D&O and Professional Liability

2017: A Year in Review

2017 was a busy year for courts addressing a wide variety of directors and officers and professional liability insurance coverage issues. Twenty-nine federal courts of appeals, four state supreme courts and dozens of other courts applying the law of 27 states issued notable decisions in this arena. We hope you find the following selection of cases helpful and informative, as we focused on topics we believe will continue to be important in the directors and officers and professional liability insurance field. (Please note the cases are organized within each topic alphabetically by the state law applied).

In this issue

Notice

Alaska Interstate Constr., LLC v. Crum & Forster Specialty Ins. Co., 696 F. App'x 304 (9th Cir. 2017)

Under Alaska law, a claims-made professional errors and omissions liability policy did not provide coverage where notice was not provided during the initial policy period. The insured argued the policy period included the initial and renewal policy periods. The court held that this interpretation was unreasonable and that a claim made during the initial period but reported during the renewal period was not covered. The court also found that the automatic 90-day extended reporting period did not apply to the initial policy period because the policy was renewed.

Centurion Med. Liab. Protective Risk Retention Grp., Inc. v. Gonzalez, No. CV 17-01581 RGK (JCx), 2017 U.S. Dist. LEXIS 181245 (C.D. Cal. Nov. 1, 2017)

Under a claims-made-and-reported professional liability policy, an insurer need not show prejudice by the insured's late notice. The policy at issue required written notice "not more than 20 days after receiving such claim." The court found that the insured's notice more than 20 days after a claim, but within the policy period, did not satisfy the policy's notice requirements and precluded coverage.

Pitzer Coll. v. Indian Harbor Ins. Co., 845 F.3d 993 (9th Cir. 2017

The 9th Circuit recognized that California law calls for the parties' choice of law to govern unless it conflicts with a "fundamental public policy" of California. The policy covered pollution remediation expenses and contained a choice of law clause stating that it was to be governed by New York law, but the court stated that it was unknown whether California's notice-prejudice rule reflected the "fundamental public policy" of California and must override that choice of law provision. Thus, the court certified two questions to the California Supreme Court: 1) Is California's common law notice-prejudice rule a fundamental public policy for the purposes of choice of law analysis? and 2) If the notice-prejudice rule is a fundamental public policy for the purposes of choice-of-law analysis, can a consent provision in a first-party claim insurance policy be interpreted as a notice provision such that the notice-prejudice rule applies? On March 22, 2017, the California Supreme Court accepted review of the certified questions above. *Pitzer Coll. v. Indian Harbor Ins. Co.*, No. S239510, 2017 Cal. LEXIS 2235. As of the date of this publication, the California Supreme Court has not filed an opinion.

Children's Hosp. Colo. v. Lexington Ins. Co., 15-cv-01904-RPM, 2017 U.S. Dist. LEXIS 56892 (D. Colo. Apr. 13, 2017)

The court granted summary judgment in favor of the insured, holding that the insurer could not disclaim coverage under a claims-made healthcare professional liability excess policy because it was not prejudiced by the insured's late notice. The insured, a large hospital network, provided notice to its insurer within the policy period of an incident resulting in a serious injury to an infant patient. When a lawsuit arising out of the incident was filed five years later, however, the insured did not provide notice until more than 22 months after the suit commenced. The insurer made no effort to be involved in a mediation between the parties or the eventual trial, which resulted in a large verdict against the insured. The court found that the insured had complied with the requirement to give notice within the policy period when it gave notice of the incident, but had not complied with the additional requirement that notice be given "as soon as practicable" after the suit was filed. The court applied the notice-prejudice rule to the "as soon as practicable" requirement. The court then held that the insurer was not prejudiced by the late notice, citing as evidence the insurer's failure to involve itself in the defense once it received notice.

Zahoruiko v. Fed. Ins. Co., No. 3:15-cv-474 (VLB), 2017 U.S. Dist. LEXIS 28204 (D. Conn. Feb. 28, 2017), *aff'd*, 2018 U.S. App. LEXIS 250 (2d Cir. Jan. 5, 2018)

The court granted an insurer's motion for summary judgment, finding that the insured's untimely notice of a claim permitted the insurer to disclaim coverage under a claims-made directors and officers liability policy that required notice to be given "as soon as practicable." The insured, an officer of a software corporation, failed to notify the insurer of a claim against it for payment of an outstanding debt until ten days before the underlying plaintiffs moved for summary judgment, and more than 16 months after the initial complaint was filed. Prior to notifying the insurer of the claim, the insured entered into a forbearance agreement with the underlying plaintiffs in which the insured agreed to waive several possible defenses for its failure to pay. Under Connecticut law, an insurer may disclaim coverage on the basis of untimely notice only if the delay was unexcused or unreasonable and resulted in material prejudice to the insurer. The court agreed with the insurer that the insured's 16-month delay was unreasonable, and that the insurer suffered material prejudice by the insured's assumption of contractual obligations under the forbearance agreement.

Ellis v. Cty. Agency, Inc., No. CV146017155S, 2017 Conn. Super. LEXIS 136 (Jan. 12, 2017)

An insurer was prejudiced by an insured's late

notice because by the time the insurer received notice, the underlying case had resulted in a default judgment and the insurer was precluded from timely filing a motion to reopen the judgment. The insurance policy required written notice of an occurrence "as soon as practicable," but the insured only provided oral notice to the insurer's agent. The court held that oral notice plainly did not satisfy the policy's written notice requirement, and granted the insurer's motion for summary judgment.

Abrams v. RSUI Indem. Co., 16-cv-4886, 2017 U.S. Dist. LEXIS 127227 (S.D.N.Y. Aug.10, 2017)

Under Delaware law, an insurer was not required to pay for an insured's defense expenses incurred before notice of the lawsuit had been provided to the insurer under a directors and officers liability claims-made-and-reported policy. Even though the policy did not contain a voluntary payments provision, the court found that the policy plainly required the insured to notify the insurer before incurring any reimbursable expenses; described notice as a "condition precedent"; and defined defense expenses as "expenses incurred, with the Insurer's consent."

Trelles v. Cont'l Cas. Co., 211 So. 3d 1206 (La. Ct. App. 2017)

The court concluded that a claims-made-and-reported lawyer's professional liability policy did not apply where notice of the underlying proceeding was received by the insured prior to the effective date of the policy. The insured argued that initial notice of the disciplinary investigation was not necessary and that notice of formal charges was provided after the effective date of the policy, which therefore triggered coverage. The court disagreed, concluding that the definition of "disciplinary proceeding" included "initial inquiry," which occurred prior to the policy's inception, and therefore there was no coverage.

James River Ins. Co. v. Timcal, Inc., 81 N.E.3d 185 (Ill. App. Ct. 2017)

The policies at issue covered claims first made against the insured and reported to the insurer in writing during the policy period. The insured failed to provide notice during the policy period in which the claim was made, but provided notice during the policy period of the renewal policy. The insured argued that the policy extended the reporting period indefinitely as long as the policy was renewed. The court disagreed, finding that the notice requirements under a professional liability claims-made-and-reported insurance policy were unambiguous, and that reading an extended reporting period into a renewal policy would create an unintended long-tail liability exposure.

Nat'l Union Fire Ins. Co. v. Fund for Animals, Inc., 153 A.3d 123 (Md. 2017)

The insurer issued a claims-made-and-reported, not-for-profit individual and organization liability policy to the insured. The court found that to disclaim coverage under Maryland Insurance Code Section 19-110, an insurer must show, by a preponderance of the evidence, that the delay in giving notice resulted in actual prejudice to the insurer. Here, the court found no actual prejudice based on the insured's two-year late notice where the insurer could not have intervened in the underlying action and could only have, at best, monitored the underlying action.

Mora v. Lancet Indem. Risk Retention Grp., Inc., No. PX 16-960, 2017 U.S. Dist. LEXIS 30067 (D. Md. Mar. 1, 2017)

The court denied an insurer's motion for summary judgment on its contention that a claims-made-and-reported medical malpractice professional liability policy was void because, *inter alia*, the insured failed to comply with the policy's notice provision. The insured, a doctor, was sued for medical malpractice in connection with his alleged failure to refer a patient to a cardiologist several

days before the patient's death. An attorney for the patient's family provided notice of the lawsuit to the insurer, but the insured himself neither provided notice nor appeared at any of the subsequent proceedings. The insurer argued the policy's notice provision required that notice come from an insured, rather than a third party, and denied coverage on that basis. The court found that Maryland courts had not yet decided whether third-party notice can satisfy an insurance policy's notice requirement, but held based on the trend in other jurisdictions that such notice does indeed satisfy a policy's notice requirement. The court reasoned that notice from a third party fulfills the dual aims of a notice provision, namely to provide the insurer with an opportunity to investigate the matter and prepare an adequate defense if necessary.

James River Ins. Co. v. Brick House Title, LLC, No. PWG-16-3464, 2017 U.S. Dist. LEXIS 183225 (D. Md. Nov. 6, 2017)

There was no coverage under a claims-made-and-reported lawyers professional liability insurance policy where the insured knew about the potential claim against it during the first policy period but failed to notify the insurer until the second policy period. Although Maryland's notice-prejudice statute applies to both claims-made and claims-made-and-reported policies, the court concluded the insurer did not need to show prejudice where there was a non-occurrence of a condition precedent to coverage (*i.e.*, no notice) rather than a breach of the policy.

Food Mkt. Merch., Inc. v. Scottsdale Indem. Co., 857 F.3d 783 (8th Cir. 2017)

The Eighth Circuit, applying Minnesota law, affirmed summary judgment in favor of the insurer under a claims-made-and-reported business and management policy requiring notice "as soon as practicable." The insured argued that notice provided seven months after a former employee sued it was reasonable, and that the district court failed to consider whether the insurer's ability to investigate the claim was inhibited, whether the underlying claim had been reduced to judgment, or whether any facts changed from when the insured knew of the claim until the insurer received notice. The court rejected these arguments and found that these factors address whether the delay prejudiced the insurer, and prejudice was neither the issue nor required when notice was a condition precedent to coverage.

Kennedy Univ. Hosp. v. Darwin Nat'l Assur. Co., No. 16-2494 (RBK/JS), 2017 U.S. Dist. LEXIS 53603 (D.N.J. Apr. 7, 2017)

The court granted summary judgment in favor of an insurer on its claim that it had no duty to indemnify its insured under a claims-made medical malpractice professional liability policy. The insured, a healthcare organization, was sued by a patient for burns suffered as a result of the insured's negligence. The insured provided notice of the incident shortly after it occurred, but the insured never notified the insurer of the subsequent lawsuit or settlement demand. The court held that the insurer had no duty to indemnify the insured because the insured failed to comply with a condition precedent to coverage under the policy, namely that the insured provide quarterly reports summarizing all claims and potential claims. Additionally, the court found that the insured's failure to notify the insurer of the injured patient's settlement demand constituted a breach of the policy's notice provision, and as such the policy afforded no coverage for the settlement.

Goldshmidt v. Endurance Am. Specialty Ins. Co., No. 653304/2013, 2017 N.Y. Misc. LEXIS 8 (N.Y. Sup. Ct. Jan. 3, 2017)

A general liability policy issued to a construction subcontractor required notice "as soon as practicable" of an occurrence which may give rise to claim. Relying on New York Insurance Law Section 3420(c)(2)(C), the court held that genuine

issues of material fact remained as to whether the insurer had been materially prejudiced by the insured's late notice. The court noted that by the time the insurer received notice, pre-suit discovery had already taken place, motions in the underlying case were filed, the complaint had been answered, and evidence critical to the insured's defense had been destroyed. However, issues of fact remained as to whether the insurer's ability to conduct a defense was "materially" impaired, as Section 3420(c) required.

N.Y. Inst. of Tech. v. Nat'l Union Fire Ins. Co., No. 650376/16, 2017 N.Y. Misc. LEXIS 646 (N.Y. Super. Ct. Feb. 23, 2017)

An extended reporting period in a claims-made liability policy violated minimum regulatory standards set forth by New York Insurance Regulation No. 121. Specifically, the court determined that the 60-day extended reporting period impermissibly restricted the insured's ability to report claims during the period to those claims that were also "made" during that extended period. The court reasoned that conditioning the extended reporting period in that way created a potential gap in coverage, where a claim made during the original policy period could not be reported during the extended reporting period.

John Hiester Chrysler Jeep, LLC v. Greenwich Ins. Co., No. 5:17-CV-00140-FL, 2017 U.S. Dist. LEXIS 202327 (E.D.N.C. Dec. 8, 2017)

Two claims-made-and-reported employment practices liability policies required that notice be given within 60 days after the end of the policy period. The court found that an insurer need not show prejudice by late notice for a claims-made-and-reported policy. The court also rejected the insured's argument that its late notice should be excused because the insurer allegedly wrongfully refused to defend.

GMS Mgmt. Co. v. Evanston Ins. Co., 689 F. App'x 439 (6th Cir. 2017)

The Sixth Circuit affirmed the Northern District of Ohio's decision granting summary judgment for the insurer, holding that the insurer properly denied coverage under its tenant discrimination liability insurance policy based on the insured's four-month delay in notifying the insurer of a housing discrimination charge filed by the state civil rights commission. The policy required that claims be "promptly reported" and "in no event later than sixty (60) days from the date of the institution of any legal or administrative proceeding." The policy clearly stated that the requisite 60 days was a condition precedent to coverage, and thus the court affirmed the district court's decision.

McCarty v. Nat'l Union Fire Ins. Co., 699 F. App'x 464 (6th Cir. 2017)

Under Ohio law, a claims-made-and-reported malpractice insurance policy did not cover a suit where notice was provided beyond the prescribed reporting period. The insureds argued the insurer had actual and constructive notice of the claim because the state docket was publicly available and because the insurer was not prejudiced. The court found there was no coverage because an insurer is not required to monitor dockets and need not show prejudice for a claims-made-and-reported policy.

Adi WorldLink, LLC v. RSUI Indem. Co., No. 4:16-CV-665, 2017 U.S. Dist. LEXIS 150505 (E.D. Tex. Sep. 18, 2017)

Under claims-made-and-reported directors and officers liability insurance policies, the court found there was no coverage for a claim where the insured failed to provide notice during the initial policy period. The court further found there was no coverage for subsequent related claims due to the policy's "Interrelatedness Condition" that aggregated the initial claim and the later claims into a single claim under the first policy.

Ironshore Specialty Ins. Co. v. Callister, No. 2:15-cv-00677-RJS-BCW, 2017 U.S. Dist. LEXIS 210973 (D. Utah Dec. 21, 2017)

The insured's notice of a potential claim, which was provided through a renewal application, did not strictly or "substantially" comply with a claims-made-and-reported professional liability policy's notice requirement. The court recognized that a renewal application is only designed to seek continuation of coverage from an insurer's underwriters, whereas a formal notice is designed to seek recovery under the policy using the insurer's claims mechanism.

Nat'l Union Fire Ins. Co. v. Zillow, Inc., No. C16-1461JLR, 2017 U.S. Dist. LEXIS 57496 (W.D. Wash. Apr. 13, 2017)

Under Washington law, an insurer was not liable for losses incurred by the insured as a result of a demand letter sent to the insured for intellectual property infringement. The insurer issued a specialty risk protector claims-made policy to an online media content provider. A photography company issued a demand letter to the insured, and nearly one year after sending the demand letter, the company filed suit. The insured notified the insurer of the demand letter 13 months after it was mailed. The court determined that the demand letter was a claim under the policy, and the insured's failure to provide notice within 45 days after the end of the policy period did not trigger coverage.

Sheffield v. Darwin Natl. Assur. Co., 902 N.W.2d 809 (Wis. Ct. App. 2017)

Under a claims-made-and-reported lawyers professional liability insurance policy, the court found no coverage where a claim was reported five days after the two-year extended reporting period. The court also concluded that an insurer may deny coverage based on late notice under claims-made-and-reported policies without a showing of prejudice.

Related Claims

Attys. Ins. Mut. Risk Retention Grp., Inc. v. Liberty Surplus Ins. Corp., No. CV 15-4756 FMO (JCx), 2017 U.S. Dist. LEXIS 46618 (C.D. Cal. Mar. 28, 2017)

In ruling on a summary judgment motion in a case involving two professional liability policies issued during successive policy periods, the court noted the later policy provided that all related claims shall be considered first made during the "Policy Period," as that term is defined in the policy. It thus held that two suits by the same claimants against the same insured attorney filed during different policy periods were not a single claim first made during the first policy period because the later policy's language dictated that any related claims would be considered a single claim first made during the later policy's "Policy Period."

Ciber, Inc. v. ACE Am. Ins. Co., 261 F. Supp. 3d 1119 (D. Colo. 2017)

In a case involving a professional liability policy, the court granted an insurer's motion for summary judgment, and denied the insured's cross-motion, finding that two lawsuits, one first filed prior to the policy period, and one filed during the policy period, were interrelated and thus first made prior to the inception of the policy period because both suits were based on allegations of a "single scheme." The court also rejected the insurer's argument that the policy's interrelated wrongful acts provision required the claims to be causally related.

Denver Investment Advisers LLC v. St. Paul Mercury Ins. Co., No. 17-cv-00362-MEH, 2017 WL 3130923 (D. Colo. Jul. 24, 2017)

The court denied an insurer's motion for summary judgment, finding a genuine issue of material fact as to whether two arbitration demands were the same or similar to a pre-policy period arbitration demand against the insured, such that they would

have been time-barred under the investment adviser and funds management liability policies' "first made" language. The policies' language stated, "all Claims arising out of the same Wrongful Act and all Interrelated Wrongful Acts of the Insureds shall be deemed one Claim," and the court did not have sufficient evidence to determine whether the two later arbitration demands arose out of the "same" Wrongful Act alleged in the arbitration that occurred over 10 years prior to the operative policy periods.

Scottsdale Indem. Co. v. Convercent, Inc., No. 17–cv–01236–RBJ, 2017 U.S. Dist. LEXIS 187939 (D. Colo. Nov. 14, 2017)

In granting an insurer's motion for summary judgment, the court held that two letters sent by a terminated employee to company management demanding continued salary and benefits, reinstatement, and an investigation into his allegations, and threatening litigation if the demands were not met, constituted a "claim" made during the first of two consecutive policy periods. The insured did not report the letters under its business and management indemnity policy, but only the resulting Equal Employment Opportunity Commission charge and lawsuit, which were both tendered during the second policy period, warranting the insurer's coverage denial for untimely notice because all claims were related and deemed first made during the first policy period.

Zahoruiko v. Fed. Ins. Co., No. 3:15-cv-474 (VLB), 2017 U.S. Dist. LEXIS 28204 (D. Conn. Feb. 28, 2017), *aff'd*, 2018 U.S. App. LEXIS 250 (2d Cir. Jan. 5, 2018)

Ruling on a summary judgment motion by an insurer who issued a directors and officers liability policy, the court held that a claim made by a creditor against an insured during the policy that was based on a promissory note was not related to a prior claim by the same creditor against the insured that was made prior to the policy period and based on a different promissory note.

Am. Cas. Co. v. Belcher, No. 17-10848, 2017 U.S. App. LEXIS 18664 (11th Cir. Sept. 27, 2017)

On review of an entry of summary judgment against the insured, the Eleventh Circuit, applying Florida law, affirmed the lower court's finding that the injury claims made by 11 different plaintiffs who received injections by an eye doctor were related claims and constituted a single claim under the doctor's professional liability errors and omissions policy. The court found that myriad shared facts, circumstances, and decisions logically connected the claims, including a common source of the tainted medication that was prepared by a single person using the same process and repeating the same violations of health and safety regulations, such that it was clear the claims arose out of "related acts, errors or omissions."

Health First, Inc. v. Capitol Spec. Ins. Co., 230 F. Supp. 3d 1285 (M.D. Fla. 2017)

In a case involving several directors and officers policies, errors and omissions policies, and an excess policy, the court granted the insurers' motion for summary judgment, finding that six lawsuits filed by three different sets of plaintiffs during different policy periods against the same insured hospital were related claims because they contained similar factual allegations and causes of action.

Vita Food Prods. v. Navigators Ins. Co., No. 16 C 08210, 2017 U.S. Dist. LEXIS 85257 (N.D. Ill. June 2, 2017)

The court granted the insurer's motion for judgment on the pleadings in part, holding that a demand letter sent to the insured during an earlier directors and officers liability policy was related to a subsequent lawsuit filed during a later policy. Both the demand letter and the lawsuit involved alleged breaches of fiduciary duties by the insured's board of directors primarily arising

out of a sale of stock, and therefore there was no coverage under the later policy.

Wesco Ins. Co. v. Wood, No. 15 C 7190, 2017 U.S. Dist. LEXIS 159623 (N.D. Ill. Sep. 27, 2017)

In granting an insurer's motion for summary judgement, the court held that there was no duty to defend or indemnify the insured attorney under her professional liability policy where a subpoena, which provided notice of a potential claim concerning the attorney's role in the formation of corporate trusts to shield assets from creditors in bankruptcy litigation, was given to a prior insurer. A subsequent suit filed by the bankruptcy trustee against the attorney contained comparable allegations. Even though the second suit was noticed to her present insurer, it met the definition of "related act(s) or omission(s)" under the policy and therefore there was no coverage for the suit.

Papalia v. Arch Ins. Co., No. 2:15-cv-02856, 2017 U.S. Dist. LEXIS 121520 (D.N.J. Aug. 1, 2017)

In a case involving consecutive professional liability errors and omissions policies issued to an individual who served as both a financial planner and life insurance agent, the court denied the insurer's argument that there was no duty to defend because claims were not first made within the policy period and were not "Related Claims" with the previously filed covered actions. The insured engaged in two distinct schemes (a Benefit Plan Scheme and Life Insurance Scheme), each of which resulted in multiple claims brought during and after the policy period. The court ruled that based on the broad definition of "related claims" in the policy, both the later filed Benefit Plan claims and Life Insurance claims were related to the timely filed claims because they arose from a nexus of logically or causally related facts, as advocated by the same insurer in prior cases.

Hunter v. Town of Mocksville, 237 F. Supp. 3d 349 (M.D.N.C. 2017)

On a post-trial motion, the court ruled that claims by three police officers against the municipality who fired them, as well as others, were interrelated under the terms of an employment-practices liability policy and thus subject to a single claim limit because the jury found that the claimants were all terminated for jointly participating in the same telephone call.

S.D. Network, LLC v. Twin City Fire Ins. Co., No. 4:16–CV–04031–KES, 2017 U.S. Dist. LEXIS 154886 (D.S.D. Sep. 22, 2017)

In denying an insurer's motion for summary judgment, the court held that a cease-and-desist letter and draft complaint sent by one member of a 17-member telecommunications service provider collective to the collective did not constitute a "claim." The member's letter concerned the collective's response to a historical billing dispute between the individual entity and AT&T, and the collective heeded the letter within 30 days. The member's lawsuit filed against the collective, nearly two years later, arose out of an agreement between the collective and AT&T regarding future billing rates. Thus, the carrier's denial of coverage for the collective, on the grounds that the member's letter and lawsuit constituted one related claim involving interrelated wrongful acts notified after the termination of first policy period, was improper.

ADI Worldlink, LLC v. RSUI Indem. Co., No. 4:16-CV-665, 2017 U.S. Dist. LEXIS 150505 (E.D. Tex. Sep. 18, 2017)

In ruling on a summary judgment motion by an insurer that issued two consecutive directors and officers liability policies to the insured, the court held that the insured's failure to provide timely notice of a claim under the first policy precluded coverage for that claim, and that the second

policy's Interrelatedness Condition aggregated that claim and claims made in the second policy period, based on the same general allegations, into a single claim governed by the first policy. Because the insurer failed to provide timely notice of the first claim within the first policy period, coverage was excluded for all aggregated claims and the insurer was excused of any duty to defend or indemnify all claims.

Nat'l Union Fire Ins. Co. v. Zillow, Inc., No. C16-1461JLR, 2017 U.S. Dist. LEXIS 57496 (W.D. Wash. Apr. 13, 2017)

In a case involving a professional liability policy, the court granted the insurer's motion for judgment on the pleadings where the claimant sent a demand letter to the insured prior to the inception of the policy period, and the court found the demand letter and subsequent litigation to be related, despite, among other things, differences between the demand letter and the complaint in the subsequent lawsuit.

Prior Knowledge / Known Loss / Rescission

Woo v. Scottsdale Ins. Co., 690 F. App'x 496 (9th Cir. 2017)

The Ninth Circuit, applying California law, affirmed summary judgment in favor of the insurer, holding that the insurer had no duty to defend its insureds under a directors and officers liability policy. The court held that the prior knowledge exclusion applied because an insured, even though it was not one of the insureds seeking coverage, had knowledge of the facts and circumstances giving rise to the underlying action before the policy's inception. Furthermore, the court found that the prior litigation exclusion precluded coverage because the demand letter that resulted in the underlying action was issued prior to the policy period.

W. World Ins. Co. v. Prof'l Collection Consultants, No. 16-55470, 2018 U.S. App. LEXIS 73 (9th Cir. Jan. 2, 2018)

The Ninth Circuit, applying California law, affirmed the trial court's grant of summary judgment in favor of an insurer, finding that the insurer could rescind a directors and officers liability policy based upon a material misrepresentation in the insurance application. The policy in question covered claims arising from a civil, regulatory, criminal, or administrative investigation or proceeding against the insured. About six months before the insured completed its renewal application, the Federal Bureau of Investigation ("FBI") executed a search warrant at the insured's offices, subpoenaed a number of the insured's employees, and demanded the production of several thousand documents by the insured. Despite the investigation, the insured answered in the negative when asked on its application whether it knew of any circumstances that might lead to a claim. The court agreed with the insurer that the insured's failure to disclose the FBI investigation was material, thus permitting the insurer to rescind the policy. One member of the appellate panel dissented, arguing that the insured's answer to the application question was not misleading due to the specific wording of the question. Though the dissenter seemed to agree that the FBI investigation was material, she would have found for the insured because the application answer was "literally correct."

Kelly v. Starr Indem. & Liab. Co., No. 15cv2900 JM(RBB), 2017 U.S. Dist. LEXIS 128240 (S.D. Cal. Aug. 10, 2017)

The court granted summary judgment in favor of the insurer, holding that the insurer had no duty to defend or indemnify its insured under a directors and officers liability policy where the insured failed to disclose a demand made prior to the policy's inception. The insureds, two managing members of a real estate development company, received a demand from an investor for payment on certain

promissory notes about nine months before the insurer issued its policy, but did not disclose this demand on their insurance application. The demand stated, in pertinent part, that the investor "would like to try not to proceed with legal remedy." During the policy period, the insureds tendered another demand related to the unpaid promissory notes to the insurer, who denied coverage because the insureds failed to disclose the prior demand on their insurance application and based upon the policy's prior knowledge exclusion. The court found that there was no duty to defend any claims relating to the unpaid promissory notes because the claim was first made before the policy period.

Admiral Ins. Co. v. Super. Ct., No. D072267, 2017 Cal. App. LEXIS 1100 (Nov. 21, 2017)

The appellate court issued a writ of mandate directing the superior court to vacate an order denying the insurer's summary judgment motion. The appellate court determined that prior to the inception of the professional liability policy, the insured, a company matching surrogates and egg donors with families, had notice of a potential claim by a former client. The court found that letters sent by a lawyer representing the client of the insured showed that the insured had prior notice, and the plain language of the prior notice provision precluded coverage. The court rejected the insured's argument that the application form for the policy was ill-suited for the type of business run by the insured, as the form was designed for medical laboratories and healthcare providers rather than surrogate matching companies.

Farbstein v. Westport Ins. Corp., No. 16-cv-62361-BLOOM/Valle, 2017 U.S. Dist. LEXIS 125990 (S.D. Fla. Aug. 9, 2017)

The court granted summary judgment in favor of the insurer, finding that it properly denied coverage pursuant to the prior knowledge exclusion in a lawyer's professional liability policy. About a month before the insured attorney submitted his insurance application, he was retained to ensure that the seller of an apartment complex would not be required to pay the pre-payment penalty on its mortgage. The insured failed to include such a term in the purchase contract, but nonetheless counseled his client to proceed with the sale lest the client be sued for specific performance. The insured offered this advice in conjunction with a reference to his errors and omissions insurance, but failed to disclose the issues related to the apartment complex purchase contract on his insurance application. The client sued the insured about five months after the policy incepted, but the insurer denied coverage upon the insured's tender. The insurer argued that the prior knowledge exclusion should bar coverage because the insured knew, or could reasonably have foreseen, that his actions with respect to the apartment complex purchase contract were a wrongful act that might give rise to a claim. The court agreed with the insurer, applying an objective standard to find that the insured could reasonably have foreseen that there might be a claim against him before the policy incepted. Thus, the insurer had no duty to defend or indemnify its insured.

Title Indus. Assur. Co., R.R.G. v. First Am. Title Ins. Co., 853 F.3d 876 (7th Cir. 2017)

The Seventh Circuit, applying Illinois law, affirmed the trial court's judgment against the insurer, finding that the mere suspicion of questionable transactions by the insured title company was not sufficient to trigger the prior knowledge provision of a professional liability policy. Several former clients sued the insured for allegedly misappropriating funds while acting as an escrow agent for real estate transactions. The insurer denied coverage because, among other reasons, it had received a letter from one of the underlying claimants indicating that the alleged misappropriations began prior to the policy's inception. The court found that neither the letter nor the pleadings in the underlying lawsuit established that the insured had knowledge of the alleged misconduct prior to the policy's effective date, and therefore the insurer could not rely on the prior knowledge exclusion to deny coverage.

Carolina Cas. Ins. Co. v. Robert S. Forbes PC, No. 16-cv-40-JPG-SCW, 2017 U.S. Dist. LEXIS 3422 (S.D. Ill. Jan. 10, 2017)

The court granted summary judgment in favor of the insurer, finding that it could rescind a professional liability insurance policy issued to a law firm due to the insured's material misrepresentations in the insurance application. On the application, the insured failed to disclose that he was facing a possible malpractice lawsuit for an alleged failure to file a timely appeal and was involved in a disciplinary proceeding based on alleged professional misconduct. The court found that these misrepresentations were material because the insurer would have either charged a higher premium or refused to issue the policy. The court also rejected the insured's argument that the insurer waived its right to seek rescission because the insurer specifically reserved its right to rescind and none of the insurer's other conduct would support a waiver of its right to rescind.

Ill. State Bar Ass'n Mut. Ins. Co. v. Rex Carr Law Firm, Nos. 4-16-0365, 4-16-0546 cons., 2017 IL App (4th) 160365-U (Ill. App. Ct. June 27, 2017)

The court affirmed summary judgment for the insured, holding that the insurer was not entitled to rescind the renewal policy based on a misrepresentation in the application for a predecessor policy. The insurer, which had issued legal malpractice insurance policies to the insured law firm for six consecutive policy periods, argued that the insured's failure to disclose an involuntary dismissal for failure to pay sanctions on the initial application entitled the insurer to rescind the initial policy and all subsequent policies. The court rejected that argument, citing a state statute that prohibits rescission based on a misrepresentation unless the misrepresentation is stated in the application for the policy the insurer seeks to rescind.

ProAssurance Indemn. Co. v. Wagoner, No. 1:15-cv-01389-JMS-MPB, 2017 U.S. Dist. LEXIS 125897 (S.D. Ind. August 9, 2017)

The court denied the insurer's motion for summary judgment which sought a declaration that several professional medical liability insurance policies issued over a 12-year period were void *ab initio* based upon material misrepresentations in the insurance application. The insured medical professionals pled guilty to, or were convicted of, various crimes related to the illegal prescription and distribution of controlled substances but failed to disclose this on their insurance applications. The insurer, after having already paid out several hundred thousand dollars, sought to rescind the policies in light of the apparent misrepresentations. The court found a genuine issue of material fact as to when the insurer learned of the misrepresentations in the insurance application and whether the insurer was reasonably diligent in seeking rescission.

Svabek v. Lancet Indem. Risk Retention Grp., Inc., 86 N.E.3d 230 (Ind. Ct. App. 2017)

The appellate court affirmed the trial court's grant of summary judgment in favor of the insurer, permitting the insurer to rescind its physician's professional insurance policy based on misrepresentations in the insurance application. On his insurance application, the insured physician represented that no prior insurance carrier had refused or declined to issue coverage for any medical incident. In fact, the insured's prior professional liability carrier had sent via certified mail and email a denial letter for a claim that the insured had tendered to the prior carrier just three days before the insured completed his insurance application.

James River Ins. Co. v. Brick House Title, LLC, No. PWG-16-3464, 2017 U.S. Dist. LEXIS 183225 (D. Md. Nov. 6, 2017)

The court granted summary judgment in favor of the insurer, finding that it had no obligation to defend or indemnity its insured under a lawyer's professional liability policy because the insured knew of the claim prior to the policy's inception. The insurer issued two consecutive claims-made-and-reported policies to the insured title company. During the first policy period, the insured received a letter from two former clients indicating that the clients intended to file a lawsuit against the insured for damages arising out of the insured's alleged failure to complete a wire transfer following the closing for a real estate transaction. However, the insured did not report the potential claim to the insurer until after the first policy period had expired. The insurer argued that the insured's late notice barred coverage under the first policy, and that the prior knowledge exclusion operated to bar coverage under the second policy. The court determined, applying an objective standard, that the insured should have known that a claim was forthcoming when it received the letter from its former clients.

Nat'l Credit Union Admin. Bd. v. CUMIS Ins. Soc'y, Inc., 241 F. Supp. 3d 934 (D. Minn. 2017)

The court, applying Minnesota law, denied a fidelity insurer's motion for summary judgment. Additionally, the court determined that the insurer failed to show that the insured unequivocally accepted the offer for rescission. After determining that a manager from the insured's company lied on an application to renew the bond, the insurer sought to rescind the bond by mailing a denial letter and refund check with the premium to the insured. During the mail-sorting process, a clerk separated the check, and it was cashed pursuant to certain receivership procedures. The court determined that because the manager's misrepresentation was to benefit the employee herself, rather than the insured, the misrepresentation would not be imputed to the insured. Additionally, the court noted that merely cashing a check for the premium was not sufficient to warrant rescission. Although the insurer was unable to rescind the contract on summary judgment, the court noted that the insurer may discover additional facts that would permit rescission.

Liberty Ins. Underwriters, Inc. v. Wolfe, No. 16-2353, 2017 U.S. Dist. LEXIS 16295 (D.N.J. Feb. 3, 2017)

The court entered a default judgment in favor of the insurer permitting rescission of a legal malpractice professional liability policy and awarding the insurer all costs associated with the underwriting, insurance, and administration of the policy. The insured, an attorney, failed to disclose on his insurance application the existence of potential claims against him arising out of untimely filings in two separate matters. The court found that the insured's failure to disclose the potential claims against him constituted material misrepresentations that allowed the insurer to rescind the policy.

Cont'l Cas. Co. v. Boughton, 695 F. App'x 596 (2d Cir. 2017)

The Second Circuit, applying New York law, affirmed the district court's judgment rescinding an accountant's professional liability policy on the ground that the insured procured the policy through material misrepresentations. The insured assigned its rights under the policy to the underlying plaintiff, who argued that the insurer's actions ratifying the policy foreclosed rescission. The court held that ministerial changes to the policy, payment of legal expenses required under the policy and by state law, and an offer of extended reporting coverage to the insured as required by state law, did not constitute a ratification of the policy that would preclude rescission.

H.J. Heinz Co. v. Starr Surplus Lines Ins. Co., 675 F. App'x 122 (3d Cir. 2017)

The Third Circuit, applying New York law, affirmed a judgment in favor of the insurer that allowed the insurer to rescind a contaminated products insurance policy due to material misrepresentations in the insurance application. The insured, a global food products company, represented on its insurance application that it had only suffered one loss exceeding $5 million in the previous ten years when it had in fact sustained three such losses. The court held that the insured's misrepresentations were material because the insurer would not have issued the policy had the insured disclosed all relevant losses. The Third Circuit also held that the insurer's five-month delay in requesting rescission was not unreasonable and the insurer did not waive its right to rescind the policy.

J.P. Morgan Secs. v. Vigilant Ins. Co., 51 N.Y.S.3d 369 (N.Y. Sup. Ct. 2017)

The court declined to grant summary judgment to an insurer on its claim that it had no duty to indemnify its insured under an excess professional liability policy. The Securities and Exchange Commission ("SEC") fined the insured, a large financial institution, for unlawful securities trading practices. The insurer argued that its policy does not provide coverage for the fine because officers of the insured corporation allegedly knew of the alleged trading practices prior to the policy's effective date. New York law requires that the insurer prove that the officers had actual knowledge of the unlawful trading practices, and that a reasonable person in the insured's position should have expected those practices to result in a claim. The court, applying a subjective test, found that the insurer could not prove that any of the insured's officers had actual knowledge of the unlawful trading practices. The court further stated that, even if the insurer could prove that the insured's officers had knowledge of the specific unlawful actions, the state of securities law at the time would not have led a reasonable person to conclude that those practices would form the basis for a claim against the insured. The court thus concluded that the insurer could not rely on the prior known acts exclusion to deny coverage under the policy.

Gonakis v. Medmarc Cas. Ins. Co., No. 1:16 CV 2042, 2017 U.S. Dist. LEXIS 56789 (N.D. Ohio Apr. 13, 2017)

The court granted summary judgment for the insurer, finding that it had no duty to defend or indemnify its insured under a professional liability insurance policy. The insured, an attorney, received a letter several weeks prior to the policy's effective date advising him that a former client had retained counsel to pursue claims against the insured and others involved in a real estate transaction. The letter specifically advised the recipients to notify their professional liability carriers about the forthcoming claims, but the insured did not do so because he understood that no claim would be filed against him. The insured was served with a lawsuit several months later. The insurer denied coverage, stating that the letter informed the insured of circumstances that should reasonably have been expected to result in a claim, and therefore the claim was not first made during the policy period. The court, applying a reasonable insured standard, found that no interpretation of either the letter or the relevant reporting requirement supported the insured's argument. The court found that the policy did not provide coverage for a claim made prior to the policy period.

Ironshore Specialty Ins. Co. v. Callister, No. 2:15-cv-00677-RJS-BCW, 2017 U.S. Dist. LEXIS 210973 (D. Utah Dec. 21, 2017)

The court granted summary judgment in favor of the insurer, finding that it had no duty to defend its insured under a legal malpractice professional liability policy where the insured, prior to the policy's inception, had knowledge of circumstances that could reasonably give rise

to a claim against it. In response to a question on its insurance application, the insured law firm disclosed that a former client planned to sue the insured for negligently counseling the client to engage in a transaction prohibited by the Employee Retirement Income Security Act. The policy contained an exclusion for claims arising out of matters disclosed on the application. The court held that the exclusion was unambiguous as a matter of law, and then applied Utah's broad construction of the term "arising out of" to find that the insurer's denial of coverage was proper

Prior Acts / Prior Notice / Prior & Pending Litigation

Zucker v. U.S. Specialty Ins. Co., 856 F.3d 1343 (11th Cir. 2017)

The Eleventh Circuit affirmed summary judgment in favor of the directors and officers liability insurer under Florida law, finding that a bankruptcy trustee's fraudulent transfer claims against the insured bank's corporate officers were excluded by the policy's prior acts exclusion. The trustee for the insured argued that the exclusion did not apply because the transfers occurred after the policy incepted, and insolvency was not a wrongful act. The insurer asserted that the exclusion applied because the insured bank's insolvency resulted from its unsound lending practices that pre-dated the policy. The court found that an essential element of the fraudulent transfer claims was the transferring entity's insolvency at the time of the transfer, and that under Florida's "broad interpretation of the 'arising out of' standard," the insolvency "arose out of" wrongful acts that occurred before the policy's inception.

Reuter v. Lancet Indem. Risk Retention Grp., No. 16-80581-CIV-MARRA, 2017 U.S. Dist. LEXIS 95779 (S.D. Fla. June 19, 2017)

The court granted summary judgment in favor of the insurer, finding that the insurer had no duty to defend or indemnify its insured under a healthcare professional liability policy where the insured had given notice to its prior insurer of the claim for which it sought coverage. The insured, a physician, received a letter from the Florida Department of Health informing him that he was under investigation for a possible violation of the state's medical malpractice act. He notified his prior insurer of the potential claim against him, for which that insurer ultimately denied coverage. When a lawsuit was eventually filed, the insured gave notice to his current insurer, which denied coverage under the policy's prior notice exclusion. The court agreed with the insurer, holding that the insured's notice of the potential claim to his prior insurer was sufficient to trigger the application of the prior notice exclusion under the current insurer's policy.

Cristal USA Inc. v. XL Specialty Ins. Co., No. 2494, 2017 Md. App. LEXIS 210 (Md. Ct. Spec. App. Feb. 24, 2017)

The appellate court affirmed summary judgment for the insurer, holding that a prior acts exclusion in the primary directors, officers, and employees liability policy, which was incorporated into the subject excess policy, precluded coverage for two class action lawsuits alleging a price fixing conspiracy brought against the insured's subsidiary. The primary insurer defended until coverage was exhausted, but the excess insurer denied coverage based on the primary policy's prior acts exclusion. The insured argued that the last phrase of the provision that excluded coverage for wrongful acts, including interrelated wrongful acts committed or attempted in whole or in part "prior to [the exclusion date] for [the insured] and Its Subsidiaries," meant that the acts must be for the benefit of both the insured and its subsidiaries. Further, the subsidiary alleged that because it was not acquired by the insured until after the exclusion date, the acts pre-dating its acquisition could not be for the purpose of benefiting the insured and its subsidiaries. The court rejected this argument, finding that the "for" referred to the prior acts cut-off date, meaning any wrongful act committed prior to that date was excluded from coverage. The court also found that even though the underlying actions alleged acts before and

after the exclusion date, the interrelated language precluded coverage for the entire action because the acts were related to the same conspiracy claim. The court also held that the excess insurer was free to take a different policy interpretation than the primary insurer.

Dishonesty & Personal Profit Exclusions

Gallup, Inc. v. Greenwich Ins. Co., No. N14C-02-136 FWW, 2017 Del. Super. LEXIS 46 (Jan. 30, 2017)

Where a policy precluded coverage for claims brought about or contributed to by dishonest, fraudulent, or criminal acts or improper profits gained by an insured, "as determined by a final adjudication in the underlying action or in a separate proceeding," the court held that the insurer was permitted to establish the insured's fraud in the coverage litigation initiated by the insured. The court reasoned that the coverage action constituted a "separate proceeding" under the clear policy terms, and rejected the insured's contention that "separate proceeding" meant a "parallel proceeding" to the underlying action.

Stein v. Axis Ins. Co., No. B265069, 2017 Cal. App. Unpub. LEXIS 1628 (Mar. 8, 2017)

The court held that a willful misconduct exclusion in a directors and officers liability policy, requiring an insured to repay defense expenses if it has been "finally determined" the insured committed willful misconduct, did not operate to preclude coverage for an insured's litigation expenses incurred in directly appealing a criminal conviction for securities fraud. The court reasoned there could be no "final determination" of the insured's culpability until the insured's direct appeals for his criminal conviction had been exhausted.

J.P. Morgan Secs. Inc. v. Vigilant Ins. Co., 51 N.Y.S.3d 369 (N.Y. Sup. Ct. April 17, 2017)

The court held that a personal profit exclusion in several professional liability policies did not preclude coverage for a $140 million disgorgement payment by an insured broker-dealer to the U.S. Securities and Exchange Commission. The court explained that the exclusion applies only if the loss is based upon a personal profit or advantage actually derived by the insured and the profit itself is unlawful. Because the insurers could not show the insured's profit or gain was in itself unlawful, the court concluded that the exclusion did not bar coverage for the $140 million payment.

Twin City Fire Ins. Co. v. Oceaneering Int'l, Inc., No. H-16-666, 2017 U.S. Dist. LEXIS 47798 (S.D. Tex. Feb. 28, 2017), 2017 U.S. Dist. LEXIS 46287 (S.D. Tex. Mar. 29, 2017)

In a dispute involving a directors and officers liability policy, a magistrate judge recommended that cross-dispositive motions be resolved in favor of the insurer, rejecting the insureds' argument that an exception to the policy's personal profit exclusion restored coverage, because the insureds failed to establish the underlying claim fell within the coverage provisions in the first instance. The district court adopted the magistrate judge's recommendations in full and overruled the insureds' objection that the magistrate judge failed to interpret the policy as a whole in determining that the exception to the personal profit exclusion did not restore coverage.

Emplrs Mut. Cas. Co. v. Helicon Assocs., 894 N.W.2d 545 (Mich. 2017)

In reversing the decision of the intermediate appellate court, the Supreme Court of Michigan held that, although the appellate court correctly recognized that a policy's "fraud or dishonesty"

exclusion did not eliminate coverage for acts of mere negligence by the insured, the appellate court erred in concluding the exclusion barred coverage for an underlying consent judgment whereby the insured admitted to allegations of a securities law violation under a Connecticut statutory provision. The court explained that because the statute imposed liability for untrue statements and omissions made either knowingly or negligently, and because the claims on which the consent judgment was based contained allegations of negligent misrepresentations and omissions, the consent judgment did not determine that acts of fraud or dishonesty were committed by the insured, such that coverage for the consent judgment was barred by the "fraud or dishonesty" exclusion.

Restitution, Disgorgement & Damages

Li v. Ironshore Indem., Inc., No. 17-0323-DOC, 2017 U.S. Dist. LEXIS 210320 (C.D. Cal. June 19, 2017)

The court dismissed a breach of contract claim filed by the insured-attorney against his insurer for refusing to cover the attorney's required forfeiture of fees in an underlying action, reasoning that the attorney was seeking coverage for uninsurable restitution.

Phila. Indem. Ins. Co. v. Sabal Ins. Grp., Inc., No. 16-62168, 2017 U.S. Dist. LEXIS 159508 (S.D. Fla. Sept. 28, 2017)

The court held that a Private Company Protection Plus Liability Policy did not cover an insured's stipulated settlement agreement of a grand theft claim because the settlement payments were restitutionary in nature and thus did not constitute a covered loss under the policy. The court found that because coverage for the stipulated settlement agreement did not exist in the first instance, the insured's reliance on language contained in the policy's dishonesty and personal profit exclusions was misplaced.

J.P. Morgan Sec., Inc. v. Vigilant Ins. Co., 51 N.Y.S.3d 369 (Sup. Ct. 2017)

An insurer argued that $140 million in loss was uninsurable because it was merely the disgorgement of the policyholder's ill-gotten gains. The court rejected the argument and held that the amount was an insurable loss because the gains were to the policyholder's customers, not the policyholder.

Twin City Fire Ins. Co. v. Oceaneering Int'l, Inc., No. H-16-166, 2017 U.S. Dist. LEXIS 46287 (S.D. Tex. March 29, 2017)

The court held that any part of the settlement in a shareholder derivative action against the insured directors that was deemed disgorgement of the directors' alleged excess compensation would not be a covered loss under the directors and officers policy.

Insured Capacity

Title Indus. Assur. Co., R.R.G. v. First Am. Title Ins. Co., 853 F.3d 876 (7th Cir. 2017)

Under Illinois law, a professional liability carrier was found to have wrongfully denied coverage where the underlying complaints alleged that the insured company and its employees engaged in "irregular and suspicious" activities. The Seventh Circuit explained that, although one of the insured's employees was eventually convicted for wire fraud in connection with a Ponzi scheme, the underlying claimants did not know that or allege that when they filed their complaints, and there was no indication that the professional liability carrier was aware of the employee's crimes when it denied coverage. As such, the insurance carrier "could not possibly have known whether its Insured, defined to include not only [the Named Insured] but also its members and employees acting within the scope of their employment, were in on the scheme, aware of the scheme, or innocent victims of the scheme," and thus owed a duty to defend.

Aaron Ambulance Med. Transp., Inc. v. Certain Underwriters at Lloyd's, No. 16-cv-04564 (CLW), 2017 U.S. Dist. LEXIS 149409 (D.N.J. Sep. 14, 2017)

The court held that a professional liability policy, which through endorsement deleted the policy's sexual harassment exclusion and provided coverage for "[a]ny Claim(s), in whole or in part, based upon, or arising out of any sexual misconduct, sexual abuse, and/or child abuse," did not provide coverage for the underlying claim of sexual harassment brought by a former employee of the named insured company. The court explained that a plain reading of the endorsement only extended coverage to sexual harassment in the rendering of professional ambulatory services and did not "expand coverage beyond professional services and into the realm of sexual harassment and discrimination – all without using or defining such terms or referring to related definitions, declarations, or exclusions."

Law Offices of Zachary R. Greenhill, P.C. v. Liberty Ins. Underwriters, Inc., 147 A.D.3d 418 (N.Y. App. Div. 2017)

The court held that an Insured Capacity exclusion, which excluded coverage under a professional liability policy for claims arising out of an insured's "services and/or capacity as . . . an officer, director, partner, . . . or employee of an organization other than that of the name insured[,]" precluded coverage for the underlying action. The court found that it was clear from the pleadings in the underlying action and the coverage action that the allegations in the counterclaims against the insured attorney fell within the exclusion because they arose out of the insured attorney's capacity as the president and CEO of one entity and as a senior manager and partner of another entity.

Palmer v. Twin City Fire Ins. Co., Case No. 17-826, 2017 U.S. Dist. LEXIS 190993 (E.D. Pa. Nov. 17, 2017)

The court held that an underlying action brought against a director of the named insured company was not covered by the directors' and officers' policy because the director did not act in his insured capacity when he attempted to file a conservator petition on a property. The court explained that the evidence was "conclusive" that the director did not act in his insured capacity because he admitted that he was not a director or officer of the named insured when he filed the petition for conservatorship, he did not ask the named insured for permission before filing the petition, and the named insured did not provide any permission to file the petition.

Insured v. Insured Exclusion

Hawker v. Doak, 685 F. App'x 565 (9th Cir. 2017)

Applying California law, the Ninth Circuit affirmed a lower court ruling that the insured v. insured exclusion in a directors and officers liability policy barred coverage for a lawsuit brought by the Federal Deposit Insurance Company in its capacity as a receiver for the insured company. The insured company argued that the removal of a regulatory exclusion by endorsement rendered the insured v. insured exclusion ambiguous. The court rejected this argument, reasoning that the plain language of the exclusion barred coverage and there was nothing in the endorsement that varied the terms of the exclusion.

Sunrise Specialty Co., Inc. v. Scottsdale Ins. Co., No. 16-16856, 2017 U.S. App. LEXIS 26860 (9th Cir. Dec. 27, 2017)

Applying California law, the Ninth Circuit affirmed the lower court's decision that the insured v. insured exclusion in a directors and officers

liability policy applied to a breach of fiduciary duty lawsuit brought by minority shareholders and former board members against the insured company and chief executive officer. The court rejected the argument that a "derivative claim" exception to the insured v. insured exclusion applied, reasoning that the exception only applied where the lawsuit was instigated and continued without the active participation of an insured. The court concluded that the exception did not apply because the insured plaintiffs were named plaintiffs in the lawsuit and the record suggested they were actively involved, or at least assisted in, the drafting of the complaint.

W.G. Hall, LLC v. Zurich Am. Ins. Co., No. 17-CV-646, 2017 U.S. Dist. LEXIS 141389, (N.D. Cal. Aug. 31, 2017)

Where a professional liability policy included an insured v. insured exclusion, the court held that the exclusion did not apply to a class action lawsuit brought by former employees of the insured because, although the policy stated that employees were insureds, it did not specify that former employees were also insureds. The court also relied on the policy's distinction between employees and former employees in other parts of the policy to support the conclusion that the term "employee" did not include "former employee."

Marbella Condo. Ass'n v. RSUI Indem. Co., No. 16-cv-80987, 2017 U.S. Dist. LEXIS 12363 (S.D. Fla. Jan. 30, 2017)

The court held that the insured v. insured exclusion in a directors and officers liability policy barred coverage where the underlying lawsuit involved both insured and non-insured plaintiffs. The court distinguished other cases that held the exclusion did not apply because, in those cases, the lawsuit was commenced by non-insured plaintiffs and insured plaintiffs were later added to the lawsuit. The court reasoned that because the insured plaintiff had been a party to the lawsuit from the inception, the exclusion completely barred coverage.

Vita Food Prods., Inc. v. Navigators Ins. Co., No. 16 C 8210, 2017 U.S. Dist. LEXIS 85257 (N.D. Ill. June 2, 2017)

The court held that where a lawsuit involved insured and non-insured plaintiffs, the insured v. insured exclusion in a directors and officers liability policy did not completely bar coverage and the loss had to be allocated pursuant to the policy's allocation provision. The court reasoned that the allocation provision had to be given effect and the non-insured plaintiffs had a reasonable expectation of coverage under the allocation provision.

Indian Harbor Ins. Co. v. Zucker, 860 F.3d 373 (6th Cir. 2017)

Applying Michigan law, the Sixth Circuit affirmed a lower court's ruling that the insured v. insured exclusion in a directors and officers liability policy barred coverage where the underlying lawsuit was brought by the trustee of the insured company's bankruptcy estate against corporate officers for breach of fiduciary duty. The court reasoned that the bankruptcy estate was an assignee of the insured company and therefore stood in the shoes of the insured company with the same rights and obligations.

Abboud v. Nat'l Union Fire Ins. Co., 163 A.3d 353 (N.J. Super. Ct. 2017)

The court held that the insured v. insured exclusion in a directors and officers liability policy barred coverage for a cross-complaint against the insured company's chief executive officer for breach of fiduciary duty. The court rejected the officer's arguments that he had a reasonable expectation of coverage under the policy and that evidence of collusion was necessary for the insured v. insured exclusion to apply. The court held there was no reasonable expectation of coverage because the policy language was straightforward and was

meant to provide coverage for third-party claims. The court further reasoned that the plain language of the exclusion had no collusion requirement.

Intelligent Digital Sys., LLC v. Beazley Ins. Co., Inc., No. 16-3548-cv, 2017 U.S. App. LEXIS 18273 (2d Cir. Sept. 19, 2017)

Applying New York law, the Second Circuit affirmed a lower court ruling that the insured v. insured exclusion in a directors and officers liability policy barred coverage for an underlying lawsuit filed by a board member against the insured company for payments owed to him under a promissory note. The company argued the exclusion did not apply because the board member was not suing in his capacity as a member of the board. The court rejected this argument, reasoning the exclusion applied on its face and there was no limitation in the exclusion for claims brought by an insured in the capacity of a board member or director.

Orthopedic & Neurological Consultants v. Cincinnati Ins. Co., No. 16CV-5552, 2017 Ohio Misc. LEXIS 426 (Ohio C.P. May 8, 2017)

Under Ohio law, an insured v. insured exclusion precluded coverage for an underlying action brought by plaintiffs who were both shareholders and employees of the insured company. Although the directors' and officers' policy did not preclude claims brought by shareholders, the exclusion unambiguously precluded coverage for claims brought by an insured in any capacity and regardless of collusion.

Phila. Indem. Ins. Co. v. Providence Cmty. Action Program, Inc., No. 15-388 S, 2017 U.S. Dist. LEXIS 9345 (D.R.I. Jan. 24, 2017)

The court held that the insured v. insured exclusion in a directors and officers liability policy did not bar coverage where a breach of fiduciary duty lawsuit was brought by a court-appointed receiver against board members, because the receiver did not act on behalf of the pre-receivership insured, but instead was an agent of the court working for the potential benefit of various parties.

Great Am. Ins. Co. v. Primo, 512 S.W. 3d 890 (Tex. 2017)

The court held that the insured v. insured exclusion in a directors and officers liability policy applied to bar coverage for an underlying action where the plaintiff was a successor-in-interest to an insured. The court reversed a lower court ruling and reasoned that the successor-in-interest stood in the shoes of the insured and was bound by the terms of the policy.

Contractual Liability

Magnolia Fin. Grp. v. Antos, No. 15-7144, 2017 U.S. Dist. LEXIS 140347 (E.D. La. August 30, 2017)

In an action to recover on a promissory note, the plaintiff in an underlying action filed a cross claim against the defendant's insurer seeking a declaration that the insurer's policy provided coverage for claims for breach of contract and tort brought by the plaintiff against the insured. The insurer argued that the policy's contract exclusion precluded coverage. The court held that the policy's contract exclusion applied, but only to those claims related strictly to breach of contract against the insured, and not to other claims sounding in tort.

Mau v. Twin City Fire Ins. Co., No. 1:16-CV-325, 2017 U.S. Dist. LEXIS 174582 (D.N.D. Oct. 3, 2017)

The insured sought a declaration that its directors and officers liability policy provided coverage in an action for breach of a noncompetition agreement. The insured argued that its insurer breached the duty to defend and engaged in bad faith where

the allegations against the insured arose out of his acts or omissions as a director and officer. The court agreed with the insurer, and found that the allegations against the insured did not arise out of his actions or inactions as a director of the company and there was no potential for coverage.

Great Lakes Beverages, LLC v. Wochinski, 373 Wis. 2d 649 (Wis. Ct. App. 2017)

Great Lakes Beverages, a successor-in-interest to an insured who entered into a purchase agreement with a noncompetition clause with the defendant, sued after the defendant helped his son start a competing business. The defendant then filed a third-party complaint against the insured, raising claims for breach of contract and tortious interference. The insurer initially provided its insured with a defense, but later sought a declaration that it owed no coverage to the insured for the breach of contract claims. The court agreed with the insurer, and ruled that the breach of contract exclusion in its policy precluded coverage for the insured.

Professional Services

Cases Addressing Policies Providing Coverage for Professional Services

Cont'l Cas. Co. v. Kool Radiators Inc., 689 F. App'x 877 (9th Cir. 2017)

The Ninth Circuit, applying Arizona law, affirmed the trial court's grant of summary judgment in favor of an insurer, finding that the insurer did not owe its insured indemnity under an accountants' errors and omissions policy because the insured's actions did not constitute "professional services." The individual insured, an accountant, was sued for allegedly making misrepresentations to a client of the named insured – the accountant's employer – in order to induce the client to invest in a business partially owned by the accountant. The court held that the accountant's conduct did not qualify as "professional services" because the policy defined "professional services" to require work that inures to the benefit of the named insured company.

Colony Ins. Co. v. Expert Grp. Int'l Inc., No. 1:15-cv-02499-RPM, 2017 U.S. Dist. LEXIS 75073 (D. Colo. May 17, 2017)

Three au pair placement agencies were sued for price fixing, among other claims. The placement agencies all sought coverage under professional liability policies issued by the same insurer which defined "professional services" to include "counseling." After applying Colorado, Utah, and Florida law to the three policies, the court found that the agencies generally provided "counseling" by connecting au pairs to host families and informing the parties about what to expect from the employment relationship. However, the court determined the insurer had no duty to defend one of the placement agencies because the underlying complaint only alleged price fixing against that placement agency and "counseling" did not include the alleged agreement to fix wages. With respect to the other two placement agencies, the court noted the complaint also asserted causes of action for breach of fiduciary duty and negligent misrepresentation based on alleged erroneous advice and information to au pairs about the terms of their employment. Accordingly, the court found the insurer had a duty to defend those two placement agencies because the professional services insuring agreement was triggered.

Willey v. Minn. Lawyers Mut. Ins. Co., No. 5-16-0452, 2017 IL App (5th) 160452-U (Ill. Ct. App. Dec. 6, 2017)

The Appellate Court of Illinois, applying Iowa law, affirmed the trial court's grant of summary judgment in favor of an insured, finding that the insurer owed a duty to defend its insured under a legal malpractice professional liability policy. The insured, an attorney, allegedly breached his fiduciary duties as an escrow agent by mishandling funds in a transaction where he also acted as an attorney and corporate officer for one of the

parties to the transaction. The other party to the transaction alleged that the insured's position as corporate officer, attorney, and escrow agent created an inherent breach of fiduciary duty. The court rejected the insurer's argument that there was no coverage under the policy because the insured was acting as an escrow agent rather than as an attorney, citing the inclusion of "escrow agent" as an example of services included within the policy's definition of "professional services."

Cases Addressing Professional Services Exclusions

Energy Ins. Mut. Ltd. v. Ace Am. Ins. Co., 14 Cal. App. 5th 281 (2017)

Numerous lawsuits were filed after an unmarked petroleum pipeline was struck causing an explosion. After settling lawsuits against the pipeline owner, an insurer for the pipeline sought to recover from the insurer of a staffing agency that provided personnel to the pipeline. The staffing agency's insurer issued a commercial general liability policy which contained a professional services exclusion. The court found that both the named insured (the staffing agency) and the additional insured (the pipeline owner) provided professional services in connection with the pipeline. Accordingly, coverage was barred under the professional services exclusion. Significantly, however, the court noted that in determining coverage for the *additional insured*, the relevant question was not whether the named insured engaged in professional services but whether the additional insured did so.

Stettin v. Nat'l Union Fire Ins. Co., 861 F.3d 1335 (11th Cir. 2017)

Certain executives of a bank were sued after one if its clients used an account with the bank to orchestrate a Ponzi scheme resulting in substantial losses to various plaintiffs. The bank's client filed for bankruptcy and the bankruptcy trustees received an assignment of the bank's policy rights as part of the settlement of the underlying suits. The trustees then sought coverage under the bank's executive and organization liability insurance policies. The trustees argued that the professional services exclusion should be read severally and therefore only bar claims against executives who directly provided professional services to the bank's client. However, the court disagreed, noting that the policy did not contain a severability clause and the professional services exclusion applied to all the bank's executives because the exclusion twice used the phrase "any insured," once in referring to the claim made and once in referring to the professional services rendered. Accordingly, the Eleventh Circuit, applying Florida law, affirmed the district court's grant of the insurers' motion to dismiss based on a professional services exclusion.

Witkin Design Grp. v. Travelers Prop. Cas. Co. of Am., No. 17-10488, 2017 U.S. App. Lexis 20431 (11th Cir. Oct. 19, 2017)

The Eleventh Circuit, applying Florida law, affirmed the trial court's ruling that an insurer did not have a duty to defend or indemnify its insured under a commercial general liability policy for a suit alleging that the insured negligently designed an intersection. The insured, a landscape architecture firm, was named in a suit commenced by the estate of a child killed in a traffic accident. The insurer denied coverage for the suit, relying on a professional services exclusion that barred coverage for bodily injury arising out of any service requiring specialized skill or training. The court agreed with the insurer, holding that the design of an intersection is a service requiring specialized skill or training such that the insurer justifiably relied on the professional services exclusion to disclaim its duty to defend or indemnify the insured.

Westfield Ins. Co. v. Orthopedic & Sports Med. Ctr. of N. Ind., Inc., 247 F. Supp. 3d 958 (N.D. Ind. 2017)

Clients of a sports medicine center filed various lawsuits against the center after allegedly receiving contaminated steroid medication administered by injection for pain management. The center

sought coverage under a commercial liability portion of a package policy which contained a professional services exclusion. The court found that the "efficient and predominating cause" of the injuries was the injection of steroid medication and because the injections constituted the rendering of a medical service or "treatment," coverage was barred under the professional services exclusion, among other reasons.

Orchard, Hiltz & McCliment, Inc. v. Phx. Ins. Co., 676 F. App'x 515 (6th Cir. 2017)

A village hired an engineering firm to oversee upgrades to its wastewater treatment plant. After an explosion at the treatment plant, plaintiffs filed personal injury and wrongful death suits against the engineering firm. The engineering firm sought coverage as an additional insured under the general contractor and subcontractor's commercial general liability policies. The Sixth Circuit, applying Michigan law, affirmed the district court's finding that the professional services exclusion barred coverage for the engineering firm as an additional insured. The court found that the allegations that the engineering firm failed to provide adequate safety supervision implicated the professional services exclusion. In response to the insured's argument about various tangential allegations, the court advised, "[e]ven if some of the underlying factual allegations implicate tasks that do not, in and of themselves, involve a specialized skill, such acts and omissions are reasonably related to [the engineering firm's] overall provision of professional services."

Diocese of Duluth v. Liberty Mut. Grp. (In re Diocese of Duluth), 565 B.R. 410 (Bankr. D. Minn. 2017)

After the Diocese filed for bankruptcy because of liabilities arising from negligence claims asserted by victims of sexual abuse by priests, the Diocese sought coverage under its commercial general liability policies. The court found that the professional service exclusions in the policies did not apply to the sexual abuse claims, stating, "in no world – legal or religious – would raping or sexually battering children be the rendering of professional service." The court also found that causes of action based on negligent supervision did not implicate the exclusions because "supervising an employee or other subordinate is not the rendering of professional services."

Independent Counsel

DePasquale Steel Erectors, Inc. v. Gemini Ins. Co., 249 F. Supp. 3d 899 (N.D. Ill 2017)

The court denied cross-motions for summary judgment, finding that the parties did not provide sufficient facts regarding whether there was a conflict of interest between the insured construction contractor and commercial general liability insurer. The insured argued that a jury demand in excess of the policy limits created a conflict of interest giving rise to the insured's right to independent counsel. The court explained that there is a conflict of interest when the insured's and insurer's interests in the underlying action are in serious conflict and the parties are completely adversarial. The court also noted that a conflict of interest could be found when the insurer has an interest in a less vigorous defense. However, without further facts, the jury demand exceeding the policy limit does not automatically create a conflict of interest.

Mount Vernon Fire Ins. Co. v. VisionAid, Inc., 875 F.3d 716 (1st Cir. 2017)

In a case involving an employment practices liability policy, the First Circuit, interpreting Massachusetts law, affirmed a decision that an embezzlement counterclaim filed by the insured did not create a conflict of interest entitling the insured to separate defense counsel in the underlying action. The court found that the insurer and insured had aligned interests to assert a strong counterclaim to defeat the underlying plaintiff's claims. Although under Massachusetts law defense counsel selected by the insurer owes a duty to both the insurer and insured, the court

determined that the policy's settlement clause, which required the insured's consent to settle, adequately protected the insured's interests. The court also determined that because the insurer did not have an obligation to prosecute an affirmative counterclaim, neither the insurer nor defense counsel selected by the insured would play a role in asserting the counterclaim, and the insured's private attorney could ensure against the "devaluing" of the counterclaim.

OneBeacon Am. Ins. Co. v. Celanese Corp., 84 N.E.3d 867 (Mass. App. Ct. 2017)

The court held that an insurer had a right to control the insured's defense after offering to defend without a reservation of rights and that there was no conflict of interest. The insured raised three arguments alleging that there was a conflict of interest between the insurer and the insured: (1) the insurer made a conditional offer that required the insured to terminate counsel that had been representing the insured for 14 years in similar lawsuits; (2) the insurer demonstrated through a prior jury verdict and trial testimony that it would put its own interests before the insured's interest; and (3) the parties disagreed on the defense strategies of the underlying claims. The court rejected all three arguments and explained that none of the situations created a sufficient conflict of interest to justify the insured's refusal of the insurer's control of the defense. As a result of the insured's unjustified refusal of the insurer's control of the defense, the insurer was not liable for the attorneys' fees incurred in conducting its own defense.

Med-Plus, Inc. v. Am. Cas. Co. of Reading, No. 16-cv-2985, 2017 U.S. Dist. LEXIS 123553 (E.D.N.Y. Aug. 3, 2017)

The court granted the insured's request for declaratory judgment and held that it was entitled to independent counsel because the threat of punitive damages in the underlying action created a conflict of interest. The court rejected the insurer's argument that the mere possibility of punitive damages created only a "hypothetical" conflict of interest and explained that it was illogical to delay appointing independent counsel until after the risk of a conflict of interest fully materialized. The court further reasoned that a conflict of interest could insidiously impact counsel's professional decision making, so the conflict of interest must be addressed prophylactically to avoid a "challenging retrospective analysis of whether a conflict of interest had a material effect on representation." The court limited the insured's right to independent counsel to only the punitive damage claims.

Advancement of Defense Costs

Braden Partners, LP v. Twin City Fire Ins. Co., No. 14-CV-01689-JST, 2017 WL 63019 (N.D. Cal. Jan. 5, 2017)

The insured sought a declaration that its insurer breached the duty of good faith and fair dealing when it refused to advance defense costs under a claims-made-and-reported policy. The insured provided notice of a circumstance in 2012, but was denied coverage under a medical incident exclusion. In 2014, the insured sought declaratory relief and the insurer argued that it had no duty to advance defense costs under California law based on willful acts of the insured. The court agreed with the insured that its insurer was required to advance defense costs pursuant to the claim and rejected the insurer's argument relating to the insured's willful acts. The court reasoned that the insured was not asking for indemnity, but merely for the insurer to honor its separate and distinct obligation to advance defense costs under the policy.

Denver Inv. Advisors LLC v. St. Paul Mercury Ins. Co., No. 17-cv-00362-MEH, 2017 U.S. Dist. LEXIS 114564 (D. Colo. July 24, 2017)

An insured sought a declaration that the insurer was required to advance defense costs under an investment advisor and funds insurance policy in a breach of contract action brought by former

employees. Applying Colorado law, the court concluded that some of the claims asserted against the insured were covered claims under the policy which required the insurer to advance defense costs, and that allocation of amounts the insurer was required to pay under the policy would be a factual determination made at a later date.

Vita Food Prods. v. Navigators Ins. Co., No. 16 C 08210, 2017 U.S. Dist. LEXIS 85257 (N.D. Ill. June 2, 2017)

The court granted the insurer's motion for judgment on the pleadings, concluding that the insurer was not required to advance defense costs under a directors and officers liability policy when former shareholders brought RICO and breach of fiduciary duty claims against the insured. The insured argued the insurer breached its duty to defend and was estopped from refusing to advance defense costs. In ruling for the insurer, the court determined that the plain language of the policy required the insured to pay its own defense costs and that the insurer had no such obligation under the policy.

Freedom Specialty Ins. Co. v. Platinum Mgt. (NY), LLC, No. 652505/2017, 2017 N.Y. Misc. LEXIS 5165 (N.Y. Sup. Ct. Dec. 21, 2017)

An insured sought advancement of defense costs from excess insurers under a directors and officers liability policy after the SEC brought an enforcement action against it. The primary and first-level excess insurers had exhausted their respective policies. The remaining excess insurers sought a declaration that no coverage was owed to the insured under their policies and asked that the policies be declared void for the insured's breach of warranty statements made in the application of coverage and under the prior claim exclusion. The court found that the excess insurers were obligated to advance defense costs under their policies because the exclusionary clauses in directors and officers policies are highly favorable to an insured and the criminal risk faced by the insured outweighed the economic risk faced by the excess insurers.

Allocation

Vita Food Prods., Inc. v. Navigators Ins. Co., No. 16 C 08210, 2017 WL 2404981 (N.D. Ill. Jun. 2, 2017)

In ruling on an insurer's motion for summary judgment concerning coverage for a 2009 lawsuit against the insured's directors by former shareholders, the court held that the insured v. insured exclusion barred coverage for claims brought by two plaintiffs who were formers directors. However, the court ruled that the directors and officers policy's allocation clause would apply to claims that did not fall with within the insured v. insured exclusion, which also barred claims by "security holders." In a separate ruling, the court held that the 2009 lawsuit was a related claim to a 2007 letter concerning the same alleged wrongful acts. The court ruled that whether the remaining underlying plaintiffs (all former shareholders at the time the suit was filed) would qualify as "security holders," whose claims would be barred by the insured v. insured exclusion and not subject to the allocation clause, must be assessed at the time the 2007 letter claim was made.

Jerry's Enters., Inc. v. U.S. Specialty Ins. Co., 845 F.3d 883 (8th Cir. 2017)

In affirming grant of an insurer's motion for summary judgment, the Eighth Circuit, predicting Minnesota law, held that the more specific language in an insured v. insured exclusion barring coverage for all loss associated with a suit where an insured person (here a former company director) was an active participant in the litigation controlled over a more general allocation clause. The allocation clause required the insured and insurer to use their best efforts to determine a fair and proper allocation between covered and uncovered matters. Recognizing the tension between the applicable exclusion and allocation

clauses, the court ruled that the allocation clause did not restore coverage that the insured properly denied under the insured v. insured exclusion. Applying the allocation clause would render exceptions to the exclusion superfluous, and the exclusion was more specific than the general allocation clause.

UnitedHealth Grp., Inc. v. Exec. Risk Specialty Ins. Co., 870 F.3d 856 (8th Cir. 2017)

In affirming the grant of four professional liability excess insurers' motion for partial summary judgment, the court held that, where the insured requested reimbursement for a portion of a $350 million combined settlement of two lawsuits, plus defense costs, it failed to meet its burden of allocating the settlement between the potentially covered claims from the first suit and non-covered claims from the second suit. Predicting Minnesota law, the court held that it was not enough for the insured to show simply that its settlement included a covered claim of an unspecified amount; the insured bore the burden to allocate the settlement between the potentially covered suit and the non-covered suit with enough specificity to permit a reasoned judgment about liability. The court affirmed that the evidence presented by the insured, which included neither contemporaneous evidence of valuation nor expert testimony on relative value, failed to give a jury more than a speculative basis on which to allocate the settlement between the two suits.

Recoupment

Colony Ins. Co. v. Expert Group Int'l Inc., No. 15-02499, 2017 U.S. Dist. LEXIS 75073 (D. Colo. May 17, 2017)

A professional liability insurer could obtain reimbursement of its defense expenses where it had defended an underlying action but the court determined coverage ultimately was not available under the relevant policy.

Holyoke Mut. Ins. Co. v. Vibram USA, Inc., No. SUCV2015-2321, 2017 Mass. Super. LEXIS 12 (Mar. 20, 2017)

The court held that an insurer could not unilaterally reserve its rights to recoup defense expenses if such right was not included in the insurance policy.

Am. Home Assur. Co. v. Port Auth. of N.Y. & N.J., No. 651096/2012, 2017 N.Y. Misc. LEXIS 4589 (N.Y. Sup. Ct. Nov. 28, 2017)

The court held that an insurer could recoup both defense and indemnity payments if a court determines they are uncovered, as long as the insurer has reserved the right to do so, even if the policy does not expressly grant the right of recoupment.

Aldous v. Darwin Nat'l Assur. Co., 851 F.3d 473 (5th Cir. 2017)

Applying Texas law, the Fifth Circuit held that an insurer cannot claim equitable reimbursement of defense costs where a claim is not covered if its policy does not include such a right.

Consent

OneWest Bank, FSB v. Hous. Cas. Co., 676 F. App'x 664 (9th Cir. 2017)

The Ninth Circuit, applying California law, held that a professional liability policy, which provided that "[t]he Insureds shall not admit or assume any liability, enter into any settlement agreement, stipulate to any judgment, or incur any Defense Costs without the prior written consent of the Insurer[,]" precluded coverage for an underlying settlement that was agreed to by the insured bank without the insurer's consent. The court found that the term sheet, which provided all the relevant terms of a settlement agreement, was entered into

before the insured provided notice of the matter to the insurance company.

Abrams v. RSUI Indem. Co., No. 16-cv-4886 (JGK), 2017 U.S. Dist. LEXIS 127227 (S.D.N.Y. Aug. 10, 2017)

Applying Delaware law, the court held that a directors' and officers' liability policy, which provided that "[n]o Insured may incur any Defense Expenses . . . without the Insurer's prior written consent," unambiguously precluded coverage for pre-tender defense expenses. The court held that the provision was enforceable, without regard to prejudice, and barred the reimbursement of over $3.5 million in defense invoices the insured incurred prior to tendering the underlying action to the insurer.

EmbroidMe.com, Inc. v. Travelers Prop. Cas. Co. of Am., 845 F.3d 1099 (11th Cir. 2017)

The Eleventh Circuit, applying Florida law, held that a voluntary payments provision, which provided that "no insured will, except at that insured's own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent[,]" precluded coverage for over $400,000 in defense expenses the insured incurred prior to tendering the underlying matter to the insurer. The court found that the policy language was unambiguous and further found that the insurer was "obviously prejudiced" by the insured's decision to start the defense of the case without notifying the insurer for 18 months.

Ill. Union Ins. Co. v. La. Health Serv. & Indem. Co., 257 F. Supp. 3d 763 (E.D. La. 2017)

The court refused to grant summary judgment on the issue of whether a consent-to-settle provision in a managed care organization errors and omissions policy operated to preclude coverage for an underlying settlement where the insured failed to obtain written consent from the insurer prior to settling. Although the court explained that such consent provisions have been found to be consistent with public policy under Louisiana law, the court found that there were disputes of material fact regarding the reasonableness of the insurer's denial of written consent and whether the insurer had denied coverage for the underlying matter.

J.P. Morgan Sec. Inc. v. Vigilant Ins. Co., 151 A.D.3d 632 (N.Y. App. Div. 2017)

The Second Circuit, applying New York law, found that a consent-to-settle provision did not apply to bar coverage for the insureds' settlements obtained without insurer consent. The court found that the insureds' settlement without consent was justified because of the insurers' unreasonable delay and consistently stated position regarding the unavailability of coverage, which constituted a denial of liability.

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