

Specialty Lines

Advisory

Special Announcement

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JOE SAYS...

The Foreign Corrupt Practices Act (FCPA) and D&O Exposures

There has been a fair amount of attention given recently to actual and alleged violations of the FCPA and the impact they may have on director, officer and company defendants in securities fraud class action litigation. There are also some, unfortunately, prevalent myths and realities about the FCPA among D&O insurers.

While the undisputed reality is that there is no direct private right of action for violations of the FCPA, the concomitant myth that has arisen is that the FCPA should not be a cause of concern for D&O insurers.

The FCPA has received only a modicum of attention from D&O insurers since the 1980s, primarily because of the absence of private rights and remedies and the fact that the governmental remedies are typically in the nature of civil penalties excluded from coverage. If anything, the incidents of FCPA violations primarily served as reminders to insurers of the perils of writing these types of financial insurance products outside the U.S.

Late last month, however, the SEC brought some renewed attention to the FCPA by announcing the filing and settlement of an enforcement action against Nature's Sunshine Products Inc. and its CEO and CFO. The company paid a penalty of \$600,000 and the CEO and CFO each agreed to pay \$25,000. While the penalties are not shocking, the theory of recovery against the officers - Section 20(a) of the Securities Exchange Act of 1934¹ - has garnered much

1 - The statute is as simple as it is broad in its application. "Every person who, directly or indirectly, controls any person liable under any provision of this chapter or any rule or regulation thereunder shall also be liable jointly and severally with and to the same extent as such controlled person to any person to whom such controlled person is liable,

attention in the legal press and blogosphere. In particular, I commend our readers to my friend Kevin Lacroix's excellent post and linked documents on August 24, 2009 on *The D&O Diary*².

Prior to this, FCPA enforcement against individuals was largely in the form of Department of Justice (DOJ) criminal proceedings. In the Nature's Sunshine case it would have been difficult, if not impossible, to establish criminal liability of the officers under the FCPA, as they appeared not to have been directly involved in the alleged bribery at issue. Instead, the SEC took an arguably easier route to a §20A settlement based upon their "control" of and responsibility for the company's export of products.

As stated above, the quantum of the penalties here does not shock, but what should be borne in mind is that §20A is often used as a theory of liability by private litigants in securities fraud, class actions where the settlements often run into the tens or hundreds of millions of dollars. Although the cost of legal representation in connection with an SEC investigation, if not the imposition of a penalty, is often a covered and significant amount under many D&O policies, the specter of class action damages and the concomitant defense expenses is what should be even more worrisome. Indeed, Nature's Sunshine may not be an aberration, as the author is representing an insurer in a major securities class action with FCPA undercurrents and that is proceeding to mediation within the next few days. While there are and cannot be any directly actionable FCPA violations in that case, the allegations of the violations as a method of doing business will no doubt be argued by plaintiffs as indicative of the fraudulent nature of the business enterprise, much akin to the practices at issue in the Enron litigation earlier this decade.

unless the controlling person acted in good faith and did not directly or indirectly induce the act or acts constituting the violation or cause of action."

2 - <http://www.dandodiary.com/2009/08/articles/foreign-corrupt-practices-act/new>

In summary, the civil exposure would lie not in the direct FCPA violation, but rather in one's culpability as a control person because of the corporate structure in place and a failure to adequately supervise or supervise at all.

Violations of the FCPA may develop into yet another factor that makes for a potentially severe D&O exposure, along with restatements of earnings, pendency of an SEC investigation, excessive insider sales and purchases and other factors.



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.



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THE THIRD CIRCUIT STANDS BY ITS EARLIER DECISION THAT A MIXED SUBJECTIVE-OBJECTIVE STANDARD APPLIES TO THE KNOWN CIRCUMSTANCES EXCLUSION

In Colliers Lanard & Axilbund v. Lloyds of London, 2009 U.S. App. LEXIS 14987 (3d Cir. July 8, 2009) ("Colliers II"), the Third Circuit Court of Appeals, while applying New Jersey law, held that the Known Circumstances Exclusion, found in most professional liability policies, requires an application of the subjective-objective standard, rather than a mere subjective analysis.

In our April 2009 *Specialty Lines Advisory*, Joe Monteleone says that "a ball of confusion [exists] with respect to this issue as a result of a number of puzzling, if not contradictory, decisions from state and federal courts." In an apparent effort to clarify the confusion, the Third Circuit upholds its prior decision and applies the subjective-objective standard to the Known Circumstances Exclusion, in spite of the New Jersey Supreme Court opinion in Liberty Surplus Ins. Corp. v. Nowell Amoroso & Mattia, P.A., 189 N.J. 436 (2007). See Colliers Lanard & Axilbund v. Lloyds of London, 458 F.3d 231 (3d Cir. 2006) ("Colliers I").

In Colliers I and II, West Jersey Medical and Professional Plaza hired Colliers Lanard & Axilbund ("CL&A"), a real estate brokerage firm, to market and lease the Plaza. A CL&A salesperson did not correctly enter the operating expenses term in two tenants' leases. This error was not noticed by Colliers' general counsel – George Gordon – when he reviewed the leases prior to execution by the tenants. CL&A became aware of the errors in July 2000. On July 14, 2000, Mr. Gordon drafted a letter to each tenant, indicating the discovery of the mutual mistake in the lease agreement. On July 24, 2000, one tenant stated that "there was no mutual mistake" and directed CL&A to his attorney for further discussions.

In August 2000, Mr. Gordon completed and signed a real estate errors and omissions liability application, which included a question regarding whether Colliers was "aware of any act, error, omission or other circumstances which might reasonably be expected to be the basis of a claim against the applicant." Mr. Gordon answered "no." Subsequently, Lloyds issued a policy on November 2000, with a retroactive date of November 4, 1992. This professional liability policy provided coverage for retroactive claims "provided that the insured had no knowledge of any suit, or any act or error or omission, which might reasonably be expected to result in a claim or suit as of the date of signing the application for this insurance."

The underlying litigation ultimately settled and CL&A sued Lloyd's for its failure to provide a defense and indemnification on

the ground that CL&A was aware of issues or circumstances which might reasonably be expected to result in a claim or suit as of the date of signing the application for insurance. The U.S. District Court for the District of New Jersey found that the exclusion did not apply because the evidence reflected that Mr. Gordon believed that a claim was unlikely.

In Colliers I, the Third Circuit vacated and remanded the District Court's judgment, finding that the exclusion was unambiguous and that it should be interpreted according to its plain language. The Third Circuit predicted that the New Jersey Supreme Court would hold that a mixed subjective-objective standard would not violate New Jersey public policy or the insured's objectively reasonable expectations with respect to obtaining a professional liability policy with retroactive coverage.

On remand, the District Court denied the parties' cross-motions for summary judgment. Prior to trial, the parties stipulated that Mr. Gordon was aware of the drafting errors at the time he completed the Lloyds application in August 2000. The only question at trial was thus whether a "reasonable professional in [their] position might expect a claim or suit to result." The jury found in favor of Lloyds. CL&A appealed the District Court judgment.

On Appeal, the Third Circuit reiterated its prior holding in Colliers I and found that the newly-decided New Jersey Supreme Court decision in Liberty, did not contradict with Colliers I, but rather, when "properly considered, is entirely consistent with our earlier decision." The [Liberty] court sought to review whether the trial court properly concluded that there was no genuine issue of fact regarding the insured's knowledge of a potential action, even when the insured denied having knowledge. Liberty, therefore, is a case about the New Jersey summary judgment standard, and not about whether the typical exclusion in a 'claims made' policy is to be evaluated under a subjective or objective standard." Further, the Colliers II Court found that in Liberty, "the case expressly does not hold that the policy exclusion bars coverage only if the insured subjectively believed that a claim against it was forthcoming. Because the parties agreed on the standard, the decision

does not even address that issue, except to note, *in dicta*, that the exclusion 'appears to be objective.'" Liberty, 189 N.J. at 446. As such, the Third Circuit found that Liberty is consistent with its prior opinion and Colliers engaged in an "over-reading" of the Liberty decision and the circumstances surrounding the New Jersey Supreme Court's review of Liberty. The District Court's judgment was then affirmed.

TRESSLER COMMENTS

Like American Special Risk Management Corp. v. Cahow, 192 P.3d 614 (2008), as summarized in our September/October 2008 *Specialty Lines Advisory*, and as briefed by Joe Monteleone in "Joe Says" in our April 2009 edition, the knowledge standard for the Known Circumstances Exclusion is an emerging topic with numerous decisions that appear to contradict one another. As articulated by Joe, the solution may be to have a simple and straightforward application of the subjective/objective standard: (1) if there is subjective knowledge of malpractice at the time of the application or inception of the policy, denial of coverage or rescission should result; (2) if there is no subjective knowledge of malpractice at the time of the application, there should be a resultant denial or rescission if the insured could reasonably have foreseen that a claim might be made.

Further, this decision highlights a key factor in and corrects a frequent misconception about the New Jersey Supreme Court's decision in the Liberty case. Specifically, the Colliers II court found that the parties had stipulated in Liberty to the application of a subjective standard to the insured's knowledge. Thus, the standard remains effectively undecided at the high court level in New Jersey.



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NINTH CIRCUIT FINDS THAT THE “INSURED VS. INSURED” EXCLUSION BARS COVERAGE FOR CLAIMS OF AN ASSIGNEE OF A DEBTOR IN POSSESSION

In *Biltmore Assoc., LLC v. Twin City Fire Ins. Co.*, 2009 U.S.App.LEXIS 15322 (9th Cir. 2009), the Ninth Circuit held that an “insured vs. insured” exclusion in a D&O policy barred coverage for a claim asserted against former corporate officers and directors by the corporation as “debtor in possession” under a Chapter 11 bankruptcy.

This appeal arose from an action for alleged improprieties by former officers and directors of Visitalk.com Inc. (“Visitalk”), a provider of internet telephone and videoconference services. After Visitalk filed for Chapter 11 bankruptcy protection, Visitalk, as “debtor and debtor in possession,” filed the lawsuit against its former officers and directors for alleged breaches of fiduciary duties. Visitalk’s directors and officers liability insurers (“D&O Insurers”) denied coverage to the officers and directors under the policies’ “insured vs. insured” exclusion.

Visitalk filed a plan of reorganization in the bankruptcy proceedings, by which it assigned its claims against the former officers and directors to Biltmore Associates, LLC (“Biltmore”), the trustee of a trust established for Visitalk’s creditors. Biltmore subsequently settled Visitalk’s claims against the former officers and directors for approximately \$175 million, and pursuant to the settlement, obtained an assignment of the rights of the officers and directors against the D&O Insurers. Pursuant to the assignment, Biltmore filed a lawsuit against the D&O Insurers for their failure to provide coverage to the former officers and directors. The District of Arizona dismissed the lawsuit, leading Biltmore to appeal to the Ninth Circuit.

The Ninth Circuit noted that insurers began including “insured vs. insured” exclusions in D&O policies following several lawsuits filed in the mid-1980’s by insured corporations against their own officers and directors that created “problems of moral hazard, collusion, and unintended expansion of coverage.” According to the Court, the exclusions are consistent with “[t]he reasonable expectations of the parties... that they were protecting against claims by outsiders, not intra-company claims.”

The policies issued by the D&O Insurers in this case contained “insured vs. insured” exclusions providing, in relevant part:

The Insurer shall not be liable to make any payment for Loss

in connection with any Claim made against the Directors and Officers...:

(D) brought or maintained by or on behalf of an Insured in any capacity or by any security holder of the company...

Biltmore contended that the “insured vs. insured” exclusion was inapplicable because Visitalk’s lawsuit was not “brought or maintained on behalf of an Insured in any capacity.” Rejecting this contention, the Court noted that a cause of action for mismanagement belongs to the corporation and may only be brought by shareholders and creditors derivatively, on behalf of the corporation. The Court explained:

Coverage is excluded if Visitalk sues them, and it did. The lawsuit was “instigated and continued” by Visitalk. That the creditors rather than the shareholder will get whatever money the insurer paid does not avoid the exclusion.

The Court further reasoned that Biltmore, which was not insured under the D&O liability policies, had no independent right to assert a claim against the D&O Insurers and any such rights it obtained came by way of an assignment from an insured.

Biltmore also argued that, as a result of the Chapter 11 bankruptcy, Visitalk, as “debtor in possession,” was not the same entity as the pre-bankruptcy Visitalk corporation, citing several instances in which bankruptcy courts treated the post-bankruptcy entity differently from the corporation prior to filing for Chapter 11 bankruptcy protection. Noting that the Bankruptcy Code defines a Chapter 11 “debtor in possession” to be “the debtor,” the Court concluded, “Visitalk, the debtor in possession, is the same person for bankruptcy purposes as Visitalk, the pre-bankruptcy corporation.” The Court relied upon two previous Ninth Circuit bankruptcy cases, *In re Disalvo*, 219 F.3d 1035 (9th Cir. 2000) and *In re Teerlink Ranch Ltd.* (9th Cir.

1989), which held that a debtor and debtor in possession “are *not* to be treated as separate legal entities,” in connection with a Chapter 11 bankruptcy.

The Ninth Circuit rejected Biltmore’s contention that Visitalk, as debtor in possession, acted as a representative of the creditors and advanced their interests by filing suit against the D&O Insurers. Even if that were the case, the Court concluded, Biltmore was proceeding “on behalf of the pre-bankruptcy corporation,” subjecting the claim to the “insured vs. insured” exclusion.

Finding the claim to be barred under the “insured vs. insured” exclusion in the policies, the Ninth Circuit affirmed the district court’s dismissal of Biltmore’s action against the D&O Insurers.

TRESSLER COMMENTS

This decision confirms that a Chapter 11 bankruptcy will not transform an insured’s claim against its officers and directors, which is clearly barred from coverage under the “insured vs. insured” exclusion, into a third-party claim beyond the scope of the exclusion.

It is fairly common now for D&O policies to be endorsed or to provide in their definition of “Insured” that such term includes the company in the capacity of “debtor in possession”. However, bankruptcy trustees, receivers, creditors’ committees and others are typically not included as insureds, and a suit brought or maintained by any of these entities would not ordinarily fall within the scope of the “insured vs. insured” exclusion.



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CALIFORNIA COURT UPHOLDS INSURER'S DENIAL OF COVERAGE UNDER D&O POLICY ON GROUNDS THAT OFFICER'S CONDUCT FELL OUTSIDE THE SCOPE OF HIS MANAGEMENT RESPONSIBILITIES

A California Court of Appeal held that D&O coverage was not available to a church in a foreclosure action, because the foreclosure proceedings did not seek "money damages," and because the applicable lawsuit arose out of a church director's intentional and unauthorized sale of church property in contravention of the church's constitution and bylaws. Mount Zion Baptist Church v. State Farm Gen'l Ins. Co., 2009 Cal. App. Unpub. LEXIS 5218 (Cal. Ct. App. June 25, 2009).

State Farm General Insurance Company issued a church liability insurance policy to Mount Zion Baptist Church, which supports minority-owned businesses as part of its mission. Mount Zion's policy included a Directors, Officers & Trustees Liability provision, making coverage available for "sums that the insured becomes legally obligated to pay as damages because of 'wrongful acts' committed by an insured solely in the conduct of their management responsibilities for the church." The policy defined "wrongful acts" as negligent acts "directly related to the operations of [the] church." The policy excluded coverage for "damages other than money damages."

Pursuant to Mount Zion's constitution and bylaws, the church's board of trustees holds all property owned by the church in trust. As such, the board cannot transfer property without a vote of the entire church. In April 2002, church president Reverend Edward V. Hill transferred property owned by the church to himself without the board of trustees' knowledge or authorization. In September 2002, Rev. Hill used the subject property as collateral for a performance bond, so that minority-owned business EAI International could secure a government contract to work on a project in Marin County, California. EAI subcontracted part of its work to Manson Construction Company, but failed to pay Manson as promised. Rev. Hill died in 2003, prompting the church secretary to execute a grant deed transferring the subject property back to Mount Zion, signing Rev. Hill's name.

After Rev. Hill's death, and transfer of the subject property back to Mount Zion, Manson filed several lawsuits, including two against Mount Zion seeking foreclosure of the subject property, and payment of proceeds to satisfy EAI's debt to Manson. Mount Zion tendered one of the suits to State Farm, which disclaimed coverage. After settlement of both cases, Mount Zion filed suit against State Farm for breach of insurance contract and

bad faith. The Los Angeles County Superior Court entered judgment in State Farm's favor.

The California Court of Appeal (Second District) affirmed the trial court's judgment for three reasons:

- *The Underlying Action Did Not Seek "Money Damages":* The applicable lawsuits (only one of which was actually tendered to State Farm) sought foreclosure and subsequent distribution of proceeds, not compensatory damages. The Court noted that under California law, "damages" are limited to money damages ordered by a court. The Court rejected the argument that the foreclosure action sought "money damages" because it requested payment of foreclosure proceeds to satisfy EAI's debt. Actions seeking injunctive relief may similarly require that the defendant pay funds to comply, but because they do not directly seek monetary relief, actions for injunctive relief are not covered under liability insurance policies.
- *Rev. Hill Was Not Acting "Within the Scope of [His] Duties" for Mount Zion:* Although Rev. Hill purported to be acting on behalf of Mount Zion in selling the subject property to himself and using it as collateral for EAI, his actions were in direct violation of Mount Zion's constitution, which required board and church approval for sale of any church property. Furthermore, under California law, directors cannot act in a corporate capacity on their own, but must have corporate authorization. The fact that Rev. Hill's actions furthered the church goal of supporting minority-run businesses was irrelevant.
- *Rev. Hill Acted Intentionally, Not Negligently.* Rev. Hill intentionally sold the subject

Mount Zion property to himself, and offered the property as collateral on behalf of EAI. It is irrelevant that his motives may have been good, or that he may have mistakenly believed that he or Mount Zion could not be liable for his actions.

TRESSLER COMMENTS

The California Court of Appeal ordered this decision to be unpublished, which means that pursuant to California statute, it cannot be cited in California state courts. Accordingly, this case is of limited use to insurers that are parties to coverage actions in California. Nevertheless, the case provides a good discussion of California law on the type of conduct that falls outside the scope of an officer's "management responsibilities". The case also emphasizes the general rule that in California and other states, no D&O coverage is available for the acts of a director or officer acting outside the scope of his or her authorized duties for the insured organization.



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FIRST CIRCUIT STRICTLY ENFORCES "CLAIMS MADE AND REPORTED" NOTICE REQUIREMENT UNDER LAWYERS' PROFESSIONAL LIABILITY INSURANCE POLICY

In Gargano et al. v. Liberty International Underwriters, Inc., et al, 572 F.3d 45 (1st Cir. July 14, 2009), the First Circuit Court of Appeals affirmed the District Court's order dismissing the Gargano's Complaint because Mr. Gargano's insurance claim was not made and reported within the relevant coverage periods. The District Court held that, based upon these facts, Mr. Gargano and his firm could state no plausible claim for breach of contract or for deceptive business practices under Massachusetts law.

Background: In 2005, Christopher Hug filed suit against Mr. Gargano, claiming that he was owed attorneys' fees pursuant to an attorney's lien in a worker's compensation claim for permanent disability benefits. Mr. Hug had worked on the worker's compensation case for four years, achieving a \$200,000 settlement offer. The client discharged Mr. Hug and hired Mr. Gargano. Mr. Hug filed a Notice of Attorney's lien and sent it to the appropriate entities. In 2005, Mr. Hug learned that the case had been settled in June 2004 for \$300,000 and the Department of Industrial Accidents ("Department") authorized a payment of \$58,760 for attorneys' fees to Gargano & Associates. Mr. Hug then filed suit.

The state court determined that Mr. Gargano assisted the client in falsely representing to the Department that the firm had represented the client all along and there were no outstanding liens. The state court concluded that Mr. Gargano's "numerous misrepresentations or material omissions of fact" amounted to an "unfair and deceptive business practice," and ordered Mr. Gargano and his law firm to pay over \$102,000 in damages, treble damages, and attorney's fees. An order finding Mr. Gargano liable to Mr. Hug was entered in December 2005 and a judgment for damages was entered in July 2007.

However, Mr. Gargano did not report the claim when the lawsuit was initially filed in March 2005. Only after the entry of the

judgment for damages, did Mr. Gargano report a claim on each of his professional liability policies.

Policies: Mr. Gargano had a "claims made and reported" policy from NCMIC that afforded coverage from September 1, 2004 through September 1, 2005. A Greenwich "claims made and reported" policy covered Mr. Gargano from September 1, 2005 through September 1, 2006. Lastly, a "claims made and reported" policy from Liberty covered the period September 1, 2006 through September 1, 2007. Each policy expressly provided "coverage only for claims that are both first made against the insured and reported to the insurance company during the term of the policy."

NCMIC and Greenwich denied the claim, stating that it was not reported during the term of coverage under their policies. Liberty denied coverage stating that while the claim was reported during the policy's coverage period, it was first made during the term of another policy.

After receiving these denials of coverage, Mr. Gargano filed a suit for breach of contract and deceptive business practices. Mr. Gargano claimed that the insurance companies failed to deliver their policies to him and therefore should be precluded from relying on the policy language. Mr. Gargano also claimed in his suit that the insurance companies breached their contracts and violated Massachusetts statutes addressing deceptive business practices by failing to investigate or settle the claim. Although Mr. Gargano had originally brought the case in state court, the insurance companies removed it to federal court and then moved to dismiss the complaint.

Standard: The Circuit Court of Appeals reviews a district's court dismissal of a complaint pursuant to a *de novo* standard. The court will accept as true all well-pleaded facts and draw all reasonable inferences in favor of the plaintiff. Only a short plain statement of the claim showing that the plaintiff is entitled to relief is necessary to meet the federal pleading requirements. The defendant only need fair notice of what

the claim is and upon what grounds it rests.

Holding: Even in spite of the liberal pleading standing, Mr. Gargano and his firm failed to state a claim for of breach of contract or deceptive business practices in violation of Massachusetts law, because the claim they made for coverage did not fall within the coverage period of any of the three professional liability insurance policies.

The court found that each was a "claims made and reported" policy, stating explicitly that its coverage applied only to claims first made against the insured during the policy period and reported to the company during the policy period. "A claims-made policy covers the insured for claims made during the policy year and reported within that period or a specified period thereafter regardless of the requirements that when the covered act or omission occurred." Under Massachusetts law, "the insured event" is a combination of: (1) the claim must be made against the insured during the policy period, and, (2) it must be reported to the insurer within the policy period.

In this situation, the claim was first made when Mr. Hug filed suit against Mr Gargano in 2005, thus potentially falling within the NCMIC policy. However, Mr. Gargano did not report it until 2007, outside of the coverage period. Although the suit was pending during the coverage period for the Greenwich policy, mere pendency does not satisfy the policy's reporting requirements. Lastly, Mr. Gargano had reported the claim in 2007, thus falling with the coverage period for Liberty, however, the claim was first made in 2005 when Mr. Hug filed suit. As a result, Mr. Gargano did not meet the "claims made" and "reported" requirements of any of his policies.

Mr. Gargano argued that failure to deliver the policy made him unaware of the language and thus the insurance companies cannot rely on the policy language. However, delivery is not essential to the making of an insurance contract unless the contract specifically and expressly states such a requirement, which none of these policies state. Further, Mr. Gargano cannot claim that he did not know the terms of the policies, when the policies



See Gargano on page 7 for conclusion

THIRD CIRCUIT FINDS PREJUDICE NOT REQUIRED TO ESTABLISH D&O INSURER'S LATE NOTICE DEFENSE

The Third Circuit U.S. Court of Appeals, in an unpublished decision, recently affirmed the entry of summary judgment in favor of a D&O insurer holding that, under Pennsylvania law, reporting requirements in claims-made policies are strictly construed such that an insurer need not show prejudice to establish its late notice defense. *4th Street Investments, LLC, et al., v. James Dowdell, et al.*, 2009 U.S. App. LEXIS 14995 (3rd Cir., July 2, 2009).

After securing a judgment against James Dowdell and his company, SafeDrive Technologies, the plaintiff 4th Street sued Federal Insurance Company to garnish the proceeds of the D&O policy Federal issued to Dowdell and SafeDrive. The District Court entered summary judgment in favor of Federal determining that Dowdell had not satisfied the policy's reporting requirement. 4th Street appealed.

On appeal, 4th Street argued first that the D&O section of the policy did not contain a notice provision and therefore the notice requirement was inapplicable to D&O claims. The Court of Appeals pointed out however that the first page of the D&O section stated that it was "subject to the Declarations" which contained the claims-made and reported requirement. The Declarations also provided that the claims-made and reported requirement applied to "any Liability Coverage Section." The policy's language thus clearly provided that timely written notice was a condition precedent to coverage for Dowdell's claim.

4th Street also asserted that, even if notice was untimely, the District Court should not have required strict compliance with the claims-made and reported provision and should have instead required Federal

to demonstrate that it was prejudiced by the untimely notice. The Court of Appeals rejected this argument noting that the Pennsylvania Supreme Court in *ACE American Ins. Co. v. Underwriters at Lloyds and Cos.*, 2009 WL 1176268 (Pa. Apr. 14, 2009), recently held that an insurer need not prove prejudice when denying coverage for late notice under a claims-made policy. The Court stated that, in affirming summary judgment in favor of Federal, the reporting requirement in a claims-made policy is strictly construed and enforced and that, if an insured does not give notice within the required time, there is "simply no coverage under the policy."

TRESSLER COMMENTS

Although historically prejudice has not been required to establish late notice under a claims-made policy, strict enforcement of the reporting requirement has been eroding of late as Charmagne Topacio reported in our July 2009 edition of the *Advisory* where she analyzed the *XL Specialty Insurance v. Financial Indus. Corp.*, 2009 WL 1532047 (5th Cir. June 1, 2009) and *Financial Indus. Corp. v. XL Specialty Insurance Co.*, No. 07-1059, 2009 WL 795529 (Tex. Mar. 27, 2009) decisions from the Texas courts. As reflected by this 3rd Circuit decision, and

the Pennsylvania Supreme Court's decision in *ACE* referenced therein, Pennsylvania remains a favorable jurisdiction in which insurers may enforce their clearly written reporting requirements in their claims-made policies without the need to show prejudice as a result of untimely notice.

It will be interesting to see how the neighboring state of New York deals with this issue in light of the statute that became effective earlier this year with regard to having to establish prejudice in support of a late notice defense. While most commentators view the New York statute as clearly not requiring prejudice where there is a notice or reporting provision with a definitive cut-off date, we await the first case in which a policyholder may contest that view.



Prepared by Thomas K. Hanekamp, a Partner in our Chicago office.

Gargano continued from page 6

were delivered to his agent or broker. Under Massachusetts law, knowledge by the agent is imputed to knowledge by the insured. Additionally, an insured cannot abandon all responsibility for ascertaining and understanding the terms of coverage that his agent or broker procured.

Lastly, the court held that the insurance companies do not need to demonstrate prejudice from untimely notice to escape liability. That would defeat the purpose of a "claims made and reported" policy.

TRESSLER COMMENTS

Although there are a variety of reasons why it is beneficial for insureds to report claims to their insurers on a timely basis, the court's holding in this decision is an example of the serious consequences an insured may face for failing to do so. This decision is also a welcome one for insurers,

as many jurisdictions do not enforce claims-made and reported insurance policies as written. From an insurer's perspective, the court's decision is correct as it effectuated the policy's intent and would be fair in light of the premium that was charged for the policy. The premium charged for claims-made and reported policies is typically significantly less than policies providing comparable coverage triggered by an "occurrence" which have a broader span of time during which a potential loss may be claimed under the policy than do claims-made and reported policies.



Prepared by Katherine Haennicke, an Associate in our Chicago office.

CALIFORNIA COURT UPHOLDS E&O INSURERS' DENIAL OF COVERAGE FOR SPAMMING BASED ON "INTENTIONAL ACTS" EXCLUSIONS AND COLLATERAL ESTOPPEL ARISING FROM AN ARBITRATION AWARD

In Greenwich Insurance Company v. Media Breakaway, LLC, et al., United States District Court, Central District California, No. CV08-937 CAS (CTx), (C.D. Ca. July 22, 2009), two insurers sought to disclaim coverage for an online marketing company's wrongful and illegal internet practices. The United States District Court, Central District of California, granted summary judgment to the insurers on the basis that two exclusions and California Insurance Code section 533 barred coverage for claims arising out of the insured's online activities.



At issue in Greenwich was the application of several exclusions contained in insurance policies issued by Greenwich

Insurance Company ("Greenwich") and Indian Harbor Insurance Company ("Indian") to Media Breakaway, LLC and its CEO (collectively "Media"). As a result of Media's online marketing activities, MySpace, Inc. ("MySpace") filed a federal court action against Media and others entitled MySpace, Inc. v. Optinrealbig.com, LLC, et al., Case No. CV 07-496 GHK (RCx) (C.D.Cal) (the "MySpace Action").

The MySpace Action alleged that Media sent spam mail through MySpace users' accounts without their knowledge (practices described as "phishing" and "spamming") which violated state and federal law. After arbitration was compelled pursuant to the Federal Arbitration Act in the MySpace Action, the arbitrator determined that Media "permitted, encouraged, supported and benefitted from spamming, illegal spamming on the MySpace network" and was therefore liable for damage (the "Arbitration Award").

In 2008, Greenwich filed the instant declaratory relief action against Media which then counterclaimed against Indian. Greenwich brought a motion for summary judgment against Media on the basis that two exclusions applicable to its Management Liability and Company Reimbursement Coverage barred coverage. The first exclusion precluded defense and indemnity for claims "brought about or contributed to" by "any . . . intentionally dishonest, fraudulent or criminal act or omission or any willful violation of any statute, rule or law." The second exclusion barred coverage for claims "brought about or contributed to" by "profit or remuneration gained by any Insured to which such Insured is not legally entitled." Both exclusions provide that the

determinative facts are "as determined by a final adjudication in the underlying action or in a separate action or proceeding."

Indian also brought a motion for summary judgment against Media on the basis that two exclusions in its errors and omissions policy barred coverage. The first exclusion bars coverage for claims "[b]ased on or arising out of any dishonest, intentionally wrongful, fraudulent, criminal or malicious act or omission by an Insured." The second exclusion precludes coverage for any claim "[b]ased on or arising out of the gaining of any personal profit or advantage to which the Insured is not legally entitled."

The District Court granted summary judgment to Greenwich and Harbor based on the application of all of the asserted exclusions to the Arbitration Award in the MySpace Action. As a threshold issue, the District Court found that under federal law, which applied, the Arbitration Award was entitled to non-mutual collateral estoppel effect. The District Court held that an arbitration award confirmed by a federal district court qualifies as a federal judgment. Based on the doctrine of issue preclusion, Media was precluded from arguing that it did not intentionally and illegally launch "spam attacks" against MySpace users.

Based on the findings in the Arbitration Award, the District Court found that the claims in the MySpace Action clearly constituted claims "brought about or contributed in fact by any ... intentionally dishonest, fraudulent or criminal act" under the wording of the first exclusion in the Greenwich policy and the similar exclusion in the Indian policy. The Court also concluded that the claims at issue involved intentional illegal online practices which were inherently harmful acts and therefore barred under California Insurance Code section 533.

In the alternative, the District Court concluded that the Greenwich policy exclusion for claims involving wrongful "profit or remuneration gained by any Insured," applied to the claims in the MySpace Action. This followed from the finding in the Arbitration Award that the

damage award was necessary to prevent Media "from profiting for its wrongful and illegal past behavior." Based on the same facts, the District Court held that the similar exclusion in the Indian policy for the wrongful "gaining of any personal profit" applied.

As a result of the above rulings, the District Court further concluded that: (1) Greenwich and Indian were entitled to reimbursement of defense costs previously paid in the defense of the MySpace Action; and (2) were entitled to summary judgment on Media's counterclaims for breach of contract and bad faith.

TRESSLER COMMENTS

This is a favorable decision for insurers in many respects. It highlights the various bases on which an insurer may correctly preclude coverage for acts such as "phishing" and "spamming" under an errors and omissions policy. While the insurer initially provided coverage for defense costs given the "final adjudication" requirement in the "intentional wrongful act" exclusions, such acts are not intended to be covered under errors and omissions insurance policies, as evidenced by the court's ultimate ruling. The decision also highlights the importance of Cal. Ins. Code §533 in insurance disputes involving these types of exclusions. Finally, the decision is a reminder of the effect a judgment or an award in one case can have upon other matters.



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