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Specialty Lines Advisory



JOE SAYS...

RISING DEFENSE EXPENSES MAY BE AN INCREASING AREA OF DISPUTE BETWEEN D&O INSURERS AND THEIR INSURED

Securities class actions, and to a somewhat lesser extent shareholder derivative litigation, have historically presented the largest class of claims exposures to directors' and officers' liability ("D&O") insurers. Defense expenditures frequently exceed \$1M in these litigations that are not subject to an early dismissal or settlement, and often extend into the tens of millions of dollars in the more protracted actions. In the so-called "mega cases", such as Enron, defense expenses have even topped the \$100M level – a threat to exhaust most, if not all, available excess layers in a typical tower of insurance.

There is little in the way of hard data in this area, but it is not unusual for something in the range of 15 - 20% of D&O insurance loss dollars spent in securities litigation to be attributed to defense expenses. In the Enron situation, over 35% of the available D&O limits were exhausted by defense payments.

Insurance policy language generally gives little practical guidance as to what defense expenses must be paid by the insurer, generally referencing solely an obligation on the part of the insurer to pay "reasonable and necessary" defense expenses. Insurer Litigation Management Guidelines may be of some additional assistance,

but their enforceability is frequently disputed by insureds and their counsel. Although there are occasionally disputes over the reasonableness of rates, many skilled securities litigation firms can command rates for the most senior partners at \$750 per hour and higher. Other areas of dispute may lie in whether multiple counsel are necessary in the absence of clear and present conflicts of interest, and whether certain items are more coverage related, and thus not covered defense expenses.

Putting those specific areas of dispute aside, perhaps the most vexing problem in this area is inherent in the insurance structure itself.

The program structure varies according to the size of the risk, but many public companies will bear a self-insured retention of at least a few hundred thousand dollars and then layers of primary and excess insurance which can range anywhere from \$1M or \$2M to as high as \$25M per layer. \$5M and \$10M layers are fairly commonplace.

The primary insurer will generally receive defense bills while they are still within the retention amount so that they can ensure that the retention is being properly eroded. They will continue to receive, review and ultimately pay bills as the amounts exceed the retention and impact their layer of coverage. However, in most instances, these bills are not submitted to the excess insurers for review, and these insurers typically defer to the primary to examine the bills and pay what they deem to be appropriate under the primary policy.

In cases that begin to move into a settlement mode, an unfortunate dynamic begins to develop – the insurer that is reviewing the bills often realizes that its limits will become exhausted by any combination of



INSURER'S DISCLAIMER OF COVERAGE BASED UPON LATE NOTICE OF CLAIM UNDER LAWYERS PROFESSIONAL LIABILITY POLICY UPHELD

In June 2003, attorney Savino Russoniello, Jr. was retained by Columbia to represent its interest in a proposed plan to redevelop an area within West Orange, New Jersey, referred to as the Columbia Court Development. Columbia chose Mr. Russoniello because it viewed him as "one of the foremost land use attorneys in Essex County, [New Jersey] with nearly 30 years experience." Russoniello v. Twin City Fire Ins. Co., et al, No. 09-452 (PGS), 2010 U.S. Dist. LEXIS 50015 (D.N.J., May 20, 2010).

The relationship between Mr. Russoniello and Columbia, however, quickly soured. In a September 2003 meeting, Columbia emphasized that "time was of the essence" on the project and that Mr. Russoniello was to take swift action once the architect completed his evaluation and drawings. Columbia contended that, despite making known the urgency of its request, Mr. Russoniello "dragged his feet on the project, and often failed to timely return its phone calls." Columbia argued that a pattern soon developed, wherein Mr. Russoniello failed to return phone calls for weeks, and when he finally did so, he provided evasive nondescript answers. Moreover, according to Columbia, Mr. Russoniello failed to properly communicate with the architect in drafting plans that would meet the expectations of town officials.

Although Columbia intended to present its redevelopment project in May 2004, it was not until October 2005 that it attended a "pre-variance" meeting with township officials. At the meeting, representatives of the township provided positive comments about the plan, but expressed substantial concerns that the large number of residential and commercial units proposed by Columbia was excessive for the lot area.

By letter dated August 2, 2006, Columbia stated that it was dissatisfied with Mr. Russoniello's representation, and terminated him. In that same letter, Columbia requested that Mr. Russoniello make available the casefile as well as attorney notes and memos. The letter additionally sought a refund of all remaining funds from a recently-issued check.

By letter dated October 12, 2006, Columbia wrote to Mr. Russoniello again. In part, that letter sets forth:

I have had time to compare your file with mine and have determined that your representation of Columbia []

for the purposes of redevelopment of our owned properties was completely inadequate and may well be considered malpractice. You may have had another agenda, but it was not the proper legal protection or representation of our company. You have cost us hundreds of thousands of dollars[,] if not millions of dollars. I am therefore making demand for the entire payment to your firm of eleven thousand one hundred and fifty dollars. I feel that your invoicing is also inaccurate.

I therefore request a response by you no later than Monday October 16, 2006. I am hopeful of settling this matter amicably. In the event you do not agree to return our money, I will be forced to refer this matter to The Office of Attorney Ethics and The Client Protection Fund. A brief is also being prepared and will be forwarded to the attorney that has been selected who handles these types of matters.

Thereafter, Columbia hired another law firm and, with new counsel, again submitted its redevelopment project to township officials. However, Columbia's plan was again denied.

Columbia subsequently filed a legal malpractice complaint against Mr. Russoniello for his alleged failure to bring the Columbia Court Development to fruition. While the malpractice action remained ongoing, Mr. Russoniello brought a declaratory judgment action against Twin City Fire Insurance Company ("Twin City"), seeking coverage for the legal malpractice suit.

Twin City had issued to Mr. Russoniello a claims-made policy for the 06-07 period. (The policy was subsequently renewed for the 07-08, 08-09, and 09-10 policy

periods. However, it was undisputed that the 06-07 Policy was the only operative Policy governing any possible coverage for Columbia's claim. Under the terms of the Policy, "[a]ll claims arising out of the same or related negligent acts, errors, omissions or personal injury will be deemed to have been made when the first of such claims is made . . . whether such demands are made by one or more persons and will be treated as a single claim.") That policy required the insured to notify Twin City of any claim made against the insured "during the policy period or applicable extended reporting period . . . in writing to the company immediately but in no event less than sixty (60) calendar days after the expiration date of the policy period, or applicable extended reporting period." The Policy defined a "claim", in part, as "[a] demand received by an insured for money or services, alleging a negligent act, error, omission or personal injury in the rendering of or failure to render professional legal services for others" by the insured. In turn, the Policy defined "professional legal services", in part, as "services performed or advice given" for others in connection with the insured's practice as a lawyer.

Mr. Russoniello notified his legal malpractice carrier, Twin City, of the underlying legal malpractice suit against him by letter dated October 23, 2008 – more than two years after the Columbia letter alleging malpractice. By letter dated October 29, 2008, Twin City conveyed that it would not provide either a defense or indemnity coverage to Mr. Russoniello, based upon his untimely notice.

Twin City made a motion for summary judgment, arguing that under New Jersey law the notice provided was late as a matter of law. Applying New Jersey insurance law, the court held that summary judgment was appropriate because the insured failed to notify Twin City in accordance with the terms of the Policy. It cited Zuckerman v. Nat'l Union Fire Ins. Co., 100 N.J. 304, 324

defense expenses and settlement amount. There is thus created a disincentive for that insurer to vigorously review and cut the bills (typically this review would be done by counsel for the insurer and therefore at incremental cost to them) when any "savings" will only inure to the benefit of an insurer higher in the tower.

Although it did not involve D&O insurance, but rather a multilayered employment practices liability insurance ("EPL") program, a decision last year by a Minnesota appellate court addressed some of the problems that are inherent in these insurance structures. Royal Indemnity Co. v. C.H. Robinson Worldwide, Inc., 2009 Minn. App. Unpub. LEXIS 772 (Minn. Ct. App., July 21, 2009). This decision was not officially reported and received scant attention, but the Court there held that an excess insurer was entitled to dispute the reasonableness and necessity of defense expenses already paid by an underlying insurer, and thus question whether the underlying limits were properly exhausted. While the policyholder in that case argued strongly against this insurer being allowed a second bite at the apple, it appeared that the Court appreciated the unfortunate dynamics and inappropriate disincentives that would result if it did not so rule. A special master had been involved in reviewing bills and it is uncertain as to what took place after the Court remanded to the trial court for further proceedings.

Notwithstanding this decision, what then are some practical steps that can be taken by insurers and insureds alike in these situations to avoid unnecessary and costly disputes over legal fees?

First, defense invoices should be submitted to all insurers – both primary and excess – in the tower of insurance. This is not particularly burdensome on the law firms involved, particularly when the invoices are sent electronically. Not every insurer will take the opportunity to review the bills, with most deferring that task to the primary insurer or whoever may be the "working layer" for paying the invoice at issue. Nonetheless, if

any excess insurer may have doubts that an insurer below them is adequately scrutinizing the bills, they will be free to voice any objections and seek a potential resolution, as discussed further below.

Second, as soon as there is a settlement agreement in principle, all invoices should be submitted solely to the topmost layer of insurance impacted by the settlement. That is the only layer that should have any real interest in vetting the bills for reasonableness and necessity, as the layers below will be exhausted regardless of reductions in defense expenses. This may result in the top layer paying defense expenses before a settlement is actually funded, but it is actually in that layer's interest not to stand on their legal and contractual right not to pay in order to gain appropriate control over the defense fees and expenses.

It should be noted that, in the absence of a settlement in principle, it would not be a workable solution to simply have one or more excess layers attempt to dictate to the insureds and lower layer insurers what should or should not be paid as covered defense expenses. Unless the insureds and all insurers consent to such an arrangement, an insurer cannot delegate its responsibility under the policy to an insurer in a layer above them.

Third, insurers often overlook the notion of approaching the general counsel or other key contact at the policyholder's organization to attempt to reach an agreement on how to deal with defense expense issues. Although general counsel will want the best defense counsel available for the corporation and its management, they should not be insensitive to the need to control defense expenses and preserve available limits for a potential settlement, judgment and even other claim matters under the same policy. In instances where agreement unfortunately cannot be reached on where to reduce a bill, a possible solution would be to mutually agree to have the corporation bear any disputed amount uninsured. This effectively removes the outside defense counsel from the equation

and leaves them to focus solely on the defense of their clients and not their bills.

Lastly, where fees are in dispute, insurers and the policyholder should consider the retention of a third party to act as an arbiter in those disputes. Ideally, this neutral will be a lawyer with a well-developed understanding of the issues in the underlying litigation and D&O insurance coverage. Such a procedure is frequently employed in bankruptcy proceedings. In fact, in the ongoing Lehman bankruptcy, fees disputes involving a number of prominent law firms have been submitted to the present federal bailout pay czar, Kenneth Feinberg, for resolution. The cost of such an arbiter should be borne as an additional defense expense to be paid by the appropriate insurer, but the benefit of that work would be enjoyed by all insurers through the reduction of the ultimate loss exposure, as well as by the insured's in the elimination of an item of contention.

This article is abridged and adapted from one originally published in the May 17 issue of National Underwriter.



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“SUBJECTIVE/OBJECTIVE” STANDARD APPLIED IN ENFORCING PRIOR KNOWLEDGE EXCLUSION IN LAWYERS’ PROFESSIONAL LIABILITY POLICY

The United States District Court for the District of New Jersey held that a professional liability insurance policy’s prior knowledge exclusion excluded coverage for an underlying action against an insured law firm and its attorneys where the acts which prompted the underlying action were known to the insureds and could reasonably have been expected to form the basis of a claim. Navigators Specialty Ins. Co. v. Scarinci & Hollenbeck, LLC, et al., Case No. 09-4317, 2010 U.S. Dist. LEXIS 47124 (D. N.J. May 12, 2010).



In 2008, Scarinci Hollenbeck, LLC (“Scarinci”), a New Jersey law firm, purchased a Primary Lawyers Professional Liability Insurance Policy (the “Policy”) from Navigators Specialty Insurance Company (“Navigators”) for the period from June 14, 2008 to June 14, 2009. Under the Policy, Navigators agreed to pay claims arising out of acts, errors or omissions of Scarinci, and lawyers employed by Scarinci, in rendering or failing to render “Professional Services”.

In September 2008, Bel Air Holdings LLC and 201 Kennedy Consultants LLC (collectively, the “Bel Air Plaintiffs”) filed an action (the “Bel Air Action”) in New Jersey Superior Court against Scarinci, and Scarinci attorneys, Joel Glucksman (“Glucksman”) and Frank Kapusinski (“Kapusinski”) (collectively the “Insureds”). The Bel Air Plaintiffs alleged that the Insureds represented First Bank and Trust Company of Illinois (“First Bank”) and Heritage Estates, LLC (“Heritage”) in connection with a foreclosure action on certain property owned by the Bel Air Plaintiffs. The Bel Air Plaintiffs alleged that in representing First Bank and Heritage, the Insureds “materially assisted in their clients’ scheme to steal plaintiffs’ property and rental income from the property, and to prevent plaintiffs from redeeming the mortgage and retaining ownership in the property”. Specifically, the Bel Air Plaintiffs alleged that the Insureds withheld material information from the foreclosure court and falsified accounting information regarding damage to the subject property.

Navigators provided a defense to the Insureds in the Bel Air Action, subject to a full reservation of rights. On August 24, 2009, while Navigators continued to defend the Insureds in the Bel Air Action, Navigators

filed a complaint in the United States District Court for the District of New Jersey (the “District Court”) seeking a declaratory judgment that the Policy did not provide coverage to the Insureds for the Bel Air Action. The Insureds filed a motion to dismiss the declaratory judgment action which was subsequently converted into a motion for summary judgment after a settlement was reached in the Bel Air Action. On January 27, 2010, Navigators opposed the Insureds’ motion and crossed-moved for summary judgment before the District Court.

Navigators and the Insureds disputed the meaning of certain terms of the Policy. First, Navigators alleged that the claims asserted in the Bel Air Action did not fall within the scope of the Policy’s coverage because they did not arise out “Professional Services” rendered by the Insureds. Secondly, Navigators alleged that even if these claims did fall within the scope of coverage, they are specifically excluded from coverage pursuant to the Policy’s prior knowledge exclusion (the “Prior Knowledge Exclusion”). The Insureds argued that Navigators’ no-coverage allegations were unsupported by the text of the Policy.

The District Court first addressed Navigators’ cause of action seeking a declaratory judgment that there was no coverage under the Policy as the acts alleged in the Bel Air Action do not qualify as Professional Services. The Policy defines Professional Services as services “provided as a lawyer, notary public, title agent, trustee, arbitrator, mediator, lobbyist or Fiduciary”.

In its motion to dismiss, the Insureds argued that that they performed legal services on behalf of First Bank and Heritage and that the Bel Air Action clearly “arises out of the rendering of those Professional Services”. The Insureds also argued that the Bel Air Plaintiffs’ filing of an Affidavit of Merit in support of its breach of fiduciary duty claim further supported this argument because “under New Jersey law, an ‘Affidavit of Merit’ is required solely in professional liability and negligence actions against licensed professionals”.

Navigators argued that because the Bel Air Action was brought by non-clients for whom

the Insureds did not provide legal services, its first cause of action, should survive a motion to dismiss. The Insureds responded to this argument by asserting that the Policy “contains no restriction limiting the scope of ‘Professional Services’ to those associated with claims brought by clients”. Further, in Navigators’ cross-motion for summary judgment, Navigators argued that the alleged fraudulent conduct simply did not qualify as “professional services provided by a lawyer”. Navigators also argued that the Affidavit of Merit at issue was irrelevant to the question of coverage, as coverage is determined by comparing the allegations in the underlying action with the language of the Policy. Thus, Navigators argued that the Bel Air Plaintiffs’ allegations did not fall within the scope of coverage and did not create a duty to defend or to indemnify.

The District Court rejected Navigators’ first argument that claims brought by non-clients are not covered by the Policy. Applying New Jersey law, the District Court held that the plain and ordinary meaning of the Policy did not limit the class of persons who may bring claims because the Policy obligates Navigators to cover claims “arising out of any act, error or omission of the Insured in rendering or failing to render Professional Services to others”. Thus, the District Court held that Navigators was obligated to cover claims brought by non-clients.

In addressing Navigators’ second argument, that the fraudulent conduct alleged in the Bel Air Action did not qualify as Professional Services, the District Court applied the Third Circuit’s “substantial nexus” test as established in Princeton v. Chunmuang, 698 A.2d 9 (N.J. 1997). In Chunmuang, the Supreme Court of New Jersey held that in determining whether acts constitute professional services, the “important question is simply whether a substantial nexus exists between the context in which the acts complained of occurred and the professional services sought”. The District Court held that there was clearly a substantial nexus between the alleged fraudulent acts which occurred in the context of the Insureds’ representation of First Bank and Heritage in the foreclosure action and the professional services that First Bank and Heritage sought. Accordingly, the District

SUBJECTIVE/OBJECTIVE continued on page 5

Court held that because the Bel Air Action arose out of an “act, error or omission of the Insured in rendering or failing to render Professional Services”, the Action was covered by the Policy.

Next, the District Court addressed the applicability of the Policy’s Prior Knowledge Exclusion. The Prior Knowledge Exclusion provides:

The coverage under this insurance does not apply to Damages or Claims Expenses incurred with respect to any Claim arising out of any acts, errors, or omissions which took place prior to the inception date of the first policy issued and continuously renewed, if any Insured on the effective date knew or could have reasonably foreseen that such acts, errors, or omissions might be expected to be the basis of a Claim.

Navigators argued that under the Third Circuit’s mixed “subjective-objective” test, the Prior Knowledge Exclusion applied because the Insureds had subjective knowledge of certain occurrences that a “reasonable professional” in their position would conclude may result in a claim. Specifically, Navigators noted that in a deposition over a year before inception of the Policy, counsel for the Bel Air Plaintiffs accused the Insureds of fraud and threatened a lawsuit. Navigators argued that a reasonable insured in the Insureds’ position could have reasonably foreseen that these alleged acts might be expected to be the basis of a claim.

In response, the Insureds argued that neither Scarinci, Glucksman and/or Kapusinski knew or could have reasonably foreseen that it was *their* acts errors or omissions that might reasonably be expected to be the basis of a claim. Additionally, the Insureds argued that the Prior Knowledge Exclusion was not applicable because neither Scarinci, Glucksman nor Kapusinski subjectively believed that certain acts, errors or omissions might be expected to be the basis of a claim. Finally, the Insureds argued that “threats” from the Bel Air Plaintiffs’ counsel did not trigger the exclusion because the threats were not “acts, errors, or omissions” by the defendants. Navigators responded to this argument by asserting that the Prior Knowledge Exclusion did not require that the “acts, errors, or omissions” be committed by the insured.

In interpreting the Policy’s Prior Knowledge Exclusion, the District Court noted that the Third Circuit had adopted a mixed subjective-objective test as affirmed in Colliers Lanard & Axibund v. Lloyds of London, 458 F.3d 231 (3rd Cir. N.J. 2006). In Colliers, the Third

Circuit held that under New Jersey law:

the plain language of the [prior knowledge exclusion] mandates a subjective test for the first part of the necessary inquiry - - whether the insured had knowledge of a suit, act, error or omission - - and an objective test for the second part of the necessary inquiry - - whether the suit, act, error or omission might reasonably be expected to result in a claim or suit[.]

In applying the mixed subjective-objective test as set out by the Third Circuit, the District Court held that the Policy’s Prior Knowledge Exclusion excluded coverage for the Insureds with respect to the Bel Air Action. First, the District Court concluded that the subjective prong of the exclusion had been met. As noted by the District Court, the subjective prong requires the insured to have had knowledge of relevant acts, errors or omissions which took place prior to the inception date of the Policy. The District Court noted that the Insureds were clearly aware of their alleged wrongful acts in withholding material information from the foreclosure court and falsifying accounting information because they participated in these acts. Accordingly, the District Court held that this awareness, regardless of the characterization of their culpability in these incidents, satisfied the subjective prong of the exclusion.

In connection with the objective-prong of the exclusion, which excludes coverage if “any insured on the effective date knew or could have reasonably foreseen that such acts, errors, or omissions might be expected to be the basis of a Claim”, the District Court held that a reasonable professional in the position of the Insureds might have expected a claim or suit to result from these acts. The District Court reasoned that the Insureds had ample reason to believe that the Bel Air Plaintiffs would make a claim based on these acts, as they knew the Bel Air Plaintiffs were extremely dissatisfied with the Insureds’ conduct based on direct accusations of fraud and threats of litigation. The District Court further noted that a reasonable professional cannot assume that a claim will not be brought because he subjectively believes it lacks merit. Thus, the Insureds’ subjective belief that the Bel Air Plaintiffs’ claims lacked merit was irrelevant.

Accordingly, the District Court found that because the Insureds had knowledge of acts, errors or omissions that could reasonably be expected to form the basis of a claim against them, the Prior Knowledge Exclusion excluded coverage for the Bel Air Action.

TRESSLER COMMENTS

The Scarinci decision is significant because it reaffirms the Third Circuit’s application of the mixed subjective-objective test in interpreting prior knowledge exclusions as established in Selko v. Home Ins. Co., 139 F.3d 146 (3d Cir. Pa. 1998) and again reaffirmed in Colliers. In Scarinci, the District Court expressly rejected the Insureds’ position that the application of the prior knowledge exclusion depends on a subjective test. Accordingly, Scarinci is instructive in holding that, in interpreting the applicability of prior knowledge exclusions, the Third Circuit is indifferent to insureds’ subjective belief about the likelihood of a claim.



Prepared by Kyle P. Barrett, an associate in our New York office.

RESCISSION OF FIDELITY BOND ON BASIS OF MATERIAL MISREPRESENTATION UPHELD BY SECOND CIRCUIT

On June 7, 2010, the Second Circuit Court of Appeals, in an opinion written by Judge John Keenan, issued its decision in FDIC v. Great American Insurance Company, Docket No. 09-1052, which interpreted the FDIC's statutory rights as a receiver, and could serve as instructive precedent in future insurance-related litigation resulting from bank failures. Per the outcome of the case—the FDIC, acting as receiver of a failed bank, was unable to avoid rescission of a fidelity bond procured by material misrepresentation, notwithstanding its statutory receiver rights.

The opinion was issued in response to an appeal from a grant of summary judgment in favor of Great American, which entitled Great American to rescind a fidelity bond on the basis of material misrepresentations made in Connecticut Bank of Commerce's ("CBC") application for insurance. The facts of the case arise from circumstances that followed CBC's entrance into a Purchase and Assumption ("P&A") agreement to acquire MTB Bank ("MTB") in 1999.

Prior to the closing of the P&A agreement on March 30, 2000, two events occurred which would later become the central component of the insurance dispute in the litigation.

First, in September 1999, MTB management discovered that some of MTB's agents advanced \$950,000 based on fraudulent invoices under a factoring agreement with a company called Harmony Designs, Inc. Although MTB submitted a claim for indemnity with its fidelity bond carrier, it eventually settled with Harmony Designs for an amount which reduced its loss below the amount of the deductible, and therefore it did not recover payment for this claim. Next, in March of 2000 the president and several officers of MTB were indicted for participating in an alleged conspiracy involving the importation of Argentinean minerals. MTB also noticed its fidelity bond insurer for losses related to these indictments.

After the CBC/MTB P&A agreement closed, CBC was added to MTB's insurance policy, and because the fidelity bond was set to expire on June 30, 2000, CBC sought a renewal from its insurer. Due to the insurer's concerns surrounding the two claims that MTB had made, it refused to renew unless CBC representatives went to insurer's headquarters in London in person to provide more information regarding the renewal. Ultimately, no representatives from CBC went to London, and two weeks prior to the bond's expiration, CBC requested a 30-day extension of coverage, which the insurer declined. As a result, CBC sought fidelity bond coverage from a different insurer, Great American Insurance Company ("GAIC"), and submitted a policy application requiring it to disclose, among other things, (1) losses sustained during the preceding three years; (2) whether there were any additional relevant circumstances that would materially affect the application, and (3)

whether any insurance had been declined or cancelled during the past three years. CBC answered "no" to these three questions. In its application, CBC failed to disclose the Harmony Designs loss, the indictments of MTB officers, and that its previous insurer had declined to renew its fidelity bond insurance. Upon receipt of the application, GAIC issued a fidelity bond to CBC with coverage retroactive to June 30, 2000.

In June 2002, CBC was placed into receivership by the FDIC. Three and a half years later, in January of 2006, the FDIC brought suit against GAIC, claiming that it breached its contractual duty by dishonoring claims for coverage under the fidelity bond for losses sustained by CBC, which related to a loan scheme that was used to fund the acquisition of MTB. The district court granted summary judgment to GAIC, finding that it properly rescinded the fidelity bond due to omissions and misstatements made by CBC in its application for the fidelity bond.

In his opinion, Judge Keenan responded to FDIC's argument that 12 U.S.C. Section 1823(e) protected it from defenses not apparent on the face of an asset it acquired as a receiver of a failed bank, by finding that (1) a fidelity bond was in fact an "asset" to which this provision applied, and (2) the statute did not bar GAIC's misrepresentation defense.

Although the Court found the fidelity bond to be an asset under 12 U.S.C. Section 1823(e), it explained that the statute was intended to bar "secret" defenses which would diminish the FDIC's interest in a failed bank's assets. Additionally, the Court noted that defenses raised by the bond could nevertheless prevent recovery by the FDIC. The Second Circuit determined that because the grounds for rescission were "plainly stated on the face of the bond," there was "nothing secret about GAIC's misrepresentation defense," and therefore no reason to apply Section 1823(e).

After the determination of whether the fidelity bond was an asset within the meaning of Section 1823, the opinion continues with an inquiry into whether CBC's statements or omissions in its application amounted to a material misrepresentation. Although the Court stated that a single misrepresentation would allow GAIC to rescind the bond, all

three statements made by CBC – (1) the failure to report the Harmony Designs loss, (2) the failure to report the loss arising from the indictments of the MTB officers, and (3) the insurer's decision not to renew or extend the fidelity bond – were considered individually. The Court determined that each of these constituted sufficient grounds for rescission, mainly because it was undisputed that CBC was aware of the losses when it applied for the new fidelity coverage, and that the losses played a role in the previous insurer's decision not to renew or extend its bond upon expiration. Furthermore, the Court found that the prior losses were the subject of the inquiry included in CBC's application for coverage, and that CBC's responses were deemed "presumptively material," especially since "common sense tells us that an applicant's prior loss history is material to a reasonable insurance company's decision whether to insure that application, or in determination of the premium." Finally, the Court stressed the notion that a "determination of risk is one properly left to the insurer, not the insured, and the insurer cannot make an accurate risk assessment without full disclosure from the applicant." According to the Second Circuit, "the very purpose of such broadly worded catch-all questions," such as those present in CBC's application, was to "prevent the type of self selective reporting that occurred" in this situation.

TRESSLER COMMENTS

This decision highlights the importance of the policy application process and the extent of insurer's rights to rescind coverage in some cases. While the breadth of the Court's holding regarding rescission could provide helpful guidance to insurers, the opinion emphasizes the fact that CBC knew that disclosure of its prior losses would prevent it from obtaining replacement insurance, which could potentially limit the applicability of the holding to cases with similar facts.



Prepared by Jillianne Arugello, an associate in our New York office.

INSURANCE INTERMEDIARY'S FAILURE TO OBTAIN CERTAIN COVERAGE WAS AN "ACT" THAT UNDERLAYS A PRIOR LITIGATION, SO "PENDING AND PRIOR LITIGATION" EXCLUSION APPLIES



In *Hilb Rogal & Hobbs Insurance Services of California, Inc. v. Indian Harbor Insurance Company*, 2010 U.S. App. LEXIS 10033, (9th Cir. May 4, 2010), the Ninth Circuit Court of Appeals, applying California and New York law, upheld the "pending and prior litigation" exclusion of the professional liability insurance policy issued to Hilb Rogal & Hobbs Insurance Services of California, Inc. ("HRH") due to HRH's failure to obtain workers' compensation coverage for one of its clients.

HRH was sued by its client, Rhino Linings, which alleged that it incurred damages as a result of HRH's employee's negligent failure in obtaining workers' compensation coverage on Rhino Linings' behalf. Following a jury trial in the Los Angeles County Superior Court, Rhino Linings was awarded \$5,807,233 in damages, plus interest. HRH notified its professional liability insurer – Indian Harbor Insurance Co. – who denied coverage in September 2007.

HRH subsequently sued Indian Harbor in the U.S. District Court for the Central District of California, seeking a declaration that its professional liability policy provided coverage for the Rhino Linings Judgment. The District Court granted summary judgment in favor of Indian Harbor and found that the "prior and pending litigation" exclusion was unambiguous and precluded coverage. HRH's policy excluded coverage for:

claims based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving ... any claim, cause of action, demand, arbitration, litigation or other legal or quasi-legal proceeding [pending on or resolved prior to the date of inception of the policy or] any actual or alleged act, error, misleading statement, omission, misstatement or breach of duty underlying or alleged in any such [litigation].

Hilb Rogal & Hobbs at *2-*3 (emphasis removed).

The Ninth Circuit held that HRH's failure "to obtain workers' compensation coverage for its client, Rhino Linings, is an 'act ... underlying or alleged in' prior litigation." The Ninth Circuit noted that:

Under California law, the tort lawsuit brought against Rhino Linings by its employee before the inception of the policy could not have proceeded to judgment if Rhino Linings had had workers'

compensation coverage. [citations omitted.] The failure to obtain coverage was, therefore, an "act" that underlays [the employee's] lawsuit. Moreover, HRH's claim in this case "arises out of" that "act." Both New York and California have interpreted the "arising out of" phrase to mean merely "having a connection with." [citations omitted.] There is such a connection in this case because both the prior litigation and current claim feature the same failure to obtain workers' compensation coverage.

Id. at *3-*4 (emphasis in original).

The Ninth Circuit rejected HRH's argument that the policy provisions must be interpreted in light of HRH's reasonable expectations on the basis that HRH did not provide evidence "of a reasonable expectation of coverage for the type of claim in this case." In this regard, the Court further stated: "General statements that HRH sought a claims-made policy do not establish a reasonable expectation of coverage for a particular situation in which a claims-made policy interacts with California workers' compensation law." *Id.* at *4.

The Ninth Circuit, while dismissing HRH's argument that the policy was ambiguous, noted that "It is true...that the language is broad. But broad language is not necessarily ambiguous." *Id.* at *5, citing *ML Direct, Inc. v. TIG Specialty Ins. Co.*, 79 Cal. App. 4th 137, 93 Cal. Rptr. 2d 846, 852-53 (Cal. Ct. App. 2000).

Lastly, HRH argued that by utilizing the interpretation the Ninth Circuit adopted, this improperly institutes a "but for" test regarding the connection between a claim and a prior litigation instead of a "significant factual nexus" test. *Id.* at *5, citing *ML Direct*, 93 Cal. Rptr. 2d at 853. Again, the Ninth Circuit rejected HRH's argument and held:

We do not hold that the claim is

excluded by the policy solely because it would not have arisen "but for" the lawsuit between the employee and Rhino Linings. Rather, we hold, as did the district court, that the claim is not covered because it "arises out of" an "act ... underlying or alleged in" prior litigation, namely the failure to obtain workers' compensation coverage that allowed the employee suit to proceed to judgment. The importance of that same failure in both the employee suit and the claim at issue constitutes the required "factual nexus" between them.

Id. at *5-*6.

TRESSLER COMMENTS

The Court's general holding that a broad policy clause is not necessarily also an ambiguous one is interesting as it is more often the case that an over-breadth in policy language creates ambiguity such that broad policy provisions are construed against a carrier's interpretation. But, perhaps even more important to note here is that the court, in applying a "pending and prior litigation" chose not to adopt a "but for" test in seeking to apply the policy exclusion, but rather adopted a more broad "arising out of" standard. Thus, because the same failure to procure workers' compensation insurance was at the heart of both the prior suit and the subsequent suit/claim, the current claim arose out of an act alleged in the prior, and was thus excluded from coverage.



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INSUREDS' SETTLEMENT WITH UNDERLYING CARRIERS FOR LESS THAN POLICY LIMITS PRECLUDES ACCESS TO EXCESS D&O POLICIES

On June 22, 2010, the U.S. District Court for the Northern District of Illinois granted summary judgment to excess D&O carriers Ace American Insurance Company and Fireman's Fund Insurance Company finding that the excess policies unambiguously required the payment of the underlying policies' full liability limits by the underlying carriers before the excess carriers were required to respond. The insureds' settlement with the underlying carriers for less than full policy limits therefore precluded recovery under the excess policies, regardless of the amount of loss incurred by the insureds. **Tressler LLP** represented Fireman's Fund in this case. Great Am. Ins. Co. v. Bally Total Fitness Holding Corp., No. 06 C 4554, 2010 U.S. Dist. LEXIS 61553 (N.D. Ill. June 22, 2010).

This coverage dispute arose from various lawsuits filed against Bally Total Fitness Holding Corporation and certain of its directors and officers (collectively the "Insureds") alleging that the Insureds' filed or otherwise provided false and/or misleading financial statements, corporate records and press releases. The Insureds sought coverage for these underlying claims under primary and excess D&O policies effective from June 30, 2002 to June 30, 2003. The primary and first and second layer excess carriers provided a total of \$30 million in liability limits ("Underlying Carriers") while the third and fourth layer excess carriers, Ace American Insurance Company and Fireman's Fund Insurance Company, respectively, provided coverage in excess of \$30 million ("Excess Carriers"). The primary carrier filed a complaint against the Insureds seeking to rescind the policies. The Insureds then filed a third party complaint against all of the excess insurers. The excess insurers filed counterclaims against the Insureds seeking rescission and asserting other coverage defenses.

The Underlying Carriers entered into a settlement agreement with the Insureds, under which the carriers paid less than their respective policy limits in exchange for a dismissal with prejudice of the Insured's claims and a release of any further coverage obligations (the "Settlement"). The Excess Carriers, however, refused to contribute to the settlement on grounds that their policies were not triggered, if at all, until the Underlying Carriers paid the full amount of their liability limits. The Insureds contended that: (1) the Settlement, although for less than policy limits, functionally exhausted the underlying coverage; and (2) the policy language of the Excess Carriers was ambiguous as to whether the \$30 million liability limits had to be paid by the Underlying Carriers. According to the Insureds, since they had incurred in excess of \$30 million in defense and settlement of the underlying claims, the Excess Carriers had no rational interest in whether the Insureds collected the full amount of the underlying

policies from the Underlying Carriers so long as the Excess Carriers were only called upon to pay claims in excess of their policies' attachment points.



U.S. District Court Judge Wayne R. Andersen recognized that the line of cases which have held that a settlement below policy limits triggers excess coverage have done so based on ambiguous language contained in the excess policy, such as the requirement that underlying insurance be exhausted by "payment of claims" because the term "payment" could refer to actual payment or satisfaction of a claim by compromise. Where, however, the policy language is clear regarding the exhaustion of underlying coverage, courts will enforce the unambiguous language as written.

Applying these principles, Judge Andersen looked to the language in the excess policies, which provided, in part, the following:

the liability for any covered loss shall attach to the Insurer only after the insurers of the Underlying Policies shall have paid, in the applicable legal currency, the full amount of the Underlying Limit...

[t]he insurance coverage afforded by the Policy shall apply (1) only in excess of all Underlying Insurance and (2) only after all Underlying Insurance has been exhausted by payment of the total underlying limit of insurance.

[i]n the event of exhaustion of all of the limits of insurance of the Underlying Insurance solely as a result of actual payment of loss or losses thereunder, this Policy shall ... apply as Primary Insurance

The court found that this policy language clearly defined what underlying insurance must be exhausted and how it must be exhausted before the Excess Carriers were

obligated to respond and should therefore be enforced as written. Under the unambiguous language of the policies, the Underlying Insurance could be exhausted only by the actual payment of loss or losses thereunder by the Underlying Carriers. Awarding summary judgment to the Excess Carriers, the court concluded that the Excess Carriers' policies had not been triggered because the Underlying Carriers had not paid the entire limits of their policies.

TRESSLER COMMENTS

This is a significant ruling for excess carriers considering whether there is an obligation to respond when the insured has settled with the underlying insurers for less than full policy limits but has incurred loss in excess of the excess insurer's attachment point. There is a line of cases that holds, under the policy language at issue in those cases, the excess carrier may be obligated to respond in those circumstances as they are only being called upon to pay claims in excess of their policies' attachment points, precisely what they contracted to do. Judge Andersen's ruling is significant in that it establishes that insurers, with careful wording of the exhaustion condition precedent to coverage, may require actual payment of full policy limits by the underlying insurers before the excess policies are triggered regardless of the amount of defense and settlement dollars incurred by the insured. This ruling is consistent with the relatively recent Qualcomm and Comerica decisions which may indicate a trend or, more likely, reflect improvements in draftsmanship of exhaustion requirements.



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DELAWARE CHANCERY COURT OFFERS GUIDANCE AS TO REASONABLE ATTORNEYS' FEE AWARDS IN "BUMP UP" SETTLEMENTS

A recent decision by the Court of Chancery of the State of Delaware is likely to provide assistance to insurance carriers who are asked to approve a "reasonable" plaintiffs' attorneys' fees requested as part of a "bump" or "bump up" settlement. In the consolidated action styled *In re Cox Radio, Inc. Shareholders Litigation*, Civil Action No. 4461-VCP, 2010 Del. Ch. LEXIS 102 (May 6, 2010) (the "Action"), the Court held that in "bump cases", several factors are to be analyzed when calculating an award for attorneys' fees, including the relative contribution of the plaintiffs' counsel's efforts to the settlement benefits.

Cox Radio, Inc. ("Cox Radio") is a radio broadcasting company engaged in the acquisition, development, and operation of radio stations in the United States. In March 2009, Cox Enterprises, Inc., the controlling shareholder of Cox Radio, commenced a tender offer through its wholly owned subsidiary, Cox Media Group, Inc., for all of the Cox Radio stock that it did not already own. In the Action commenced in March 2009, plaintiffs alleged that the defendants breached their fiduciary duties to Cox

Radio by offering inadequate consideration and making misleading and incomplete disclosures in connection with the tender offer. Approximately one month later, on April 29, 2009, the parties entered into a Memorandum of Understanding (the "MOU") which allowed the tender offer to close successfully. The terms of the MOU were confirmed in a Stipulation and Agreement of Compromise and Settlement (the "Settlement") that was filed with the Court on September 4, 2009.

The Settlement provided for a \$1 per share "bump" in the tender offer price as well as the dismissal of the Action and the release of any other current or future claims in connection with the transaction. In filing the Settlement, the plaintiffs sought for the Court to: (1) certify the proposed class set forth in the Settlement; (2) approve the proposed Settlement terms; and (3) award attorneys' fees and costs in the amount of \$3.6 million. The Court certified the class and approved the terms of the Settlement. However, the Court denied the full amount requested for attorneys' fees. Instead, the Court ordered that a smaller amount be paid.

The Court stated that the general or American rule, as noted in *Greenfield v. Frank B. Hall & Co.*, 1992 Del. Ch. LEXIS 207 at *8 (Del. Ch. Oct. 19, 1992), is that a litigant typically must defray her attorneys' fees and litigation costs. However, the Court recognized an exception to that rule, known in Delaware courts as the "common corporate benefit" doctrine. See *United Vanguard Fund, Inc.*

v. Takecare Inc., 693 A.2d 1076, 1079 (Del. 1997). As explained in *United Vanguard Fund, Inc.*, a litigant who confers a common monetary benefit upon an ascertainable stockholder class is entitled to an award of counsel fees and expenses for its efforts in creating the benefit. The parties agreed that the plaintiffs were entitled to attorneys' fees but they disagreed as to the amount.

The Court noted that in determining the proper fee award, Delaware courts consider the "Sugarland factors" as outlined in *In re Plains Res. Inc.*, 2005 Del. Ch. LEXIS 12 at *9 (Del. Ch. Feb. 4, 2005) (citing *Sugarland Indus., Inc. v. Thomas*, 420 A.2d 142, 149-150 (Del. 1980)). These factors include: (i) the amount of time and effort applied to the case by counsel for the plaintiffs; (ii) the relative complexities of the litigation; (iii) the standing and ability of petitioning counsel; (iv) the contingent nature of the litigation; (v) the stage at which the litigation ended; (vi) whether the plaintiffs can rightly receive all the credit for the benefit conferred or only a portion thereof; and (vii) the size of the benefit conferred.

The attorneys' fees sought by the plaintiffs were \$3.6 million, which amounted to approximately 21 percent of the \$16.8 million "bump" agreed to in the Settlement. The defendants argued that the plaintiffs should only receive \$423,598, which is approximately 2.52 percent of the \$16.8 million "bump". The plaintiffs argued that their time and efforts were substantially responsible for the initial proposed increase in the tender offer, and thus, the plaintiffs should receive the fee award requested. The defendants, on the other hand, looked to case law to argue that recent "bump cases" showed that courts have awarded fees ranging from 1.30 percent to 4.97 percent of the "bump", therefore making the plaintiffs' request unreasonable.

The Court found that the time spent by the plaintiffs' counsel on the case was excessive in relation to what was necessary for prosecution of the case, and thus, the Court declined to credit the full amount of hours submitted as being reasonable. In addition, the Court noted that although the matter was a moderately complex case, the plaintiffs' counsel did not undertake much risk even though the case was taken on a contingent basis.

The Court then analyzed whether the plaintiffs' counsel should receive credit for

the benefit conferred in the Settlement. The Court stated that three factors played a role in the benefit received by the plaintiffs: (1) the market's tepid reaction to the tender offer; (2) the efforts of a special negotiating committee; and (3) the plaintiffs' counsel's efforts in the Action. However, the Court found that the plaintiffs' counsel's efforts did not provide the "primary impetus" for the price bump. The Court wrote that although the Action "was not the driving force behind the bump, it did contribute to the increase in consideration." The Court ultimately determined that while the plaintiffs were not entitled to the requested 21 percent, they were entitled to more than 2.52 percent suggested by the defendants. The Court noted that the plaintiffs had shown that the Action was sufficiently different from and more difficult than the cases cited by the defendants. On that basis, the Court determined to approve an award higher than the "comparable" cases analyzed by the defendants.

With all factors taken into consideration, the Court awarded the plaintiff's attorneys' fees and costs in the amount of \$1,077,038 which is approximately 6 percent of the \$16.8 million. This total included attorneys' fees in the amount of \$1,010,450 and \$66,588 for documented expenses.

TRESSLER COMMENTS

In the standard "bump" case and pursuant to typical D&O policy language, plaintiffs' attorneys' fees are generally the only component of a settlement that an insurer will fund as covered "Loss". Very often, the plaintiffs will seek multi-million dollar fee awards for cases involving only minimal effort. Because any fee award is to be paid by the insurer, the defendants/insureds are often not sufficiently motivated to challenge the fees requested by plaintiffs' counsel. Accordingly, it is the insurer, when asked to consent to a settlement, that must make the case for a "reasonable" fee award. The *Cox* decision will provide welcome guidance and support for insurers when they are called upon to address these issues.



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FIFTH CIRCUIT HOLDS THAT A PROFESSIONAL SERVICES EXCLUSION SHOULD EXCLUDE ONLY “PROFESSIONAL SERVICES,” EVEN THOUGH THE EXCLUSION STATES THAT IT APPLIES TO “ALL OPERATIONS OF THE INSURED”

In *Admiral Insurance Company v. Randall K. Ford d/b/a R.K. Ford and Associates*, 607 F.3d 420 (5th Cir. May 21, 2010), the Fifth Circuit interpreted a professional services exclusion that applies to “all operations of the insured.” The insured argued that the exclusion is unenforceable, because as written, the exclusion would eliminate coverage for all claims brought against the insured. The District Court for the Western District of Texas agreed with the insured, but the Fifth Circuit reversed, finding that the insured could not reasonably have believed it was purchasing an insurance policy that provided no coverage. Accordingly, the Fifth Circuit determined that the parties intended to exclude only those claims arising from the insured’s operations involving “specialized knowledge and training,” thereby reading Texas’s usual definition of “professional services” into the exclusion.

Randall K. Ford d/b/a R.K. Ford (“Ford”) and Associates is a consulting company that provides engineering, drilling, and other consulting services for oil and gas field owners and operators. Exco Resources, Inc., an independent energy company specializing in oil and natural gas extraction, hired Ford to create a drilling plan for an oil well. After a well blowout, Exco sued Ford.

Ford tendered Exco’s claim to Admiral Insurance Company under two insurance policies Ford had purchased from Admiral: a professional liability policy, and a general liability policy. The professional liability policy provided limits of \$50,000 per claim, while the general liability policy provided limits of \$1 million per occurrence. The general liability policy contained a “professional services” exclusion that eliminated coverage for designated professional services, defined on a Schedule providing a “Description of Professional Services” to include “all operations of the insured.”

Admiral paid the \$50,000 in limits under its professional liability policy, but refused to defend Ford under the general liability policy, based on the professional services exclusion. Admiral filed this declaratory relief action, arguing that it had no duty to provide coverage to Ford under either the professional liability or the general liability policy. Admiral ultimately abandoned its efforts to seek reimbursement for the \$50,000 it paid under the professional liability policy, but continued to seek a declaration that it had no obligation to provide coverage under the general liability policy.

The parties brought cross-motions for summary judgment. Admiral argued that the “professional services” exclusion eliminated the potential for coverage, because Exco’s lawsuit against Ford arose entirely out of Ford’s professional consulting services to Exco regarding oil extraction. Ford argued that the “professional services” exclusion was impermissibly broad, because it purported to exclude coverage for “all operations of the insured,” not just professional services.

The District Court for the Western District of Texas ruled in favor of Ford. It agreed that

the “all operations” language in the Admiral insurance policy’s “professional services” exclusion was so broad that it eviscerated coverage. Therefore, the District Court agreed that the exclusion could not be enforced because it rendered coverage under the policy illusory. Accordingly, the District Court concluded that Admiral owed coverage to Ford under the general liability policy.

Admiral appealed, and the Fifth Circuit reversed. As an initial matter, the Fifth Circuit found that despite the “all operations” language in the professional services exclusion, it was not reasonable to believe that Ford paid premiums for a policy it thought excluded coverage for claims arising out of all of its operations. The Fifth Circuit found that the “all operations” language is a “Description of [the] Professional Services” that are incorporated within the exclusion, not a *definition* of professional services. Texas courts have defined “professional services” as those services using the insured’s “specialized knowledge and training.” Based on its reading of the exclusion, and the definition of “professional services” approved by Texas courts, the Fifth Circuit found that the reasonable interpretation of the exclusion was that it excluded coverage for claims arising out of any “specialized knowledge and training” with respect to any of Ford’s operations.

Applying its interpretation of the “professional services” exclusion to eliminate coverage only for those operations requiring Ford’s specialized knowledge or training, the Fifth Circuit found that the exclusion applied to Exco’s action against Ford. Exco’s claims against Ford were for professional negligence in failing to identify safeguards that could have prevented a well blowout. Accordingly, the “professional services” exclusion eliminated



the potential for coverage.

TRESSLER COMMENTS

The posture of this case was unusual, because the insured argued for an extremely broad interpretation of the applicable exclusion, in an effort to have it found unenforceable.

Substantively, this case provides guidance regarding the limits of the “plain language” rule for policy interpretation. In general, courts enforce the plain language of insurance policy provisions, unless there is any ambiguity. Here, the professional services exclusion

applied to “all operations of the insured.” Nevertheless, the Fifth Circuit found that the “usual interpretation” of a “professional services” exclusion prevails, rather than its “plain language,” based on the reasonable expectations of the parties. It was significant that Texas has a well-developed body of law regarding professional services exclusions, which allowed the Fifth Circuit to cite to previous findings regarding the intent of such exclusions.



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(1985) for the proposition that New Jersey courts strictly enforce notice requirements of a claims made policy. The court found that the October 12, 2006 letter was a “claim” as defined in the policy, because it was a demand for money and it alleged “completely inadequate” representation on the part of Russoniello, which “may well be considered malpractice.” The court further noted that the letter went so far as to threaten to refer the matter to the Office of Attorney Ethics and the Client Protection Fund, and that papers were being forwarded to a selected attorney.

Pursuant to the aforementioned terms of the Policy, the court calculated that the insured was obligated to report the allegation of malpractice under the 06-07 Policy after receipt of the October 12, 2006 letter, but in no event later than 60 days after the expiration date of that policy, or November 22, 2007.

The insured did not dispute that his October 23, 2008 notification to Twin City of Columbia’s claim occurred approximately eleven months after the reporting period ended. Instead, the insured’s sole argument in opposition to summary judgment was based upon his subjective state of mind, and “belief” that Columbia’s letters were nothing more than a “shake down” – “a disgruntled client who wanted his money back because of poor planning on his part” - which negated his obligation to notify Twin City of Columbia’s claim. The insured explained that this subjective belief was the reason why he had not notified Twin City of Columbia’s claim until October 28, 2008.

The court rejected the insured’s argument for two reasons. First, it found that the definition of a “claim” does not include a subjective component, which would allow an insured to determine whether a demand has merit. Second, pursuant to Zuckerman, the notice requirement of a claims made

policy are “strictly enforced without regard to an insured’s subjective assessment of the merits.” The court found the case factually analogous to Zuckerman. There, the plaintiff did not provide timely notice of a claim against him because “he believed the claim was ‘minimal’ and could be settled within the deductible limits of his insurance policy.” Id. at 306. The New Jersey Supreme Court, however enforced the terms of the claims made policy as written, and affirmed summary judgment in favor of the insurer, reasoning that any extension of the notice period would constitute “an unbargained-for expansion of coverage.”

The court viewed the insured’s reluctance to make timely notice of Columbia’s claim to Twin City as understandable. It recognized that the insured, as a solo practitioner, was perhaps concerned that such notice may result in his malpractice premiums increasing in the future, and that it would be more cost effective not to report the claim and settle the client dispute informally. Critically, however, the court held that the notice provisions within the insured’s claims made policy were for the most part absolute and, therefore, the insured’s approach turned out to be wrong.

TRESSLER COMMENTS

The defendant insurer was able to obtain summary judgment by relying on late notice because the definition of a “claim” entailed no subjective determination on the part of the insured as to the relative merits of the demand. This case should be compared and contrasted with those wherein an insurer seeks to disclaim coverage based upon an exclusion within the policy withholding coverage for a claim which the insured “knew or reasonably could foresee” might give rise to a malpractice claim.

As alluded to by the court, the standard in such “known circumstances” cases under

New Jersey state law is dependent solely upon the insured’s subjective assessment. See Liebling v. Garden State Indemnity, 337 N.J. Super. 447 (App. Div. 2001) (applying New Jersey state law); contrast Colliers Lanard & Axilbund v. Lloyds of London, 458 F.3d 231 (3d Cir. 2006) (Third Circuit decision predicting the New Jersey Supreme Court would adopt a mixed subjective/objective standard) and Navigators Specialty Ins. Co. v. Scarinci & Hollenbeck, LLC, et al., Case No. 09-4317, 2010 U.S. Dist. LEXIS 47124 (D. N.J. May 12, 2010) (New Jersey federal district court decision discussed in this same issue of *Specialty Lines Advisory* and applying a mixed subjective/objective standard).

Nonetheless, all of these decisions are inapposite to the court’s straightforward analysis here pertaining simply to late notice of an actual claim.



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