Wiley Rein & Fielding

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The Executive Summary

Developments Affecting Professional Liability Insurers

Second Circuit Certifies Notice Prejudice Rule to New York Court of Appeals

The Second Circuit Court of Appeals has certified to the New York Court of Appeals the question whether an insurer is required to demonstrate prejudice in order to disclaim coverage based on an insured's failure to comply with a notice of suit requirement where the insured has already complied with the policy's notice of claim requirement. *Varrichio and Assoc. v. Chicago Ins. Co.*, 312 F.3d 544 (2d Cir. Nov. 14, 2002).

The insurer issued a legal malpractice policy to an attorney. That policy provided that "[i]f Claim is made or suit is brought against the Insured, the Insured or its representative shall immediately forward to the Company every demand, notice, summons or other process received by the Insured or the Insured's representative." In early 1999, the attorney notified the insurer that he was likely to be sued for malpractice. The insurer began investigating the case and maintained regular contact with the attorney after that time. When the insured was actually served with a summons and complaint in the matter in July 2000, however, he failed to forward those papers to his insurer for approximately two months. Although the attorney and insurer had been in communication concerning the claim, the insurer disclaimed coverage based on the late notice, and coverage litigation ensued.

The court initially rejected three of the attorney's arguments with little discussion. First, the court refused to consider arguments that communications with the attorney constituted an implied waiver of the notice provision or estopped the insurer from relying on the notice provision because those arguments had not been raised at the trial level and were therefore forfeited. Second, the court rejected the attorney's argument that his delay in forwarding the papers was reasonable, noting that "where a policy has an *immediate* notice of suit requirement, even a relatively short delay in providing notice violates that requirement." Third, the court found that it was unreasonable for the attorney to infer, based on the fact that the insurer was investigating and defending the case, that the insurer had therefore received copies of the suit papers.

The Second Circuit then addressed the question whether, under New York law, the insurer was required to demonstrate prejudice in order to disclaim coverage. The court stated that the holding in *In re Brandon,* 769 N.E.2d 810 (N.Y. 2002), that insurers relying on the late notice of legal action defense should be required to demonstrate prejudice, "casts doubt on the traditional New York rule that when the insured has failed to comply with an immediate notice of suit provision in the insurance contract, an insurer need not show prejudice in order to refuse coverage." Even though *In re Brandon* involved coverage for uninsured motorists and suits brought by an insured, rather than a professional liability policy where the implicated suit was brought against an insured, the court noted that the

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Court Enjoins Arbitration by D&O Insurers Where ADR Provision Allows Insured to Elect ADR Process

In an unpublished opinion, a Delaware trial court held that an insured's directors and officers liability policies allowed the insured to elect the form of ADR and therefore issued a preliminary injunction ordering a group of insurers to withdraw their demand for arbitration and submit themselves to mediation. *Qwest Communications Int'l Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, No. Civ. A. 20009, 2002 WL 31888303 (Del. Ch. Dec. 20, 2002).

Qwest Communications International, Inc. (Qwest) held various primary and excess directors and officers liability policies and a primary fiduciary liability policy that each contained a similar ADR provision. That ADR provision stated that all disputes concerning the policy shall be subject to ADR and that "[e]ither the Insurer or the Insureds may elect the type of ADR discussed below; provided, however, that the Insureds shall have the right to reject the Insurer's choice of ADR at any time prior to its commencement, in which case the Insured's choice of ADR shall control." The two types of ADR identified were non-binding mediation and binding arbitration.

The insurers decided to rescind the policies and filed a demand for arbitration with the American Arbitration Association. Qwest asked the insurers to withdraw their demand for arbitration and submit to mediation. When the insurers refused, Qwest filed suit, seeking to enjoin the arbitration. The court issued an injunction, holding that "[t]he ADR provision of the Policies plainly and unambiguously gives Qwest the right to reject the defendant carriers' choice of arbitration as their preferred form of ADR." The court rejected the insurers' argument that Qwest failed to reject the insurers' choice of dispute resolution process prior to "commencement" of the ADR, which the insurers argued was the filing of the demand for arbitration. The court reasoned that the insurers' interpretation of the policy would render the provision illusory, as the insured would never have the opportunity to elect the ADR process if the insurer filed its demand at the same time it notified its insured of its selection. While declining to determine what constitutes "commencement" of an ADR process under the policy provisions, the court concluded that the provision at least allows a reasonable opportunity for the insured to reject the process elected by the insurer. The court also found that the insured demonstrated irreparable harm if forced to participate in binding arbitration rather than non-binding mediation. Finding that the insured satisfied the requisite elements for a preliminary injunction, the court therefore entered an order directing the insurers to dismiss the arbitration demand and submit themselves to mediation. ✦

Coverage Available for Claim Caused by Both Covered Act and Excluded Event

The Ninth Circuit Court of Appeals, applying California law, has held that when two acts or events give rise to a claim, an errors and omissions policy affords coverage if one of the events (malpractice) was an act covered by the policy, even though the other event (bankruptcy) triggered an exclusion. *Conestoga Servs. Corp. v. Executive Risk Indem. Inc.* 312 F.3d 976 (9th Cir. Nov. 27, 2002).

The policyholder in this case was an insurance brokerage firm that assisted a surety in issuing a surety bond as part of a retail store's self-insurance plan. Several months after the bond had been issued, the surety and the retail store attempted to reduce the amount of the bond, but the brokerage firm failed to take the necessary steps to complete the reduction. The retail store later filed for bankruptcy, and the obligee on the bond attempted to recover for the bond's original value. The surety then sued the brokerage firm for malpractice, and the brokerage firm tendered the claim to the issuer of its errors and omissions liability policy for defense and indemnity. The insurer denied coverage based on an exclusion in the policy for claims "based on or directly or indirectly arising out of or resulting from the bankruptcy of, or suspension of payments or failure or refusal, in whole or in part, to pay by…any self-insurance plan." Coverage litigation followed.

The insurer argued that the exclusion applied because the claim was a result of the bankruptcy of the retail store. The brokerage firm contended that the claim was a result of its alleged negligence. The court ruled in favor of the brokerage firm, holding that the exclusion did not bar coverage. The court noted that the California Supreme Court had previously addressed the issue of assessing multiple causes for the purpose of determining coverage under a liability policy, and had found that coverage was available in two scenarios. *See Garvey v. State Farm Fire & Cas. Co.*, 770 P.2d 704 (Cal. 1989) (*en banc*). First, *Garvey* held that coverage is available where "the efficient cause—the one that sets others in motion—is the cause to which the loss is to be attributed, though the other causes may follow it, and operate more immediately in producing the disaster." *Garvey* held that in the second scenario, where

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No Duty to Defend Proceeding Before Administrative Agency

The Florida Supreme Court, in a decision not yet released for publication, held that under Florida law, a proceeding before an administrative agency was not a proceeding in a "court of law," thereby allowing an insurer to avoid any duty to defend. *Coregis Ins. Co. v. Mosquito Control Special Taxing Dist.*, No. SC02-311, 2002 WL 31662636 (Fla. Nov. 27, 2002).

A Florida taxing district (District) purchased a public officials and employees liability insurance policy. The policy obligated the insurer to defend any "Suit" and defined "Suit" as "a proceeding in a court of law where Money Damages may be awarded." An employee of the District filed a petition before the Monroe County Career Service Council (MCCSC), as well as an action in circuit court, alleging employment discrimination by the District on the basis of political affiliation. The insurer defended the circuit court action but not the proceeding before the MCCSC. Coverage litigation ensued in federal court, and ultimately the Eleventh Circuit certified to the Florida Supreme Court the question whether the proceeding before the MCCSC was a proceeding in a "court of law." The Florida Supreme Court held that it was not. The court based its decision on the provision in the Florida Constitution vesting judicial power in certain specified courts, including circuit courts. The Florida Supreme Court reasoned that "a petition before the MCCSC is not a proceeding before a court of law under Florida law because the MCCSC is not a court as expressly set forth in the Florida Constitution. The MCCSC is an administrative agency possessing only quasi-judicial powers." ✦

Professional Liability Policy May Provide Coverage for Sexual Abuse Claims by Insured's Foster Children

The Wyoming Supreme Court, applying Wyoming law, has held that (1) coverage existed under a psychologist's professional liability policy for sexual abuse to the insured's foster children if the psychologist provided psychological services to the children and (2) the application of a household member exclusion required a factual determination as to whether the foster children "regularly reside[d] with" the insured. *T.M. ex rel. Cox v. Executive Risk Indem. Inc.*, 59 P.3d 721 (Wyo. Dec. 16, 2002).

A psychologist's foster children brought a negligence action against the psychologist for sexual abuse by the psychologist's husband, alleging, among other things, that the insured breached her professional duties by failing to disclose her husband's alleged history of sexual abuse. The psychologist's professional liability policy provided coverage for "wrongful acts," which was defined as "any actual or alleged negligent act, error or omission, or any actual or alleged Defamation solely in the performance of, or actual or alleged failure to perform, professional services for others in your profession as a psychologist." The policy also contained a household member exclusion precluding coverage for claims by household members of the insured. The exclusion defined "household member" as "any person who regularly resides with" the insured. Coverage litigation ensued between the insurer and the foster children, who intervened in a declaratory action brought by the insurer against the psychologist.

The court first held that the definition of "wrongful acts" was poorly drafted and ambiguous. It pointed to a number of perceived ambiguities in the definition, such as that the policy could be read to provide negligence coverage for providing services to "others" rather than only to "patients" or "clients" and that the policy provided coverage for "any" negligent act rather than enumerated acts. The court rejected the insurer's argument that the term "solely" limited coverage to those acts exclusively performed as a psychologist, reasoning that a narrow interpretation of the term "solely" might also preclude coverage for professional services rendered to persons with whom the policyholder also has a nonprofessional relationship, despite the otherwise broad language of the policy. Given the finding of ambiguity, the court held that coverage existed if a jury determined that the insured provided psychological services to the foster children. The court stated that the jury must determine whether the psychologist "provided services to the children arising out of her specialized knowledge or experience as a psychologist," and if so, whether such services fell below the applicable standard of care.

The court also held that the application of the household member exclusion was a matter for the jury. The children argued that, as foster children, they did not "regularly reside with" the policyholder. The court considered the meaning of "regularly resides with" a matter of first impression and noted that Wyoming cases interpreting the term "resident" in the context of statutes have found that the determination of residency is generally a question of fact. The court also pointed to decisions from other jurisdictions holding that the phrase "regularly resides with," in the insurance context, was ambiguous and should be construed in favor of coverage. The court therefore refused to apply the exclusion as a matter of law and instead remanded the issue for a jury's factual determination as to whether the foster children "regularly resided" with the insured. ✦

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Insureds' Delay of 58 Days in Notifying Insurer of Claim Against It Precludes Coverage

In a recent unpublished opinion, a California appellate court, applying New York law, held that an insured's delay of 58 days in reporting a claim made against it to its insurer was untimely and that the insurer's denial of coverage based on this late notice was proper. *Lincolnshire Mgmt., Inc. v. Seneca Ins. Co., Inc.*, No. 798139, 2002 WL 31058285 (Cal. App. 4th Sept. 16, 2002).

The insurer issued two policies, a business owners' policy and an umbrella policy, to its insureds, an investment banking firm and its executive officer, board of trustees, directors, stockholders and employees. Both policies contained notice of claim provisions. The business owners' policy provided that "[i]f a claim is made or suit is brought against the insured, the insured shall immediately forward to the Company every demand, notice, summons or other process received by him or his representative." The umbrella policy required that "[w]hen an occurrence takes place which is reasonably likely to involve the insurance afforded hereunder written notice shall be given…to the company…as soon as practicable…. The insured shall give like notice of any claim made because of such occurrence."

In April 1997, the investment bank and some of its officers and directors were sued, in a counter-complaint from another action, for defamation and abuse of process. The record is unclear as to whether the investment bank had notice of the claim at that time because it was not served with the complaint. But the record reflects that the investment bank was aware of the complaint by July 9, 1997, when it retained defense attorneys in the matter. Furthermore, on August 14, 1997, the investment bank was served with a first amended counter-complaint. The investment bank did not notify the insurer of the claim until the insureds filed their defense to the amended counter-complaint 58 days later on September 5, 1997. The insurer denied coverage, and the insured filed suit.

The court ruled in favor of the insurer. As an initial matter, the court held that, applying California choice of law, New York law governed. The court reasoned that under California's "governmental interest analysis," New York had a greater interest in its law governing because both the insurer and the investment bank were New York corporations, the investment bank had its principal place of business in New York, the policies were issued and delivered in New York and the dispute arose in New York. The court then held that the 58-day delay in notification was untimely under the policy. The court rejected the investment bank's argument that the policy only required notice upon service of legal process, reasoning that under the policy "notice is required if a claim is made *or* suit is brought, two distinct events." The court distinguished a recent New York case holding that a showing of prejudice was required for notice of suit provisions, reasoning that the issue in this case was whether notice of the claim had been given, not whether notice of a suit must be given after notice of a claim has been made. Additionally, the court rejected the investment bank's position that there were disputed issues of fact regarding whether or not the delay was longer than 58 days as irrelevant because a 58-day delay was in and of itself unreasonable. The court noted that "New York has drawn hard and fast lines establishing when notice is untimely as a matter of law, and—unfortunately—[the insureds are] on the far side of the line." The court pointed out that New York courts previously have found delays of 22 days, 51 days, one and a half months, four months, and three and a half months to be unreasonable.

The court also rejected the investment bank's position that the court should not permit extrinsic evidence to deny coverage or a defense. In particular, the insured argued that the insurer could not present evidence that the investment bank had retained defense counsel because it was not alleged in the underlying complaint. The California appellate court found that, while the four corners rule should apply where the court can make determinations from the complaint and the policy alone, in situations involving notice, "[f]acts bearing on when the insured first received notice of the claim will rarely be in the complaint, so extrinsic inquiry seems reasonable and necessary." The court dismissed the possibility that the delay was excused by the investment bank's good faith belief that there was no coverage or a good faith belief that there was no liability because the investment bank did not present any evidence that it had either of these beliefs at the time it was served with process. Finally, the court rejected the investment bank's argument that the insurer's two-month delay in disclaiming coverage precluded the insurer from denying coverage, an argument that was made by extrapolation from a New York law applying to insurance for motor vehicle accidents. The court dismissed this argument because the investment bank did not present any evidence that it was prejudiced by the two-month delay and the investment bank did not explain why the rules concerning liability insurance for motor vehicles should apply to this case. ✦

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No Coverage Under Business Enterprise Exclusions

A federal district court, applying Louisiana law, has held that an insurer was not obligated to provide a defense or coverage to an attorney under a malpractice policy because business enterprise exclusions in the policy excluded coverage for claims arising out of legal services the attorney provided for companies the attorney controlled or intended to control. *Cont'l Cas. Co. v. James E. Smith, Jr. et al.*, No. 02-0282CW01-3625, 2003 U.S. Dist. LEXIS 50 (E.D. La. Jan. 2, 2003).

The insurer issued a legal malpractice policy to the insured attorney. The policy defined a claim as "a demand received by the Insured for money or services arising out of an act or omission, including personal injury, in the rendering of or failure to render legal services." The policy also contained three exclusions relating to work for business enterprises. The first exclusion was a "Specific Person Or Entity Exclusion Endorsement" that excluded coverage for legal services provided to certain specified entities. The second exclusion provided that the policy did not apply "to any claim based on or arising out of an Insured's capacity as: 1. a former, existing or prospective officer, director, shareholder, partner or manager of a business enterprise or charitable organization…." The third exclusion precluded coverage for "any claim based on or arising out of legal services performed for any existing or prospective [business enterprise]…, not named in the Declarations, if at the time of the act or omission giving rise to such claim: 1. any Insured controlled, operated or managed or intended to control or manage such enterprise; or 2. any Insured was: a. a partner or employee of such enterprise…."

The insured attorney had served as counsel to his uncle and father in their joint business ventures and to his uncle individually. These business ventures involved the entities identified in the policy's exclusions. In 1996, the attorney was given responsibilities in the management of the corporations, and in 1999, the attorney assumed the position of president, a position previously held by his uncle. In 2001, the uncle sued the attorney in federal court alleging that the attorney had unlawfully wrested control of the corporation from him. The uncle alleged that the attorney failed to amend the bylaws, diverted profits to other corporations, had a conflict of interest with other companies he managed or that employed him, falsified corporate records and failed to disclose relevant information affecting the uncle's rights in the companies. The uncle asserted various legal theories, including that, in providing legal services, the attorney had operated under an unwaivable conflict of interest. The uncle also filed an action in state court seeking injunctive relief to restrain the attorney from denying the rights and privileges of the uncle as the CEO of the corporations, from destroying or removing any of the client's files and from undertaking any unethical conduct. After the attorney sought coverage under the policy for both suits, the insurer filed a motion for declaratory judgment.

The court ruled in favor of the insurer. The court found the policy exclusions to be clear and unambiguous and noted that "when an insurance policy excludes coverage for claims 'arising out of' certain conduct, the exclusion is given a broad, general, and comprehensive interpretation." The attorney conceded that there was no coverage for claims brought based on acts or omissions in the performance of legal services for the entities specifically identified in the first exclusion, but argued that claims arising out of representation of the uncle in his individual capacity were not excluded. The court rejected this argument, concluding that none of the claims made against the attorney arose out of representation of the uncle in his individual capacity. Specifically, the court found that the attorney's alleged actions were taken in the attorney's capacity as an officer of the corporations or during the attorney's work for the corporations. The court explained that "all of [the client's] allegations [arose] out of [the attorney's] activities as president of the corporations, in anticipation of his role as president, or from legal services performed for companies that an insured managed, controlled, or intended to control."

The court also found that the policy exclusions barred coverage for the state claims against the attorney because they mirrored the actions in the federal action. The court also held that, because the state court petition sought only injunctive relief, the claim did not make a demand for "money or services," and thus was not a "'claim' within the meaning of the policy." ✦

Coverage Available for Claim Caused by Both Covered Act and Excluded Event

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a claim is the proximate result of two independent causes, coverage is available based on either cause. Relying on *Garvey*, the Ninth Circuit reasoned that coverage for the brokerage firm's claim was available under either scenario because the firm's alleged malpractice was at least a proximate cause, if not the efficient cause, of the claim. In particular, the court pointed to the fact that the underlying suit was based on the grounds that the brokerage firm was negligent in issuing the bond, not that the retail store surety bond was a poor risk or that the retail store went bankrupt. ✦

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Insurer May Recover Legal Fees Paid to Defend Claim When Insured Has Recovered the Fees From Another Party

A Texas appellate court has held that, under Texas law, an insurer may seek reimbursement from an insured for defense costs incurred in an underlying legal malpractice lawsuit that were paid by the insurer and recovered by the insured as part of a counterclaim. *St. Paul Fire & Marine Ins. Co. v. Beirne, Maynard & Parsons, LLP*, No. 01-00-01065-CV, 2002 WL 31771102 (Tex. App. Ct. Dec. 12, 2002).

The insurer issued to a law firm a professional liability insurance policy that required the insurer to pay defense costs for claims covered by the policy. The policy also provided that "[a]ny person protected under this policy may be able to recover all or part of a loss from someone other than us…. If [the insurer makes] a payment under this policy that right of recovery will belong to us." A former client sued the law firm for legal malpractice, and the insurer, reserving all of its rights, paid the defense costs. The law firm successfully counterclaimed for its defense costs, and ultimately recovered all of its expenses, including those paid by the insurer. When the law firm refused to reimburse the insurer from the money recovered, the insurer filed suit.

On appeal, the Texas appellate court reversed the lower court's decision awarding summary judgment to the law firm. The court first rejected the law firm's argument that the insurer was not entitled to any of the defense costs because the award in the underlying action had been only to the law firm and not to the insurer. The court reasoned that the policy language addresses recovery of all or part of a loss from a third party and gave the insurer a right of recovery. The court also rejected the law firm's argument that the term "loss" did not include defense costs, reasoning that total coverage under the policy could be depleted equally for settlements, awards and defense costs and that, as a result, any such payment constituted a "loss."

The court then rejected five affirmative defenses asserted by the law firm. The court first rejected the law firm's argument that the insurer was seeking to attack collaterally the judgment in the underlying suit, reasoning that the insurer merely sought reimbursement from the prior judgment for expenses paid during that suit. The court next held that the law firm did not satisfy any of the requirements for collateral estoppel because the issue of reimbursement was not litigated in the underlying lawsuit and the insurer and the law firm were not adverse parties in that proceeding. Similarly, the court also held that the law firm did not conclusively satisfy the elements of *res judicata*. Although the insurer was seeking reimbursement from the law firm for defense costs incurred while defending the law firm in the underlying suit, the insurer's claims did not arise out of the same transaction that was at issue in the underlying action. The court rejected the law firm's argument that the insurer was judicially estopped from taking the position it did, reasoning that the insurer was not a party to the underlying action, and that it therefore could not have made any allegations or admissions in that proceeding that would contradict its position in the subsequent reimbursement action. Finally, the appellate court rejected the law firm's argument that the insurer did not provide timely notice of its reimbursement claim, as required by Texas law. In support of its notice defense, the law firm relied on a case where an insurer had settled a claim on behalf of the insured without providing notice and subsequently denied coverage and sought reimbursement. The appellate court found the case readily distinguishable because the insurer was not seeking to deny coverage, nor was it seeking to recover costs from the law firm's pocket. Instead, it was seeking to recover costs awarded as part of a judgment that included those costs. ✦

Second Circuit Certifies Notice Prejudice Rule to New York Court of Appeals

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holding in *In re Brandon* might signal a "shift" to a prejudice requirement under New York law. The court stated that if it were to decide the case itself, it would likely conclude that New York law would require the insurer to make a showing of prejudice because the traditional reasons for the no-prejudice rule, such as "the insurer's need to protect itself from fraud by investigating claims soon after the underlying events; to set reserves; and to take an active, early role in settlement discussions," were met by the insured's timely notice of the claim. Nevertheless, the Second Circuit found the issue sufficiently uncertain to warrant certification. It therefore certified to the New York Court of Appeals the following question: "Where an insured has already complied with a policy's notice of claim requirement, does New York require the insurer to demonstrate prejudice in order to disclaim coverage based on the insured's failure to comply with the policy's notice of suit requirement?" ✦

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Underlying Claimants Are Not Entitled to Separate Per Person Limits Arising From One Occurrence

An Ohio appellate court has held that (1) the spouse and child of a patient injured as a result of medical malpractice are not entitled to separate per-person limits of coverage under a professional liability policy for their loss of consortium claims, and (2) the limits applicable to the patient's bodily injury claim also applied to any wrongful death claim even though the injury occurred during one policy period and death during a subsequent policy period. *Thomson v. OHIC Ins. Co.,* Nos. CA 2002-03-055, CA 2002-03-064, 2002 WL 31682204 (Ohio App. Ct. Dec. 2, 2002).

The insurer provided yearly, claims-made professional liability policies to a physician and his medical corporation. The policies provided coverage of $1 million for "Each Person," up to a total limit of $3 million. Under the terms of the policy "[a]ny derivative 'claims' share in the Each Person Limit." The policy further provided that "[i]f a 'claim' is first reported to us during the policy period…that 'claim' will be considered a single 'claim' under this policy, regardless of whether the 'professional services' were provided during more than one policy period and the 'claim' will be subject exclusively to the Limits of Coverage of the current policy."

The physician treated a patient who then suffered a massive stroke during one policy period and died during a subsequent policy period. The patient brought a medical malpractice action against the physician, and the patient's wife and son brought loss-of-consortium claims against the physician. Coverage litigation ensued over the amount of coverage available.

The patient's wife and son argued that they were entitled to separate per-person limits for their loss of consortium claims. The appellate court rejected that argument, holding that, under the policy's terms, a single "Each Person Limit" applied to all of the claims. The wife and son contended that this provision of the policy was unenforceable pursuant to prior decisions by the Ohio Supreme Court. However, the appellate court pointed out that those prior decisions had been overturned by the Ohio legislature, which had enacted a law providing that "[a]ny liability policy of insurance including, but not limited to, automobile liability or motor vehicle liability insurance" may include an "Each Person Limit" and that "[a]ny such policy limit shall be enforceable." Ohio Revised Code, R.C. 3937.44. The court rejected the argument that the statute applied only to automobile accidents, relying on the "including, but not limited to," language in the statute. The court also rejected the argument that "accident" does not include medical malpractice, reasoning that "accident" in a liability insurance policy refers to "unintended and unexpected happenings," which was what occurred in this case.

The court also rejected the family's contention that the policy provided new limits for the death of the patient, which occurred in a subsequent policy period to the period in which the patient and his family brought their claims for injury and loss of consortium. The court reasoned that the policy language clearly provided that all of the claims would be treated as a single claim subject to a single limit, and that there was not "a convincing rationale for ignoring the plain, unambiguous terms of the policy." ✦

Sixty-Day Notice Requirement for Nonrenewal Inapplicable if Replacement Policy Obtained

The Ninth Circuit, in an unpublished opinion, held that the 60-day notice of nonrenewal required under California law does not apply where the insured has obtained a replacement policy prior to termination of the policy that was not renewed. *Clarendon Nat'l Ins. Co. v. Foley & Bezek, LLP*, Nos. 01-56878, 02-55450, 2002 WL 31819692 (9th Cir. Dec. 13, 2002).

A law firm purchased a lawyers' professional liability insurance policy from insurer number one. Prior to the expiration of that policy, the law firm's insurance broker informed the law firm that the policy would not be renewed by insurer number one and that the policy was being replaced by a policy issued by insurer number two. Both policies required that claims be made and reported during the same policy period. After coverage was denied under both policies for a claim made during the first policy period and reported during the first 60 days of the second policy period, the law firm argued that it was entitled to invoke a 60-day extended reporting requirement under the first policy because insurer number one failed to give the 60-day notice of nonrenewal required under California law. The court rejected the argument in one sentence, stating that "[t]he extended reporting period was not available to [the law firm] because under the terms of the policy it applied only if [the law firm] had not obtained another policy of lawyers' professional liability insurance within sixty days of the policy's termination." The court did not quote the policy language on which it relied. ✦

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The Speaker's Corner

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American Bar Association Section of Litigation, Committee on Corporate Counsel
February 15, 2003 Coral Gables, FL
Daniel J. Standish, Speaker, "Directors' and Officers' Liability Insurance Coverage for the New Frontier: From Enron to Sarbanes and Beyond"

Annual Insurance Coverage Litigation Committee Meeting, Tort Trial and Insurance Practice Section of the American Bar Association
February 21, 2003 Miami, FL
Daniel J. Standish, Speaker, "The Corporate Sky Is Falling - Who Picks Up the Mess? Insurance Coverage and the Financial Collapse of a Business"

American Bar Association Litigation Committee, Insurance Coverage Section
March 7, 2003 Tuczon, AZ
Daniel J. Standish, Speaker, "Directors and Officers Liability Coverage for the New Frontier: From Enron to Sarbanes and Beyond"

ACI Conference on Directors and Officers Liability
May 15, 2003 New York, NY
Daniel J. Standish, Speaker, "The D&O Policy and Corporate Bankruptcies"

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