April 2013

Insurance Coverage Law Report

FC&S LEGAL
The Insurance Coverage Law Information Center

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Developments and Article Submission:

Submit insurance coverage law decisions, developments, and articles to be considered for use on our Developments page or in the *Insurance Coverage Law Report,* to our Director, Steven A. Meyerowitz, at smeyerowitz@sbmedia.com. Please consult the Editorial Guidelines for the *Insurance Coverage Law Report*.

Industry News and Events Submission:

Submit industry news and events to our Associate Director, Victoria Prussen Spears, at vspears@sbmedia.com. Although we welcome all submissions, selection for publication will be at the discretion of our Directors, and are subject to space limitations.

From the Editor

Expanding Content

By Steven A. Meyerowitz

Regular readers of the *Insurance Coverage Law Report*, which is available both in print and online at http://www.fcandslegal.com/, will notice that this issue contains some new elements.

Case Law and Legislative/Regulatory Developments

First, reflecting how the Developments column of ***FC&S Legal*** is structured, we have a column on Case Law Developments and a separate column on Legislative/Regulatory Developments.

Eye on the Experts

Second, this issue also is publishing our first Eye on the Experts pieces by lawyers talking about their own cases. We believe you will find their perspectives of great interest.

Features

Of course, we also have special feature articles in this issue.

The first, by two lawyers at Reed Smith – Timothy P. Law (a member of the Editorial Advisory Board of ***FC&S Legal***) and Anthony B. Crawford – is entitled, "Insurance Appraisals Can Resolve Disputed Property and Business Interruption Claims."

The second, entitled, "Who? What? When? 'Ware – An Illinois Appellate Court Addresses the 'Number of Occurrences' Issue," is by Julie N. Johnston and Molly McGinnis Stine of Locke Lord LLP.

And More…

This issue of the *Insurance Coverage Law Report* also contains our usual broad range of Industry News on People, News, Thought Leaders, and New Products, as well as a Focus article on a pending Illinois Supreme Court case on the insurability of TCPA awards and punitive damages, and our Calendar.

We look forward to hearing from you. You can reach me directly by email at smeyerowitz@sbmedia.com.

Enjoy the issue!

Steven A. Meyerowitz, *Editor-in-Chief*
April 2013

Steven A. Meyerowitz, who can be reached at smeyerowitz@sbmedia.com, is the Editor-in-Chief of *The Insurance Coverage Law Report* and the Director of ***FC&S Legal: The Insurance Coverage Law Information Center***.

Insurance Appraisals Can Resolve Disputed Property and Business Interruption Claims

By Timothy P. Law and Anthony B. Crawford

The authors suggest that the proper use of the appraisal process can be a valuable tool to move a disputed claim toward full payment.

Timothy P. Law

In the wake of Superstorm Sandy, many people and corporations are rebuilding their lives, property, and businesses. Insurance proceeds are needed to make that happen. For some policyholders, those proceeds will be slow in coming. Their insurance companies may offer to pay significantly less than what is due.

Policyholders may feel that their options are limited; either they accept what the insurance company is willing to pay or face a prolonged legal battle. Often, there is another option. Virtually every property insurance policy for both homeowners and corporations has a provision specifying "appraisal" as a means of resolving disputes about the "amount of loss" for a covered claim.[1] Proper use of the appraisal process can be a valuable tool to move a disputed claim toward full payment.

What is Appraisal?

Most appraisal provisions follow the same general format. For example, the statutory standard fire policy in Pennsylvania contains the following appraisal provision:

> In case the insured and this Company shall fail to agree as to the actual cash value or the amount of loss, then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within twenty days of such demand. The appraisers shall first select a competent and disinterested umpire; and failing for fifteen days to agree upon such umpire, then, on request of the insured or this Company, such umpire shall be selected by a judge of a court of record in the state in which the property covered is located. The appraisers shall then appraise the loss, stating separately actual cash value and loss to each item; and, failing to agree, shall submit their differences, only, to the umpire. An award in writing, so itemized, of any two when filed with this Company shall determine the amount of actual cash value and loss. Each appraiser shall be paid by the party selecting him and the expenses of appraisal and umpire shall be paid by the parties equally.[2]

Anthony Crawford

Different jurisdictions view appraisal differently: as a type of arbitration, as akin to arbitration, or as something fundamentally different from arbitration.[3] Unlike arbitration, appraisal is limited to determining what constitutes a fair price, valuation, or estimation of worth of a covered loss under an insurance policy.[4] The appraisal cannot be used to determine the existence of coverage. Even while recognizing the distinctions between arbitration and appraisal, courts may enforce appraisal provisions in much the same way as they enforce arbitration provisions. Courts can compel a party to submit to the appraisal process and can confirm appraisal awards.

1. Timothy P. Law & Jillian L. Starinovich, *What is it Worth? A Critical Analysis of Insurance Appraisal*, 13 Conn. Ins. L.J. 291, 292 (2007).
2. 40 P.S. § 636(2).
3. Law, *supra*, note 1 at 297.
4. *Id*. at 294.

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What are the Advantages and Disadvantages of Appraisal?

The biggest advantage of appraisal is speed. Resolving a lawsuit can take a considerably longer amount of time than appraisal. A second advantage of appraisal is cost. When compared with litigation, it is significantly cheaper for both the insurance company and the policyholder to value the loss through appraisal rather than through litigation. A third advantage of appraisal is that it places the decision about the value of the claim into the hands of experts who may be better equipped to reach a fair resolution than a judge or jury.

Appraisal is not free, and it does take some time. Each party must bear the expense of its own appraiser and share the cost of the umpire, who is appointed by the appraisers to resolve differences between the appraisers. Most policyholders do not deal with the appraisal process often, or ever, so the insurance company has an information advantage in the appointment of appraisers and umpires, as well as throughout the appraisal process. Especially for larger claims, it is important for the policyholder to have a team on its side, which can include attorneys, experts, and public adjusters.

When Does Appraisal Take Place?

Appraisal should be demanded promptly when it becomes clear that the key dispute, or the only dispute, is about the value of the property loss, the period of business interruption, or other damages. Appraisal is a contractual right held by both the policyholder and the insurance company. Some jurisdictions have held that the right to appraisal is waived if a party files a lawsuit before demanding appraisal.[5] Some states will allow one party to prevent appraisal if a coverage issue must be resolved in court.[6] Other states allow appraisal to take place even if there is a coverage issue, reasoning that the appraisal process may actually help resolve the liability issue.[7] In some instances, it can be difficult to determine whether the dispute is really about the valuation of the loss or the cause of loss or the interpretation of insurance policy language.

How Does the Appraisal Process Work?

Insurance policies generally provide little guidance and instruction about how the appraisers are to be selected and how the appraisal is to be conducted.[8] As a practical matter, policyholders should use the opportunity to appoint a professional who understands the full value of the claim. There are three primary considerations in selecting a party appraiser: familiarity with the subject matter of the appraisal, familiarity with the appraisal process, and familiarity with the other side.[9]

Each side is required to select a disinterested appraiser, who may also need to be "competent" if the appraisal language requires it, within the timeframes specified in the policy. Generally, a "disinterested" appraiser is someone who is not under the control of either party.[10] Some courts narrowly construe the "disinterested" requirement to mean anyone not on the regular payroll of the insurance company or policyholder.[11] Other courts recognize that an individual "who is frequently or habitually employed by insurers as an appraiser and who . . . understands that he is acting in their interests is not disinterested."[12]

Some arguments about an appraiser being not "disinterested" have included the number of times the appraiser has worked for the company,[13] the percentage of income that comes from the insurance company,[14]

5. *See, Giulietti v. Connecticut Ins. Placement Facility*, 534 A.2d 213, 217 (Conn. 1987) (holding that "the plaintiffs, by proceeding to trial before the jury upon the question of the amount of their loss, the very issue to be determined by appraisers, effectively waived their rights under the appraisal clause").
6. *See, American Nat'l Fire Ins. Co. v. Unigraphic-Color Corp.*, No. 84-1512, 1984 U.S. Dist. LEXIS 15646, at *8 (E.D. Pa. June 22, 1984).
7. *See, Masonic Temple Assoc. of Grand Rapids v. Michigan Fire & Marine Ins. Co.*, 36 N.W.2d 317, 321 (Mich. 1949).
8. *See generally*, JONATHAN J. WILKOFSKY, THE LAW AND PROCEDURE OF INSURANCE APPRAISAL (Ditmas Park Legal Publishing 2003) (discussing various state laws and precedents).
9. Jay M. Levin, *Demystifying Appraisal: Getting Through the Process*, December 2007, http://www.irmi.com/expert/articles/2007/levin12.aspx.
10. *See, e.g., Norwich Union Fire Ins. Soc'y v. Cohn*, 68 F.2d 42, 44 (10th Cir. 1933); *Phoenix Assur. Co. of N.Y. v. Singer*, 221 F. Supp. 890, 894-95 (E.D. Mo. 1963), *aff'd*, 331 F.2d 10 (8th Cir. 1964).
11. See, e.g., Tiger Fibers, LLC v. Aspen Specialty Ins. Co., 571 F. Supp. 2d 712 (E.D. Va. 2008).
12. See, e.g., Orr v. Farmers Mut. Hail Ins. Co. of Mo., 201 S.W.2d 952 (Mo. 1947).
13. *See, Sterling Spinning & Stamping Works v. Knickerbocker Ins. Co. of N.Y.*, 242 N.Y.S. 201, 204 (Manhattan Borough Mun. Ct. 1930) (A contractor employed over 1800 times by insurance company was judged ineligible to serve as an appraiser).
14. *Holt v. State Farm Lloyds*, No. CA 3:98-CV-1076-R, 1999 U.S. Dist LEXIS 6257, at *13 (N.D. Tex. Apr. 22, 1999) (holding that whether an appraiser who derived more than one-quarter of his income from work done from the insurance company was independent is a question for the jury).

reputation,[15] and payment based on a contingent fee.[16] In many instances, the policyholder's best choice for appraiser will be the expert who valued the loss for submission of the proof of loss, which could be a public adjuster. If the public adjuster will receive a percentage of the appraisal award, the appraiser could be challenged as not being disinterested. Accordingly, if a public adjuster is selected as the appraiser, a new fee agreement should be reached which compensates the appraiser in a manner that is not tied to the result of the appraisal.

The two appraisers will select a competent and disinterested umpire to resolve differences between the appraisers. Most policies set a time limit for selecting the umpire, and if the party-appointed appraisers cannot agree then either the policyholder or the insurance company can request that a court appoint the umpire. This may be the least preferred method of selecting an umpire, given that "the umpire is almost invariably a friend of the appointing judge, frequently has no experience in property insurance, and almost never has any experience (much less expertise) in construction, engineering, or time element analysis."[17] The parties can avoid this situation by agreeing in advance to a selection process or, at a minimum, by submitting a short list of potential umpires to the judge for consideration.[18]

Once the appraisal panel is set, the two appraisers will attempt to agree upon a value. A loss can be comprised of many elements. If the two agree on a value for one element of the loss, then that is the set value of the loss for that element. The appraisers will continue this process until they have resolved the entire matter. However, if there are elements on which the appraisers disagree, those disputes are submitted to the umpire. The umpire and the appraisers will try to resolve any disputed issues through inspection and discussion. Once two of the three members agree on the value, they sign the appraisal award and it becomes the set value of the loss. This value is binding on both parties. The appraisal award should be in writing and contain an itemized determination of the loss.

15. *Bunting v. State Farm Lloyds*, No. 3-98-CV-2490-BD, 2000 U.S. Dist. LEXIS 1674, at *7 (N.D. Tex. Feb. 14, 2000) (holding that a reputation in roofing industry as being rude and unfair to homeowners and biased in favor of insurance companies will not disqualify appraiser).
16. *Galvis v. Allstate Ins. Co.*, 721 So. 2d 421, 421 (Fla. Dist. Ct. App. 1998) (holding that the fact that appraiser was paid on a contingent fee basis did not result in a finding that appraiser was not disinterested); *Hozlock v. Donegal Cos./ Donegal Mut. Ins. Co.*, 745 A.2d 1261 (Pa. Super. Ct. 2000).
17. Levin, *supra,* note 9.
18. *Id.*

What is the Scope of Appraisal?

It is a good idea to define in writing exactly what is (and equally important, what is not) being submitted to the appraisers for decision and what is expected of the appraisers. As an initial matter, the demand for appraisal should define the issues being submitted for appraisal and may list any requests for procedural protections, an itemized award, or a reasoned award.

Beyond the demand for appraisal, the parties can negotiate an agreement to govern the appraisal process. An agreement can be drafted either between the parties for their signatures, or for the appraisers and umpire to sign.[19] Typically, an agreement to be signed by the appraisers and umpire would confirm that they meet the requirements of the insurance policy, such as any requirement that the appraisers be competent and disinterested, and that they will make a true and just award based upon their best knowledge, skill and judgment.

An agreement could identify the specific property and the exact loss to be appraised, the procedures and timeline for the appraisal process, and the form of the appraisal award. Depending upon the amount of loss and the complexity of the issues, the parties may desire very little process to the appraisal proceedings or, alternatively, may desire substantial due process protections. An agreement could provide for a hearing, for evidence and testimony to be taken, an opportunity for cross examination, and for the submission of preliminary memoranda by the parties. Any thought of requesting such extensive due process protections should be weighed against the benefits of a speedy and more informal assessment of the loss. Setting timelines can be helpful in moving the process to completion.

In specifying the award to be issued, a policyholder will want, at a minimum, an itemized award showing the amount of loss for specific categories of repair, replacement, or other loss. Generally, the parties will want separate itemization of replacement cost, the actual cash value if different than replacement cost, and any depreciation applied to reach actual cash value. It would be unusual to require a reasoned award in which the appraisal panel would explain why it reached any particular valuation. One strategic question for policyholders is whether to request that the appraisers award interest from the time of loss. Generally, it is wise to either explicitly submit the interest calculation to the appraisers or not submit that issue and explicitly reserve the right to

19. *See, Brethren Mut. Ins. Co. v. Filsinger*, 458 A.2d 880, 884 (Md. Ct. Spec. App. 1983) (noting that a separate agreement can only be entered with the consent of both parties, and insurance company could not compel the policyholder to sign a separate agreement that defines policy terms).

later demand or recover pre-award interest. One court ruled that, "a reasonable interpretation of the policy language necessitates only an itemization of the damage to the basic component systems (e.g. electrical, plumbing, heating, structure, carpentry, painting, refinishing) so as to insure a modicum of accountability and reliability in the appraisal process."[20] If an itemization requirement is not agreed upon by the parties, then a general conclusion or lump sum may suffice.[21]

What Happens If the Insurance Company Abuses the Appraisal Process?

If the appraisal award is much higher than the amount that the insurance company was willing to pay in the absence of appraisal, then the insurance company's actions could be challenged in a subsequent bad faith action.[22] Unfair Claims Settlement Practices Acts govern the conduct of insurance companies in resolving claims. Those statutes typically require the insurance company to have as its goal the prompt and fair resolution of covered claims. In some states, unfair trade practice statutes authorize treble damages.[23]

20. *DeCrescenzo v. Capital Mut. Ins. Co.*, 589 N.Y.S. 2d 669 (App. Div. 3d Dep't 1992).
21. *Mich. Fire Repair Contractors' Ass'n v. Pacific Nat'l Fire Ins. Co.*, 107 N.W.2d 811 (Mich. 1961).
22. *See, e.g.. Willow Inn, Inc. v. Public Serv. Mut. Ins. Co.*, 399 F.3d 224 (3d Cir. 2005) (affirming punitive damages award of $150,000 in case involving insurance company's initial refusal to submit to appraisal and delayed payment of $117,000 property loss); *Knight v. Allstate Ins. Co.*, No. Civ. A. 3:02-CV-2030, 2005 WL 1309064 (M.D. Pa. May 31, 2005) (holding that a reasonable fact-finder could conclude that insurance company acted in bad faith where insurance company delayed payment for four months and had paid less than one-half the value of the claim as later determined in appraisal).
23. *High Country Arts & Craft Guild v. Hartford Fire Ins. Co.*, 126 F.3d 629 (4th Cir. 1997) (affirming jury award of treble damages under unfair trade practices act).

Insurance companies abandon their good faith obligations, at much risk to themselves, if they view appraisal as an opportunity to delay payment. In *Green v. International Insurance Co.*, the Illinois appellate court held that an insurance company's actions could reasonably be seen by a court as unreasonable and vexatious delay in settling plaintiff's claim.[24] The insurance company's appraiser in *Green* repeatedly insisted on naming umpire candidates who currently or formerly had dealings with the company and cancelled a series of meetings at the last minute, usually without explanation, which led to the appraisal process taking four years.[25]

Similarly, an insurance company's refusal to submit to the appraisal process could be viewed as a bad faith effort to avoid its contractual obligations. Insurance companies owe policyholders a duty of good faith and fair dealing in the performance of their obligations, and that includes the insurance company's behavior during the appraisal process.

Conclusion

Appraisal is a contractual right. Policyholders should view appraisal as a part of the property insurance claim process that can be utilized to great advantage when there are no significant questions of coverage and the dispute centers on the amount of loss. Where the insurance company has not fairly valued the loss, demanding appraisal will often yield additional uncontested payments as the insurance company adjusts its evaluation to present a credible case in appraisal. The appraisal award also may yield substantial additional payments and provide objective and persuasive evidence of the insurance company's failure to value the loss fairly and in good faith prior to the appraisal proceedings.

24. *Green v. Int'l Ins. Co.*, 605 N.E.2d 1125, 1129 (Ill. App. Ct. 1992).
25. *Id.*

Who? What? When? "Ware" — An Illinois Appellate Court Addresses the "Number of Occurrences" Issue

By Julie N. Johnston and Molly McGinnis Stine

The authors discuss the significance of a recent Illinois appellate court decision that spotlights some of the issues and tensions emerging from the two different "number of occurrences" analyses provided by the Illinois Supreme Court.

In *Ware, et al. v. First Specialty Ins. Corp.*,[1] an Illinois appellate court determined that damages arising from a porch collapse in 2003 arose from a single occurrence.

Julie N. Johnston

Facts

A party was held at the second and third floor units of a three floor apartment building in Chicago, Illinois. While several individuals were standing on the second or third floor back porches, the third floor porch suddenly collapsed onto the second floor porch which immediately collapsed onto the first floor porch. As a result of the porch collapse, 13 people died and at least 29 more were injured that night and in the days or weeks after the collapse.

The owner of the property and others were identified as named insureds on a Bodily Injury and Property Damage Liability insurance policy issued by First Specialty Insurance Corporation. The policy covered the subject apartment building and had limits of $1 million per occurrence and $2 million in the aggregate, subject to a $5,000 deductible.

The injured and the decedents' estates sued the property owner and the other named insureds in the Circuit Court of Cook County, Illinois, claiming, among other things, that the insureds' failure to inspect the porch and maintain it in a reasonably safe manner was the cause of the injuries and deaths of the plaintiffs. The parties ultimately agreed to resolve their differences, with one of the arrangements being First Specialty's agreement to contribute its $1 million per occurrence limit.

Following the First Specialty agreement and pursuant to an assignment of rights, the plaintiffs filed a declaratory judgment action as to whether there was more than one occurrence and thus whether First Specialty must pay the policy's aggregate limit of $2 million.

Molly McGinnis Stine

The parties agreed for purposes of the lawsuit that there were "no intervening acts or circumstances which could have or did in fact contribute to and/or cause" the deaths or injuries suffered. The parties cross-moved for summary judgment on the issue of the number of occurrences. The trial court denied the plaintiffs' motion and granted First Specialty's, concluding that the injuries resulted from one occurrence.

The plaintiffs appealed. They argued that because the several injuries and deaths did not all occur at the same time, First Specialty could not establish that the injuries constituted a single occurrence under the Policy. First Specialty contended that the injuries and deaths were

1. 2012 Ill. App. (1st) 113340 (Jan. 11, 2013).

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the result of one thing, the porch collapse, and thus the injuries arose out of a single occurrence.

The Appellate Ruling

In its recent decision, the Illinois appellate court sided with First Specialty, relying on the language of the policy that defined "bodily injury" to mean "injury, sickness or disease sustained by a person, including death resulting from any of these at any time." Based on this language, the appellate court rejected the plaintiffs' argument that there were separate occurrences and determined the policy's definition of "bodily injury" to mean that the phrase "deaths . . . at *any time*" controlled. When the deaths or injuries actually occurred was irrelevant to the appellate court's determination that there was a single occurrence.

The appellate court then discussed Illinois Supreme Court precedent on the "number of occurrences" issue. The appellate court first considered the Illinois Supreme Court's decision in *Nicor, Inc. v. Associated Electric & Gas Ins. Services*,[2] which said that the "cause theory" obligates the court to determine the source of the claims or injuries arising out of the event in order to determine the number of occurrences. Using the *Nicor* ruling as a guide here, the appellate court determined that the parties agreed there were no intervening acts or circumstances which could have caused the injuries and that the porch collapse was the single cause of the injuries. As the appellate court noted, "the time at which injuries manifest is irrelevant." Rather, there was one cause and, thus, only one occurrence.

The plaintiffs also asked the appellate court to consider the "time and space test" discussed in the Illinois Supreme Court's decision in *Addison Insurance Co. v. Fay*.[3] The "time and space test" limits the *Nicor* "cause theory" and if "cause and result are simultaneous or so closely linked in time and space as to be considered by the average person as one event," then the court must conclude that the injuries arise from a single occurrence. The *Addison* court used the "time and space test" to say that the deaths of two boys who were found on private property constituted two occurrences because, even though there was an "ongoing omission" by the property owner in securing the land, there was insufficient evidence to determine how or when the boys died.

The appellate court determined that the "time and space test" was not useful in this instance because the porch collapse was a distinct incident and not an "ongoing omission" as in *Addison*. Further, the appellate court stated that even under the "time and space test," a single occurrence determination is warranted because the evidence made it so overwhelmingly clear that the cause of the injuries was "so closely linked in time and space as to be considered by the average person as one event. . . . All of the [p]laintiffs' deaths and injuries can be directly traced to one cause: the porch collapse."

Considerations

The *Ware* decision spotlights some of the issues and tensions emerging from the two different "number of occurrences" analyses provided by the Illinois Supreme Court in its *Nicor* and *Addison* opinions. Both insurers and policyholders will need to analyze the relevant policy language and the specific facts of a situation in order to assess the possible outcomes when applying the growing body of Illinois law on the "number of occurrences" issue.

2. 223 Ill. 2d 407 (2006).

3. 232 Ill. 2d 446 (2009).

By Steven A. Meyerowitz

Commercial General Liability

Using 'Cause Test,' Circuit Finds One Occurrence Where Hundreds of Surgical Instruments Were Washed with Hydraulic Fluid

The U.S. Court of Appeals for the Fourth Circuit has decided that there was one occurrence where hydraulic fluid was used to wash hundreds of surgical instruments.

The Case

In 2004, Duke University Health System, Inc., hired Automatic Elevator Company to renovate two elevators in a hospital's parking deck. After Automatic Elevator completed its work, it placed barrels full of used hydraulic fluid in its designated storage area at the hospital. Duke employees saw the barrels, mistakenly thought they contained surgical detergents and lubricants, and ultimately used the hydraulic fluid to wash hundreds of surgical instruments. Approximately 127 patients who may have come into contact with the tainted instruments sued Duke, which settled the claims for over $6 million. Duke then sued Automatic Elevator.

Mitsui Sumitomo Insurance Company of America, which had issued two policies to Automatic Elevator, argued that the hydraulic fluid mistake constituted one "occurrence," obligating it to pay $1 million under the policies, which it had already paid to settle the surgical patients' claims against Automatic Elevator. Duke countered that each instance of a waste-laden medical instrument being used to operate on an unsuspecting patient gave rise to a separate "occurrence." A federal district court agreed with the insurer, and the coverage dispute reached the Fourth Circuit.

The Policy

The insurance policies included a $1 million limit for "any one occurrence." The policies defined "occurrence" as:

> an accident, including the continuous repeated exposure to substantially the same harmful condition

Neither policy defined "accident."

The policies included a $3 million aggregate limit, and both policies contain a "per elevator" endorsement that applied the aggregate limit to

> each and every elevator ... that is either serviced, repaired, installed, renovated, refurbished or worked upon by [Automatic Elevator] during the policy period.

The Circuit Court's Decision

In its decision, the circuit court explained that, under applicable North Carolina law, it had to apply a "cause test" to determine how many occurrences an event encompassed. Under this type of test, the number of occurrences was determined by the cause or causes of the resulting injury, the circuit court continued. It noted that the cause test stood in opposition to the effect test, which treated each injury as a separate occurrence. Therefore, to determine how many occurrences stemmed from the hydraulic fluid mistake, the circuit court said that it had to evaluate the cause or causes of the incident rather than its effects.

It then explained that the only action that Automatic Elevator – the insured – took in this case was placing the barrels of hydraulic fluid in its designated storage area at the hospital's parking deck. The circuit court then held that Automatic Elevator's alleged negligence in leaving the barrels in its storage area constituted a single occurrence.

The case is *Mitsui Sumitomo Ins. Co. of America v. Duke University Health System, Inc.*, No. 11–2057 (4th Cir. Feb. 11, 2013). Attorneys involved include: ARGUED: Charles Holton, Womble Carlyle Sandridge & Rice, PLLC, Durham, North Carolina, for Appellant. Richard H. Nicolaides, Jr., Bates Carey Nicolaides, LLP, Chicago, Illinois, for Appellee. ON BRIEF: Julie B. Bradburn, Womble Carlyle Sandridge & Rice, PLLC, Raleigh, North Carolina; Hada de Varona Haulsee, Womble Carlyle Sandridge & Rice, PLLC, Winston–Salem, North Carolina, for Appellant. Barbara I. Michaelides, Paula M. Carstensen, Bates Carey Nicolaides, LLP, Chicago, Illinois, for Appellee.

Concrete Sealant Used in Insured's Business Is Not A Pollutant, Court Rules

A federal district court in Missouri has ruled that a chemical sealant used by an insured in its business was not a pollutant under the insured's commercial general liability ("CGL") insurance policy and that claims

asserting that individuals were harmed by exposure to the chemical were not excluded from coverage by the policy's total pollution exclusion.

The Case

Plaintiffs brought a personal injury action against Titan Contractors Service, Inc., alleging that they had been harmed by exposure to a chemical concrete sealant applied by Titan to a warehouse area adjacent to the plaintiffs' office space. Titan's CGL insurer, United Fire & Casualty Company, sought a determination of its rights and obligations under the policy. United moved for summary judgment based on the CGL policy's total pollution exclusion, arguing that the underlying claims were caused by exposure to pollutants.

The Policy

The policy provided as follows:

SECTION I—COVERAGES

COVERAGE A BODILY INJURY AND PROPERTY DAMAGE LIABILITY

1. Insuring Agreement

a. We will pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damage" to which this insurance applies. We will have the right and duty to defend the insured against any "suit" seeking those damages. However, we will have no duty to defend the insured against any "suit" seeking damages for "bodily injury" or "property damage" to which this insurance does not apply. We may, at our discretion, investigate any "occurrence" and settle any claim or "suit" that may result.

The policy also provided:

TOTAL POLLUTION EXCLUSION WITH A HOSTILE FIRE EXCEPTION

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

Exclusion **f.** under Paragraph **2., Exclusions of Section I—Coverage A—Bodily Injury and Property Damage Liability** is replaced by the following: This insurance does not apply to:

f. Pollution

(1) "Bodily injury" or "property damage" which would not have occurred in whole or part but for the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of "pollutants" at any time.

This exclusion does not apply to "bodily injury" or "property damage" arising out of heat, smoke or fumes from a "hostile fire" unless that "hostile fire" occurred or originated:

(a) At any premises, site or location which is or was at any time used by or for any insured or others for the handling, storage, disposal, processing or treatment of waste; or

(b) At any premises, site or location on which any insured or any contractors or subcontractors working directly or indirectly on any insured's behalf are performing operations to test for, monitor, clean up, remove, contain, treat, detoxify, neutralize or in any way respond to, or assess the effects of, "pollutants."

(2) Any loss, cost or expense arising out of any:

(a) Request, demand, order or statutory or regulatory requirement that any insured or others test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or in any way respond to, or assess the effects of "pollutants"; or

(b) Claim or suit by or on behalf of a governmental authority for damages because of testing for, monitoring, cleaning up, removing, containing, treating, detoxifying, or neutralizing, or in any way responding to, or assessing the effects of, "pollutants".

The policy defined "pollutants" as:

> SECTION V—DEFINITIONS
>
> **15.** "Pollutants" mean any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes materials to be recycled, reconditioned or reclaimed.

The Court's Decision

In its decision, the court observed that the underlying plaintiffs' alleged exposure to the chemical sealant occurred in the normal course of Titan's business of sealing concrete floors and that the sealant belonged in the environment in which Titan routinely worked.

In the court's view, it was reasonable for Titan to expect that its work in sealing concrete floors would be covered by its CGL insurance policy, and that the sealant would not be deemed a pollutant. The court held that there was ambiguity in the policy language as it related to Titan's allegedly negligent application of the sealant to seal the concrete floor, deciding that the pollution exclusion did not unambiguously preclude Titan from insurance coverage for its common business activity.

The court acknowledged that this was "not an easy case" but rather was "a close case." It pointed out that because United was seeking to avoid coverage under the exclusion, it had the burden of proving the applicability of the exclusion. Finding that the policy's ambiguity had to be construed in favor of the insured, and that the scope of the pollution exclusion was governed by the expectations of a reasonable policyholder, the court concluded that a reasonable policyholder in Titan's position would not expect that injury or damage arising from its use of the chemical sealant in the course of its business would be considered pollution within the meaning of the policy's pollution exclusion.

The case is *United Fire & Cas. Co. v. Titan Contractors Service, Inc.*, No. 4:10–CV–2076 CAS (E.D.Mo. Jan. 28, 2013). Attorneys involved include: David K. Simkins, M. Adina Johnson, Wuestling and James, L.C., St. Louis, MO, for Plaintiff and Counter Defendant; M. Quinn Murphy, Nicholas J. Garzia, Patrick J. Kenny, Armstrong Teasdale, LLP, St. Louis, MO, for Defendant and Counter Claimant.

FC&S Legal Comment

Cases from other jurisdictions involving fumes from floor sealants, glues, and chemicals are inconsistent. *Cf. Meridian Mut. Ins. Co. v. Kellman,* 197 F.3d 1178 (6th Cir.1999) (finding movement of fumes from chemical floor sealant was not "discharge, dispersal, seepage, migration, release or escape" within terms of policy's pollution exclusion); *Calvert Ins. Co. v. S & L Realty Corp.,* 926 F.Supp. 44 (S.D.N.Y.1996) (fumes from cement used to install plywood floor not a pollutant); *Freidline v. Shelby Ins. Co.,* 739 N.E.2d 178 (Ind. Ct.App.2001) (fumes from carpet glue not a pollutant), *rev'd on other grounds,* 774 N.E.2d 37 (Ind.2002) *with Firemen's Ins. Co. v. Kline & Son Cement Repair, Inc.,* 474 F.Supp.2d 779 (E.D.Va.2007) (finding fumes from epoxy/eurathane sealant are pollutants) (citing cases).

Press Release Triggered Insurer's Duty to Defend under Policy's 'Advertising Injury' Provision

A press release issued by an insured triggered its insurer's duty to defend the insured, under the advertising injury provision of the insured's policy, in a lawsuit against the insured alleging violation of the Lanham Act.

The Case

Natural Organics, Inc. ("NOI"), a manufacturer of health supplement products including those sold under the trade name Nature's Plus, was sued in an action that alleged that it had wrongfully terminated its exclusive distributorship agreement with Nature's Plus Nordic A/S ("NPN") and that it had issued a press release announcing the appointment of House of Nature A/S ("HON"), a competitor of NPN, as the exclusive distributor for Nature's Plus products in Norway, Denmark, Sweden, and Finland (the "Nordic region").

The complaint asserted causes of action against NOI alleging unfair competition pursuant to the Lanham Act on the basis that, through the press release, NOI misrepresented to consumers that HON was the sole distributor for Nature's Plus products in the Nordic region when NPN remained the sole distributor for those countries. It alleged that the press release caused confusion and mistake and deceived consumers as to the affiliation, connection, or association of NPN, HON, and NOI, and as to the origin, sponsorship, or approval of NPN's and HON's products, causing a diversion of trade from NPN and harm to its reputation and goodwill.

NOI tendered its defense to its insurer, OneBeacon America Insurance Co., pursuant to coverage that provided for "personal and advertising injury liability."

After OneBeacon disclaimed, NOI sued. The insurer moved for summary judgment, arguing that the

allegations of the complaint against NOI did not fall within the definition of "personal and advertising injury" and, further, that the policy contained an exclusion of coverage for personal and advertising injury "arising out of a breach of contract." The trial court denied its motion and OneBeacon appealed.

The Appellate Court Decision

The appellate court affirmed, finding that the allegations against NOI fell within the policy's coverage for "personal and advertising injury" arising from product disparagement. It reasoned that the statement that HON had been appointed the exclusive distributor of Nature's Plus products in the Nordic region "could imply that NPN's inventory of Nature's Plus products was unauthorized."

It also found that the press release was allegedly false and disparaging to NPN's products without regard to whether NOI had breached its agreement with NPN. In the appellate court's view, although the complaint against NOI alleged that the announcement of HON as exclusive distributor for the region was false and misleading because NPN remained the sole distributor for the region "by nature of the agreement," the product disparagement claim did "not necessarily arise out of NOI's alleged breach of contract," and, thus, coverage was not excluded under the policy.

Simply put, the appellate court found, without reference to the contract, NPN could potentially establish product disparagement by the press release that "called into question the genuineness of the product and whether the remaining inventory was unauthorized." Thus, OneBeacon's duty to defend NOI in the federal litigation was triggered, it concluded.

The case is *Natural Organics, Inc. v. OneBeacon America Ins. Co.*, --- N.Y.S.2d ---- (N.Y.App.Div. 2d Dep't Jan. 16, 2013). Attorneys involved include: Day Pitney, LLP, Hartford, Connecticut (Joseph K. Scully, pro hac vice, and Matthew J. Shiroma of counsel), and Goldberg Segalla LLP, Buffalo, N.Y., for appellant; Meyer, Suozzi, English & Klein, P.C., Garden City, N.Y. (Kevin Schlosser of counsel), for respondent.

Worker's Compensation

Immigration Status Does Not Affect Worker's Comp Award, Kansas Supreme Court Holds

The Kansas Supreme Court has ruled that an employee's immigration status may not preclude that person from being awarded benefits for work disability under Kansas law.

The Case

Martha Fernandez was working at a McDonald's restaurant in Topeka, Kansas, when she injured her lower back while lifting a box of meat. After McDonald's submitted an accident report form to the Kansas Division of Workers Compensation, the agency informed McDonald's that Ms. Fernandez' Social Security number was invalid. During the course of the worker's compensation proceedings, Ms. Fernandez' unauthorized alien status was confirmed; she had no legal authority or documentation to work in the United States.

The administrative law judge ("ALJ") awarded Ms. Fernandez a functional impairment of seven percent permanent partial disability. The ALJ, however, denied the claim for permanent partial general work disability on public policy grounds. The ALJ opined that the purpose of the Kansas Workers Compensation Act (the "Act") was to assist injured workers to return to work; that an unauthorized alien cannot legally return to work in the United States; and that, therefore, awarding an unauthorized alien a work disability would be inconsistent with legislative intent.

Ms. Fernandez filed an application for review by the Kansas Workers Compensation Board, and a majority concluded that the Act's plain language did not prohibit an unauthorized alien from receiving an award for work disability. Accordingly, the Board majority found that Ms. Fernandez was entitled to the full measure of work disability, calculating that she should be awarded a 59 percent work disability.

McDonald's appealed the Board's decision and the dispute reached the Kansas Supreme Court.

The Statute

At the time Ms. Fernandez was injured, the permanent partial general disability computation described in K.S.A. 44–510e(a) stated:

> Permanent partial general disability exists when the employee is disabled in a manner which is

> partial in character and permanent in quality and which is not covered by the schedule in K.S.A. 44–510d and amendments thereto. The extent of permanent partial general disability shall be the extent, expressed as a percentage, to which the employee, in the opinion of the physician, has lost the ability to perform the work tasks that the employee performed in any substantial gainful employment during the fifteen-year period preceding the accident, averaged together with the difference between the average weekly wage the worker was earning at the time of the injury and the average weekly wage the worker is earning after the injury. In any event, the extent of permanent partial general disability shall not be less than the percentage of functional impairment.... An employee shall not be entitled to receive permanent partial general disability compensation in excess of the percentage of functional impairment as long as the employee is engaging in any work for wages equal to 90% or more of the average gross weekly wage that the employee was earning at the time of the injury.

The Kansas Supreme Court's Decision

In its decision, the Kansas Supreme Court explained that, under K.S.A. 44–510e(a), the calculation of permanent partial general disability payments under worker's compensation depended on the extent to which the work injury had reduced the worker's ability to perform his or her pre-injury work tasks (task loss) and the extent of the reduction in average wages that the worker had experienced after the injury (wage loss). If the claimant's post-injury wages were at least 90 percent of the pre-injury wages, then permanent partial general disability payments were based solely on the worker's functional impairment percentage. If the claimant's post-injury wages were less than 90 percent of the pre-injury wages, the wage loss percentage was averaged with the task loss percentage to arrive at the percentage of permanent partial general disability, so long as that average equaled or exceeded the functional impairment percentage.

The court rejected McDonald's assertion that because Ms. Fernandez' post-injury wages must always be less than 90 percent of her pre-injury wages because her immigration status precluded her from going back to work (relying on the federal Immigration Reform and Control Act of 1986, 8 U.S.C. § 1324a(a)(2) (unlawful for employer to continue to employ unauthorized alien upon learning of illegal status), K.S.A. 44–510e(a) should be construed to add an exception to work disability to prohibit an unauthorized alien from receiving permanent partial general disability compensation in excess of the percentage of the worker's functional impairment.

The court decided that the plain language of K.S.A. 44–510e provided only two exceptions to basing the permanent partial general disability award in part upon the claimant's post-injury wage reduction percentage: (1) where the post-injury wage reduction was 10 percent or less, i.e., the injured worker continued to earn at least 90 percent of his or her prior wage; or (2) where the functional impairment percentage was greater than the result of averaging the task loss percentage with the wage loss percentage. "An additional exception based upon the claimant's immigration status cannot reasonably be gleaned from the language employed in K.S.A. 44–510e," the court declared.

The case is *Fernandez v. McDonald's*, No. 104,951 (Kan. Jan. 25, 2013). Attorneys involved include Wade A. Dorothy, The Dorothy Law Firm LLC, Overland Park, for appellants; Conn Felix Sanchez, Kansas City, for appellee.

FC&S Legal Comment

The Kansas legislature made changes to K.S.A. 44–510e in 2011 that require a work disability claimant to prove that he or she has a post-injury wage loss by showing that the person has the legal capacity to enter into a valid employment contract. *See* L.2011, ch. 55, sec. 9. The parties in *Fernandez* did not argue how those statutory changes may have impacted their case, and the Kansas Supreme Court declined to decide that on its own.

Automobile Insurance

Insurer May Reduce UIM Benefits By Punitive Damages Paid to Its Insured, Connecticut's Supreme Court Says

The Supreme Court of Connecticut has decided that an insurer is entitled to reduce its limits of liability for underinsured motorist ("UIM") coverage by an amount equal to the amount of punitive damages paid to its insured.

The Case

The plaintiff in this case and her husband held an insurance policy that provided UIM coverage up to a maximum of $250,000. The plaintiff and her husband were injured in an automobile accident with another car allegedly driven by a woman with a blood alcohol level of 0.407 – more than five times the legal limit. The plaintiff and her husband sued for compensatory damages, common law punitive damages, and exemplary damages under Connecticut statutory law. The parties reached a $415,000 settlement; $100,000 was paid by the other driver's insurer and $315,000 was paid personally by the other driver and her husband to settle her claim for common law punitive damages and statutory exemplary damages predicated on the alleged reckless conduct of the other driver.

At the time of the collision, the motor vehicle driven by the other driver was "underinsured" as defined by the plaintiff's insurance policy because the $100,000 coverage limit of that driver's policy was lower than the $250,000 UIM limit of the plaintiff's policy. The plaintiff therefore submitted a claim for UIM coverage to her insurer. The insurer denied the claim in light of the plaintiff's recovery under the settlement agreement. The plaintiff sued.

The insurer moved for summary judgment, claiming that it was entitled to a setoff equal to the amount of the entire settlement. The trial court granted the motion and rendered judgment in favor of the defendant, and the dispute reached the Connecticut Supreme Court.

The Regulation

As provided in Section 38a–334–6 of the Regulations of Connecticut State Agencies:

> The insurer shall undertake to pay on behalf of the insured all sums which the insured shall be legally entitled to recover as damages from the owner or operator of an uninsured or underinsured motor vehicle because of bodily injury sustained by the insured caused by an accident involving the uninsured or underinsured motor vehicle....

The regulation also allows an insurer to limit its underinsured motorist liability. Specifically, the regulation permits an insurer to limit its liability:

> to the extent that *damages* have been ... paid by or on behalf of any person responsible for the injury....

(Emphasis added.)

The Policy

The policy provided that the insurer could reduce its underinsured motorist liability by:

> *all sums* ... [p]aid because of the "bodily injury" by or on behalf of persons or organizations who may be legally responsible....

(Emphasis added.)

The Connecticut Supreme Court's Decision

In its decision, the Connecticut Supreme Court explained that the regulation permitted insurers to reduce the amount payable pursuant to a claim for uninsured or underinsured motorist coverage "to the extent that *damages* have been ... paid by or on behalf of any person responsible for the injury...." (Emphasis added.) It then noted that the plaintiff's policy differed from the regulation and provided that the insurer could reduce its UIM liability by "*all sums* ... [p]aid because of the 'bodily injury' by or on behalf of persons or organizations who may be legally responsible...." (Emphasis added.)

The court then decided that the plain meaning of the term "damages," as used in the regulation, encompassed common law punitive damages and that, therefore, the regulation permitted an insurer to offset its UIM motorist liability by an amount equal to any punitive damages paid to an insured by a party responsible for the injury.

Accordingly, the court held that the use of "all sums" in the limitation provision of the plaintiff's insurance policy corresponded in all material respects to the use of "damages" in the regulation. Thus, the court concluded, the trial court properly determined that the policy language was unambiguous and substantially congruent with the regulation.

The case is *Anastasia v. General Cas. Co. of Wisconsin*, No. 18766 (Conn. Feb. 5, 2013). Attorneys involved include: Enrico Vaccaro, for the appellant (plaintiff); Jon Berk, for the appellee (defendant).

Missouri Supreme Court Finds 'Owned' Is Ambiguous and Construes Policies against Insurers

The Missouri Supreme Court has ruled that the word "owned" in "owned-vehicle" exclusions in underinsured motorist ("UIM") endorsements was ambiguous.

The Case

Nathaniel Manner was injured in an accident while he was riding a Yamaha motorcycle. The insurer for the

other party involved paid its $100,000 limit of liability to Mr. Manner and he sought to recover UIM benefits under the policy he had purchased from American Family Mutual Insurance Company for the Yamaha motorcycle, under additional American Family policies he had purchased for his two trucks, and under a policy issued to his father by American Standard Insurance Company for a Suzuki motorcycle.

Both insurers denied coverage, arguing that that Mr. Manner owned the Yamaha and that the policies' "owned-vehicle" exclusion therefore precluded coverage.

The trial court ruled in favor of the insurers, and the dispute reached the Missouri Supreme Court.

The Policies

The policies' owned-vehicle exclusions stated:

> This coverage does not apply for bodily injury to a person: ... While occupying, or when struck by, a motor vehicle *that is not insured under this policy if it is owned by you* or any resident of your household. (Emphasis added).

The Missouri Supreme Court's Decision

In its decision, the Missouri Supreme Court determined that the insurers had not met their burden of showing that Mr. Manner owned the Yamaha motorcycle. It explained that the record showed that Mr. Manner's uncle had agreed to sell him the motorcycle and had allowed him to take possession of it; that Mr. Manner had obtained insurance coverage for the motorcycle before driving it; and that, at the time of the accident, he still was in the process of paying his uncle for the Yamaha, his uncle still retained title, and he did not yet consider it his own: when police arrived at the accident scene, Mr. Manner explained that the motorcycle belonged to his uncle.

The Missouri Supreme Court rejected the insurers' argument that even though he did not have title to the vehicle or other indicia of ownership of it, they met their burden by showing that he had possession of and an interest in the Yamaha sufficient to allow him to obtain an insurance policy on it. The court explained that the policies could have defined "owned," for purposes of the UIM endorsement, to include all those who had an insurable interest in the vehicle, but "they did not do so." According to the court, the insurers chose to use the term "owned" in the policies' underinsured motorist endorsement but not to define it. It then added that no case or dictionary defined "ownership" and "possession of an insurable interest" as equivalences.

The Missouri Supreme Court ruled that, at best, the term was ambiguous as used in the policy, that any ambiguity would be interpreted in favor of the insured, and that the insurers therefore failed to meet their burden of showing that the owned-vehicle exclusion applied.

The case is *Manner v. Schiermeier*, No. SC 92408 (Mo. Jan. 8, 2013). Attorneys involved include Gretchen Garrison, Maurice B. Graham, Morry S. Cole, Gray, Ritter & Graham PC, St. Louis, for Appellant; Robert J. Wulff and Mary Anne Lindsey, Evans & Dixon LLC, St. Louis, for Respondents.

FC&S Legal Comment

There were several other significant holdings in this case. First, the Missouri Supreme Court found that stacking was permitted under the four policies. It then ruled that because Mr. Manner's net damages amounted to $1.4 million ($1.5 million stipulated, less the $100,000 he had received), which exceeded the $400,000 aggregate amount of UIM benefits under the four policies, he could recover the full $400,000 under those policies.

Interestingly, in a footnote, the court also rejected the insurers' argument that the full amount of any insurance Mr. Manner recovered by settling the lawsuit he had brought against both the manufacturer and seller of the helmet should be deducted, finding "no authority" that UIM coverage should be offset by products liability insurance that was "not related to vehicles at all." The court rejected the suggestion that insureds "basically must show that they had no opportunity to sue for tort damages unrelated to underinsured motorist coverage in order to recover on their underinsured motorist coverage."

Commercial Property

2 Families Alleging Lead Paint Exposure from 1 Apartment = 1 Occurrence

An intermediate appellate court in New York has reversed a trial court's decision and ruled that allegations of one family that children were exposed to lead paint in an apartment and allegations of a second family that children were exposed to lead paint in the same apartment amounted to one occurrence.

The Case

In November 1991, Allstate Insurance Company issued an insurance policy to Tony Clyde Wilson, the owner of an apartment building in the City of Rochester, New York. The policy, which had a per-occurrence limit of $500,000, was for one year, and it was renewed for two additional one year periods.

In 1993, two children allegedly were exposed to lead paint while living in an apartment in that building, and one allegedly suffered injuries as a result of that exposure. According to Mr. Wilson's deposition testimony, he attempted to remediate the lead paint condition. That family moved out of the apartment shortly thereafter, and the mother of those children later sued Mr. Wilson, seeking damages for injuries that the child allegedly sustained as a result of her exposure to lead ("first tort action").

In 1994, two children of a subsequent tenant also allegedly were exposed to lead in the same apartment, and a lawsuit was filed against Mr. Wilson to recover damages for the personal injuries allegedly sustained by those two children ("second tort action"). While the second tort action was pending, the first tort action settled for $350,000, which Allstate paid pursuant to its policy.

Allstate took the position that the noncumulation clause in the policy limited its liability for all lead exposures in the apartment to a single policy limit of $500,000, and offered plaintiffs in the second tort action the remaining $150,000 of coverage to settle the second action. The parties entered into a stipulation whereby Mr. Wilson was released from liability. They further agreed that the plaintiffs in the second tort action would recover $150,000 if the noncumulation clause limited recovery to a single policy limit as claimed by Allstate, but they would recover $500,000 if the policy also required Allstate to pay the full policy limit for the injuries sustained by the second set of children.

The plaintiffs in the second tort action then filed a declaratory judgment action to resolve that issue. The trial court ruled in their favor, and Allstate appealed.

The Policy

The policy provided:

> Regardless of the number of insured persons, injured persons, claims, claimants or policies involved, our total liability under the Family Liability Protection coverage for damages resulting from one accidental loss will not exceed the limit shown on the declarations page. All bodily injury and property damage resulting from one accidental loss or from continuous or repeated exposure to the same general conditions is considered the result of one accidental loss.

(Emphasis omitted.)

The Appellate Court's Decision

In its decision, the appellate court explained that the issue was whether the exposure of children to lead paint in an apartment during different tenancies was encompassed by the phrase "resulting from ... continuous or repeated exposure to the same general conditions" in the noncumulation clause. It then held that "the only reasonable interpretation of that clause" required that the two claims be classified as a single accidental loss within the meaning of the policy.

The appellate court reasoned that two sets of children lived in the same apartment at different times, less than a year apart and that there was nothing in the record to establish that the owner, who testified that he had attempted to remediate the lead hazard, had removed all of the lead paint from the apartment. Indeed, the appellate court continued, there was no evidence to establish what, if any, action the owner actually took to remediate the lead paint hazard. Furthermore, it stated, there was no evidence that the owner added other lead paint to the apartment in the interim, and indeed paint containing lead could not legally have been sold anywhere in the United States for more than 15 years prior to that time. Consequently, the appellate court decided, the lead paint that injured the second set of children was the same lead paint that was present in the apartment when the first set of children lived there.

It ruled that as the claims arose from exposure to the same condition, and the claims spatially were identical and temporally close enough that there were no intervening changes in the injury-causing conditions, "they must be viewed as a single occurrence within the meaning of the policy."

The appellate court concluded that although the children may have ingested the lead at different times and their blood tests showed different levels of exposure, the injuries all flowed from the same conditions in their immediate environment, and thus the noncumulation clause limited the plaintiffs in the first and second tort actions to a single policy limit, and the plaintiffs' losses in the second tort action were encompassed by the $500,000 per occurrence limit in the policy.

The case is *Nesmith v. Allstate Ins. Co.*, --- N.Y.S.2d ---- (N.Y.App.Div. 4th Dep't Feb. 1, 2013). Attorneys involved include: Shapiro, Beilly & Aronowitz, LLP, New

York City (Roy J. Karlin of Counsel), for Defendant–Appellant; Nixon Law Firm, PLLC, Whitesboro (James E. Nixon of Counsel), for Plaintiffs–Respondents; Anderson Kill & Olick, P.C., New York City (John G. Nevius of Counsel), for United Policyholders, Amicus Curiae.

Homeowner's Insurance

Insurer's EUO Request Must Be Reasonable, and It Must Show Prejudice from Insured's Failure to Comply, Washington's Top Court Holds

In a case involving an insured's duty to cooperate with an insurer's claim investigation, the Washington Supreme Court has ruled that an insurer's request that an insured submit to an examination under oath ("EUO") must be reasonable, and that an insurer must demonstrate actual prejudice from its insured's failure to submit to the EUO before it is entitled to dismissal of the insured's complaint against it.

The Case

After John Staples told the police that tools worth around $15,000 had been stolen from a van he described as a "work truck," he filed a claim with Allstate Insurance Company, his homeowner's insurance carrier, for loss of tools worth between $20,000 and $25,000 that were for his personal use (although he indicated that they "could be used" for work). Based on these apparently inconsistent statements, Allstate transferred Mr. Staples' claim to its special investigation unit.

Allstate requested that Mr. Staples appear for an examination under oath ("EUO") on a date that his attorney said he could not appear. When Mr. Staples did not attempt to reschedule, Allstate denied his claim, and he sued the insurer.

Allstate moved for summary judgment, and the trial court granted the motion. An intermediate appellate court affirmed, and the dispute reached the Supreme Court of Washington.

The Washington Supreme Court's Decision

In its decision, the Washington Supreme Court first rejected Allstate's argument that it had an absolute right to an EUO without regard to materiality or reasonableness because the EUO was an essential and valid tool for investigating claims and cross-examining policyholders. Rather, the court decided, there must be some limit to an insurer's ability to demand an EUO and it held, as a matter for first impression, that an insurer's request for an EUO must be reasonable or material to the insurer's claim investigation.

The court next held that Allstate was not entitled to summary judgment because there were facts issues regarding whether Mr. Staples had substantially complied with Allstate's request for an EUO. For example, it pointed out that although it was clear that no EUO had taken place, Mr. Staples had appeared for two scheduled interviews, giving Allstate "ample opportunity to examine him."

Finally, the court held that an insurer must demonstrate prejudice before denying a claim for failure to submit to an EUO, rejecting Allstate's argument that an EUO was a valid condition precedent to bringing suit, so that no prejudice need be shown.

According to the court, in "duty to cooperate" cases, it had required a showing of prejudice in nearly all other contexts "to prevent insurers from receiving windfalls at the expense of the public." It ruled that the same standard applied to the EUO requirement.

Moreover, it observed, Allstate's policy provided:

> **We** have no duty to provide coverage under this section if **you,** an **insured person,** or a representative of either fail to comply with items a) through g) above, and this failure to comply is prejudicial to **us.**

Thus, the court stated, a showing of prejudice was required by the "clear terms" of Mr. Staples' policy.

Concluding that prejudice was an issue of fact that would "seldom be established as a matter of law" and that would be presumed only in "extreme cases," it found that genuine issues of material fact existed regarding whether Allstate was prejudiced by Mr. Staples' failure to appear for an EUO, and it therefore concluded that Allstate was not entitled to summary judgment.

The case is *Staples v. Allstate Ins. Co.*, No. 86413–6 (Wash. Jan. 24, 2013). Attorneys involved include Daniel Ross Fjelstad, Scott Kinney & Fjelstad, Seattle, WA, for Petitioner; Rory W. Leid, Midori Rachel Sagara, Cole/

Wathen/Leid/Hall, P.C., Seattle, WA, for Respondent; Bryan Patrick Harnetiaux, Attorney at Law, Spokane, WA, George M. Ahrend, Ahrend Albrecht PLLC, Ephrata, WA, Amicus Curiae on behalf of Washington State Association.

FC&S Legal Comment

The court's decision may create incentives for insureds in Washington State to cooperate less than they have in the past, leading to factual questions of whether they have "substantially complied" with their policies. If this occurs, this will, almost definitely, increase litigation between policyholders and insurance companies in the state.

Cyberliability

'Computer Systems Fraud' Rider Covers Hacking Claims, Not Fraud By Authorized System Users, N.Y. Court Rules

A New York trial court has decided that a "Computer Systems Fraud" rider to a financial institution bond covered only unauthorized entry into the insured's computer system and not authorized users' fraud.

The Case

Among the products offered by Universal American Corporation were "Medicare Advantage Private Fee–For–Service" plans ("MA–PFFS"), government-regulated alternatives to Medicare. Essentially, members enrolled in health care plans offered by private insurers, which plans received reimbursement payments from the Centers for Medicare and Medicaid Services ("CMS"), an agency of the U.S. Department of Health and Human Services. The plans also received payments from plan members themselves.

Under these plans, health care providers submitted claims for services provided to plan members, similar to traditional health insurance policies. In Universal's case, many of the claims were "auto-adjudicated" through Universal's computer system, with payments rendered without any manual review.

Universal claimed that it suffered millions of dollars in losses from fraudulent claims made against its MA–PFFS plans. Most of these claims were submitted by providers directly into Universal's computer system and processed through the system. In some cases, Universal contended, the perpetrators enrolled new members in the MA–PFFS plan with the person's cooperation, in return for which the new members received kickbacks. In some cases, according to Universal, a provider used a member's personal information without that person's knowledge. In either event, the provider itself did not enroll in the plan but was able to submit claims after obtaining a National Provider Identifier ("NPI") from CMS, according to Universal. In some cases, the NPI was obtained for a fictitious provider, in other cases it was fraudulently taken from a legitimate provider, Universal asserted.

Universal stated that approximately 80 percent of its losses resulted from claims submitted to its computer system, and it submitted a proof of loss to National Union Fire Insurance Company of Pittsburgh, PA, which had issued it a fidelity bond. National Union denied the claim, and Universal sued, asserting claims for breach of contract and for a declaratory judgment stating that its losses were covered by the policy and were not subject to any exclusions. It alleged losses of $7,764,211, after the application of the deductible.

National Union moved for summary judgment. The central issue before the court was whether the policy covered the entry of fraudulent information, *e.g.* fraudulent claims, even by an authorized user such as a provider with a valid NPI, or whether it provided coverage against computer hackers, *i.e.* situations in which an unauthorized user accessed the system and caused money to be paid out.

The Financial Institution Bond

A rider to the Financial Institution Bond issued to Universal by National Union, entitled "Computer Systems Fraud," provided indemnification for:

> Loss resulting directly from a fraudulent
>
> (1) entry of Electronic Data or Computer Program into, or
> (2) change of Electronic Data or Computer Program within the Insured's proprietary Computer System ... provided that the entry or change causes

> (a) Property to be transferred, paid or delivered,
> (b) an account of the Insured, or of its customer, to be added, deleted, debited or credited, or
> (c) an unauthorized account or a fictitious account to be debited or credited.

The term "Computer Program" was defined as:

> related electronic instructions which direct the operations and functions of a computer ... which enable the computer ... to receive, process, store or send Electronic Data.

The term "Electronic Data" was defined as:

> facts or information converted to a form usable in a Computer System by Computer Programs, and which is stored on magnetic tapes or disks, or optical storage disks or other bulk media.

The Court's Decision

In its decision, the court found that the clause was not ambiguous, holding that the policy did "not extend as far as providing coverage for fraudulent claims which were entered into the system by authorized users."

The court reasoned that the rider had two headings, "Computer Systems" and "Computer Systems Fraud," and had no headings that referred to the content of medical claims submitted to the system. Thus, the court said, the headings indicated that the coverage was directed at "misuse or manipulation of the system itself" rather than at situations where the fraud arose from the content of the claim and the system was otherwise properly utilized, *e.g.* a fraudulent claim submitted by an authorized user. Further, the court continued, the rider stated that it covered "fraudulent entry" of data or computer programs into Universal's computer system that resulted in a loss. In the court's view, this indicated that coverage was for an unauthorized entry into the system, *i.e.* by an unauthorized user such as a hacker, or for unauthorized data, *e.g.* a computer virus. In the court's view, nothing indicated that coverage was intended where an authorized user utilized the system as intended, *i.e.* to submit claims but where the claims themselves were fraudulent.

The court found that the plaintiff's interpretation of the policy would expand coverage to "any fraudulent underlying claim" that was entered into its computer system by any user, even by an authorized user. It concluded that this interpretation was not supported by the language of the rider.

The case is *Universal American Corp. v. National Union Fire Ins. Co. of Pittsburgh, PA*, --- N.Y.S.2d ----, 2013 WL 69241 (N.Y.Sup.Ct. N.Y. Co. Jan. 7, 2013).

Employee Benefits

Massachusetts Top Court Upholds Contract Providing for Health Insurance Reimbursement to School Superintendent for Indefinite Future

The highest court in Massachusetts, the Supreme Judicial Court, has ruled that an employment contract between a school committee and a superintendent that contained a provision for annual reimbursement of health insurance premiums into the indefinite future was not invalid and unenforceable because it exceeded the six year limit on such contracts imposed by Massachusetts statutory law.

The Case

The school committee of North Brookfield, Massachusetts, hired Robert O'Neill as superintendent of schools in 1998, a position he held until July 2005. A series of employment contracts provided that while employed as superintendent, Mr. O'Neill would receive all employment-related benefits available to teachers, including health insurance coverage. On October 21, 2002, Mr. O'Neill and the school committee executed an employment contract with an effective date of July 1, 2002, and extending through June 30, 2005. This contract contained for the first time a provision entitling Mr. O'Neill, on his retirement, to be reimbursed annually for a fixed percentage of the premium costs for an individual health insurance plan. The reimbursement clause provided:

Upon retirement from the North Brookfield Public Schools, the Superintendent will be reimbursed annually for the cost of an individual retirement [health] plan of

his choice. Said reimbursement will equal the percentage of the cost of the plan based on years of service as Superintendent. For each year of completed service, the reimbursement will equal 10% of the annual cost of the plan. Said reimbursement percentage will be capped equal to the town reimbursement percentage for retired employees at the time of the Superintendent's retirement."

The subsequent, and final, employment contract between the school committee and Mr. O'Neill, effective July 1, 2003, contained the same reimbursement clause.

After he retired, Mr. O'Neill requested that the school committee reimburse 70 per cent of his health insurance costs accruing from August 2005, to the date of the request. After his request was denied, he brought suit.

A trial court ruled in favor of Mr. O'Neill, entered judgment providing that he was to recover from the defendants a total of $46,052.57—representing the amount of his health insurance premium costs that should have been reimbursed from August 15, 2005, to the date of judgment, plus interest and costs, and ordering the defendants to reimburse Mr. O'Neill annually for 70 per cent of the cost of his health care plan. The case reached the Massachusetts Supreme Judicial Court.

The Statute

Under Massachusetts G.L. c. 71, § 41:

> A school committee may award a contract to a superintendent of schools or a school business administrator for periods *not exceeding six years* which may provide for the salary, fringe benefits, and other conditions of employment, including but not limited to, severance pay, relocation expenses, reimbursement for expenses incurred in the performance of duties or office, liability insurance, and leave for said superintendent or school business administrator.

(Emphasis added).

The Supreme Judicial Court's Decision

The Supreme Judicial Court ruled that the annual reimbursement of a portion of health insurance costs simply was a benefit provided for in Mr. O'Neill's final employment contract, and the fact that it was to be paid annually after the contract expired did not mean that the contract itself extended beyond its stated three year term. The court specifically rejected the defendants' contention that the reimbursement clause converted Mr. O'Neill's final employment contract of three years' duration into a lifetime agreement that would presumptively exceed six years, declaring that it entitled him to reimbursement for a percentage of his health insurance costs going forward, but all the remaining provisions of the contract—for example, those describing his duties and responsibilities as superintendent, requiring his fulfilment of those duties, fixing his salary, and entitling him to all medical, hospital, and life insurance benefits available to the town's teachers—ceased to be in effect on his retirement.

According to the court, the directive of § 41 that no employment contract between a school committee and a superintendent exceed six years did not absolve the defendants of responsibility to fulfill this contractual obligation, because Mr. O'Neill's final contract "fit well within the statute's term limitation."

The case is *O'Neill v. School Committee of North Brookfield*, SJC–11108 (Mass. Feb. 8. 2013). Attorneys involved include: *Brian M. Maser* for the defendants; *John J. Driscoll* for the plaintiff; *Sandra C. Quinn & Matthew D. Jones,* for Massachusetts Teachers Association, amicus curiae, submitted a brief.

The Circuit Court's Decision

Under the policy, the circuit court explained, disability benefits could be offset in their entirety if the act under which they were paid was "similar" to the SSA; otherwise, they could not be offset at all. It then held that it "most assuredly" would not be a "logical and reasonable" interpretation of the offset provision to hold that the RRA was not "similar" to the SSA.

The circuit court reasoned that, under the usual and common meaning of the word, the RRA and SSA certainly were "similar." The RRA was substantially a Social Security Act for employees of common carriers, according to the Eleventh Circuit, providing a system of annuity, pension, and death benefits similar to the SSA.

The circuit court rejected Mr. Duckworth's contention that it was significant that the RRA offered benefits in two tiers, the first of which resembled Social Security benefits and the second of which resembled benefits paid under a private pension fund, ruling that this difference between the two acts did not make them dissimilar "when viewed holistically."

Accordingly, the circuit court declared, if the words "disability ... benefits [paid] under the United States Social Security Act ... or any similar ... act" were to have any meaning at all, they "at the very least encompass[ed] disability benefits paid under the RRA." Indeed, the circuit court continued, it was "difficult to envision an act that more closely resemble[d] the SSA than … the RRA."

FC&S Legal Comment

Other circuit courts also have ruled that the provisions of the RRA are so closely analogous to those of the SSA that regulations and cases interpreting the latter are applicable to the former. *See, e.g., Harris v. R.R. Ret. Bd.,* 198 F.3d 139 (4th Cir.1999); *Aspros v. R.R. Ret. Bd.,* 904 F.2d 384 (7th Cir.1990); *Burleson v. R.R. Ret. Bd.,* 711 F.2d 861 (8th Cir.1983); *Estes v. R.R. Ret. Bd.,* 776 F.2d 1436 (9th Cir.1985); *Abbruzzese v. R.R. Ret. Bd.,* 63 F.3d 972 (10th Cir.1995).

Legislative/Regulatory Developments

Automobile Insurance

21 States Likely to Consider Electronic Proof of Insurance Coverage Legislation

With almost half of state legislatures in the country likely to consider changing their laws to allow drivers to use their cell phones to show their insurance identification card in order to prove they are insured, electronic proof of coverage is one of the hottest insurance-related legislative trends for 2013, according to the Property Casualty Insurers Association of America ("PCI").

"States are taking another step into the Electronic Age by changing their laws to allow drivers to show their insurance ID cards on their smartphone," said Alex Hageli, PCI director, personal lines policy. "Pretty much every motorist has been there at one time or another, digging around in the glove compartment box desperately trying to find your insurance card after being pulled over by the police. No longer will motorists be ticketed and have to take time off of work to go to court for driving without insurance just because they couldn't find a current ID card in their car. This is such a common sense switch that will save everybody time and effort."

PCI anticipates over 20 states will consider electronic proof of coverage bills or regulations in 2013. The states discussing e-Card proposals include: Arkansas, Colorado, Florida, Georgia, Hawaii, Indiana, Iowa, Kansas, Maine, Michigan, Missouri, Mississippi, Ohio, Oregon, Rhode Island, South Carolina, Texas, Utah, Washington, Wisconsin, and Wyoming. Wyoming's measure, SF 87, has already cleared the Wyoming State Senate.

"Electronic proof of coverage, or e-Card, is a win-win-win for consumers, insurers and state officials. Consumers are using their cell phones for more and more things. They want less paper and more online account features," said Mr. Hageli. "Like any other business, insurers want to meet their policyholders' needs and are developing apps and expanding online services to satisfy customer expectations. Without changing the law, though, insurers are still required to send paper ID cards to each customer. These proposed laws will enable insurers to adapt to changing consumer behavior. Finally, the courts win because the docket will be cleared up of individuals who had insurance but just didn't have a current ID card."

In 2012 five states made the change to e-Card including: Arizona, California, Idaho, Louisiana, and Minnesota. Alabama approved regulations allowing electronically displayed proof of insurance at both registration and during traffic stops. Colorado already has a regulation allowing electronic proof of coverage when vehicles are registered, and will consider legislation to expand it to traffic stops this year.

PCI supports flexible proposals that are not mandatory and give both the policyholder and the insurance company a choice to offer electronic proof of coverage options.

"Every year, thousands upon thousands of tickets are issued to drivers just because they forgot to put their new ID card in their vehicle," said Mr. Hageli. "It's a big waste of everybody's time and effort, especially the courts. Now is the time to make a small change in the law so insurers and consumers can take advantage of technology and avoid those annoying fix-it tickets."

New California Regulations Govern Use of Aftermarket Auto Parts

New regulations regarding the use of non-original equipment manufacturer ("OEM") replacement crash parts, generally known as aftermarket parts, are going into effect in California on January 30 and apply to claims handling that takes place on or after March 30, 2013.

California Insurance Commissioner Dave Jones said that he sought these regulations "to further protect California consumers from physical and financial harm caused by defective or inferior aftermarket parts and to enhance insurer accountability in the claims process."

According to Commissioner Jones, "The amendments

build on existing protections by requiring insurers to settle automobile insurance claims using repair standards described by the Bureau of Automotive Repair, and not the insurer's own standards of repair." He added that the regulations also place "greater accountability on the insurer when they require use of an aftermarket replacement part so that damaged automobiles are repaired properly and safely."

The California Department of Insurance investigated complaints from consumers and automobile repair shops and concluded that defective or otherwise non-compliant aftermarket parts "continued to infiltrate the repair process due to insurers' failure to perform the necessary steps to ensure public safety." The new rules require:

- an insurer to pay for the costs associated with returning a defective part and the cost to remove and replace the defective part with a compliant non-OEM part or an OEM part;
- that the current insurer's warranty be expressly stated in the estimate of repair generated by the insurer;
- an insurer to cease use of a part known to be non-compliant, and to notify the part distributer within 30 days; and
- an insurer to pay for an amount to repair the damaged vehicle to its pre-loss condition in a good and workmanlike manner, based upon the repair standards required by auto body repair shops licensed by the Bureau of Automotive Repair.

Farm

Is Crop Insurance Program on the Chopping Block?

With estimates that the federal crop insurance program may have to cover about $16 billion in losses for 2012, there appears to be some growing bipartisan momentum for scaling back the New Deal program.

According to Ron Nixon in an article in *The New York Times*, "Record Taxpayer Cost Is Seen for Crop Insurance," both the Environmental Working Group and the Heritage Foundation contend that the program primarily benefits insurers and large farmers and that the program's expenses should be cut.

The federal government subsidizes the insurance premiums for policies sold by 15 private insurance carriers, and underwrites certain insurer losses.

Read more: http://www.nytimes.com/2013/01/16/us/politics/record-taxpayer-cost-is-seen-for-crop-insurance.html?hpw.

Employee Benefits

Bill Would Mandate Eating Disorders, Alcoholism, Substance Abuse, and Mental Illness Coverage for New Jersey State Workers

A New Jersey Senate committee has approved a bill that would require health insurance coverage for state employee for eating disorders, alcoholism, and some other substance-abuse and "non-biologically based mental illnesses" under the same terms and conditions as for other diseases or illnesses.

The bill is S-1253.

Read more: http://www.njspotlight.com/stories/13/01/22/bill-seeks-to-close-gap-in-insurance-coverage-for-state-employees/; S-1253: Bill Expanding State Public Employees' Health Benefits to Include More Mental Illnesses and Disorders; Council of State Governments Report.

Alternative Risk and Captives

Congressman Affirms Dodd-Frank is Not Applicable to Captive Insurance

U.S. Congressman Scott Garrett (R-NJ), the co-author and one of the principal sponsors of the Nonadmitted and Reinsurance Reform Act ("NRRA") of the Dodd-Frank Act, addressed the Speaker of the U.S. House of Representatives on January 6, 2013, to state unequivocally that the legislation was never intended to apply to captive insurance.

In addressing the Speaker, Congressman Garrett said, "Unfortunately, several states have indicated that they plan to interpret the NRRA to also apply to the captive insurance industry. This was not the intent of Congress. In drafting this legislation, it was never contemplated to have the captive industry fall under the NRRA." He went on to state, "At no time was the legislation's application to the captive industry addressed or suggested. Furthermore, in the bill's summary, the intent of this legislation was clearly stated to impact only two specific industries – surplus lines and reinsurance."

Congressman Garrett, a Republican representing New Jersey's 5th Congressional District, has served on the House Financial Services Committee since his election in 2002. He also currently serves as the chairman of the subcommittee on Capital Markets and Government-Sponsored Enterprises for the House Financial Services Committee.

NRRA, a sub-section of the Dodd-Frank legislation, has caused confusion over whether it is applicable to captive insurance. A coalition comprised of the captive insurance industry, the Coalition for Captive Insurance Clarity ("CCIC") has been formed under the leadership of the Vermont Captive Insurance Association ("VCIA") to push for clarity that may include legislative language that would reaffirm that the intent of the new federal NRRA was never intended to apply to captive insurance.

"This should send a clear message to any domicile that any information to the contrary can only be interpreted as a self-serving tactic that is neither accurate nor in the interest of clients and the industry," said Daniel Towle, Vermont's Director of Financial Services. "Congressman Garrett's statement is further testimony that we have understood the purpose and intent of the passage of this law," added Towle.

In his statement, New Jersey Representative Garrett stated, "At no point during the bill's multi-year consideration was its application to the captive insurance industry ever discussed." He went on to add, "Should regulators implement this faulty interpretation, captive insurance companies would be subject to additional taxation and regulation – the exact opposite intent of the underlying legislation."

Richard Smith, president of the Vermont Captive Insurance Association expressed his thanks for the clarification from Representative Garrett. "We are grateful for further clarification that captive insurance is not part of the NRRA. It is our intent to work with Congress to craft a technical amendment to eliminate the inaccurate interpretation and the turmoil it is causing in the captive industry. We urge continued support for the Coalition and our efforts to enact clarifying language that will solidify Congressional intent once and for all."

This statement of record from Congressman Garrett reaffirms a recent letter from former chair of the subcommittee on insurance of the Committee on Financial Services in the House of Representatives who stated that the Nonadmitted and Reinsurance Reform Act (NRRA) of the Dodd-Frank Act was never intended to apply to captive insurance. In a letter to the new Chairman and Ranking Member, former Chair of the Insurance Subcommittee Representative Judy Biggert wrote, "As a supporter of NRRA and an advocate for its inclusion and passage as part of Dodd-Frank, I can tell you unequivocally that the NRRA was never intended to include the captive insurance industry."

The full text of Congressman Garrett's statement can be found at http://www.VermontCaptive.com/DoddFrank.

Banner Year for Cayman Captives

The captive insurance industry in the Cayman Islands is booming.

The Cayman Islands Monetary Authority ("CIMA") has reported that it received 67 applications for new licenses in 2012, with 52 licenses granted and the remainder scheduled for approval in 2013. Since January 1, 2013, one license has been approved and another 11 have been approved in principle. The total number of new licenses accounts for an increase of more than 58 percent over 2011 and is the biggest year for captives since the hard market of 2004.

Although Cayman may be largely known as being a health care captive domicile, the 52 new formations came from various sectors including health care, life

reinsurance, P&C reinsurance, manufacturing and technology. A number of group captives were also formed as segregated portfolio companies.

Existing Cayman captives also dramatically grew their assets. Total premiums written by captives were reported at US$11.8 billion and total assets under management climbed to US$88.1 billion, their highest ever levels, which grew 24 percent and 51 percent, respectively.

"Cayman understands the captive insurance business and the role it plays in the risk management space, and when I say Cayman, I mean the industry together with the regulator," said Rob Leadbetter Chairman of the Insurance Managers Association of Cayman ("IMAC"). "These statistics are not surprising to us, because we have been building our core competencies over decades to make Cayman the 'go to' domicile in the insurance industry."

There are some 5,000 captives globally and since 1980, 3,095 captives have been licensed in the Cayman Islands. The Cayman Islands remain a very popular jurisdiction for captive formations, which including the 780 segregated portfolios, is close to 1,500 entities.

Commercial Property

Florida Insurance Commissioner Proposes Reforms to Property Insurance Market

Florida Insurance Commissioner Kevin McCarty has presented a proposal entitled "Principle-Based Reforms for Florida's Property Insurance Market" to the state's Senate Banking and Insurance Committee. Commissioner McCarty had been asked to outline a plan for strengthening the property insurance market in Florida.

The commissioner outlined steps that he said would return the property market to a free market approach; enhance Florida's attractiveness as a place for insurers to do business; align policyholder risk and reward; expand risk-sharing opportunities; stimulate additional private sector capital; reduce the overall exposure of Citizens Property Insurance Corporation; and ensure policies and coverage benefits remain meaningful for Florida consumers.

Commissioner McCarty provided the following four desired outcomes that could assist in achieving these goals:

1. Restructure alternative markets so they become residual markets to provide quantifiable risk management for Florida.
2. Maximize the risk-bearing capacity of the private market, including attracting new capital.
3. Promote consumer choice, responsibility and market power.
4. Enhance meaningful risk mitigation programs.

The members of the Senate Banking and Insurance Committee are: Senator David Simmons (R), Chair; Senator Jeff Clemens (D), Vice Chair; Senator Lizbeth Benacquisto (R); Senator Nancy C. Detert (R); Senator Miguel Diaz de la Portilla (R); Senator Alan Hays (R); Senator Tom Lee (R); Senator Gwen Margolis (D); Senator Bill Montford (D); Senator Joe Negron (R); Senator Garrett Richter (R); and Senator Jeremy Ring (D).

Personal Lines

Gun Liability Insurance Bill Introduced in California Assembly

Two member of the California Assembly – Philip Y. Ting (D – San Francisco) and Jimmy Gomez (D – Los Angeles) – have introduced legislation, AB 231, that would require gun owners to purchase liability insurance to cover the cost of damage that may be caused by their weapons.

"The government requires insurance as a condition of operating a car – at the very least we should impose a similar requirement for owning a firearm," Mr. Ting said. "The cost to society of destruction by guns is currently being born collectively by all of us, and not by those who, either through carelessness or malice, cause the destruction. It is time to change that equation so that those who cause the harm pay the costs."

"Our goal is to make sure that those who own guns do so in the most responsible way possible. A liability insurance requirement will incentivize gun owners to take safety precautions – such as using a trigger lock, keeping their guns locked when not in use, and participating in a training course – in order to get a more affordable insurance policy," Mr. Gomez said.

Other states considering mandatory gun liability insurance include Massachusetts, Maryland, and Connecticut.

Sandy Hook Victim's Mother Calls for Mandatory Insurance for Gun Owners

Noah Pozner was killed at Sandy Hook Elementary School on December 14, 2012. About six weeks later, speaking about the horrific events to Connecticut legislators, Noah's mother, Veronique Pozner, called for legislation to require that gun owners carry liability insurance before they can purchase a gun.

Since Sandy Hook, a growing number of people have suggested that mandatory liability insurance should be required for gun owners. A bill has been introduced into the Massachusetts legislature that would mandate such insurance.

For more on the issue, visit: http://www.ctnewsjunkie.com/ctnj.php/archives/entry/sandy_hook_families; http://www.forbes.com/sites/johnwasik/2012/12/17/newtowns-new-reality-using-liability-insurance-to-reduce-gun-deaths/; http://business.time.com/2012/12/18/3-approaches-to-curbing-gun-violence-using-economics/; http://articles.courant.com/2013-01-24/news/hc-ed-gun-insurance-0125-20130124_1_gun-owners-liability-insurance-rapid-fire-weapons; http://www.xinsurance.com/insurance-options/personal-liability/concealed-weapons/.

Massachusetts Bill Proposes Mandatory Gun Insurance

A bill has been introduced in Massachusetts that would require that gun owners obtain liability insurance. Penalties for failure to obtain insurance would include fines from $500 to $5,000 or up to one year in jail.

If enacted, Massachusetts apparently would be the first state to require liability insurance for gun owners.

Read more: http://www.boston.com/news/local/massachusetts/2013/01/18/advocates-push-idea-requiring-gun-insurance/9sMkaMGAuAKoTRx8Dcvn5K/story.html.

Commercial Lines

New Mexico Senate Approves Spaceport Bill with Insurance Requirement

The New Mexico Senate has approved a bill that would limit liability suits against companies that supply parts for Virgin Galactic's spacecrafts at a $209 million spaceport in the southern part of the state – so long as certain minimum insurance requirements are met.

Learn more: http://www.santafenewmexican.com/Local%20News/013113XGRSPACEPORT?utm_medium=Email&utm_source=ExactTarget&utm_campaign=&utm_content=#.UQqNUx3m27y.

Focus On . . .

By Steven A. Meyerowitz

Focus On: Insurability of TCPA Awards and Punitive Damages

The Illinois Supreme Court soon will be addressing whether the statutory penalty of $500 per faxed advertisement allowed under the federal Telephone Consumer Protection Act (the "TCPA"), 47 U.S.C. § 227 et seq., is in the nature of punitive damages and uninsurable as a matter of public policy. The court also may address the insurability of punitive damages generally.

The issues arise in *Standard Mutual Ins. Co. v. Lay*, No. 114617. In this case, Locklear Electric, Inc., received unsolicited advertisements by fax from the Ted Lay Real Estate Agency. Locklear filed a class action against the agency for violating the TCPA and the Illinois Consumer Fraud and Deceptive Practices Act and for committing common law conversion. The agency eventually settled the underlying class action by permitting the federal court to enter judgment against it for $1.7 million in statutory penalties and assigning its rights against its insurer, Standard Mutual Insurance Company, to Locklear and the class Locklear represented. The trial court entered summary judgment in favor of Standard, an intermediate appellate court affirmed, and the case now is before the Illinois Supreme Court.

The issues presented, as described in the appellant's brief, are:

1. Does Illinois public policy nullify an insurance policy covering claims arising from the sending of unsolicited fax advertisements?
2. Does Illinois public policy nullify insurance coverage for punitive damages where they arise from the misconduct of an agent employed by the insured, and the insured is unaware of the misconduct?
3. Are TCPA claims "punitive damage" claims because the TCPA allows a successful litigant to recover $500 in statutory damages as an alternative to actual damages, but does not allow any recovery of costs or attorney's fees?
4. Should the appellate court have reversed the trial court because Locklear's claims were covered by Standard's policies under either the "advertising injury" or "property damage" provisions?

In Standard Mutual's view, the questions presented for review are:

1. Did Standard Mutual have a duty to defend the agency for the underlying action against it?
2. Does Standard Mutual have a duty to indemnify the agency for the settlement it with the plaintiff class?

The *amici*, Property Casualty Insurers Association of America ("PCI") and the National Association of Mutual Insurance Companies ("NAMIC"), argue, among other things, that:

1. The appellate court correctly applied Illinois' public policy against insuring penalties and punitive damages.
2. In Illinois, punitive damages are uninsurable as a matter of public policy.
3. The court should not abrogate the rule precluding insurance coverage for punitive damages or penalties.
4. The TCPA's statutory award of $500 per fax is punitive rather than compensatory.
5. Business entities have no privacy rights under the TCPA or at common law.

Attorneys involved include: Michael T. Reagan (Law Offices of Michael T. Reagan), Brian J. Wanca and David Oppenheim (Anderson + Wanca), Phillip A. Bock and Robert M. Hatch (Bock & Hatch, LLC), Paul W. Bloomer (Denby, Meno, Bloomer & Denby), Attorneys for Defendant Norma Lay and Defendant-Appellant Locklear Electric, Inc.; Robert Marc Chemers and Peter G. Syregelas (Pretzel & Stouffer LLP), Attorneys for Appellee Standard Mutual Insurance Company; Shaun McParland Baldwin and Dan J. Cunningham (Tressler LLP), Attorneys for *Amici Curiae* Property Casualty Insurers Association of America ("PCI") and the National Association of Mutual Insurance Companies ("NAMIC").

We will follow developments in this case and provide updates as they occur.

"Eye on the Experts"
New York District Court Upholds 'Classification Limitation'

By Debra Krebs, Christopher B. Weldon and James C. Keidel

It is not unusual today for construction contractors who are applicants for liability insurance to be subject to special underwriting tools of insurers. This occurs for a variety of reasons. Among them are that the contractor is new to the business; does not have a proven track record; has a bad loss history; experiences difficulty in finding insurance; or has no specialty and merely takes whatever work comes about.

The underwriting tool in question is a so-called classification limitation. In other words, assuming the underwriter is willing to accept the applicant for insurance, the liability policy will list the specific kind of work the contractor will perform. This information about the work to be performed is taken from the insurance application and from answers to any questions of the underwriter. It is of obvious importance that the producer obtain a signed application that clearly identifies the work. The more specific, the better. Part of the reason is that the premiums are based on how the work is classified. Also, if the contractor ventures into an entirely different kind of work, and an accident happens, the contractor may find himself or herself without the coverage being relied on.

Case On Point

A recent case on point is *Atlantic Cas. Ins. Co. v. Value Waterprooofing, Inc., et al.,* No. 1:11-cv-07565-DLC (U.S. Dist. Ct. So. Dist. N.Y. 2013). Briefly, the facts are as follows: Value (contractor) contacted a broker to obtain a liability policy. The broker completed the application, based on information provided by the contractor, and sent it to an intermediary of Atlantic Casualty (insurer) for a quote.

Based on the application submitted, coverage was requested for:

(1) Painting;
(2) Masonry;
(3) Drywall; and
(4) Tiling.

The broker intermediary required the contractor to submit a signed and dated copy of the Acord application, and a supplemental application. In this latter document, the contractor indicated that 100 percent of the construction work it performed was remodeling, inside buildings, and that this work performed was residential as opposed to commercial.

After the policy was written, the contractor contacted his producer to obtain coverage for roofing. There were two roofing classifications, residential and commercial, with the latter being more expensive. The insurer's intermediary calculated the premium based on residential roofing because the application had advised the insured's work was only residential and had not indicated any change. The endorsement issued also reflected a classification number and the description: "ROOFING---RES." The exposure was payroll of $1,000.

This dispute arose after the contractor performed work (the scope of which was still in dispute) on a roof truss in a commercial building. Shortly after the work was performed, both the truss and part of the roof collapsed due to significant snowfall. The building owner contacted the contractor about the collapse that day, and asked for a certificate of insurance a few days later.

At that time (and when the insurance certificate was provided) repairs to the building were ongoing but not completed. Approximately six months later, the property owner's insurer notified the contractor's insurer (Atlantic Casualty) of the loss. By this time, however, all of the damages had been repaired. The contractor's insurer denied coverage asserting, among other things, late notice and the fact that the work performed did not fall within any classifications in the policy.

Whether insurance in dispute applies is for a court to decide. This issue, therefore, went before the federal district court, which was required to address, among other things, the following three questions (issues):

(1) Who bears the burden of establishing that its work falls within one or more of the policy classifications where a classification limitation applies;
(2) Is an insurer prejudiced by late notice if such notice deprives the insurer of its inability to inspect the premises where the loss occurred;

and

(3) May the duty to defend be contractually modified by the policy?

Interestingly, if not importantly, is the fact that, while these kinds of issues have been dealt with by the courts before, prior courts have never outwardly discussed these issues as the federal district court did with this matter.

The Court's Decision

In answering the first question, the court looked at the language of the policy, noticed that the premiums were based on the classifications purchased, and concluded that the named insured (contractor) had the burden to prove that the claimed loss fell within the scope of the policy – in particular, that the insured's work fell within one of the purchased classifications. The insurer's burden, the court said, was to prove the application of any applicable exclusions.

In this case, the court initially found that that the designation "RES" unambiguously limited the classification to residential roofing. However, the court further opined that if there was any ambiguity, it was easily clarified by the extrinsic evidence of the named insured's signed application identifying its work as a "100% residential." The court specifically found the application particularly compelling since the insured had signed it and made no changes up through the time it requested the addition of the roofing classification.

With regard to late notice, the court found that since the contractor (Value) knew of the collapse on the day it occurred, and the property owner had requested an insurance certificate within five days of the collapse, the delay of six months in providing notice was untimely.

The court also stated that the insurer had a right to inspect the site. Although the court imposed upon the contractor's insurer the initial burden of establishing that it was prejudiced by an inability to inspect the premises, it further stated that "it was unreasonable to impose upon Atlantic the burden to show precisely how it would have been advantaged by that inspection."

The court also held that the insurer (Atlantic) had no duty to defend. The contractor argued that the duty hinges on the allegations of the broadly-worded complaint. The court, however, rejected this argument, explaining that, since the duty to defend is purely a contractual obligation, the parties may modify that duty.

It was explained that, because the policy expressly contemplated that extrinsic evidence could be used to evaluate the duty to defend, the court allowed consideration of such evidence; that is, the insurer may be relieved of the duty to defend, if it can be shown that there was "no possible factual or legal basis on which an insurer's duty to indemnify under any provision under the policy could be held to attach."

Since the court reasoned that there was no possible factual or legal basis on which Atlantic would be required to defend the contractor (Value), in the underlying lawsuit, the court determined that Atlantic did not owe Value any duty to defend or indemnify it in the underlying lawsuit.

The case is *Atlantic Casualty Ins. Co. v. Value Waterproofing, Inc.*, No. 11 Civ. 7565(DLC) (S.D.N.Y. Jan. 15, 2013). Attorneys involved include: Christopher Weldon, Debra Krebs, Robert Lewis, Keidel, Weldon & Cunningham LLP, White Plains, NY, for Plaintiff Atlantic Casualty; Timothy G. Griffin, Law Offices of Timothy G. Griffin, Bronxville, NY, for Defendant Value Waterproofing, Inc.; Donald Sweetman, Gennet, Kallmann, Antin & Robinson, P.C., New York, NY, for Defendant Greenwich Insurance Company; Barry S. Gedan, Riverdale, NY, for Defendants Bullard Purchasing and Sales, Inc. and Kansas Fried Chicken, Inc.

Debra Krebs is of counsel, and Christopher B. Weldon and James C. Keidel are partners, in Keidel, Weldon & Cunningham, LLP. The authors, who represented Atlantic Casualty Insurance Company in the case discussed here, can be reached at dkrebs@kwcllp.com, cweldon@kwcllp.com, jkeidel@kwcllp.com, respectively.

Behind the Staples Case against Allstate

By Daniel R. Fjelstad

In the summer of 2008, John Staples, who was semiretired, split his time between a vacation home north of Seattle and a condominium in Kirkland, a Seattle suburb. Throughout his life, he had enjoyed working with his hands and, accordingly, had acquired quite a collection of tools. To ensure access to his tools at whichever home he might be, he obtained a Ford Econoline van. The van had a 14' walk-in bed. He filled the back of the van with his tools, some of them over 50 years old, and converted the back into a mobile workshop.

On August 18, 2008, Mr. Staples discovered that his van had been stolen. He reported the theft to both law enforcement and to his Allstate agent. He had both motor vehicle and homeowner's insurance with Allstate at that time, and had had some form of insurance with Allstate since at least 1984. Without incident, Allstate paid for the stolen van under Mr. Staples' motor vehicle policy. Allstate considered Mr. Staples' claim for the lost tools under his homeowner's policy. Naturally, given the large number of tools involved and how long Mr. Staples had owned some of them, proof of their loss and value presented a challenge. Mr. Staples had to rely upon materials such as instruction manuals, photographs, and the few receipts he had, as well as upon his memory, to try to construct an itemization of the stolen tools. As he located such materials, he provided them to Allstate.

From the outset of the claim handling process, Allstate personnel appear to have suspected Mr. Staples of having submitted an inflated claim. In particular, Allstate compelled Mr. Staples to undergo a recorded interview on September 23, 2008. The questions were wide-ranging, even touching on such matters as his domestic partner's income. Shortly thereafter, by letter dated September 29, 2008, Allstate notified Mr. Staples that his claim was being transferred to its Special Investigation Unit.

Over the next few months, Allstate made repeated requests for a broad range of materials, which Mr. Staples either had already provided Allstate or which he did not possess. In December, Mr. Staples provided Allstate with a signed authorization giving it access to a broad range of financial and personal information concerning him—mortgage, bank, and employment records, tax returns, credit standing, insurance information, medical records, and more. Despite obtaining this authorization, Allstate continued making the same demands for information which it had been making for months.

On January 13, 2009, at Allstate's insistence, Mr. Staples again participated in a recorded interview. Allstate did not explain to him why another interview was necessary. Two days later, Allstate sent a letter to Mr. Staples scheduling an Examination Under Oath ("EUO") at Allstate's counsel's office. Again, Allstate offered no explanation for its request. In the letter, Allstate made demands for financial information from Mr. Staples that were quite onerous. For instance, Allstate requested "[a] list of all . . . debts and liabilities in excess of $500 existing on the date that the loss occurred, showing a) the creditor; b) the date the debt was incurred; c) the original amount of the indebtedness; d) the amount owed at the time of the loss; e) the reason the debt was incurred." Allstate also requested ". . . documents received from any creditor or other person to whom [Staples] owed money in the twelve months prior to the loss."

At this point, frustrated and at a loss to know how to deal with his insurer's repetitive requests for information and statements, Mr. Staples contacted counsel. Subsequently, on a number of occasions, counsel for Mr. Staples requested that Allstate provide copies of the information that it had already received from Mr. Staples, as well as transcripts of the two interviews, and inquired why he must give a third statement via the EUO. Allstate never provided the requested materials nor offered any substantive explanation for why the EUO was necessary.

Allstate, by letter dated April 30, 2009, denied Mr. Staples' claim. Allstate's stated basis for the denial was Mr. Staples' purported noncooperation for failing to report for an EUO and for failing to provide Allstate with requested information. After further exchanges between counsel, and in an effort to avoid litigation and further delay in Mr. Staples' receipt of insurance proceeds, his counsel wrote Allstate's counsel indicating that Mr. Staples would appear for an examination under oath if Allstate would agree to an extension of the one year contractual time limitation on filing suit, which deadline was impending. The following day, Allstate rejected the offer.

The Litigation

Mr. Staples sued Allstate for breach of contract and violation of Washington's Insurance Fair Practices Act. Allstate promptly moved for summary judgment. In its motion, Allstate relied upon an August 18, 2009 police

report pertaining to Mr. Staples' theft complaint. That report stated that Mr. Staples estimated the value of the stolen tools at $15,000. Allstate asserted that because that sum was less than the $20,000 to $25,000 estimate Mr. Staples later gave an Allstate investigator, an investigation into Mr. Staples' financial status was warranted. Despite Mr. Staples' counsel's numerous prelitigation requests for Allstate's justification for investigating Mr. Staples' financial circumstances, Allstate had not provided him with that report.

The Superior Court granted Allstate's motion "based upon his failure to appear for an examination under oath." The Court of Appeals affirmed. The Supreme Court granted Mr. Staples' petition for review. The Washington Association for Justice Foundation successfully moved to participate as *amicus curiae*.

The Supreme Court's Decision

By an 8-1 margin, the Supreme Court reversed the Court of Appeals in a decision issued on January 24, 2012. The court undertook an extensive analysis of what a Washington insured must do to satisfy an insurance policy's cooperation clause, and specifically focused on when an insurer can demand an EUO and when an insurer can deny coverage based on an insured's failure to attend an EUO.

The court first examined whether an insurer has an "absolute right to an EUO without regard to materiality or reasonableness." Stating that the issue appeared to be one of "first impression," the court determined that "there must be some outside limit to an insurer's ability to demand an EUO." In particular, the court stated that an insurer cannot demand an EUO unless it is material to the investigation of a claim. The court then stated that although Allstate may have been within its rights to demand that Mr. Staples attend an EUO, the record was not adequately developed to permit resolution of that issue as a matter of law.

The court then examined whether the lower courts erred in determining that Mr. Staples failed to cooperate with Allstate's investigation as a matter of law. Finding that genuine issues of material fact existed with regard to whether Mr. Staples substantially complied with Allstate's investigation, the court reversed summary judgment on that issue and remanded for trial.

Lastly, in an important clarification of Washington law, the court determined that summary judgment was inappropriate because genuine issues of material fact existed with regard to whether Mr. Staples' failure to attend an EUO prejudiced Allstate. In making this determination, the court made clear that an insurer cannot deny a claim based an insured's failure to attend an EUO unless the insurer can show such failure actually prejudiced the investigation of a claim. The court then found that Allstate was not entitled to summary judgment because the record did not permit a finding of actual prejudice as a matter of law.

The Significance of the Ruling

While the *Staples* decision does impose limits on how an insurer may interact with an insured during the first-party claims handling process, that is not all bad news for insurers. By clarifying boundaries, the decision gives insurers guidance concerning how to properly conduct a claim investigation. The decision also provides a reminder that the relationship between an insurer and an insured is quasi-fiduciary in nature, with duties and obligations flowing in both directions in a first-party claims handling process.

The case is *Staples v. Allstate Ins. Co.*, No. 86413–6 (Wash. Jan. 24, 2013). Attorneys involved include Daniel Ross Fjelstad, Scott Kinney & Fjelstad, Seattle, WA, for Petitioner; Rory W. Leid, Midori Rachel Sagara, Cole/Wathen/Leid/Hall, P.C., Seattle, WA, for Respondent; Bryan Patrick Harnetiaux, Attorney at Law, Spokane, WA, George M. Ahrend, Ahrend Albrecht PLLC, Ephrata, WA, Amicus Curiae on behalf of Washington State Association.

Daniel R. Fjelstad, a partner in the firm of Scott, Kinney, Fjelstad & Mack, Attorneys at Law, in Seattle, Washington, represented the petitioner in the case discussed here. Mr. Fjelstad can be reached at fjelstad@skfmlaw.com.

Elegant Slumming in the Delaware Supreme Court

By Craig A. Karsnitz

Stuff happens. This phrase in a slightly altered form is often used to describe the unpredictable nature of life. The ***Elegant Slumming*** case illustrates the point as well. Elegant Slumming is a small business located in Rehoboth Beach, Delaware, that sells, ***inter alia***, unusual jewelry. As is common in the business, Elegant Slumming will receive items of jewelry on consignment from other dealers for sale. In the early part of the summer of 2010, Elegant Slumming received two boxes that contained jewelry to be held on consignment. The jewelry was worth almost $150,000. Unfortunately, the day was busy and the two boxes of jewelry were placed in an area with a number of empty boxes. At the end of the day, the boxes, including the two containing the jewelry, were put in the trash. They were never seen again.

Elegant Slumming made a claim with its insurance carrier, National Grange, for the loss. The carrier denied the claim, relying upon a provision in the policy often euphemistically called the "physical evidence" provision. While there are a number of variations of this provision used across the country, the one at issue provided as follows:

> We will not pay for loss of or damage to: (3) property that is missing, but there is no physical evidence to show what happened to it, such as shortage disclosed on taking inventory.

Shortly after the denial of the claim, Elegant Slumming filed suit in the Superior Court of the State of Delaware, in and for Sussex County. After a record was created in discovery, both parties moved for summary judgment. The trial court granted summary judgment in favor of Elegant Slumming and against National Grange for the amount of the loss, plus interest and attorney's fees pursuant to Delaware statute, 18 Del. C. §4102. The trial court dealt with the knotty issue of what is physical evidence, and whether testimonial evidence can be "physical evidence." The court specifically held:

… the physical evidence requirement demands something more than nothing. That is the only conclusion that can be reached by the entire sentence in accepting its plain meaning. The Court holds that the language in question clearly and unambiguously required some evidence of what happened to the missing property. The Exclusion is not ambiguous.

After making this determination, the court determined that the evidence showed that the employee responsible for disposing the jewelry specifically recalled the events of the day and that he had mistakenly thrown the jewelry in the trash. The court further found that there was evidence about what happened to the packages unlike an inventory case where there was no explanation. As a result, the court determined the Physical Evidence Exclusion did not apply.

On appeal, the Supreme Court of the State of Delaware affirmed but used different reasoning. The Supreme Court viewed the case in a much more limited fashion. The Supreme Court determined that there was physical evidence, including the receipt showing the jewelry was delivered on the day in question, and photographs of the area where the loss occurred. As a result, the Supreme Court determined that the provision was satisfied and affirmed the decision of the trial court.

The case is *National Grange Mut. Ins. Co. v. Elegant Slumming, Inc.*, No. 278, 2012 (Del. Jan. 9, 2013). Attorneys involved include Daniel P. Bennett (argued) and Christian G. Heesters of Mintzer, Sarowitz, Zeris, Ledva & Meyers, LLP, Wilmington, Delaware for Appellant; Craig A. Karsnitz (argued) and Erika R. Caesar of Young Conaway Stargatt & Taylor, LLP, Georgetown, Delaware for Appellee.

Craig A. Karsnitz is a partner in the Georgetown and Wilmington, Delaware, offices of Young Conaway Stargatt & Taylor, LLP. Mr. Karsnitz, who represented the appellee in the case discussed here, can be reached at ckarsnitz@ycst.com.

Industry News

By Victoria Prussen Spears

People

Insurance Duo Joins Holland & Knight

John Sarchio has joined the law firm of **Holland & Knight** as chair of its Insurance Industry Practice Team. Mr. Sarchio was most recently co-founder and co-head of the Insurance and Reinsurance Practice Group at Chadbourne & Parke LLP. **Richard G. Liskov**, who formerly led the insurance practice at White & Case LLP, also has joined Holland & Knight as a partner.

Mr. Sarchio's practice concentrates on insurance industry mergers, acquisitions and financings, reinsurance transactions, self-insurance and captives, and insurance regulatory matters. He provides guidance in connection with insurance company demutualizations, bank-insurer affiliations and mutual insurer mergers. Mr. Sarchio also has advised a variety of professional service firms in a wide range of matters relating to their professional liability insurance programs and has counseled numerous industrial and financial services companies regarding their risk management and corporate insurance programs. In addition to his work for commercial clients, he has advised several state and foreign governments on insurance issues and has drafted a number of laws and regulations governing various aspects of the insurance industry, including Vermont's captive insurance law.

Mr. Sarchio received a J.D. degree from University of Pennsylvania Law School, where he was executive editor of the Law Review, and graduated magna cum laude from Bucknell University. He also holds an LL.M. degree from the London School of Economics and Political Science.

Mr. Liskov focuses his practice on insurance regulatory, transactional and litigation matters. He regularly counsels corporate and banking clients on regulatory and coverage issues, as well as advising and representing insurers and intermediaries. Prior to joining his previous firm, he served as the deputy superintendent and general counsel of the New York State Insurance Department ("NYSID"). In addition, Mr. Liskov was an assistant attorney general in New York, which included service as litigation deputy chief and a concentration on matters involving the NYSID. He also teaches insurance regulatory law at Columbia Law School on an adjunct basis.

Mr. Liskov completed his undergraduate work at Brandeis University, where he graduated magna cum laude, and earned a J.D. degree from Columbia Law School as a Harlan Fiske Stone Scholar.

Former Senator Ben Nelson to Lead National Association of Insurance Commissioners

Former Nebraska Senator **Ben Nelson** has been named chief executive officer of the **National Association of Insurance Commissioners** ("NAIC"), the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories.

The NAIC said that Sen. Nelson will lead the NAIC's efforts to meet the needs of its members and represent their interests as the primary advocate and chief spokesperson in Washington, D.C. His responsibilities will include outreach to federal and international governmental entities, as well as state government associations, consumers and insurance industry representatives.

"Sen. Nelson's impressive credentials and deep knowledge of state insurance regulation are simply unmatched," said **Jim Donelon**, NAIC President and Louisiana Insurance Commissioner. "His rare and valuable combination of experience in insurance and government will be a tremendous asset to our organization. In addition to skillfully navigating the political arena, the stalwart leadership and collaborative nature that marked his time in public service will be integral to elevating our efforts on Capitol Hill. Moreover, as a former regulator and Executive Vice President of the NAIC, Sen. Nelson has a keen understanding of the insurance marketplace, which will make him an effective advocate for the preservation of our state-based system of regulation."

"I am honored to serve as CEO during such an important and exciting time in the regulatory community," said Sen. Nelson. "After years in government, this is a homecoming for me. It is also an opportunity to advance the work of the NAIC to safeguard the insurance sector through the promotion of our outstanding regulatory framework. In my new role, I look forward to continuing our relationship with the Federal Insurance Office as well as working with state regulators on matters affecting the economy and consumers."

Prior to retiring from the Senate in 2012 after two terms, Sen. Nelson served as Governor of Nebraska from 1990-1998. He also served as Executive Vice President and Chief of Staff for the NAIC (1982-1985); Director of the Nebraska Department of Insurance (1975-1976); and Executive Vice President and then President/CEO of the Central National Insurance Group (1977-1981). Sen.

Nelson earned a Juris Doctorate, as well as undergraduate and graduate degrees in philosophy, from the University of Nebraska.

Sen. Nelson replaces NAIC Acting CEO **Andrew Beal**, who stepped into the role after former CEO **Therese M. Vaughan** left the association in November. Mr. Beal now returns to his roles as Chief Operating officer and Chief Legal Counsel.

For more information, visit www.naic.org.

2 Insurance Lawyers Become Partners at Nelson Levine

The law firm of **Nelson Levine de Luca & Hamilton** has some personnel news: **Lawrence H. Mirel** is joining the firm's Washington, D.C., office as a partner in the Insurance Regulation Practice on February 1, 2013, and **Marc S. Voses** has joined the firm's New York office as a partner in the Insurance Coverage Practice.

Mr. Mirel has more than 25 years of insurance-related experience and served for more than six years as the Commissioner of Insurance, Securities and Banking for the District of Columbia. Mr. Mirel focuses his practice on helping insurers understand what the rapidly-evolving regulatory landscape means for their businesses. He earned his B.A. from Oberlin College and his J.D. from Columbia University Law School. Prior to joining Nelson Levine, Mr. Mirel served as a partner and co-chair of the Insurance Regulation and Legislation Group at Wiley Rein LLP.

Mr. Mirel will be based in Nelson Levine's Washington, D.C., office led by **Susan T. Stead**, chair of the firm's Insurance Regulation Practice and a former regulator. Focused on insurance regulatory reform with a special emphasis on federal legislation affecting insurers, Ms. Stead will move the home base of her national regulatory practice to the firm's D.C. office while continuing to lead Nelson Levine's Ohio operations.

Mr. Voses has devoted his entire legal career to advising insurers and reinsurers in large exposure, complex claims and coverage matters arising from various product lines, including Directors & Officers, Financial Lines, and Errors & Omissions. He also advises insurers on extracontractual issues and represents insurers in claims alleging bad faith as well as in matters arising out of insurers' commercial operations. Mr. Voses earned his B.S. in accounting from St. John's University College of Business Administration and his J.D. from St. John's University School of Law. Prior to joining Nelson Levine, he was a partner in the New York office of Edwards Wildman Palmer LLP.

Jeffrey O'Connell, Who Teamed with Robert Keeton to Create 'No Fault' Auto Insurance, Dies at 84

Professor Jeffrey O'Connell, who worked with Harvard Law Professor Robert E. Keeton to create the model for "no fault" automobile insurance, has died.

The 1965 book by the two law professors, "Basic Protection for the Traffic Victim: A Blueprint for Reforming Automobile Insurance," led states across the country to create a "no fault" system.

Read more: http://www.nytimes.com/2013/01/11/business/jeffrey-oconnell-legal-scholar-of-no-fault-coverage-dies-at-84.html.

Robert McCarthy is New Chair of NY Bar Insurance Section

Robert F. McCarthy will be named the new chair of the New York State Bar Association's Torts, Insurance and Compensation Law Section at the next annual meeting.

Mr. McCarthy is a regional leader with the staff counsel operations of **Nationwide Mutual Insurance**. His primary specialization is commercial, excess, surplus, and specialty lines of insurance.

Mr. McCarthy graduated from St. John's University and earned his law degree from Fordham University School of Law.

New Partner and Special Counsel at Mound Cotton

Mound Cotton Wollan & Greengrass has named **Sanjit S. Shah** as a partner and **Ann E. Halden** as Special Counsel, effective as of January 1.

Mr. Shah's litigation experience includes first party and third party insurance coverage disputes, defense of professional liability claims, and other complex commercial matters, including securities actions. He has argued before the U.S. Courts of Appeals for the Second and Federal Circuits and the First and Second Departments of the Appellate Division of the New York Supreme Court.

Prior to joining the firm, Mr. Shah served as an assistant district attorney in Bronx County. He is admitted to the bars of New York and New Jersey. He is also a member of the Association of the Bar of the City of New York and the New York State Bar Association.

Mr. Shah joined the firm in 2003. He is a graduate of The John Hopkins University and Fordham University School of Law, where he was an editor of the Fordham Urban Law Journal.

Ms. Halden joined the firm in 2001. She graduated from the College of the Holy Cross, where she received a Bachelor of Arts degree in Economics/Accounting. She is a 1997 graduate of the Fordham University School of Law, where she was an editor of the Environmental Law Journal. Prior to joining the firm, she worked as an associate in a New York law firm, where she concentrated in reinsurance-related matters involving environmental, asbestos, and health hazard issues. Ms. Halden is admitted to practice in New York.

William Erickson Becomes Chair of Insurance Group at Robins Kaplan

William N. Erickson has been named chair of the Insurance Group at the law firm of Robins, Kaplan, Miller & Ciresi L.L.P.

Mr. Erickson has handled hundreds of coverage disputes under first and third party policies for claims arising from fire, explosion, collapse, design defect, environmental impairment, flood, and other losses. He has litigated disputes concerning fortuity, reformation, physical damage, insured risk, insured property, exclusions, obligations in case of loss, extra expense, business interruption, sue and labor, limits and deductibles, arson and fraud, and fair claims practices.

For more information, visit http://www.rkmc.com.

▸ News

Gov. Christie Speaks Out: Flood Insurance Program 'Has Stunk'

New Jersey Governor Chris Christie says that the way the National Flood Insurance Program has handled the state's Superstorm Sandy claims "has stunk." By contrast, the governor stated, "Our local insurance companies have been doing a great job of settling and moving these claims very quickly."

AmTrust Financial Services to Acquire Sequoia Insurance

AmTrust Financial Services, Inc., has entered into a definitive agreement, pending regulatory approval, to acquire **Sequoia Insurance Company** and its subsidiaries, **Sequoia Indemnity Company** and **Personal Express Insurance Company**, for approximately $60 million.

Sequoia offers a variety of low hazard, property/casualty insurance products including worker's compensation and commercial package insurance to small businesses in the western U.S. In 2012, Sequoia wrote gross written premium of approximately $140 million.

"We believe current market conditions will continue to provide opportunities to supplement our organic growth with strategic acquisitions similar to Sequoia where our proprietary technology, economies of scale, pricing discipline and experienced management improves the profitability of acquired insurance businesses in our chosen niche markets," said AmTrust Financial Services, Inc. President and CEO, **Barry Zyskind**. "In addition, we believe combining organic growth with appropriate strategic acquisitions maintains attractive returns on equity and thus, improves shareholder value."

As Jurors, 59 Percent Would Be Biased Against Insurance Companies, Poll Finds

Insurance companies that are pitted against individuals as litigants in civil cases would be advised to seek out potential jurors who are college grads with an income in excess of $100,000. According to a recent national poll by **DRI – Voice of the Defense Bar**, that is the demographic that is least likely to be biased in favor of the individual in such cases. In fact, it is the only demographic surveyed in which fewer than half would be inclined toward bias in favor of the individual.

Overall, 59 percent of respondents said that they would be inclined to favor the individual in such a lawsuit with virtually no difference between male and female respondents. The poll found that 20 percent of respondents said they would not favor either.

"The results of our poll show two things," said **John R. Kouris**, DRI Executive Director. "The fact that only 20 percent would approach their responsibilities as a juror in an objective manner means that we have a bit of public education to do on the role of a juror in the administration of justice. Second, while some of the demographic responses are expected, others are quite surprising."

The poll also found a "bias spike" among the respondents in the youngest age category, individuals 18-29. There, 71 percent said that they would be inclined to favor the individual over the insurance company. That was 15 percent higher than among all adults age 30 and over.

The poll also found that 73 percent of liberals and 50 percent of conservatives saying that they would favor the individual.

Thought Leaders

Keep Lawyers Out of Auto Industry Accident Claims, Aviva Urges

The automobile insurance system in the United Kingdom is "dysfunctional" and has resulted in above-inflation premium increases for drivers, a report prepared by **Aviva**, one of the U.K.'s largest motor vehicle insurers, asserted.

The Aviva report cited the main reason for this as a "disproportionate increase in minor bodily injury claims, most commonly for whiplash." According to Aviva, since 2009, the number of whiplash claims has risen by 32 percent, despite the number of accidents falling by 16 percent. In the same period, personal injury claims soared to become more than half of all motor vehicle claims costs at Aviva, rising to 52 percent in 2011, the report asserted.

Aviva surveyed 2,437 drivers, including 383 who had made a personal injury claim, in December 2012 to get their views on premiums and reform. Aviva said that its findings demonstrated an "overwhelming belief among drivers that an excessive cash-compensation culture" existed in the U.K.

Aviva proposed reforms that it asserted would take £1.5 billion of excess cost out of the current motor vehicle claims system, "lowering premiums while improving customer service for those that have been injured in an accident."

Central to Aviva's proposals for reform was its call for a legal requirement on personal injury claimants "to contact the 'at fault' insurer in the first instance rather than them be handled by intermediaries including claims management companies and PI lawyers." In Aviva's view, this would give the at fault insurer the first chance to accept responsibility and begin the compensation process immediately.

Aviva also said that it supported the introduction of independent panels of medical experts to determine whiplash cases with a greater focus upon targeted rehabilitation, which, it said, 83 percent of consumers supported.

Dominic Clayden, Claims Director at Aviva, said: "Our primary concerns are that injured parties receive care and compensation as quickly as possible and that all motorists benefit from a reduction in the excessive costs that have built up in claims over the past few years. We are campaigning for a more efficient system that removes the 'interested parties' and requires people to deal directly with the insurer of the at-fault party."

Aviva contended that this would result in a halving of the cost per claim as third party legal fees (average current legal fee is £2500 for a "typical" whiplash claim) were removed from low-value personal injury claims, a saving that would benefit all motorists in reduced premiums, according to Aviva.

Aviva said that its research showed that there was no difference in the compensation awarded to the injured party if handled directly or via third parties. However, it declared, the multiple third parties that can get involved in a claim add significant cost in fees. Aviva estimated that handling claims directly would cut £1.5 billion of excess cost, approximately 50 percent of the current cost of handling the 550,000 whiplash claims received by insurers every year. This cost reduction could lead to premium falls of around £60 a year for the average driver, in its view.

Aviva also said that it supported the introduction "of a truly independent panel of medical experts to determine whiplash cases with a greater focus upon targeted rehabilitation, which consumers support."

Aviva reported that its research revealed that almost two in three (63 percent) think that people seek compensation to get money to spend on whatever they choose rather than rehabilitation. Aviva said that this view was supported by its research of almost 400 U.K. drivers who have made a PI claim; this revealed that only 33 percent of people spent their cash compensation on medical treatment or physiotherapy, others said it was used to pay off household debt (29 percent), to buy luxury items such as television sets (12 percent) or to go on vacation (nine percent). Other uses admitted to included buying a car, putting it into savings, and paying for college.

Aviva said that its research of U.K. motorists showed that they identified a strong link between rising personal injury claims and rising premiums, with 95 percent saying unnecessary claims were behind premium increases. Additionally 94 percent blamed the involvement of third parties and 93 percent the rise in whiplash claims specifically, according to Aviva.

Aviva said that the changes that the majority of motorists backed were:

- No cash compensation for minor motor accidents where no-one was injured - simply the insurance cover for the cost of repairing the vehicle (85 percent)
- A preference for care above cash – insurers should provide access to rehabilitation for their injuries, not cash compensation (55 percent)

- A ban on excessive legal fees (69 percent) and the unnecessary involvement of lawyers or claims management companies (67 percent)
- Independent medical advisers not connected to the person making the claim to assess injuries (59 percent)
- Tighter regulation on how claims management companies and personal injury lawyers market their services (95 percent)
- A removal or clamping down on exaggerated claims via more stringent procedures to challenge suspicious minor injury claims. (83 percent)

Mr. Dominic continued, "Our figures for average compensation settlements show that dealing direct with an insurer directly results at least as much compensation for the claimant and has the advantage of being quicker – meaning their treatment and rehabilitation can start almost immediately. Our focus is on their recovery and settling their claim quickly and fairly. It would also prompt a significant reduction in the costs of the current system which would benefit all U.K. motorists, who will begin to see a reduction in their premiums."

Read more: Road to Reform report; Infographic.

Staged Accidents Top Questionable Insurance Claims Filed By Organized Crime, Report Finds

The National Insurance Crime Bureau ("NICB") has released an analysis that examines the impact that organized crime groups have on insurance fraud. Covering the period from January 1, 2008, through June 30, 2012, analysts reviewed 13,014 questionable insurance claims ("QCs").

The insurance policy type most represented in the analysis was "personal automobile," accounting for 10,659 referrals. The NICB said that this suggested a rather strong correlation between the kinds of alleged fraud schemes most perpetrated by "organized group/ring activity" ("OGA"): staged and caused accidents. Moreover, according to the NICB, this was further evident when looking at these QCs by loss type.

The referral reason most often coupled with the OGA referral was by far "staged/caused accident." It was indicated 4,347 times. The loss type with the most referrals was bodily injury with 4,401 referrals.

The results of this QC analysis correlated with what NICB agents and analysts are seeing in their cases—particularly in the no-fault, personal injury protection ("PIP") states like Florida, Michigan and New York, according to the NICB.

The top five states that generated the most were: Florida (3,530), California (2,679), Michigan (1,080), Texas (1,050) and New York (765). The top five cities generating the most were: Los Angeles (752), New York (595), Miami (575), Detroit (545) and Tampa (545).

QCs are claims that NICB member insurance companies refer to NICB for closer review and investigation based on one or more indicators of possible fraud. A single claim may contain up to seven referral reasons. For this report, just QCs with a referral reason of OGA were identified.

The NICB defines organized crime groups as "any specific group made up of entities and/or individuals who systematically and repeatedly conduct pre-planned activities for the purpose of generating fraudulent insurance schemes."

Read more: here and www.nicb.org.

Swiss Re Study Spotlights Role that Insurance Can Play in Improving Food Security

In a new study, **Swiss Re** concludes that agricultural insurance is an "indispensable part of agricultural risk management" that helps to smooth farm income as well as incentivize food investment.

The Swiss Re study also says that agricultural insurance penetration in emerging markets is currently very low but potential premiums by 2025 can reach an estimated US$15-20 billion.

Swiss Re's latest *sigma* research publication, "Partnering for food security in emerging markets," proposes a multi-stakeholder approach to address the problem of food insecurity, putting agricultural insurance on the table to help manage agricultural risks, stabilize farm income, and encourage agricultural investment to strengthen the food chain infrastructure.

According to Swiss Re, agricultural insurance "can help to manage risks in the agricultural value chain, stabilize farm income, and promote investment in agriculture," and can act as collateral for credit. Swiss Re points out that a typical example of agricultural insurance is area-yield crop insurance, which bases pay-out on the shortfall of an area's realized crop yield relative to its average historical yield. This kind of insurance was implemented in 2010, for example, by the Vietnamese government in partnership with re/insurance companies to provide rice farmers with risk protection, Swiss Re noted.

"Tapping the full power of agricultural insurance

in emerging markets requires a lot: proactive and enabling government policies, supportive infrastructure, innovative products, cost-effective business models, new distribution channels, and advanced technology. Much of this can be achieved by partnering with insurers," says **Amit Kalra**, a co-author of the *sigma* study.

New Products

American Bankers Insurance Introduces Property & Casualty Coverage

The **American Bankers Association** ("ABA") has announced that **ABA Insurance Services** – the ABA-endorsed program providing directors and officers, bond and related insurance to community banks – is now offering property and casualty insurance.

The ABA said that the new P&C program includes standard lines coverage of property, general liability, business automobile, worker's compensation and umbrella, as well as unique coverage enhancements designed to address bank-specific hazards.

The ABA-endorsed insurance program was created more than 25 years ago to be a long term, stable source of insurance for community banks, the ABA said. The ABA noted that the addition of property and casualty coverage to ABA Insurance Services' product suite would allow the market's only bank-owned and banker-directed insurance program to compete more effectively in the community bank marketplace.

"The ability to offer property and casualty to our customers will give them the convenience of one-stop shopping for all of their insurance needs," explained **John N. Wells**, president and CEO of ABA Insurance Services. "With our P&C program, our customers will not only enjoy greater convenience, they will also benefit from working with underwriters with the industry's highest customer service standards."

"The ABA Insurance Services program is designed by bankers for bankers," stated **John C. Wolff**, executive vice president, ABA and Corporation for American Banking, an ABA subsidiary. "The new property and casualty program demonstrates the commitment of ABA Insurance Services and its reinsurer, **American Bankers Mutual Insurance Ltd**. to identify needs and provide insurance solutions for the banking industry."

To learn more, visit www.abais.com.

Microinsurance Fund to Help Insure Haitians against Natural Disasters

IFC, a member of the **World Bank Group**, is partnering with donors and the **Microinsurance Catastrophe Risk Organisation** ("MiCRO") to help thousands of low-income micro entrepreneurs in Haiti protect their livelihoods against weather-related risks and natural disasters.

Haiti is highly prone to earthquakes, hurricanes, floods, and other natural disasters that have devastating effects on the country's population and economy. However, only 0.3 percent of the population has some form of insurance, one of the lowest rates in the world. IFC believes that micro-entrepreneurs are particularly vulnerable to uninsured losses, as these can force them to default on debts and disqualify them from future loans at a time when they need capital to recover.

IFC's $1.96 million project with MiCRO includes a $1.7 million performance-based grant and $260,000 in technical assistance from the **Global Index Insurance Facility** ("GIIF"). GIIF is a program managed by IFC and jointly implemented with the World Bank. GIIF is funded mainly by the European Union with additional funding from the Netherlands and Japan.

The project will help provide Haitian micro-entrepreneurs with affordable weather-index insurance. It will be distributed through **Fonkoze**, a microfinance institution in Haiti. Over the next three years, close to 70,000 Fonkoze clients, mostly rural women, are expected to be insured through the program. They include shopkeepers, traders and market vendors who provide their communities with the essential goods and services.

"In Haiti, entrepreneurs at the base of the pyramid, and women in particular, must be given the opportunity to generate income for their households, grow their businesses, create jobs, and build assets," said **Ary Naim**, IFC Representative in Haiti. "With this innovative product, IFC hopes to have a strong impact, preventing natural disasters from wiping out the hard work of thousands of Haitian entrepreneurs to get out of poverty."

MiCRO was founded by Fonkoze and **Mercy Corps**, a global humanitarian agency.

"MiCRO and Mercy Corps are committed to developing innovative solutions that help the world's poor be more resilient to the threat of natural catastrophe and the effects of climate change," said **Steve Mitchell**, Acting Chairman of MiCRO's Board and Vice President

of Financial Services for Mercy Corps. "MiCRO is the result of a partnership of leading global organizations committed to this vision."

"There is tremendous potential in Haiti. By working with IFC and our local partners we can provide much-needed insurance that helps Haitians unleash economic growth," said **Javier Niño Perez**, Head of the EU delegation in Haiti. "GIIF has supported projects in African countries such as Kenya, Rwanda, and Senegal; in South Asian countries, such as Sri Lanka and Bangladesh; and an additional 20 countries jointly with the World Bank. This project in Haiti is an important step toward developing sustainable local markets for insurance that helps the poor protect themselves from natural disasters and weather-related risks."

Affinity Group Announces New Bicycle Accident Insurance

Affinity Group Underwriters ("AGU") has launched a new bicycling accident insurance policy. The new coverage is part of AGU's cycling initiative called Balance For Cyclists.

Underwritten by the **Zurich American Insurance Company**, the Bicycle Accident Insurance coverage pays lump sum cash benefits to cyclists or their family who suffer a covered critical injury or death as the result of a cycling accident.

In addition to providing coverage for accidental death from a cycling accident, the insurance features payments for critical injuries like dismemberment, paralysis, and severe traumatic brain injury. Coverage is available in amounts of $50,000 to $250,000. The policy also pays $100 per day for any cycling accident that results in the rider being admitted to a hospital. To qualify for coverage the insured must be wearing a helmet at the time of the accident.

According to Zurich, unlike other bicyclist specific insurance policies, this coverage insures the rider, not the bicycle.

Currently the coverage is approved for sale in 26 states and should be available in most states within the next six months. Learn more at: http://www.balanceins.com.

Travelers Adds New Cyber Protection Coverage

Travelers is introducing CyberFirst Essentials® – Small Business for small businesses concerned about cyber liability risks.

"This new coverage targeted exclusively to small businesses extends Travelers' cyber insurance expertise to a critical driver of the economy. Small businesses may have exposures to sensitive information that can be compromised," said **Marc Schmittlein**, Executive Vice President, Small Commercial. "Cyber threats are on the rise and our customers rely on Travelers for products that provide them with the depth of protection they need."

CyberFirst Essentials – Small Business offers insurance coverage to protect against some of the most common information security breaches including:

- Online hacking and data theft of confidential information such as credit card number, Social Security number, medical data, etc.
- Accidental loss or sharing of personally-identifiable information regardless of whether that information was from electronic data or from physical paper records.

CyberFirst Essentials– Small Business is part of a Travelers MasterPac business owners policy and can include coverage for the costs associated with breach disclosure, credit monitoring services, resulting litigation and more, starting at $120 with flexible limits ranging from $25,000 to $250,000.

For more information, visit www.travelers.com.

April 6-9. *NAIC Spring 2013 National Meeting.* Hilton Houston and Four Seasons Houston, Houston, TX. Sponsored by NAIC. For more information, contact NAIC, (816) 783-8100, http://www.naic.org/meetings_home.htm.

April 7-9. *Verisk Insurance Solutions Customer Conference 2013.* Omni Orlando Resort, Champions Gate, FL. Sponsored by Verisk Analytics. For more information, contact Verisk, (800) 888-4476, http://www.verisk.com/conferences/verisk/2013/Overview.html

April 15-16. *NAMIC Congressional Contact Program.* (New York Insurance Association (NYIA) members only). The Hotel George, Washington, DC. Sponsored by New York Insurance Association. For more information, contact NYIA, (518) 432-4227, http://nyia.org/wp/wp-content/uploads/2012/07/NAMIC-CCP-2013-Brochure.pdf

May 29-31. *NYIA 2013 Annual Conference.* High Peaks Resort, Lake Placid, NY. Sponsored by NYIA. For more information, contact NYIA, (518) 432-4227, http://nyia.org/wp/wp-content/uploads/2013/01/NYIA-2013-Annual-Conference-Brochure-Final.pdf.

May 29-31. *NAIC Financial Summit.* Marriott Marquis and Marina, San Diego, CA. Sponsored by NAIC. For more information, contact NAIC, (816) 783-8100, http://www.naic.org/frs_financial_summit.htm.

July 23-25. *Montana Captive Insurance Association, Inc., 8th Annual Conference.* The Lodge at Whitefish Lake, Whitefish, MT.

August 24-27. *NAIC Summer 2013 National Meeting.* JW Marriott Indianapolis and Indianapolis Marriott Downtown, Indianapolis, IN. Sponsored by NAIC. For more information, contact NAIC, (816) 783-8100, http://www.naic.org/meetings_future_meetings.htm.

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Published Monthly by
The National Underwriter Company
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