Wiley Rein LLP

EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | October 2015

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Attorney Sanctioned for Failure to Disclose Client's D&O Insurance Policy

The United States Court of Appeals for the Tenth Circuit has held that an attorney may be sanctioned under Rule 37 of the Federal Rules of Civil Procedure for failing to disclose a client's D&O policy that potentially covered securities-related claims asserted against the client. *Sun River Energy, Inc. v. Nelson*, 2015 WL 5131947 (10th Cir. Sept. 2, 2015).

The district court set a deadline for the parties' disclosures, pursuant to Rule 26(a)(1)(A), of "any insurance agreement under which an insurance business may be liable to satisfy all or part of a possible judgment in the action or to indemnify or reimburse for payments made to satisfy the judgment." The plaintiff had a D&O insurance policy that potentially covered securities-related counterclaims asserted by the defendants. The plaintiff did not disclose the existence of the D&O policy until 18 months after the deadline for doing so, and only after the defendants repeatedly requested the information and filed a motion to compel. The defendants then moved for sanctions against the plaintiff and its in-house and outside counsel. The district court concluded that the plaintiff itself should not be held responsible for the non-disclosure, but held the plaintiff's in-house and outside counsel personally liable for the defendants' attorneys' fees in pursuing the motion for sanctions.

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Even Without Express Demand for Money, Pre-Policy Period Letter is a "Claim"

Applying New Jersey law, a New Jersey federal court has found that a letter to an insured law firm referencing an "action against the Firm for damages" arising out of the firm's actions and requesting that the firm put its insurer on notice constituted a "claim" made prior to the inception of the firm's claims-made professional liability policy. *Innes v. St. Paul Fire & Marine Ins. Co.*, 2015 WL 5334580 (D.N.J. Sept. 11, 2015). The court also found that the letter demonstrated that the firm had knowledge prior to the policy period of an act, error or omission that might reasonably be expected to result in a claim, barring coverage for the dispute.

The insured firm had represented the underlying claimant's ex-wife in divorce proceedings. The claimant

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Neither Bond Nor E&O Policy Covers Entity Losses from Employee Theft of Client Funds

Applying Michigan law, the United States District Court for the Eastern District of Michigan has held that a fidelity bond did not provide coverage for an employee's theft of client funds because the insured's losses were suffered indirectly through reimbursing client losses. *Hantz Fin. Servs., Inc. v. Nat'l Union Fire Ins. Co.*, 2015 WL 5460632 (E.D. Mich. Sept. 17, 2015). In addition, the court held that an E&O policy did not provide coverage for claims arising out of the employee's theft because the employee intended to steal client funds.

The employee of the insured financial services company stole investment funds from the company's clients by depositing client checks meant for investments or insurance directly into his personal account. After discovery of the scheme, several clients brought suit against the company, and with the bond insurer's consent, the company settled the clients' suits and fully repaid to its clients the funds misappropriated by the employee. The company then sought coverage for the amounts it paid to its clients under a fidelity bond and an E&O policy.

The court held that the bond did not provide coverage for the losses resulting from settling the clients' claims for misappropriation of their investment funds. The bond provided coverage for "[l]oss resulting directly from dishonest or fraudulent acts committed by an Employee with the manifest intent to cause the insured to sustain

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Settlement Communications Within Ten Days Of Mediation Protected From Discovery In Coverage Litigation By California's Mediation Privilege

The United States District Court for the Northern District of California has held that, pursuant to California rules of evidence, a mediation privilege applied in coverage litigation to preclude discovery of underlying settlement communications between an insured and a claimant within ten days following the mediation. *Silicon Storage Tech., Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 2015 WL 5168696 (N.D. Cal. Sept. 3, 2015).

In the underlying litigation, the insured and the claimant attended a mediation with an insurer in attendance with the insured. The mediation was unsuccessful, but following the mediation, the claimant made a $20 million demand on the insured to resolve the misappropriation of trade secret allegations asserted by the claimant against the insured and certain of its employees. The insurers rejected the settlement demand, but the insured agreed to settle the underlying litigation for the $20 million. The insured then sought coverage for the entirety of the settlement from its insurers. According to the insurers, the $20 million settlement also included a settlement of separate patent litigation between the two parties. For this reason, the carriers contended that an allocation was necessary between the settlement amounts attributable to the trade secret litigation and the separate patent litigation.

In the ensuing coverage litigation, the insurers requested discovery of communications between the insured and claimant concerning the $20 million settlement demand following the mediation and the resulting discussions that ultimately led to the settlement approximately 15 days after the mediation.

On appeal of the magistrate judge's ruling that the insurers were entitled to discovery of the underlying settlement communications following the mediation based on the insured's counsel's admission at argument that such documents were discoverable, the district court held that, pursuant to California Evidence Code § 1119(a)-(b), the underlying settlement communications through ten days following the mediation were protected by the mediation privilege. The court also held that counsel for the insured "could not have waived the mediation privilege because [the claimant], which also participated in the mediation, did not 'expressly agree . . . to disclosure' of the communications at issue," as required by the mediation privilege rule to waive the privilege. ■

Professional Services Exclusions Bar Coverage for Failure to Give Prescribed Drugs to Prisoner

Applying Texas law, the United States Court of Appeals for the Fifth Circuit has held that "medical services" and "professional services" exclusions in general liability and umbrella policies issued to a private prison operator barred coverage for a civil rights claim of an inmate who died while in custody due to the failure of the prison to provide prescribed doses of benzodiazepine. *LCS Corrections Servs., Inc. v. Lexington Ins. Co.*, 2015 WL 5155056 (5th Cir. Sept. 2, 2015).

"Medical Services" was defined to include "medical, surgical, dental or nursing treatment to such person or the person inflicting the injury including the furnishing of food or beverages in connection therewith"; or "furnishing or dispensing of drugs or medical, dental or surgical supplies or appliances if the injury occurs after the Named Insured has relinquished possession thereof to others." The parties agreed that the latter subpart of the definition did not apply, but the court determined that the disjunctive "or" in the definition required it to consider each subpart independently. The court rejected the insured's argument that the inmate died due to the insured's administrative policy not to provide certain medications rather than a failure to render medical services. Even if no specific professional decision was made in denying the prisoner medication, the court held that "providing and administering medicine to an inmate is a medical service, which [the insured] failed to render, for whatever reason."

The "professional services" exclusion bared coverage for "liability arising out of the rendering of or failure to render professional services, or any error, or omission, malpractice or mistake of a professional nature committed by or on behalf of the 'Insured' in the conduct of any of the 'Insured's' business activities." The term "professional services" was undefined, and the court applied a general definition: "[t]he task must arise out of acts particular to the individual's specialized vocation, [and] . . . it must be necessary for the professional to use his specialized knowledge or training." The insured did not contest that distributing medications to

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Professional Services Exclusion in D&O Policy Bars Coverage for Claim Arising from Provision of Payroll Services

Applying California law, the United States Court of Appeals for the Ninth Circuit has held that a professional services exclusion bars coverage for a suit against the directors and officers of a payroll services company because the suit arose from their failure to provide payroll services. *Begun v. Scottsdale Ins. Co.*, 2015 WL 4910137 (10th Cir. Aug. 18, 2015).

The directors and officers of the insured payroll services company sought coverage from their D&O insurer for a suit alleging the failure to render payroll services. The insurer denied coverage for the suit based on the D&O policy's professional services exclusion, and the insureds sued the insurer for purported breach of the duty to defend the suit.

The court held that the insurer had no duty to defend the insureds in the lawsuit pursuant to the plain terms of the professional services exclusion contained in the D&O policy. The court reasoned that the professional services exclusion applied to preclude coverage because the suit "centered" on the insureds' personal failure to render payroll services, which qualifies as a "professional service" under California law. In addition, the court rejected the insureds' argument that extrinsic evidence developed during discovery established a duty to defend. First, the court stated that "when an insured waits to present evidence that may give rise to a duty to defend until after the conclusion of the underlying action, an insurer is not required to consider the evidence." Moreover, even if the extrinsic evidence were considered, the court concluded that the professional services exclusion still operated to preclude coverage because the evidence presented by the claimant was only offered "to substantiate his alter ego theory, not to hold [the insureds] liable" in their roles as insured persons. ■

Mutual Mistake Requires Reformation of Retroactive Date for Additional Insured

Applying Illinois law, the United States District Court for the Northern District of Illinois has held that the retroactive date for an additional insured under claims-made policies should be reformed to the inception date of each policy because of a mutual mistake. *Hallmark Spec. Ins. Co. v. Roberg*, 2015 WL 5163216 (N.D. Ill. Sept. 2, 2015). The court also held that estoppel, waiver, and laches did not apply to prevent policy reformation because the insurer never defended the insured and promptly filed a lawsuit to reform the policy after first learning of the mutual mistake.

The insured doctor was affiliated with a medical group as an independent contractor. Under the agreement with the medical group, the doctor was required to purchase E&O insurance and name the medical group as an additional insured. When purchasing two consecutive claims-made policies, the doctor requested policies with the retroactive date at the inception date of the policy in exchange for paying a lower premium. The insurer agreed to issue the policies with the retroactive date at inception after the insured acknowledged the limited coverage provided by the policies and that the limitation would apply to the doctor and "additional named insureds." However, when the policies were issued, the policies included retroactive dates for the additional insured that were before the policies' inception dates. When a claim was tendered for coverage for wrongful acts allegedly committed before the policies incepted, the insurer learned that the retroactive dates for the additional insured were incorrect and filed a declaratory judgment action to reform the policies based on the parties' mutual mistake.

The court held that, based on clear and convincing evidence, the policies should be reformed because, as written, the policies' retroactive dates for the additional insured did not reflect the agreement between the parties. It found that the insurer's intent was for the retroactive date at policy inception because the underwriter offered testimony that he would never

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Lawyer Rendered "Professional Services" in Failure to Advise Investment Transaction Counterparty Regarding Title Insurance

A federal district court has held that an insurer breached a lawyers professional liability policy when it denied coverage in connection with a real estate investment transaction between a claimant and the insured lawyer, holding that the claimant believed the lawyer was representing him and that the lawyer rendered "professional services" when he failed to advise the claimant to obtain title insurance. *Zhuang v. Hanover Ins. Co.*, 2015 WL 5173061 (W.D. Pa. Sept. 3, 2015).

The claimant sought the insured lawyer's advice as a second opinion in connection with a real estate investment. Within days, the lawyer contacted the claimant, through the claimant's primary attorney, regarding an investment opportunity related to a property the insured owned. The claimant agreed to the deal, and the insured prepared the loan documents. The claimant did not pay the insured lawyer for preparing the documents and knew the insured had an interest in the transaction. However, he believed the insured represented him in connection with the transaction. The claimant also believed that the insured lawyer was to obtain title insurance for the claimant's benefit.

The claimant later filed an involuntary bankruptcy petition against the property, and another investor sought an order confirming that it held a first-priority lien on the property. The claimant then filed a malpractice action against the insured lawyer. The insurer was notified of the claim against the insured lawyer and denied coverage, and a default judgment was entered against the insured. The insured then settled with the claimant and assigned his claims against the insurer, and the claimant filed a coverage action.

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Insurer's Declaratory Judgment Action Stays in Federal Court Despite Parallel State Court Proceeding Initiated by Insured

A federal district court in Virginia has denied an insured's motion to dismiss or stay an insurer's declaratory judgment coverage action in favor of the insured's parallel state court coverage action, citing the insured's earlier praise of the federal court as the "superior forum" for the dozens of underlying suits filed against the insured. *Liberty Mutual Fire Ins. Co. v. Lumber Liquidators Inc.*, No. 4:14-cv-00034 (E.D. Va. Sept. 4, 2015).

The insured, a retailer of hardwood flooring, was sued in multiple lawsuits by customers who alleged that the insured sold them laminate wood veneer flooring that contained toxic levels of formaldehyde. The lawsuits were consolidated in a multidistrict litigation proceeding in the United States District Court for the Eastern District of Virginia (EDVA). The insured tendered the matter to its insurers for coverage, but the insurers denied coverage because there were no allegations of "bodily injury" or "property damage" as defined in the policies. The insurers then filed a complaint in the EDVA seeking a declaration of no coverage, and requesting reformation of one of the insurance policies.

Five days later, the insured responded by filing its own complaint in Wisconsin state court, alleging that the insurers breached the terms of the policies and requesting a declaratory judgment that the insurers were obligated to defend and indemnify the insured in connection with the underlying lawsuit. The insured then filed a motion to dismiss the federal declaratory judgment action or, in the alternative, stay the action in favor of the insured's parallel Wisconsin state court coverage action. The insured also moved to dismiss the insurers' reformation claim for failure to state a claim.

In addressing the insured's motion, the court first discussed the proper abstention standard to be applied. According to the court, where there are parallel federal and state court proceedings, the federal court must analyze the nature of the federal claims to determine which of two discretionary abstention doctrines identified by the Supreme Court of the United States should apply: *Brillhart/Wilton* or *Colorado River*.

The court explained that the *Brillhart/Wilton* standard should be applied where the sole relief sought in the complaint is declaratory in nature. The court noted that, under that standard, the

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"Bargaining Leverage" Does Not Suffice to Trigger Personal Profit/Financial Advantage Exclusion

A federal court in Idaho has held that "bargaining leverage" in violation of state and federal anti-trust laws is an insufficient gain for purposes of triggering an insurance policy's improper personal profit or financial advantage exclusion. *St. Luke's Health Sys., Ltd., v. Allied World Nat'l Assurance Co.*, No. 1:14-CV-475-BLW (D. Idaho Sept. 4, 2015).

The insured, a non-profit hospital network , was found to have violated state and federal antitrust laws by acquiring more "bargaining leverage" with the purchase of another company, which the court predicted would result in higher prices. The insurer initially defended the underlying anti-trust claims against the hospital subject to a reservation of rights. After the court's ruling against the insured, however, the insurer denied coverage based on a policy exclusion for any claims based on "the gaining of any profit or financial advantage or improper or illegal remuneration by [the insured], if a final judgment or adjudication establishes that [the insured] was not legally entitled to such profit or advantage or that such remuneration was improper or illegal[.]"

In the coverage litigation that followed, the court concluded that the exclusion did not apply because the insured was not found to have gained an improper monetary or financial benefit. In reaching this conclusion, the court rejected the insurer's argument that the phrase "financial advantage" in the exclusion included "bargaining leverage." According to the court, interpreting the phrase in this manner would (1) allow the insurer to "add words to … avoid liability," and (2) broaden the use of the words "financial advantage" beyond its plain meaning. ■

Advancement When Bank Customer Had Insufficient Funds Not a "Transaction in the Nature of a Loan"

The United States Court of Appeals for the Eleventh Circuit, applying Georgia law, has held that an advancement made by a bank similar to that made in connection with overdraft protection was not a "loan" within the meaning of a definition of "Lending Services" in a bankers' professional liability policy. *Greater Community Bancshares, Inc. v. Fed. Ins. Co.*, 2015 WL 4897467 (11th Cir. Aug. 18, 2015).

A bankruptcy trustee filed an adversary complaint against an insolvent entity that allegedly operated a Ponzi-like scheme. The complaint also alleged that an insured bank knew or should have known that transfers of money made by the now-insolvent entity that were routed through the insured bank were fraudulent, and sought to void those transfers as fraudulent transfers. The complaint additionally alleged that when the now-insolvent entity had "insufficient funds," the bank "paid out" those funds on the now-insolvent entity's behalf, obligating the now-insolvent entity to repay the bank. Ultimately, the insured bank won summary judgment in the adversary proceeding, rejecting the bankruptcy trustee's theory that the bank lent money to the now-insolvent entity.

The insured bank held a duty-to-defend E&O policy that provided specified coverage for "Lending Services," defined to include any act "in the course of extending or refusing to extend credit or granting or refusing to grant a loan or any transaction in the nature of a loan." The carrier denied coverage, arguing that the temporary advancements did not constitute "Lending Services" and thus did not implicate coverage.

In the ensuing coverage action, the court of appeals affirmed the district court's decision to grant summary judgment to the insurer. The court explained that the underlying complaint did not indicate that the purported "debt" to the bank could be understood as a loan or extension of credit, as there were no indicia commonly associated with loans such as a "claim of a loan agreement, an interest rate, or even a due date." According to the court, the conduct alleged relating to advancements made when the now-insolvent entity had insufficient funds, at most, was "some form of overdraft protection, rather than a loan" as the term "loan" is commonly understood. ■

Attorney Sanctioned for Failure to Disclose Client's D&O Insurance Policy *continued from page 1*

On appeal, the Tenth Circuit first considered the sanctions imposed against the plaintiff's in-house counsel pursuant to Rule 37(c)(1), which authorizes sanctions for the failure to disclose or supplement information as required by Rule 26(a) in the absence of a substantial justification for the nondisclosure. The court held that sanctions under Rule 37(c)(1) apply only to parties and not to their counsel. The court further held that it could not uphold the sanctions award under its inherent power to sanction abuse of the judicial process because the standard for doing so is much more stringent than the "no substantial justification" standard of Rule 37(c)(1) and requires a finding that the conduct was taken in bad faith, vexatiously, wantonly, or for oppressive reasons.

The court then considered the sanctions imposed against the plaintiff's outside counsel, under Rule 37(b)(2), which authorizes sanctions against a party or an attorney for failing to comply with a discovery order—here, the district court's scheduling order setting forth the initial disclosure deadline. The outside counsel argued that his conduct was substantially justified, and thus did not warrant the sanctions, because he had assumed that the plaintiff's in-house counsel had reviewed the insurance policy and that it would be unusual for a D&O policy to cover securities claims against a corporation. The court found that the outside counsel's assumption that the in-house attorney had reviewed the policy was baseless and that the outside counsel had an obligation to review the actual terms of the insurance policy to evaluate the possible availability of coverage. Accordingly, the court held that the district court did not abuse its discretion and upheld the sanctions award against the plaintiff's outside counsel for failing to disclose the D&O policy. ■

Even Without Express Demand for Money, Pre-Policy Period Letter is a "Claim" *continued from page 1*

contended in a letter prior to the inception of the claims-made policy at issue that the firm had given the passport of the claimant's daughter to the claimant's ex-wife, who had fled the country, causing the claimant to expend tens of thousands of dollars to locate his daughter. The letter was signed by the claimant's attorney, stating that he represented the claimant "in an action against [the insured] Firm]" and requesting that the firm "please put your carrier on notice." After the policy incepted, the claimant sued the firm, alleging the same misconduct.

The policy defined "claim" as a "demand received by an insured for money or services alleging an error, omission, negligent act or 'personal injury in the rendering of or failure to render 'professional legal services' for others by you or on your behalf." The court held that "despite the fact that [it] does not contain a verbatim demand for money or services," the claimant's pre-policy period letter could "reasonably be construed as a demand to recover" the tens of thousands of dollars in legal fees that the claimant allegedly incurred following the asserted wrongful actions by the insured firm. Accordingly, the court determined that the "claim" was first made at the time of the letter, prior to the inception of the claims-made policy period, and that no coverage was available.

In the alternative, the court concluded that the letter triggered the policy's provision extending coverage for acts occurring prior to the policy period "provided that the insured had no knowledge of any suit, or any act or error or omission, which might reasonably be expected to result in a claim or suit as of the date of signing the application for this insurance." The court concluded that the firm had subjective knowledge of the acts leading to the underlying claim because it received the claimant's letter. The court next determined that, on an objective basis, a reasonable professional in the insured's position might have expected a claim or suit to result in light of the letter's reference to "an action" and request to put the firm's carrier on notice. Accordingly, the court determined that the policy did not cover the underlying claim because the firm could have reasonably foreseen that certain errors and acts might become the basis of a claim or suit. ■

Neither Bond Nor E&O Policy Covers Entity Losses from Employee Theft of Client Funds
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such loss." The court interpreted "[l]oss resulting directly from" to mean a direct loss immediately flowing from the employee's conduct. Because the insured's only loss was reimbursement of client funds stolen by the employee and the bond did not cover indirect third party losses, the insured's reimbursement of its clients' funds was not a direct loss. In addition, the court held that the employee did not manifestly intend that the insured reimburse the clients and sustain a loss. Although the insured settled the clients' claims with the bond insurer's consent, the court held that the bond insurer was not estopped from denying coverage because the bond insurer explicitly cautioned that its consent to settlement provided no indication that the settlement might be covered under the bond.

The court also held that the insured's E&O policy did not provide coverage for the settlement of the client's claims. The E&O policy barred coverage for claims "arising out of . . . any actual or alleged Wrongful Act committed with knowledge that it was a Wrongful Act." The exclusion applied because the employee "intended to steal the money, and schemed, plotted, and concealed his actions."

The court held that the exclusion also applied to the allegations against the insured for negligent supervision of the employee for two reasons. First, the allegations of negligent supervision arose out of the employee's intentional acts. Second, even if the employee's intentional acts and the insured's negligent supervision were concurrent causes of the claims, the exclusion would apply because there is no coverage for a loss concurrently caused by covered and uncovered acts. ■

Professional Services Exclusions Bar Coverage for Failure to Give Prescribed Drugs to Prisoner

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inmates requires professional training, care and judgment. Instead, the insured argued that administrative personnel adopted a policy of refusing to provide certain medications, and that development of *the policy* did not require the exercise of professional skill or judgment. The court rejected this argument, reasoning that the underlying plaintiff had alleged "only a *failure* . . . to provide a *professional service*, i.e., the distribution of medication to [the inmate]. Even if the policy were adopted for administrative reasons, the effect of the policy is that [the insured] failed to provide a professional service to an inmate, which is alleged to have caused [his] death." ■

Mutual Mistake Requires Reformation of Retroactive Date for Additional Insured

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issue a retroactive date for an additional insured that was earlier than for the named insured and that the insurer would have charged a higher premium for an earlier retroactive date. The court also held that the insured doctor intended for the policies to provide no retroactive coverage because the doctor acknowledged in writing that the retroactive date would be the policy inception date for the additional insured and never requested an earlier retroactive date for the additional insured.

The court rejected the insureds' contention that the insurer could not reform the policies because of estoppel, waiver, or laches. It held that the insurer was not estopped from denying coverage because it never defended the insureds against the claim and promptly sought to reform the policies when it learned of the mistaken retroactive date. ■

Lawyer Rendered "Professional Services" in Failure to Advise Investment Transaction Counterparty Regarding Title Insurance

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In the coverage litigation, the court held that the insurer wrongfully denied coverage, finding that the insured's actions in connection with the investment property constituted "professional services." The court found that the services on which the malpractice complaint focused—the failure to obtain title insurance and failure to advise the claimant to do so—were "services ordinarily performed by a lawyer," such that they fell within the policy's definition of professional services. The court considered these services as a continuation of the legal relationship that began with the insured's advice in connection with the first real estate investment opportunity. Although the insurer argued that the insured had no formalized legal relationship with the claimant, the court held that an attorney can owe ethical and legal duties to an individual absent a formalized relationship, and that no reasonable jury could find that the insured was not acting as an attorney when he presented the deal to the claimant. The court also held that three policy exclusions—regarding entities owned or operated by the insured; promoting or selling investments; and criminal, dishonest, or intentional acts—did not apply. The court reasoned that it was the failure to obtain title insurance, and not the real estate investment deal itself, that gave rise to the claim, and the exclusions did not apply to the lawyer's failure to obtain title insurance.

Regarding the claim for breach of the duty of good faith and fair dealing, the court granted summary judgment to the insurer. According to the court, the finding that the policy afforded coverage for the matter did not necessarily imply that the insurer's actions constituted bad faith. The denial may have been incorrect or negligent, but there was no evidence the insurer acted with improper purpose, and therefore the insurer was entitled to summary judgment on the bad faith count. ■

Insurer's Declaratory Judgment Action Stays in Federal Court Despite Parallel State Court Proceeding Initiated by Insured *continued from page 5*

court is given broad discretion whether to abstain from hearing the case. However, where the federal complaint is comprised of mixed claims—*i.e.*, claims seeking both declaratory and non-declaratory relief—a federal court should apply the *Colorado River* standard, under which only the "clearest of justifications will warrant dismissal' in favor of concurrent state court proceedings."

After concluding that the insurers' and the insured's suits were parallel, the court determined that the insurers' claim for reformation sought non-declaratory relief and that, accordingly, it would apply the *Colorado River* abstention standard. Under the *Colorado River* analysis, the court then considered six factors articulated under Fourth Circuit jurisprudence: whether real property was at issue; whether the federal forum was inconvenient; the desirability of avoiding piecemeal litigation; the relevant order of the actions; whether state law or federal law provides the rule of decisions on the merits; and the adequacy of the state proceeding to protect the parties' rights. Analyzing these six factors under the *Colorado River* framework, which favors the exercise of jurisdiction, the court concluded that there were no "exceptional circumstances" sufficient to justify abstention. The court highlighted the fact that the federal forum could not be considered inconvenient as the insured had stated in the underlying action that the EDVA was the "superior forum" in light of the location of the insured's headquarters and all company witness and documents. ■

SPEECHES/UPCOMING EVENTS

ACI's 10th National Forum on ERISA Litigation

KIMBERLY M. MELVIN, Speaker

• Fiduciary Liability Insurance: Assessing Current Coverage and Future Needs & Strategic Litigation and Settlement Considerations

Oct. 27, 2015 | New York, NY

DRI Seminar: Data Breach and Privacy Law

LAURA A. FOGGAN, Speaker

• Coverage for Data Breaches Under Traditional Insurance Policies and Introduction to Cyber Policies

Nov. 4-6, 2015 | Chicago, IL

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