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## Joe Says ...



Somewhat unrelated issues warrant commentary this month, two securities cases very important to those working in the D&O insurance area, and another of general importance to the insurance industry.

### UNPLEASANT BLASTS FROM THE PAST

#### **Tellabs Proves To Have Been A Pyrrhic Victory**

When the Supreme Court decided Tellabs in 2007, many commentators hailed it as another important victory for the defense bar on the issue of *scienter* in the era since passage of the Private Securities Litigation Reform Act of 1995 (PSLRA). Others among us were a bit more reserved, and hastened to note that defendants would have fared much better if either the concurring opinions of Justices Scalia or Alito prevailed rather than the standard set forth in the majority opinion written by Justice Ginsburg. Indeed, the prevailing standard in at least one federal appellate circuit was already more pro-defendant than the one enunciated by the Court.

In effect, the Court held that in order for a complaint's *scienter* allegations to survive a motion to dismiss, plaintiff's must demonstrate that their inferences of actionable fraud are as "cogent and compelling" as those non-actionable inferences raised in defense. Plaintiffs need not prove they are *more* cogent and compelling. To draw a baseball analogy, a tie goes to the runner.

Now, a little less than two years after the Supreme Court's decision, the case has wound its way back to the trial court level in litigation that has consumed the better part of this decade.

Demonstrating that the devil is always in

the details (or at least in the execution upon remand), the trial court, applying the *scienter* standard mandated by the Supreme Court, has now granted certification of the class and has allowed the case going to forward. Makor Issues & Rights, Ltd. v. Tellabs, Inc., 2009 U.S. Dist. LEXIS 13523 (N.D. Ill., February 23, 2009). Although the court denied standing to one of the class representatives and reserved final judgment on class certification issues until after discovery is complete, the plaintiffs now have achieved an essentially long and hard-fought win.

#### **Dura Settles for \$14M**

In the halcyon days of 2005 when the real estate bubble was at maximum inflation, now-crippled financial institutions were thriving and new automobiles were selling at almost twice the levels they are now, the U.S. Supreme Court blessed us with its decision in Dura setting forth an arguably stringent test for pleading loss causation in a securities fraud class action. Notwithstanding that burden visited upon the plaintiffs, the litigation continued and it was reported that it recently settled for \$14M. One can only speculate as to what the settlement may have been otherwise without the decision from the high court. But, one can also imagine the amount of legal costs incurred as the litigation wound its way up and down the appellate process.

At least for the Dura defendants and their likely involved insurers, put this one next to Tellabs in the category of Pyrrhic victories.

### CONTRACT CERTAINTY

In a luncheon address to attendees at the PLUS D&O Symposium on February 26, New York Insurance Department Superintendent Eric Dinallo delivered a number of insightful comments on a wide range of issues impacting upon the economy and the insurance industry. However, perhaps his remarks on a relatively mundane topic – contract certainty – bear additional comments in this space.

Nothing illustrates the perils of not having a precisely worded and final policy document in place before a claim takes place as did the disputes over property insurance coverage arising from the destruction of the World Trade Center on September

11, 2001. Without commenting upon the merits of that dispute, it is fair to say that the industry has not performed well in this area.

Too often we see hastily and sloppily constructed binder language with reference to ambiguous provisions such as "absolute pollution exclusion to be added". Using this as an example, this only sows the seeds for a future problem. "Absolute pollution exclusion" has no universally accepted meaning in the insurance world, and it may mean different things to CGL insurers, as opposed to professional liability insurers. Binders should ideally contain relatively few "subjectivities" to be resolved later, and it should be clear what those subjectivities are and how they are to be resolved.

Regardless of the binder process, it is imperative that the formal and final policy be issued on time. Unfortunately, this mandate is honored more in its breach than its observance. Insurers need to pay as much attention and devote sufficient resources to this as they do to quoting and binding the business. Brokers, too, bear some responsibility here, particularly where we have complex, manuscript contracts that are the product of negotiation on both sides of the transaction. Simply put, the money must be spent to close the deal accurately, completely and on time. Anything less is unacceptable.

*Would you like to offer a comment? [Click here to let me know what you think.](#)*

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# KANSAS HIGHEST COURT HOLDS THAT E&O INSURERS HAD OBLIGATION TO DEFEND INSURANCE AGENTS AGAINST CLAIMS THAT THEIR CLIENTS' MONEY WAS STOLEN BY A DEBT-ADJUSTMENT ORGANIZATION

In the recent case of *Miller v. Westport* decided on January 30, 2009, the Supreme Court of Kansas reversed the district court's grant of Summary Judgment to E&O insurers and the ruling of the Kansas Court of Appeals which had affirmed Summary Judgment in favor of the insurers. The question presented to the Kansas highest court was whether the E&O insurers Westport and Employers were obligated to defend insurance agents Miller, Zeller and Kohn (hereinafter "Insurance Agents"). Examining extrinsic evidence along with the pleadings and the policies issued, the Court determined that Westport and Employers were obligated to defend the Insurance Agents.

The claims against the Insurance Agents arose out of their referral of insurance clients to Associated Financial Solutions, Inc. ("Associated"). Associated was a non-profit debt-adjustment organization that guaranteed its services would not have a negative impact on its clients' credit ratings. The Insurance Agents referred 12 of their own clients to Associated so that those clients could pay insurance premiums and fund the purchase of other insurance products.

The Insurance Agents referred clients to Associated over the course of about a year until their clients complained that their debts were not being discharged and they could not get in touch with Associated. Associated had been under investigation by the Kansas Attorney General's office, and its principal absconded with approximately \$55,000 belonging to the Insurance Agents' clients.

The Insurance Agents were also investigated by the Kansas Attorney General's office. Upon presentation of the claims to the E&O insurers, the E&O insurers denied coverage. The Insurance Agents did not admit any liability or violations but entered into an Assurance of Voluntary Compliance and agreed to reimburse their clients monies paid to Associated.

The E&O insurers based the denial of coverage on the argument that the agents' claim did not arise out of services rendered as licensed insurance agents. Additionally, the insurers relied upon the policy exclusions which preclude coverage for:

B. Any intentional, dishonest, fraudulent, criminal or malicious act, or assault or battery committed by or contributed to by any insured;

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T. Any 'claim' arising out of or in connection with a fraudulent or nonexistent entity.

The trial court granted summary judgment to the E&O insurers having found there was no "wrongful act" as defined in the policy, that there was no evidence the Insurance Agents could have foreseen their clients' money would

be stolen and there was no proximate cause between the referral and Associated's theft of the funds. The court of appeals affirmed for substantially the same reasons.

The Kansas Supreme Court, however, noted the E&O insurers had a duty to investigate and defend even frivolous claims. Under Kansas law, an insurer has a duty to defend if there is the potential for coverage. Kansas considers the pleadings as a mere starting point in a coverage determination. Extrinsic evidence is also considered in Kansas.

The Westport and Employers E&O policies covered the Insurance Agents for wrongful acts arising out of the conduct of the business of the 'insured agent' in rendering services for others as a licensed life, accident and health insurance agent. The Court found that a summary prepared by a plan administrator for the professional liability program indicated that "financial planning activities would be covered under the policy."

Having determined that financial planning was covered by the policy, the Court concluded the "allegations" fell within the coverage afforded so as to warrant a defense. Specifically, the Court pointed to the allegation that the Insurance Agents owed their clients a fiduciary duty to perform due diligence in connection with the referral. Furthermore, the Court found that none of the exclusions relied upon by the E&O insurers would preclude coverage. Examining findings that Associated's theft of money from the clients of the Insurance Agents was dishonest and fraudulent, but not foreseeable, and noting that there was no evidence that the Insurance Agents committed deceptive acts, the Court rejected the applicability of Exclusion B. As to Exclusion T, the Court also found it inapplicable since Associated was a company incorporated for "ostensibly lawful purposes."

## TRESSLER COMMENTS

Always inquire whether the jurisdiction follows the four corners rule. While it appears that the claims the Insurance Agents submitted to the E&O insurers did not explicitly contain

an allegation that the Insurance Agents (also financial planners) had a fiduciary duty to their clients to perform due diligence in the referral of clients to a debt-adjustment organization, the fact that Kansas considers extrinsic evidence beyond the four corners of the pleadings and four corners of the policy provided information and evidence that may not be admissible in other jurisdictions.



Prepared by Joanna L. Crosby, a Partner in our Newark office.

# FEDERAL DISTRICT COURT IN MAINE ACKNOWLEDGES HISTORY AND PURPOSE OF D&O INSURANCE IN UPHOLDING A DENIAL OF COVERAGE FOR A CLAIM MADE AGAINST THE CORPORATION ITSELF

In *Medical Mutual Insurance Company of Maine v. Indian Harbor Insurance Company*, Civil No. 08-48-P-H (D. Me. Nov. 19, 2008) the Court held that a D&O insurer had no duty to pay the named insured company for the settlement of a discrimination claim that sought relief against only the company itself and not the directors and officers, even where the directors and officers were alleged to have committed some discriminatory conduct.

Medical Mutual Insurance Company of Maine (“MMIC”)’s former chief executive officer (“CEO”) filed an administrative complaint with the Maine Human Rights Commission (“MHRC”) charging that he had been discriminated against because of his disability. The ‘Charge of Discrimination’ complaint form that the CEO filed with MHRC contained a section for the complainant to identify the “employer, labor organization, employment agent apprenticeship committee, [or] state or local government agency” that had discriminated against him. In that section, the CEO listed only “Medical Mutual Insurance Co. of Maine.” Along with the form, the CEO submitted a ‘Statement of Charge,’ wherein he listed the alleged offending conduct which referred to conduct on the part of MMIC management, members of the board of directors, and committees of the board.

The CEO was given a right to sue letter, and the CEO then sued MMIC in this federal court. In the factual portion of his complaint in the federal lawsuit, the CEO referred to “MMIC acting through members of its Board of Directors and its agents.” In each of his seven counts, however, he referred to only the conduct of “MMIC” itself, or, in one instance, “MMIC, acting through its agents, representatives and members of its Board of Directors.” He directed his prayer for relief against MMIC and, in addition to damages and other relief, he requested the court to “[e]njoin MMIC, its agents, employees, and successors, from continuing to violate Plaintiff’s rights.”

Ultimately, MMIC settled the case and contributed \$325,000 of its own money. In the settlement language, the CEO agreed to release and “to waive any claims he may have against MMIC, and its officers, agents, employees, attorneys, and members of the Board of Directors, successors, affiliates, subsidiaries and insurers, and any and all other persons, firms and corporations employed by or acting as agents of MMIC [...]” MMIC then brought its lawsuit against Indian Harbor Insurance Company (“Indian Harbor”) seeking reimbursement under the Directors and Officers insurance policy issued by Indiana Harbor. Indian Harbor counterclaimed for declaratory relief that it has no obligation to pay.

The Indian Harbor policy Insuring Agreement provided:

The Insurer [Indian Harbor] shall

pay on behalf of the Company [MMIC] Loss which the Company is required or permitted to pay as indemnification to any of the Insured Persons *resulting from a Claim ... made against the Insured Persons...* for a Wrongful Act or Employment Practices Wrongful Act.

“Insured Person” was a term defined as:

[A]ny past, present or future director or officer, or member of the Board of Managers, of the Company [MMIC]...

“Claim” was defined in the Indian Harbor policy as:

1. a written demand for monetary or non-monetary relief;
2. any civil proceeding in a court of law or equity, or arbitration;
3. any criminal proceeding which is commenced by the return of an indictment; and
4. a formal civil, criminal, administrative regulatory proceeding or formal investigation of an Insured Person... including any proceeding before the Equal Employment Opportunity Commission or any similar federal, state or local governing body...

According to the court, the only question before it was whether MMIC paid funds as a result of a “Claim...made against [an] Insured Person[ ].”

The court answered this question in the negative finding that the CEO may have accused individual MMIC officers and directors of wrongful conduct, but never did he make a claim against any officer or director for relief. The court took note of the fact that the CEO’s administrative claims “listed only MMIC; his detailed statement of charge was focused on MMIC; and his federal lawsuit sued only MMIC.” Moreover, the court found that the fact that the CEO’s prayer for relief sought injunctive relief against “MMIC, its agents, employees, and successor” did not alter the court’s conclusion. The court described this language as boilerplate language that is always used in an injunction against a corporation. Likewise, the fact that the settlement included not only MMIC, but also “its officers, agents, employees,

attorneys, and members of the Board of Directors, successors, affiliates, subsidiaries and insurers, and any and all other persons, firms and corporations employed by or acting as agents of MMIC” was also no more than boilerplate settlement language.

The court noted that its decision was consistent with the general caselaw from other jurisdictions and was consistent with the purpose of a Directors and Officers policy, which is “to give [directors and officers] insurance coverage to protect them from *personal* liability.”

## TRESSLER COMMENTS

This well-reasoned decision by the court upholds the purpose behind a D&O policy’s indemnification coverage agreement, which is to protect the directors and officers, and not the company, from liability resulting from business decisions. The court’s reasoning in this case can be compared with the court’s approach in *Julio & Sons Co. v. Travelers Casualty and Surety Co. of America*, which is discussed elsewhere in this newsletter and which does not consider the history and purpose of D&O insurance in reaching what we found to be a puzzling decision.



Prepared by Shevonn K. Smith, an Associate in our Chicago office.

# FAXING IS NOT A PROFESSIONAL SERVICE

In a recent decision by an Illinois appellate court, a professional liability insurer owed no coverage to an insurance agency that allegedly violated the Telephone and Consumer Protection Act (TCPA) by faxing unsolicited advertisements. Specifically, in Westport Ins. Corp. v. Jackson National Life Ins. Co., No. 2-07-1205, 2008 Ill.App. LEXIS 1302, (2nd Dist. 2008), the Court ruled that the insurance agency was not performing a “professional service” when it faxed unsolicited advertisements for group health policies to potential customers.

## *Background and Procedural History*

Stonecrafters, Inc. (“Stonecrafters”) filed a class action lawsuit against Handleman Insurance Agency, Inc. (“Handleman”) alleging that the insurance agent’s transmission of unsolicited faxes to Stonecrafters and other businesses violated the TCPA. The advertisement facsimile promoted group health insurance, setting forth a table of premiums based upon both age and gender, and invited potential customers to request a quotation.

The parties eventually settled the class action lawsuit and entered into an agreed order entering a judgment in the amount of \$2 million in favor of the plaintiff class. As part of the settlement, Handleman assigned to the plaintiff class all of its rights to indemnity from its insurers, including Westport Insurance Corporation (“Westport”).

Westport issued a professional liability policy for insurance agents and brokers to Jackson National Life Insurance Company. Handleman was insured under the policy as one of Jackson’s agents.

Westport denied coverage and filed a declaratory judgment action. Stonecrafters filed a counterclaim seeking a declaration that Westport was obligated to pay the proceeds of the policy. Stonecrafters then moved for summary judgment on the pleadings, and Westport moved for summary judgment. The trial court granted Westport’s motion and denied Stonecrafters’ motion. Stonecrafters appealed.

Westport maintained that Handleman’s liability in the class action lawsuit did not arise from the conduct of Handleman’s business in rendering professional services for others as a licensed insurance agent. Stonecrafters, on the other hand, argued that the distribution of the unsolicited advertisement was part of the conduct of Handleman’s business as it provided information to potential customers about the availability of group health insurance, and constituted a professional service for others, thereby falling within the scope of coverage provided by the policy.

## *Summary of Decision*

The Appellate Court recognized that the title of the policy, “Insurance Company Coverage

for Insurance Agents and Brokers Professional Liability,” clearly indicated that the policy provided coverage for “professional liability.” According to the Court, the title of the policy demonstrated that the type of insurance purchased by Jackson was specifically meant to cover its agents, including Handleman. The court stated further that the type of insurance purchased was “germane” to determining the meaning of the policy language. Therefore, the Court read the policy phrase, “rendering services for others as a licensed life, accident and health insurance agent, a licensed life, accident and health insurance general agent or a licensed life, accident and insurance broker,” to signify and define the agent or broker’s professional services.

The Court found that insurance sales professionals use specialized knowledge and training regarding specific insurance products in order to assist customers in selecting products that are best suited for their particular needs. However, in this case, Handleman merely sent out an advertisement describing general features of a plan for “Group Health Insurance With Affordable Premiums.” The advertisement set forth a table of illustrated monthly premiums, but made clear that actual premiums would depend upon the “overall composition” of the insured group. Thus, the advertisement was merely an overture to potential customers.

The Court noted that even if Stonecrafters was correct that the delivery of the general information was “an act of assistance” and, thus, in very broad terms, “a service,” it did not amount to rendering a service “as an insurance professional” within the contemplation of the policy. The Court found that no expertise was employed to help a particular customer purchase a particular product, and as a result, the mere offer to perform a professional service was not a professional service in its own right.

## TRESSLER COMMENTS

The facts presented here involve alleged conduct of the insurance agency that clearly did not require any specialized knowledge, skill, or expertise. Sending an advertisement over a fax machine may be considered a business activity, but it certainly does not require a professional’s skill or expertise. Many companies have sought coverage for these so-called “fax blast” claims under

general liability policies. Professional liability policies, as the title suggests, typically provide specific coverage designed to protect against only those liabilities arising from rendering, or failing to render, professional services.



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# BANKRUPTCY COURT RELIES ON 'BUT FOR' TEST TO UPHOLD INADEQUATE CONSIDERATION EXCLUSION IN D&O INSURANCE POLICY AS BASIS FOR DENIAL OF COVERAGE

In *Delta Financial Corp. v. Westchester Surplus Lines Insurance Co.*, 2008 BL 277766 (Bankr. D. Del. Dec. 15, 2008), the U.S. Bankruptcy Court for the District of Delaware granted insurers' motions to dismiss a declaratory judgment action brought by a bankrupt insured, concluding that the inadequate consideration exclusion barred coverage based on the operative act common to all allegations in the underlying action.

**Background:** The coverage litigation stemmed from the second of two restructuring transactions undertaken by Delta Financial Corp. ("Delta Financial") to restructure its debt in light of financial difficulties. The first restructuring transaction began in August 2000, when Delta Financial offered its holders of unsecured senior notes the opportunity to exchange these for senior secured notes and warrants for Delta Financial common stock. Delta Financial's senior secured notes were secured by excess cash flow certificates held by Delta Financial and its affiliates. These excess cash flow certificates entitled their holder to cash payments if the return on the securitized pool of mortgages (which Delta Financial originated and created) exceeded the amount due to investors. A few weeks after the first restructuring transaction, Delta Financial informed holders of the senior secured notes that it could not meet its obligations to them, and that unless they agreed to a second restructuring transaction, bankruptcy was likely.

The second restructuring transaction involved the transfer of assets that Delta Financial represented had an initial value of at least \$150 million to Delta Funding Residual Exchange Co., LLC ("Delta LLC"), which was created to facilitate the second restructuring transaction. These transferred assets consisted primarily of certain excess cash flow certificates under mortgages previously originated and securitized by Delta Financial (the "Contributed Cash Flow Certificates"). The Contributed Cash Flow Certificates were valued by Delta Financial at \$153 million. The holders of the unsecured senior notes and senior secured notes (collectively, the "notes") exchanged their \$150 million worth of notes for interests in Delta LLC, and received new preferred Delta Financial stock valued by Delta Financial at \$15 million (the "Exchange Agreement"). The offering documents in support thereof stated that the intent of the parties was that "cash and the fair market value of the preferred stock and other assets received in the exchange will approximately equal the outstanding balance of the notes surrendered." In mid-November 2001, Delta Financial informed LLC that it had devalued its excess cash flow certificates by sixty percent. A month later, Delta Financial delivered to Delta LLC a balance sheet that showed the value of the Contributed Cash Flow Certificates at approximately \$60 million.

In 2003, Delta LLC and its managing member,

Delta Funding Residual Management Inc. ("Delta Management") filed suit against Delta Financial and five of its directors, alleging, among other things, that Delta Financial overstated the value of the Contributed Cash Flow Certificates by approximately \$110 million and failed to fulfill its obligation under the offering documents to contribute assets to Delta LLC "approximately equal to the outstanding balance of the notes surrendered. Further, the suit alleged that Delta Financial had failed to fulfill its obligation under the Exchange Agreement to indemnify and hold harmless Delta LLC against the \$110 million loss.

Shortly thereafter, Delta Financial provided notice of the underlying suit to Westchester Surplus Lines Insurance Co. ("Westchester"), its primary D&O insurance coverage provider, and United States Fire Insurance Co. ("U.S. Fire") and Axis Specialty Insurance Co. ("Axis"), which provided excess coverage and followed form to the Westchester policy. The Westchester policy contained an "**Inadequate Consideration Exclusion**" which provided that: "**the insurer shall not be liable for Loss on account of any Claim made against any Insured . . . based upon, arising out of, or attributable to the actual or proposed payment by the Company of allegedly inadequate to excessive consideration in connection with the Company's purchase of securities issued by any company.**" In April 2005, Westchester denied coverage for the claim, on a variety of grounds, including the Inadequate Consideration Exclusion.

In February 2008, shortly after Delta Financial and its affiliates filed for Chapter 11 bankruptcy protection, Delta Financial sued Westchester, U.S. Fire and Axis (the "Insurers") seeking a declaratory judgment that the Insurers were obligated to defend and indemnify Delta Financial against the plaintiffs' claim in the underlying suit and alleging bad faith against Westchester for its 18-month delay in denying coverage. Thereafter, Westchester filed a motion for judgment on the pleadings primarily arguing that the Inadequate Consideration Exclusion operated to bar coverage.

**Legal Standard and Discussion:** The Bankruptcy Court relied on New York law's "**but for**" test to conclude that the Inadequate Consideration Exclusion applied and barred coverage. Under this three-part test, a court must determine: (a) the specific type of harm

or damage the plaintiffs in the underlying suit claim to have suffered, (b) what specific act brought about the alleged harm, i.e. the operative act, based upon the alleged facts and without reference to plaintiffs' theories of liability, and (c) whether the operative act is explicitly covered by the exclusion (if the operative act is explicitly covered by the exclusion, the clause will exclude any claims that only arise because of that act). The court found it crucial to ask if a cause of action would not exist "but for" the subject of the exclusion, and emphasized that it is the act giving rise to liability, i.e. the "operative act" that is determinative, and not the theories of liability alleged.

In its application of the first prong of the "but for" test, the court reasoned that the specific type of harm of which the plaintiffs' inherently complain in the underlying suit is the difference between the actual value of the Contributed Cash Flow Certificates, and the value Delta Financial gave them, which they assert is approximately \$110 million.

As to the second prong, the court held that the operative act was the closing of the second restructuring transaction whereby Delta LLC surrendered the notes with a face amount of \$153 million to Delta Financial in exchange for the Contributed Cash Flow Certificates and other assets, which were worth approximately \$110 million less than the exchanged debt. The court then examined the plaintiffs' causes of action and concluded that, although the plaintiffs' theories of liability varied, the underlying cause of the alleged harm—the second restructuring transaction—remained constant. The court concluded that the causes of action in the underlying suit would not have existed "but for" the closing of the second restructuring transaction.

In connection to the third prong, the court analyzed whether the exchange of the Contributed Cash Flow Certificates for the notes was: (i) an actual payment (ii) by Delta Financial (iii) of inadequate consideration (iv) in connection with Delta Financial's purchase (v) of securities issued by any company. The court found that based on the plain meaning of the Westchester policy it was obvious that the exchange of the Contributed Cash Flow Certificates for the notes constituted an "actual payment" by Delta Financial. Further, the court reasoned that the transfer was "inadequate consideration" given that the Contributed Cash Flow Certificates were

See *Delta Financial* on page 7

# SEVENTH CIRCUIT: DISCOVERY RULE TOLLS FILING STATUTE IN SECURITIES FRAUD ACTION

The Seventh Circuit Court of Appeals held that the five-year statute of limitations applicable to a securities fraud action filed by the SEC is not triggered until the SEC discovers or reasonably could have discovered the alleged fraud. *Securities and Exchange Commission v. Koenig*, No. 08-1373, (Feb. 26, 2009).

## Background Facts

From 1992 through 1997, the former chief financial officer of Waste Management, Inc., James E. Koenig, and other top officers engaged in a massive scheme to falsify and misrepresent Waste Management's financial results. This scheme included using one-time gains to offset unrelated operating expenses and transferring the depreciation of one landfill to another. Such practices resulted in the company overstating profit for several years by approximately \$1.7 billion.

Koenig finally stepped down as CFO in January 1997. His accounting misconduct was not revealed to the public until October 1997 when the company issued a press release declaring that its financial statements were unreliable and that future earnings projections would be rescinded. The October 1997 press release placed the SEC on notice of the need for an investigation. In February 1998, the company issued a formal restatement of its accounts.

## District Court Rules SEC Fraud Claim Timely Filed

It was not until March 26, 2002 that the SEC filed a complaint against Koenig and other officers in the U.S. District Court for the Northern District of Illinois. The complaint generally alleged that the defendants violated antifraud, reporting, and record-keeping provisions of the federal securities laws. The SEC sought relief in the form of a final judgment

permanently enjoining defendants from further violations, disgorgement of defendants' ill-gotten gains with prejudgment interest, civil money penalties, and a prohibition against defendants serving as officers or directors of public companies.

Koenig argued that since the statute of limitations for the SEC's claim is five years (under 28 U.S.C. § 2462), the complaint was untimely filed. Koenig contended that all of the alleged misconduct occurred more than five years before the SEC filed its complaint. The SEC asserted that it did not discover the fraud until October 1997 when the press release issued. Therefore, its claim should not have expired until after five years of the date of its discovery of potential fraud.

The District Court accepted the SEC's position. Under Section 2462, any "action, suit or proceeding for the enforcement of any civil fine, penalty, or forfeiture, pecuniary or otherwise" is barred "unless commenced within five years from the date when the claim first accrued." 28 U.S.C. § 2462. The District Court concluded that the SEC's claim did not accrue until it discovered the fraud in October 1997.

## Seventh Circuit Affirms Application of Discovery Rule to Toll Statute

The Seventh Circuit affirmed the District Court's ruling. The court, citing nineteenth century law, stated that there is a "recognized special rule for fraud, a concealed wrong" which allows for

equitable tolling of the time limitations period for fraud claims. The court declared: "[A] victim of fraud has the full time from the date that the wrong came to light, or would have done had diligence been employed. And the [SEC] is entitled to the benefit of this rule when it sues to enforce laws that protect the citizenry from fraud, but is not itself a victim." Adopting this principle, the court found that "the SEC's clock started no earlier than the press release" and determined that the SEC's claim against Koenig was timely filed.

## TRESSLER COMMENTS

The Seventh Circuit did not indicate whether the SEC was required to prove anything more than the date it discovered fraud, or reasonably could have discovered such fraud, to toll the five-year statute of limitations. Certain courts outside of the Seventh Circuit, however, have required that the SEC prove that its continuing ignorance was not attributable to lack of diligence on its part. Other courts have held that the discovery rule does not apply to the five-year statute. Practitioners should be reminded that the *Koenig* decision is only binding in the Seventh Circuit and to check applicable law in the relevant jurisdiction.



Prepared by Charmagne Topacio, an Associate in our Chicago office.

Continued from *Delta Financial* on page 6

allegedly worth \$110 million less than the notes for which they were exchanged. Finally, the court determined that the transfer was indeed a "purchase" of a security by Delta Financial and that Delta Financial would be included in the meaning of "any company" for purposes of the Inadequate Consideration Exclusion.

In addition, the court also dismissed Delta Financial's bad faith claims finding that allowing a bad faith delay claim in disclaiming coverage to survive, where coverage did not exist in the first place, would create an absurd result where an insured without coverage would otherwise be allowed to maintain a claim under the policy. Further, the court found that punitive damages were unavailable in an insurance dispute because absent evidence of gross misconduct and wanton dishonesty, New York law precludes

such discovery. Here, Delta Financial did not allege that Westchester engaged in such conduct. The court also rejected Delta Financial's arguments that Westchester should be deemed to have waived its right to disclaim coverage or estopped thereto noting that, under New York law, the doctrine of waiver is inapplicable where the sole issue is the existence of coverage. Delta Financial could not establish that it changed its position to its detriment as a result of Westchester's delay as it would have incurred defense costs regardless of Westchester's position on coverage.

As such, the court dismissed Delta Financial's complaint finding that the Inadequate Consideration Exclusion barred coverage for the underlying suit and held that the insurers were not estopped from nor waived their right to disclaim coverage.

## TRESSLER COMMENTS

These exclusions are commonly found in policies issued to Real Estate Investment Trusts (REITs) and similar financial services companies, and are most commonly applied when there is a merger or "roll up" transaction in which the selling investors are suing for a "bump up" in the price per share at which their holdings were acquired. Hence, they are often called "bump up exclusions". This was not the typical bump up situation, and the exclusion here was broadly worded and held effective to bar coverage for the claim at issue. This case is thus a good illustration of the benefits (or pitfalls, dependent upon one's perspective) of having such a broadly worded exclusion in the policy.

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# PUZZLING DECISION BY TEXAS COURT FINDS COVERAGE FOR DIRECTOR UNDER D&O POLICY BASED ON DIRECTOR'S PERSONAL LIABILITY OSTENSIBLY ARISING FROM THE CORPORATION'S WRONGFUL ACTS

In *Julio & Sons Co. v. Travelers Casualty and Surety Co. of America*, 2008 WL 5273986 (S.D.N.Y. Dec. 17, 2008), a federal judge, applying Texas law, held that an insurer owed an obligation to advance defense costs given that the complaint contained allegations of breaches of fiduciary duty unrelated to the breach of contract allegations which primarily comprised the complaint and which were excluded from coverage based on a breach of contract exclusion. The court also ruled that an individual defendant was entitled to a complete defense despite the fact that the allegations against him involved conduct by him in an uninsured capacity.

An investment firm that loaned money to a restaurant management company pursuant to a note purchase agreement filed the underlying suit. The parties also entered into a warrant agreement under which the investment firm had the right to purchase stock in the restaurant management company. The individual defendant, who was the restaurant management company's majority shareholder at the time of the alleged wrongful conduct, caused the company to purchase another entity and to guarantee leases which that entity had entered into. These actions were taken without the knowledge or consent of the investment company. The entity that the restaurant management company purchased went into bankruptcy, thus diminishing the value of the warrants the investment firm had received. The investment firm sued the restaurant management company and the majority shareholder for damages, asserting claims for breach of contract, breach of fiduciary duties, fraud, and negligent representation.

The insurer denied coverage, contending that a contract exclusion applied to all of the claims and contending that the individual was not covered in any event because his alleged wrongful conduct was not undertaken in an insured capacity. In the coverage litigation that followed, the restaurant management company sought a preliminary injunction requiring the insurer to advance the costs of defending the underlying suit. The court treated the injunction motion as a motion for partial summary judgment and granted it.

The court noted that under Texas law, the "eight corners" rule is normally applied in determining whether an insurer has a duty to defend. Under this rule, evidence is limited to the four corners of the complaint and the four corners of the insurance policy to determine if a claim is potentially covered. The court, however, also noted that under Texas law, it was appropriate to consider evidence extrinsic to the complaint where that evidence was highly relevant to a coverage issue and where the extrinsic evidence was not relevant to any issue in the underlying suit. The court noted that under duty-to-defend case law in Texas, if one claim is potentially covered, the insurer is obligated to defend the entire case, even if the suit pleads some claims that are not covered. The court applied this same rule to the duty to advance defenses costs, even though the court acknowledged that the insurance policy at issue before it did not require the insurer to

defend. With those preliminary rulings behind it, the court proceeded to analyze whether any of the claims pleaded were potentially covered.

The contract exclusion upon which the insurer relied in disclaiming coverage provided that the coverage "shall not apply to, and the [insurer] shall have no duty to defend or to pay, advance or reimburse Defense Expenses for, any Claim . . . for or arising out of or in consequence of any actual or alleged liability of the Insured Organization under any express contract or agreement." The court easily concluded that the breach of contract cause of action fell within the terms of the contract exclusion and therefore was not potentially covered. Whether coverage was also excluded for the remaining causes of action depended upon how broadly the court construed the "arising out of" language in the contract exclusion. The court noted that under Texas law, courts have construed similar language as requiring the application of a "but for" test subject to a "limiting principle" that requires the court to "focus on the underlying pleading's factual allegations that show the origin of the damages rather than on the legal theories alleged." Applying this test, the court ruled that the causes of action for fraud and negligent misrepresentation fell within the contract exclusion. The court reasoned that these particular claims were based on an "extant duty to disclose and duty to exercise reasonable care," that such duties exist only if there is a "legally material relationship" between the parties, and that the source of that relationship was the contracts or agreements the restaurant management company had with the investment company. The court ruled, therefore, that "but for" the existence of the agreements, the fraud and negligent misrepresentation claims could not have been asserted and that the contract exclusion barred coverage for these claims.

With respect to the breach of fiduciary claim, the court found that this claim did not depend on any contractual relationship between the parties, but instead arose out of duties owed to the investment company based on its status as a warrant holder. The court noted that although the investment company obtained the warrants as a result of the agreement it entered into with the restaurant management company, the court relied on a federal district court decision out of Texas which had rejected the argument that securities claims arose out of the contract by which the securities were

obtained and held that a contract exclusion did not bar coverage for those claims. The court also noted that there were no allegations in the underlying complaint which suggested that the agreement between the parties created any fiduciary duties. Because the contract exclusion did not apply to this particular cause of action, the court held that the insurer owed an obligation to the restaurant management company to advance the full costs of defending the entire action.

Turning to the issue of whether the individual defendant was also entitled to defense costs, the court held that it could consider extrinsic evidence that the individual became a director on the very same day the underlying complaint had been filed. The policy provided that any "past, present or future duly elected . . . director" qualified as an "Insured Person." The insurer, however, argued that the individual was not covered because the wrongful conduct he was accused of in the underlying action was not committed in his capacity as a director. The policy contained several parts to the definition of a Wrongful Act, but the

The individual argued that he was covered under the third part of the definition which defined "Wrongful Act" as "any actual or alleged act, error or omission . . . by the Insured Organization." The individual argued that by combining "this definition with the clause prescribing coverage for Insured Persons incurring losses from 'Claims first made during the Policy Period against the Insured Persons for Wrongful Acts,' [the investment company] concludes that the 'Policy promises coverage for defense costs incurred in lawsuits which may seek to hold an Insured Person personally liable for alleged Wrongful Acts by an Insured Organization.'" In the briefs that were filed, the insurer never responded to this argument, but the court noted that the insurer presumably would have taken the position that this definition was intended to apply only when determining whether the Insured Organization was entitled to coverage. The court, however, held that the investment company's interpretation of the policy language was "equally reasonable," held that the policy was ambiguous, and construed the ambiguity against the insurer, finding that the individual was also entitled to advancement of all costs of defense. The court conceded that its holding would grant coverage to the individual merely because "he became a director after his own allegedly

# DISCRIMINATION COMPLAINT FILED WITH LOCAL AGENCY CONSTITUTED A "CLAIM" MADE PRIOR TO EMPLOYMENT PRACTICES LIABILITY POLICY PERIOD

Applying California law, the United States District Court for the Southern District of Florida held that a sexual harassment complaint, which the employee filed with a local government agency, qualified as a "claim" under an employment practices liability (EPL) policy. Because the claim was made prior to the policy's inception, the court found no coverage for the claim or for multiple other discrimination complaints that arose out of interrelated wrongful employment practices. [KB Home v. St. Paul Mercury Ins. Co.](#), 2008 WL 5263420 (S.D. Fla. Dec. 17, 2008).

The policy was a claims-made EPL policy for the period from April 15, 2006 to April 15, 2007. On March 7, 2006, one of the insured's employees filed a discrimination complaint against the insured with the County Civil Rights Division (the "Division"). The complaint included allegations of sexual harassment. On March 13, 2006, the insured received notice of the complaint from the Division, along with a letter stating that the Division would be forwarding the charge to the Equal Employment Opportunity Commission ("EEOC") for further processing because the alleged issues were outside of the Division's jurisdiction. In May 2006, the EEOC sent the insured a copy of the EEOC Notice of Discrimination with regard to the complaint. In the interim, three additional employees filed discrimination complaints, two of which involved the same event that led to the original sexual harassment complaint.

The insured sought coverage under the employment practices liability policy for all four of the discrimination claims. The insurer denied coverage for the first employee's complaint and asserted that the complaint was a claim made prior to the policy period, (i.e., when the insured received notice of the employee's complaint from the Division). The insurer also denied coverage for the other three complaints based on the related claims provision in the policy. The related claims provision provided that all claims arising out of the same or interrelated wrongful employment practices are deemed one claim made on the date that the earliest claim was made.

The insured settled the discrimination actions and sued the insurer, arguing that the four claims were unrelated and all of the claims were made during the policy period and

that the Division's letter regarding the first complaint was not a claim because it did not initiate of a governmental or administrative proceeding.

The court held that the filing of the first employee's charge with the Division constituted a claim under the policy and, therefore, that the claim predated the policy and was not covered. The court relied upon the definition of a claim as "an administrative or arbitration proceeding against any Insured commenced by the Insured's receipt of a complaint, notice of charges, arbitration petition, formal investigative order or similar document," and that the insured received notice of the charge on March 13, 2006 through the Division's correspondence. The court expressly rejected the argument that the Division's lack of jurisdiction to investigate and handle the complaint somehow negated the notice of the discrimination charge.

In addition, the court held that the policy's interrelated wrongful employment practices definition of practices that have "as a common nexus any fact, circumstance, situation, event, transaction, cause or series of related facts, circumstances, situations, events, transactions or causes," was unambiguous. Based on this language, the two later complaints based on same facts as the first complaint interrelated.

However, with respect to the fourth complaint, it was not related to the original claim because it involved alleged discrimination during a different time frame. By making this ruling as to the fourth complaint, the court rejected the insurer's argument that interrelatedness could be established by showing a workplace "infused with sexual harassment."

Finally, the court addressed the insured's argument that, in making the interrelatedness determination, the court was limited to reviewing the employee's charging documents. The court rejected this contention, emphasizing that the policy language required it to look at all of the relevant facts underlying the discrimination claims, including facts developed by the insurer during discovery.

## TRESSLER COMMENTS

Two salient lessons can be taken from this decision.

First, expansive claim definitions in EPL policies often cut both ways with respect to policyholder benefit and detriment. While of obvious benefit in expanding the scope of actions and proceedings that may be covered, as well as the point in time when coverage commences, a policyholder must also be careful to note when a claim may be first made and timely report it to the appropriate insurer, lest it find itself without coverage under any policy.

Second, evaluation of whether claims and wrongful acts are interrelated is always fact-sensitive and oftentimes a close call. Here we had different individual claimants, but there was a common nexus in the sexual harassment event at issue.



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wrongful conduct . . . and even though he is sued for his own acts, not those involving an insured capacity," but blamed that result on the insurer, stating that it "is the insurer's responsibility to draft its policies with sufficient precision to avoid ambiguities like the one found here." On February 13, 2009, the court denied a motion for reconsideration filed by the insurer, rejecting a number of arguments that the insurer relied in support of its contention that the policy required allocation of defense costs between covered and non-covered claims.

## TRESSLER COMMENTS

There is no question that this court's decision

reaches, in its own words "an anomalous result" as it ignores the distinctions between, and the purpose behind, the separate insuring agreements applicable to directors and officers and the entity in D&O policies. While the decision may not contain all of the relevant policy language, the court's conclusion that the directors could be held personally liable for the wrongful acts of the company is puzzling in this context and the court does not discuss how such a result would even be possible under Texas law. This decision is even more troubling as the court acknowledges the anomaly of its decision, but reasons that the result is justified given "ambiguities" in the policy language. The court's reasoning in this case

can be compared with the court's decision in [Medical Mutual Insurance Company of Maine v. Indian Harbor Insurance Company](#) which is discussed elsewhere in this newsletter and which considers the history and purpose of D&O insurance in reaching what we found to be a well-reasoned decision.



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# SEVENTH CIRCUIT FINDS COVERAGE UNDER FINANCIAL INSTITUTION BOND FOR BANK THAT CASHED CHECKS OVER THE COUNTER; LOSS WHEN CHECKS WERE RETURNED UNPAID RESULTED DIRECTLY FROM FALSE PRETENSES ON THE PREMISES

In *First State Bank of Monticello v. Ohio Casualty Insurance Co.*, 555 F.3d 564 (7th Cir. 2009), James Stilwell was a small-town entrepreneur in downstate Illinois. He defrauded First State Bank of Monticello by tendering checks drawn on an unfunded account at Tuscola National Bank in return for 130 money orders totaling almost \$2 million over a three month period. First State ordinarily did not cash checks for noncustomers and became suspicious but Stilwell engaged in misrepresentations that persuaded the bank to allow him to continue the activity. For example, he handed a phone to an officer so the officer could listen to a recording supposedly giving the balance in the Tuscola account. The scheme ended when Tuscola froze the account, leaving First State Bank with worthless checks totaling \$307,000.

First State Bank made a claim for on-premises fraud under Insuring Agreement B of a Financial Institution Bond issued by Ohio Casualty (“OC”). OC denied the claim. The bank filed suit. On cross-motions for summary judgment, OC claimed the bank (1) did not suffer a “loss;” (2) did not suffer a loss resulting directly from Stilwell’s conduct; or (3) suffered a loss caused by the bank’s own employees within an exclusion of such loss. The Central District of Illinois entered judgment for the bank. OC appealed to the Seventh Circuit.

Insuring agreement B(1)(b) covers “[l]oss of property resulting directly from . . . false pretenses . . . committed by a person present in an office or on the premises of the Insured while the property is lodged or deposited within offices or premises located anywhere.” OC did not dispute that Stilwell committed fraud on the bank’s premises but contended the loss did not result directly from false pretenses. OC argued that the bank did not in fact suffer a loss because it received valid and enforceable checks from Stilwell in exchange for its money orders. The loss did not occur until the bank found itself unable to collect the checks, an event that did not take place on the bank’s premises nor resulted directly from any false pretenses.

The Seventh Circuit recognized the bond (a Standard Form No. 24) is jointly drafted by the banking and insurance industries so any ambiguities are not construed against the insurer. The court conceded further that a loss does not occur until there is an actual depletion of funds. A bookkeeping or theoretical loss is not covered. However, the court concluded that the bank suffered an actual loss. True, this did not occur when Stilwell exchanged his checks for the money orders (even though the account was empty the checks might be paid just as earlier ones had been). However, the loss did become actual when Tuscola refused to honor the checks. The act of nonpayment occurred off First State’s premises but the insuring agreement only requires that the false pretenses be committed by a person on

the bank’s premises, not that the loss occur there.

Moreover, the conduct did amount to false pretenses because that term includes, at a minimum, deceptive practices under criminal law and it is a crime in Illinois to issue a check knowing it will not be paid. Failure to have sufficient funds in the account is prima facie evidence of such knowledge. Stilwell did not have sufficient funds in his account at Tuscola. There was no evidence to rebut the presumption that he intended to defraud the bank.

The court also determined that the loss resulted directly from the false pretenses. The proximate cause standard that OC was arguing (what insurers usually find themselves arguing against) did not apply. The bond had been revised to avoid any resort to that tort law standard. Contract principles governed instead. Direct meant direct. But First State’s disbursement of funds to Stilwell, followed by the return of his unpaid checks, despite the “slight gap in time,” was sufficient “to satisfy a common and ordinary understanding of a loss resulting directly from a fraud occurring on the bank’s premises.” 555 F.3d at 571.

Other intervening or contributing causes such as Stilwell’s death (he had begun to repay the loss), his corporation’s bankruptcy or the bank’s failure to follow its own policy did not change the fact that the bank suffered a direct loss as a result of Stilwell’s on premises fraud. But for Stilwell’s on premises fraud, the bank would not have suffered a loss.

As for the exclusion of loss caused by an employee (with an exception for employee dishonesty), the court found it did not apply even if the bank employees failed to follow bank policy in accepting Stilwell’s checks and thus failed to prevent the loss. That broad an interpretation of the exclusion would “swallow all-or nearly all-of the bond’s coverages because a bank must necessarily operate through its employees.” *Id.*

The opinion does not discuss the loan fraud exclusion, which extends to any extension of credit in exchange for an Evidence of Debt. The standard bond form defines Evidence of Debt as a “Written instrument including a Negotiable Instrument, executed by . . . customer of the Insured and held by the Insured which in the regular course of business is treated as evidencing the customer’s debt to the insured.” Stilwell arguably qualified as a customer of the bank and his checks, until paid, were negotiable instruments evidencing his debt to the bank. However, the problem seems to be that the bank did not “hold” the checks at the time it extended the credit; it sent them to Tuscola for collection.

The opinion also does not touch on the uncollected funds exclusion. It excludes “loss resulting directly or indirectly from payments made or withdrawals from a depositor’s account involving items of deposit which are not finally paid, for any reason, including . . . any other fraud . . . .” The problem here evidently is that Stilwell tendered his checks to the bank in exchange for cash (the money orders) over the counter, not as a depositor with an account at the bank.

## TRESSLER COMMENTS

The Seventh Circuit has left us with the anomaly of a bank’s loss being covered when it was so lax as to cash checks for someone who did not even have an account with it, while there would be no coverage if the fraud had been conducted through an account.



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