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2025
Professional Liability Year In Review

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Introduction

The past year once again saw a breadth of court decisions addressing a wide variety of professional liability insurance coverage issues. At various levels, state and federal courts across the country issued notable decisions in this arena. We focused on topics we believe will continue to be important in the directors and officers and professional liability insurance fields, and we hope you find the following case selections to be informative and helpful.

Please note: Cases are organized within each topic alphabetically by the state law applied.

I. Notice

***Evanston Ins. Co. v. Frederick*, No. 8:23-cv-00882-FWS-KES, 2025 U.S. Dist. LEXIS 142026, 2025 WL 2019379 (C.D. Cal. June 12, 2025)**

Under California law, the U.S. District Court for the Central District of California held that certain insured physicians were not entitled to coverage for a lawsuit alleging wrongful termination because they did not comply with the policy's reporting requirements. The insurer issued a claims-made For Profit Management Liability Policy for the August 29, 2018 to August 29, 2019 policy period, which provided, in relevant part, that "[a]s a condition precedent to their rights under such Coverage Part, the Insureds shall give to the Insurer written notice of any Claim made against the Insureds as soon as practicable after an Executive Officer or an employee of the Company's office of general counsel, risk management or functionally equivalent departments … first learns of such Claim, but in no event later than: (i) ninety (90) days after expiration of the Policy Period; or (ii) the expiration of the Extended Reporting Period, if exercised." The insurer argued, and the court agreed, that it was entitled to summary judgment because the "only notice of [the third party's] claims to [the insurer] was on behalf of [the insured company], and that entity alone." The court was unconvinced by the insured persons' argument that, because the insured company had provided notice, the insurer was on "constructive notice of the claim." The court reasoned that each insured was required to comply with the policy's reporting requirements because the policy "plainly provides that each Insured must provide written notice of the Claim as a condition precedent to coverage." The court held that "the [insured persons] failed to comply with the Policy's reporting requirements[,]" and to hold otherwise "would impermissibly rewrite the Policy and alter the coverage for which the parties bargained."

***Starstone Spec. Ins. Co. v. Avenior Senior Living, LLC*, No. 2:24-cv-06768-FLA (BFMx), 2025 U.S. Dist. LEXIS 231423, 2025 WL 3248686 (C.D. Cal. Oct. 24, 2025)**

Under California law, the U.S. District Court for the Central District of California held that an insured's counterclaim for breach of contract was subject to dismissal because the insured had failed to provide notice within the timeframe provided for in the policy. The insurer issued a claims-made Healthcare Liability Follow Form Excess Insurance Policy for the September 29, 2021 to September 29, 2022 policy period to its insured, a senior living facility company. The policy's reporting and notice provisions stated, in relevant part, that, "[a]s a condition precedent to the obligations of the Insurer under this Policy the Insureds shall give written notice to the Insurer … as soon as practicable of any occurrence, offense, Claim or suit reasonably expected to involve this Policy; but … when the Followed Policy provides coverage on a claims-made basis, in the event of any Claim [involving unexpected death, infectious disease, or other specified injuries], notice must be provided as soon as practicable; but in no event later than 30 days after the end of the Policy Period." The insured was served with the complaint in the underlying action, which involved allegations of elder abuse and negligent care and treatment of a decedent, on or around August 12, 2022, but the insured did not provide notice to the insurer until January 26, 2023 (i.e., after the end of the policy period). The insured argued that it provided constructive notice prior to the end of the policy period because its brokers had allegedly submitted a loss run as part of the renewal process to the insurer's underwriters that included information regarding the underlying claim. The court, however, held that such constructive notice was insufficient under California law, noting that California courts have "consistently rejected this type of loss run notice argument, stating such 'notice' does not satisfy the condition where it defies the express requirements of the policy." The court found that the insured's loss run was insufficient to establish actual or constructive notice to the insurer.

***Scott v. Certain Underwriters at Lloyd's*, No. 24-12441, 2025 U.S. App. LEXIS 21679, 2025 WL 2443382 (11th Cir. Aug. 25, 2025)**

Under Florida law, the U.S. Court of Appeals for the Eleventh Circuit affirmed the district court's ruling that the insured, a former CEO of an insured company, failed to provide notice of a claim or a notice of circumstances for a future claim. The insurer issued a claims-made-and-reported Professional Liability, Directors & Officer's Liability and Fiduciary Liability Insurance policy to the insured, a financial holdings company. The former CEO of the insured was terminated from that role following a failed attempt to purchase the majority interest held by a controlling shareholder of the insured. The former CEO received several letters from the insured company that accused him of misconduct and demanded the return of company property, but the former CEO did not receive a summons, subpoena, or formal arbitration demand from the insured company during the policy period. The former CEO submitted a letter to the insurer shortly after his termination entitled "Notice of Claim," which enclosed the letters from the insured company. The former CEO then sued the insured company for wrongful termination and the insurer for coverage. The district court dismissed the coverage claim and the Eleventh Circuit affirmed, reasoning that the "letters cited by [the former CEO] do not contain a demand for relief against him" but rather, explained why, in the insured company's view, "[the former CEO] was terminated and request that he preserve documents and return company equipment." These letters, the court held, did not constitute a claim because they did not request "monetary payment or legal remedies" and instead asserted "a cause for [the former CEO]'s termination and outline expectations for his post-employment conduct." Further, because the former CEO, upon his termination, was "not one of the specified officers who could provide a notice of circumstances under the policy when he sent his November letter," his November 13 letter could not be considered a notice of circumstances under the policy. Accordingly, the court held that the "district court correctly rejected [the former CEO's] arguments that his documents reflected a 'claim,' or, in the alternative, a 'notice of circumstances' for a future claim."

***Sterling Seacrest Pritchard, Inc. v. Holderfiled*, 923 S.E.2d 63, 69 (Ga. Ct. App. 2025), reconsideration denied (Nov. 18, 2025)**

Under Georgia law, the Court of Appeals of Georgia held that the insureds were not entitled to coverage because they did not satisfy the specific notice requirements required under a claims-made policy. The insurer issued a medical professional liability policy that covered "liability for only those claims that are first reported in writing to the [insurer] while the policy is in force." The policy also required each named insured to submit his or her own claim report for each claim, defined as the insured's written communication received at the insurer's offices that notifies the insurer of "(1) [the insured's] receipt of a Claim; or (2) [the insured's] awareness of a Probable Claim Event and for which you provide all of the information described" in a policy provision setting forth the insured's duties in the event of a Claim or Probable Claim Event. An insured doctor submitted a claim report attaching medical records with references to two other insured doctors' names and acts. The other doctors referenced in the attached reports had also been sued for medical malpractice. Because the subject line, email body, and incident date only discussed the submitting doctor, the court determined that the claim report did not satisfy the notice requirement as to the other two doctors who failed to submit their own claim reports. The court also noted that the medical records attached to the claim report were insufficient to satisfy the notice requirement under the policy as the claim report failed to name the two doctors and report their conduct. Because the claim report did not satisfy the notice requirement, the insurer owed no duty to cover the two doctors who did not submit claim reports.

***Berkley Ins. Co. v. Caraway*, No. 24-cv-256-DWD, 2025 U.S. Dist. LEXIS 232077, 2025 WL 3280220 (S.D. Ill. Nov. 25, 2025)**

Under Illinois law, the U.S. District Court for the Southern District of Illinois held that an insurer was entitled to deny coverage because the claim was not reported within the policy period. The insurer issued a claims-made-and-reported lawyers professional liability policy to its insured, a law firm, for the policy period of June 1, 2022 to May 1, 2023. The policy included automatic and optional 60-day Extended Reporting Periods, defined as "the period of time after the end of the Policy Period for reporting Claims that are first made against the Insured during the applicable Extended Reporting Period by reason of an act or omission that occurred prior to the end of the Policy Period and is otherwise covered by this Policy." The insured was served with the underlying lawsuit on February 11, 2023 (i.e., during the policy period), but the insured did not report the claim to the insurer until July 20, 2023 (i.e., after the policy period expired, but during the Extended Reporting Period). The insured argued that because it reported the underlying lawsuit within the Extended Reporting Period it had purchased, its notice was timely. The court disagreed, noting that the policy's Extended Reporting Periods applied only to claims first made against the insured after the Policy Period ends. The court concluded that the Extended Reporting Periods "do not extend the reporting deadline for claims already made before the Policy expired; they solely create a limited grace period for newly arising claims." The court held that "[b]ecause the Underlying Lawsuit was first made against [the insured] while the Policy was still in force, the Extended Reporting Periods provide no additional reporting window." Further, the court rejected the insured's argument that the notice-prejudice rule applied, noting that "[i]t is well established that, with respect to claims-made policies, timely reporting within the policy period … is a condition precedent to coverage, and the insurer need not prove that it was prejudiced by untimely notice."

***Katherine Shaw Bethea Hosp. v. Nautilus Ins. Co.*, 2025 IL App (1st) 231084-U, No. 1-23-1084, 2025 Ill. App. Unpub. LEXIS 121, 2025 WL 290203 (Ill. App. Ct. Jan. 24, 2025)**

Under Illinois law, the Appellate Court of Illinois held that the circuit court properly entered summary judgment in favor of an insurer because the insured reported the claims to the insurer outside of the contractually mandated reporting period. The insurer issued a claims-made-and-reported Healthcare Professional Liability Policy providing coverage "only if: … [a] 'claim' or 'suit' with respect to the 'medical professional injury' is first made against the insured and reported to us in writing, in accordance with [the Policy's notice provisions], during the policy period or an extended reporting period we provide with accordance with [Extended Reporting Period provisions]." The policy also included a notice condition that required notice

"as soon as practicable"; however, that notice condition was replaced by a self-insured retention endorsement providing, in pertinent part, that "[t]he Insured must notify the Company in writing upon exhaustion of 25% of the self-insured retention, either by payments or reserves, or a 'claim' in which we are named as a defendant." There was no dispute that the insured did not report either of two underlying lawsuits within the policy period or any extended reporting period. Accordingly, the court reasoned that the only way the insured might be entitled to coverage would be if the policy's self-insured retention endorsement altered the policy to eliminate the policy's reporting requirements. Despite the fact that the endorsement replaced the section of the policy requiring notice "as soon as practicable" as a condition precedent to coverage, the court held that the endorsement did nothing to alter the fundamental "claims made and reported" language in the insuring agreement. The court held that the insured's failure to report the claim within 30 days of the policy's expiration entitled the insurer to deny coverage.

Ottawa Bancshares, Inc. v. Great Am. Sec. Ins. Co., 764 F. Supp. 3d 1079 (D. Kan. 2025)

Under Kansas law, the U.S. District Court for the District of Kansas held that the delay by the insured to provide notice to the insurer of a consultant's demand for payment failed to satisfy the notice obligations under the policy, but the court declined to grant summary judgment because the insurer had not shown that it was prejudiced by the delay. The insurer issued a claims-made directors and officers liability policy for the policy period of September 26, 2021 to September 26, 2024 to its insured, a bank holding company. The policy provided, among other things, that "[t]he Insured, as a condition precedent to any rights under this Policy, shall give the Insurer written notice, as soon as practicable, of any Claim first made and brought to the attention of an Executive Officer during the Policy Period or the Extended Reporting Period ..." The policy was amended by endorsement to provide that notice could not be made in any event later than "ninety" or "one hundred and eighty" days after the end of the policy period "depending on the circumstances." In or around February 2022, the insured received a demand letter from a former consultant. The consultant and the insured mediated their dispute unsuccessfully, and the consultant sued the insured on March 24, 2023. The insured then provided notice of that lawsuit to the insurer on April 3, 2023. The insurer denied the insured's claim for coverage due to the thirteen-month delay between the initial demand letter and when the insured provided notice. The court, after noting that the insurer bears the burden to show that an insured's notice was not made as soon as practicable, found that burden was met here, because under Kansas law's objective standard, thirteen months was not as soon as practicable, and the insured failed to provide a reasonable explanation for the delay. However, because the insured still provided notice within the policy period, the court reasoned that the notice-prejudice rule applied. The court found that the insurer had not carried its burden on summary judgment that it was prejudiced by the insured's delay

Jeffery v. Med. Prot. Co., No. 24-5724, 2025 U.S. App. LEXIS 4793, 2025 WL 655543 (6th Cir. Feb. 28, 2025)

Under Kentucky law, the U.S. Court of Appeals for the Sixth Circuit affirmed the U.S. District Court for the Eastern District of Kentucky's ruling that the insured failed to provide the required information about a potential claim against him before his policy expired. The insurer issued a claims-made-and-reported professional liability policy to the insured, a periodontist, and the policy provided that the insurers "shall have no duty to defend or pay damages ... on a claim unless it was reported to [the insurer] during the terms of this policy or thirty (30) days thereafter ... [or] on a potential claim unless it was reported to [the insurer] during the term of this policy and the report includes all reasonably obtainable information, including the time, place and circumstances of the incident; the nature and extent of the patient's injuries; and the names and addresses of the patient and any available witnesses." The insured verbally reported a potential claim to the insurer prior to the expiration of the policy, but did not provide "specifics about the treatment" during their phone calls. The court compared the information available to the insured and the information the insured reported to the insurer and found that the insured did not notify the insurer of the known information. The court held that because the insured "did not provide the 'specifics' of what he knew about [the underlying] case to [the insurer] ..., he failed to provide all reasonably obtainable information before [the]

coverage period expired." Thus, the "condition precedent to [the insurer]'s duty to indemnify … did not occur."

***Jewish Fed'n of Greater Wash., Inc. v. Cincinnati Ins. Co.*, No. DKC 23-1816, 2025 U.S. Dist. LEXIS 58066, 2025 WL 948154 (D. Md. Mar. 28, 2025) and 2025 U.S. Dist. LEXIS 58066, 2025 WL 3496190 (D. Md. Dec. 5, 2025)**

Under Maryland law, the U.S. District Court for the District of Maryland held that an insured's notice to the insurer after the policy period expired was not timely as a matter of law. The insurer issued a claims-made liability policy with multiple coverage parts, including Nonprofit Organization Directors and Officers Liability Coverage, for the policy period of August 15, 2017 to August 15, 2020 to its insured, a nonprofit charitable organization. The policy provided that, "[i]f prior to the end of the policy period of the applicable Coverage Part, any of the insureds first become aware of a specific wrongful act they believe is likely to give rise to a claim, and if any of the insureds give us written notice as soon as practicable, but prior to the end of the policy period of the applicable Coverage Part, of … [t]he specific wrongful act; … [t]he injury or damage which has or may result therefrom; and … the circumstances by which the insureds first became aware thereof … then any claim subsequently made arising out of such wrongful act shall be deemed to have been made when notice of the wrongful act was first given." The policy also provided for a 90-day automatic extended reporting period, and thus, there were "two avenues for making a timely claim for events occurring during the policy period for which a claim is asserted later: providing notice of the wrongful act during the policy period or reporting a claim during an extended reporting period." During the policy period, on August 12, 2020, the insured reported to the insurer that it had fallen victim to a fraudulent wire transfer scheme. On September 29, 2020, after the policy expired, the insured was sued in connection with a data breach. The insured argued that the August 12, 2020 notice of wire fraud satisfied the reporting requirement for the later data breach lawsuit. The court disagreed and noted that the August 12 email notice did not specify whether there were any claims being made against the insured or whether the insured had committed any wrongful acts. The court found that the notice did not indicate how the wire transfers would likely give rise to a claim and, therefore, was not sufficient notice. After further briefing on the policy's extended reporting period, the court found that the policy's extended reporting period did not apply because the policy had been replaced by the insurer and, therefore, granted summary judgment for the insurer.

***Capitol Spec. Ins. Corp. v. Steadfast Ins. Co.*, No. 24-2314, 2025 U.S. App. LEXIS 9017, 2025 WL 1121660 (9th Cir. Apr. 16, 2025)**

Under Nevada law, the U.S. Court of Appeals for the Ninth Circuit held that the district court correctly granted summary judgment to the insurer because the insured failed to give timely notice. The insurer issued a claims-made contractor's professional liability policy that provided: "[w]ritten notice must be provided to [the insurer] no later than 60 days after the expiration or termination of the policy." The insured requested that its broker provide notice to the insurer of the claim against it during the policy period, but the broker did not do so. The insured argued that because the claim involved similar issues as a different project, claims arising out of both projects should be deemed related and notice for the different project should satisfy the policy's notice requirements. The insured contended on appeal that notice should have been considered timely because it had provided timely notice of a claim for the different project. The court noted that the policy provisions relied on by the insured only related to the limits of liability of the policy, not the notice requirement, and separate notice was required. The court held that because notice was not provided within the timeframe required by the policy the insurer was entitled to deny coverage, and the court affirmed summary judgment for the insurer.

***ESSA Bank & Tr. v. Travelers Cas. & Sur. Co. of Am.*, No. 23-cv-03447, 2025 U.S. Dist. LEXIS 65010, 2025 WL 1019780 (E.D. Pa. Apr. 4, 2025), appeal filed, No. 25-1872 (3d Cir. May 5, 2025)**

Under Pennsylvania law, the U.S. District Court for the Eastern District of Pennsylvania held that an insured bank's untimely notice to an excess insurer entitled the excess insurer to deny coverage, notwithstanding the insured's prompt notice to the primary insurer. The excess insurer issued a claims-made excess policy for the policy period of May 28, 2014 to May 28, 2015 excess of a primary Bankers Professional Liability Policy to its

insured, a bank. The excess policy required that "[t]he Insured(s) shall, as a condition precedent to their rights under this policy, give the Insurer notice in writing of any claim or loss in the same time and manner required by the terms and conditions of the Followed Policy. Notice given under the Followed Policy or Underlying Insurance shall not constitute notice under this policy." The primary followed policy required notice of claims to be provided no later than 180 days after the expiration of the policy. On January 28, 2015, one group of third-party plaintiffs sued the insured, and the insured provided prompt notice to the primary insurer (but not to the excess insurer). Two years later, on January 3, 2017, the insured notified both the primary and excess insurers of a second pending claim involving the same type of illegal banking schemes involved in the 2015 lawsuit, and three years after that, in June 2020, the insured provided notice to the primary and excess insurers of another lawsuit, which involved the same allegations of illegal banking schemes as in the first and second lawsuits. The insured argued that its notice to the primary insurer sufficed as notice to the excess insurer. The court noted that Pennsylvania law "strictly construe[s]" notice requirements for claims made insurance and that "[e]ach insurance company is a separate and distinct entity and has its own specific notice requirements." The court concluded that "[n]otifying a primary insurer does not fulfill the obligation of notifying the excess insurance carrier." Accordingly, because the insured failed to provide the requisite separate notice to the excess insurer within the specified time period, the insured was not entitled to coverage under the excess policy for any of the three lawsuits.

Trull v. W. Va. Mut. Ins. Co., No. 3:24-cv-0202, 2025 U.S. Dist. LEXIS 114307, 2025 WL 1690148 (S.D. W.Va. June 16, 2025)

Under West Virginia law, the U.S. District Court for the Southern District of West Virginia held that a self-insurance program for professional liability for physicians did not cover a physician who failed to provide notice to the self-insurer. The "Self Coverage Plan" insured against "the risks of professional, general, and employers' liability" and, in relevant part, required the insured to "notify the Program via the contact person in writing as soon as possible" if there was "a claim, suit, notice of claim or certificate of merit." In determining whether the self-insurance program provided coverage to the insured, the court held that the foregoing language was "dispositive of the issue" because the self-insurance program provided that the self-insurer was obligated to provide coverage "only to claim(s) that … are reported to the Program subject to the requirements specified in this Description of Coverage." In this case, the underlying claimant provided notice of her claim to the self-insurer, but the insured physician never did. The court determined that because the physician "was the insured under this policy," he was the "one required to provide notice" and because he never did so, he was not entitled to coverage under the self-insurance program.

II.

Related Claims

***Scottsdale Ins. Co. v. Beachcomber Mgmt. Crystal Cove LLC*, No. 8:22-cv-01300-JWH-KES, 2025 U.S. Dist. LEXIS 10403, 2025 WL 257599 (C.D. Cal. Jan. 21, 2025)**

Under California law, the U.S. District Court for the Central District of California held that a bankruptcy trustee's lawsuit against restaurant principals and related entities was not covered because the lawsuit was "sufficiently related" to a draft complaint noticed in a prior policy period. The policy was a business and management indemnity policy providing directors and officers and company coverage, with an "Interrelated Wrongful Acts" provision deeming related claims a single claim and a broad prior-notice exclusion for any claim "in any way involving" wrongful acts previously noticed under a prior policy. Before the policy began, the bankruptcy creditors' committee sent the prior directors and officers' insurer a draft complaint alleging self-dealing, improper insider distributions, and misuse of company funds by the principals. After the policy incepted, the Chapter 7 trustee filed a more expansive action that repeated and broadened those fiduciary allegations and added claims about usurped corporate opportunities connected to the beachside restaurant entities. The insurer denied coverage, asserting that the trustee's complaint involved the same core self-dealing conduct described in the prior draft complaint and therefore related back to the prior policy under the interrelated-acts wording and fell within the prior-notice exclusion. The court agreed, emphasizing the breadth of "in any way involving" and finding a common nexus of facts and transactions between the draft complaint and the trustee's suit, such that the later suit was deemed a single claim first made under the prior policy and excluded under the insurer's prior-notice exclusion.

***USA Equestrian Trust, Inc. v. Old Republic Insurance Co.*, No. 2:24-cv-07661-AH-(SKx), 2025 U.S. Dist. LEXIS 26580, 2025 WL 829969 (C.D. Cal. Feb. 13, 2025) appeal filed, No. 25-1697 (9th Cir. March 14, 2025)**

Under California law, the U.S. District Court for the Central District of California granted an insurer's motion for summary judgment, holding that a sexual-abuse lawsuit against an insured equestrian organization was not interrelated with earlier abuse suits and thus was a separate claim first made outside of the policy period. The court interpreted a non-profit organization and management liability policy that treated "all Claims arising out of the same Wrongful Act and all Interrelated Wrongful Acts" as a single claim first made when the earliest related claim was made. Earlier suits alleged that two different trainers sexually abused minors at different facilities in the 1970s and that the insured, as successor to the national governing body, negligently failed to protect riders and adopt adequate policies. A later suit alleged similar negligence by the insured, but centered allegations on a third trainer at a different club and different events. The court acknowledged that "arising out of" and "interrelated wrongful acts" were broadly defined to encompass a common nexus of "any fact, circumstance, situation, event, transaction, cause or series of related facts." Even so, it concluded that the only connection among the suits was a general theory that the insured should have had stronger abuse-prevention policies, which was too attenuated to constitute a sufficient factual nexus. Focusing on the specific trainers, victims, locations, time periods, and alleged knowledge, the court found that each lawsuit arose from distinct facts, not common circumstances or a unified business practice.

***In re Alexion Pharmaceuticals, Inc. Ins. Appeals*, 339 A.3d 694 (Del. 2025)**

Under Delaware law, the Delaware Supreme Court held that a federal securities class action against an insured was related to a U.S. Securities and Exchange Commission (SEC) investigation previously noticed under an earlier directors and officers liability insurance tower. The case involved two consecutive towers of claims-made directors and officers liability policies, each with a notice of circumstances provision and an interrelated claims provision deeming related claims a single claim first made at the time of the earliest related claim. During the first policy period, the insured received a formal SEC order and subpoena regarding its worldwide grant-making activities, Foreign Corrupt Practices Act (FCPA) compliance, and related securities disclosures. The order provided a broad written notice describing the insured's conduct and warning that shareholder suits could follow. During the second policy period, shareholders filed a securities class action alleging misleading disclosures and improper practices. The insurers denied coverage based on the prior notice exclusion. Applying the "meaningful linkage" standard, the court found that both the SEC investigation and the class action were centered on the same underlying conduct. The court rejected the insured's contention that any relationship was merely tangential because the SEC investigation focused on the FCPA and bookkeeping issues while the class action focused on securities fraud and involved different legal theories and plaintiffs. The court explained that different remedies sought do not defeat the meaningful linkage when the same core conduct is at issue. The court reversed the lower court, holding both that the securities class action was a claim first made during the policy period of the first tower and that coverage for the class action claim was barred under the prior notice exclusion in the second tower.

***Chicago Rest. Mgmt. Grp., LLC v. Great Am. Ins. Co.*, 2025 IL App (1st) 232353, 264 N.E.3d 528, 484 Ill. Dec. 624 (Ill. App. Ct. Mar. 5, 2025), appeal denied 270 N.E.3d 861 (Table) (Sept. 24, 2025)**

Under Illinois law, the Appellate Court of Illinois held that an investors' arbitration demand alleging misappropriation was not related to an earlier books-and-records lawsuit and thus was first made within a later policy period. The case involved a claims-made management liability policy providing directors and officers liability coverage that treated all claims involving "Related Wrongful Acts" as a single claim first made when the earliest related claim was made. Before the later policy incepted, investors filed a limited "books and records" action seeking only injunctive relief and access to company information, and the insured never sought coverage or gave notice. During the subsequent policy period, those investors initiated an arbitration seeking more than $8 million in damages based

on alleged self-dealing and misappropriation of company funds. The insurer argued that both matters shared a common nexus because the misappropriation allegedly predated and motivated the books-and-records request. The court disagreed, emphasizing that the earlier case focused on transparency duties and non-monetary relief, while the arbitration targeted distinct financial misconduct, duties, evidence, and damages. Because the failure to provide records neither caused, nor was meaningfully linked to the alleged misappropriation, the claims did not involve "Related Wrongful Acts," and the arbitration was a separate, timely claim under the later policy.

Boyne USA, Inc. v. Fed. Ins. Co., No. CV 24-70-H-TJC, 2025 U.S. Dist. LEXIS 164762, 2025 WL 2438708 (D. Mont. Aug. 25, 2025)

Under Montana law, the U.S. District Court for the District of Montana granted the insurer's motion for judgment on the pleadings, holding that two putative class actions filed in different states against a resort developer were "Related Claims" under a directors and officers liability policy and therefore were deemed first made under the earlier policy year and shared a single limit of liability. The court interpreted a claims-made management liability policy under which "Related Claims" were defined as all claims "for Wrongful Acts based upon, arising from, or in consequence of the same or related facts, circumstances, situations, transactions or events or the same or related series" of such facts or events, and which provided that all Related Claims are treated as a single claim made when the earliest related claim was first made. In the first action, the Montana condominium-hotel unit owners alleged that the insured's mandatory rental management program forced them into non-negotiable agreements, allowed unilateral changes by the insured, and enabled the insured to siphon revenue, impose unreasonable costs, and conceal its conduct, in violation of state and federal securities, antitrust, and contract law. The later Michigan action asserted nearly identical allegations on behalf of unit owners at different resorts, again challenging a mandatory rental program and asserting that the arrangement constituted an unlawful investment contract and security. Comparing the complaints, the court found that they were substantively parallel, often using nearly identical language to describe the challenged rental program, the insured's control over owners, and the alleged financial exploitation. The court rejected the insured's argument that there were distinctions between the properties, jurisdictions, time frames, and governing documents because the court found that both suits targeted the same core course of conduct. Relying on widely accepted interpretations of "related claims" language, the court concluded that the actions shared a common factual scheme and therefore were a single claim subject to one $5 million limit and the retention applicable to the earlier-filed Montana action.

Urena v. Travelers Cas. & Sur. Co. of Am., No. 22-cv-200-PB, 2025 U.S. Dist. LEXIS 194180, 2025 WL 2826199 (D.N.H. Oct. 6, 2025), appeal filed, No. 25-2054 (1st Cir. Nov. 6, 2025)

Under New Hampshire law, the U.S. District Court for the District of New Hampshire granted the insurer's motion for judgment on the pleadings, holding that an employee's administrative complaint and pregnancy-discrimination lawsuit were related claims deemed first made prior to the policy period. The directors and officers liability policy contained an employment practices liability ("EPL") endorsement providing employment practices liability coverage for "Loss for any Employment Claim first made during the Policy Period." The EPL endorsement incorporated a "Related Claims" provision providing that "[a]ll Claims or Potential Claims for Related Wrongful Acts will be considered as a single Claim or Potential Claim, whichever is applicable, for purposes of this Liability Policy" and deeming such related claims made when the earliest such claim or potential claim was made whether prior to or during the policy period. The employee filed an administrative discrimination charge and began related proceedings in 2019. After the EPL endorsement's coverage began in December 2020, the employee filed a federal discrimination lawsuit. The court reasoned that the administrative charge constituted a claim and that the later-filed lawsuit arose from the same alleged wrongful acts. Thus, pursuant to the EPL endorsement's related claims language, both the administrative charge and the federal proceedings were treated as one pre-EPL endorsement claim. The court rejected arguments that different types of proceedings (administrative vs. judicial) should be treated as separate claims with independent "first made" dates.

III.

Prior Knowledge, Known Loss, and Rescission

***Manchester v. Endurance Assurance Corp.*, 350 F.R.D. 166 (S.D. Fla. 2025)**

Under Florida law, the U.S. District Court for the Southern District of Florida denied an insured officer's motion for a preliminary injunction to force the insurer to pay additional limits of liability in defense expenses because the insurer had presented evidence of potential prior knowledge. The insurer issued a directors and officers liability policy to the insured. The policy had a "Claim Free Warranty" stating that that "[n]o person or entity proposed for coverage [under the policy] is aware of any fact, circumstance, or situation which he or she has reason to suppose might give rise to a future claim that would fall within the scope of any of the proposed coverage part limit of liability stated above[.]" The policy also included a separate retroactive date for $3 million policy limits in excess of an initial $1 million, which provided that the insurer "shall not be liable for Loss on account of any Claim based upon, arising from, or attributable to any litigation, administrative or regulatory proceeding, alternative dispute resolution proceeding, or investigation that was pending, or any order, decree, or judgment entered, on or before [the additional limits retroactive date]." The insured was sued in state attorney general enforcement actions arising out of investigations into the insured entity and the insurer initially defended, paying $1 million toward defense costs. The insurer then declined further coverage based on the prior investigation limitation on the excess $3 million and the "Claim Free Warranty" provision barring additional coverage. The insurer argued that the insured committed a misrepresentation on the insurance application because it was aware of a prior investigation by the Florida attorney general. The court held that an affidavit from a Florida attorney general investigator was evidence of the insured's prior knowledge of the loss at issue, because it showed subpoenas and an investigation predating the warranty statement. The court held that the affidavit evidence was sufficient for the insurer to contest that the insured was "likely to succeed

on the merits," a necessary element for the insured to be granted a preliminary injunction. The court independently held that the related claims provision potentially placed the claim prior to the policy period, also defeating the "likelihood of success on the merits" element of injunctive relief.

Call One Inc. v. Berkley Ins. Co., No. 21-CV-00466, 2025 U.S. Dist. LEXIS 193697, 2025 WL 2802071 (N.D. Ill. Sept. 30, 2025)

Under Illinois law, the U.S. District Court for the Northern District of Illinois granted the insurer's motion for summary judgment on rescission based on the insured's failure to disclose regulatory investigations that later resulted in litigation. The insurer issued professional liability insurance policies to the insured, a telecommunications service provider, from 2011 through 2018, including a renewal in June 2018. The original application asked whether the insured was "aware of any fact, circumstance of situation involving any Insureds that might reasonably be expected to result in a Claim," to which the insured answered "no." Renewals asked whether there had "been any change in the status of any claims, loss or circumstance reported in any application previously submitted to the Insurer," to which the insured answered "no" in 2015 and 2017 and did not respond in 2018. However, starting in 2016, the City of Chicago began auditing the insured regarding the insured's remittance of various types of local taxes from 2009 until 2014 and the insured signed a "Consent to Waive Statute of Limitations" form relating to this audit in 2016, 2017, and 2018. The insured later sought coverage for a *qui tam* action filed in September 2018 alleging the insured failed to collect and remit certain excise taxes and infrastructure maintenance fees owed by its customers, followed by a subpoena from the Illinois Attorney General's Office. At summary judgment, the insurer argued the insured's failure to disclose (1) the insured's failure to collect and remit state taxes; (2) the audit; and (3) the failure to remit certain other state taxes were material representations and that the renewal question implicitly incorporated the original application's broader inquiry. The court agreed that the audit and the related circumstances should have been disclosed, rejecting the insured's argument that the renewal question was limited to changes in active claims. Although the court found an underwriter's testimony and the policy's materiality provision were each insufficient to prove materiality, it concluded that the misrepresentation was "of such a nature that no one would dispute its materiality." This satisfied Illinois' objective test, because a reasonably careful and intelligent person who learned that the insured was engaged in an ongoing audit in multiple types of taxes, would "at the very least, reconsider" the premiums. The court rescinded the policy based on the failure to disclose the audit, finding that the City's audit was a suspicion of wrongdoing, and therefore a Wrongful Act that could reasonably result in a Claim. The court rejected the argument that the failure to collect the taxes alone was sufficient to constitute a misrepresentation, but held that only one sufficient ground is required to rescind the policy.

Edward Homes, Inc. v. Scottsdale Ins. Co., No. 2:22-CV-00725-RFB-EJY, 2025 U.S. Dist. LEXIS 60282, 2025 WL 959501 (D. Nev. Mar. 31, 2025)

Under Nevada law, the U.S. District Court for the District of Nevada denied the insurer's motion for summary judgment on the issue of rescission, because factual disputes precluded a finding that the policy was void as a matter of law. The insurer sought to rescind a builder's risk insurance policy issued to the insured, a construction and real estate managing entity, for a nightclub construction project. The policy application had a vacancy supplement that asked about "any loss or damage in the past 5 years" and "any unrepaired damage," but did not define "damage" or specifically ask about vagrant activity or break ins. The insured answered "no" to the application questions. After a fire loss at the property, the insured sought to rescind the policy based on the insured's alleged failure to disclose prior incidents involving break-ins, vandalism, and theft of copper wire in its application. The court held that "damage," as used in the application questions, was ambiguous and that a reasonable insured could understand it to mean damage causing monetary loss or an insurance type claim, so whether any misrepresentation occurred, including as to alleged theft of materials, was a genuine issue of fact. The court further held that materiality was a jury question, because the insurer's own underwriting file (including photos showing graffiti and debris but rating vandalism as having "no issues noted") could support a finding that any non-disclosure was not material to underwriting. The court also held that a jury could find the insurer had prior knowledge

of the very conditions it later labeled misrepresented and that, under Nevada law, such knowledge could constitute a waiver of the right to rescind, further defeating rescission at summary judgment.

Ascot Specialty Ins. Co. v. Mason, Griffin & Pierson, P.C., CV 24-4712 (ZNQ) (TJB), 2025 U.S. Dist. LEXIS 159397, 2025 WL 2388433 (D.N.J. Aug. 18, 2025)

Under New Jersey law, the U.S. District Court for the District of New Jersey held that an insurer had no duty to defend or indemnify an insured law firm in a legal malpractice action because a prior knowledge condition barred coverage. The insurer issued a lawyers professional liability policy to its insured that covered wrongful acts occurring before the policy period only if, before commencement of the policy, "no Insured has any basis (1) to believe that any Insured breached a professional duty; or (2) to foresee that any such Wrongful Act or Related Circumstances might reasonably be expected to be the basis of a Claim against any Insured." In addition, the decedent's estate sought his disqualification for conflicts, accused him of breaching fiduciary duties and withholding records, and cited ethical rule violations. The court distinguished case law relied upon by the insured regarding the mixed subjective-objective test for prior knowledge, finding that the policy language at issue required only an objective attorney standard. The court held that the probate allegations would lead a reasonable attorney to believe a professional duty had been breached or to foresee a malpractice claim and, therefore, the later malpractice action was not a covered claim, and the insurer had no duty to defend or indemnify.

Allied World Assurance Co. (U.S.) Inc. v. Golenbock Eiseman Assor Bell & Peskoe, LLP, 236 A.D.3d 488, 229 N.Y.S.3d 155 (2025)

Under New York law, the Supreme Court of New York, Appellate Division, First Department held that an insurer owed no coverage for a malpractice suit against an insured law firm because the claim was first made before the policy period and the policy's no prior knowledge condition was not satisfied. The policy was a lawyers professional liability policy that defined a claim to include any request to toll or waive a statute of limitations seeking to hold an insured responsible for a legal wrongful act. The policy conditioned coverage on no insured before August 1, 2019 having any basis to believe a professional duty was breached or to foresee facts that might reasonably be expected to be the basis of any claim. In 2018, the insured entered into a tolling agreement with a former client which expressly reserved the client's potential claims against the firm in connection with the same real estate transactions later at issue in the malpractice suit, but the insured did not disclose that agreement before the 2021-2022 policy began. The court held that the tolling agreement was a pre-policy claim within the policy definition and under New York's subjective/objective prior knowledge test, the agreement itself established that the insured both knew of the facts and should have known the client was preserving potential malpractice claims which breached the prior knowledge condition. Therefore, the court affirmed the judgment for the insurer and issued a declaration that the insurer had no duty to defend or indemnify.

Green Bay Metro. Sewerage Dist. v. Axis Surplus Ins. Co., 764 F. Supp. 3d 781 (E.D. Wis. 2025)

Under New York law, the U.S. District Court for the Eastern District of Wisconsin granted summary judgment in favor of an insurer, holding that the insurer owed no coverage under a claims-made professional liability policy for an engineering firm's settlement of a sewer pipe failure dispute. The policy was a professional liability policy for engineering services and the court focused on a multiple claims provision, other insurance/no liability clause, and a prior knowledge exclusion. The insured engineering firm designed and oversaw construction of a sewer relocation project and was first notified in 2014 that the installed pipe was deformed and leaking, potentially due to design flaws, construction issues, or material defects, which it reported to a prior professional liability insurer that defended under a reservation and contributed to a later settlement. The insured then sought coverage under a 2019-2020 policy and argued that negligent construction oversight was a separate claim from the original design related issues. The policy excluded coverage for claims arising out of an actual or alleged wrongful act with respect to professional services which occurred prior to the inception of the policy and known to any of the insured's officers and which "could reasonably be expected to give rise to a claim." The court applied New York's subjective/objective test for a prior knowledge exclusion, finding

that the insured's president knew of the facts underlying the claim before inception, satisfying the subjective prong, and that the facts would lead a reasonable person to expect a construction oversight claim, satisfying the objective prong. The court also independently found that the design and construction oversight violations were related to wrongful acts on the same project and therefore constituted a single claim first made in 2014, outside the 2019-2020 policy period.

Liberty Ins. Underwriters, Inc. v. Martin, No. 2:15-CV-11013, 2025 U.S. Dist. LEXIS 85152, 2025 WL 1298110 (S.D.W. Va. May 5, 2025)

Under West Virginia law, the U.S. District Court for the Southern District of West Virginia held that an attorney's concealment of incidents that could give rise to a claim rendered his professional liability policy void and entitled his insurer to rescind the policy. In a renewal application for a lawyers professional liability policy, the insured attorney indicated that no incidents or circumstances existed that could result in a claim. In fact, the court found that at the time of the application, the attorney had at least twenty-three disciplinary complaints filed against him. The court observed that under West Virginia law a misrepresentation in an application must be material, and although that is generally a question for a jury, if the evidence "excludes every reasonable inference except that the misrepresentation was material," then it becomes a question of law for the court. Consistent with governing case law, the court admitted an affidavit of an employee of the insurer that the insurer would not have issued the policy if the complaints had been disclosed, which satisfied the insurer's burden to prove a material misrepresentation in the insurance application. Notably, the employee affidavit said that the policy may not have been issued at all, may not have been issued in as large an amount as it was, and would not have provided coverage for any matters relating to the firm's handling of client funds. The court found that the insured was aware of the complaints and that the insured had acknowledged the materiality of the application questions due to a provision in the signed application, therefore allowing the insurer to rescind the policy.

IV.

Prior Acts, Prior Notice, and Prior and Pending Litigation

***Reconstruction Experts, Inc. v. Associated Indus. Ins. Co.*, No. CV 25-07872-MWF (SSCX), 2025 U.S. Dist. LEXIS 199628, 2025 WL 3030586 (C.D. Cal. Oct. 8, 2025)**

Under California law, the U.S. District Court for the Central District of California found that a prior acts exclusion in a directors and officers liability insurance policy eliminated coverage for an underlying lawsuit against an insured. The "Prior Acts Exclusion Endorsement" in the Policy stated: "The Company will have no liability for Loss for any Claim based upon or arising out of any Wrongful Act committed or alleged to have been committed, in whole or in part, prior to the applicable Retroactive Date [December 31, 2021]." The insured had been performing contracting work at a construction project for a luxury condominium in California. Following a payment dispute, the condominium sued the insured. In amended pleadings, the condominium alleged, among other things, that the insured made various material misrepresentations regarding its expertise and business relationships in April and July of 2021, before the policy's retroactive date. The court observed that the operative pleadings alleged an overarching scheme connecting alleged Wrongful Acts occurring both before and after the retroactive date in the policy. The court noted that for purposes of the prior acts exclusion, all acts related to the 2021 misrepresentations, for example, were to be treated as having occurred in 2021 and that the exclusion barred coverage even with respect to any post-retroactive date Wrongful Acts. In reaching this decision, the court rejected the argument that even if certain alleged misrepresentations occurred before the retroactive date, other post retroactive date conduct should preserve coverage.

***Scottsdale Ins. Co. v. Beachcomber Mgmt. Crystal Cove, LLC*, No. 8:22-CV-01300-JWH-KES, 2025 U.S. Dist. LEXIS 10403, 2025 WL 257599 (C.D. Cal. Jan. 21, 2025)**

Under California law, the U.S. District Court for the Central District of California concluded that a Prior Notice Exclusion barred coverage for an underlying action for breach of fiduciary duty against the individual founders and principals of an insured entity. The insurer issued a management liability insurance policy that excluded coverage for any matter "alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving: a. any Wrongful Act, fact, circumstance, or situation which has been the subject of any written notice given under any other policy of which this Policy is a renewal or replacement or which it succeeds in time; or b. any other Wrongful Act, whenever occurring, which together with a Wrongful Act which has been the subject of such notice, would constitute Interrelated Wrongful Acts." In an underlying action filed in 2021, plaintiffs alleged the individual managers of the insured entity engaged in misconduct, including making improper distributions to themselves for personal gain in disregard of the company's best interests. Several days later, the insured tendered the matter to its insurer; however, upon completion of its coverage review, the insurer denied coverage, citing, among other things, the language of the exclusion and the fact that before filing suit, the underlying plaintiff prepared a draft complaint that had been previously tendered to another insurer on or about October 28, 2019. The court observed that "[a]lthough the Underlying Action includes allegations that are not present in the Draft Complaint, the allegations are similar, involving the same overall nexus of facts and law, and, at minimum, having an incidental relationship to the allegations in the Draft Complaint." Citing the broad language of the exclusion, the court held the prior notice exclusion barred coverage and issued declaratory judgment in favor of the insurer because, among other things, both the 2019 draft complaint and the 2021 underlying action asserted similar causes of action against the individual corporate actors.

***AmTrust Fin. Servs., Inc. v. Liberty Ins. Underwriters Inc.*, No. CV 21-374-JLH, 2025 U.S. Dist. LEXIS 187596, 2025 WL 2720960 (D. Del. Sept. 24, 2025), appeal filed No. 25-3080 (3rd Cir. Oct. 27, 2025)**

Under Delaware law, the U.S. District Court for the District of Delaware concluded that an insured's costs incurred with respect to underlying securities and derivative litigation were excluded from coverage based on a prior notice exclusion. The insurer issued a directors and officers liability insurance policy to an insured company that excluded coverage for "Claims … arising out of any circumstances of which notice has been given under any directors and officers liability insurance policy in force before the inception date of this policy." The parties cross-moved for summary judgment on whether the lawsuits fell under an earlier or a later program year. The insured had previously submitted a Notice of Circumstance to an earlier insurer. The Notice of Circumstance contained a copy of a 19-page letter addressed to the insured's audit committee that alleged that the insured's financial statements contained numerous discrepancies, suggesting that the insured's financial statements had been materially misstated. The insurer argued that the lawsuits arose out of the previously tendered circumstances and were therefore subject to the policy's prior notice exclusion. The court acknowledged that the term "arising out of" is broadly construed and that the linkage between the matters must be meaningful and not tangential, and that absolute identity is not required. The court found that there was a meaningful link between the Notice of Circumstance and the later litigation because they involved the same alleged conduct — specific accounting improprieties and material misrepresentations in financial statements regarding those improprieties — and relied upon the same evidence, including the insured's financial statements and public statements regarding its accounting. The court found that the costs relating to the subsequent securities and derivative litigation were properly excluded under the later insurance program based on the language of the prior notice exclusion.

***Berkley Assurance Co. v. John H. Fisher, P.C.*, 771 F. Supp. 3d 292 (S.D.N.Y. 2025)**

Under New York law, the U.S. District Court for the Southern District of New York held that the insurer had no duty to defend or indemnify the insureds in a legal malpractice action. The case involved a professional liability insurance policy with a retroactive date of July 10, 2020, and a Known-Claims Exclusion provision. The insurer filed a declaratory judgment action against the insureds seeking a ruling that the insurer did not have a duty to defend or indemnify the insureds. The court agreed with the insurer and found that the legal services giving rise to the legal malpractice action occurred before the policy's retroactive date, and thus, the insurer had no duty to defend or indemnify. Additionally, the court found the Known-Claims Exclusion barred coverage on the grounds that the insureds were aware of potential claims before the policy's effective date because the insureds received a letter informing the insureds about an investigation of "a legal malpractice claim arising out of" the insureds' handling of a former client's medical malpractice claim before the insureds submitted their application for the policy. The court found that no "reasonable juror could find" that the insureds could not have reasonably foreseen that their handling of the underlying medical malpractice case could give rise to a claim against them. Accordingly, the court found the insureds' claim fell entirely within the Known-Claims Exclusion and the insurer had no duty to defend or indemnify the insureds for the legal malpractice claim. The insurer's motion for summary judgment was granted, dismissing the insureds' counterclaims, including those for attorney fees and emotional distress.

***ISMIE Indem. Co. v. Harras Bloom & Archer, LLC*, Civil No. 24-3424, 2025 U.S. Dist. LEXIS 185977, 2025 WL 2698989 (E.D. Pa. Sept. 22, 2025)**

Under New York law, the U.S. District Court for the Eastern District of Pennsylvania granted in part and denied in part the insured's Rule 12(b)(6) motion to dismiss against several claims the insurer asserted in a declaratory judgment action against the insured. The case involved a lawyers professional liability policy which included a Prior Knowledge Exclusion and a Conversion Exclusion. The insurer sought a declaratory judgment to relieve it of its duties to defend and indemnify the insured in a malpractice action against the insured. The court found that whether a reasonable insured knew or should have anticipated a forthcoming malpractice claim at the time the insureds submitted their insurance application was fact-intensive but sufficiently pled to defeat the insured's 12(b)(6) motion to dismiss. Accordingly, the court declined to dismiss the insurer's claim for declaratory judgment that it had no duty to defend and denied in part the insured's motion to dismiss. However, the court granted the insured's motion to dismiss the insurer's declaratory judgment claim that it had no duty to indemnify as premature on the grounds that the underlying legal malpractice suit was still ongoing, and therefore "the facts necessary to determine whether [the insurer] had a duty to indemnify [the insured] will remain undetermined until the discovery has run its course." The court also dismissed the insurer's claim concerning the Conversion Exclusion as premature, as the underlying conversion claim was subject to arbitration, the outcome of which was unknown.

***Somerset Condominium Association, Inc. v. RC Somerset, LLC*, 418 Wis. 2d 330 (Wis. App., 2025)**

Under Wisconsin law, the Court of Appeals of Wisconsin determined that a Prior Notice Exclusion did not bar coverage with respect to counterclaims asserted against an insured because those counterclaims did not arise out of related "wrongful acts" alleged in a prior lawsuit filed against the insured. The insurer issued a directors and officers liability insurance policy with a Prior Notice Exclusion that barred coverage for "[a]ny liability arising out of the facts alleged, or to the same or related 'wrongful acts' alleged or contained in any 'claim' which has been reported, or in any circumstances of which notice has been given, under" a prior insurance policy. In an earlier action, the insurer agreed to defend the insured in a lawsuit filed by certain project developers alleging that the insured wrongfully refused to approve specific multifamily housing construction proposals. The case was dismissed, and a final judgment was entered. The insured commenced a subsequent action against the same project developers to enjoin further work, and the developers counterclaimed against the insured alleging tortious interference and slander of title. In determining whether the Prior Notice Exclusion barred coverage for the subsequently filed counterclaims against the insured, the court agreed with the insured that the liability for the two counterclaims

asserted did not arise out of wrongful acts alleged in the earlier litigation. The court noted that the counterclaims involved additional parties not at issue in the first suit, were based on the insured's alleged acts that occurred after a final judgment was entered in the first suit, and that nothing in the record suggests that the insured knew or was reasonably sure that the counterclaims would be filed against it before that second policy period began. Therefore, the court found that the Prior Notice Exclusion did not bar coverage with respect to those counterclaims because the conduct underlying those counterclaims did not occur until after the relevant policy period began and did not accrue before that policy went into effect.

v.

Dishonesty and Personal Profit Exclusions

***Nat'l Liability & Fire Ins. Co. v. Sternberg*, No. 24 cv 01749, 2025 U.S. Dist. LEXIS 149374, 2025 WL 2214081 (E.D. Pa. Aug. 1, 2025)**

Under Pennsylvania law, the U.S. District Court for the Eastern District of Pennsylvania held that an attorney's professional liability insurer had no duty to defend a law firm in a fraud-based escrow dispute, in part because the claims fell within broad misappropriation of funds exclusions. The policy provided coverage only for "wrongful acts" defined as negligent acts, errors, or omissions in the rendering of legal services, and it contained exclusions for malicious, intentional, dishonest, or criminal acts and separate exclusions for conversion, misappropriation, embezzlement, defalcation, commingling, and loss of any asset in the insured's care, custody, or control. The underlying complaint alleged that the attorney and his firm intentionally induced a company to wire nearly $2 million into their IOLTA account for COVID-19 test kits, wrongfully released the funds without satisfying escrow conditions, never delivered the goods, and refused to return the money. The complaint asserted claims for fraud, civil conspiracy, and related intentional torts. The court analyzed the allegations against the exclusions and concluded they described conversion, misappropriation, defalcation, and loss of assets in the insured's control, all squarely within the policy's asset loss exclusions that do not require a final adjudication. Because the insuring clause did not reach purely intentional misconduct and the alleged escrow scheme fit the misappropriation of funds exclusions, the insurer owed no duty to defend.

VI.

Restitution, Disgorgement, and Damages

***Scottsdale Ins. Co. v. Beachcomber Mgmt. Crystal Cove, LLC*, No. 8:22-CV-01300-JWH-KES, 2025 U.S. Dist. LEXIS 10403, 2025 WL 257599 (C.D. Cal. Jan. 21, 2025)**

Under California law, the U.S. District Court for the Central District of California found an insurer had no duty to defend an action against its insured that sought restitution of wrongfully acquired money and property. Under the directors and officers liability policy, the insurer covered "losses," including legal damages but excluding punitive damages, exemplary damages, taxes, fines, and "matters uninsurable" under California law. In the underlying action, a trustee alleged the insured breached its fiduciary duties and misused funds and personnel to "prop up" other entities, including by paying salaries, sharing insurance policies, paying messenger fees, and loaning money. The trustee sought recovery of all fraudulent transfers and the amounts of improper distributions, among other damages. The district court held, in pertinent part, that the insurer had no duty to defend the underlying action because the claim sought to recover the money and property that the insured wrongfully acquired. Although some of the remedies sought were labeled as compensatory damages, the court held that at its essence, the underlying action sought restitution from the insured, which is uninsurable as a matter of law.

***Tandem Fund II, L.P. v. Scottsdale Ins. Co.*, No. 23-16187, 2025 U.S. App. LEXIS 19537, 2025 WL 2206112 (9th Cir. Aug. 4, 2025)**

Under California law, the U.S. Court of Appeals for the Ninth Circuit affirmed a district court order dismissing a complaint against an insurer for failing to pay an arbitration award that was deemed uninsurable restitution. The insurer issued a Business and Management Indemnity Policy to the insured, a start-up company, that included coverage for "losses" to include various legal damages but excluded "matters uninsurable" under California law. The insured obtained

loans from a venture capital firm, which relied on the insured's critical supply contract with a wholesaler, but that contract was later found to have been terminated before the loans were made. Based on the insured's intentional misrepresentation and fraudulent concealment, an arbitration panel awarded damages to the venture capital firm, including the loan amounts, expenses, interest, and fees. The insured sued its insurer for failing to cover the arbitration award, which it contended was a covered "loss" under the policy. However, the district court held, and the Ninth Circuit affirmed, that the arbitration award was restitutionary, rather than compensatory, because it was for the return of funds that had been wrongfully acquired. As a matter of public policy, California law prohibits insuring against the risk of being ordered to return ill-gotten gains, and the restitutionary award was therefore uninsurable.

***Midvale Indem. Co. v. AMC Ent. Holdings, Inc.*, No. 206, 2025, 2025 Del. LEXIS 460, 2025 WL 3527665 (Del. Dec. 9, 2025), *affirming AMC Ent. Holdings, Inc. v. XL Specialty Ins. Co.*, No. N23C-05-045 MAA CCLD, 2025 Del. Super. LEXIS 84, 2025 WL 655595 (Del. Super. Ct. Feb. 28, 2025)**

Under Delaware law, the Supreme Court of Delaware affirmed the Delaware Superior Court's finding that settlement of a shareholder lawsuit, which included issuing stock to resolve the claims, constituted a covered "loss" within the meaning of the policy. Under the directors and officers liability insurance policy, a "loss" was defined as "damages, judgments, settlements, pre-judgment and post-judgment interest or other amounts (including punitive, exemplary or multiplied damages, where insurable by law) that any Insured is legally obligated to pay and Defense Expenses, including that portion of any settlement which represents the claimant's attorneys' fees." The Superior Court held that the policy's definition of "loss" did not limit coverage to monetary payments, and that stock is a valid form of currency under Delaware law. While the insurer argued that the insured did not suffer any economic harm or financial detriment from the issuance of new shares of stock, the court held that the "loss" definition was nonetheless satisfied because the insured had made a covered payment when it issued nearly seven million shares of common stock to its shareholders pursuant to the settlement agreement.

***Scottsdale Ins. Co. v. McGrath*, No. 19-CV-7477 (LJL), 2025 U.S. Dist. LEXIS 169795, 2025 WL 2509190 (S.D.N.Y. Sept. 2, 2025), appeal filed, No. 25-2578 (2d Cir. Oct. 20, 2025)**

Under New York law, the U.S. District Court for the Southern District of New York held that a claim for restitution of money that was wrongfully obtained by an insured was not considered "damages" and was therefore uninsurable under the policy's definition of "loss." The insurer issued a business and management indemnity policy that included directors and officers liability coverage for "losses," which was defined to include "damages, judgments, settlements, pre-judgment or post-judgment interest awarded by a court, and Costs, Charges, and Expenses incurred by Directors and Officers," but not "matters uninsurable under the laws pursuant to which this Policy is construed." An insured manager sought coverage for a demand made against him by a bankruptcy trustee for the value of a fraudulently transferred loan to the company that he personally guaranteed. Under New York law, "damages" does not include claims for restitution of money that was wrongly obtained by an insured. The court therefore found that the trustee's demand for restitution was not a "loss" insurable under the policy, and the insurer had no duty to defend. This case is on appeal to the U.S. Court of Appeals for the Second Circuit.

VII.

Insured Capacity

***Evanston Ins. Co. v. Frederick*, No. 8:23-cv-00882-FWS-KES, 2025 U.S. Dist. LEXIS 142026, 2025 WL 2019379 (C.D. Cal. June 12, 2025)**

Under California law, the U.S. District Court for the Central District of California held that a lawsuit sufficiently alleged that several physicians were acting in an insured capacity in their involvement with multiple kickback schemes. The insurer issued a "For Profit Management Liability Policy" to the insured, a fertility management company. The underlying lawsuit alleged, among other things, wrongful termination and business torts arising from alleged kickback schemes. The pleadings included allegations that the insured participated in certain schemes alongside a related medical company, which was not an insured under the policy. The insurer sought summary judgment on the ground that the physician defendants were not Insured Persons, Insureds, or sued in an insured capacity, arguing that they acted on behalf of uninsured entities like the medical company because they were involved in directing patients to specific pharmacies and engaging in business practices in connection with other entities. The court determined that allegations in the complaint reasonably permitted a finding that the individual physicians could have acted on behalf of the insured because the complaint described their involvement in schemes where the insured was directly implicated, suggesting potential wrongful acts were undertaken on behalf of the insured entity. Thus, the court denied summary judgment for the insurer in part.

***Hanover Ins. Co. v. Larson*, 2025 U.S. Dist. LEXIS 127534, No. 4:24-cv-00730-SRB (W.D. Mo. July 2, 2025), appeal filed No. 25-2543 (8th Cir. Oct. 31, 2025)**

Under Missouri law, the U.S. District Court for the Western District of Missouri held that several directors and officers who personally guaranteed two loans were not acting in an insured capacity and granted judgment on the pleadings in favor of the insurer. Under the directors and officers liability policy, an "insured

individual" was an employee "acting solely … on behalf" of the insured entity. The guarantors defaulted on the loans entered into on behalf of the insured entity and the creditors sought to recover the amount of the loans. Because the guarantors signed personal guarantees, the court held that the guarantors were not acting solely on behalf of the insured entity, and there was no coverage under the policy. The case is pending on appeal.

VIII.

Insured v. Insured Exclusion

***Scottsdale Ins. Co. v. Hamerslag, No. 23-CV-780 JLS (AHG)*, 2025 U.S. Dist. LEXIS 118805, 2025 WL 1736873 (S.D. Cal. June 23, 2025)**

Under California law, the U.S. District Court for the Southern District of California held that an insured versus insured exclusion did not bar coverage for a shareholder suit by a former director because the status of the plaintiff as an insured trustee was a disputed fact, and regardless, a dilution claims exception restored coverage, and the insurer owed both a defense and indemnity. The case involved a Business and Management Indemnity Policy providing directors and officers liability and company coverage, which contained an insured versus insured exclusion for "any Claim brought … by, on behalf of, or at the direction of any insured," and also contained an exception for claims by "any former Directors or Officers [brought] solely in their capacity as a securities holder … and … is solely based upon … alleged unfair dilution … in connection with … the merger … ." Here, a former CEO and founder sued a director over a merger and subsequent sale that allegedly unfairly diluted his equity and diverted value in a technology company. The insurer denied a defense based on the insured versus insured exclusion, arguing that all plaintiffs were insureds or were acting at the direction of insureds, including a family trust. The court found a factual dispute over whether the family trust was in fact acting at the direction of insureds and therefore refused to hold, on the pleadings, that the exclusion clearly barred all claims. The court then analyzed the dilution claims exception and focused on the gravamen of the lawsuit, which was that the director orchestrated a merger and sale that unfairly diluted the former CEO's securities interest. Because at least some claims met every condition of the exception, the court held that the exception reinstated coverage and triggered the duty to defend and indemnify. The court denied the insurer's motion for judgment on the pleadings and granted summary judgment in favor of the insured director. An appeal to the Ninth Circuit was filed on July 22, 2025.

***Avellone as Tr. of Ford City Condo. Ass'n v. United States Liab. Ins. Co.*, No. 23-CV-12436, 2025 U.S. Dist. LEXIS 60472, 2025 WL 963921 (N.D. Ill. Mar. 31, 2025)**

Under Illinois law, the U.S. District Court for the Northern District of Illinois, sitting in its appellate capacity, held that an insured versus insured exclusion barred coverage for claims brought by a Subchapter V bankruptcy trustee against former directors and officers of a condominium association. The case involved a directors and officers liability policy issued to a condominium association which contained an insured versus insured exclusion for "any Claim made by … the Organization or any Individual Insured," and which defined the "Organization" to include a "bankruptcy trustee … but only while performing such duties on behalf of any Insured." After the condominium association filed a Subchapter V Chapter 11 case, the trustee sued former officers and board members for alleged mismanagement and breaches of fiduciary duty and then sought coverage under the directors and officers policy. The insurer denied coverage based on the insured versus insured exclusion, contending that the trustee was part of the organization as defined in the policy and therefore this was insured against insured. The court agreed that the policy expressly included a bankruptcy trustee within the definition of the organization while the trustee acted in that capacity and on behalf of the insured estate. Because the trustee sued in his official capacity for the estate, the court held that he was an insured and that the exclusion unambiguously applied to his claim. The trustee argued that his suit was akin to a derivative action and should fall within the derivative action exception, but the court held that the exception required the action to be brought totally independent of any insured, which was impossible where the plaintiff was himself an insured. Therefore, the district court affirmed the bankruptcy court's dismissal of the trustee's coverage claims.

***Vill. at Flat Hill PRA Condo. Tr. v. Mount Vernon Fire Ins. Co.*, No. 24-12109-BEM, 2025 U.S. Dist. LEXIS 183966, 2025 WL 2673965 (D. Mass. July 30, 2025)**

Under Massachusetts law, the U.S. District Court for the District of Massachusetts held that the insured versus insured exclusion did not relieve the insurer of its duty to defend a condominium trust in an action brought by a former trustee and his spouse. The case involved a community association professional liability policy affording management and directors and officers liability-type coverage to the condominium trust, which contained an insured versus insured exclusion barring "any Claim by … any Individual Insured," unless the claim is brought by a former director, trustee, officer, volunteer, or committee member and does not "arise out of, directly or indirectly result from, is in consequence of, or in any way involve" wrongful acts, responsibilities, or failures to act during that person's tenure. The insured was sued in state court by a former trustee and his spouse, who alleged harassment, improper fines, and refusals to provide records and certificates of common expenses. The insurer denied a defense, arguing that the lawsuit was a claim by insureds and that the allegations "arose out of" the former trustee's prior role as a trustee, triggering the insured versus insured exclusion and taking the case outside the former-fiduciary exception. The court noted that some counts referenced events during the former trustee's tenure, but several claims were based solely on conduct in 2022 and 2023 by different trustees. The court held that these post-tenure claims did not arise out of or meaningfully involve the former trustee's service as a trustee and therefore fell within the policy's exception for claims by former fiduciaries. Because at least one covered claim existed, the court held that the insurer owed a duty to defend the entire action under Massachusetts' broad duty-to-defend standards.

IX.

Coverage For Contractual Liability

***AIG Specialty Ins. Co. v. Agee*, No. 24-30245, 2025 U.S. App. LEXIS 4723, 2025 WL 655069 (5th Cir. Feb 28, 2025) (per curiam)**

Under Louisiana law, the Fifth Circuit Court of Appeals held that there was no coverage for a breach of contract claim for unpaid wages and commission because breach of contract exclusions barred coverage. The insurer issued three successive Employment Practices Liability policies, which included breach of contract exclusions in the Directors and Officers section and the Employment Practices Liability section. The exclusions precluded coverage for any actual or alleged contractual liability of the company under any express written contract or agreement, but the exclusions did not apply to "liability which would have attached in the absence of such express contract or agreement." The insurer sought declaratory judgment that there was no coverage for the judgment entered in the underlying lawsuit, where the court ruled in favor of the former employees on their breach of contract claim for unpaid wages and commissions. The court affirmed the lower court's holding that a carve back provision that provides coverage for claims that would exist independent of the contract did not apply because the employment agreements set forth their entitlement to the commissions and bonuses that made up the underlying court's judgment award.

***Zaftr Inc. v. Kirk*, Civil Action No. 24-2702, 2025 U.S. Dist. LEXIS 213524, 2025 WL 3025675 (E.D. Pa. Oct. 29, 2025)**

Under Pennsylvania law, the U.S. District Court for the Eastern District of Pennsylvania held that a contractual liability exclusion barred coverage for a breach of settlement agreement claim. The insurer issued a professional liability policy, which excluded coverage for "any claim…based upon, arising out of, directly or indirectly resulting from or in consequence of, or in any way involving…[the insured's] liability under any oral or written contract or agreement." A company

previously filed a lawsuit against the insured law firm for its failure to comply with escrow agreements regarding a Bitcoin transaction. The parties thereafter reached a settlement, under which the insured agreed to pay part of the settlement. When the insured failed to make final payments, the company filed a lawsuit for breach of settlement agreement claim and obtained a default judgment against the insured. To enforce its money judgment, the company sought to establish the insurer's liability as a garnishee. The court held that, given that the default judgment rested on the firm's failure to comply with the settlement agreement, the claim fell squarely within the contractual liability exclusion because the exclusion's lead-in clause was broader than most standard "arising out of" insurance exclusions precluding all claims that would not exist but for the excluded conduct.

x.

Professional Services

PROFESSIONAL SERVICES INSURING AGREEMENTS

***BJS Ins., LLC v. Houston Cas. Co.*, No. 24-CV-974-ABA, 2025 U.S. Dist. LEXIS 59626, 2025 WL 958759 (D. Md. Mar. 31, 2025)**

Under Maryland law, the U.S. District Court for the District of Maryland held that fraudulent-transfer claims against a life insurance brokerage firm alleged a wrongful act arising from professional services. The professional liability policy at issue included an insuring agreement that covered wrongful acts "arising from Professional Services." The policy defined "Professional Services" as including "arrangement of premium financing for a client in connection with the placement of insurance coverage." The underlying action alleged a premium-financing entity made a series of multi-million-dollar transfers to the insured brokerage and a related company without receiving reasonably equivalent value and sought to recover those payments as fraudulent transfers under federal and state law. The insurer argued the transfers were not made in connection with the provision of professional services but rather constituted mere billing and fee sharing practices. The court rejected the insurer's argument, reasoning that the transfers constituted an act originating from the insured's work to arrange premium financing, consistent with the policy's definition of "Professional Services." The court declined to determine whether the insurer owed a duty to defend until further discovery was conducted on the issue of the insured's prior knowledge.

***Singh, RX, PLLC v. Selective Ins. Co. of S.C.*, No. 24-1678, 2025 U.S. App. LEXIS 9028, 2025 WL 1103968 (6th Cir. Apr. 14, 2025)**

Under Michigan law, the U.S. Court of Appeals for the Sixth Circuit held there was no coverage for an underlying lawsuit against an insured pharmacy because although the claim arose from the insured's professional services, it was not asserted by a natural person. The case involved a business owner liability policy, which excluded coverage for claims resulting from the performance of professional services, as well as a professional liability policy that covered any claims

arising out of the provision of professional services brought "by a natural person." The underlying plaintiff, a drug manufacturer, alleged that the insured pharmacy bought and sold counterfeit HIV medications. The court characterized dispensing and handling prescription drugs as core pharmaceutical functions requiring specialized skill, meaning the claim resulted from the insured's "professional services" and thereby the business owner liability policy's professional services exclusion precluded coverage. The court further reasoned that because the underlying plaintiff was a corporation and not a "natural person," the claim was also not covered under the professional liability policy. The court rejected the insured's argument that this reading rendered the professional liability coverage illusory, explaining that many potential professional services and personal injury claims by natural persons, such as patient bodily-injury or defamation claims, would still fall within the insuring agreement.

EnviroAnalytics Group LLC, et al., v. Axis Surplus Ins. Co., et al., No. JKB-24-2974, 784 F.Supp.3d 821 (D. Md. May 22, 2025)

Under Missouri law, the U.S. District Court for the District of Maryland found that damages did not flow from a professional service so there was no coverage under a professional liability policy. Two environmental remediation and demolition firms sued their insurers for failing to provide coverage for litigation brought against the insureds by a third party. The court dismissed all claims against one of the insurers finding that the professional liability coverage of the Policy did not apply. Specifically, the Policy covered, "those services performed by [it] or on [its] behalf, that are related to [its] practice as an engineer, consultant, architect, or surveyor that are performed for others for a fee." The court relied on prior Missouri case law holding that a professional act is one that arises out of a "vocation, calling, occupation, or employment involving specialized knowledge labor or skill, and the labor or skill involved is predominantly mental or intellectual rather than physical or manual." Here, there were no allegations that the insureds' demolition work arose out of special knowledge, labor, or skill associated with the engineering profession.

Scholastic Inc. v. St. Paul Fire & Marine Ins. Co., No. 23-CV-3485 (JMF), 2025 U.S. Dist. LEXIS 179713, 2025 WL 2643981 (S.D.N.Y. Sept. 15, 2025), appeal filed No. 25-25-5 (2nd Cir. Oct. 10, 2025)

Under New York law, the U.S. District Court for the Southern District of New York held that an insurer owed coverage for defense costs and settlement of an intellectual property and contract dispute because the insured's alleged misconduct arose from its professional services. The case involved an excess professional liability policy that provided coverage for claims "caused by the rendering of, or failure to render, any professional service" by the insured. The policy did not define "professional service," but the court reasoned that the phrase means services requiring "special acumen and training." The underlying action alleged that the insured published licensed educational software and marks to develop and market literacy and math products without paying agreed-upon royalties, asserting claims for breach of contract and trademark infringement. The insurer argued the allegations exclusively arose from the insured's advertising and marketing activities, as opposed to the insured's professional services. Looking to the nature of the insured's work, the court held the underlying actions arose from a core professional service of designing, developing, publishing, and selling specialized educational software and instructional products, thereby triggering the policy's insuring agreement.

Marcus & Cinelli, LLP v. Aspen Am. Ins. Co., 158 F.4th 333 (2d Cir. 2025)

Under New York law, the U.S. Court of Appeals for the Second Circuit held that an insurer owed a duty to defend because the underlying judgment-creditor action arose from the insured law firm's professional services. The case involved a lawyers professional liability policy that covered claims "by reason of an act or omission…in the performance of professional services." The policy defined "professional services" to include services rendered as an attorney. The underlying complaint, brought by a judgment creditor of the insured's client, alleged the insured arranged for the sale of its client's diamond ring, with a portion of the proceeds covering the past fees owed to the insured and thereby tortiously interfered with the judgment creditor's collection. The insurer denied coverage for

the claim, alleging the claim arose out of the insured's self-dealing as opposed to the rendering of professional services. The court rejected this argument, holding the insured's conduct, which included offering a legal opinion as to the client's title to the diamond ring, involved special acumen and training and thereby constituted professional services.

PROFESSIONAL SERVICES EXCLUSIONS

Great Am. All. Ins. Co. v. Continental Cas. Co., No. 23-cv-1796-BAS-JLB, 2025 U.S. Dist. LEXIS 155878, 2025 WL 2323512 (S.D. Cal. Aug. 12, 2025)

Under California law, the U.S. District Court for the Southern District of California found that Continental owed a duty to defend the insured. Continental, the primary insurer for the insured, declined to participate in the defense of a lawsuit against the insured. Great American alleged that it was forced to contribute more than it should have to defend the insured. The underlying lawsuit involved a slip and fall at a property managed by the insured. The insured's commercial general liability policy excluded coverage for bodily injury "caused by the rendering or failure to render any professional service." The policy provided thirteen examples of professional services. The court agreed with prior California cases that the injury must occur during the performance of professional services rather than happening while the insured was otherwise providing professional services. Here, the professional services exclusion did not apply, because the injury was not caused, but merely occurred at the same time as, the provision of professional services. The initial complaint alleged a fall down a "dangerous single step," but the court reasoned that the complaint did not contain allegations that implicated the professional services exclusion to the commercial general liability policy because the fall down the single step was not caused by the provision of professional services.

Call One Inc., v. Berkley Ins. Co., No. 21-cv-00466, 2025 U.S. Dist. LEXIS 193697, 2025 WL 2802071 (N.D. Il. Sept. 30, 2025)

Under Illinois law, the U.S. District Court for the Northern District of Illinois found that the professional services exception to an insurance policy did not apply. The Policy's professional services exclusion stated: "[t]he Insurer shall not be liable to make any payment for loss in connection with a claim made against any Insured: … based upon, arising out of, directly or indirectly resulting from or in consequence of, or in any way involving the performance of any professional services for others, and caused by any act error or omission…" The court found that when "professional services" is not defined in a policy, courts adopt a definition referring to business activity conducted by the insured involving specialized knowledge, labor, or skill and is predominantly mental or intellectual opposed to physical or manual. Preparation of tax returns or furnishing advice on the same may be professional services. The insured prepared tax returns for themselves, not customers, and even though they communicated with their customers about tax benefits, the court found that the communications did not rise to professional services, because the insured is not in the tax advice business.

Scottsdale Ins. Co. v. Seven Counties Serv., Inc., No. 3:23-cv-357-DJH-CHL, 2025 U.S. Dist. LEXIS 156496, 2025 WL 2337961 (W.D. Ky. Aug. 13, 2025)

Under Kentucky law, the U.S. District Court for the Western District of Kentucky found that a professional services exclusion did not preclude defense coverage. The policy did not define professional services, but the court explained that Kentucky courts consider whether conduct requires "judgment or training" to determine whether the conduct involves professional services. The insurer argued they had no duty to defend the insured, a corporation that provides mental and behavioral health, substance use, and intellectual and developmental disability services. A child died at the insured's facility after being restrained by one of the custodial employees. The insurer claimed that the restraint required training under a Kentucky regulation defining emergency service. The court found that the insurers' complaint did not allege sufficient facts leading up to the incident, so it could not determine whether the restraint required training or experience. As such, the professional services exclusion did not absolve the insurer of its duty to defend.

***Lehigh Valley Toxicology LLC v. Continental Cas. Co.*, No. 5:24-cv-06152-JMG, 2025 U.S. Dist. LEXIS 170933, 2025 WL 2535615 (E.D. Pa. Aug. 29, 2025)**

Under Pennsylvania law, the U.S. District Court for the Eastern District of Pennsylvania found that the professional services exclusion in a Commercial Package Insurance Policy applied, and the insurer had no duty to defend. The professional services exclusion at issue defined professional services to include medical or nursing services treatment, advice, or instruction, and any health or therapeutic service, treatment, advice or instruction. The court found that the professional services exclusion applied. Specifically, the insured was required to have a certification from the government, and the insured's acts in administering tests, reporting results, and reporting changed results, were part of the laboratory's professional services. As a result, the court found that the professional services exclusion applied and held the insurer had no duty to defend or indemnify.

***Sioux Steel Co. v. Ins. Co. of the State of Pa.*, 127 F.4th 1113 (8th Cir. 2025)**

Under South Dakota law, the U.S. Court of Appeals for the Eighth Circuit affirmed the District Court's grant of summary judgment based on an unambiguous and applicable professional liability exclusion. The insured designed a grain system and sold one to a company in Mexico. The insured obtained a Foreign Commercial General Liability Policy containing a professional services exclusion which stated: "[t]his insurance does not apply to bodily injury, property damage or personal and advertising injury arising out of the rendering of or failure to render any professional services by you or any engineer, architect or surveyor who is either employed by you or performing work on your behalf in such capacity." The grain system that the insured sold subsequently failed due to engineering defects. The insurer denied coverage citing the above professional liability exclusion. The insured argued that the word "render" in the policy meant services rendered to a third party rather than internal design of the product. The Eighth Circuit disagreed, finding that the language in the contract was not ambiguous and there was no requirement that the professional services covered by the policy be rendered to a third party. Consequently, the professional liability exclusion applied.

XI. Independent Counsel

***Berkley Assurance Co. v. John H. Fisher, P.C.*, 771 F. Supp. 3d 292 (S.D.N.Y. 2025)**

Under New York law, the U.S. District Court for the Southern District of New York held that the insurer's purported failure to inform its insureds of a right to select independent counsel did not estop the insurer from disclaiming coverage. The case involved a professional liability insurance policy issued to an attorney and his law firm. The insureds were sued in an underlying legal malpractice action arising out of the insureds' alleged mishandling of a medical malpractice claim on behalf of their client. The insurer filed a declaratory judgment action against the insureds seeking a ruling that the insurer did not have a duty to defend or indemnify the insureds. The insureds argued that the insurer should be estopped from disclaiming coverage on the basis that the insurer sought to disclaim coverage without first creating an internal wall between its coverage investigation and the underlying liability defense and notifying the insureds of their right to independent counsel. The insureds also argued that a conflict existed because defense counsel had not filed a motion to dismiss in the underlying action. The court disagreed, noting that under New York law an insurer does not have a conflict of interest in every case where it defends subject to a reservation of rights. The court explained that the right to independent counsel is only triggered when the reservation creates a potential conflict of interest, specifically divergent interests in how to defeat the underlying malpractice action against the insureds. The court found the insureds failed to provide any evidence the insurer acted improperly by providing a defense of the legal malpractice claim under a reservation of rights and granted summary judgment for the insurer on the estoppel and independent counsel issues.

XII.

Advancement of Defense Costs

***Origis USA LLC v. Great Am. Ins. Co.*, 345 A.3d 936 (Del. 2025)**

Under Delaware law, the Supreme Court of Delaware held that remand was appropriate for further consideration of whether a no-action clause bars an action for advancement of defense costs. The insurer issued a directors and officers liability policy to the insured. The policy contained a no action clause barring an action against the insurer until the insured's obligation to pay has been fully determined by an adjudication against the insured or by written agreement of the insured, the claimant, and the insurer. The policy also contained a provision requiring the insurer and the insured to use their best efforts to agree on an allocation of loss, including defense costs, between covered and uncovered matters. In the absence of such an agreement, the policy required the insurer to advance those amounts it believes to be covered until a different allocation is negotiated, arbitrated, or judicially determined. Finally, the policy contained an advancement provision requiring the insurer to advance defense costs, subject to the allocation provision, prior to the claim's final disposition. The trial court found that a dispute over the advancement of defense costs was not excepted from the policy's no action clause and, accordingly, held that a final determination of the insured's obligation to pay in the underlying claim was a precondition to any action to resolve the insured's dispute with the insurer over the advancement of defense costs. The Supreme Court of Delaware found however that the trial court record was not adequately developed as to the relationship among the no action clause and allocation and advancement provisions. The Supreme Court of Delaware remanded the case for the trial court to construe the directors and officers liability policy as a whole and take into account how the noted provisions were intended to function in the absence of a duty to defend.

XIII.

Allocation

***Flextronics International, Ltd. v. Allianz Global Corporate & Specialty SE*, 25 Civ. 1511 (PAE), 2025 U.S. Dist. LEXIS 223418, 2025 WL 3168187 (S.D.N.Y. 2025)**

Under New York law, the U.S. District Court for the Southern District of New York held that an excess directors and officers liability insurer could not vacate an arbitral award requiring it to pay a 100% allocation of an underlying settlement to covered insureds because the arbitration panel reasonably applied New York's relative-exposure allocation rule and acted within its broad evidentiary discretion. The coverage dispute involved a directors and officers liability insurance policy containing an allocation provision obligating the insured and insurers to use their "best efforts" to reach a "fair and proper allocation" between covered and uncovered parties. The insured faced trade-secret and fiduciary duty claims in which both insured individuals and uninsured corporate entities were sued on joint-and-several theories and ultimately settled. After the primary and first two excess insurers resolved their shares, an arbitration panel heard the insured's claim against the insurer and found that all defendants in the underlying case had essentially identical exposure and that the insurer bore the burden under New York law to prove any non-covered share. The panel found the insured's settlement negotiations with other insurers admissible only for the narrow purpose of evaluating whether the insured satisfied its contractual "best efforts" obligation. The insurer argued that these evidentiary rulings effectively removed the "best efforts" requirement from the policy, and that the panel had in substance applied a "larger settlement" rule rather than New York's relative-exposure test. However, applying the Federal Arbitration Act's deferential standard, the court held that the panel's evidentiary choices were well within its discretion, that the panel's fact-intensive "best efforts" analysis reflected at least a reasonable application of New York contract principles, and that the panel had explicitly adopted and applied the relative-exposure rule.

***Scholastic Inc. v. St. Paul Fire and Marine Insurance Company*, No. 23-CV-3485 (JMF), 2025 U.S. Dist. LEXIS 179713, 2025 WL 2643981 (S.D.N.Y. Sept. 15, 2025)**

Under New York law, the U.S. District Court for the Southern District of New York held that an excess professional liability insurer had to reimburse an insured's unpaid defense costs and settlement payments because the claims arose from the insured's covered professional services and the excess policy effectively stepped into the primary insurer's shoes once the primary limit was exhausted. The coverage dispute involved an eroding primary professional liability policy that covered amounts the insured was legally obligated to pay "to compensate others for damages as a result of" specified "wrongful acts" in performing multimedia services. The excess professional liability policy provided no broader coverage than the primary, applied to liability "because of loss" caused by rendering or failing to render "professional services" and was triggered upon exhaustion of the primary limits by payments for covered losses. The insured faced claims relating to misuse of intellectual property, breach of contract, and trademark infringement. After motion practice and summary judgment, only a trademark claim and a breach-of-contract claim remained against the insured and the parties settled. The primary insurer had defended the case and paid up to its limit, leaving both defense costs and a portion of the settlement unpaid. The insured then sought coverage under the excess policy, but the excess insurer denied coverage on the grounds that the trademark claim was not related to professional services and thus the contract damages were not a covered or insurable loss. The court rejected those arguments, finding that the use of the claimant's marks on the insured's own materials could still constitute covered trademark infringement in the course of those professional services and that the claim was within the primary policy's wrongful act coverage and thus within the excess policy's scope under the "no broader coverage" clause. On defense costs, the court held that once the primary insurer exhausted its limits by paying the settlement, the excess coverage "continued in force as underlying insurance," and in the absence of clear language limiting reimbursement to costs incurred after exhaustion, the excess insurer was responsible for all remaining defense costs, even if those costs were incurred before the exhaustion date. The excess insurer filed an appeal of this ruling on October 10, 2025.

XIV.

Recoupment of Defense Costs and Settlement Payments

***Explorer Ins. Co. v. Nagel Farm Serv., Inc.*, Case No. 24-1346-ABA, 2025 U.S. Dist. LEXIS 123252, 2025 WL 1798132 (D. Md. June 30, 2025)**

Under Maryland law, the U.S. District Court for the District of Maryland held that an excess insurer could not recoup defense costs from its insured where the claims were potentially covered and a duty to defend existed. The dispute involved a workers' compensation and employers liability policy issued by Explorer Insurance Company and a commercial liability umbrella policy issued by Penn Millers Insurance Company that "followed form" to Explorer's employers liability coverage. The Penn Millers Policy had no express reimbursement clause, and recoupment was asserted only in a reservation-of-rights letter. An employee of the insured farm business was electrocuted while unloading lime in Delaware, and a third-party indemnity claim was asserted against the insured, prompting coverage disputes over whether injuries outside Maryland were "necessary or incidental" to the insured's Maryland work. The court found at least a potential for coverage because the policy language could reasonably be read to extend employers liability coverage to injuries arising from work connected to operations in a listed state even if the accident occurred elsewhere, and because there was at least a potential that Delaware law allowed the underlying indemnity claim. Having concluded that Penn Millers owed a duty to defend based on this potential for coverage, the court applied Fourth Circuit precedent interpreting Maryland law to hold that an insurer has no equitable right to reimbursement of defense costs for uncovered claims absent an express reimbursement provision in the policy itself. The court rejected Penn Millers' reliance on other jurisdictions' law allowing recoupment and distinguished prior federal cases, emphasizing that Penn Millers had not identified any Maryland law authorizing insurers to recoup defense costs from an insured if it is later determined that coverage is unavailable. Accordingly, the court granted the insured's motion to dismiss Penn Millers' counterclaim seeking reimbursement of defense fees and expenses incurred in defending the third-party action.

***New York Marine & Gen. Ins. Co. v. Xport Forwarding, LLC*, 772 F. Supp. 3d 1142 (C.D. Cal. 2025)**

Under New York law, the U.S. District Court for the Central District of California held that an insurer could both terminate its duty to defend once its errors and omissions policy limit was exhausted by defense payments and recoup defense costs it paid in excess of that limit. The case involved a professional liability errors and omissions policy with a first-dollar defense endorsement that removed a deductible but preserved language stating that the policy limit could be exhausted "by paying judgments, legal fees, loss adjustment expenses, and/or settlements," after which the insurer would have no further duty to defend. An insured freight forwarder and its executive were sued during the policy period, and the insurer defended under a general reservation of rights, ultimately paying more than $600,000 in defense costs against a $250,000 limit. The court ruled that New York law allows recoupment of defense expenses paid where there is no coverage or no remaining limit, provided the insurer defends under a reservation of rights. Because the insureds did not meaningfully contest the sufficiency of the insurer's general "reserves all rights" reservation (i.e., it did not explicitly reserve the right to recoup defense costs paid in excess of the limit), the court ordered the insureds to reimburse all defense costs the insurer had paid over the $250,000 limit.

***In re OTARMA (OTARMA v. Miami Twp.)*, 2025-Ohio-2897 (Ohio Ct. App. Aug. 15, 2025)**

Under Ohio law, the Court of Appeals of Ohio, Second Appellate District, held that a governmental risk pool was entitled, on restitution principles, to recoup defense costs it paid after a declaratory judgment established it had no duty to defend, even though the pool's coverage documents did not contain an express reimbursement clause. The coverage at issue was a governmental liability coverage agreement and a legal defense and claim payment agreement issued by OTARMA, a joint self-insurance pool for Ohio townships, which obligated OTARMA to defend suits seeking covered damages but said nothing about repayment of defense costs. After a civil rights and wrongful conviction suit was filed against a township officer, OTARMA initially defended under a reservation of rights and later obtained a declaratory judgment that its duty to defend had ended as of a specific date, but a trial court stay order required OTARMA to keep funding the defense through trial pending appeal. Once the appellate court confirmed there was no ongoing duty to defend, OTARMA brought a "further relief" action under Ohio's declaratory judgment statute seeking restitution of defense expenses it had paid solely because it was judicially compelled to do so during the stay. The appellate court held that, under Ohio's law of restitution and the Restatement (Third) of Restitution, a party that reasonably performs an obligation under protest or subject to a reservation, which is later determined not to be owed, may obtain restitution of those payments. Applying that framework and after considering decisions from other jurisdictions, the court ruled that OTARMA's continued defense funding after the cut-off date was not voluntary, the insureds knew OTARMA disputed any duty to defend, and OTARMA "never owed" those post-cut-off defense costs under the coverage documents. Therefore, the court affirmed OTARMA's entitlement in principle to recoup those defense costs, but remanded for a hearing on whether the amount claimed was reasonable and necessary.

***Zurich Am. Ins. Co. v. Burlington N. & Santa Fe Ry. Co.*, No. 02-23-00245-CV, 2025 Tex. App. LEXIS 1741, 2025 WL 807496 (Tex. App. Mar. 13, 2025)**

Under Texas law, the Court of Appeals for the Fort Worth District held that an insurer defending asbestos suits under old "owners', landlords' and tenants' liability" policies could not recoup defense costs from its insured absent an express policy provision or the insured's consent, and that a unilateral reservation letter could not create such a right. The policies gave the insurer the "right and duty to defend any suit" and broad discretion to investigate and settle, and they further stated that defense costs (other than settlements) were payable in addition to the limits, but they did not include any recoupment or reimbursement clause. After contributing to a global asbestos settlement and continuing to defend hundreds of suits, the insurer sought to recoup defense costs that it paid after the time it concluded it had exhausted its limits. The court held that the insurer had not proven that its earlier settlements exhausted the policy limits or terminated its duty to defend, because the settlement agreement expressly

disclaimed any admission of coverage or allocation to specific policies. Applying Texas law, the court held that an insurer cannot recoup defense costs absent either (1) clear policy language granting that right, or (2) a separate agreement with the insured; a unilateral reservation letter is not enough, according to the court.

xv. Consent

***AMC Entertainment Holdings, Inc. v. XL Specialty Ins. Co.*, et al., C.A. No. N23C-05-045 MAA (CCLD), 2025 Del. Super. LEXIS 84, 2025 WL 655595 (Del. Super. Ct. Feb. 28, 2025)**

Under Delaware law, the Superior Court of Delaware (Complex Commercial Litigation Division) held that the stock component of the insured's settlement in an underlying shareholder action constituted covered "Loss" under a directors and officers liability insurance program, but that factual disputes about consent to settle and prejudice precluded summary judgment on the insurers' consent defense. The decision involved a primary directors and officers liability policy and follow-form excess policies that defined "Loss" to include "damages, judgments, settlements … [and] that portion of any settlement which represents the claimant's attorneys' fees," and contained a standard consent-to-settle provision stating that no insured may settle a claim without the insurer's consent, which shall not be unreasonably delayed or withheld. The shareholders sued the insured in Delaware Chancery Court over its preferred equity unit structure and proposed charter amendments, and the insured settled by issuing millions of shares of common stock and paying plaintiffs' attorneys' fees. The insurers argued that "Loss" was limited to cash amounts "paid in legal tender" and did not encompass settlement consideration in stock, and that the "bump-up" exclusion and exhaustion/legal-tender wording showed the parties intended only cash indemnity. The court rejected those arguments, reasoning that nothing in the policies limited "Loss" to cash because Delaware law recognizes stock as a form of currency, interpreting the policy to mean the bump-up exclusion itself assumes that consideration in stock can be "paid," and the policies contemplate value in multiple forms (including foreign currency). However, the court found material disputes to be considered by a jury regarding what occurred at a key mediation and follow-up call, whether the insured sought or obtained the insurers' consent or waiver, and whether any breach of the consent provision prejudiced the insurers. The

court therefore granted the insured's partial summary judgment that the stock-based settlement consideration is covered "Loss," but denied both sides' motions as to the consent-to-settle and voluntary-payments defenses.

Ottawa Bancshares, Inc. v. Great Am. Sec. Ins. Co., 764 F. Supp. 3d 1079 (D. Kan. 2025)

Under Kansas law, the U.S. District Court for the District of Kansas held that a directors and officers liability insurer could enforce a provision requiring consent to defense costs to deny coverage for pre-tender legal fees without showing prejudice, even though a separate notice of claim provision was subject to a notice prejudice rule. The directors and officers liability policy defined "Defense Costs" as reasonable and necessary fees and expenses "incurred by or on behalf of an Insured with the Insurer's prior written consent" and required notice of any "Claim" within the policy period or a designated reporting window. The insured received a multimillion-dollar demand letter from a consulting firm and retained counsel, engaging in mediation and substantial presuit defense work, but did not notify the insurer for more than a year. Once the plaintiff filed suit, the insured finally tendered and sought reimbursement for over $150,000 in legal fees incurred before consent was obtained. The court held that, as a matter of policy interpretation, fees incurred without prior written consent did not fall within the definition of "Defense Costs," making them uncovered regardless of prejudice, and noted that national authority overwhelmingly rejects coverage for pre-tender defense costs in the absence of consent.

eQHealth AdviseWell, Inc. v. Homeland Insurance Co. of New York, No. 23-30528, 2025 U.S. App. LEXIS 8901, 2025 WL 1113224 (5th Cir. Apr. 15, 2025)

Under Louisiana law, the U.S. Court of Appeals for the Fifth Circuit held that an insured's settlement and payment of a Medicaid reimbursement dispute without the insurer's prior written consent barred coverage under a managed care errors and omissions liability policy, regardless of whether a "Claim" was timely reported. The policy was a claims-made managed care organizations errors and omissions liability policy that covered damages and claim expenses arising from managed care services, but expressly provided that the insured would not "incur any expense, make any payment, admit any liability, assume any obligation, or settle any Claim without our prior written consent, and no coverage will be available … for any such settlement [or] payment." After Florida's Medicaid agency disputed the insured's authorization of out-of-state care and demanded reimbursement, the insured negotiated and agreed to pay the provider $262,500, effectively committing to settlement months before it notified the insurer of the details and without ever seeking consent to the amount or terms. The insurer later denied coverage on several grounds, including an assertion that no "Claim" had been made or reported. Conversely, the insured argued that the insurer's supposed "improper denial" excused compliance with the consent provision and that the insurer should be estopped from relying on that provision while also disputing the existence of a "Claim". The Fifth Circuit affirmed judgment for the insurer, concluding that the insured's unilateral settlement, admissions of liability, and payment fell squarely within the policy's consent clause, and that the insurer had never actually denied a covered "Claim" before the settlement was finalized. The court rejected estoppel arguments and emphasized that the policy allocates control of negotiations and settlements to the insurer. Therefore, the insured cannot treat the insurer as a bystander and then seek reimbursement after consummating an agreement and making payment on its own.

Falls Lake Nat'l Ins. Co. v. Best Interior Solutions Inc., No. 22-CV-9354 (VEC), 2025 U.S. Dist. LEXIS 22006, 2025 WL 437888 (S.D.N.Y. Feb. 6, 2025)

Under New York law, the U.S. District Court for the Southern District of New York held that an insured's reimbursement of certain property damage costs after the insurer had already disclaimed coverage did not violate a no voluntary payments clause, and that the insurer's prior refusal to defend barred it from relying on that condition to avoid its defense obligations. The case involved a commercial general liability policy that prohibited any insured from "voluntarily mak[ing] a payment, assum[ing] any obligation, or incur[ring] any expense" without the insurer's consent, except at the insured's own cost. After a subcontractor's work caused a major water leak at a Manhattan condominium, the unit owner paid an assessment for damage to common areas and was later

reimbursed by the construction manager at a time when the insurer had already issued multiple disclaimers of coverage to the contractor and related parties. In the coverage litigation, the insurer argued that construction manager's promise to "take care of" the damage and its reimbursement of the common area invoice were voluntary payments and admissions of liability made without consent, voiding coverage. The court found factual disputes about the timing and content of any oral assurances and credited testimony that some statements occurred weeks after the loss, making it unclear they preceded the disclaimers. Notably, the court held that because the insurer had already denied coverage and refused to defend, New York law allowed the insureds to protect themselves by settling or making payments without seeking the insurer's consent, so long as the payments were reasonable. The court therefore rejected the insurer's voluntary payments argument and held that the insurer owed and had breached a duty to defend.

Flextronics Int'l, Ltd. v. Allianz Glob. Corp. & Specialty SE, No. 1:25-cv-001511, 2025 U.S. Dist. LEXIS 265709, 2025 WL 3688681 (S.D.N.Y. Dec. 19, 2025)

Under New York law, the arbitral panel (whose award was later confirmed by the Southern District of New York) held that an excess directors and officers liability insurer acted unreasonably in withholding consent to a time sensitive settlement and could not avoid coverage based on policy consent provisions. The insurance program consisted of a primary directors and officers liability policy and several follow form excess policies, all of which included provisions giving the insurers rights to associate in the defense and requiring the insured to obtain the insurers' prior written consent to settlements. Facing an imminent trial in a high exposure conspiracy case, the insured company and its insured directors negotiated a settlement at a court ordered conference and kept the insurance tower timely informed, requesting that the insurers waive consent while reserving rights. The subject insurer issued a "provisional" waiver conditioned on receiving the final settlement agreement and other documents but did not substantively challenge the reasonableness of the settlement. Applying New York law, the panel acknowledged that consent to settle is a condition precedent, but also emphasized an insurer's duty of good faith and the rule that an insurer may not arbitrarily withhold consent while insisting on strict compliance with conditions. The panel found that the insured company had adequately involved the subject insurer in the process, that the settlement amount was reasonable, and that the subject insurer's "conditional" consent position was unjustified given the timing and lack of any contrary evidence. Accordingly, the panel rejected the insurer's consent and participation defenses, allocated 100% of the settlement to covered loss, and awarded the insured the full amount due from the insurer (plus interest), which ultimately resulted in the federal court confirming the panel's decision.

Tindall Corp. v. Berkley Assurance Co., No. 1:22-cv-00745-JLS-MJR, 2025 U.S. Dist. LEXIS 31616, 2025 WL 677028 (W.D.N.Y. Feb. 20, 2025)

Under New York law, the U.S. District Court for the Western District of New York found that an insured's pre notice admissions of responsibility and commitments to remediate defects, made without the insurer's prior written consent, breached a voluntary payments provision that was a condition precedent to coverage and barred recovery of mitigation costs. The case involved a contractor's professional liability policy with a specific "Mitigation" insuring agreement and a broad voluntary payments clause stating that, as a condition precedent, the insured would not "voluntarily make any payment, assume or admit any liability, consent to any judgment, settle any … Claim, or incur any … Mitigation Cost" without the insurer's prior written consent, and that the insurer would not be liable for any payment or assumed liability to which it had not consented. After a water treatment plant owner issued nonconformance reports about precast roof members, the insured repeatedly acknowledged in writing that its work did not meet specifications, promised the owner and construction manager that it would "address the issues" and "absolutely uphold" the contractual requirements, and retained consultants and subcontractors to design and implement a remedial plan — all before notification to the insurer on the voluntary payments provision. The court held that the insured's series of written statements and commitments to repair constituted admissions or assumptions of liability and incurring of mitigation costs without consent, thereby violating the voluntary payments clause. The court rejected the insured's argument that the breach should be excused because many invoices were

paid only after the insurer denied coverage, finding that the breach lay in the binding commitments made prior to notice, which deprived the insurer of any meaningful opportunity to investigate, defend, or negotiate. The court treated the breach as a complete bar to coverage under New York law without requiring the insurer to show prejudice.

***Martin Marietta Materials, Inc. v. ACE Am. Ins. Co.*, No. 5:23-CV-313-FL, 2025 U.S. Dist. LEXIS 134572, 2025 WL 1944020 (E.D.N.C. July 14, 2025)**

Under North Carolina law, the U.S. District Court for the Eastern District of North Carolina held that an insurer's decision to settle an underlying bodily injury suit within a large per occurrence deductible was not a "voluntary" payment, and the insured was contractually obligated to reimburse the insurer for that settlement under a deductible endorsement, even though the insured objected to the settlement. The policies were a commercial general liability and umbrella package, under which the insurer had the "right and duty to defend" any suit seeking covered damages and "may, at [its] discretion, investigate any 'occurrence' and settle any claim or 'suit' that may result," coupled with a reimbursement endorsement obligating the insured to "reimburse [the insurer] up to the Deductible Amount for any amounts [the insurer] have paid under this policy." Faced with a Texas personal injury trial where plaintiffs' counsel announced plans to seek $9–12 million, the insurer believed the insured faced a substantial risk of an excess verdict and, over the insured's objection and after assuming direct control of negotiations, settled the case for $2.5 million, entirely within the $3 million deductible. When the insurer demanded reimbursement, the insured argued the payment was "voluntary" and not made under any legal obligation, so it fell outside the reimbursement clause. The court rejected that argument, explaining that once the insurer exercised its contractual right to settle, it became legally obligated to pay the settlement amount and thus its payment was not voluntary. The court further held that the endorsement's wording — requiring the insured to reimburse the insurer for "any amounts [the insurer] have paid under this policy" — did not limit reimbursement to court ordered payments or payments made with the insured's consent, and that North Carolina law does not require an insurer to place the insured's interests above its own so long as it acts in good faith.

***ACE American Insurance Co. v. Zurich American Insurance Co.*, No. 2:21-cv-1127, 765 F. Supp. 3d 705 (S.D. Ohio 2025)**

Under Ohio law, the U.S. District Court for the Southern District of Ohio held that an insurer must show prejudice before relying on a voluntary payments provision to avoid contributing to an insured's pre-tender defense costs. The case involved a series of commercial general liability policies that required notice "as soon as practicable" and stated that no insured would "voluntarily make a payment, assume any obligation, or incur any expense" without the insurer's consent. The insured defended a Lanham Act suit for several years before tendering to prior insurers. Eventually, the defending insurer funded nearly $5 million in defense costs that the prior insurers refused to contribute toward, citing their policies' late notice and the voluntary payments clause. The Sixth Circuit held that, under Ohio's Ferrando framework, an insurer generally must show prejudice to avoid coverage based on late notice and remanded the case to the district court to consider voluntary payments. On remand, the court reasoned that voluntary payments clauses serve the same function as notice and consent to settle provisions—allowing the insurer to investigate, control the defense, and manage settlement — so Ohio's prejudice rule logically extends to them. While the court found breaches of both the notice and voluntary payments provisions, the court found that the insurers were not prejudiced, because they had stipulated the defense costs were reasonable, the underlying case was resolved favorably, and no evidence or witnesses were lost. Accordingly the court ordered that the prior insurers reimburse the defending carrier for their shares of the pre tender defense costs under equitable contribution principles.

***In re Mining Project Wind Down Holdings Inc. (Tribolet Advisors LLC v. Relm Insurance Ltd.)*, Case No. 22-90273, Adv. No. 24-3144, 2025 WL 3522403 (Bankr. S.D. Tex. Dec. 8, 2025)**

Under Texas law, the U.S. Bankruptcy Court for the Southern District of Texas held that a litigation trustee's within-limits settlement demand under a post-petition directors and officers liability policy was reasonable and that the insurer's refusal to consent was wrongful, but that the court lacked authority to compel the insurer to fund the

settlement prospectively. The policy was a post-petition directors and officers liability policy providing Side A coverage for "Loss," including settlements and defense costs, on account of claims first made during an extended reporting period for wrongful acts committed on or before a specified date. The policy required the insureds to obtain the insurer's consent to any settlement, which could not be unreasonably withheld. The trustee alleged that the debtors' former directors and officers committed pre- and post-petition wrongful acts by failing to preserve and maintain cryptocurrency mining containers, causing tens of millions of dollars in lost value compared to sale projections, and sought to resolve those claims through a settlement funded entirely by the director and officer limits. The insurer argued that the policy did not cover pre-petition conduct and that more time and defense spending were needed before agreeing to settle, while the trustee presented multiple damages methodologies and expert evidence showing that the proposed $4.65 million settlement — just under the remaining limits — was reasonable when measured against likely liability, prejudgment interest, and very substantial projected defense costs. The court rejected the insurer's coverage arguments, finding that the extended reporting provisions reached the alleged pre-petition conduct, and concluded that a prudent insurer, acting in good faith would accept the proposed settlement in light of the risk that defense and indemnity would exhaust or exceed the limits. Nonetheless, bound by Texas Supreme Court authority, the court held that the remedy for an unreasonable refusal to settle is retrospective (damages after judgment or a funded settlement), and that it could not force the insurer to consent or to pay the settlement in advance. The motion to compel the insurer to fund the settlement was therefore denied, despite the court expressly finding the demand reasonable and the refusal wrongful.

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