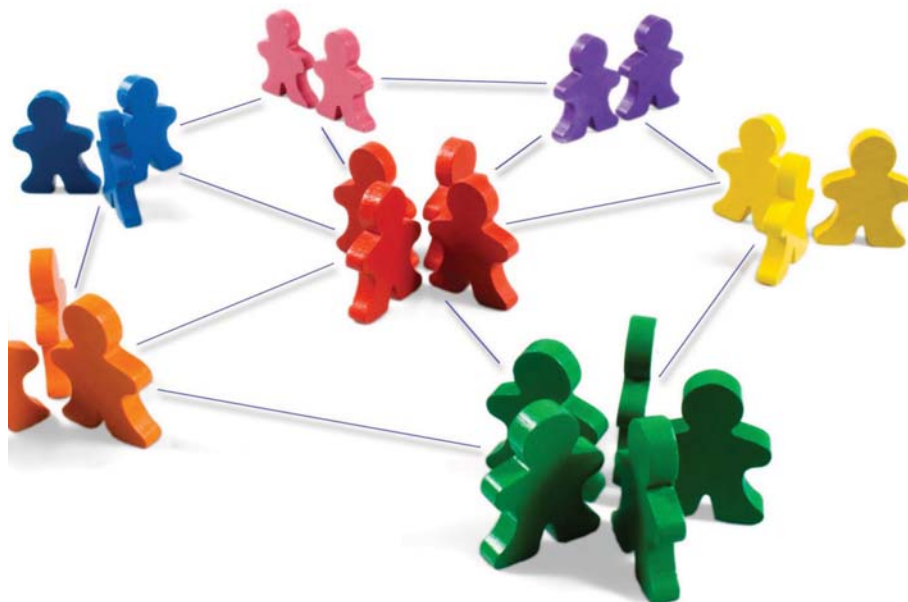


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CGL Dispatch



GEORGIA SUPREME COURT HOLDS INSURER THAT DEFENDS AN INSURED WITHOUT RESERVING ITS RIGHTS IS ESTOPPED FROM DENYING COVERAGE

In World Harvest Church, Inc. v. GuideOne Mut. Ins. Co., 2010 Ga. LEXIS 365 (Ga. May 3, 2010), the Georgia Supreme Court held that an insurer was estopped from denying coverage after it defended an insured without issuing a reservation of rights that fairly informed the insured of its coverage position. The court held that the insurer's control of the defense for over ten months conclusively prejudiced the insured.

The insured, World Harvest Church, received \$1.8 million in donations from an individual that operated a ponzi scheme. In a Securities and Exchange Commission civil enforcement suit, the appointed receiver filed a lawsuit in Illinois against World Harvest and demanded that World Harvest return the donations. After World Harvest's insurer, GuideOne, was informed of the lawsuit, GuideOne's sister company responded to World Harvest with a reservation of rights letter concluding that the policy did not cover the Receiver's action.

After the Illinois action was dismissed for lack of personal jurisdiction, the Receiver filed another lawsuit in the Northern District of Georgia. After being informed of the Georgia lawsuit, GuideOne began to defend World Harvest. GuideOne split its World Harvest claim file between two adjusters; one of the adjusters handled coverage issues and the other oversaw the defense of the Georgia action. While GuideOne did not issue a formal reservation of rights letter, the coverage adjuster told World Harvest that he "did not see coverage" and would continue to evaluate coverage issues. After defending World Harvest for several months, GuideOne informed World Harvest that it would

stop defending in 30 days because there was no coverage. GuideOne withdrew its defense while there was only one month remaining in the discovery period. Thereafter, the Receiver obtained summary judgment and settled with World Harvest for \$1,000,000.

After settling, World Harvest brought an insurance coverage action against GuideOne in the Northern District of Georgia. The district court found that GuideOne was not estopped from denying coverage because World Harvest did not establish that GuideOne prejudiced World Harvest's defense. On appeal, the Eleventh Circuit certified several questions to the Georgia Supreme Court, including whether GuideOne effectively reserved its rights to deny coverage and, if not, whether GuideOne was estopped from denying coverage.

The court first addressed whether GuideOne effectively reserved its rights. The court found that a reservation of rights letter must fairly inform the insured that the insurer may disclaim liability notwithstanding its defense of the action and should inform the insured of the specific basis upon which the insurer may disclaim coverage. Correspondence

See World Harvest page 2 for conclusion

will not constitute a reservation of rights if it is only a “statement of intent” or a mere allegation that the claim is not covered. The court noted that while a written reservation of rights letter is preferred, an oral reservation of rights may be valid. The court held that GuideOne did not validly reserve its right to deny coverage. The court found that the oral statement of GuideOne’s adjuster did not “fairly inform” World Harvest of GuideOne’s position. Moreover, the court found that the reservation of rights letter issued by GuideOne’s sister company in response to notice of the Illinois lawsuit was ambiguous as to whether GuideOne intended to offer a conditional defense for the Georgia action. The court held that an insurer is estopped from denying coverage where it does not effectively reserve its right to deny coverage and assumes the insured’s defense “with actual or constructive knowledge

of noncoverage.” Under Georgia law, the court found that “prejudice to the insured is conclusively presumed, or that the loss of the right to control and manage the case is itself sufficient prejudice to the insured.” Though an insurer may not be estopped from denying coverage if it merely enters an appearance for its insured without reserving its rights, the court held that an insurer will be estopped from denying coverage where it “assumes and conducts an initial defense without effectively notifying the insured that it is doing so with a reservation of rights.” Because GuideOne conducted the defense for ten months without reserving its rights, the court held that GuideOne was estopped from denying coverage to World Harvest.

TRESSLER COMMENTS

This decision alerts insurers to the harsh

consequences of a defending insurer’s failure to reserve its rights in Georgia. Additionally, the Georgia Supreme Court outlines certain technical requirements of a valid reservation of rights. Under Georgia law, an insurer must *immediately* issue a reservation of rights letter that *thoroughly* describes its coverage defenses. A supplemental reservation of rights may be necessary if there are substantial changes in the underlying action, such as the dismissal and refiling of the underlying action.



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TIT FOR TAT – WHERE AN EXCESS INSURER ALLEGES THE PRIMARY INSURER ACTED IN BAD FAITH, THE EXCESS INSURER’S OWN CONDUCT IN SETTLEMENT NEGOTIATIONS BECOMES FAIR GAME AND IS SUBJECT TO DISCOVERY

In New Jersey Manufacturers Insurance Company v. National Casualty Company, 992 A.2d 837, 2010 N.J. Super. LEXIS 72 (N.J. Super. Ct. App. Div. April 29, 2010), the New Jersey Appellate Court held that where an excess insurer accuses a primary insurer of bad faith in settlement negotiations, it is fair game for a primary insurer to obtain discovery from the excess insurer in the form of depositions of the excess carrier’s counsel and excess carrier’s litigation specialist as to the excess insurer’s settlement position.

The primary insurer, New Jersey Manufacturers Insurance Company (“NJM”) and the excess insurer, National Casualty Company (“NCC”) settled an underlying tort action after judgment was entered against their insured. Specifically, a judgment in the amount of \$1,640,000 was entered against their insured, plus \$580,322.07 in pre-judgment interest. NJM paid its \$1 million policy limit and NCC paid the remaining \$640,000 of the damages award. The insurers each paid half of the pre-judgment interest award, under a reservation of rights. The instant case followed concerning which insurer had the obligation to pay the pre-judgment interest award.

In an earlier interlocutory appeal, the appellate court held that NJM, the primary insurer, may be held liable for the payment of pre-judgment interest that is in excess of its policy limits if the trial court finds that the primary insurer did not engage in good faith negotiations to settle the claim within the policy’s coverage limit. The appellate court remanded the matter to the trial court for an evidentiary hearing as to whether NJM violated its fiduciary duty to engage in meaningful, timely, good faith efforts to settle the claims asserted by the party suing its insured within the policy’s coverage limit. On remand, NJM sought discovery from NCC, and specifically sought the deposition and files of NCC’s attorney and Senior Litigation Specialist. NCC moved to quash the discovery

on relevancy and privilege grounds, and it moved for a protective order. The trial court denied NCC’s motion to quash and motion for a protective order. The instant interlocutory appeal followed.

In order to determine the relevancy of NCC’s conduct in the settlement negotiations, the appellate court looked at the seminal case dealing with an insurer’s obligation to engage in good faith negotiations for guidance, Rova Farms Resort, Inc. v. Investors Insurance Co. of America, 65 N.J. 474, 323 A.2d 495 (1974). The appellate court reasoned that under Rova Farms, an insurer that fails to negotiate in good faith is not automatically liable for any judgment in excess of the policy limits. Instead, the court recognized that the insurer may avoid liability if it can show that there was no realistic possibility of a settlement within the policy limits because the insured (or in this case the excess insurer) would not have contributed the amount above the primary policy limit that would have been necessary to settle the case. Here, the arguments advanced suggested that even after the primary insurer had extended its full policy limits, the excess insurer had requested that it withhold such disclosure in the hopes of the matter settling within primary limits. Accordingly, the appellate court concluded that the primary insurer, NJM, was entitled to conduct appropriate discovery to support that defense.

Finally, for the guidance of the trial court, the appellate court commented that NCC’s claim against NJM involves the difficult issue of establishing the point in time at which the primary insurer’s failure to settle occurred. Establishing that time period would, of necessity, impact whether the prejudgment interest accrued before or after the insurer’s breach of its fiduciary duty to its insured.

TRESSLER COMMENTS

This case presents the pitfalls that may arise where an excess insurer claims that a primary insurer acted in bad faith. Specifically, in New Jersey, if an excess insurer intends to scrutinize the timing and conduct of a primary carrier, the excess insurer must be prepared to provide its evaluation and strategy since the primary carrier is entitled to discovery on those issues from the excess insurer to mount its defense.



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NY APPELLATE COURT FINDS NO BREACH OF THE COVENANT OF GOOD FAITH AND FAIR DEALING WHERE A PRE-LITIGATION SETTLEMENT DEMAND IS NOT ISSUED

The court in CBLPath, Inc. v. Lexington Insurance Company, 2010 N.Y. App. Div. LEXIS 4045, 2010 N.Y. Slip Op. 4128 (N.Y. App. Div. May 11, 2010) held that Lexington Insurance Company (“Lexington”) did not breach the covenant of good faith and fair dealing. Specifically, the court found that despite Lexington’s failure to make any substantive response to the underlying plaintiff’s numerous attempts to begin settlement discussions prior to filing suit, it was undisputed that the underlying plaintiff never made a pre-litigation settlement demand.

The insured, CBLPath, Inc. (“CBL”) filed suit against its medical malpractice carrier, Lexington, asserting one count for breach of the covenant of good faith and fair dealing implied in the insurance contract. The insured’s claim against its insurer arose out of an underlying suit filed against CBL, which alleged that in March 2006 CBL, a medical diagnostic laboratory, negligently switched the biopsy specimen of Darrie Eason (“Eason”), the underlying plaintiff, with another patient’s specimen, resulting in Eason being wrongly diagnosed with cancer and undergoing a double mastectomy. CBL notified Lexington of the suit. From February 2007 to September 2007, Eason’s counsel made numerous attempts to open settlement discussions, to which Lexington never substantively responded, prior to filing litigation. The underlying lawsuit was filed in October 2007. The first settlement demand of \$5 million was issued in December 2007. The underlying lawsuit was settled several months later for \$2.5 million, with Lexington paying its policy limits of \$1 million and CBL paying the remaining \$1.5 million.

Thereafter, CBL instituted this lawsuit alleging that Lexington had acted in bad faith by refusing to enter into pre-litigation settlement discussions with Eason. CBL

alleged that Lexington exercised its right as the “sole authority” to handle the Eason claim. In affirming the grant of summary judgment in favor of Lexington, the court acknowledged that an insurer may be liable for breach of the covenant of good faith and fair dealing in defending and settling claims where it exercises exclusive control, as the insurer is required to act in the insured’s best interest. The court noted that while an insurer can be exposed to damages in excess of the policy limits to the extent it has breached its covenant of good faith and fair dealing by refusing to settle within the policy limits, because an award exceeding the policy limits is punitive in nature, it is only awarded when there is an “extraordinary showing of a disingenuous or dishonest failure to carry out the contract.”

The court held that Lexington was entitled to judgment as a matter of law because it had submitted evidence that the first settlement demand was not issued until after the underlying lawsuit had been filed and, once the demand was issued, settlement negotiations began and a settlement was reached. CBL submitted an affidavit in opposition indicating that Lexington refused to contact Eason’s counsel after it asserted exclusive control over the claim so as to

avoid negative publicity to CBL. Yet, because CBL could not demonstrate that it lost an opportunity to settle because of Lexington’s conduct, Lexington was entitled to judgment as a matter of law.

TRESSLER COMMENTS

Under New York law, the insured has a heavy burden in demonstrating entitlement to damages as a result of the breach of the covenant of good faith and fair dealing where such an award exceeds the policy limits. An insured must demonstrate more than some evidence of bad faith on the part of the insurer. Rather, the insured must prove that a settlement opportunity was, in fact, presented and such an opportunity was lost as a result of the insurer’s conduct.



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ILLINOIS APPELLATE COURT RULES EMPLOYER'S LIABILITY EXCLUSION BARS COVERAGE

In James McHugh Construction Co. v. Zurich American Insurance Co., No. 1-09-2135, 2010 Ill. App. LEXIS 318 (1st Dist. April 13, 2010), the Illinois Appellate Court upheld a trial court and ruled that an employer's liability exclusion in a general liability policy precluded coverage to an additional insured. The Appellate Court ruled that because the plaintiffs in the underlying cases were employees of the additional insured, their claims fell within the scope of an exclusion that barred coverage for bodily injury to an employee of "the insured," rejecting the argument that the words "the insured" referred only to the named insured and not to an additional insured.

James McHugh Construction Company ("McHugh") was the general contractor on a construction project. It entered into a subcontract with JMS Electric, Inc. ("JMS") to perform electrical work. Pursuant to the terms of the subcontract, JMS had McHugh added as an additional insured under a general liability policy issued by Zurich American to JMS. Thomas Searle, an employee of McHugh, filed suit against JMS, alleging that he was injured due to the negligence of JMS. JMS filed a third-party contribution claim against McHugh, alleging that McHugh's negligence contributed to Searle's injury. McHugh tendered the third-party claim to Zurich American. Zurich denied coverage pursuant to an employer's liability exclusion which precluded coverage for bodily injury to an "employee of the insured arising out of and in the course of: (a) Employment by the insured; or (b) Performing duties related to the conduct of the insured's business."

Zurich also denied coverage to McHugh for a claim that was asserted against McHugh by Stevenson Crane Services ("Stevenson"). McHugh had subcontracted a portion of the construction work to Perdel Contracting Corporation ("Perdel"), which, in turn, subcontracted with Stevenson Crane Service. A McHugh employee, Paul Novovesky, filed a personal injury action against Stevenson and Perdel, and Stevenson filed a third-party action against McHugh. McHugh was an additional insured under a Zurich policy issued to Perdel. After McHugh tendered the third-party action to Zurich, Zurich denied coverage based on the same employer's liability exclusion.

After commencing a coverage action against Zurich, Zurich filed a motion for judgment on the pleadings, arguing that although McHugh was an additional insured under the policies, the employer's liability exclusion applied because both of the underlying plaintiffs were employees of McHugh. McHugh cross

moved for judgment on the pleadings, contending that the employer's liability exclusion applied only to "the insured." McHugh argued that it was "an insured" under the policy, but was not "the insured." "The insured," McHugh contended, meant the named insured to whom the policy was issued. McHugh argued that because the words "the insured" were not defined in the policy, the policy was ambiguous and therefore had to be construed in McHugh's favor. Zurich argued that "the insured" language was clear and referred to the insured party seeking coverage, regardless of whether that party was the named insured or an additional insured.

The Appellate Court sided with Zurich, ruling that there was no language in the policy suggesting that the words "the insured" meant only the name insured. The Court noted that "an insured" refers to both the named insured and an additional insured, and held that there was no reason to construe "the Insured" language any differently. The Court ruled that "the obvious reading of 'the insured' is 'the insured seeking coverage,' which, depending on the circumstances of each particular claim, could be a named insured or an additional insured."

The court also reasoned that if "the insured" were to mean only the named insured, an additional insured would receive more protection under the policy because the employer's liability exclusion could never apply to an additional insured. The court felt that the scope of coverage should have been the same for both the insured and an additional insured. The court also noted that if "the insured" language were construed to mean only the named insured, then an additional insured would never be entitled to coverage to begin with because the insuring agreement obligated Zurich to pay those sums that "the insured" becomes legally obligated to pay. The Appellate Court thus held that Zurich had correctly disclaimed

coverage and owed no defense or indemnity obligation.

TRESSLER COMMENTS

There have been many insurance coverage cases litigated through out the United States that have dealt with similar issues. Unlike this case, which went in favor of Zurich, many of those cases have been resolved in favor of an additional insured. Many insurers have sought to avoid the type of controversy that developed in this case by modifying the language in their policies and using the words "an insured" to make sure that an exclusion, or some other policy provision, will be deemed to apply to both the named insured and an additional insured. Here, had the employer's liability exclusion barred coverage for bodily injury to the employee of "any insured," the coverage litigation between Zurich and McHugh probably would never have materialized.



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ONE OCCURRENCE AND ONE LIMIT: WASHINGTON COURT OF APPEALS ENFORCES ANTI-STACKING PROVISION

In Certain Underwriters at Lloyd's London v. Valiant Ins. Co., 229 P.3d 930 (Wa. Ct. App. 2010), the Washington Court of Appeals held (1) exposure to harmful moisture that gradually intrudes through a building envelope over a five year period constituted a single occurrence; and (2) given a single occurrence, an anti-stacking provision applied to restrict affiliated insurers' exposures to the limits of one insurance policy.

Valiant Insurance Company ("Valiant") and Northern Insurance Company of New York ("Northern") are both Zurich-affiliated companies. They insured Stratford Construction, LLC ("Stratford") under three successive primary policies ("Zurich policies.") The Zurich policies limit recovery to one policy limit per "occurrence" when the insured holds two or more policies issued by companies affiliated with Zurich. Certain Underwriters at Lloyd's London ("Underwriters") insured Stratford during two subsequent policy periods.

GCG Associates, LP ("GCG"), hired Stratford to construct a four-story retirement center in Washington. After construction was completed, GCG filed two suits against Stratford related to the construction, which were later consolidated. Expert reports, including a moisture mapping survey, indicated that there were "numerous points of water intrusion" over a five-year period resulting from a variety of construction defects.

Stratford settled the construction defect lawsuits for \$5 million. Valiant contributed the \$1 million limits of its policy. Northern refused to contribute to the settlement, relying on its one occurrence position and the "anti-stacking" provision in its policy. Underwriters and others paid the remainder of the settlement; Underwriters then sued Valiant and Northern for contribution and subrogation.

In granting Valiant and Northern's motion for summary judgment, the trial court held that the continuing water intrusion damage to the building was caused by a single "occurrence" even though the damage occurred at different locations and at different times. The trial court also held that because there was only one occurrence, the anti-stacking provision in the Zurich policies applied.

On appeal, Underwriters argued that evidence of "varying causes" of leaks was sufficient for a jury to find more than one cause of water damage, and thus more than

one "occurrence." As such, the anti-stacking provision would not apply, and Valiant would not be able to limit its contribution to \$1 million. In a 3-0 decision, the Washington Court of Appeal rejected these arguments.

Stating that the "key to the present case is the . . . policy definition of 'occurrence' as an 'accident, including continuous and repeated exposure to substantially the same general harmful conditions," the court found that the continuous and repeated exposure of the building to harmful moisture that gradually intruded through the building envelope over a five year period from different sources fits the definition of a single occurrence. In reaching its decision, the Court relied heavily upon Gruol Construction Co. v. Insurance Co. of North America, 524 P.2d 427 (Wa. Ct. App.), review denied, 84 Wn.2d 1014 (Wa. 1974), and American National Fire Insurance Co. v. B & L Trucking & Construction Co., 951 P.2d 250 (Wa. 1998), which hold that an "occurrence" can be a continuing condition or process; it need not be a single, isolated event.

Underwriters also argued that the anti-stacking provision was ambiguous because it conflicted with the Limits of Insurance provisions. The anti-stacking provision stated: "If this Coverage Form and any other Coverage Form or policy issued to you by us or any company affiliated with us apply to the same 'occurrence,' the maximum Limit of Insurance under all the Coverage Forms or policies shall not exceed the highest applicable Limit of Insurance under any one Coverage Form or policy." The Limits of Insurance provision provided, that "the limits of this Coverage Part apply separately to each consecutive annual period." Underwriters argued that because the anti-stacking provisions entitled the insured to \$1 million, and the Limit of Insurance sections afforded the insured \$3 million, there was a conflict between provisions, creating ambiguity.

The court disagreed. Based on its conclusion that the Zurich policies all applied to the same "occurrence", the court held: "The anti-

stacking provision does not, as Underwriters suggests, render the annual limits provision meaningless nor does it mean that the insured has paid premiums for illusory coverage. If Stratford had sustained damage from separate occurrences in each of the three separate policy periods covered by a Zurich affiliate, the anti-stacking provision would not apply and the full \$1 million limit per period would be available for each occurrence. . . . " However, here "[b]ecause the policies issued by Zurich's affiliated companies all applied to the same occurrence, the anti-stacking provision limited coverage to the highest applicable policy limit under any one of those policies."

TRESSLER COMMENTS

This decision confirms current Washington law, i.e. that on-going and continuous events stemming from the same cause can constitute a single occurrence in the construction defect context. This case is also important because it gives force and effect to policy language intended to restrict exposure to a single policy limit through an anti-stacking provision.



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