TROUTMAN SANDERS

D&O and Professional Liability

2016 | A Year In Review

2016 again saw numerous courts address a wide variety of notable directors and officers and professional liability insurance coverage issues. Twenty-nine federal courts of appeals, five state supreme courts, and dozens of other courts applying the law of 36 states issued decisions involving numerous types of insurance policies. We hope you find the following selection of cases helpful, as we focused on issues we believe will be important in the directors and officers and professional liability insurance field for years to come. (Please note the cases below are organized within each topic alphabetically by the state law applied).

In This Issue

Notice

S. Cleaning Service Inc. v. Essex Ins. Co., No. 1140870, 2016 Ala. LEXIS 23 (Feb. 19, 2016)

The court reversed summary judgment granted to the insurer on late notice grounds because a genuine issue of material fact existed as to whether an independent insurance agency had apparent authority to accept notice of claims on behalf of the insurers. Although apparent authority is determined by the acts of the agent and principal, in this case there was substantial evidence that an independent insurance agency had apparent authority to accept notice of claims on behalf of the insurers, because the policy identified the agency and provided no other contact information regarding how to provide notice of claims. Further, the insurers accepted and responded to other notices of claims forwarded to them by the agency.

Med. Depot, Inc. v. RSUI Indem. Co., No. N15C-04-133, 2016 Del. Super. LEXIS 484 (Sept. 29, 2016)

The insurer issued two consecutive policies that provided coverage "only if the Claim for Damages is first made against the Insured and reported to us in writing during the Policy

Period, any subsequent renewal and any applicable discovery period." The policy also required the insured to provide notice of a claim "as soon as practicable" during the policy period. The court held that, although an insurer issuing claims-made policies does not usually have to demonstrate prejudice where notice is given outside the policy period, here, where the notice was not as soon as practicable during the first policy period but was made during the renewal period, the insurer had to demonstrate prejudice in order to disclaim coverage.

Lexington Ins. Co. v. Horace Mann Ins. Co., 186 F. Supp. 3d 920 (N.D. Ill. 2016)

The court issued a directed verdict against an insured, holding that it did not satisfy the notice requirements of its claims-made-and-reported professional liability policy. Although the parties conceded that notice of a potential claim must be in writing, they disagreed about what form the notice of an actual claim must take when the insured previously provided written notice of a potential claim. The insured argued that because it provided written notice of a potential claim, the policy did not require the subsequent notice of an actual claim to be in writing as long as it "promptly reported" the actual claim. The court disagreed because the policy required the insured to give the insurer written notice of "any Claim" and it did not carve out an exception for potential claims that had already been noticed. Even if the insured gave written notice of a potential claim, it still had to provide a second written notice once it knew the potential claim had ripened into a "Claim."

Sentinel Ins. Co., Ltd. v. Cogan, No. 15 C 8612, 2016 U.S. Dist. LEXIS 107761 (N.D. Ill. Aug. 15, 2016)

An insured law firm's eight-month delay in notifying its insurer of a claim against it barred coverage under an occurrence-based commercial general liability policy, even though the insured asserted it was unaware the claim fell within the policy's scope of coverage. The court noted that, because the insured was a law firm, its delay in obtaining an expert or evaluating the policy was unreasonable.

St. Paul Mercury Ins. Co. v. Hershare Fin. Corp., No. 15 C 9676, 2016 U.S. Dist. LEXIS 76289 (N.D. Ill. June 13, 2016)

An insured bank's claims-made liability policy included a notice provision that extended coverage past the policy period if the insured provided written notice of circumstances that could give rise to a claim. Before expiration of the policy, the insured sent a notice of circumstances letter to the insurer, warning that its weak lending controls and regulatory problems could result in future claims by regulators or shareholders. The court held this letter was insufficient notice of creditors' later claims against the insured for misrepresenting its financial stability and failure to timely pay interest.

Levy & Dubovich v. Travelers Cas. & Sur. Co. of Am., No. 2:15-CV-278, 2016 U.S. Dist. LEXIS 42144 (N.D. Ind. Mar. 30, 2016)

The court analyzed whether coverage was afforded under a claims-made professional liability policy that had an Automatic Extended Reporting Period ("AERP"), which meant "the period of time beginning with the effective date [the policy] is cancelled or not renewed" and ending the earlier of "(1) 60 days after such cancellation or nonrenewal takes effect . . . or (2) the date any other policy obtained by the Named Insured that provides similar coverage for Professional Services takes effect." After the insured received notice of non-renewal of the subject policy and purchased a replacement professional liability policy with a different insurer, the insured provided notice of a claim to its former insurer, which was within 60 days after the nonrenewal of the subject policy took effect. The court held that the former insurer properly denied coverage under the subject policy because the claim was not reported during the applicable AERP; the insured provided notice after it had already obtained "similar coverage for Professional Services" with its current insurer. Although only the subsequent policy contained a fee dispute exclusion – which apparently barred coverage for the claim – the court found that both policies provided "similar coverage" for purposes of the AERP because they insured the same pool of risk.

Ashland Hosp. Corp. v. RLI Ins. Co., 632 F. App'x 271 (6th Cir. 2016)

Applying Kentucky law, the Sixth Circuit agreed with the district court's prediction that the Supreme Court of Kentucky would not extend the notice-prejudice rule to a claims-made excess liability policy, which contained unambiguous notice requirements as a condition precedent to coverage. The Sixth Circuit also declined the insured's alternative request to have the question

certified to the Kentucky Supreme Court, because such certification is disfavored when it is sought only after the district court has entered an adverse judgment.

St. Paul Mercury Ins. Co. v. Am. Bank Holdings, Inc., 819 F.3d 728 (4th Cir. 2016)

The Fourth Circuit affirmed a district court's holding that, pursuant to Maryland Insurance Code Section 19-110, an insurer properly denied coverage under a claims-made policy where the insured did not provide notice of an underlying lawsuit until eight months after receipt of the summons and until after default judgment had been entered against it. The insured did not provide notice "as soon as practicable" – as the policy required – and this late notice prejudiced the insurer because it deprived it the opportunity to participate in the selection of defense counsel and to discuss credible defense strategies for dismissing the suit against the insured before the default judgment.

Fund for Animals, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, 226 Md. App. 644 (2016)

Under Maryland Insurance Code Section 19-110, when an insured gives delayed notice of a claim and during the period of delay the insured's defense becomes impaired to the actual prejudice of the insurer, the insurer may disclaim coverage only if there is a causal link between the late notice and the prejudice. The appellate court held that the trial court erred in granting summary judgment to the insurer in connection with denying coverage under a claims-made-and-reported policy as a result of the insured providing notice more than two years after it was filed. There was insufficient evidence to establish as a matter of law that there was a causal link between the late notice and the prejudice.

Food Mkt. Merch., Inc. v. Scottsdale Indem. Co., No. 15-2874 (RHK/FLN), 2016 U.S. Dist. LEXIS 96234 (D. Minn. July 22, 2016)

An insured's claims-made-and-reported business management indemnity policy required it to provide written notice of any claim "as soon as practicable" or within 60 days after the end of the policy period. The insured waited seven months to tender a former employee's breach of contract suit, although notice was given within the policy period. The court held that notice was not given "as soon as practicable" and that the insurer need not show prejudice because the policy explicitly stated that timely notice was "a condition precedent" to coverage.

Templo Fuente De Vida Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, 224 N.J. 189 (2016)

The court held that coverage under a claims-made directors and officers liability policy was precluded where the insured failed to comply with the policy's notice provision, which required, as a condition precedent to coverage, written notice of any Claim "as soon as practicable." The insured's unexplained six-month delay in providing notice did not satisfy this notice requirement and the insurer was permitted to decline coverage without demonstrating appreciable prejudice.

Nelson v. Northland Ins. Co., No. 2:14-cv-00112-RDP, 2016 U.S. Dist. LEXIS 89996 (N.D. Ala. July 12, 2016)

Under New York law, a plaintiff may recover an unsatisfied judgment from an insurer if it reasonably diligently discovers the insurer's identity and expeditiously provides written notice of the claim. The court held that in the case before it, plaintiff counsel's belated telephone call was insufficient to trigger coverage under the insured's claims-made-and-reported errors and omissions policies. There was no evidence of the judgment creditor's written attempt to identify or notify the insurer of his default judgment against the insured.

Wright State Physicians, Inc. v. The Doctors Co., No. 27084, 2016-Ohio-8367, 2016 Ohio App. LEXIS 5183 (Dec. 23, 2016)

Construing a claims-made policy, the court affirmed summary judgment for the insurer where the insured did not give notice of the claim until after the policy expired, despite the insurer having actual notice of the claim prior to the policy's expiration pursuant to a third-party communication. It would be contrary to the intent expressed in the policy's notice provisions (requiring the insured to report and provide details of a claim) to allow an unrelated party that was not acting on behalf of the insured to satisfy the policy's notice requirements.

Thames v. Evanston Ins. Co., Nos. 15-5125, 16-5051, 16-5054, 2016 U.S. App. LEXIS 22176 (10th Cir. Dec. 14, 2016)

Applying Oklahoma law, the Tenth Circuit held that a judgment creditor's garnishment claim against an insurer failed because the insured did not give proper notice to the insurer of the creditor's underlying suit. Notice of a prior temporary restraining order action was inadequate to trigger coverage for the judgment resulting from the later suit.

Wolf v. Liberty Ins. Underwriters, Inc., No. 000066, 2016 Phila. Ct. Com. Pl. LEXIS 359 (Oct. 11, 2016)

A claims-made insurer's coverage obligations were not triggered where the insured did not receive service of a lawsuit against it until after the expiration of the policy and its automatic extended reporting period.

Univ. of Pittsburgh v. Lexington Ins. Co., No. 13-cv-335 (KBF), 2016 U.S. Dist. LEXIS 128947 (S.D.N.Y. Sept. 16, 2016)

Applying Pennsylvania law, the court granted summary judgment to an insurer that issued a claims-made policy, where on the last day of the policy period the insured filed a notice of potential claim which was "plainly deficient on its face." The notice did not, as required, provide any indication of the actual or alleged breach of professional duty, describe the professional services rendered which may result in a claim, or provide a description of the injury or damages that could result. The court emphasized that failure to comply with the reporting provisions of a claims-made policy precludes coverage under Pennsylvania law.

Evanston Ins. Co. v. Cheetah, Inc., No. 7:15-CV-082, 2016 U.S. Dist. LEXIS 114589 (S.D. Tex. Aug. 26, 2016)

An insurer issued six consecutive claims-made-and reported professional liability and general liability policies, which covered claims arising out of specific errors or omissions for which an insured provided written notice during the policy period. The policies effectively excluded coverage for claims arising out of incidents for which an insured had knowledge but failed to provide notice during the policy period. Here, the insured's reporting of an incident to its own insurance agent did not constitute notice to the insurer. The court concluded that the insurer properly declined coverage for the subsequent personal injury lawsuit arising out of the unreported incident.

Century Sur. Co. v. Jim Hipner LLC, 377 P.3d 784 (Wyo. 2016)

The insured failed to give timely notice of an accident under a general commercial liability policy. On certification from the Eighth Circuit, the Supreme Court of Wyoming adopted the notice-prejudice rule, holding that before being entitled to deny coverage based upon untimely notice of an occurrence that triggers coverage, an insurer must be prejudiced, regardless of the express language of the policy. This notice-prejudice rule trumped a policy provision excluding coverage unless the insured notified the insurer "as soon as practicable … whether the insurer is prejudiced or not."

Related Claims

Hanover Ins. Co. v. Vemma Int'l Holdings, Inc., No. CV-16-01071-PHX-JJT, 2016 U.S. Dist. LEXIS 99554 (D. Ariz. July 29, 2016)

An insured individual and an insured entity sought a preliminary injunction requiring their insurer to cover a claim after the insurer denied coverage on the basis that the claim at issue related to claims made in prior policy periods. The court granted the preliminary injunction in favor of the individual because none of the prior claims were made against him individually, but denied the preliminary injunction as to the entity because, based on the record, the court could not determine if the claims were related.

SP Syntax LLC v. Fed. Ins. Co., No. 1 CA-CV 14-0638, 2016 Ariz. App. Unpub. LEXIS 278 (Mar. 3, 2016)

The court affirmed the trial court's decision that an excess insurer was not liable for coverage under two claims-made directors and officers liability policies due to the policies' related claims provisions. The appellate court determined that the allegations in a class action against a corporation's CEO and CFO arose out of the same or similar wrongful acts alleged in a lawsuit by the corporation against certain officers and directors. The assignees of the insureds failed to sufficiently differentiate additional allegations from the underlying litigations; thus, coverage was barred by an

endorsement in the primary carrier's policy, to which the excess policy followed form. The court rejected the insured's argument that the prior or pending litigation exclusion superseded the related claims provision.

Previti v. Nat'l Union Fire Ins. Co., 639 F. App'x 416 (9th Cir. 2016)

In a case involving directors, officers, and private company liability policies, the Ninth Circuit affirmed the California district court's decision to grant partial summary judgment for the insurer because the court's interpretation of "related wrongful acts" encompassed a broad range of acts extending to all underlying actions. During an underlying bankruptcy litigation, the insureds repeatedly conceded that the underlying acts were related.

Liberty Ins. Underwriters, Inc. v. Davies Lemmis Raphaely Law Corp., 162 F. Supp. 3d 1068 (C.D. Cal. 2016)

Interpreting a professional liability policy, the court granted an insurer's motion for summary judgment holding that, although allegations of wrongdoing were filed by different plaintiffs in the underlying litigations, the litigation arose from "a single course of conduct, a unified policy of making . . . misrepresentations to investors to induce them to invest." The court ruled that the allegations in the underlying litigations were sufficiently related and should be considered a single claim for purposes of the policy's per-claim limit.

Citrus Course Homeowner's Ass'n v. Great Am. Ins. Co., No. EDCV 15-2443 JGB (KKx), 2016 U.S. Dist. LEXIS 10199 (C.D. Cal. Jan. 7, 2016)

The court granted an insurer's motion to dismiss because the allegations in an amended complaint did not constitute new claims under a directors and officers liability policy, and thus were deemed made at the time of the original complaint during an earlier policy period. Although the initial complaint was considerably shorter than the amended complaint, both contained allegations regarding the same set of material facts and the amended complaint simply provided further detail and added causes of action which were supported by the same set of operative facts as the initial complaint.

Cove Partners LLC v. XL Specialty Ins. Co., No. CV 15-07635 SJO (GJSx), 2016 U.S. Dist. LEXIS 14772 (C.D. Cal. Feb. 2, 2016)

In a case involving a professional liability policy, the court granted an insurer's motion to dismiss because the insured's claims related back to claims made before the policy period. The interrelated claims provision, which provided that claims arising from the "same Interrelated Wrongful Acts shall be deemed to constitute a single Claim and shall be deemed to have been made at the earliest of the time at which the earliest such claim is made," read in conjunction with a prior litigation exclusion, operated to broadly exempt coverage.

RSUI Indem. Co. v. Atty's Title Ins. Fund Inc., No. 2:13-cv-670-FtM-38CM, 2016 U.S. Dist. LEXIS 97088 (M.D. Fla. June 6, 2016)

The court granted summary judgment in favor of an insurer and against an insured's assignee, various real estate investment companies, reasoning that a related claims condition in the directors and officers liability policy barred coverage. The claims asserted against the insured, a title insurance company, in an underlying litigation shared a factual basis with the counterclaim filed against the insured for slander and tortious interference, which was filed before the policy period's inception. The court rejected the insured's argument that a prior or pending exclusion endorsement modified the related claims provision, noting that "there is no conflict between the Related Claims Condition and the Prior and Pending Litigation Exclusion."

John Marshall Law Sch. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, No. 16 C 5753, 2016 U.S. Dist. LEXIS 178365 (N.D. Ill. Dec. 26, 2016)

In a case involving an employment practices liability policy, the court denied an insurer's motion to dismiss, wherein the insurer argued that the relevant claim was first made when the claimant filed an EEOC charge, as opposed to when a complaint was filed. The court rejected that argument, finding that the charge and the complaint were two separate claims. It also noted that, although the policy contained an exclusion for Related Wrongful Acts alleged or contained in any claim made

under a prior policy period, nothing in the policy required that multiple claims arising from the same facts be considered the same claim.

Williams v. SIF Consultants of La., Inc., No. 16-343, 2016 La. App. LEXIS 2461 (Dec. 29, 2016)

In interpreting an errors and omissions policy, where a claim was made and reported during a more recent policy period, and the insurer argued that there was no coverage because the claim related to an earlier claim first reported under a prior policy, the court affirmed summary judgment against the insurer because the earlier claim would have been excluded under the more recent policy.

Old Bridge Mun. Utils. Auth. v. Westchester Fire Ins. Co., No. 12-6232 (MAS) (TJB), 2016 U.S. Dist. LEXIS 99327 (D. N.J. July 29, 2016)

The court granted an insurer's motion for summary judgment that two lawsuits against the insured made in different years were related claims under a public entity liability policy because they arose out of the insured's alleged failure to honor agreements regarding the provision of utility services.

Fiserv Solutions, Inc. v. Endurance Am. Specialty Ins. Co., Case No. 11-C-0603, 2016 U.S. Dist. LEXIS 136938 (E.D. Wis. Sept. 30, 2016)

In a case involving two towers of professional liability insurance issued for successive years, the insured gave notice of actual and potential claims during the first tower period, and the claim at issue was made during the second tower period. The court, applying New York law, granted summary judgment to the insurers on the first tower because the claimant's eventual claim was different in type from the noticed actual claims and potential claims. The court denied summary judgment to the insurers on the second tower while applying Wisconsin law, holding that the claimant's claim was, as a matter of law, not related to the prior actual claims, but found a jury question as to whether the claimant's claim was related to the prior noticed claims.

Westport Ins. Corp. v. Mylonas, No. 14-5760, 2016 U.S. Dist. LEXIS 114867 (E.D. Pa. Aug. 26, 2016)

The court granted summary judgment for an insurer and rejected the claimant's argument that the aggregate limits of a professional liability policy were triggered, reasoning that even though the claimant argued that the insured attorney committed malpractice in several different ways, ultimately one claimant brought one suit against the insured attorney, and all of the alleged wrongful acts by the attorney were related.

Connect Am. Holdings, LLC v. Arch Ins. Co., 174 F. Supp. 3d 894 (E.D. Pa. 2016)

The court denied an insurer's summary judgment motion, finding that the insured's wrongful conduct in a 2004 cease-and-desist letter alleging trademark violations and unfair competition and a 2009 lawsuit were not "interrelated" to the wrongful acts in a 2013 lawsuit for unfair competition and violations of the Lanham Act. The court determined that the acts alleged in the 2013 lawsuit did not share a sufficient causal link with acts alleged in the 2004 letter or 2009 lawsuit to preclude coverage under the corporate canopy policy.

CAMICO Mut. Ins. Co. v. Jackson CPA Firm, No. 2:15-cv-1823-PMD, 2016 U.S. Dist. LEXIS 177122 (D.S.C. Dec. 22, 2016)

Following a bench trial, the court ruled that malpractice claims made against an accounting firm over a series of years were related under a professional liability policy because the related claims language in the policy only required a "low threshold" of relatedness, and all of the claims ultimately arose out of a disease that affected the accountant's ability to do his work.

Direct Gen. Ins. Co. v. Indian Harbor Ins. Co., No. 15-14887, 2016 U.S. App. LEXIS 17665 (11th Cir. Sept. 29, 2016)

In a case involving an errors and omissions policy decided under Tennessee law, the court affirmed summary judgment for the insurers, finding that a series of claims made over the course of several years against an auto insurer for alleged systematic underpayment of personal injury protection benefits were a single claim, and were not covered under the policies because all of the underlying claims related back to the initial claims, which pre-dated the applicable policy period.

Hanover Ins. Co. v. Clemmons, No. 3:14-cv-288, 2016 U.S. Dist. LEXIS 135966 (M.D. Tenn. Sept. 30, 2016)

In a suit for coverage under an attorney malpractice policy, the court granted summary judgment for an insurer, finding that a claim against an attorney for negligent failure to procure an adequate surety bond was related to a claim against the same attorney for embezzlement from an estate because both flowed out of the nature of the injury inflicted upon the clients.

Sw. Risk, L.P. v. Ironshore Specialty Ins. Co., 188 F. Supp. 3d 621 (S.D. Tex. 2016)

An insured broker selling property insurance had represented to potential insureds that it would cover risks of up to $100 million but only retained coverage for $35 million, and after a hurricane struck, the policies were exhausted, and the realty companies sued the broker in several state courts. In the ensuing coverage action, the court granted the insurer's motion for summary judgment, reasoning that the multiple claims against the insured for misrepresenting the amount of risk covered for property damage "stemmed from related wrongful acts."

Prior Knowledge/Known Loss/ Rescission

Admiral Ins. Co. v. AZ Air Time, LLC, No. 2:15-cv-00245, 2016 WL 7743026 (D. Ariz. Aug. 10, 2016)

The court granted summary judgment for the insurer, finding that it could rescind a professional liability policy issued to an insurance brokerage firm and its two owners because of their failure to disclose prior regulatory actions in their application for coverage. In their application, the insureds falsely represented that they had not been investigated by regulators in the previous five years. In fact, within the previous five years, the firm and owners had faced disciplinary actions following two investigations into potential fraud and embezzlement by the Arizona Department of Insurance. The court held that the insurer was entitled to rescind the policy because the misrepresentations rose to the level of legal fraud, and the relevant question on the policy application was unambiguous.

Kurtz v. Liberty Mut. Ins. Co., No. 14-55931, 2016 U.S. App. LEXIS 16217 (9th Cir. Sept. 1, 2016)

Applying California law, the Ninth Circuit affirmed summary judgment to the insurers and permitted them to rescind a tower of fidelity bond policies because the insured falsely claimed in its insurance applications that proceeds from certain real estate investment transactions were held in bank accounts segregated from operating funds. The question on the application regarding segregated bank accounts was unambiguous, and the insurers established as a matter of law that the insured's response to this question constituted a material misrepresentation entitling the insurers to rescission.

Maxum Indem. Co. v. Nat'l Condo & Apt. Ins. Grp., No. 1:13-cv-00191, 2016 U.S. Dist. LEXIS 155576 (S.D. Ohio Nov. 9, 2016)

Applying California law, the court held that an insurer was not entitled to rescind its errors and omissions policy based on alleged misrepresentations by the insured in its application. The court applied a substantive standard in evaluating the insured's knowledge because the application did not specifically indicate that an objective standard applied and California law requires ambiguities in insurance policies and applications to be construed in favor of coverage.

Goldsmith Seeds v. Great Am. Ins. Co., No. H037791, 2016 Cal. App. Unpub. LEXIS 241 (Jan. 14, 2016)

The appellate court affirmed a trial court's rescission *ab initio* of an excess liability policy due to the policyholder's failure to disclose information on its policy application of a prior pathogenic outbreak.

Known Litig. Holdings, LLC v. Navigators Ins. Co., No. 3:13-cv-269, 2016 U.S. Dist. LEXIS 82675 (D. Conn. June 24, 2016)

The court held that an insurer properly rescinded multiple armored car operators' insurance policies based on the insureds' failure to disclose known losses in their applications, reasoning that "no reasonable jury" could find that the insureds did not knowingly make false representations of material fact regarding their past losses because the evidence was clear that, when the

applications were submitted, the insureds knew they had suffered significant losses due to employee theft.

Diamond State Ins. Co. v. Boys' Home Ass'n, 172 F. Supp. 3d 1326 (M.D. Fla. 2016)

The court held that a prior knowledge exclusion in a professional liability coverage policy did not apply so as to preclude an insurer's duty to defend a foster care licensing agency in an underlying lawsuit alleging professional negligence. The court determined that it was appropriate for it to consider extrinsic evidence relevant to the applicability of the prior knowledge exclusion; however, none of the extrinsic evidence proffered by the insurer unequivocally established that the insured subjectively knew of facts from which a reasonable professional might expect a claim.

ProAssurance Cas. Co. v. Smith, No. 4:15-cv-00051, 2016 U.S. Dist. LEXIS 105033 (S.D. Ga. Aug. 9, 2016)

The court granted summary judgment for an insurer and found it could rescind a professional liability policy issued to a law firm based on a material misrepresentation in the application. In the application, one of two named partners represented on behalf of the firm that there were no circumstances which could rise to a claim. However, that partner was in the process of stealing more than $1 million of his clients' money. The firm and other named partner argued they were entitled to coverage under the policy's "innocent insured" provision because they had no knowledge of the partner's actions or false statements on the application. The court disagreed, finding that rescission of a policy based on a material misrepresentation in the application voids the policy *ab initio*. Because there was never a contract for insurance in the first place, the "innocent insured" provision was inapplicable.

Essex Ins. Co. v. Galilee Med. Ctr. S.C., 815 F.3d 319 (7th Cir. 2016)

An insured health clinic represented in its professional liability policy application that it did not offer weight loss drugs to patients. After a former patient brought suit based on complications from a controversial weight loss treatment, the insurer sought to rescind the policy. Applying Illinois law, the Seventh Circuit affirmed summary judgment in favor of the insurer and held that the omissions in the application were "sufficiently material to warrant rescission." To determine materiality, the court followed Illinois' use of an objective test that asks whether a "reasonably careful and intelligent underwriter would regard the facts as stated to substantially increase the chances of the event insured against, so as to cause a rejection of the application."

Minn. Lawyers Mut. Ins. Co. v. Schulman, No. 3:14-cv-50142, 2016 U.S. Dist. LEXIS 127261 (N.D. Ill. Sept. 19, 2016)

The court granted an insurer's motion for summary judgment to rescind three consecutive claims-made professional liability policies due to material misrepresentations by the patent and trademark attorney applicant. In each renewal application, the insured misrepresented both that he had no knowledge of any circumstances that could result in claims and that he required written client acknowledgment to abandon a patent application. The court noted that Illinois law permits an insurer to rescind a policy for a misrepresentation in the application that materially affects the risk undertaken by the insurer. The court applied an objective test to both the misrepresentation and materiality prongs of the analysis and ultimately determined that the record supported a finding that the insured made material misrepresentations in each renewal application.

Capson Physicians Ins. Co. v. MMIC Ins. Inc., 829 F.3d 951 (8th Cir. 2016)

Applying Iowa law, the Eighth Circuit affirmed rescission of a retroactive professional liability policy due to the insured's failure to notify the insurer of a medical negligence lawsuit filed after the application but before the policy was issued. The court noted that under Iowa law, the insured has a duty to disclose any material information discovered while its request for prior-acts coverage is pending. The court agreed with the lower court's assessment that the post-application lawsuit constituted a significant change that affected the risk that the insurer was offering to underwrite, and rendered part of the application untrue. The court concluded that the insured's nondisclosure of the lawsuit was the equivalent of a false assertion entitling the insurer to rescission.

Everest Nat'l Ins. Co. v. Tri-State Bancshares, Inc., No. 5:15-cv-01491, 2016 U.S. Dist. LEXIS 104534 (W.D. La. Aug. 2, 2016)

An insurer could not rescind a fidelity bond issued to a bank based on material misrepresentations by the bank's vice president in the bond application. To rescind the policy under Louisiana law, an insurer must prove that an insured's material misrepresentations were made with intent to deceive. Though it was undisputed that the defalcating employee lied on the application with the intent to deceive, the bank argued that the employee's knowledge could not be imputed to it under the "adverse interest" exception. The court agreed, holding that an agent's knowledge is not imputed to his principal if the agent is acting adversely to his principal and solely for his own benefit. The court reasoned that the vice president acted adversely to the bank by embezzling funds and made the misrepresentations for his sole benefit.

Thomson v. Hartford Cas. Ins. Co., 656 F. App'x 109 (6th Cir. 2016)

Applying Michigan law, the Sixth Circuit affirmed a lower court's ruling of no coverage under a legal malpractice insurance policy where, years earlier, the attorney-insured "knew or could have foreseen" that the malpractice suit would be filed but had not notified the insurer at that time. The panel dismissed plaintiffs' argument that the attorney could not have foreseen the malpractice suit, noting that "[a]ny reasonable lawyer would have known that [the] course of events bore the seeds of a malpractice claim."

Alterra Excess & Surplus Ins. Co. v. Excel Title Agency, LLC, No. 2:13-cv-11672, 2016 U.S. Dist. LEXIS 150267 (E.D. Mich. Oct. 31, 2016)

The court granted summary judgment for the insurer because the claim at issue was barred by the professional liability policy's known circumstances exclusion. In so holding, the court noted that the applicable standard is whether a reasonable juror could find that a professional in the party's position could have reasonably foreseen a future claim – not whether a reasonable juror could find that the party was subjectively reasonable in claiming that he or she could not have foreseen a future claim. Because the known circumstances exclusion was dispositive, the court did not address the insurer's prior and pending litigation and rescission arguments.

Imperium Ins. Co. v. Shelton & Assocs. P.A., No. 1:14-cv-00084, 2016 U.S. Dist. LEXIS 134566 (N.D. Miss. Sept. 29, 2016)

The court granted summary judgment for the insurer and held that it was entitled to void and rescind a professional liability policy based on material misrepresentations by the insured attorney and law firm in their application. The court noted that its analysis did not turn on whether the insureds subjectively knew that a specific malpractice action was going to be filed. Rather, the inquiry is whether they subjectively knew of any legal work or incidents that might objectively reasonably be expected to lead to a claim or suit. The court found that the record established that the insureds did make a misrepresentation in the application by giving incomplete and/or misleading answers, and that said misrepresentation was material.

United Nat'l Ins. Co. v. Program Risk Mgmt., No. 1:13-cv-00741, 2016 U.S. Dist. LEXIS 42898 (N.D.N.Y. Mar. 31, 2016)

An insurer sought to rescind three professional liability policies due to the insured's misrepresentation and concealment of material facts in its applications for coverage. The court denied the insurer's motion for summary judgment because the record was insufficient for the issue of materiality to be decided as a matter of law. The court noted that cases in which courts have found materiality as a matter of law have generally involved such extraordinary facts that only one conclusion could possibly be reached by a rational jury. Here, the changing statutory and regulatory landscape surrounding the insured's business created a question of fact of whether the insured's misrepresentation was material, thereby precluding summary judgment.

Univ. of Pittsburgh v. Lexington Ins. Co., No. 1:13-cv-00335, 2016 U.S. Dist. LEXIS 170285 (S.D.N.Y. Dec. 8, 2016)

The court granted summary judgment in favor of the insurer, finding that any reasonable juror would conclude that a principal of the insured had a reasonable

expectation of liability prior to policy inception, and as a result the prior knowledge exclusion applied. The court noted that the phrase "reasonably be expected" was unambiguous and meant that a claim will be excluded if it was reasonably foreseeable under the facts known to the insured (or its principal) before commencement of the subject policy period.

Cont'l Cas. Co. v. Marshall Granger & Co., LLP, No. 7:11-cv-03979, ECF No. 192 (S.D.N.Y. June 8, 2016)

The court permitted an insurer to rescind a professional liability policy in its entirety, including as to any "innocent insureds," due to significant misrepresentations in the accounting firm's application. The insurer did not waive its rights to pursue rescission by (1) issuing two administrative endorsements that changed the name of the insured, paying defense costs or sending a notice of non-renewal that offered extended reporting period coverage; or (2) by failing to promptly assert rescission after it learned of sufficient facts to justify rescission.

Evanston Ins. Co. v. Agape Senior Primary Care, Inc., 636 F. App'x 871 (4th Cir. 2016)

Applying South Carolina law, the Fourth Circuit upheld the lower court's refusal to completely void a professional liability policy after it was discovered that a doctor added to the policy was posing as a physician under a stolen identity. Citing principles of law and equity, the court concluded that the policy did not cover the imposter but remained effective as to the innocent co-insured parties – here, the company itself and its legitimate practitioners. The court cited three factors that weighed in favor of maintaining coverage for the innocent co-insureds: 1) the insurer, as the drafter of the policy, could have included forfeiture language in the policy to address fraudulent misrepresentations by one applicant, 2) neither the company nor any of its employees had any knowledge of the fraud and 3) public interest would not be served by rescission where the fraudulent actions of one insured cannot deprive the other innocent insureds of the benefits of their respective contracts.

CAMICO Mut. Ins. Co. v. Jackson CPA Firm, No. 2:15-cv-01823, 2016 U.S. Dist. LEXIS 177122 (D.S.C. Dec. 22, 2016)

Following a bench trial, the court held that claims against the defendant-accountant firm and its accountants were subject to the professional liability insurance policy's known-claims reduced coverage limit. The court found that the claims at issue arose from one accountant's negligent handling of various tax matters due to limitations he was experiencing as a result of a disease-induced impairment. Because that accountant and others in the firm were aware of these errors in late 2010, but did not report the problem to the insurer until September 2011, the claims were subject to the known-claims endorsement's reduced coverage limit of $100,000.

OneBeacon Ins. Co. v. T. Wade Welch & Assocs., 841 F.3d 669 (5th Cir. 2016)

Applying Texas law, the Fifth Circuit affirmed the lower court's ruling against the insurer as to its motion for judgment as a matter of law based on the professional liability policy's prior knowledge exclusion. On appeal, the insurer argued that the district court incorrectly concluded that the prior-knowledge exclusion, if applied as written, would render the policy's retroactive coverage illusory. The Fifth Circuit disagreed and found that it could not apply the literal policy language because of the extreme overbreadth of the wrongful act definition used in the exclusion, which defined a wrongful act to include every single thing an attorney does or does not do, wrongful or not. As written, the court found that the insurer's interpretation of the exclusion rendered coverage illusory. The court further found that the most logical interpretation of the exclusion in the context of the policy was whether the insured was aware of a wrongful act reasonably likely to lead to a malpractice claim.

Prior Acts/Prior Notice/Prior & Pending Litigation

Cove Partners, LLC v. XL Specialty Ins. Co., No. CV 15-07635 (C.D. Cal. Feb. 2, 2016)

Granting an insurer's motion to dismiss without leave to amend, the court held that underlying claims all involved the same allegations as earlier claims that were pending before the management liability policy incepted or the policy's prior and pending litigation date. The court gave no weight to the insured's assertion that he advised the insurer prior to the issuance of the policy that if such claim arose, the insured would expect the policy to respond, because the clear terms of the policy precluded coverage.

Maxum Indem. Co. v. Sullivan Vineyards Corp., No. 16-cv-03611, 2016 U.S. Dist. LEXIS 164505 (N.D. Cal. Nov. 7, 2016), *adopted by* 2016 U.S. Dist. LEXIS 164506 (N.D. Cal. Nov. 29, 2016)

The court granted a default judgment to the insurer because the insurer introduced facts demonstrating that the underlying claim arose from litigation preceding the policy's effective date.

Alterra Excess & Surplus Ins. Co. v. Excel Title Agency, LLC, No. 2:13-cv-11672, 2016 U.S. Dist. LEXIS 150267 (E.D. Mich. Oct. 31, 2016)

The court granted an insurer's motion for summary judgment, finding that a claims-made policy's "Known Circumstances" exclusion was clear and unambiguous, and applied even when construed strictly and narrowly. The court found the insured knew or reasonably could have foreseen the potential for a claim after three other similar lawsuits had been made against it prior to the start of the policy period and the insured's client clearly stated a desire to proceed with an action against the insured for a professional service performed.

Weaver v. Axis Surplus Ins. Co., 639 F. App'x 764 (2d Cir. 2016)

Applying New York law, the Second Circuit held that a directors and officers liability policy excluded coverage for any claim involving "any demand, suit or other proceeding pending" against the insured prior to the policy period. The court concluded that a letter from the Securities Division of the Maryland Attorney General's Office received by the insured prior to the policy period constituted a "demand" within the exclusion because it notified the insured of legal consequences in the event of the insured's noncompliance with its requests.

Univ. of Pittsburgh v. Lexington Ins. Co., No. 13-cv-335 (KBF), 2016 U.S. Dist. LEXIS 170285 (S.D.N.Y. Dec. 8, 2016)

An insured architect tendered a potential claim related to construction delays to its professional liability insurer. The court upheld the insurer's denial based on the "prior notice" provision, which excluded coverage if, prior to the policy period, the insured had "knowledge of any act, error, omission, situation or event that could reasonably be expected to result in a Claim." The court found that prior to the policy period, the insured believed that a claim related to the foundation system design and construction delays was "inevitable." Because the insured was eventually sued for foundation system design and construction delays, the court held that there was no coverage due to the "prior notice" provision.

Minn. Lawyers Mut. Ins. Co. v. Protostorm, LLC, No. 1:15-cv-1485, 2016 U.S. Dist. LEXIS 81888 (E.D. Va. June 22, 2016)

The court granted summary judgment in favor of the insurer, finding the insurer was only obligated to provide $5 million in coverage, rather than $10 million. The insurer issued an errors and omissions professional liability policy to a law firm that provided $10 million in limits for claims arising from acts, errors or omission that occurred after a certain date and $5 million for claims arising before that date. The underlying claim arose from the insured's failure to protect a client's ability to preserve a patent. Construing the elements of the underlying action, the court ruled that all of the elements necessary for the accrual of the malpractice cause of action were present well before the policy's cutoff. The court rejected the insured's argument that the claim was dependent on a post-cutoff act to toll the statute of limitations based on the continuation of the attorney-client relationship. Following Virginia Supreme Court precedent, the court held that acts tolling the statute of limitations do not extend the time out of which a claim arises. The court also rejected the insured's theory that legal malpractice occurred after the cut off by the insured's failure to keep its client informed of the patent application process.

Design Basics LLC v. Fox Cities Constr. Corp., No. 13-C-548, 2016 U.S. Dist. LEXIS 35085 (E.D. Wis. Feb. 9, 2016)

The court held that the known loss doctrine prevented an insured from obtaining coverage under a commercial general liability policy after a copyright owner sent a prior cease and desist letter to the insured. Even though advertising injury coverage was triggered, the court found the insured knew about potential liability or loss already occurring before purchasing the policy, in part by receiving the cease and desist letter. The court rejected the concept that the known loss doctrine only applies in cases where there is knowledge of actual versus potential liability, holding that an insured's knowledge

of potential liability connotes knowledge of a risk to be insured against and is sufficient to warrant application of the known loss doctrine.

Fiserv Solutions, Inc. v. Endurance Am. Specialty Ins. Co., No. 11-C-0603, 2016 U.S. Dist. LEXIS 136938 (E.D. Wis. Sept. 30, 2016)

The insured, a financial services company, sued several of its insurers for coverage under various claims-made policies for a number of claims arising out of the insured's loan-closing-related services, which it provided to financial institutions. The court denied the insurers' motions for summary judgment based on the prior notice exclusion and same claim provision, finding that, although the same services were involved in notices tendered prior to the policies' inception, the later claims were sufficiently different from earlier noticed claims. Similarly, the court rejected the insurers' argument that certain of the later filed lawsuits involved the same or substantially the same facts as the earlier filed suits under the prior and pending litigation exclusion. The court found that a question of fact remained as to whether the insured reasonably could have foreseen that such Wrongful Act would result in a claim under the prior knowledge exclusion.

Dishonesty & Personal Profit Exclusions

Office Depot Inc. v. AIG Specialty Ins. Co., No. 2:15-cv-02416, 2016 WL 6106408 (C.D. Cal. July 6, 2016)

The court held that an insured's liability under the California False Claims Act was uninsurable as a matter of law under Section 533 of the California Insurance Code, which provides that "an insurer is not liable for a loss caused by the willful act of the insured." The Court reasoned that a False Claims Act violation necessarily requires the intent to induce reliance, so Section 533 necessarily precluded coverage.

Health Net v. Am. Int'l Specialty Lines Ins. Co., No. B262716, 2016 Cal. App. Unpub. LEXIS 7296 (Oct. 6, 2016)

The court held that a RICO claim is not necessarily excluded by Section 533 of the California Insurance Code or a policy provision barring coverage for claims "arising out of any Wrongful Action committed with the knowledge that it was a Wrongful Act" because RICO liability for mail fraud can be predicated on *reckless* misstatements that do not rise to Section 533 or the professional liability policies' exclusion for knowingly committing Wrongful Acts.

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.

Arch Ins. Co. v. Murdock, No. N16C-01-104 EMD CCLD, 2016 Del. Super. LEXIS 645 (Dec. 21, 2016)

The court held that a directors and officers policy did not bar coverage for an insured's alleged fraudulent acts, even though there was a memorandum opinion finding the insured liable, because the opinion was not a final and appealable judgment. The "final judgment" against the insured was in connection with a settlement and did not make findings regarding fraudulent acts by the insured.

Johnson v. Federated Rural Elec. Ins. Exch., No. CV 13-18-BU-DLC, 2016 U.S. Dist. LEXIS 173037 (D. Mont. Dec. 14, 2016)

The court held that an insurer did not have to advance defense costs under a directors and officers policy for a conversion claim because of a personal profit exclusion. However, the court held the insurer must continue to advance defense costs for the other actions against the director because they were not "in connection with" or "inextricably related to" the conversion claim.

Allied World Nat'l Assur. Co. v. Great Divide Ins. Co., 140 A.D.3d 103 (N.Y. App. Div. 2016)

Applying Ohio law, the court held that an insurer had no duty to defend its insured against an underlying arbitration because the arbitration demand specifically alleged that the insured acted "knowingly and intentionally" and, therefore, the commercial general liability policy's exclusion for personal and advertising injury "arising out of oral or written publication of material, if done by or at the direction of the insured with knowledge of its falsity" barred coverage.

Hanover Ins. Co. v. Clemmons, No. 3:14-cv-288, 2016 U.S. Dist. LEXIS 135966 (M.D. Tenn. Sept. 30, 2016)

The court held that an attorney who had taken client funds was not entitled to coverage under a professional liability policy for claims alleging professional negligence, because the "negligence" claims arose out of the same conduct that gave rise to the claims for breach of fiduciary duty, misappropriation and conversion of funds. Those claims were not covered due to a provision barring coverage unless the insured at the inception date "had no knowledge of facts which could have reasonably caused [him] to foresee a claim, or any knowledge of the claim, prior to the effective date of the policy." Because the attorney did not dispute he had stolen client funds, he could have reasonably foreseen that claims for conversation and misappropriation would be asserted against him.

Restitution, Disgorgement & Damages

Phila. Indemn. Ins. Co. v. First Multiple Listing Servs., Inc., 173 F. Supp. 3d 1314 (N.D. Ga. 2016)

The insured, a company providing real estate listing services for the benefit of licensed real estate professionals, was named as a defendant in an underlying class action seeking recovery of "hidden settlement fees" and "kickbacks." In the ensuing coverage action, the insurer argued that these amounts constituted restitution that was not covered by the directors and officers liability policy. The court disagreed, holding that the "hidden settlement fees" and "kickbacks" did not constitute restitution because the underlying plaintiffs did not pay any of the fees at issue directly to the insured. Accordingly, the amounts sought constituted damages owed as reimbursement, not uninsurable restitution.

Ill. Munic. League Risk Mgmt. Ass'n v. City of Genoa, 51 N.E.3d 1133 (Ill. Ct. App. 2016)

In the underlying action, the Illinois Regional Transportation Authority ("RTA") sought compensation from the City of Genoa for sales tax revenue that RTA allegedly was precluded from collecting from an oil company because of an agreement between Genoa and the oil company. In the subsequent coverage litigation, the insurer argued that it had no duty to defend Genoa in connection with the underlying action because the RTA was seeking uninsurable restitution or disgorgement. Reversing the trial court's grant of judgment on the pleadings to the insurer, the appellate court held that RTA was not seeking restitution or disgorgement, but instead compensation from the City for additional taxes RTA claimed should have been collected on the oil company's sales but were not.

TIAA-Creff Indiv. & Inst. Servs., LLC v. Ill. Nat'l Ins. Co., No. N14-C-05-178 JRJ CCLD, 2016 Del. Super. LEXIS 545 (Oct. 20, 2016)

Construing two towers of professional liability policies under New York law, the court held that amounts TIAA-CREF paid to settle three underlying class action lawsuits did not represent uninsurable disgorgement, where the suits alleged that TIAA-CREF failed to pay out investment gains to clients earned during a processing delay period. The court distinguished several decisions where New York courts had ruled that amounts paid to settle regulatory enforcement actions by the Securities and Exchange Commission represented uninsurable disgorgement. The court noted that in this matter, unlike the other cases it discussed, TIAA-CREF settled and expressly denied any liability. As a result, the court found no conclusive link between the settlements of the underlying class actions and wrongdoing by TIAA-CREF that would render the settlement uninsurable disgorgement.

PNC Fin. Servs. Grp., Inc. v. Houston Cas. Co., 647 F. App'x 112 (3d Cir. 2016)

Applying Pennsylvania law, the Third Circuit held that a bank's $102 million payment to settle lawsuits alleging improper collection of overdraft protection fees did not constitute covered "Damages" under the bank's

professional liability insurance policies because the payment fell within an exception to the general definition of "Damages" for "fees, commissions, or charges for 'Professional Services' paid or payable to an 'Insured.'"

Darwin Nat'l Assur. Co. v. Luzerne Cnty. Transp. Auth., No. 3:14-2417, 2016 U.S. Dist. LEXIS 41733 (M.D. Pa. Mar. 30, 2016)

The court held that restitution arising out of criminal acts is uninsurable and to allow such coverage "would effectively permit the purchase of a 'freedom of misconduct' that is inconsistent with the purpose of restitution, which is to impress upon the offender the gravity of his action."

Insured Capacity

Feldman v. Fid. & Deposit Co. of Md., No. 0102, 2016 Md. App. LEXIS 733 (Mar. 7, 2016)

An insurer denied coverage for a bank officer who was the subject of an investigation by a regulatory agency, where it was later discovered that the investigation related to the officer's conduct in another company that he was involved in. The court agreed that because the claim against the officer was not brought solely by reason of his status as a director of the insured, the policy did not provide coverage.

Todd v. Vt. Mut. Ins. Co., 137 A.3d 1115 (N.H. 2016)

In a case involving an employment practices liability and non-profit directors' and officer's policy, the court affirmed summary judgment for the insurer, holding that it did not have a duty to defend where an underlying complaint alleged that an insured individual, whom the court assumed to be an employee and officer of the insured entity, "hacked" a computer and committed an assault, determining that such alleged conduct was not performed in the individual's capacity as an employee or officer of the organization because the alleged conduct was not within the scope of his duties as an employee, or his responsibilities as an officer.

Law Offices of Zachary R. Greenhill, P.C. v. Liberty Ins. Underwriters, No. 650414/2014, 2016 N.Y. Misc. LEXIS 147 (Sup. Ct., NY Cnty., Jan. 7, 2016)

The court ruled on summary judgment that an insurer had no duty to defend under a lawyer's professional liability policy due to a capacity exclusion because the relevant counterclaims arose out of the insured's actions as an officer, director and/or manager of an entity other than the named insured.

Nat'l Union Fire Ins. Co. of Pittsburgh, PA v. Thornsbury, No. 2:14-cv-30098, 2016 U.S. Dist. LEXIS 83482 (S.D. W.Va. June 28, 2016)

In a declaratory judgment action involving a general liability policy issued to a state government, the court granted summary judgment to the insurer where a state court judge who was sued in his capacity as an individual sought coverage, because the court determined that the policy would only provide coverage where the judge was sued in his official capacity.

Insured v. Insured Exclusion

AMERCO v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, 651 F. App'x 649 (9th Cir. 2016)

Applying Arizona law, the Ninth Circuit affirmed the lower court's holding that an insured v. insured exclusion barred coverage for a suit against an insured because one of the five underlying plaintiffs was also a "named insured" under the directors' and officers' policy. The insured did not meet its burden of proving that an exception to the exclusion for suits "instigated and continued totally independent of" any insured applied.

St. Paul Mercury Ins. Co. v. FDIC, No. 14-56830, 2016 U.S. App. LEXIS 18811 (9th Cir. 2016)

Applying California law, the Ninth Circuit affirmed the lower court's holding that the insured v. insured exclusion did not apply because it was ambiguous as to whether the exclusion applied to the FDIC's suit against the defunct insured's former directors and officers. The court reasoned that it was not clear whether the suit by the FDIC was "on behalf of" the now defunct-insured bank within the meaning of the exclusion. Furthermore, the exclusion did not expressly refer to suits by the FDIC as "receiver."

FDIC v. BancInsure, Inc., No. 14-56132, 2017 U.S. App. LEXIS 452 (9th Cir. 2017)

Where a directors' and officers' liability policy excluded losses arising from "legal actions brought by, or on behalf of, or at the behest of" the insured or insured person, or "any successor, trustee, assignee or receiver" of the insured, the court applied California law and held that

the exclusion "unambiguously" barred coverage for a suit brought by the FDIC as receiver for the insured bank.

Durant v. James, 189 So. 3d 993 (Fla. 1st DCA 2016)

An insurer was not liable to cover a judgment a corporation's director obtained against the CEO due to the policy's insured v. insured exclusion. That the claim was brought in the director's personal capacity had no bearing on the exclusion's application. The exception to the exclusion for claims arising out of employment with the corporation did not apply because a Florida statute provided that a director is not an employee of a corporation, and there was no evidence that the director accepted any duties beyond those required of a director.

Indian Harbor Ins. v. Zucker, 553 B.R. 633 (W.D. Mich. 2016)

An insurer sought a declaratory judgment that two directors' and officers' liability policies issued to a bank did not cover a lawsuit filed against three of the bank's officers for alleged breaches of fiduciary duties. At issue was whether the insured v. insured exclusion applied where the insured bank became bankrupt and suit was brought against the directors by a post-bankruptcy liquidation trust. Recognizing a split in case law regarding the application the exclusion to post-bankruptcy insured entities, the court held that the exclusion applied and agreed with the insurer's argument that the post-bankruptcy entity and the insured were effectively the same. Primarily, the court reasoned that the causes of action belonging to a post-bankruptcy trustee are nonetheless asserted "in the name of" the insured company.

Jerry's Enters v. U.S. Specialty Ins. Co., No. 15-3324, 2017 U.S. App. LEXIS 475 (8th Cir. 2017)

Applying Minnesota law, the Eighth Circuit affirmed the lower court's holding that there was no coverage under an insured v. insured exclusion for a suit by a former director of the insured. The court reasoned that the application of the "unambiguous" exclusion in the case was "straightforward," noting that a "past director" was expressly included within the policy's definition of "insured person."

Boro Park Land Co., LLC v. Princeton Excess Surplus Lines Ins. Co., 140 A.D.3d 909 (N.Y. App. Div. June 15, 2016)

An insured v. insured exclusion in a senior living professional liability, general liability and employee benefits liability policy did not apply to a suit against the insured by an employee of the insured. The employee of the insured slipped and fell when arriving for work and brought suit against the insured based on a negligent failure to maintain the premises. The appellate court affirmed the lower court's denial of the insurer's motion for summary judgment because it was not clear whether the employee was an "insured" under the applicable definition in the policy, which the court determined was ambiguous.

Church Mut. Ins. Co. v. Ma'Afu, 657 F. App'x 747 (10th Cir. 2016)

Applying Utah law, the Tenth Circuit held that a directors' and officers' liability policy did not exclude coverage for a suit brought by an entity that was formerly the named insured, but had validly changed its name. In holding that the insured v. insured exclusion did not apply, the court reasoned that it was "impossible" to tell whether the newly named entity was "affiliated" with the former named insured entity, which the court considered to be a precondition to being a "named insured" under the policy.

Contractual Liability

Educ. Impact v. Travelers Prop. Cas. Co. of Am., No. 15-cv-04510-EMC, 2016 U.S. Dist. LEXIS 55653 (N.D. Cal. Apr. 26, 2016)

The claimant contracted with an author to develop a video-based online professional development program. The author then entered into a contract with the insured, the claimant's competitor. The claimant sued the insured for tortious interference with contract. The insured's errors and omissions liability coverage excluded claims for "breach of contract, representation, warranty or guarantee." The court held that the exclusion did not apply because the insured was not alleged to have breached the contract; rather, the author allegedly breached the claimant's contract. The court explained that the exclusion was not broad enough to apply to

claims based on a breach of contract where the insured was not alleged to have committed the breach.

Ironshore Specialty Ins. Co. v. 23andMe, Inc., No. 14-cv-03286-BLF, 2016 U.S. Dist. LEXIS 96079 (N.D. Cal. July 22, 2016)

The insured offered its customers a DNA testing service that provided information regarding ancestry and genetic health risks. The customers sued, claiming that the health information was false and misleading, had not been approved by the FDA, and had been disclosed to pharmaceutical companies without authorization. The insured's professional liability policy excluded coverage for claims, "based upon, arising out of, directly or indirectly resulting from or in any way involving… Your assumption of liability or obligations in a contract or agreement." The insurer contended that the exclusion precluded coverage because the claims arose out of the insured's contracts with its clients. The court disagreed and held that the use of the phrase "assumption of liability" in the context of a contractual liability exclusion meant the exclusion only applied to those contracts where the insured assumed the liability of another.

Health Net v. Am. Int'l Specialty Lines Ins. Co., No. B262716, 2016 Cal. App. Unpub. LEXIS 7296 (Oct. 6, 2016)

The insured administered employee-sponsored health plans under ERISA. The claimants sued the insured alleging that it improperly denied their claims for health insurance benefits. The insurers contended there was no coverage under the insured's professional liability policies because all of the damages sought were contractual benefits owed under the health insurance plan. The court rejected that argument and held there was a potential for coverage because extra-contractual damages could be recovered under ERISA.

Town of Monroe v. Discover Prop. & Cas. Ins. Co., 169 Conn. App. 644 (2016)

The insured and claimant entered into a contract to develop and implement a wireless communications tower. The claimant sued the insured alleging breach of contract, promissory estoppel, and negligent misrepresentation. The insured's errors and omissions policy excluded coverage for claims arising out of a breach of contract, unless the insured would be liable absent the contract. The court held the exclusion did not eliminate the duty to defend because the allegations of the complaint left open the possibility that a negligent misrepresentation count did not arise out of the contract.

Payroll Mgmt. v. Lexington Ins. Co., 815 F.3d 1293 (11th Cir. 2016)

The insured employer contracted with the claimant to provide health insurance coverage to its employees. The claimant cancelled coverage after the insured failed to pay premiums for five months. The claimant sued to recover the unpaid premiums, and the insured tendered the lawsuit under its professional and employer's practices liability policy. The insurer denied coverage based on a policy exclusion for claims "arising out of liability the Insured assumed under any contract or agreement." Applying Florida law, the Eleventh Circuit held this exclusion was unambiguous and the failure to pay premiums owed under a contract for health insurance coverage fell "squarely" within the exclusion because the lawsuit was a "run-of-the-mill breach-of-contract claim."

Hartford Cas. Ins. Co. v. Karlin, Fleisher & Falkenberg, LLC, 822 F.3d 358 (7th Cir. 2016)

An insured law firm sought coverage under the "employee benefits liability provision" of its business owners policy for a former employee's claim for unused vacation and sick time upon his retirement from the firm. The insurer denied coverage because the claim was not the result of a negligent act, error or omission in the administration of the employee benefits program and the policy excluded coverage for claims for failure to pay employee benefits. Applying Illinois law, the court held that the denial was proper because (1) the claim was essentially a breach of contract for failure to pay compensation owed, (2) the alleged violation of Illinois' wage statutes were based on the same breach of contract and (3) the claim did not result from a negligent act, error or omission in the administration of the employee benefits program.

Altom Transp., Inc. v. Westchester Fire Ins. Co., 823 F.3d 416 (7th Cir. 2016)

The insured transport company hired the claimant as an independent contractor. The claimant sued after the insured terminated the contract, alleging that the insured (1) breached their contract by failing to pay required compensation, (2) violated Department of

Transportation regulations and (3) was unjustly enriched by the underpayment. The insured's professional liability policy excluded coverage for claims "alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of or in any way involving the actual or alleged breach of any contract or agreement; except and to the extent the Company would have been liable in the absence of such contract or agreement." The insured argued that the allegations fell within the exception to the exclusion because the complaint alleged that the insured had liability separate and apart from the contract for violating Department of Transportation regulations. Applying Illinois law, the Seventh Circuit affirmed the ruling that the exclusion applied because all of the claims for relief were premised on the contract. The court reasoned that "no matter what the legal theory may be," the claims against the insured "rest[ed] fundamentally" on the insured's contract with the claimant.

Winbrook Commc'n Servs., Inc. v. U.S. Liab. Ins. Co., 52 N.E.3d 195 (Mass. App. Ct. 2016)

The claimant sued the insured alleging it made negligent misrepresentations about its financial condition which induced the claimant to continue working on a children's storybook series. The insurer denied coverage under the insured's directors and officers liability policy on grounds that the claimant sought recovery of contractual debts, which were not "wrongful acts" under the policy. The court rejected the insurer's argument, reasoning that the policy's definition of "wrongful act" expressly included negligent misrepresentation and that the "policy contained no general exclusion for damages for a wrongful act — such as misrepresentation — simply because those damages also might be similar or equivalent to contract damages."

Allied World Nat'l Assur. Co. v. Great Divide Ins. Co., 32 N.Y.S.3d 72 (Sup. Ct. App. Div. 2016)

The insured entered into a licensing agreement with the claimant, who subsequently served the insured with a demand for arbitration, alleging claims for breach of contract and tortious interference with contract. The insured tendered the demand for coverage under a general liability insurance policy. The insurer denied coverage on the basis of an exclusion for claims "arising out of breach of contract." Applying Ohio law, the court affirmed that the exclusion applied because, when "viewed in its entirety," all of the claims for relief arose out of the insured's alleged breach of the licensing agreement.

X2 Biosystems, Inc. v. Fed. Ins. Co., 656 F. App'x 864 (9th Cir. 2016)

The claimant entered into a technology licensing agreement with the insured, which terminated the agreement after the claimant paid the insured $2 million in advance royalties. The claimant then sued the insured, alleging breach of the agreement and conversion. The insured's professional liability policy excluded claims "based upon, arising from or in consequence of any actual or alleged liability of an Insured Organization under any written or oral contract or agreement, provided that this [exclusion] shall not apply to the extent that an Insured Organization would have been liable in the absence of the contract or agreement." Applying Washington law, the Ninth Circuit affirmed the district court's dismissal of the complaint based upon the breach of contract exclusion, reasoning that the claims alleged against the insured were not independent of the contract. Specifically, the claimant alleged that the insured had a contractual duty to disclose its intent to terminate the agreement and that the insured wrongfully received and retained the advanced royalty payments under the contract.

Professional Services

Hotchalk, Inc. v. Scottsdale Ins. Co., No. C 16-3883 CW, 2016 U.S. Dist. LEXIS 163046 (N.D. Cal. Nov. 15, 2016)

An insured was sued under the False Claims Act alleging that it falsely claimed that it complied with Title IV of the Higher Education Act of 1965, which prohibits institutions receiving federal grants from paying employees charged with admissions or financial aid "any commission, bonus or other incentive payment." The insured submitted the claim under its business and management indemnity policy which provided directors and officers coverage. The insurer denied the claim based on a professional services exclusion arguing that the underlying suit arose out of the insured's alleged practice of compensating its employees based on their success in securing enrollments. The insured argued that its employee compensation system was an internal aspect of its business and was not related to its

professional services. The court held that the exclusion applied, finding that the incentive-based compensation system was only improper because of the type of professional services the insured provided.

Sentinel Ins. Co. v. Cogan, No. 15 C 8612, 2016 U.S. Dist. LEXIS 107761 (N.D. Ill. Aug. 15, 2016)

An insured law firm was sued for defamation based on an email that a lawyer sent to a law clerk alleging that another law firm had engaged in serious ethical and professional misconduct. The insured submitted the claim to its commercial general liability carrier which denied based on a "professional services exclusion" which applied to any "personal and advertising injury" arising out of the rendering or failure to render professional services as a lawyer. The court held that although reporting suspected attorney misconduct is a professional duty, it does not involve service "to another." Further, the court found that "service to the profession is not the same as professional service" and therefore the professional services exclusion did not apply.

Edwards v. Cont'l Cas. Co., 841 F.3d 360 (5th Cir. 2016)

An attorney represented an employee in a personal injury suit against his employer which resulted in a multi-million dollar settlement. Subsequent to the settlement, the employer sued the attorney and the employee alleging that it was fraudulently induced to settle because the employee exaggerated the extent of his injuries. The attorney submitted the fraudulent inducement claim to his professional liability carrier which denied coverage. The Fifth Circuit, applying Louisiana law, held that the insurer had no duty to defend because the attorney was only added as a defendant because of his receipt of settlement funds for his representation of the employee. Accordingly, the professional liability policy did not afford coverage, because the fraudulent inducement claim did not arise out of an act or omission relating to the attorney's legal services.

Beazley Ins. Co. v. Ace Am. Am. Ins. Co., No. 15-cv-5119 (JSR), 2016 U.S. Dist. LEXIS 90332 (S.D.N.Y. July 12, 2016)

The court applied a professional services exclusion in a directors and officers policy to bar coverage for a class action lawsuit brought against NASDAQ for its alleged mishandling of an initial public offering. Because the design and operation of NASDAQ's trading platforms required the "special acumen and training of professionals," and the failure of NASDAQ's system during the initial public offering caused damages to the class, the professional services exclusion barred coverage.

PNC Fin. Servs. Grp., Inc. v. Hous. Cas. Co., 647 F. App'x 112 (3d Cir. 2016)

The Third Circuit, applying Pennsylvania law, applied a "professional services charge exception" to the definition of "damages" to exclude coverage for a $102 million settlement payment made by the insured bank. The settlement payment resolved several class action lawsuits relating to improper overdraft fees charged to the bank's customers. The definition of "damages" did not include "fees, commissions or charges for Professional Services." Accordingly, the Third Circuit determined that the entire $102 million settlement, including the $30 million awarded to class counsel as attorneys' fees, was not covered because the charges did not constitute "damages" under the professional services charge exception.

Independent Counsel

Hollyway Cleaners & Laundry Co. v. Ctr. Nat'l Ins. Co. of Omaha, Inc., No. 2:13-cv-07497-ODW(E), 2016 U.S. Dist. LEXIS 155003 (C.D. Cal. Nov. 7, 2016)

The court held the insured was not entitled to independent counsel because there was nothing to suggest that appointed counsel could or would manipulate the defense of the underlying action to result in a finding that the insured's acts were intentional.

St. Paul Mercury Ins. Co. v. McMillin Homes Constr., Inc., No. 15cv1548 JM(BLM), 2016 U.S. Dist. LEXIS 134972 (S.D. Cal. Sept. 29, 2016)

The court held the insured was not entitled to independent counsel, rejecting the insured's argument that the insurer's five-to-seven-week investigation mandated the appointment of independent counsel, and finding that the insured could only point to theoretical conflicts.

Brooks Kushman P.C. v. Cont'l Cas. Co., No. 15-12351, 2016 U.S. Dist. LEXIS 135311 (E.D. Mich. Sept. 30, 2016)

Applying California law, the court held independent counsel retained to represent an insured had no standing to bring a direct action against the insurer for portions of fees the insurer refused to pay.

DHR Int'l, Inc. v. Travelers Cas. & Sur. Co. of Am., No. 15 C 4880, 2016 U.S. Dist. LEXIS 17719 (N.D. Ill. Feb. 12, 2016)

The court held the insured was not entitled to independent counsel because the insurer's interest in negating coverage alone is not sufficient to create a conflict of interest that would trigger the right to independent counsel.

Gen. Ins. Co. of Am. v. Walter E. Campbell Co., No. 12-3307-WMN, 2016 U.S. Dist. LEXIS 62842 (D. Md. May 12, 2016)

The court held that an insured could not retain a conflicted independent counsel – which also represented the insured in the instant coverage action – in underlying actions against it, because there was a risk that the insured's choice could steer the defense in a manner that could render the underlying claims as covered. The court explained that, so long as the conflicted independent counsel represented the insured, the insurers had no defense or indemnity obligations.

Mid-Century Ins. Co. v. Windfall, Inc., No. CV 15-146-M-DLC, 2016 U.S. Dist. LEXIS 67482 (D. Mont. May 23, 2016)

The court held because there were no inconsistent positions between multiple insureds in connection with the underlying claim, the insurer was not required to provide independent counsel.

Siltronic Corp. v. Emp'rs Ins. Co. of Wausau, 176 F. Supp. 3d 1033 (D. Or. 2016)

The court held an insurer was required to provide independent counsel to assist appointed counsel at the request of the insured. The court rejected the insurer's argument that the insured waived any conflict of interest between the insurer and insured by consenting to appointed counsel's continued representation in light of the insured's insistence that the insurer retain both appointed counsel and the insured's independent counsel.

Allstate Cnty. Mut. Ins. Co. v. Wootton, 494 S.W.3d 825 (Tex. App. 2016)

The court rejected the insured's argument that a potential conflict of interest between an insurer and its insured triggered the right to independent counsel, holding that the insured was not entitled to independent counsel.

Advancement of Defense Costs

Hanover Ins. Co. v. Vemma Int'l Holdings, No. CV-16-01071-PHX-JJT, 2016 U.S. Dist. LEXIS 99554 (D. Ariz. July 29, 2016)

The court granted the insured's preliminary injunction that its directors' and officers' liability insurer must pay defense costs in a suit brought against it by the Federal Trade Commission in part because the failure to pay such costs constituted "irreparable injury" to the insured. The court agreed with other federal district courts in holding that the insurer's refusal to advance defense costs is an immediate and direct injury to the insured, and such injury is comprised of more than money damages. Furthermore, the court held that granting the injunction mandating advancement of defense costs furthered the public interest in holding an insurer to the terms of an insurance policy.

Everest Nat'l Ins. Co. v. Santa Cruz Cty. Bank, No. 15-cv-02085-BLF (HRL), 2016 U.S. Dist. LEXIS 149975 (N.D. Cal. Oct. 28, 2016)

The court rejected the insurer's argument that loss reserve information is "irrelevant" and not discoverable where there was no duty to defend but instead merely a duty to advance defense costs. Such information is discoverable where the insured had alleged that the failure to advance defense costs was in bad faith because whether the insurer kept loss reserve information was probative of whether it thought it had any potential liability, and more importantly, whether its initial assessment of the claim was in good faith.

Braden Partners, LP v. Twin City Fire Ins. Co., No. 14-cv-01689-JST, 2016 U.S. Dist. LEXIS 180958 (N.D. Cal. Jan. 5, 2017)

The court granted the insured's motion for summary judgment that its general liability policy required the insurer to advance defense costs. The court reasoned that the insurer's duty to advance defense costs was clear and not negated by California Insurance Code Section 533's prohibition against insurance coverage for willful acts. Section 533, the court reasoned, only prohibited indemnification of willful acts and "does not allow an insurer to evade a 'specific and distinct commitment' under the policy where the insured has a reasonable expectation regarding that commitment." Here, the promise to advance defense costs was a "specific and distinct" promise and thus not subject Section 533's prohibition. Secondarily, the court held that the duty to advance defense costs extended to all "potentially covered" claims.

Johnson v. Federated Rural Elec. Ins. Exch., No. CV-13-18-BU-DLC, 2016 U.S. Dist. LEXIS 173037 (D. Mont. Dec. 14, 2016)

Where a directors' and officers' liability policy did not contain a duty-to-defend clause, the court granted partial summary judgment for the insurer and looked at the plain meaning of the policy and the definition of "Loss" for its defense duties. The court found that the policy specifically included "defense costs, charges and expenses incurred in the defense of actions, suits or proceedings" resulting in a duty to advance defense costs at the time they were incurred by the insured. Although the court ultimately found that the specific costs were excluded based on the personal profit exclusion in connection with the underlying conversion claim, the court held that the duty to advance defense costs for covered claims as they are incurred remained for the insurer until specifically excluded from coverage.

Petroterminal de Pan., S.A. v. Hous. Cas. Co., 659 F. App'x 46 (2d Cir. 2016)

Applying New York law, the Second Circuit affirmed a grant of summary judgment directing an insured to pay back $2 million in defense costs to its insurers after winning a suit that was triggered by an oil spill, but which involved losses that were excluded from coverage under the primary marine liability and excess bumbershoot policies. Though neither insurance policy contained a "duty to defend," both policies provided for indemnification of defense costs, and also contained potentially applicable exclusions. The insurers agreed to an advancement of defense costs, subject to an agreement that the insured would repay the amounts if it were unsuccessful in any later coverage action, per New York law. Because the eventual resolution of the underlying case did not create an obligation for the insurers to pay for the defense under the policies, the court found that the insured had to repay the insurers for advanced defense costs.

Allocation

Hanover Ins. Co. v. Vemma Int'l Holdings, No. CV-16-01071-PHX-JJT, 2016 U.S. Dist. LEXIS 99554 (D. Ariz. July 29, 2016)

The insurer argued that an allocation provision in a directors' and officers' liability policy that required it to pay 100 percent of defense costs was inapplicable because the claims for which the insured sought coverage were related to a claim made in an earlier time period and thus not covered under the policy. The court disagreed with the insurer's interpretation of the policy's related claims provision and entered a preliminary injunction requiring the insurer to cover all of the insured's defense costs.

SavaSeniorCare, LLC v. Beazley Ins. Co., No. 1:14-CV-2738-RWS, 2016 U.S. Dist. LEXIS 111101 (N.D. Ga. July 14, 2016)

The court was tasked with resolving competing motions for judgment on the pleadings regarding the interpretation of an allocation provision in an excess directors' and officers' liability policy. The insurer argued it had no obligation to pay for the defense of claims brought against two former officers of the insured because they were not sued in their official capacity as officers. In denying the excess insurer's motion, the court found the two individuals were sued in their official capacity as officers of the insured and, as a result, the defense cost allocation provision required the insurer to pay 100 percent of the defense costs incurred by the insured for the claims.

Hous. Auth. of New Orleans v. Landmark Ins. Co., No. 15-1080, 2016 U.S. Dist. LEXIS 24419 (E.D. La. Feb. 29, 2016)

In a coverage action involving a directors' and officers' liability policy, the court held the policy's allocation

provision was unambiguous and not void as against Louisiana public policy. The court first explained directors and officers policies frequently include allocation provisions, and the insured should not have expected the policy to afford a broad defense like a general liability policy. It further concluded the policy's language was not ambiguous and was easily reconciled with the policy's duty-to-defend provision. The court rejected the public policy argument because other jurisdictions have upheld similar allocation provisions and the Louisiana Department of Insurance had approved directors and officers policies with allocation provisions.

United Nat'l Ins. Co. v. Indian Harbor Ins. Co., 160 F. Supp. 3d 828 (E.D. Pa. 2016)

The court upheld an insurer's right under an errors and omissions policy to allocate settlements between covered and non-covered amounts and affirmed the insurer's allocation of two settlements made by the insured. In granting summary judgment in favor of the insurer, the court specifically found the allocation provision was unambiguous and Pennsylvania law required the insured to prove what portion of each settlement was covered under the policy.

Recoupment

Atty's Liab. Prot. Soc'y, Inc. v. Ingaldson Fitzgerald, PC, 838 F.3d 976 (9th Cir. 2016)

Interpreting Alaska and federal law as applied to malpractice insurance, the court held that an Alaska statute barring insurers from obtaining reimbursement of uncovered defense costs was preempted by federal law and thus invalid.

Columbia Cas. Co. v. Abdou, No. 15cv80-LAB (KSC), 2016 U.S. Dist. LEXIS 110900 (S.D. Cal. Aug. 18, 2016)

The court held that a professional liability insurer was entitled to reimbursement of defense costs expended to defend uncovered claims because it reserved the right to seek such reimbursement.

Ga. Interlocal Risk Mgmt. Agency v. City of Sandy Springs, 788 S.E.2d 74 (Ga. Ct. App. 2016)

The court held that although the U.S. District Court for the District of Georgia had predicted that Georgia courts would follow the majority rule that, where no contractual provision exists, an insurer's right to recoup defense costs still exists where the insurer timely and explicitly reserves the right to do, no Georgia court had so held, and – regardless – the insurer did not timely reserve the right to do so.

Johnson v. Federated Rural Elec. Ins. Exch., No. CV-13-18-BU-DLC, 2016 U.S. Dist. LEXIS 173037 (D. Mont. Dec. 14, 2016)

The court held that an insurer can recoup defense costs only if it reserves the right to do so in its first reservation of rights letter and only if uncovered costs are distinguishable from covered costs.

Consent

One W. Bank FSB v. Hous. Cas. Co., No. 15-55579 (9th Cir. Jan. 19, 2017)

The Ninth Circuit affirmed a California court's grant of summary judgment to the insurer and enforced a voluntary payments/consent provision of a professional liability policy. The court found that the insurer properly denied coverage for a settlement entered into by the insured without the insurer's prior knowledge or consent. The insured initially sought to tender the suit but addressed its notice to the wrong individual, resulting in a claim not being opened by the insurer. The insured then executed a settlement term sheet without the knowledge or consent of the insurer, and for which the insurer subsequently denied coverage. The court rejected the insured's argument that the insurer's delay in acknowledging the claim or reserving rights excused it from obtaining the insurer's consent prior to settling the claim and rejected the argument that the insurer was estopped from relying on the policy's consent provision because it had not called the provision to the attention of the insured before the insured agreed to the settlement. The court found the policy's consent provision unambiguous, that the term sheet provided the relevant terms of a settlement agreement and that, under California law, the insured breached the insurance policy by failing to request or obtain the insurer's written consent before executing the term sheet. As such, the insurer had no coverage obligation for the settlement and no exception applied.

Corthera, Inc. v. Scottsdale Ins. Co., No. 14-cv-05014-EMC, 2016 U.S. Dist. LEXIS 8388 (N.D. Cal. Jan. 22, 2016)

The court held that a no voluntary payment provision precluded coverage for defense expenses voluntarily incurred by an insured pursuant to its agreement to indemnify its directors and officers prior to providing notice to the insurer of its indemnity obligation. The insured asserted that the insurer's prior reservation of rights letter accepting coverage for the matter and consenting to counsel for some of the defendants entitled the remaining director, who was conflicted from original counsel, to a separate counsel of his choosing. When the insurer disagreed, the insured initiated coverage litigation. The court enforced the voluntary payments provision as to defense expenses incurred voluntarily by the insured prior to providing the insurer notice of the additional director's claim, and choice of counsel, without the insurer's consent. The court cited the importance of providing notice to the insurer and providing an opportunity to consent or refuse coverage. The court also found that it could not grant complete summary judgment as to all claims under the provision because there still was a question of fact as to whether the insurer unreasonably withheld consent after receiving notice at a later date.

Travelers Prop. Cas. Co. of Am. v. Stresscon Corp., 370 P.3d 140 (Colo. 2016)

The Supreme Court of Colorado held that where the insured voluntarily settled and paid the third-party claim without the insurer's consent, the insurer did not have to indemnify or reimburse the insured for those payments, even in the absence of prejudice. The court held that its adoption of a notice-prejudice rule in a prior case involving untimely notice did not overrule any existing "no voluntary payments" or consent provisions jurisprudence in Colorado.

Sidman v. Travelers Cas. & Sur., 841 F.3d 1197 (11th Cir. 2016)

The Eleventh Circuit, applying Florida law, held that an insurer's breach of the duty to defend did not render it liable for a consent judgment where the insured did not consider the reasonableness of the settlement amount. The insured entered into a consent judgment with the claimant after the insurer denied coverage for the claim. In subsequent proceedings the court determined that the insurer breached its duty to defend and indemnify the insured in connection with the claim, but the court in a bench trial ruled that the insurer was not bound by the settlement because the settlement was neither reasonable in amount nor negotiated in good faith. The appeals court affirmed and noted that an insurer that breaches its duty to defend is liable for a settlement entered into by its insured unless the agreement is obtained through fraud or collusion. The court also ruled that the evidence supported the trial court's finding that the insured agreed to settle the claim for any amount in exchange for the claimant's agreement not to execute the judgment against it, showing sufficient evidence to find the settlement agreement was negotiated in bad faith, and eliminating the need to consider whether the settlement was a reasonable amount.

Lexington Ins. Co. v. Horace Mann Ins. Co., 186 F. Supp. 3d 920 (N.D. Ill. 2016)

The court found that due to lack of proper notice, an errors and omissions liability insurer had no duty to indemnify its insured's $7 million settlement payment stemming from a bad faith claim in an underlying lawsuit. The court determined that the insured did not provide timely notice of its claim under the policy, which required notice of potential and actual claims as well as a provision that the insured could not enter into any settlement agreement without written consent by the insurer. According to the court, even if the insured previously gave written notice of a potential claim, the policy required it to provide a second written notice once it knew that the potential claim had ripened into a claim. Consequently, the court held that because the insured settled its case with the claimant before it provided the insurer with written, contractually compliant notice or consent, the insurer had no duty to indemnify the insured.

Stryker Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, 842 F.3d 422 (6th Cir. 2016)

Applying Michigan law, the Sixth Circuit found that an excess liability policy that required the written consent of the insurer in order for a settlement by the insured to constitute a covered loss was not latently

ambiguous. The insured argued that the insurer waived its ability to assert the consent-to-settle provision because the language was ambiguous and the insurer's claim handlers did not establish that they believed consent was required for settlements below the excess policy layer. However, the court found that, under the provision, consent by the insurer was required for any settlements that were presented for payment and that the direct settlements did not constitute ultimate net loss. Additionally, the court rejected the insured's argument that the insurer violated the covenant of good faith and fair dealing by refusing to consent to the settlements after the fact because that reasoning contravened the purpose of the consent-to-settle provision – which is to give an insurer the prospective opportunity for input.

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