Wiley Rein LLP

EXECUTIVE SUMMARY

Legal Developments Affecting Professional Liability Insurers | May 2017

No Coverage for Accountant's Solicitation of Investment in Entity He Partially Owned

In a win for Wiley Rein's client, the United States Court of Appeals for the Ninth Circuit, applying Arizona law, has held no indemnity coverage was available under an accountants E&O policy because the insured was not providing "professional services" when soliciting an investment in an entity in which the accountant held a personal stake. *Continental Cas. Co. v. Evans,* 2017 WL 1457031 (9th Cir. Apr. 25, 2017).

A former client of an insured accountant filed suit against the accountant for alleged misrepresentations made to induce the former client to make a $250,000 investment in a business entity that was partly owned by the accountant. The former client agreed to invest $250,000 in the business entity, which was planning to purchase an airplane charter company. The former client alleged that the insured promised to return the investment if the airplane charter company was not purchased. When the airplane charter company was not purchased, the former client filed suit against the accountant for making misrepresentations to induce the investment. The accountant tendered the lawsuit to his insurer, and the insurer defended under a reservation of rights. After a jury returned a verdict in favor of the former client, the insurer filed suit seeking a determination that it had no duty to indemnify the insured for the judgment. The district court held that no indemnity coverage was available under the policy for the judgment

continued on page 5

ALSO IN THIS ISSUE

Insured's Lack of Notice of Claims and Settlement Demand Bars Coverage

In a win for Wiley Rein's client, the United States District Court for the District of New Jersey has held that, even though the insured provided notice of circumstances that might lead to a claim, an excess insurer properly denied coverage because the insured failed to notify the excess insurer of the actual claim and a subsequent settlement offer. *Kennedy Univ. Hosp. v. Darwin Nat'l Assurance Co.,* 2017 WL 1352208 (D.N.J. Apr. 7, 2017). The court also held that the excess insurer was not barred by estoppel or waiver from denying coverage.

The insured, a health care organization, caused a patient to suffer second degree burns. The insured reported the incident to its excess insurer in 2012. In 2013, the patient later filed an action against third parties, which in turn asserted a claim

continued on page 10

Failure to Defend and Bring Timely Coverage Action Precludes Insurer from Raising Policy Defenses Under Illinois Law

Applying Illinois law, the United States Court of Appeals for the Seventh Circuit has held that an insurer who initially refused to defend its insured and waited five years to bring an action for declaratory relief was precluded from raising policy defenses to indemnity. *Title Indus. Assurance Co. v. First American Title Ins. Co.,* 2017 WL 1314934 (7th Cir. Apr. 10, 2017).

The insured, a title company, was sued in Illinois state court in 2008 by a title insurance company and two financial firms. The insured tendered the lawsuits to its errors and omissions liability insurer. The insurer refused to defend the suits, asserting that the policy's exclusions for claims relating to "any dishonest, fraudulent, criminal, malicious or intentional wrongful acts" and claims arising out of or relating to "any defalcation, commingling of, or failure to pay any funds, notes, drafts, or other negotiable instruments" barred coverage. In 2014, one of the claimants in the underlying actions filed a fourth amended complaint. The insurer then appointed counsel to defend the insured. At the same time, the insurer sought a declaratory judgment in federal court that coverage was precluded by the two policy exclusions, as well as by the policy's prior knowledge provision.

The Seventh Circuit first addressed the insurer's reliance on the policy's prior knowledge provision. While concluding that the insurer did not waive the defense by failing to cite the provision in its letters denying coverage, the court held that the insurer did waive it by only first raising the defense in its motion for summary judgment (as opposed to in its complaint). The court went on to hold that in any event, the prior knowledge provision did not justify the insurer's refusal to defend because the complaints originally tendered to the insurer for coverage did not implicate the insured in any misconduct occurring before the relevant date – i.e., the effective date of the policy – nor did they otherwise provide a basis to conclude that the insured had the requisite knowledge for the provision to apply to bar coverage.

Next, the court held that the dishonesty/fraudulent acts exclusion did not relieve the insurer from its duty to defend because the allegations in the underlying complaints did not "indisputably remove the complaint[s]" from coverage. According to the court, because "just one path toward a covered claim" triggers the duty to defend, and the complaints "did not compel the conclusion that the claimants' losses were attributable to intentional wrongdoing," the exclusion did not excuse the duty to defend. Likewise, the court found that the commingling exclusion as applied to the underlying complaints "[was not] clear enough to establish that no claim could possibly fall within the scope of coverage."

After concluding that the insurer had breached its duty to defend, the court noted that Illinois law requires that an insurer either defend its insured subject to a reservation of rights or timely bring suit for declaratory relief. Here, according to the court, the insurer's suit was untimely as a matter of law, as the insurer did not bring it until after one of the underlying actions had been resolved by settlement. The court therefore held that the insurer was estopped from invoking any policy defenses to coverage that might otherwise apply and was obligated to indemnify any judgment against or reasonable settlement by the insured. ■

Disgorgement Payment Is Insurable Loss Where Payment Did Not Disgorge Insured's Own Profits, but Those of its Customers

A New York trial court, applying New York law, has held that a $140 million disgorgement payment by an insured broker-dealer to the U.S. Securities and Exchange Commission constitutes insurable loss, based on evidence that the payment did not disgorge the insured's ill-gotten gains, but rather those of its customers. *J.P. Morgan Secs. Inc. v. Vigilant Ins. Co.*, 2017 WL 1399820 (N.Y. Sup. Ct. Apr. 17, 2017). The court also held that the policies' personal profit exclusion did not bar coverage and that the disgorgement payment was not uninsurable as a matter of public policy. Finally, the court held that the insurers failed to show that an issue of material fact existed with respect to whether the settlement was unreasonable.

Following an SEC investigation of the insured broker-dealer for possible violations of federal securities law in connection with alleged late trading and deceptive market timing practices, the insured entered into a settlement with the SEC in which it agreed to pay a $160 million "disgorgement" payment and a $90 million penalty. The insured's professional liability insurers denied coverage for the $160 million payment on the basis that the settlement constituted uninsurable disgorgement of ill-gotten gains.

The trial court held that $140 million of the disgorgement payment was not uninsurable disgorgement because it represented the profits of third parties – the insured's customers – and not those of the insured. The insurers argued that the SEC order, on its face, did not show that the disgorgement payment represented only the customers' ill-gotten gains. While the court agreed that the SEC order did not establish whose ill-gotten gains the disgorgement payment represented, the insured presented evidence showing that $140 million of the $160 million payment was predicated on its clients' profits. The insurers did not offer any specific evidence to refute this, and the court therefore granted the insured's motion for summary judgment dismissing the insurer's disgorgement defense.

The court also granted the insured's motion for summary judgment that the amount constituted "loss" under the policies. The court held that, under New York law, an insured is barred from obtaining coverage for a settlement paid to a regulatory body only where the regulator's findings "conclusively link" the disgorgement payment to improperly acquired funds possessed by the insured. The court reasoned that the policies' definition of "loss" was broad, and that the SEC order did not "conclusively link" the disgorgement to any improperly acquired funds in the hands of the insured.

The court also held that the policies' personal profit exclusion did not preclude coverage because, by its plain terms, the exclusion applies only if the loss is based upon a personal profit or advantage actually derived by the insured and the profit itself is unlawful. Because the insurers could not show that the insured's profit or gain was in itself unlawful, the court held that the exclusion did not bar coverage.

The court also rejected the insurers' argument that public policy barred indemnification. The court held that public policy bars coverage only where the insured acted intentionally and with the intent to harm or injure others, and concluded that the findings in the SEC order did not establish, nor did the insured admit, that the insured had intended to cause harm.

With respect to the prior knowledge exclusion, the court held that the exclusion's use of the undefined term "officer" in identifying whose knowledge was material for the purposes of

continued on page 10

Notice-Prejudice Rule Applies to Claims-Made Policy

Applying the notice-prejudice rule to a claims-made policy, the United States District Court for the District of Colorado has held that there is defense and indemnity coverage for the medical malpractice case filed against its hospital insured because, while notice of the malpractice suit was not given "as soon as practicable," the insurer had not shown that it was prejudiced by the delay. *Children's Hosp. Colo. v. Lexington Ins. Co.,* 2017 WL 1356092 (D. Colo. Apr. 13, 2017). The court reasoned that certain failures by the insurer to inquire about, comment on, or otherwise participate in the trial from the time it learned of the suit to the jury's verdict in excess of $17 million undermined the argument that the insurer had been prejudiced.

The insured, a children's hospital, held a professional liability claims–made policy that required that the insured notify the insurer "as soon as practicable" if it became aware during the policy of any "medical incident" which could reasonably be expected to give rise to a claim. If such a claim did arise, the policy provided that it would be considered first made at the time notice was given, but only if notice of the claim or suit was made "as soon as practicable." The hospital notified the insurer's claims affiliate of an incident regarding injuries to a patient via a reporting form a few days prior to the expiration of the policy period. The patient's family filed suit against the hospital more than four years later, but the hospital did not notify the insurer about the filing of the suit for almost two years, during which time an unsuccessful mediation occurred where the family demanded over $13 million. The matter proceeded to trial, and a jury eventually returned a verdict against the hospital in excess of $17 million.

After the insurer disclaimed coverage, citing noncompliance with the policy's notice requirements, the hospital filed a declaratory judgment action. On the parties' cross-motions for summary judgment, the court first determined that the notice-prejudice rule would apply such that the insurer would have to prove unreasonably late notice and prejudice in order to deny coverage on account of late notice. In extending the notice-prejudice rule, the court acknowledged that the Colorado Supreme Court had previously declined to extend the rule to a date-certain notice requirement in a claims-made policy, but that it had not addressed whether the rule would apply when the insured has complied with the date-certain notice requirement, but not with the requirement that notice be provided "as soon as practicable" after a lawsuit or claim is filed.

The court determined that the hospital did not provide notice of the lawsuit "as soon as practicable" after it was presented to the hospital, but that the insurer's failures with respect to monitoring, participating in, or otherwise showing any desire to learn about the trial once it learned of the lawsuit, "completely undermines [the insurer's] speculative and unsupported position that it was prejudiced because with earlier notice [of the suit] it would have been able to avoid or mitigate the liability it now faces by resolving the [family's] lawsuit for less than the ultimate judgment entered against [the hospital]." Accordingly, the court awarded summary judgment to the hospital. ■

Explicit Allegation of Acts Arising from Professional Services Required to Trigger E&O Policy

Applying Illinois law, the United States Court of Appeals for the Seventh Circuit has held that a lawsuit that mentioned that the insured provided professional services to the claimant, but did not directly assert that any of the wrongdoing in the complaint arose from those services, was not a covered claim under a real estate broker's errors and omissions liability policy. *Madison Mut. Ins. Co. v. Diamond State Ins. Co.*, 2017 WL 1065557 (7th Cir. Mar. 21, 2017).

Through a real estate broker that represented the original owners of the property, two individuals purchased a home near a dam that created an artificial lake. As it happened, the broker was also the original developer of the lake and the dam, and she owned a home in the neighborhood. In 2006, the two homebuyers sued the broker for failing to disclose that the original owners had not obtained the proper legal permit to build the dam. The broker's E&O insurer defended the broker in the suit, and the broker ultimately obtained dismissal of the counts asserted against her.

In 2011, the two homebuyers brought a second suit against the broker. This time, the two homeowners alleged a "pattern of harassment, intimidation, and interference with . . . property rights," and asserted counts for, inter alia, trespass, malicious prosecution, intentional and negligent infliction of emotional distress, nuisance, and for an order of protection. The broker tendered the 2011 suit to her E&O insurer. The E&O insurer denied coverage, asserting that the suit did not arise out of covered professional services. The broker's homeowner's insurer defended and sued the E&O carrier, alleging the two suits were related and therefore the E&O carrier owed a defense.

In the ensuing coverage litigation, the Seventh Circuit held that the E&O insurer owed no duty to defend the broker. The court acknowledged that there were some overlapping factual allegations between the 2006 and 2011 suits but focused on whether the 2011 suit implicated "professional services." The court held that, while the complaint referenced that the defendant was a real estate broker, there were no specific allegations that she had wronged the homebuyers in her capacity as a realtor. According to the court, the complaint did not allege the violation of any duty of care arising from professional services provided to the homebuyers. Given the absence of a specific allegation of wrongdoing in the broker's capacity as a realtor, the court held that the 2011 suit did not arise from a covered professional service and was therefore not covered under the E&O policy. ■

No Coverage for Accountant's Solicitation of Investment in Entity He Partially Owned
continued from page 1

against the insured. A summary of the district court's decision can be found here.

The Ninth Circuit affirmed the district court's decision. It held that the insurer had no duty to indemnify the insured because the actions giving rise to the insured's liability did not constitute "professional services." The policy defined "professional services" as "those services performed in the practice of public accountancy by you or others for remuneration that inures to the benefit of [the named insured] or pro bono services." The court held that there was no evidence that remuneration inured to the benefit of the named insured accounting firm. It also held that the accountant's solicitation of an investment in a company in which he held a financial stake was not "pro bono" investment advice. ■

Insured's Failure to Provide Notice of Demand Letter Precludes Coverage for Related Lawsuit Noticed in Subsequent Policy Period

A Washington federal court has held that an insured's failure to provide notice of a demand letter to its insurer during the policy period in which the letter was received precludes coverage under a claims-made and reported policy for a related lawsuit filed during a subsequent policy period. *National Union Fire Ins. Co. v. Zillow, Inc.,* 2017 WL 1354147 (W.D. Wash. Apr. 13, 2017).

In 2014, the insured, an online real estate marketer, received a demand letter from a company specializing in property photography, alleging that the insured was misusing the claimant's images and demanding that the insured remove the images. Almost a year later, the claimant filed suit against the insured based on substantially similar, albeit expanded, allegations. The insured provided notice of the lawsuit to its insurer, which agreed to provide a defense. However, when the insurer received a copy of the demand letter for the first time nearly a month later, it withdrew from the defense on the grounds that coverage was not available under the policy because the relevant claim was first made during the prior policy period when the insured received the demand letter and such claim had not been timely noticed. The insurer then filed a breach of contract and declaratory judgment action.

In ruling on the insurer's motion for judgment on the pleadings, the court first held that the demand letter constituted a "written demand for . . . non-monetary relief or injunctive relief" and therefore a Claim under the Policy. Moreover, the court held that the demand letter and subsequent lawsuit were a single, related Claim first made when the demand letter was received, and therefore coverage was not available because such Claim was not timely noticed.

In so holding, the court rejected several arguments by the insured that the demand letter and the lawsuit were separate claims. First, the insured contended that, because the Policy defined Claim to mean either a written demand or a suit, the demand letter and lawsuit were, by definition, different claims. Second, the insured argued that the demand letter and the lawsuit were not "related" because the letter cited slightly different legal authority, did not request damages, and was more narrow in scope than the ultimate lawsuit. However, the court found the demand letter and the lawsuit sufficiently "related" because they involved the same alleged wrongful acts.

Finally, the court rejected the insured's argument that the demand letter and the lawsuit were separate claims because the policy did not contain commonly used language that would have defined the demand letter and the lawsuit as the same Claim. The Policy did provide that "[i]f written notice of a Claim . . . has been given to the Insurer . . . then . . . any subsequent [related] Claim . . . shall be considered made at the time such notice was given." The insured argued this provision was conditional and that, because it did not provide notice of the demand letter, the aggregating language did not apply. However, the court found that such focus on the absence of a "claims integration clause" ignores the claims-made nature of the policy and the insurer's rights to investigate and settle claims. ■

Underlying Insurer's Agreement to Pay Limits Does Not Trigger Exhaustion for Excess Policy Requiring "Actual Payment"

An Illinois intermediate appellate court has held that excess insurance policies requiring "actual payment" by an underlying insurer for exhaustion purposes were not triggered where the insurer "pledged" its policy as collateral and agreed to advance defense costs until its policy was exhausted but did not make "actual payment" in legal currency. *Ritchie v. Arch Specialty Ins. Co.*, 2017 IL App (1st) 160413-U (Ill. App. Ct. Mar. 31, 2017).

The insureds operated a hedge fund, which collapsed in 2006. Shortly thereafter, the insureds were sued for, among other things, rescission, fraud, breach of fiduciary duty, and violation of state securities laws, and they were ultimately found liable for certain claims. After a primary insurer exhausted its policy limit in paying defense costs, a judgment was entered against the insureds. The first-layer excess insurer agreed to advance defense costs for an appeal and to file its policy in lieu of an appeal bond to stay execution of the judgment, but the claimants still sought to execute the judgment because the first-layer excess insurer's remaining limits were not sufficient to satisfy their judgment. To avoid execution, the insureds sought to require the second- and third-layer excess insurers to post collateral for an appeal bond, but they refused. Coverage litigation ensued. In ruling in favor of the insureds, the trial court rejected a "strict reading" of the excess policies' exhaustion language and concluded that the first-layer excess insurer's "pledge" of its policy as collateral for an appeal bond was sufficient to trigger exhaustion.

On appeal, the court reversed, holding that the second- and third-layer excess insurers had no duty to post collateral for the appellate bond because the insureds could not show that the first-layer excess policy was exhausted. In so ruling, the court found the exhaustion language – which provided for exhaustion "solely as a result of actual payment in legal currency" in one policy and "solely as the result of actual payment of losses thereunder by the applicable insurers" in another – to be unambiguous and to require "actual payment," which did not occur here. The court rejected the assertion that a "Defense Expenses" provision in the primary policy, to which the excess policies followed form, rendered the exhaustion language ambiguous. In addition, the court rejected the insureds' argument that "notice" to an excess insurer that an underlying insurer "agreed to pay" its limits for an ongoing suit constituted exhaustion sufficient to trigger excess insurer defense cost obligations, noting that the excess policies at issue, unlike other authority upon which the insureds relied, required "actual payment." ■

Lack of Prior Knowledge of Claim a Condition Precedent to Coverage

The United States District Court for the District of West Virginia, applying West Virginia law, has held that lack of prior knowledge of a claim constitutes a condition precedent to coverage under an accountant's professional liability policy. *Camico Mutual Ins. Co. v. Hess, Stewart & Campbell P.L.L.C.,* 2017 WL 926770 (S.D. W. Va. Mar. 8, 2017). In so holding, the court found that the insurer was not estopped from declining coverage based on an insured's prior knowledge of a claim despite issuance of a prior reservation of rights letter that only reserved the insurer's right to raise "all policy provisions and defenses."

The named insured, an accounting firm, discovered that one of its employees misappropriated assets from client accounts, resulting in multiple claims against the firm. The firm's professional liability insurance policy contained a provision in the insuring agreement stating that no coverage exists for a claim arising from circumstances, which prior to the effective date of the policy, any insured might reasonably expect would be a basis for a claim. The policy also contained an endorsement providing limited coverage up to $100,000 for certain "known claims" by insureds. The firm tendered the claims for coverage under the professional liability policy, and the insurer issued several reservation of rights letters agreeing to provide coverage subject to a $100,000 sublimit, but incorrectly referred to the sublimit as applicable to claims arising from "misappropriation, misuse, theft, or embezzlement of funds" instead of "known claims." The insurer also reserved all rights pursuant to "all policy provisions and defenses."

The insurer ultimately filed a declaratory judgment action seeking a declaration that it had no obligations beyond the $100,000 sublimit, arguing that the firm had failed to fulfill a condition precedent to coverage because the former employee, an insured under the policy, was aware prior to the effective date of the policy that her activities might reasonably serve as the basis of a claim. The firm argued that the insurer should be estopped from trying to limit coverage because the insurer failed to raise the prior knowledge condition in its reservation of rights letters.

The court granted summary judgment to the insurer. First, the court found that under the terms of the insuring agreement, a lack of prior knowledge is "clearly a condition precedent to coverage," which the firm had failed to satisfy. In so holding, the court rejected the firm's estoppel argument, determining that the firm could not demonstrate any detrimental reliance since the insurer was not seeking reimbursement of any of the funds already tendered. In addition, the court found that although the insurer had already agreed to pay the $100,000 sublimit, the insurer properly reserved its right to raise "all policy provisions and defenses" in its prior reservation of rights letters. The court noted that even though the insurer did not cite the $100,000 "known claims" sublimit in its reservation of rights letters, "the funds nevertheless were paid and are consistent with the [applicable] sublimit." ■

No Coverage Under E&O Policy for Real Estate Transaction Involving Payment of Undisclosed Fee

The Supreme Court of Utah has affirmed summary judgment in favor of an insurer, holding that language regarding the scope of coverage under a real estate brokerage company's insurance policy encompassed only services performed for compensation through a traditional real estate commission. *Compton v. Houston Cas. Co.,* 2017 WL 1101816 (Utah Mar 23, 2017).

The brokerage company had a professional liability errors & omissions policy that provided coverage for insureds when acting "[s]olely in the performance of services as a Real Estate Agent/Broker of non-owned properties, for others for a fee." In a prior action, a group of real estate investors obtained a judgment against a real estate agent working for the insured. The agent had arranged for a transaction between the investors and a developer where the investors deposited $705,000 into escrow as a "reservation deposit." The developer was to develop land into individual lots, after which the investors would pay a final contract price. The agent did not disclose that he was to be compensated by the developer out of the $705,000 for bringing the investors into the deal. The developer breached the contract, and the investors discovered that much of the $705,000 had been spent, including some in payment to the agent. The investors obtained a judgment against the agent for approximately $1 million. They then settled with the agent and acquired his claims against the brokerage company's E&O insurer.

The investors sued the insurer for failing to defend and indemnify the agent. A lower court granted summary judgment for the insurer, holding that, because the agent did not act "solely" as the investors' real estate agent on behalf of the brokerage because of his "dual or competing roles," there was no coverage available under the policy.

On appeal, the court did not address the sole capacity issue and instead based its ruling on the alternative ground that the agent had not been performing services "for a fee." The investors argued that the clause required only "the payment of money." The Court rejected that interpretation, concluding that "for a fee" meant "traditional real estate commissions to be paid to the agent from the brokerage out of funds transferred at the closing of a real property transaction." In so holding, the court noted that Utah law required money paid to real estate agents to first go through a broker and found it "unlikely that the parties intended the word 'fee' to stretch so broadly as to include the payment of money in violation of law." Because the agent did not expect to receive such a fee and in fact testified that the deal involved "no commissionable event," the court held that the policy did not provide coverage. ■

Insured's Lack of Notice of Claims and Settlement Demand Bars Coverage *continued from page 1*

against the insured health care organization. The patient also made a settlement demand to the insured and filed a malpractice suit against the insured in 2014. However, the insured failed to provide any notice to the excess insurer of the lawsuits or the settlement demand. The excess insurer only learned of the claims in 2015, after the primary insurer informed it of the lawsuits. The excess carrier denied coverage on various grounds related to untimely notice. The insured filed a coverage action, arguing that the excess insurer had breached the policy by denying coverage.

The court held that, because the insured had failed to satisfy the policy's notice and reporting conditions, the excess carrier had properly denied coverage for the claims. The policy's notice and reporting provisions expressly required that the insured provide prompt notice of any Claim or settlement demand, and also required the insured to submit quarterly reports that summarized all Claims and circumstances. The court noted that the insured conceded that it failed to provide quarterly reports or notice of the settlement demand, as required by the policy to obtain coverage.

The court rejected the insured's argument that such failures should be excused under the theories of estoppel or waiver. The court explained that the excess insurer was not estopped from denying coverage because the insured had not suffered any prejudice. In so holding, the court concluded that the excess insurer had initially informed the insured when it received notice of the circumstances that it would not be investigating the matter, and as such the insured had no justifiable expectation that the excess insurer would provide coverage. The court further held that the excess insurer had not waived the right to deny coverage because the excess insurer's lack of action did not constitute a voluntary and intentional relinquishment of any rights under the policy. ■

Disgorgement Payment Is Insurable Loss Where Payment Did Not Disgorge Insured's Own Profits, but Those of its Customers *continued from page 3*

the exclusion, created ambiguity that must be construed in the insured's favor. It therefore construed "officer" narrowly to include only those persons appointed to officer positions by the board of directors and held that the insurers failed to raise a triable issue regarding whether any officers could reasonably have foreseen a claim based on the market timing and late trading practices.

Finally, the court held that the insurers failed to raise a triable issue of fact regarding the reasonableness of the SEC settlement, as well as several civil settlements. The court rejected the insurers' argument that the settlements were unreasonable as a matter of law because the insured blocked the insurers from discovering any information regarding its own evaluation of its exposure based on the attorney-client and work-product privileges, reasoning that the need to determine the reasonableness of settlements does not require waiver of privileges. Given that the insured had faced $520 million in potential liability when it settled, and because the insurers failed to adduce evidence that the settlement was unreasonable, the court held that the settlements were reasonable under the circumstances. ■

Professional Liability Attorneys

Kimberly A. Ashmore	202.719.7326	kashmore@wileyrein.com
Matthew W. Beato	202.719.7518	mbeato@wileyrein.com
Mary E. Borja	202.719.4252	mborja@wileyrein.com
Edward R. Brown	202.719.7580	erbrown@wileyrein.com
Ashley L. Criss*	202.719.3565	acriss@wileyrein.com
Jason P. Cronic	202.719.7175	jcronic@wileyrein.com
K. Stewart Day*	202.719.3566	kday@wileyrein.com
Cara Tseng Duffield	202.719.7407	cduffield@wileyrein.com
Benjamin C. Eggert	202.719.7336	beggert@wileyrein.com
Ashley E. Eiler	202.719.7565	aeiler@wileyrein.com
Jessica N. Gallinaro	202.719.4189	jgallinaro@wileyrein.com
Michael J. Gridley	202.719.7189	mgridley@wileyrein.com
Emily S. Hart	202.719.4190	ehart@wileyrein.com
John E. Howell	202.719.7047	jhowell@wileyrein.com
Leland H. Jones, IV	202.719.7178	lhjones@wileyrein.com
Parker J. Lavin	202.719.7367	plavin@wileyrein.com
Charles C. Lemley	202.719.7354	clemley@wileyrein.com
Jessica C. Lim	202.719.3749	jlim@wileyrein.com
Kimberly M. Melvin	202.719.7403	kmelvin@wileyrein.com
Alexander H. Merritt*	202.719.3571	amerritt@wileyrein.com
Laura Lee Miller	202.719.4196	lmiller@wileyrein.com
Jason O'Brien	202.719.7464	jobrien@wileyrein.com
Leslie A. Platt	202.719.3174	lplatt@wileyrein.com
Nicole Audet Richardson	202.719.3746	nrichardson@wileyrein.com
Marc E. Rindner	202.719.7486	mrindner@wileyrein.com
Kenneth E. Ryan	202.719.7028	kryan@wileyrein.com
Gary P. Seligman	202.719.3587	gseligman@wileyrein.com
Richard A. Simpson	202.719.7314	rsimpson@wileyrein.com
William E. Smith	202.719.7350	wsmith@wileyrein.com
Daniel J. Standish	202.719.7130	dstandish@wileyrein.com
Margaret D. Thomas	202.719.4198	mthomas@wileyrein.com
David H. Topol	202.719.7214	dtopol@wileyrein.com
Karen L. Toto	202.719.7152	ktoto@wileyrein.com
Bonnie Thompson Wise	202.719.3763	bwise@wileyrein.com

*District of Columbia Bar pending, supervised by principals of the firm