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NEWSLETTER

Coverage Barred for Claims Not Made, Reported in Same Period

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The U.S. District Court for the Northern District of Illinois, applying Illinois law, has granted summary judgment in favor of an E&O insurer, holding that successive "claims-made and reported" policies afford no coverage for claims first made during the initial policy period, but first reported during the renewal policy period. *Exec. Risk Indem., Inc. v. Chartered Benefit Servs., Inc.,* 2005 WL 1838433 (N.D. Ill. July 29, 2005).

The insurer issued two claims-made and reported E&O policies to the policyholder, an administrator of mortgage accidental death insurance, for an initial policy period of June 1, 2001 to June 1, 2002, and a renewal policy period of June 1, 2002 to June 1, 2003. On April 22, 2002, the administrator received a demand letter alleging that it and the insurers for whom the administrator administered the mortgage insurance had withdrawn $53 per month from the claimants' account without claimants' authorization. The letter demanded that the withdrawals cease and that the funds be returned. The letter further notified the administrator of the claimants' intent to file a class-action lawsuit—which the claimants ultimately filed on June 17, 2002. The administrator subsequently settled the underlying claims against it and one of the insurer co-defendants.

The administrator first tendered notice of the underlying claim to its E&O insurer on October 24, 2002, shortly after the other insurer co-defendant refused to defend and indemnify the policyholder. After sending the administrator two reservation of rights letters, the insurer denied coverage for the underlying claims on May 14, 2003. The administrator filed its declaratory judgment action on the same day.

To assess the availability of coverage under the policies, the court first addressed the timing of the reporting of the underlying claim. The court noted that the policies defined "Claim" to mean any written demand for money resulting from "Wrongful Acts," which were "actual or alleged" acts of professional misconduct on the part of the insured. The court then determined that the demand letter alleged acts of professional misconduct by the administrator, demanded the return of funds taken from the claimants' account and threatened litigation. The court accordingly concluded that the demand letter set forth a "Claim" under the policies. The court further observed that, under the policies, a "'Claim' was deemed first made when any Insured receive[d] [such] written demand," and that, here, such claim was "first made" against the administrator when it received the April 22, 2002 demand letter—*i.e.*, during the initial June 1, 2001 to June 1, 2002 policy period.

The court then rejected the contention that the underlying claim was not "first made" until the formal filing of the underlying complaint after the expiration of the initial policy period. According to the court, precedent required the administrator to report the demand letter to its insurer "as soon as practicable after such claim is first made and . . . during the Policy Year in which such Claim [was] made." The undisputed facts, however, showed that even though the administrator received the demand letter during the initial policy period, it did not report it to the insurer until October 24, 2002, after the initial policy period expired. Because the administrator failed to satisfy the policy period reporting requirement, the court determined that the administrator failed to trigger the insurer's duty to defend and indemnify.

The court next addressed the impact of the "prior notice/knowledge" exclusion in the renewal policy on the availability of coverage. The exclusion precluded coverage for claims that were the subject of any notice given before the policy period or were known to the policyholder before the policy period, but provided as follows:

If, however, this Policy is a renewal of one or more policies previously issued by the Underwriter to the Named Insured, and the coverage provided by the Underwriter to the Named Insured was in effect, without interruption, for the entire time between the inception date of the first such other policy and the Inception Date, the reference in this EXCLUSION (C) to the Inception Date will be deemed to refer instead to the inception date of the first policy under which the Underwriter began to provide the Named Insured with continuous and uninterrupted coverage of which this Policy is a renewal.

Based on this language, the policyholder argued that, despite the policy's "claims-made and reported" language, the exclusion allows an insured who renews its insurance policy and receives a claim during the initial policy period to wait to report the claim to its insurer until the subsequent policy period. The court disagreed, citing "the principle that an exclusion from insurance coverage cannot create coverage."

The administrator also argued that "the exclusion language must be read . . . so as to create an ambiguity that must be construed in its favor" because the insurer's reading "'renders Exclusion 3(C) redundant,' in that it does not alter the fundamental requirement that a claim made in one period must be reported in that policy period." The court rejected this argument as well, observing that the "Seventh Circuit has specifically taught that the anti-redundancy canon often is not helpful when interpreting disputed contractual language because parties and their attorney-drafters often 'want[ ] to make assurance doubly sure' about a point, 'a desire that explains much apparently superfluous language in contracts.'" The court further observed that reading the exclusion to create an open-ended insurance period—in which the insured can wait indefinitely, even after claims are actually made, to report them—substantially expanded and distorted the policy language. In addition, the court noted that case law in the Northern District of Illinois and elsewhere militated against finding that renewal of the policy created a single policy period for claims reporting purposes.

The court next addressed the administrator's remaining arguments that (i) it reported the underlying claim to its insurer "as soon as practicable," given its lack of sophistication with this type of insurance coverage and (ii) the insurer was not prejudiced by the delayed reporting. The court rejected both arguments. As to the first

argument, the court explained that, regardless of whether the administrator provided notice to its insurer "as soon as practicable," it did not provide notice of the underlying claim during the initial policy period. Because the underlying claim was not made and reported during the same policy period, the plain language of the policies dictated that the policies afforded no coverage. As to the second argument, the court explained that the "issue of prejudice is irrelevant in the context of a 'claims-made' insurance policy." The court observed that, in claims-made policies, the notice provision helps define the scope of coverage under the policy, and thus prejudice for an untimely report is not relevant.

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