multiple tax planning strategies, advising on acquisition strategies and has developed and implemented comprehensive initiatives and structures for international companies. Mr. Mabry earned a B.A. in Business, Accounting and Philosophy from Wittenberg University. He received his M.B.A. in Finance from Ohio State University and an M.S. in Taxation from the University of Cincinnati. He is a licensed Certified Public Accountant and holds the professional designation of Fellow, Life Management Institute.

Michael Douglas financial services and insurance experience is centered in the areas of operational accounting and finance, strategic planning, reengineering and analysis, and product line extensions. Previously with MetLife, Mr. Douglas held various senior management positions over nearly 15 years with the company in the U.S., Central America, the Caribbean and the UK.

Carlos Roberto Aldana has nearly a decade of insurance and financial sector experience, most recently as a director/relationship manager with Merrill Lynch, Pierce, Fenner & Smith Inc. with a focus on transaction management and execution. Mr. Aldana earned a B.S. in Industrial Engineering from the Instituto Tecnologico y de Estudios Superiores de Monterrey. He received an M.S. in Engineering from GMI Engineering and Management Institute and an M.B.A. in Analytic Finance, Economics and Accounting from the University of Chicago GSB.

Alterra Appoints Nicholas Conca as Chief Claims Officer

Alterra Capital Holdings Limited has appointed **Nicholas Conca** to the newly created position of Chief Claims Officer, Insurance.

W. Marston (Marty) Becker, President and Chief Executive Officer of Alterra, commented:

> We are excited that Nick Conca has agreed to join Alterra. Nick is a highly-qualified claims professional with an impressive track record of leading large claims and other teams in a variety of insurance organizations. As we continue to grow Alterra's insurance operations in the US and elsewhere, we expect that he will be a valuable and important addition to our leadership team. Nick will be tasked with ensuring that we continue to

provide a consistently high level of claims service to our insurance policyholders worldwide.

Mr. Conca has more than 20 years of insurance industry experience, including many years of direct or managerial involvement with insurance claims operations. He was most recently Executive Vice President, US Operations, for Integro Insurance Brokers, and was previously with Frank Crystal, Liberty International and Reliance National. Mr. Conca began his career at the law firm of Wilson Elser Edelman Moskowitz & Dicker, where he served as claims counsel to major insurance companies.

After graduating from Lehigh University with a Bachelor of Science degree in Business Finance, Mr. Conca obtained his Juris Doctor from St. John's University School of Law. He is admitted to practice law in New York and Connecticut.

Mr. Conca is expected to join Alterra in November 2012 and will be based in Alterra's New York office.

Thought Leaders

What Small Business Owners Should Know about Insurance Coverage

Linda Kornfeld, an insurance-litigation attorney with Chicago law firm Jenner & Block, spoke with *Bloomberg Businessweek* about how small business owners can get the maximum allowed under their insurance coverage. The article is available at http://www.businessweek.com/articles/2012-10-31/wringing-the-most-out-of-business-insurance.

Health Care Reform to Increase Women's Insurance Coverage for Breast and Cervical Cancer Screening, Paper Finds

A new study has concluded that implementation of the Patient Protection and Affordable Care Act of 2010 ("ACA") will increase insurance coverage and access to cancer screening for millions of women.

The study sought to estimate the number of low-income women who will gain health insurance after implementation of the ACA and thus be able to obtain cancer screening. A secondary objective was to estimate the size and characteristics of the uninsured low-income population and the number of women who will still need National Breast and Cervical Cancer Early Detection Program ("NBCCEDP") services.

The study found that approximately 6.8 million low-income women will gain health insurance, potentially increasing the annual demand for NBCCEDP cancer screenings initially by about 500,000 mammograms and 1.3 million Papanicolaou tests. The study concluded that implementation of the ACA would increase insurance coverage and access to cancer screening for millions of women, but that the NBCCEDP would remain essential for the millions who will remain uninsured.

See Levy AR, Bruen BK, Ku L. Health Care Reform and Women's Insurance Coverage for Breast and Cervical Cancer Screening. Prev Chronic Dis 2012;9:120069. DOI: http://dx.doi.org/10.5888/pcd9.120069.

Homeowner's Insurance and Hurricane Sandy

Insurance coverage and Hurricane Sandy is the focus of an article **Quentin Fottrell** has written for the *Wall Street Journal's* Market Watch column that should be of interest to counsel for insurance carriers and policyholders – and any of the 50 million East Coast residents estimated to be in the way of the storm.

Facultative Reinsurance – Jurisdiction and the Nature of the Relationship

Parties involved in the placement of facultative reinsurance of overseas risks into the London Market will be interested in the outcome of a recent appeal, which is discussed in an article by **Alex Denslow**, a partner in the London office of **CMS Cameron McKenna LLP**, and **Neil Beighton**. Their article discussing the decision is available at http://www.law-now.com/DirectMail/%7BF1EAE94C-9EFC-42BD-8644-B51001E0E694%7D_FacReinsuroct2012.htm.

New Products

Blue Cross and Blue Shield of Minnesota Subsidiary CCStpa Launches New Health Plan

With an eye toward cost savings for companies self-funding insurance coverage, **Blue Cross and Blue Shield of Minnesota** subsidiary **CCStpa** has launched a new health plan, called Simplicity.

Typically, businesses self-funding health insurance work with benefits plan administrators to create custom plans. A health insurer administers the claims for a fee, with employee claims being paid by the business. These customized plans, however, often come with high

administrative costs, draining limited resources that could be used to cover claims.

CCStpa's new product offering, Simplicity, offers employers pre-packaged plans designed to fit a variety of needs and budgets. These plan options are geared toward mid-sized employers, which have been choosing to self insure in greater numbers as health insurance rates have risen over the years.

Simplicity offers three plan options:

- Plan I provides essential coverage should a catastrophic medical event occur. This product introduces a graduated coinsurance payment where the member's coinsurance decreases as claim dollars paid increase.
- Plan II includes 100 percent coverage for retail clinic visits totaling up to $100 per member each year for basic services needed due to common illnesses plus the essential coverage desired should a major medical event occur.
- Plan III incorporates a consumer-driven health plan component providing a health savings account to manage the higher deductible out-of- pocket expenses.

To learn more about Simplicity, visit http://www.ccstpa.com/public/agents/simplicity_agent_sell_sheet.pdf.

ING U.S. Introduces New Indexed Universal Life Insurance Product

ING U.S. has launched a new indexed universal life (IUL) product that includes potential for long term accumulation and death benefit coverage for individuals and businesses. Under ING Indexed Universal Life – Global Choice (ING IUL-Global Choice), issued by Security Life of Denver Insurance Company, policyholders have four different crediting strategies available to them as well as the ability to allocate their premiums across the strategies. Also available are new options that hold particular appeal for executive benefit and premium financing programs.

"ING IUL-Global Choice is a versatile life insurance policy with cash-value accumulation potential designed to help individuals, executives and employers achieve their financial goals" said **Daniel Mulheran**, president of ING Life Distribution. "In this protracted and chronic low interest-rate environment, a product like this appeals to those who are seeking death benefit coverage and tax-advantaged cash-value accumulation. We know there's a growing interest in the market for indexed products, and we believe the ING IUL-Global Choice policy uniquely addresses the needs of our distribution partners and their clients."

Indexed universal life has emerged as one of the fastest-growing product segments of the insurance industry. Sales were up 29 percent during the first half of 2012 and represented just over 25 percent of all universal life (UL) sales, according to LIMRA industry data. Indexed life insurance products — which provide upside crediting potential if markets perform well along with protection against market downturns — are attractive to clients needing life insurance in today's low interest rate environment and unsettled markets.

Another emerging trend driving IUL growth is the increasing popularity of self-owned life insurance as a way for employers to reward and retain key employees. ING IUL-Global Choice is a life insurance policy providing death benefits that may also help meet the retirement planning needs of executives. The product includes a rider, available for an additional charge, which allows policyholders early access to the cash value of the policy. This is an important feature for Self-Owned Life and Retirement (S.O.L.A.R.) insurance arrangements. In addition to providing death benefit coverage, S.O.L.A.R. insurance arrangements may also provide employees with supplemental retirement income through a cash-value life insurance policy. Employers are increasingly adding S.O.L.A.R. insurance arrangements to executives' compensation packages. ING U.S. has seen a marked increase in the use of S.O.L.A.R. insurance arrangements in the past year.

The ING IUL-Global Choice policy provides three different indexed crediting strategies — the S&P 500® 1 1-year Point to Point Indexed Strategy, as well as 2- and 5-year Global Indexed Strategies. A Fixed Strategy is also available based upon a set interest rate. The Fixed Strategy rate is never less than the guaranteed minimum interest rate of 2 percent per year — set annually on the policy anniversary. The S&P 500® indexed crediting strategy measures the increases, if any, in the S&P 500® over a one year time period. The Global Indexed Strategies credit interest based upon a formula that uses a portion of the two better-performing of three indexes looking back over a two- or five-year period.

News

Amerigroup Stockholders Approve Merger with WellPoint

The stockholders of **Amerigroup Corporation** have voted to approve the adoption of a merger agreement, dated as of July 9, 2012, providing for the acquisition of Amerigroup by **WellPoint, Inc**.

Of the shares voting at a special meeting of stockholders, 99.94 percent voted in favor of the adoption of the merger agreement, which represented approximately 80 percent of Amerigroup's total outstanding shares of common stock as of the August 27, 2012 record date. A quorum of approximately 80 percent of Amerigroup's total outstanding shares of common stock as of the August 27, 2012 record date voted at the special meeting.

The closing of the Amerigroup and WellPoint merger is subject to certain regulatory approvals and customary closing conditions and is expected to occur during the fourth quarter of 2012.

Amerigroup, a Fortune 500 Company, coordinates services for individuals in publicly funded health care programs. It currently serves more than 2.7 million members in 13 states nationwide and expects to expand operations to its 14th state, Kansas, as a result of a previously awarded state contract.

ACE to Acquire Mexican Personal Lines Insurer ABA Seguros

ACE Limited has reached a definitive agreement to acquire **ABA Seguros** in Mexico from Ally Financial Inc. for approximately $865 million in cash.

Established in 1958, ABA Seguros is Mexico's sixth largest property and casualty ("P&C") insurer and provides auto, homeowner's, and small business coverages. Based in Monterrey, the company has over 30 sales offices throughout Mexico and distributes its products through a network of nearly 2,000 independent agents as well as through auto dealerships, banks, and direct channels.

"ABA Seguros is a highly regarded franchise in the Mexican P&C market with a terrific brand and an impressive and profitable track record," said **Evan Greenberg**, Chairman and Chief Executive Officer, ACE Limited. "ACE has been operating in Mexico for many years through ACE Seguros, a business with an industrial commercial and personal accident focus. Following our announcement last month to acquire Fianzas Monterrey, the second largest surety writer in Mexico, and now ABA, a major personal lines and agency company, we are extremely well positioned to take advantage of the many growth opportunities we believe will occur in this important country over the next decade and beyond. We expect the acquisition of ABA Seguros to be accretive to earnings in the first year and to meet or exceed our company's long-term return on equity target by the third year."

The transaction is expected to be completed during the first half of 2013 and is subject to regulatory approvals.

Towers Watson Takes Steps to Enhance LTC Insurance Capabilities

Towers Watson is planning to acquire the business of the **DaVinci Consulting Group**, a boutique actuarial consulting firm that specializes in the long term care insurance market, on or about November 1, 2012. The acquisition is subject to completion, joint approval and signing of the purchase agreement. **Vince Bodnar**, principal, DaVinci, and certain members of his team have already signed offer letters with Towers Watson.

Towers Watson anticipates that DaVinci's range of services for life insurance, health insurance and managed care products, including long term care combination products linked to life insurance and annuities, will increase its competencies and experience in the long-term care insurance market.

"DaVinci's expertise with long term care insurance analytical services and its innovative risk management strategies fit our broader efforts to protect insurers' capital and profitability," said **Craig Buck**, managing director, Life practice, Towers Watson. "We're extremely pleased about the opportunity to welcome the DaVinci team to Towers Watson."

Co-founded by Bodnar, the Yardley, PA-based firm has prepared a large number of long term care insurance block analyses. The principals and 10 member consulting staff of DaVinci are expected to join Towers Watson's Life practice and to be based in the Philadelphia area. The deal would not change Towers Watson's financial results for the fiscal year.

"The long term care industry is facing significant challenges in today's low interest rate environment," said Bodnar. "DaVinci has played an instrumental role in addressing these challenges by helping clients deploy a more effective risk management strategy on the foundation of more accurate loss projections.

"We're pleased with the opportunity to join a leading company with deep actuarial resources and market knowledge, and look forward to creating opportunities to grow this business across global markets. Our long-term care thought leadership, combined with Towers Watson's market reputation, will be a win-win for both companies' clients," continued Bodnar.

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