

Specialty Lines Advisory

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JOE SAYS...

Fallout From The Collapse of the Stanford Financial Group – The Coverage Litigation Ensues

Although there may have already been filed coverage litigation involving Allen Stanford and other executives of Stanford Financial Group¹, and Stanford Investment Bank (collectively, “Stanford”), as in the Madoff scandals, some of the key sources of recovery and coverage disputes may lie more with the various brokers and investment companies that steered individual and institutional investors to these Ponzi schemes.

One such recent decision in Stanford was rendered on January 4, 2010 in the Southern District of Texas in Endurance American Specialty Ins. Co. v. Brown, Miclette & Britt, Inc., C.A. No. H-09-2307, (S.D. Tex., January 4, 2010).

1 - In a very significant and strongly worded decision rendered on January 26, 2010, Judge David Hittner in the Southern District of Texas ruled that the D&O insurers for certain Stanford executives had an obligation to advance such executives’ defense costs under the Stanford D&O policies. Applying the same “eight corners” analysis as did Judge Nancy Atlas in the Endurance case, the Court there found a money laundering exclusion in the policy not sufficiently broad so as to preclude coverage for all counts in the underlying criminal action. Pendergest-Holt v. Certain Underwriters at Lloyd’s of London, C.A. No. H-09-3712 (S.D. Tex., January 26, 2010).

The insured defendant, Brown, Miclette & Britt, Inc. (“BMB”), was a professional business organization that provided services as an insurance agent, insurance broker and insurance consultant. The plaintiffs in the underlying litigation brought against BMB allege that they purchased certain Certificates of Deposit and deposited money into Stanford accounts and that the defendant and others violated securities laws in connection with these purchases and deposits. BMB sought coverage for these claims under a professional liability insurance policy, and the insurer disclaimed coverage on two bases, (i) that the lawsuits did not involve the scope of “professional services” covered under the policy, and (ii) the allegations in the suits fell within the scope of the policy’s securities exclusion.

The Court held that the insurer had a duty to defend the underlying litigation, applying the applicable Texas “eight corners rule”² that the plaintiffs’ pleadings are the sole determinant of the insurer’s duty to defend. As long as those pleadings allege facts that could be within the scope of coverage under the policy, the insurer must defend.

The Court then proceeded to analyze the underlying actions to determine the insurer’s defense obligation. The Court found that BMB, apparently in connection with providing certain insured professional insurance

2 - The “eight corners rule” is one that requires a court to examine *solely* the 4 corners of the complaint plus the 4 corners of the insurance policy to determine whether or not the insurer has an obligation to pay defense expenses or a duty to defend.

See Joe Says on page 3 for conclusion

SOUTHERN DISTRICT OF NEW YORK UPHOLDS COVERAGE DENIAL FOR INDEPENDENT CONSULTANT, BUT FINDS COVERAGE FOR EXPENSES BY A SPECIAL LITIGATION COMMITTEE

A recent decision in a coverage action brought by monoline insurer MBIA against its D&O carriers involved a confluence of circumstances that resulted in interesting outcomes in several of the common battlegrounds of D&O policies. *MBIA, Inc. v. Federal Ins. Co.*, No. 06-CV-4313 (S.D.N.Y. Dec. 20, 2009). The opinion by Southern District of New York Judge Richard Berman considered coverage for three categories of defense expenses – investigative costs, regulatory subpoenas and special litigation committees – with notable results.

SEC and NYAG Investigations

In 2001, the SEC issued a formal order commencing an industry-wide investigation relating to certain loss mitigation insurance products. In 2004, MBIA purchased \$15 million primary and excess D&O policies from Federal Insurance Company and ACE Insurance Company, respectively, for the policy period February 15, 2004 to August 15, 2005. Pursuant to the 2001 order of investigation, the SEC issued subpoenas to MBIA in November and December 2004. Concurrently, the New York Attorney General's office issued subpoenas seeking the same documents. In response to both subpoenas, MBIA produced documents relating to liability it incurred when the Allegheny Health, Education and Research Foundation filed for bankruptcy (the "AHERF Transaction"). In March 2005, the SEC issued another subpoena pursuant to the 2001 order of investigation, and a parallel subpoena from the NYAG was issued on the same day. Shortly thereafter, in order to mitigate the negative impact in the market of disclosures of further subpoenas, MBIA requested that the regulators forego the issuance of further formal subpoenas, and agreed voluntarily to comply with informal requests for additional documents. Both regulators subsequently made informal requests for documents relating to two additional transactions.

Independent Consultant

In October 2005, MBIA submitted an Offer of Settlement to the SEC and the NYAG "in anticipation of cease-and-desist proceedings" by the SEC. The Offer of Settlement resolved the investigation into the AHERF transaction. Additionally, MBIA agreed therein to retain an independent consultant to conduct a comprehensive review of its accounting and disclosures regarding the two additional transactions that had been the subject of informal inquiries by the regulators. MBIA did not notify its carriers of the terms of its Offer of Settlement, including the provision relating to the Independent Consultant, for at least four months after the Independent Consultant commenced working in May 2006. In January 2007, MBIA finalized settlements with both the SEC and the NYAG which included, almost verbatim, the

provisions from MBIA's Offer of Settlement with respect to the independent consultant.

Derivative Litigation

In April and November 2005, MBIA received separate shareholder demands that it investigate alleged wrongdoing by its directors and officers in connection with the AHERF transaction. In response, MBIA set up a Demand Investigation Committee (the "DIC") comprised of outside directors appointed after the transaction at issue. The DIC retained Dickstein Shapiro LLC



("Dickstein"). Each of the shareholders who had issued demands instituted derivative actions against certain MBIA directors and officers. MBIA then formed a "Special Litigation Committee ("SLC") comprised essentially of the same members as the DIC. The SLC was also represented by Dickstein. After completing its investigation, the SLC concluded that the maintenance of the derivative actions "was not in the best interests of MBIA or its shareholders." Dickstein filed successful motions to dismiss the derivative actions "on behalf of nominal defendant MBIA, Inc. through the Special Litigation Committee of the Board of Directors."

The Coverage Litigation

Federal advanced \$6.4 million to MBIA in what it asserted was full payment for covered defense costs in connection with the formal SEC investigation, securities and derivative lawsuits and the investigation of shareholder derivative demands. Federal declined coverage for the SLC's counsel's fees above the Policy's \$200,000 sublimit for "demand investigative costs." MBIA asserted that it had "spent \$29.5 million for the costs of defending and responding to the regulatory

investigation[s] and follow-on litigation" and commenced coverage litigation against Federal and ACE to recover its remaining expenses. MBIA argued that Dickstein's fees in connection with representation of the SLC were covered defense costs related to the derivative litigation. The Court considered each category of "defense costs" in turn in connection with the parties' cross-motions for summary judgment. This article will focus solely on the Court's decision on coverage for the independent consultant and the SLC.

The Independent Consultant

The Court granted summary judgment to the carriers for MBIA's claim for costs associated with the independent consultant, on the grounds that MBIA had neither sought nor obtained the carrier's consent prior to executing the Offer of Settlement by which it agreed to "retain, pay for, and enter into an agreement with an independent consultant." The Federal Policy provides that MBIA must obtain the carriers' written consent to "settle any claim, incur any Defense Costs or otherwise assume any contractual obligation or admit any liability with respect to any Claim" and that the carriers shall have the right and be given the opportunity to effectively associate with [MBIA] in the investigation, settlement or defense of any Claim. The fact that MBIA did not inform the carriers of the independent consultant provision of its Offer of Settlement for at least ten months after its execution clearly denied the carriers to effectively associate with it.

The decision on this point is hardly surprising, given the facts. More interesting, perhaps, are some of the arguments advanced by the parties that were not the basis of the Court's decision. MBIA's agreement with the NYAG states that "MBIA agrees that it shall not, collectively or individually, seek or accept, directly or indirectly, reimbursement or indemnification, including but not limited to, payment made pursuant to any insurance policy, with regard to any or all of the amounts payable pursuant to this [agreement]." Because the settlement agreement obligated MBIA to "retain, pay for, and enter into an agreement with an independent consultant," the carriers argued that MBIA was barred from seeking indemnification

See MBIA, Inc on page 3

and risk management services to Stanford, furnished Stanford with letters that Stanford had qualified for certain Lloyd's insurance policies. The underlying plaintiffs apparently pled that these letters implied that there was insurance coverage for the deposits and payments made into Stanford accounts.

That being said, the policy issued by Endurance American Specialty Ins. Co. ("Endurance") contained an exclusion for any claim based upon or arising from violations of federal or state securities laws. Although the Court appeared to recognize that many of the underlying allegations fell within the scope of this exclusion, it concluded that certain allegations of common law negligence did not. The Court viewed the letters provided by BMB as being within the scope of these negligence claims, but not within the scope

of the policy's securities exclusion.

The key to the Court's finding in favor of the insured on the duty to defend issue appears to have been a narrow reading of the securities exclusion. While BMB may have been allegedly negligent in issuing the letters discussed above to Stanford, the Court appears to lose sight of the fact that the plaintiffs in the underlying claims are investors ostensibly pursuing securities claims. Why then does the securities exclusion not "trump" the negligence analysis?

In any event, as "scandals" such as those related to Stanford and Madoff have ebbed from the front page business news, the litigation emanating from these scandals proceeds apace and we can expect to see

many more coverage disputes emerge involving various forms of D&O, E&O and professional liability policies. We can expect, in many cases, to see a vigorous pursuit of the insureds and their insurers because these may be the deepest pockets remaining from which the aggrieved investors can obtain relief.

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



Joe Monteleone is a partner in our New York office. He has more than 25 years of experience as the former head of global professional liability and other specialty lines claims operations for major insurance companies and in the practice of law representing insurance clients.

MBIA, Inc continued from page 2

for the cost of the independent consultant. MBIA argued that the prohibition on indemnification was contained in the "Disgorgement" section of the settlement, rather than the "Independent Consultant Review" section and thus did not apply to the costs of the independent consultant. MBIA also asserted that the costs incurred in connection with the independent consultant were covered because the prohibition applies to "MBIA's indemnity costs, whereas the Independent Consultant costs are most appropriately viewed as defense or response costs." Because the facts, and New York law, are clear on the issue of consent, the Court did not have to address the potentially thornier issues about the nature of the relief.

The Special Litigation Committee

The aspect of the decision that has received the most attention by commentators is the Court's grant of summary judgment to MBIA in connection with fees incurred by Dickstein in connection with its representation of the DIC/SLC. The carriers did not dispute coverage for fees incurred on behalf of the DIC, subject to the Policy's sublimit for investigative costs. The carriers argued that Dickstein's legal fees in connection with the derivative litigation and on behalf of the SLC were not covered defense costs because Dickstein did not represent MBIA or any of the individual insured persons under the Policy. Rather, Dickstein represented the SLC, which was not an insured under the Federal policy. MBIA argued that the SLC counsel's fees were covered defense costs incurred on behalf of MBIA and the individual defendants because Dickstein filed motions to dismiss the derivative complaints, which motions were joined by the individual defendants. In other words, "Dickstein represented nominal defendant MBIA through its representation of the SLC." With relatively little discussion of the background

and purpose of such committees, the Court agreed with MBIA, noting that Dickstein had entered a notice of appearance as counsel for MBIA in the derivative actions, and had filed motions to dismiss as "Counsel for nominal defendant MBIA." The Court went even further, however, stating that even if Dickstein had represented the SLC, coverage would be triggered because the SLC was comprised of MBIA board members, to whom MBIA had delegated decision-making authority in connection with the pursuit, or not, of derivative claims. Judge Berman expressly rejected the carriers' argument that the SLC was supposed to be entirely independent of MBIA, and thus Dickstein could not have represented MBIA "through" its representation of the SLC.

TRESSLER COMMENTS

The issues presented by the dispute over coverage for costs of the independent consultant are similar to those presented in other regulatory settlements, where corporations are required to take costly remedial action that does not fall squarely in the category of "disgorgement." Examples include the research analyst litigation of several years ago, where one of the remedies ordered by regulators was that investment banks were required to procure and pay for independent analysts' opinions, to the tune of tens of millions of dollars, and the HMO litigation, where insurers were required to contribute to an education fund. Carriers generally take the position that remedies to address improper business practices are in the nature of a fine or a penalty, or simply the cost of doing business properly, rather than loss covered by insurance policies.

With respect to coverage for counsel fees of the SLC, the Court arguably applied the wrong analysis to the issue. Whether or not counsel for the SLC entered an appearance in derivative litigation on behalf of the nominal

corporate defendant, the fact remains that neither the MBIA board of directors as a whole, nor MBIA itself, had any liability exposure in connection with the derivative suits. In fact, MBIA theoretically stood only to gain from a successful derivative action, either through payment from the individual defendants or by virtue of corporate therapeutics. The only parties with potential liability exposure in a derivative case are the individual director and officer defendants. In the MBIA matter, the carriers had reimbursed the costs associated with the defense of the individuals.

The decision begs the question of how the Court's rationale would apply to a situation where the SLC opts to pursue derivative litigation against individual directors and officers. The decision did not hold that all SLC costs are covered defense expenses, but that they were covered under the facts of the case, where the SLC focused its efforts on the "defense" of the derivative litigation after it was filed. The decision has the unfortunate potential to blur the line as to when other activities of responsible corporate citizens can be argued to have benefitted or contributed to the "defense" of derivative litigation. Additionally, it raises questions about the correct application of negotiated sublimits for demand investigation activities. The decision is likely to continue to generate commentary, and we welcome our readers' feedback. At this point it remains unclear whether the carriers will appeal the decision, and if so, whether other carriers will want to participate as *amici curiae*.



Prepared by Courtney Scott, a partner in our New York office.

NEW YORK APPELLATE COURT LIMITS INSURED'S LEGAL MALPRACTICE CLAIMS AGAINST ITS COVERAGE COUNSEL



In *Natural Organics, Inc. v. Anderson Kill & Olick, P.C.*, 67 A.D.3d 541 (1st Dep't. Nov. 17, 2009), an intermediate New York state appellate court held that an aggrieved insured cannot sue its coverage counsel for legal malpractice for allowing a paralegal, who pretended to be a lawyer, to handle its coverage claim.

This action stems from a large insurance coverage matter in which Natural Organics, Inc. ("Organics") retained well-known policy coverage lawyers, Anderson Kill & Olick, P.C. ("Anderson"), as its coverage counsel. Anderson advised Organics that the underlying insurance coverage matter was worth at least \$1.3 million. However, the case settled several years later for \$750,000. Sometime thereafter, Anderson advised Organics that one of the Anderson attorneys involved in the coverage matter was not a licensed lawyer, but rather, was a paralegal. Brian Valery had pretended to be lawyer despite never attending law school or passing the bar. Organics then brought this action against Anderson arguing that it would have obtained a more favorable result had Anderson exercised more care with regard to Mr. Valery's employment and had it been represented by an actual lawyer. Organics sought the difference between the \$1.3 million claimed value of the suit and the \$750,000 settlement as well as all legal fees billed by Anderson.

Organics sued Anderson for legal malpractice, breach of contract and unfair business practice. The trial court denied Anderson's motion to dismiss the malpractice and breach of contract claims and granted Organics leave to re-plead its unfair business practice claim. Anderson appealed.

The First Department dismissed the malpractice claim finding that Organics failed to allege facts that "sufficiently demonstrate a casual relationship between purported conduct on the part of defendants and damages suffered by plaintiff." Because re-pleading would be barred by the statute of limitations, the dismissal was with prejudice. The First Department also dismissed that part of the breach of contract cause of action alleging a breach of professional standards and seeking damages for the alleged shortfall from the settlement and all of Organics' legal fees, concluding that they were duplicative of the malpractice claim.

The court allowed the breach of contract claims to go forward, finding that Organics had

pleaded sufficient facts to state a claim that Anderson continuously held out Mr. Valery as a licensed attorney and billed in excess of \$70,000 for his services, even though Mr. Valery was not attorney. The court noted that it could not be said that these particular damages are too speculative given the early state of the proceedings.

In a final note in this unusually short opinion, the First Department also reversed the trial court and denied Organics permission to re-plead its unfair business practice claim. The court held that Organics cannot show that Anderson, by employing Valery, engaged in acts or practices having a broad impact on consumers at large.

The First Department did not provide many details on the back story to the dispute. However, published news sources indicate that Mr. Valery, the 32-year old paralegal at the heart of this action, led Anderson to believe that he was a licensed attorney for a few years before the truth was revealed. Mr. Valery went to work for Anderson as a paralegal in 1995, and in 2004, told Anderson that he had passed the New York bar. Valery has pled guilty before New York State Supreme Court Justice Gregory Carro, and must repay \$150,000 in salary to Anderson by January 30, 2010, or face five to 15 years in prison.

TRESSLER COMMENTS

This would appear to be the only reasonable decision under the circumstances. Typically, many civil actions settle for only a portion of the claimed damages, and it would be entirely speculative to conclude that this "faux lawyer" was the cause of any reduced settlement. Nonetheless, given that the client was billed and paid for the services of Mr. Valery as a lawyer, it is only fair and equitable that the amount of those fees (apparently \$70,000) should be refunded to the client.



Prepared by
Elizabeth Caraballo,
an associate in our
New York office.

Tressler LLP is pleased to announce that **Joanne Matousek** has joined the firm's partnership



Ms. Matousek's practice is focused on directors and officers and professional liability insurance coverage litigation and monitoring. She also handles fidelity, reinsurance and general liability coverage matters. In 22 years of practice, Joanne has successfully arbitrated, mediated and obtained judgments in favor of insurance company clients. She has also handled appeals and worked closely with defense counsel to achieve settlements in underlying securities litigation. Ms. Matousek has earned an AV Preeminent 5.0 rating by Martindale-Hubbell®, which is a testament to the fact that her peers have ranked her at the highest level of professional excellence.

Ms. Matousek was most recently a partner in the Chicago office of Duane Morris LLP. She is a member of the Professional Liability Underwriters Society (PLUS) and a graduate of the University of Notre Dame Law School.

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CALIFORNIA FEDERAL COURT PROVIDES A TREATISE ON COVERAGE ISSUES: UPHOLDS INSURER'S DENIAL OF COVERAGE UNDER SECURITIES BROKER-DEALER POLICY

In three opinions issued in November 2009, the United States District Court for the Central District of California, addressed a variety of coverage issues arising under a securities broker-dealer professional liability policy which arose from a lawsuit alleging the mishandling of investments. The Court's opinions in [Illinois Union Insurance Co. v. Brookstreet Securities Corp., et al.](#), SACV07-01095-CJC (RNBx) include an analysis of interrelated wrongful acts, late notice and the Professional Services Exclusion.

Background

Several claims were brought against Brookstreet Securities Corporation ("Brookstreet"), by its clients for investment losses allegedly arising from improper investments, churning and charging excessive margins. Illinois Union Insurance Company, ("Illinois Union") provided professional liability insurance to Brookstreet and its employees, officers and directors. Brookstreet was a nationwide investment firm that experienced solvency issues and ceased operation in June 2007. The Policy issued to Brookstreet by Illinois Union was in effect for the period of November 8, 2006 to November 8, 2007. Illinois Union brought an action for interpleader in order to determine coverage for the claims, and moved for summary judgment with respect to those claims on three bases: that the claims were interrelated Wrongful Acts that occurred prior to the Retroactive Date; that they arose from trading Collateralized Mortgage Obligations ("CMOs"), which are derivatives not covered under the Policy; and that notice was not timely.

Interrelated Wrongful Acts

In the first of three opinions, the Court addressed the issue of Interrelated Wrongful Acts. Insuring Agreement "A" of the Policy issued to Brookstreet provided:

"The Insurer shall pay on behalf of the Insured Broker-Dealer, Loss which the Insured Broker-Dealer becomes legally obligated to pay by reason of any Claim first made against the Insured Broker-Dealer during the Policy Period ... and reported in writing to the Insurer during the Policy Period, ... in accordance with the terms of this Policy, for any Wrongful Acts taking place after the Retroactive Date, but before the expiration of the Policy."

Wrongful Act was defined as "any actual or alleged negligent act, error or omission by the Insured Broker-Dealer and/or the Insured

Registered Representatives in connection with the rendering of Professional Services." Interrelated Wrongful Acts was defined as "all Wrongful Acts that have, as a common nexus, any fact, circumstance, situation, event, transaction, cause or series of related facts, circumstances, situations, events, transactions or causes."

The claims at issue involved the multi-million dollar investment portfolio left to the widow of Mr. Taylor ("Taylor") in 1992. In 1996, Taylor opened an investment account with broker Mr. Simmons ("Simmons"), who worked at several investment firms over the years including Brookstreet beginning in June 2000, while continuing to maintain Taylor's account. In June 2006, Taylor closed her account with Simmons, at which time her account contained approximately \$250,000 of the original \$2 million investment. In April 2007, Taylor commenced an NASD/FINRA Arbitration proceeding against Simmons, NPC1 and Brookstreet and alleged that Simmons "had a pattern of churning, making unauthorized trades, buying and selling high risk stocks and failing to advise Taylor of her investment losses." Taylor's claim was reported to Illinois Union on May 14, 2007, for which Illinois Union accepted Brookstreet's defense under a reservation of rights to deny coverage for any Claim arising out of an Interrelated Wrongful Act first occurring before the Retroactive Date. Prior to the arbitration, Taylor settled her claims with Simmons and NPC. At the arbitration, an award was issued in favor of Taylor and against Brookstreet in the amount of \$1.3 million in compensatory damages, and \$100,000 in attorneys' fees. In July 2008, Taylor obtained a final judgment against Brookstreet in state court, which affirmed the arbitration award and also awarded interest and other costs and fees. To date, Brookstreet has not satisfied the judgment.

In Illinois Union's motion for summary judgment in its interpleader action, Illinois Union argued that Taylor's claim against Brookstreet was not covered because it arose out of an action that commenced prior to the Policy's Retroactive Date and involved Simmons' conduct prior to his joining Brookstreet, thus constituting a

single, non-covered Interrelated Wrongful Act. Taylor's allegations against Brookstreet included breach of contract, breach of fiduciary duty, and gross negligence based upon its (and Simmons') failure to exercise reasonable care in managing her portfolio. Such failure included failing to secure suitable investments, churning, buying and selling inappropriate products, making unauthorized trades, failing to advise Taylor of her options, failing to disclose the nature of her investment and failing to disclose facts of the trading activity of her account. Taylor asserted that each of Simmons' acts was a separate Wrongful Act subjecting him to liability, and that each time Brookstreet failed to supervise Simmons constituted a discrete Wrongful Act as well.

In its analysis, the Court began by clarifying that although the allegations were brought in a single arbitration, this did not convert Taylor's claim into a single Wrongful Act. The Court, citing [Ryan v. Nat'l Union Fire Ins. Co. of Pittsburgh](#), 2008 WL 901476, at *5 (D. Conn. March 31, 2008), was not willing to grant summary judgment as it believed that there were genuine issues of material fact as to whether the Wrongful Acts that occurred after the Retroactive Date were "interrelated" with Wrongful Acts that occurred prior to the Retroactive Date. The Court noted that a reasonable jury could conclude that each act by Simmons could constitute a discrete Wrongful Act.

Professional Services Exclusion/CMOs

The next opinion issued by the Court addressed the Policy's Professional Services Exclusion, which provides that "the Insurer shall not be liable for Loss on account of any Claim made against the Insured... based upon, arising out of, or attributable to the sale, attempted sale, or servicing of... commodities, commodity future contracts, any type of option contract or derivative." The Policy did not define the term derivative.

The pertinent allegations as to this issue were divided into two groups of defendants. The first group alleged that Brookstreet caused the defendants financial losses by improperly investing in CMOs. According to

See Illinois Union on page 9 for conclusion

FEDERAL COURT IN OREGON CONSIDERS WHETHER D&O COVERAGE WAS PRECLUDED BY INSUREDS' NON-COMPLIANCE WITH POLICY'S CONSENT-TO-SETTLE PROVISION OR LIMITED BY POLICY'S COMMON CLAIM ENDORSEMENT

In a coverage dispute between the assignee of three insureds' interests and Illinois Union Insurance Co. ("Illinois Union") under a D&O policy, the U.S. District Court for Oregon, interpreting Oregon law, denied Illinois Union's motion for summary judgment with respect to the policy's consent-to-settle provision on grounds that the insureds' settlement of claims against them for breach of their fiduciary duty was reasonable, notwithstanding that the insureds violated the consent-to-settle provision and that said violation may have prejudiced the insurer. The court also granted Illinois Union's summary judgment motion on the application of the policy's common claim endorsement, which limited Illinois Union's liability and therefore the plaintiff's contract damages, because the plaintiff's claims arose out of "interrelated wrongful acts" as the term was defined in the Policy. *Alexander Manufacturing, Inc. Employee Stock Ownership and Trust v. Illinois Union Insurance Co.*, 2009 U.S. Dist. LEXIS 95897 (D.Or. October 15, 2009).

This coverage dispute arises from two lawsuits filed against cabinet manufacturer Alexander Manufacturing, Inc. ("Alexander Manufacturing") and former Alexander Manufacturing directors and officers William Klutho ("Klutho"), Donald Thoreson ("Thoreson") and Daniel Spofford ("Spofford"). The first lawsuit, filed by vendor Emerson Hardwood Company ("Emerson"), alleged that between June 2003 and January 2004, Emerson extended credit to Alexander Manufacturing based on false financial statements prepared by Klutho ("Emerson Suit"). At Alexander's request, Alexander Manufacturing's D&O carrier, Illinois Union, defended it and its former officers against the Emerson Suit and eventually settled the suit for \$40,000 under the D&O coverage section of its policy (the "Policy"). The Policy provided \$2,000,000 in total liability limits, \$1,000,000 in D&O liability coverage and \$1,000,000 in fiduciary liability coverage.

In the second lawsuit, filed by the Alexander Manufacturing Inc. Employee Stock Ownership Plan and Trust (the "Trust"), the Trust alleged breach of fiduciary duty under the Employee Retirement Income Security Act and brought a derivative action against the officers alleging breach of their duties as directors and officers when Klutho made numerous wrongful job cost adjustment entries resulting in materially deceptive financial reports, Spofford and Thoreson knew of Klutho's actions, and none of the officers disclosed Klutho's actions to the Trust's board of directors ("Trust Suit").

Illinois Union defended Alexander Manufacturing and the officers against the

Trust Suit and initially determined that the Trust's cause of action fell under the fiduciary coverage of the Policy but was not covered under the Policy's D&O coverage.

On August 8, 2005, the Trust offered to settle the action for what it asserted was the applicable policy limit: \$1,000,000 under the fiduciary coverage and \$1,000,000 under the D&O coverage. Illinois Union's counsel informed Klutho's counsel of the offer and indicated that he estimated the low end of damages at \$2.7 million and the amount available for indemnity was decreased by defense costs.

During mediation of the Trust Suit, Illinois Union asserted for the first time that it had a basis to rescind the insurance contract on the ground that it relied on the officers' false financial reports when it decided to underwrite the 2003-2004 policy. Illinois Union also changed its coverage position, concluding that both the fiduciary coverage and the D&O coverage applied, but the Policy's common claim endorsement limited coverage to \$1,000,000, minus the costs already disbursed for the Emerson Claim. Illinois Union's coverage counsel stated, incorrectly, that there was only approximately \$300,000 of coverage remaining in D&O coverage and offered to use his resources to settle the claim for \$300,000. There was actually approximately \$377,000 to \$458,900 in D&O coverage available to settle the claim. The Trust rejected the \$300,000 offer and countered to settle with Klutho, Thoreson and Spofford for payment of the fiduciary liability limits, minus defense costs, an amount the Trust estimated at \$620,000. Illinois Union rejected this offer. The Trust subsequently entered into a settlement agreement ("Settlement Agreement") with the officers without Illinois Union's knowledge or consent.

Under the Settlement Agreement, the Trust agreed to dismiss with

prejudice all causes of action against Alexander Manufacturing and its officers in exchange for the officers' agreement to each pay \$10,000 and jointly and severally pay \$1.3 million, and assignment to the Trust of the officers' interests under the Policy. The Settlement Agreement further required the officers to cooperate with the Trust in any litigation against Illinois Union and provided that the assignment of rights under the Policy did not release the officers from the liability.

The Trust then filed the lawsuit at issue against Illinois Union ("Trust Claim"). The parties filed cross-motions for summary judgment on whether the officers could assign their rights under the Policy to the Trust without Illinois Union's consent in light of the Policy's anti-assignment clause providing that Illinois Union would not be bound by an assignment of interest under the Policy unless it consented to said assignment. The district court granted Illinois Union's motion and dismissed the Trust Claim. The Ninth Circuit reversed the district court's decision, finding that, pursuant to Oregon law, the non-assignment clause applies only to pre-loss assignments.

Illinois Union subsequently filed motions for summary judgment in the district court regarding, amongst other things, the officers' settlement without Illinois Union's consent, the application of the Policy's common claim endorsement and the Trust's breach of its duty of care claim. The Trust filed a cross-motion for summary judgment on its breach of duty of care claim.

Illinois Union argued that the insureds breached the consent-to-settle provision of the Policy when they settled with the Trust without Illinois Union's consent, and, therefore, the Trust was not entitled to recover under the Policy. The court held that to prevail on such a defense under Oregon law, the insurer must not only prove that the insured failed to comply with the consent-to-settle provision, but also that the claimant's conduct prejudiced the insurer. Further, even if an insurer proves both of these elements, the insured may nevertheless prevail if he or she acted reasonably in

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FLORIDA DISTRICT COURT UPHOLDS “TANGIBLE PROPERTY” EXCLUSION IN D&O POLICY IN LIGHT OF CONDO ASSOCIATION’S FAILURE TO PROVIDE NOTICE OF AN AMENDED PLEADING

In EastPointe Condominium Association, Inc. v. Travelers Casualty & Surety Company, 2009 U.S. D.Ct. LEXIS 95720, the United States District Court for the Southern District of Florida granted summary judgment to Travelers finding that coverage was excluded under the D&O policy it issued to the EastPointe Condominium Association. The Condo Association alleged that Travelers was obligated to defend the Association in an underlying suit filed by condo owner Bursten for property damage arising out of water infiltration. Bursten had alleged that the Condo Association was negligent in failing to properly maintain and repair the roof and air conditioning system of the condominium building before, between and after two hurricanes that hit Florida in 2004. She alleged damage to the building, as well as mold and damage to her unit and its contents. Although the Condo Association had been defended in the Bursten suit under a CGL policy issued to it by another insurer and had even obtained a defense verdict on the suit, the Condo Association filed a declaratory judgment action alleging that Travelers improperly refused to defend and owed \$250,000 in counsel fees incurred by the Association in payment to its personal counsel.



In granting summary judgment to Travelers on its D&O policy, the District Court aptly noted that the policy covered loss incurred by the Association for a “Wrongful Act”. The Travelers policy, however, expressly excluded coverage for claims against the Association “for or arising out of any damage, destruction, loss of use or deterioration of any tangible property...” Finding that the Travelers “tangible property” exclusion included damage, loss or deterioration arising out of “construction defects,...mold, toxic mold, spores, mildew, fungus or wet or dry rot...”, the court held the exclusion applicable to preclude coverage. Citing to Florida case law that holds an insurer’s duty to defend is based entirely on the legal theories and facts alleged in the pleadings, the court reviewed the four corners of the Bursten Complaint and found that the allegations against the Condo Association fell clearly within the “tangible property” exclusion. Examining Florida law which interprets “arising out of” language as requiring only a “but for” causation, the court held that “[b]ut for the alleged water intrusion and damage to the building skin, there would be no Bursten claim for mold, structural damage and loss of use of the Bursten unit.”

It is worthy of note that while an Amended Complaint was filed against the Association, alleging claims of fiscal mismanagement and economic loss, that amended pleading was never tendered to Travelers; nor did the Association ever otherwise notify Travelers of the fact or substance of the amendment. The Court noted that ordinarily, the duty to defend

is determined by the most recent amended pleading, not the original pleading. However, this presumes that the insured has forwarded the amended pleading to the insurer, or that the insurer is at least on notice of the fact of an amendment. Despite an absence of Florida law directly on point, the court, citing a Ninth Circuit opinion based upon California law, held that the insurer had no continuing duty to investigate or monitor the lawsuit for possible amendments potentially bringing the Bursten’s claims within the scope of coverage. The Court adopted the Ninth Circuit’s approach, noting that under Florida law, an insurer is relieved of all liability under an insurance policy if the insurer has been prejudiced by the insured’s failure to comply with a notice of lawsuit provision. In this case, as the Association was obliged, under the policy’s notice of claim requirement, to give Travelers notice of the amended claims “as soon as practicable” if it sought to bring the Bursten’s new allegations of economic loss outside the scope of Traveler’s prior denial of coverage. The Association’s failure to provide such notice triggered a rebuttable presumption of prejudice to Travelers. As the Association proffered no evidence to rebut that presumption, the scope of Traveler’s duty to defend was defined by the allegations in the original Bursten complaint.

This matter is now before the Eleventh Circuit on an appeal filed by the Condo Association from the order granting summary judgment to Travelers and denying the Condo Association’s cross-motion for summary judgment.

TRESSLER COMMENTS

Cases in numerous jurisdictions have examined the impact of an insured’s failure to provide proper notice of a claim to the insurer when the claim is first made. This case, at least so far, is a cautionary tale for insureds that their duty to provide notice of a claim under an insurance policy may not end after they first provide notice of a claim

to the insurer. Although the insurer did not have the opportunity to review the amended pleading in this case, it is also a reminder that an insurer’s duty to evaluate coverage for a lawsuit is not a static one, but may recur, depending on the twists and turns of the underlying litigation.



Prepared by Joanna Crosby, a partner in our Newark office.

ON FEBRUARY 2, 2010, NINTH CIRCUIT TO HEAR CALIFORNIA BAD FAITH BENCH TRIAL JUDGMENT OF \$35,635,822

Following a bench trial that occurred almost two years ago in *Acacia Research Corp. v. National Union Fire Ins. Co. of Pittsburgh, PA*, 2008 U.S. Dist. LEXIS 96955, Case No. 05-501 (C.D. Cal. February 8, 2008), the Court rendered a verdict and entered judgment, making the following findings of facts and law:

- The underlying litigation involved a dispute over the rightful ownership of two patents that were allegedly developed by Nanogen, Inc. while a certain Dr. Montgomery was employed with Nanogen. After Dr. Montgomery became an Officer, Vice President-Research and Development for Acacia, he allegedly used this technology to later obtain the two patents. *Id.* at *3. Acacia and Dr. Montgomery entered into an Indemnity Agreement and Joint Defense Agreement due to the common interests between the two parties and the ability to assert certain common defenses. *Id.* at *5.
- Coverage was available to both Acacia and Dr. Montgomery under the D&O Policy issued to Acacia by National Union Fire Ins. Co. of Pittsburgh (“National Union”) due to the Indemnity Agreement entered into between Acacia and Dr. Montgomery and the joint defense presented by the two.
- Allocation of defense costs between Acacia and Dr. Montgomery was not permitted because the Policy only provided for the allocation if negotiated by the parties. National Union did not negotiate with Acacia. *Id.* at *27. Allocation was also unnecessary because Acacia and Dr. Montgomery presented a single and joint defense in the underlying litigation. *Id.*
- The “duty to advance defense costs is [as] broad as the duty to defend.” *Id.* at *30, citing *Hurley v. Columbia Cas. Co.*, 976 F.Supp. 268, 275 (D. Del. 1997).
- Acacia properly submitted a valid claim by providing written notice to National Union shortly after the underlying litigation commenced. The Policy did not require a second written notice upon Acacia’s exhaustion of self-insured retention (“SIR”) limit.
- The No-Voluntary Settlement Clause was unenforceable due to the “economic necessity, insurer breach, or other extraordinary circumstances” exception. *Id.* at *30, citing *Jamestown Builders, Inc. v. General Star Indemnity Co.*, 77 Cal. App.4th 341, 346 (1999). National Union breached its duties under the Policy and Acacia was forced to defend itself and reach a settlement in the underlying litigation. *Acacia*, at *30-*36.

- The underlying litigation settlement was a covered loss because it provided for a transfer of Acacia’s stocks and patent royalties to Nanogen and was not a restitution for wrongs committed by Acacia. *Id.* at *38.
- National Union acted in bad faith when it improperly and unreasonably withheld Policy benefits owed to Acacia due to its mishandling of the claim. The bad faith conduct included the acknowledgement of a claim about two weeks after receipt of the written notice (December 15, 2000); the re-assignment of the claim to a different claims-handler on December 21, 2000; another re-assignment of the claim to a different claims-handler two months later; National Union’s request for further information on March 9, 2001; National Union’s failures to respond to Acacia’s correspondence on March 20, April 12, and May 14, 2001, which provided status updates and requested reimbursement of defense fees and costs; the failure to assign a claims-handler from May 2001 to August 2002; the re-assignment of the claim to a claims-handler on August 29, 2002 and May 5, 2003; and the issuance of a declination on November 3, 2003 (nearly three years after receipt of the claim). *Id.* at *40-46.

Based upon the above findings of facts and law, the Court found in favor of Acacia and entered a total Judgment of \$35,635,822.

The key insurance issues now on appeal before the Ninth Circuit are:

1. Whether the No-Voluntary Settlement Clause is enforceable due to “economic necessity” when National Union had not yet denied coverage and Acacia finalized the settlement agreement after National Union’s final claims-handler requested a status update.
2. Whether Acacia must provide notice to National Union when Acacia reached its SIR limit or seek consent from National Union to incur costs in excess of the SIR. Until that time, National Union’s duty to reimburse litigation costs did not arise.
3. Whether the Policy’s “arising out of” prior or pending litigation exclusion (“Exclusion (h)”) precluded coverage when the underlying litigation arose out of a prior litigation involving Nanogen and Dr.

Montgomery

4. Whether Exclusion (h) applied to preclude coverage when the underlying litigation arose out of acts that Dr. Montgomery performed while he was employed at Nanogen, not when he was employed by Acacia.
5. Whether the settlement and defense costs should be allocated between covered and uncovered claims and covered and uncovered parties. As the Policy at issue was a D&O Policy, the liabilities of the company’s directors and officers would likely be covered, but limited coverage was available for the companies.
6. Whether a finding of bad faith can be made when no coverage existed, a “genuine dispute” existed, and National Union’s alleged breach did not cause Acacia’s damages.

TRESSLER COMMENTS

This case has been closely watched due to the interpretation of D&O policy provisions, including coverage for entities under a D&O policy, the no voluntary settlement clause, notice upon reaching the SIR limit, and allocation of costs. In its briefing, National Union focused on the District Court’s refusal to apply certain facts in the context of fundamental California insurance case law; Acacia focused on National Union’s abandonment by failing to respond for nearly two years. While both parties presented strong arguments, the Ninth Circuit is the most liberal Circuit in the nation and is highly unpredictable. Oral arguments are set for February 2, 2010 before the Ninth Circuit panel consisting of Judges Betty Fletcher, Harry Pregerson and Susan Graber.

Stay tuned for our further commentary after the Ninth Circuit issues its Opinion, presumably later this year.



Prepared by Jeanne Kuo, an associate in our Los Angeles office.

the allegations, Brookstreet routinely ran advertisements promoting themselves as “expert financial advisors who could create suitable retirement portfolios utilizing, in part, CMO’s.” Brookstreet also routinely told its clients that it was buying AAA rated, government-backed bonds that would provide a significant return on their investment without any risk to their principal. In reality, Brookstreet was trading CMO derivatives, exposing its clients to extremely high risk due to the volatile nature of the product. The defendants’ alleged that Brookstreet and its agents knowingly and intentionally lied to its clients about the risk to “generate huge commissions, fees, markups and other trading profits for themselves because CMO derivatives trade on a shadow market, frequently with large spreads due to their volatility, among other reasons.”

The second group of defendants alleged that Brookstreet, with the aid of its clearing firm, caused the loss of its clients’ savings through trading activity that was described as an Institutional Bond Fund, but was, in fact, a portfolio of illiquid, highly-leveraged CMOs including interest only derivative securities and inverse floaters, which were inappropriate investments for retirement savings. Other allegations included churning and charging excessive margins.

The Court’s analysis centered on whether CMOs in question were derivatives. Illinois Union contended that they were, and that since the Claims rested on allegations that Brookstreet improperly directed its clients’ funds to CMOs, the Claims were not covered because the Policy excludes coverage for Claims “based upon, arising out of, or attributable to the sale, attempted sale, or servicing of . . . derivatives.” Illinois Union relied on several opinions, investor publications and the Securities and Exchange Commission web site to define CMOs. In Banca Cremi, S.A. v. Alex Brown & Sons, Inc., 132 F.3d 1017, 1022-23 (4th Cir. 1997), the Court explained that CMOs were first introduced in 1983 as “securities derived from pools of private home mortgages backed by U.S. government-sponsored enterprises.” The Banca Court also explained the concept underlying a CMO to be that a CMO issuer begins with a large pool of home mortgages, often worth billions of dollars, and that each pool of home mortgages generates two streams of income, the aggregate of all interest payments and the aggregate of all principal payments made on the underlying mortgages, which are then divided into numerous CMO “tranches” and sold as securities to investors. Additionally, the Court looked to the Securities and Exchange Commission web site for guidance, which defined derivatives as “financial instruments whose performance is derived, at least in part, from the performance of an underlying

asset, security or index. For example, a stock option is a derivative because its value changes in relation to the price movement of the underlying stock.” Illinois Union also referred to Alvin Arnold, Real Estate Investor’s Deskbook, § 6.75 (3d Ed. 2009), which provided that a CMO is:

“secured by a pool of mortgages often originated by multiple lenders in different parts of the country. . . . [M]any investors do not want to buy the typical pass-through security because of the uncertainty of principal repayments. The CMO, which was created in 1983 by Freddie Mac, solved this problem by being a ‘derivative security.’ Instead of distributing the cash flow from the underlying mortgage pool pro rata among the various security holders, a CMO allocates the cash flow from the underlying mortgage pool in accordance with a predetermined plan. Because the special allocation changes the normal distribution of cash flow, the CMOs are a different kind of asset from the underlying securities even though the CMO distributions are derived from the underlying mortgages. Hence, the term ‘derivative.’”

The Court noted that not only did the defendants fail to address these authorities, relying instead on inapplicable authorities, but some of the defendants repeatedly referred to CMOs as derivatives in their Statements of Claim. The Court found that the arguments presented by the defendants did not present an issue of fact as to the exclusion of coverage for derivatives, or whether a CMO is a derivative. Since the defendants’ Statements of Claim were predicated solely on losses arising from investments in CMOs, their Claims were not covered under the Professional Services Exclusion and summary judgment was granted in favor of Illinois Union on the issue.

Notice

The Court’s third opinion contains a lengthy and detailed discussion of notice requirements under a claims-made and reported policy. In granting Illinois Union’s summary judgment motion, the Court upheld a provision in the Policy which required that notice of a Claim be given no more than 30 days after the insureds “knew or should have known, using reasonable diligence, of the existence of the Claim”. Although some claimants argued that Illinois Union needed to demonstrate prejudice in order to avoid coverage on that basis, the Court noted that the notice-prejudice rule does not apply to a

claims-made and reported policy as such an application would essentially convert it into an occurrence policy.

TRESSLER COMMENTS

This trio of opinions provides a good discussion of the sometimes complex coverage issues that arise under professional liability insurance policies issued to entities engaged in the securities industry. The first opinion illustrates how pivotal the relevant facts are to an analysis of whether acts constitute a single “Wrongful Act” or “Interrelated Wrongful Acts” as defined by professional liability policies. The second opinion shows the type of analysis that may be necessary in assessing the scope of undefined terms used in an insurance policy. The third opinion is especially interesting because, while the insureds did not provide notice of the claims in accordance with the Policy’s terms, the court enforced the notice provision even though notice was provided during the policy period. There are other jurisdictions which enforce notice provisions in claims-made and reported policies but except from that practice, situations where the insured provides notice during the policy period. Such decisions are commonly predicated on grounds of equity. As more policies have been including notice provisions such as the one referenced in the court’s third opinion, we may be seeing more disputes on this issue in the coming years.



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Alexander Manufacturing continued from page 6

breaching the consent-to-settle provision. In determining the reasonableness of the officers' decision to settle, the court held that a settlement that is made in good-faith, via arms-length negotiations creates a rebuttable presumption of reasonableness. Here, a private mediator conducted the settlement negotiations and the parties knew limited funds were available for indemnity and that defense costs decreased the available funds. The officers' counsel indicated that the officers wished to avoid the possibility of a verdict against them. Based on these factors, the court presumed that the officers' settlement was reasonable. Because Illinois Union failed to present any evidence to rebut that presumption, the court ruled that, even if Illinois Union could show prejudice as a result of the officers' settlement without consent, the settlement was reasonable and therefore Illinois Union could not rely on the consent-to-settle provision as a basis to deny coverage.

Illinois Union argued that any liability under the Policy was limited by the Policy's common claim endorsement, which provided that "any Claim or more than one Claim which arises out of any Interrelated Wrongful Acts, which would, in whole or in part, be covered under the Directors and Officers Coverage Section and the Fiduciary Coverage Section, the Limit of Liability ... for all loss incurred from all such Claims shall not exceed the sum of \$1 million." Illinois Union argued that The Policy defined Interrelated Wrongful Acts as "more than one Wrongful Act which have as a common nexus any fact, circumstance, situation, event, transaction or series of facts, circumstances, situations, events or transactions." The court looked beyond the four corners of the complaints in

the Emerson and Trust Suits in determining whether the common claim endorsement applied, holding that "while courts look to the complaint to determine whether an insurer has a duty to defend, courts determine a duty to indemnify by examining proof of actual facts demonstrating a right to coverage." In considering the allegations in the complaint and assertions in the parties' summary judgment briefing, the court found that the Trust Claim and Emerson Suits were related and involved overlapping, although not identical, issues because both claims involved the directors' decision to expend funds while hiding the company's true financial condition. The court therefore found that the Emerson and Trust Claims involved Interrelated Wrongful Acts. The court held that said acts, at least in part, fell under both the D&O and fiduciary coverage sections of the Policy and therefore triggered the Policy's Common Claim Endorsement. Accordingly, the court granted Illinois Union's summary judgment motion on the extent of its liability under the Policy. The court noted that its ruling merely limited the Trust's contract damages against Illinois Union and did not dispose of the case.

The Trust also argued that Illinois Union breached its duty of care to its insureds in handling the defense and settlement of the Trust Claim. The court agreed, finding that Illinois Union erroneously asserted that it had a basis to rescind the policy and misstated the amount remaining under the Policy for settlement. At the time Klutho signed the policy renewal application for the 2003-2004 policy year, only the 2001 financial statement was available, and not the misleading 2002 financial statement. The court found, however, that there was

a question of fact as to whether Illinois Union's breach of its duty of care caused the directors to settle for an amount in excess of the coverage limit because although the directors pointed to the provision in the settlement agreement that stated that Illinois Union's threat to rescind the Policy contributed to their decision to settle, Illinois Union pointed to evidence that the directors merely wanted to get out of the litigation, irrespective of Illinois Union's coverage position. The court therefore denied both parties' summary judgment motions on this issue.

TRESSLER COMMENTS

This decision is particularly noteworthy for its ruling on the consent to settle issue. Two particular factors appeared to weigh heavily in favor of the insureds on this issue. First, was the fact that they had sought the insurer's consent and the insurer rejected the settlement opportunity. Further, the insurer was unable to demonstrate to the Court's satisfaction that the settlement amount was unreasonable.



Prepared by Devin Maddox, an associate in our Chicago office.

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