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Joe Says ...



When An Exclusion Applies "Absolutely"

On July 15, 2009 the Delaware Superior Court in New Castle County rendered a decision in Health Corp. and Emdeon Practice Services v. Clarendon National Ins. Co., et al., C.A. No. 07C-09-102 RRC. This firm represents an insurer defendant in this litigation that was not involved in the resolution of the particular issue decided favorably by the Court to the benefit of another insurer defendant.

At issue in this decision was a "runoff endorsement" that provided as follows:

[The Insurer] shall not be liable for Loss on account of any Claim based upon, arising out of, or attributable to any Wrongful Acts where all or any part of such acts were committed, attempted or allegedly committed or attempted subsequent to [date]. (emphasis added)

Variations of this language are often called "prior acts exclusions" in D&O policies or "retroactive date exclusions" in E&O policies. The names may vary, but the substantive effect is the same. The wording above is what I have historically classified as a "super absolute" version of the exclusion, essentially because of the italicized language "where all or any part". What this is saying is that, even where only some of the wrongful acts pre-date the date in the exclusion, the entire claim is subject to denial of coverage¹. This is indeed powerful wording and understandably

1 - The Court indeed saw it exactly that way and ruled in favor of the insurer in applying the exclusion to hold that there was no coverage for criminal indictments where some of the offenses took place before the date inserted in the exclusion and some took place after.

resisted by astute brokers, agents and insureds' counsel when the insurer tries to incorporate it into its policy².

A simpler, but nonetheless "absolute" version, may read as follows:

The Insurer shall not be liable to make any payment for Loss in connection with any claim made against the insureds, that is, *directly or indirectly, based on, attributable to, arising out of, resulting from, or in any manner relating to* wrongful acts committed, attempted or allegedly committed or attempted prior to [date]. (emphasis added)

Insurers may still try to make the same contention as under the "super absolute" wording, arguing that the post-date wrongful acts relate back to, are based upon, or arise from the pre-date conduct. However, this version is fairly common in the marketplace.

Perhaps the least offensive version from the standpoint of the insureds would be the following:

The Insurer shall not be liable to make any payment for Loss in connection with any claim made against the insureds for wrongful acts committed, attempted or allegedly committed or attempted prior to [date]. (emphasis added)

This version would arguably result in - at best (or worst, dependent upon one's perspective) - the need to allocate or apportion loss between the covered and uncovered acts at issue. Nonetheless, the fact sensitivity of individual claims can result in disputes as to when wrongful acts actually took place or whether or not the pre-date acts are even allegedly wrongful for purposes of coverage.

2 - Permit me some immodesty in noting that the Court cited in its Opinion to one of my articles on the subject of this type of wording in supporting its conclusion that the wording had a broad exclusionary impact. Joseph P. Monteleone, Directors' and Officers' Liability Insurance, 686 Practising Law Institute (2003).

There is no right way or wrong way of drafting the exclusionary language here - the desirable approach simply depends on your perspective and constituency.

The language that prevailed here should almost always be advocated by insurers and their counsel who assist them in the drafting process. One can only speculate whether the result would have been the same with the less absolute wording not containing the "where all or part of" phrase. Most assuredly, the insurer would not have fully prevailed using the simple "for" version of the exclusion.

Nevertheless in today's market, perhaps putting aside the "hard" financial institution and financial services D&O/E&O markets, astute brokers and policyholder counsel will resist vigorously the "super absolute" language. Beauty however, is truly in the eye of the beholder and, as an insurer's coverage lawyer, I prefer super absolute beauty!

Would you like to offer a comment? Click here to let me know what you think.

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ELEVENTH CIRCUIT UPHOLDS PROFESSIONAL LIABILITY INSURER'S DENIAL OF COVERAGE FOR CLAIM THAT DID NOT INVOLVE THE INSURED LAW FIRM'S "PROFESSIONAL SERVICES"

In *Great American Ins. Co. v. Baddley & Mauro, LLC*, No. 09-10014, 2009 WL 1316094 (11th Cir. May 13, 2009), the Eleventh Circuit, applying Alabama law, affirmed a summary judgment finding that an insurer had no duty to defend a suit against its insured, a law firm, which alleged that the firm improperly diverted settlement funds into its own trust account, since the action did not arise out of the services provided by the firm, but out of a dispute over what the fee arrangement was between them.

This appeal arose out of a suit against a law firm, Baddley and Mauro, LLC ("Baddley" or "the firm") by its client, Serra Chevrolet ("Serra"), as a result of a suit Baddley had filed against General Motors ("GM") on behalf of Serra. Baddley and Serra had a contingency fee agreement whereby each would first recover its expenses before apportioning the remainder of any recovery according to a prearranged ratio. Serra and GM settled for \$3.5 million, and that amount was to be paid in two equal installments. Baddley sent Serra an accounting of the firm's expenses, but Serra disagreed with the accounting. GM sent the first installment of the settlement to Baddley by way of a check made payable to Baddley. Baddley deposited the check into its trust account pending resolution of the fee dispute with Serra. When Serra and Baddley could not resolve the dispute, Baddley issued a check for \$1,277,500 to itself and for \$472,500 to Serra. It then filed an action in state court seeking declaratory relief that it paid the amount properly owed to Serra.



Serra then sued Baddley, alleging that Baddley committed mail and wire fraud when it instructed GM to send the first settlement payment to Baddley rather than Serra without the approval of or notice to Serra. Serra also alleged racketeering and embezzlement, breach of civil duty as officers of the court, breach of fiduciary duty to Serra, conversion of Serra's property, malpractice, and intentional interference with contractual and business relations between Serra and GM.

Baddley notified Great American, its professional liability insurer, and requested a defense of Serra's action and approval to retain its own counsel. Great American approved the request of a defense pending its decision regarding coverage. Ultimately, Great American declined to defend or indemnify Baddley on the grounds that the "essence of the dispute" was a demand for the return of the legal fees and costs allegedly misappropriated by Baddley.

Great American sought a declaratory judgment in federal court that it was not obligated to defend or indemnify Baddley for its alleged misconduct. Both parties sought summary judgment. The district court granted summary judgment to Baddley on the ground that the issue of whether Great American had a duty to indemnify the firm was not ripe for review and to Great American on the grounds that it had no duty to defend Baddley. It concluded that Serra's action did not arise out of Baddley's representation of Serra, as defined in Great American's policy, but out of a fee dispute between Serra and Baddley.

On appeal, Baddley contended that the district court had erred on the grounds that Serra's claim was covered under Great American's policy and because the court should not have considered evidence extrinsic to Serra's complaint. The Court of Appeal rejected both of Baddley's arguments. As to coverage under the Great American policy, the Court of Appeal turned to the language of the policy to support its holding. The Great American policy covered "all Damages and Claim Expenses arising out of a Claim." The policy defined claim as "any demand received by [Baddley] for money or services . . . arising out of [their] acts, errors or omissions in providing Professional Services." Professional services were defined as "services that [Baddley] perform[ed] for a client in [its] capacity as a lawyer . . . or in any other fiduciary capacity, provided that such services are connected with and incidental to [its] profession as a lawyer."

In affirming that Great American did not have a duty to defend Baddley, the Court of Appeal stated that Serra's action had alleged that Baddley diverted GM's settlement payment to satisfy its outstanding legal fees without Serra's authority. These alleged actions were "self-serving and were not made on behalf of or to protect the interest of its client, Serra." Consequently, the claim was not covered as it did not arise out of professional services provided by Baddley.

TRESSLER COMMENTS

Based on the brevity of this decision, it is clear that the Eleventh Circuit did not strain to apply the plain language of the policy and to limit the definition of "professional services" to bar coverage for actions that were not taken to protect the interests of the firm's clients. The Court of Appeal viewed the underlying action against the firm as involving simply a fee dispute that arose after the conclusion and settlement of suit by the firm's client. Arguably, this set of facts presented a "bright line" for the Court to reach its decision.



Prepared by Linda Bondi Morrison, a Partner in our Orange County office.

TACO BELL THINKS "OUTSIDE THE BUN" IN SECURING COVERAGE FOR LOSS OF BUSINESS INCOME DUE TO AN E. COLI OUTBREAK

In the recent NJ trial level decision, *Quick Service Management, Inc. v. Underwriters of Lloyds*, N.J.L.J., July 1, 2009 (Law Div. Middlesex County), a claim for loss of business income under a "Trade Name Restoration, Loss of Business Income and Incident Response Insurance for Food Borne Illness" ("TNR") policy was found to be covered because the policy language was ambiguous. Although Underwriters of Lloyds ("Underwriters") have now filed an interlocutory appeal from the trial court's decision, the lengthy opinion issued by the trial court judge illustrates the breadth of extrinsic evidence that a NJ court will consider in its attempt to determine the reasonable expectation of the parties.

The matter arose out of an outbreak of E. coli, an infectious disease, which was traced to food sold at Taco Bell restaurants. The source of the contamination was then traced to lettuce which originated with Ready Pac Produce, Inc. At the time of the outbreak, the franchisees of Taco Bell Restaurants were insured under a TNR policy issued for the 2006-2007 policy year. It was conceded by all parties that the outbreak and media coverage of it was an "Incident" under the Policy.

On cross-motions for summary judgment and partial summary judgment, and after the court permitted

extensive discovery, the trial court considered whether the insureds were covered for lost income following the publicity related to the outbreak or whether the insurer had no indemnity obligation because the policy contained a \$0 Aggregate Supplier Incident Sublimit ("Sublimit").

While the declarations page issued to the insured reflected the \$0 Sublimit, the trial court found that there was a dispute as to what "\$0" means.

Specifically, the Sublimit reads in pertinent part that it constitutes the:

"...maximum liability for all losses affecting all "Covered Locations" insured hereunder resulting from all "Incidents" emanating from the operations of any product supplier of the Insured shall not exceed the "Aggregate Supplier Incident Sublimit"..."

In considering the argument by the insured that the policy is ambiguous, and by the insurer that the sublimit is clear, the court evaluated not only extrinsic evidence but also out of state case law interpreting language of a similar type of policy. As for extrinsic evidence, the court noted that marketing for the "Trade Name Restoration, Loss of Business Income and Incident Response

Insurance for Food Borne Illness" ("TNR") coverage stated: "even the best restaurants can suddenly be trapped in an infectious health situation...due to a food borne illness or supplier mistake that ends up totally out of control." The court also pointed out that in policies purchased by the franchisees in the pre-2003 time frame, the Food Borne Illness ("FBI") policies had no supplier sublimit. The insured franchisees argued that when the Food Borne Illness policies were discontinued, the TNR policies did not explain that coverage previously provided under the FBI policies was discontinued. Despite the insurer's argument that the



franchisees' broker bound the insureds to the \$0 Sublimit, the court determined that there was no evidence the broker ever explained to the insureds the meaning of the \$0 Sublimit. Indeed, the court held that the broker's views about the Sublimit were not dispositive as to the court's analysis of the reasonable expectation of the insureds.

With respect to the specific language contained within the Sublimit, the court criticized Underwriters for not defining critical terms. The court noted the absence of a definition for "product supplier" and contrasted the "product supplier" terminology within the policy Sublimit with a question on the policy application (made a part of the policy) which requested the insured name its "Top 5 suppliers." Since the item that caused the incident was lettuce that was incorporated into the food sold by Taco Bell, the court noted that the failure to define "product" and whether an ingredient like lettuce was considered a "product" created an ambiguity to be resolved in favor of the insured.

Additionally, in arriving at this decision, the court noted that the Underwriters TRN policy utilizing "product supplier" terminology was different than language that was at issue in another case wherein the policy language was "any supplier of goods or services." The NJ court noted that an Illinois court had interpreted "any supplier of goods or services" as unambiguous as it "denoted

an unrestricted group of those who furnish what is needed or desired."

TRESSLER COMMENTS

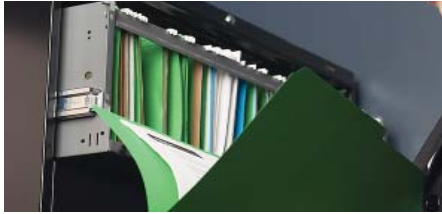
Quick Service is yet another example of an apparent extension of coverage beyond what the insurer Underwriters and the insured's broker understood and agreed the policy would provide. Despite the use of sophisticated insurance personnel to procure the franchisees' policy, the court was persuaded by the Taco Bell insureds that they reasonably expected coverage for the loss. While an interlocutory appeal has been filed from this trial level decision, in New Jersey the acceptance of an interlocutory appeal by the court is highly discretionary and only granted "in the interest of justice." Frankly, it would be surprising if the appellate court grants leave to appeal given that the outcome only affects commercial parties monetarily and the appellate court generally will grapple with such issues only on appeal from a final judgment.



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INSURER'S COMPELLING REASONS NOT COMPELLING ENOUGH TO DEVIATE FROM "FIRST-TO-FILE" RULE

In *Twin City Ins. Co. v. Key Energy Services, Inc.*, No. 09-0352, 2009 U.S. Dist. LEXIS 46267 (S.D. Tex. June 2, 2009), the court held that no compelling circumstances existed to depart from the first-to-file rule and ordered the transfer of an excess insurer's declaratory judgment action against its insured to the federal court to which the first-filed state court action was removed.



Background:

In November 2007, having settled multiple federal and state securities class action and shareholder derivative suits for \$16.6 million (in addition to incurring \$5.3 million in defense and settlement costs), Key Energy Services, Inc. ("Key Energy") made a claim with its primary insurer, National Union Fire Insurance Co. ("National Union") and its secondary insurer, RLI Insurance Co. ("RLI"). National Union paid Key Energy its \$10 million policy limit while RLI agreed to pay \$9 million in exchange for Key Energy's release of RLI's obligation to pay under the secondary policy. Thereafter, Key Energy filed a claim with Twin City Insurance Co. ("Twin City"), its excess insurer, for \$914,424.56 (the difference between the \$1 million deductible and \$20 million maximum coverage provided by National Union and RLI from Key Energy's total expenses of \$21,914,424.56). Twin City refused to pay, asserting that coverage was not available under the excess policy because RLI neither admitted liability nor paid the full amount of its liability under the secondary policy.

In late 2008, and pursuant to the excess policy, Twin City and Key Energy attended mediation, but were unable to reach a settlement. On February 9, 2009, at 12:03 a.m., Key Energy filed suit against Twin City in the District Court of Midland County, Texas, for breach of contract and seeking a declaratory judgment declaring, among other things, that Twin City was obligated to pay under the excess policy. Eight hours later, at 8:16 a.m., Twin City filed the present action in the Southern District of Texas, also asserting a breach of contract claim and seeking a declaratory judgment declaring that it was not liable to Key Energy for any amount under the excess policy. A month or so later, Key Energy moved to dismiss Twin City's complaint, alleging that because of its similarity with the issues presented in Key Energy's state action, the federal action should be dismissed or stayed in accordance with the Anti-Injunction Act. The following

day, Twin City removed Key Energy's state court action to the U.S. District Court for the Western District of Texas and then asked the Western District to transfer the action to the Southern District or, alternatively, that the Western District stay the action until the Southern District had ruled on its pending motion for summary judgment.

Before the court was Key Energy's motion to dismiss Twin City's complaint.

Legal Standard and Discussion:

The court began its analysis by pointing out that because Key Energy's state action had been removed to federal court, the standard for dismissal due to the pendency of the parallel federal proceeding was the "first-to-file" rule, which requires that when related cases are pending before two federal courts, the court in which the case was last filed may refuse to hear it if the issues raised by the cases substantially overlap. In opposition to the motion to dismiss, Twin City argued that several "compelling circumstances" justified a deviation from the first-to-file rule.

First, Twin City argued that it had been disadvantaged due to its inability to access the court's electronic filing system due to technical difficulties. The court flatly rejected this argument finding that other courts confronted with this argument have concluded that the first-to-file rule is no less applicable even when parallel suits are filed almost simultaneously. The court also rejected Twin City's argument that Key Energy engaged in forum shopping by filing a state court action in anticipation of being sued. The court keenly noted that since both parties admitted that they tried to file their actions shortly after midnight, both parties were attempting to file anticipatory suits. To agree with Twin City on this point would have essentially required the court to replace the first-to-file rule with the "second-to-file" rule.

The court was also not persuaded by Twin City's request that the court look "to the considerations that govern transfer of venue for forum *non conveniens* under 28 U.S.C. § 1404(a)" to determine if departure from the first-to-file rule was warranted. To do just that, the court reasoned, would require the court to do exactly what the first-to-file rule is designed to avoid — i.e. rulings

which may trench upon the authority of sister courts. The court further stated that the Fifth Circuit has made it clear that the first-filed court should make the § 1404(a) determinations.

Twin City then contended that the court should consider how much progress had been made in the two actions in deciding whether to follow the first-to-file rule. However, because the court agreed with Key Energy that the Western District action had actually progressed further than the present action (the pleadings were now closed in the Western District action), Twin City's argument actually favored following the first-to-file rule.

Neither did the court find Twin City's final argument persuasive that "given the presence of Twin City's breach of contract action, dismissing Twin City's declaratory action would actually create the very piecemeal litigation that the first-to-file rule was designed to avoid." The court simply concluded that the first-to-file rule was not limited to declaratory judgment claims only. In doing so, the court granted Key Energy's motion to dismiss and also transferred the action to the Western District of Texas for further adjudication.

TRESSLER COMMENTS

As one can readily see in the context of these cases filed eight hours apart, the "first-to-file" rule can serve as a powerful procedural advantage in many jurisdictions. Nonetheless, in this case there appeared to be a number of other factors, including judicial economy and fundamental fairness, underpinning the Court's enforcement of the rule.



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TEXAS LAW REQUIRES INSURER TO SHOW PREJUDICE IN ORDER TO DENY COVERAGE BASED ON LATE NOTICE UNDER A CLAIMS-MADE POLICY

In a *non-published opinion*, XL Specialty Ins. Co. v. Financial Indus. Corp., No. 06-51683, 2009 WL 1532047 (5th Cir. June 1, 2009), the Fifth Circuit Court of Appeals vacated the district court's grant of summary judgment to the insurer, holding that under Texas law, the insurer was required to show it was prejudiced from an insured's late notice before denying coverage on a claims-made policy.

Policy Background

XL Specialty Insurance Company ("XL") issued a claims-made management liability policy to Financial Industries Corporation ("FIC") for the policy period of March 12, 2005 to March 12, 2006 (herein "the Policy"). The Policy contained a prompt-notice provision. The Policy provided, in relevant part: "As a condition precedent to any right to payment under the Policy with respect to any Claim, the Insured shall give written notice to the Insurer of any Claim as soon as practicable after it is first made."



Insurer Files Declaratory Judgment Action In Federal Court

On June 5, 2005, two plaintiffs sued FIC for breach of contract and fraud. FIC notified XL of the suit seven months after the suit was filed but during the policy period. XL filed a declaratory judgment suit in the U.S. District Court for the Western District of Texas, seeking a declaration that the Policy did not cover FIC for the underlying lawsuit because FIC's late notice breached the Policy's prompt-notice provision. XL moved for summary judgment. The parties stipulated that FIC failed to give prompt notice, but that XL had not suffered any prejudice because of FIC's failure. The district court granted judgment in XL's favor. The district court held that under Texas law, an insurer need not demonstrate prejudice from late notice to avoid coverage on a claims-made policy.

Insured Appeals To Fifth Circuit

FIC appealed the matter to the U.S. Court of Appeals for the Fifth Circuit. The Fifth Circuit recognized that the case raises an important and determinative question of Texas law: "Must an insurer show prejudice to deny payment on a claims-made policy, when the denial is based upon the insured's breach of the policy's prompt-notice provision, but the notice is nevertheless given with the policy's coverage period?" Fin. Indus. Corp. v. XL Specialty Ins. Co., 259 Fed. Appx. 675

(5th Cir. Dec. 19, 2007). The Court observed that this question had not been previously answered by any controlling Texas Supreme Court precedent and that Texas Courts of Appeal appeared to take different positions on the prejudice requirement. The Court, therefore, certified the question to the Texas Supreme Court to address the issue prior to ruling on the appeal.

Texas Supreme Court Addresses The Fifth Circuit's Certified Question On Late Notice

On March 27, 2009, the Texas Supreme Court answered the question in the affirmative, concluding that the insurer must show prejudice. Fin. Indus. Corp. v. XL Specialty Ins. Co., No. 07-1059, 2009 WL 795529 (Tex. Mar. 27, 2009). The court noted that the Policy was without a "clear-cut reporting deadline" for the reporting of claims to the insurer notice was required to be given "as soon as practicable." However, while the insured failed to report a claim as soon as practicable, it had done so before the expiration of the Policy. The court noted that the "inherent benefit of a claims-made policy is the insurer's ability to close its books on a policy at its expiration and thus to attain a level of predictability unattainable under standard occurrence policies." The court held that, because notice had been received before the end of the policy period, i.e., before "XL could 'close its books' on the Policy," "XL was not denied the benefit of the claims-made nature of its policy." The court, therefore, stated that XL could not deny coverage without showing prejudice.

Fifth Circuit Vacates Summary Judgment

Since Texas law now clearly required XL to show prejudice resulting from FIC's late notice and it was undisputed by the parties that no such prejudice exists, the Fifth Circuit Court of Appeals determined that XL was not entitled to summary judgment at the district court level. Therefore, the Fifth Circuit vacated the district court's grant of summary judgment to XL and remanded the case back to the lower court for further proceedings consistent with its opinion.

TRESSLER COMMENTS

While this opinion follows the Texas Supreme court's decision to extend the prejudice requirement to claims-made policies, it

may be distinguishable under some fact scenarios. The fact that notice was given during the policy period was pivotal to the court's rationale. If the insureds had given notice *after* the Policy's expiration date, the court may have reached a different conclusion. In addition, although the "as soon as practicable" language is common in notice provisions in management liability insurance policies, the court may have reached another decision had the Policy contained a provision with a more specific time frame for providing notice of a claim. (However, using such language may change the nature of the Policy from "claims-made" to "claims-made and reported.") It is also important to note that other jurisdictions, such as Pennsylvania, still do not extend the prejudice requirement to claims-made policies. Therefore, both insurers and insureds must be familiar with the law on this issue in the applicable jurisdiction.



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SEVENTH CIRCUIT FINDS THAT THE “MERE SPECTER OF PUNITIVE DAMAGES” DID NOT CREATE AN ACTUAL CONFLICT REQUIRING THE INSURER TO PROVIDE INDEPENDENT COUNSEL

In a matter in which Tressler, Soderstrom, Maloney & Priess, LLP working in conjunction with Meagher & Geer, P.L.L.P. represented the prevailing insurer, National Casualty Company filed a declaratory action seeking a ruling that it had no obligation to reimburse Forge Industrial Staffing, Inc. (herein “Forge” or “insured”) for its independent counsel fees incurred in defending four Equal Employment Opportunity Commission (herein “EEOC”) Charges. Additionally, National Casualty sought a ruling as to the applicable coverage part of the policy arguing that the allegations of the EEOC Charges triggered only the policy’s Employment Practices Liability Coverage Part, and not the Personnel Consultants and Temporary Help Services Professional Liability Coverage Part. The U.S. District Court, Northern District of Illinois, found in favor of National Casualty on both issues, and entered a money judgment against Forge in the amount of its deductible under the Employment Practices Liability Coverage Part. On Appeal, the Seventh Circuit affirmed finding that National Casualty was under no obligation to appoint/fund independent counsel, and that the EEOC Charge allegations triggered only the Employment Practices Liability Coverage Part. National Cas. Co. v. Forge Indus. Staffing, Inc., 567 F.3d 871 (7th Cir. 2009) (applying Illinois law).

National Casualty Company (herein “NCC”) issued a Professional and Employment Practices Liability policy, number TH00001021, to Forge Industrial Staffing, Inc. for the period of May 27, 2005 to June 24, 2006. The policy contained two coverage parts, namely, the “Employment Practices Liability Insurance Coverage Part,” (herein “EPL”) and the “Personnel Consultants and Temporary Help Services Professional Liability Coverage Part” (herein “Professional Liability”). Each coverage part was provided under a separate policy form, which set forth an insuring agreement, exclusions, conditions, and definitions. The EPL Coverage Part was subject to a \$25,000 deductible. The Professional Liability Coverage Part was subject to a \$5,000 deductible.

In relevant part, the EPL insuring agreement stated, “[NCC] have the right and duty to defend any suit against You seeking Damages because of Employment Practices...[w]e have the right to appoint counsel and investigate any Claim or suit.” Furthermore, the EPL coverage part stated, “You, except at Your own cost and for Your own account, will not: (1) make any payment; (2) admit any liability; (3) settle any Claim; (4) assume any obligation; or (5) incur any expense, without Our written consent.” Finally, the policy states, “[NCC] will have full discretion in the handling of any Claim, and You will give full information and assistance as We may reasonably require. You will cooperate with Us.”

The EPL Coverage Part also excluded coverage for “punitive damage awards” or for any claim arising out of Forge’s “willful failure...to comply with any law...or regulations relating to employment practices.” “Willful” was defined under the policy as “acting with intentional or reckless disregard for such employment-related laws, orders or regulations.”

The insuring agreement of the Professional Liability Coverage Part extended coverage for “claims” seeking “damages” for “wrongful acts.” “Wrongful acts” was defined to mean “any actual or alleged negligent act, error or omission, misstatement, misleading statement, breach of duty or any alleged Personal Injury

offense You or any person or entity for whom You are legally responsible commit, but only in the performance of Personnel Consulting Services or Temporary Help Services for or on behalf of the Named Insured.”¹ Exclusion 13 of the Professional Liability Coverage Part excluded coverage for any claims alleging “wrongful termination,” “actual discrimination” or “retaliatory treatment.”

Forge, a staffing company that places temporary and, sometimes, permanent employees at companies throughout the United States, was the subject of four discrimination charges filed with the EEOC by former employees. In sum, the EEOC charges alleged that Forge terminated the claimants/former employees due to their race and/or gender and/or in retaliation for complaining about Forge’s staffing practices, which allegedly included honoring clients’ requests not to provide employees of certain races, ethnicities and/or gender. Forge tendered the EEOC Charges to NCC, and requested that NCC defend Forge in the EEOC proceedings. NCC agreed to defend Forge under the EPL coverage part of the policy, issued a general reservation of rights, and appointed counsel to defend Forge. Forge responded by alleging that NCC’s control of its defense in the EEOC proceedings created a purported conflict of interest, and demanded that NCC provide independent counsel to defend Forge. Forge reasoned that whether NCC would indemnify Forge under the policy was dependent on how the EEOC Charges were defended. In particular, Forge argued that because NCC had referenced the “punitive damage” and the “willful failure to comply” exclusions in its reservation of rights letter, NCC’s control of Forge’s defense could affect, if not nullify, NCC’s ultimate indemnity obligation. When NCC refused to appoint independent counsel to defend Forge, Forge retained its own counsel and demanded that NCC pay independent counsel’s fees and

1 - The term “Personnel Consulting Services” was defined as “the selection, recruitment or placement of any candidate(s) for permanent employment with Your client.” The term “Temporary Help Services” is defined to mean “the selection, recruitment or placement of any candidate(s) for temporary employment with Your client.”

costs. NCC filed a complaint for declaratory judgment in the United States District Court, Northern District, Illinois seeking to adjudicate not only the conflict issue, but also the issue of the applicable coverage part.

The District Court ruled in favor of NCC on all issues, finding: the allegations of the EEOC Charges did not create an actual conflict requiring NCC to provide independent counsel to defend Forge; the EPL Coverage Part, rather than the Professional Liability Coverage Part, applied based on the allegations made in the EEOC Charges; and entered a money judgment against Forge for \$25,000 – the amount of the EPL deductible. Forge appealed the ruling to the United State Court of Appeals, Seventh Circuit.

Prior to taking up the merits of the parties’ dispute, the Seventh Circuit examined Illinois’ duty to defend and independent counsel doctrines. In Illinois, an insurer has a broad duty to defend its insured in any action where the allegations in the complaint are even potentially within the scope of the policy’s coverage. See, Guillen v. Potomac Ins. Co. of Illinois, 203 Ill.2d 141, 785 N.E.2d 1 (Ill. 2003). Along with an insurer’s defense obligation, the insurer has the right to control and direct the insured’s defense. See, American Family Mutual Ins. Co. v. W.H. McNaughton Builders, Inc., 363 Ill.App.3d 505, 843 N.E.2d 492 (1st Dist. 2006). If, however, there is an actual conflict of interest between the insurer and the insured, the insured has the right to obtain independent counsel at the insurer’s expense. See, Maryland Cas. Co. v. Peppers, 64 Ill.2d 187, 355 N.E.2d 24 (Ill. 1976). An actual, not merely potential, conflict is required to trigger the insured’s right to conflict counsel. See, Murphy v. Urso, 88 Ill.2d 444, 430 N.E.2d 1079 (Ill. 1981). An actual conflict does not arise merely because an insurer has an interest in negating coverage as to every count of the underlying complaint. See, Tews Funeral Home, Inc. v. Ohio Cas. Ins. Co., 832 F.2d 1037, 1047 (7th Cir. 1987) (applying Illinois law). If, after comparing the allegations of the complaint to the terms and conditions of the insurance policy, “it appears that factual issues will be

See *National Casualty* on page 8

resolved in the underlying suit that would allow insurer-retained counsel to 'lay the groundwork' for a later denial of coverage, then there is a conflict between the interests of the insurer and those of the insured." American Family Mut. Ins. Co. v. W.H. McNaughton Builders, Inc., 363 Ill.App.3d 505, 843 N.E.2d 492, 498 (1st Dist. 2006).

Against this backdrop, the Seventh Circuit took up the issue of whether the possibility that punitive damages might be asserted in a future proceeding created an "actual conflict" for purposes of requiring NCC to provide independent counsel to its insured. Relying on Nandorf, Inc. v. CNA Ins. Cos., 134 Ill.App.3d 134, 479 N.E.2d 988 (1st Dist. 1985), Forge argued that the mere "possibility" that the EEOC Charges could result in lawsuits that seek punitive damages "dwarf[ing] the possible compensatory damages" created an actual conflict of interest. By way of background, in Nandorf the underlying plaintiffs sought \$5,000 in compensatory damages and \$100,000 in punitive damages against the insured in connection with the insured's alleged false imprisonment of the plaintiffs. In finding the appointment of conflict counsel warranted, the Court in Nandorf reasoned that an insurer may not have an incentive to provide a "vigorous defense" to its insured when the amount of punitive damages sought greatly outweighs the claimed compensatory damages. Indeed, the court in Nandorf determined that in the face of such a *de minimis* compensatory claim the insurer might find it more economically efficient to put on a "less than vigorous defense" and pay \$5,000 rather than spend excess legal fees to put on a full defense. In finding that conflict counsel was warranted, the court in Nandorf limited its ruling to the "peculiar facts and circumstances of [that] litigation."

After examining Nandorf, the Seventh Circuit concluded that the dispute between NCC and Forge did not present "peculiar facts analogous to Nandorf requiring the appointment of independent counsel." Indeed, punitive damages could not be pled in an EEOC proceeding, and even if such damages were available there was no evidence that the EEOC claimants would seek such relief. Furthermore, even if such relief was allowable and had been pled, there was no indication that such relief would be so disproportionate to the compensatory claim to resemble Nandorf. Thus, the Seventh Circuit concluded that "the specter of punitive damages in this case is merely speculative and does not create an 'actual' conflict." Citing, Littlefield v. McGuffey, 979 F.2d 101, 108 (7th Cir. 1992). To find otherwise, the Seventh Circuit reasoned, would require conflict counsel "in every case in which punitive damages potentially might be requested." Furthermore, in light of the fact that the NCC policy provided coverage for the insured's intentional conduct and because any claim for compensatory and punitive damages would be tied to the same claim, (i.e., alleged discrimination against employees), the Seventh Circuit concluded that there was "no evidence

that Forge and NCC's interest were not aligned on the issue of punitive damages."

Next, the Seventh Circuit addressed whether conflict counsel was required to avoid appointed counsel from "fleshing out" facts during the EEOC proceedings which would remove Forge's claim from the policy's coverage. Forge argued that conflict counsel was warranted to prevent NCC's appointed counsel from "shifting facts" in the EEOC proceedings to indicate that Forge had "willfully violated the law," and thus falling within the NCC policy's "willful failure...to comply with any law..." exclusion. While conceptually agreeing with NCC that because the NCC policy afforded coverage for intentional acts counsel defending against the intentional discrimination would similarly be defending against allegations that Forge willfully violated anti-discrimination laws, the Seventh Circuit focused on whether appointed counsel could "flesh out" certain facts within the EEOC proceedings which could remove the action from the scope of coverage. The Seventh Circuit determined that the danger of appointed counsel "subtly elic[it]ing facts tending to show Forge had knowledge of the applicable anti-discrimination laws" was "of little import" given that such information was likely to be discovered anyway in the EEOC process or in a separate proceeding initiated by NCC.

More importantly, the Seventh Circuit noted that the EEOC Charges contained no allegations that Forge willfully violated the law. Thus, the EEOC Charges "present[ed] neither mutually exclusive theories of liability nor factual allegations which when resolved would preclude coverage." As such, the requirements for the appointment of independent counsel had not been met. In reaching this conclusion, the Seventh Circuit examined and relied upon the matter of Shelter Mut. Ins. Co. v. Bailey, 160 Ill.App.3d 146, 513 N.E.2d 490 (1st Dist. 1987). There, the insured argued that the appointment of conflict counsel was warranted where the complaint alleged negligence and the policy excluded intentional conduct. On par with Forge's position, the insured in Shelter Mutual argued that insurer-appointed counsel could elicit facts tending to show that the insured acted intentionally thus bringing the claim outside the purview of coverage. The Appellate Court in Shelter Mutual concluded that because only one covered theory of liability could be discerned from the face of the complaint, an actual conflict could not be found based on the insured's subjective belief that future pleadings may allege intentional conduct. In acknowledging the sagacity of the Shelter Mutual holding, the Seventh Circuit noted that a contrary ruling "would require the appointment of independent counsel any time a complaint could foreseeably be amended to assert a non-covered theory." As for the dispute pending before it, the Seventh Circuit noted that none of the EEOC Charges contained any specific fact "that could conclusively be resolved such as to preclude coverage under the policy." Thus,

insofar as the EEOC Charges neither contained any claims that Forge willfully violated the law, nor did they contain any fact allegations of Forge's knowledge of anti-discrimination laws, an actual conflict was not present. In rejecting Forge's position that NCC was advantaged by appointed counsel's ability to "inquire into Forge's knowledge of the applicable laws" the Seventh Circuit strictly adhered to Illinois law requiring "crucial facts [be] alleged on the face of the complaint, which if proven completely [] took the matter out of the scope of the insurance policy's coverage." Without such "crucial facts" being alleged on the face of the complaint the alleged conflict was "entirely speculative" and insufficient to constitute an actual conflict.

Finally, the Seventh Circuit affirmed the district court's holding as to the applicable coverage part concluding that the EPL Coverage Part, rather than the Professional Liability Coverage Part, clearly applied. In reaching its conclusion, the Seventh Circuit noted the mutual exclusivity of the coverage afforded as indicated by Exclusion 13 of the Professional Liability, which excluded coverage for any claims alleging "wrongful termination," "actual discrimination," or "retaliatory treatment." Thus, the Seventh Circuit affirmed the District Court's ruling that Forge was required to pay the \$25,000 deductible under the EPL Coverage Part.

TRESSLER COMMENTS

In rejecting the insured's invitation to expand Illinois' limited independent counsel doctrine, the Seventh Circuit has reinforced the need for an actual, rather than a potential, conflict to be present prior to triggering the insurer's obligation to provide independent counsel. An insured's mere expectation or fear of a future punitive damage claim will not divest an insurer of its right to control its insured's defense. To hold otherwise, would require independent counsel in nearly all situations where the insured subjectively fears punitive exposure or in which punitive damages might be pled. Furthermore, the Seventh Circuit's analysis limits that which may be considered in determining whether an actual conflict exists. Indeed, an insured's belief that appointed counsel may develop facts or steer the matter in a direction not evident from the face of the pleading is insufficient to trigger an insurer's duty to provide conflict counsel. Rather, it is only "crucial facts" alleged on the face of the complaint which if proven will remove the matter from coverage which will be considered in evaluating the existence of an actual conflict.



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PENNSYLVANIA COURT UPHOLDS INSURER'S EXCLUSIONS BUT NONETHELESS FINDS COVERAGE FOR RICO ALLEGATIONS

In Executive Risk Indemnity, Inc. v. Cigna Corp., — A.2d —, 2009 WL 1537870 (Pa. Super. June 3, 2009), the Pennsylvania Superior Court looked to resolve the issue of whether coverage may be provided in a settlement agreement incorporating both RICO¹ and breach of contract claims, which were presumably uncovered under a professional liability insurance policy.

1 - Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. §§1961-1968.

From 1999 to 2002, the insured, CIGNA Corporation ("CIGNA"), was a defendant in federal class action lawsuits alleging that CIGNA and other "managed care organizations" were involved in a scheme to underpay the submitted medical claims from health providers. CIGNA settled the federal class actions in 2003 under the consolidated action In re Managed Care Litigation, MDL No. 1334, which was pending in the United States District Court for the Southern District of Florida. The settlement agreement acknowledged both breach of contract and RICO claims but did not apportion the settlement amount with respect to either of the different claims.

CIGNA sought reimbursement from its professional liability insurers, including Executive Risk as an excess carrier. Executive Risk denied coverage based on its view that the losses "[were] directly attributable to CIGNA's contractual duty to pay the claims of its medical providers seeking reimbursement." CIGNA argued that the settlement incorporated both contractual liability and RICO claims. The trial court found for Executive Risk holding that the settlement was based on a breach of contract claim of the service provided.

The Pennsylvania Superior Court examined the possibility of coverage for the two claims under the Executive Risk Policy. With respect to the contract claims, the court focused on two policy exclusions, which precluded coverage:

4. for liability of the Assured under contract or agreement[.]

7. for benefits, coverage, or amounts due or allegedly due, including any amount representing interest thereon, from the Assured as: (a) an insurer or reinsurer, under any policy or contract or treaty of insurance...

First, the court agreed that the breach of contract claim would not be covered as a matter of public policy- policyholders should not be awarded for avoiding their responsibilities under contract with a third party.

Concluding that coverage was not available for the breach of contract claims, the court then examined whether RICO claims would be covered under the policy. The court found that coverage would be provided for RICO claims under the general insuring agreement² because they fell within the definition of a claim and constituted wrongful acts "in the performance of [CIGNA's] professional service regarding [its] operation as a managed care organization."

The court, however, disagreed with the trial court's interpretation of the exclusions precluding coverage for RICO claims. The court looked to the underlying "root" of the RICO claims: "the actions in agreement and the agreement itself between CIGNA and other insurers to systematically underpay claims." CIGNA did not necessarily need to enter into an agreement in order to develop this "method of doing business." For example, some of the lawsuits involved CIGNA as a sole defendant for its improper business practices. The court did not find that the breach of contract claim and the RICO claim were so inextricably linked that they could not be identified as separate claims and subject to a separate coverage analysis under the policy. The court determined that the RICO claim should not be excluded based on any slight connection to a contractual obligation to provide managed care. In further support of its argument, the court analyzed the policy's definition of loss which provided payment of "punitive or exemplary damages, treble damages and multiple damages." The court reasoned that since treble damages, the type of damages awarded in a RICO claim, were granted under the policy through the definition of loss, then coverage must be afforded to the RICO claim.

2 - The general insuring agreement of the Executive Risk policy provides:

If during the Policy Period or the Extended Reporting Period, if applicable, any Claim is made against the Assured for Wrongful Acts in the performance of Professional Services by or on behalf of the Assured or by persons whose Wrongful Acts the Assured is legally responsible...Underwriters agree to pay on its behalf Loss resulting from such Claim.

Additionally, the Superior Court disagreed with the trial court's interpretation of coverage with respect to the claim forms used by providers specifying un- or underpaid services pursuant to contract. The Superior Court did find that all claims submitted were excluded based on the breach of contract exclusion. Again, the court focused on the fact that RICO damages provide for treble damages and surmised that the claim forms would be the starting point for estimating the underlying damages (before they were trebled). The court stated that damages for the RICO claims were subject to allocation from the non-covered breach of contract claims.

The dissent disagreed and cited specifically that CIGNA entered into an agreement in a prior litigation not to classify its conduct as violating the RICO statute. CIGNA should therefore be estopped from seeking coverage from its insurer in the current action based on its agreement for an early resolution in the prior action.

TRESSLER COMMENTS

The court accurately stated that separate claims are subject to an allocation based on their coverage under the policy. However, the court drew conclusions that coverage could also be afforded for the RICO claims based on the notion that damages awarded in RICO claims, or "treble damages", were provided in the definition of loss in the policy. A stronger basis for affording coverage in this instance would be supported by evidence distinguishing RICO claims as separate wrongful acts which did not arise out of CIGNA's breach of contract with its providers. As raised by the dissent, prior litigation suggests that CIGNA would not classify its alleged conduct as violations of the RICO statute. Based on such materials in the record, the court did not convincingly justify coverage for the RICO claims.



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ELEVENTH CIRCUIT FINDS COVERAGE FOR TRUTH-IN-LENDING ACT CLASS ACTIONS NOT LIMITED BY NON-STACKING PROVISIONS

In a recent non-published decision by the United States Court of Appeals for the Eleventh Circuit, two auto dealerships were entitled to coverage in connection with two separate class action lawsuits filed against them because the “non-stacking” limitations contained in each policy were ruled inapplicable. In doing so, the Court affirmed the district court’s granting of the dealerships’ motion for summary judgment as to the scope of coverage available to them in the suits for multi-year patterns or practices involving automobile sales that allegedly violated the Federal Truth-in-Lending Act (“TILA”), 14 U.S.C. § 1601 et seq. Ernie Haire Ford, Inc. v. Universal Underwriters Insurance Company, No. 08-13303, 2009 WL 1362990 (11th. Cir. May 18, 2009).

TILA Violations Covered Under STEO of Uncover Policies

According to the suits, the class period for claims against Ernie Haire Ford, Inc. (“Ford”) ran from August 30, 1998 to August 1, 2003, while the class period against Crown Auto Dealerships (“Crown”) ran from January 5, 2000 to July 5, 2005. Both Ford and Crown purchased five successive Uncover insurance policies from Universal Underwriters Insurance Company (“Universal”) during the timeframe of the TILA violations alleged in the respective suits.

Coverage for TILA violations under the Uncover policies was provided for in Coverage Part 500 as part of “STATUTE AND TITLE E & O” (“STEO”) under which Universal agreed to pay “all sums the INSURED legally must pay as DAMAGES ... because of STEO.” The policies further defined STEO as “any claim or SUIT filed against [the policyholder] ... by or on behalf of ... a customer ... because of an alleged violation during the Coverage Part period, or any federal, state, or local ... truth-in-lending or truth-in-leasing law.” In addition, “DAMAGES” were defined as “amounts awardable by a court of law, while “SUIT” was defined as “a civil action for DAMAGES.” The policies also specifically provide that “a class action is one SUIT.”

Non-Stacking Provision

The “General Conditions” section of the policies contained the following “non-stacking” provision:

“NON-STACKING OF LIMITS” – “If more than one Coverage Part or policy issued by U.S. to YOU should insure a LOSS, INJURY, OCCURRENCE, claim, or SUIT, the most WE will pay is the highest limit applicable. The limit under that Coverage Part or policy will be inclusive of the lower limit in the other Coverage Part(s) or policy(s), not in addition to them.

Also of particular note, the policies provided that for those policy periods before April 1, 2002, Universal would pay no more than the “annual aggregate” and “per suit” limits of \$500,000, however that provision was later revised for policy periods after April 1, 2002 to set “per suit” limits at \$25,000,

while the “annual aggregate” limit remained \$500,000.

Summary Judgment Granted In Favor Of Insureds

After attempts at resolving the dispute through mediation proved unsuccessful, Ford and Crown filed separate declaratory judgment suits against Universal concerning the scope of coverage available to them under the Uncover policies relative to the TILA class action suits. Originally filed in Florida state court, the two largely identical suits were eventually removed to the United States District Court for the Middle District of Florida, and also later consolidated.

Included in the complaint was a request for a declaration that Ford and Crown were entitled to \$500,000 in liability limits under Coverage Part 500 for each of the years involved in the class action. Finding that the policies provided a separate limit for each policy period equivalent to the “per suit” limit in each policy, the District Court found the non-stacking provision to be inapplicable because no single policy insured the entire class action suit. Accordingly, the District Court granted Ford and Crown’s motion for summary judgment as to the proper scope of coverage available.

Eleventh Circuit Applies Narrow Interpretation Of Non-Stacking Provision

On appeal, Universal contended that since the Uncover policies treated a class action as a single suit, the non-stacking provision limited coverage for a class action to the highest “per suit” limit contained in any of the applicable policies, which would be \$500,000. The Court found the wording “If more than one Coverage Part or policy ...should insure a ... suit...” to be ambiguous, on the ground that it had two potential interpretations. The Court noted that the language could be read either broadly to encompass all situations in which multiple policies cover some portion of the underlying suit or narrowly to address only those circumstances in which multiple policies insured the complete suit. Ultimately, the Eleventh Circuit applied the narrower interpretation of the non-stacking provision and found that the non-stacking provision would therefore not limit Ford or Crown’s STEO coverage.

In doing so, the Court pointed to the “consecutive, non-concurrent” nature of the policies and the fact that the policies’ own terms base STEO coverage on the timing of the violations. Further relying on the fact that both of the underlying class actions stemmed from patterns and practices of violations that allegedly occurred over a number of years, the Court also reasoned that multiple policies would have been in effect during the time when the violations took place, with no policy governing during the full class period. As a result, each policy covered a portion of the class action suits, but contrary to Universal’s contentions, more than one policy did not insure the entirety of the either suit. The Court affirmed the holding that the non-stacking limitation was therefore inapplicable and echoed the District Court’s conclusion that Ford and Crown’s coverage in the underlying class actions would be equal to the “per suit” limitation for each applicable policy period.

TRESSLER COMMENTS

Some states, such as Illinois, prohibit the use of non-stacking provisions in insurance policies issued on an admitted basis for certain types of coverage. In jurisdictions that do not prohibit the use of such provisions, courts may nevertheless be reluctant to enforce such provisions where the effect would be to deprive the insureds of coverage under more than one non-successive policy on the ground that the insureds should be able to obtain the full amount of coverage under each policy for which they paid a premium, regardless of whether the policies provide overlapping coverage. Although that was not the situation in this case, which involved successive policies, the court was particularly concerned by its conclusion that none of the policies, or any provision thereof, would have insured the entirety of either suit. Under some types of policies, such as claims-made policies, this issue is often successfully addressed, from the insurer’s standpoint, by tying claims together that involve “related claims” or “interrelated acts”.



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