

# Claims Made and Professional Liability Insurance Coverage

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# Claims Made and Professional Liability Insurance Coverage

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PENNSYLVANIA BAR INSTITUTE  
5080 RITTER ROAD  
MECHANICSBURG, PENNSYLVANIA 17055-6903  
800/932-4637 OR 717/796-0804

E-MAIL: [info@pbi.org](mailto:info@pbi.org)  
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## Foreword

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Professional liability policies operate on a claims-made basis, covering only claims made during the policy period and not claims based on occurrence. Discover the complexities of the professional liability policy and learn how to avoid malpractice claims by understanding coverages and ethical obligations.

We are especially grateful to our course planners for developing an outstanding program. They are Jay M. Levin, Esquire of Reed Smith LLP in Philadelphia and Deborah M. Minkoff, Esquire of Cozen O'Connor in Philadelphia. Each faculty member has devoted significant time and effort developing the course and preparing written materials. All of them are listed in the biographical section that follows.

Every PBI faculty member serves without compensation, out of a commitment to the profession. On behalf of the lawyers who will benefit from the tremendous contribution of time and expertise made by the faculty, we offer our deepest appreciation.

**Penina Kessler Lieber, President**

**Erin Tate, Program Attorney**

Pennsylvania Bar Institute

April 2014



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# Biographies

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## **COURSE PLANNERS:**

### **Jay M. Levin, Esquire**

Mr. Levin is a member of the Insurance Recovery Group of Reed Smith LLP and is based in the firm's Philadelphia office. He focuses his practice on representing policyholders in coverage disputes with insurers, with an emphasis on first-party property, professional liability coverage, directors' and officers' liability coverage, and bad faith. Mr. Levin also counsels policyholders about insurance issues, including analyzing existing coverage or renewal proposals to make sure that the policyholder understands the scope of coverage and any important gaps in coverage. He has drafted contractual insurance provisions and procedures for testing compliance with those provisions. Mr. Levin received his J.D. from The University of Pennsylvania Law School in 1981 and his A.B. from The University of Pennsylvania in 1977. He is an active member and 2007-2008 Chair of the American Bar Association Tort Trial and Insurance Practice Section's Property Insurance Law Committee. Mr. Levin is admitted to practice in Pennsylvania, New Jersey, New York and Washington, D.C. He is also admitted to practice before the United States Supreme Court, the United States Courts of Appeal for the Second and Third Circuits, and numerous United States District Courts.

### **Deborah M. Minkoff, Esquire**

Ms. Minkoff is a member of Cozen O'Connor, resident in the Philadelphia office. She joined the firm in 1984 and has been practicing in the Global Insurance Group since 1989, where she handles complex coverage litigation, with an emphasis on liability coverage issues. Ms. Minkoff's representative cases include disputes under claims-made liability coverages, disputes over the scope of professional liability coverage, coverage for product-related claims, advertising injury and personal injury coverages, employment-related claims under liability policies, and sexual misconduct claims under both professional liability coverage and commercial liability coverage. Ms. Minkoff has lectured on claims-made and reported coverage, coverage for product-related claims, multiple insureds and whether a good faith settlement terminates the duty to defend, employment-related claims under CGL policies, and effective legal writing. Ms. Minkoff is a member of the American Bar Associations Tort Trial and Insurance Practice Section, and the Defense Research Institute (DRI). In May 2000, she published an article in DRIs For the Defense, entitled Multiple Insureds: Can a Good Faith Settlement Terminate a Right to a Defense? In the June 2001 edition of For the Defense, Ms. Minkoff published an article entitled, Defense Cost Sharing Agreements: A Practical Approach. Ms. Minkoff graduated from Franklin and Marshall College in 1981, with a major in Psychology and a minor in Latin. She is a 1984 graduate of Villanova Law School, where she was a member of the Law Review and received the Pulling Award for outstanding student authorship. Ms. Minkoff returned to Villanova Law School as a full-time visiting professor for the Fall 2004 semester. She currently serves as an adjunct professor at Drexel University Law School. Ms. Minkoff appears in the 2008, 2009, and 2010 editions of The Best Lawyers in America, in the category of Insurance Law.



## **FACULTY:**

### **Nicholas M. Centrella, Esquire**

Mr. Centrella is the Managing Shareholder of the Philadelphia firm of Conrad O'Brien PC, where he focuses his practice on litigation. During his 19-year career, Mr. Centrella has been selected as one of the top lawyers in the state for Legal Malpractice Defense by *Best Lawyers in America*, a leading lawyer in *Chambers USA*, *The Clients Guide to Americas Leading Litigation Attorneys*, and as one of 50 on the Fast Track by the *Legal Intelligencer*. He regularly represents law firms in legal malpractice and other civil actions, and has defended major corporations and other clients in complex commercial, regulatory, civil RICO, and white collar criminal defense matters.

### **Kate M.K. Owen, Esquire**

Ms. Owen joined Reed Smith in 2002, and is a member of the Insurance Recovery Group, resident in the Pittsburgh office. Ms. Owen represents policyholders in insurance coverage disputes, including negotiation, litigation and other forms of dispute resolution. She also represents policyholders in the negotiation, review and evaluation of all types of insurance policy forms, including errors and omissions coverage, financial institutions professional liability coverage, directors' and officers' coverage, and first-party property insurance. Ms. Owen's practice also involves work on complex commercial litigation matters. She is an affiliate member of the Pittsburgh Commercial Litigation Group, where she began her practice at Reed Smith. She represents parties in state and federal court in civil and commercial disputes, and counsels clients in litigation avoidance and management. Her experience includes a range of litigation matters, such as preliminary injunction, class action and contract dispute work. Among other topics, Ms. Owen has experience in class action notice-issues and managing large electronic discovery matters. Ms. Owen's pro bono legal work focuses on adoption work on behalf of Allegheny County Children Youth and Families. Additionally, she has handled a complex private adoption matter in Orphan's Court. Ms. Owen received her J.D., cum laude, from the University of Pittsburgh School of Law and her B.A., summa cum laude, from the University of Pittsburgh College of Arts and Sciences. Ms. Owen also has a Master of Public and International Affairs degree from the University of Pittsburgh Graduate School of Public and International Affairs.

### **Thomas M. Reiter, Esquire**

Mr. Reiter is a partner in the Pittsburgh office of K& L Gates LLP. He is a member of the firm's insurance coverage practice group and concentrates his practice in the representation of businesses in complex insurance coverage matters. Mr. Reiter is and has been responsible for major D&O, environmental, asbestos, product liability, residual value, fidelity, and professional liability insurance coverage actions in trial and appellate courts throughout the country. His practice includes counseling policyholders concerning placing a wide array of insurance contracts, including D&O policies and blended insurance programs. On behalf of clients, Mr. Reiter devotes substantial time to negotiating with insurers with respect to D&O, asbestos, technology, business tort, professional liability, fiduciary, general commercial, property loss and other complex insurance coverage claims. Mr. Reiter has published and lectured extensively on insurance coverage and is the co-author, along with partners Peter J. Kalis and James R. Segerdahl, of a leading insurance

treatise, “Policyholder’s Guide to the Law of Insurance Coverage,” Aspen Law & Business (1997) (revised annually). He received his J.D. from Columbia Law School, where he was a Harlan Fiske Stone Scholar, and his B.A., magna cum laude, from Kenyon College. Mr. Reiter is admitted to practice to the Bar of Pennsylvania and the United States Court of Appeals for the Eighth, First, Ninth, Second, Sixth and Third Circuits.

**Kathryn M. Rutigliano, Esquire**

Ms. Rutigliano is an Associate in the Global Insurance Department of Cozen O’Connor’s Philadelphia office. She focuses her practice in the area of complex liability coverage, with an emphasis on professional liability and appellate matters. In addition, she has experience counseling clients with issues arising in underwriting. Her article, *Conduct Unbecoming: The Impact of the Professional Services Exclusion on Negligent Supervision and Sexual Molestation Claims*, co-authored with Deborah Minkoff, appeared in the May 17, 2012 edition of Claims Management magazine. Ms. Rutigliano received her J.D. from Boston College Law School, and her B.A. from Villanova University, *summa cum laude*.



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Chapter One:

## **Practical Issues In Enforcement of Claims-Made Policies: Timing is Everything**

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**Deborah M. Minkoff, Esquire**  
Cozen O'Connor  
Philadelphia

Originally published in the course book for PBI's seminar #7177 *Claims Made & Professional Liability Insurance Coverage* in December 2012.



More insurance coverage is being written on a claims-made basis than ever before. Several important distinctions exist among traditional "occurrence" coverage, "claims-made" coverage, and "claims-made and reported" coverage. Courts enforce the time parameters that characterize both "claims-made" and "claims-made and reported" policies. In order to enforce the policy language, policyholders, insurers and the lawyers who represent them must understand differences between the policies.

## I. OVERVIEW OF CLAIMS-MADE COVERAGE

### A. Key Differences Between Claims-Made and Occurrence Based Coverage

"Claims-made" coverage differs from "occurrence" coverage in three significant ways:

1. The claim, not the injury, is the threshold event. For a claims-made policy, the threshold event is a claim against the insured during the policy period. In contrast, occurrence-based coverage looks to whether injury or damage occurred during the policy period.
2. Reporting is an element of coverage. In a claims-made policy, the reporting of the claim during the specified time period is typically an element of coverage; in occurrence policies, notice is a condition.
3. No prejudice is necessary. Because reporting is an element of coverage, late notice generally precludes coverage as a matter of law, without proof of prejudice.

### B. Key Differences Between Claims-Made and Claims-Made and Reported Coverage

There are two distinct types of claims-made forms. One is the "claims-made and reported" form, and the other is a pure "claims-made" form.

1. **Claims-Made Policies** require that the *claim first be made during the policy period*. The report can be made after the policy period, but it generally must be reported to the insurer in compliance with a standard such as "immediately" or "as soon as practicable" after the claim is made. What those standards mean is a matter of state law, and may vary with each jurisdiction.
2. **Claims-Made and Reported Policies** require that a *claim first be made during the policy period, and also reported to the insurer during the policy period or designated time period*. While some policies require the payment of an additional premium to extend the discovery and/or reporting period, the courts enforce the reporting deadlines established in the policies. Unlike the claims-made policy, this form defines the acceptable timing parameters for reporting a claim rather than leaving it to an insured to guess or a court case to determine.

- But see E. Texas Med. Ctr. Reg'l Healthcare Sys. v. Lexington Ins. Co., No. 04- cv-

165, 2007 U.S. Dist. LEXIS 50613 (E.D. Tex. July 12, 2007) (refusing to recognize a difference between claims-made and claims-made-and-reported policies for purposes of applying the notice-prejudice rule).

3. Most courts follow the distinctions established by the policy language and do not require a showing of prejudice to deny a claim based on late reporting under a claims-made and reported policy. Other jurisdictions go so far as not requiring a showing of prejudice under a policy that is only “claims-made.” Some courts, however, distinguish between claims-made and claims-made and reported policies, applying a prejudice requirement to late reporting under the former, but not the latter.

- a) **Examples of Cases Holding That No Prejudice Is Required To Be Shown To Deny a Claim Under Claims-Made and Claims-Made and Reported Policies:** Heydar v. Westport Ins. Corp., 158 Fed. Appx. 774, 776 (9th Cir. 2005); Federal Insurance Company v. CompUSA, 319 F.3d 746 (5th Cir. 2003); Andy Warhol Found for the Visual Arts, Inc. v. Fed. Ins. Co., 189 F.3d 208, 215 (2d Cir. 1999); 4th St. Invest., LLC v. Dowdell, 340 Fed. Appx. 99, 101n. 1 {3d Cir. 2009} (applying PA law); Oregon Sch. Activities Ass'n v. Nat'l Union Fire Ins. Co. of Pittsburgh, No. 05-36129, 2008 U.S. App. LEXIS 11389 (9th Cir. May 22, 2008) (stating “We believe that Oregon would follow the weight of authority and hold that the notice-prejudice rule does not apply to claims-made-and-reported policies because of the different purpose the notice provision served under each type of policy.”); Webb Operating Co. v. Zurich Am. Ins. Co., 2010 U.S. Dist. LEXIS 73675, \*8 (E.D. Mich. July 8, 2011); Jennings Const. Svcs. Corp. v. Ace Am. Ins. Co., 2011 U.S. Dist. LEXIS 49999, \*8 (M.D. Fla. May 10, 2011); Moody v. Am. Guar. & Liab. Ins. Co., 2011 U.S. Dist. LEXIS 38024, \*6 (W.O. Wash. April 7, 2011); Nations First Mortg. LLC v. Tudor Ins. Co., 2009 U.S. Dist. LEXIS 90343, \*17 (M.D. Pa. Sept. 30, 2009); East Texas Medical Center Regional Healthcare System v. Lexington Ins. Co., 2007 U.S. Dist. LEXIS 50613 (E.D. Tex. 2007); Salt Lake Toyota Dealers Ass'n v. St. Paul Mercury Ins. Co., 2006 WL 1547996 (D. Utah 2006); Farm Bureau Life Ins. Co. v. Chubb Custom Ins. Co., 780 N.W.2d 735 (Iowa 2010); ACE American Ins. Co. v. Underwriters at Lloyds, 939 A. 2d 935 (Pa. Super. 2007), *aff'd* without opinion 601Pa. 95 (Pa. 2009);

- (1) The Pennsylvania Supreme Court's affirming of the Superior Court's decision in ACE American Ins. Co. v. Underwriters at Lloyds confirms what federal courts have predicted for decades: that Pennsylvania would decline to extend the notice-prejudice rule to claims-made policies. *See, e.g., Westport Ins. Corp. v. Mirsky*, No. 00-4367, 2002 U.S. Dist. LEXIS 16967

(E.D. Pa. Sept. 10, 2002) ("Under Pennsylvania law, the 'notice-prejudice' rule does not apply to 'claims made' policies"); Pizzini v. American Int'l Specialty Lines Ins. Co., 210 F. Supp. 2d 658, 669:..70 (E.D. Pa. 2002) ("the weight of existing case law leads me to conclude, as have the courts in this circuit, that under Pennsylvania law the Brakeman 'notice-prejudice' rule does not apply to 'claims made' policies"); Borish v. Britamco Underwriters, Inc., 869 F. Supp. 316, 319 (E.D. Pa. 1994) (noting that courts within the Eastern District of Pennsylvania adopted the rule that "an insurance company need not show prejudice where there has been failure to comply with notice provisions in a claims-made policy"); Clemente v. The Home Ins. Co., 791F. Supp. 118, 121-22 (E.D. Pa. 1992) (holding that an insurer was not liable to the insured for coverage due to late notice regardless of the question of prejudice, where the insurance policy was claims-made); Employers Reinsurance Corp. v. Sarris, 746 F. Supp. 560, 565 (E.D. Pa. 1990) (declining to apply notice-prejudice rule to claims made policy); City of Harrisburg v. International Surplus Lines Ins. Co., 596 F. Supp. 954, 962 (M.D. Pa. 1984), aff'd without opinion, 770 F. 2d 1067 (3d Cir. 1985) (notice prejudice rule does not apply to claims made policies).

- b) **Examples of Cases Holding that Actual Prejudice Must Be Shown Before Coverage May Be Denied Under a Claims-Made Policy:** Westport Insurance Corp. v. Albert, 208 Fed. Appx. 222 (4th Cir. 2006); Oakland-Alameda County Coliseum, Inc. v. Nat'l Union Fire Ins. Co., 480 F. Supp. 2d 1182, 1197 (N.D. Cal. 2007); Wendy's Int'l, Inc. v. Ill. Union Ins. Co., 2007 U.S. Dist. LEXIS 15699 (S.D. Ohio 2007); Maynard v. Westport Insurance Corp., 208 F. Supp.2d 568 (D. Md. 2002); Sunnen Prods. Co. v. Travelers Cas. & Sur. Co. of Am., 2010 U.S. Dist. LEXIS 16953, \*14 (E.D. Mo. Feb. 25, 2010) Antonacci et al. v. Darwin Select Ins. Co., No. 085009088, 2010 Conn. Super. LEXIS 1003 (Conn. Super. April 21,2010).

### C. Types of Coverage Often Written on Claims-Made Basis

1. Directors and Officers Liability Coverage
2. Medical Liability Coverage
3. Legal Liability Coverage
4. Employment Practices Liability Coverage
5. Brokers Errors and Omissions Coverage
6. Media Liability Coverage

7. Cyber Liability Coverage
8. Technology Errors and Omissions Coverage
9. Other Types of Professional Liability Coverage
10. Certain Types of Product Liability Coverage

**D. The Benefits of Claims-Made Coverage (To Insurer and Insured)**

1. The timing requirements of claims-made policies eliminate exposure for "long tail" claims, thereby allowing for better pricing. Claims based on a historical injury with recent manifestation are expensive and unpredictable. The leading example of this type of claim is asbestos injury claims where exposure may have occurred in the 1950's or 1960's. Under most jurisdictions' current law, these types of injuries trigger multiple policy periods, often multiplying the exposure faced by insurers. Because claims-made policies generally do not trigger multiple policy periods, insurers can evaluate their exposures relatively close in time to the claim's presentation, and do not have to price for "surprise" causes of action.
  - "[T]he two key benefits of a [claims-made] policy for the insured are lower premiums and coverage for acts or omissions occurring before the effective date of the policy. The benefit for the insurer is that there is no open-ended 'tail' after the ending date of the policy." Farm Bureau Life Ins. Co. v. Chubb Custom Ins. Co., et al., 780 N.W. 2d 735 (Iowa 2010).
  - "The insurer is afforded greater certainty in computing premiums, since it does not need to be concerned with the risk of claims filed long after the policy period has ended, and as a result the insured may benefit from lower premiums." Checkrite Limited, Inc. v. Illinois National Ins. Co., 95 F. Supp. 2d 180,192 (S.D.N.Y. 2000).
  - "An underwriter who is secure in the fact that claims will not arise under the subject policy... after its termination or expiration can underwrite a risk and compute premiums with greater certainty. The insurer can establish his reserves without having to consider the possibilities .of inflation beyond the policy period, upward-spiraling jury awards, or later changes in the definition and application of negligence. . . . This theoretically results in lower premiums for an insured since there is no open-ended 'tail' after the expiration date of the policy." Gulf Ins. Co. v. Dolan, Fertig & Curtis, 433 So. 2d 512, 516 (Fla. 1983).
  - "Claims made" policies beneficially permit insurers more accurately to predict the limits of their exposure and the premium needed to accommodate the risk undertaken, resulting in lower premiums to insureds than are charged for an occurrence-based policy. Montrose Chern. Corp. v. Admiral Ins. Co., 913 P.2d

878,904 (Cal. 1995).

- As practitioners, we expect insureds' counsel to attack this judicial recognition. See, <http://www.insurancescrawl.com/archives/claimsmade> ("insurers did a good job in convincing courts - without evidence - that claims-made policies were inherently cheaper than are occurrence policies").
2. Under professional liability, products liability, and certain other types of coverage, it can be difficult to determine exactly when the "occurrence" took place for purposes of determining coverage. Claims-made policies remove the uncertainty, and avoids the "trigger" issue, by focusing on either the timing or the reporting, which are easily ascertainable.
- Claims-made policies provide coverage against claims made and reported during the policy period, regardless of when the events giving rise to the claims took place. Ballow v. PHICO Ins. Co., 875 P.2d 1354, 1357 (Colo. 1993); see also 4th Street Investors LLC, et al. v. Dowdell, No. 06-536, 2007 U.S. Dist. LEXIS 99670 (W.O. Pa. Dec. 3, 2007). In contrast, an occurrence policy is one in which coverage is provided for events that occur during the policy period, even though a claim may not be made or reported until some time after the policy period has expired. Ballow, 875 P.2d at 1357.
3. Claims-made policies eliminate most litigation over prejudice caused by late notice. A frequent source of litigation between policyholders and insurers under occurrence-based policies is whether the policyholder timely reported a claim and, in most states, whether the insurer was prejudiced by the late notice. These suits frequently require jury trials because prejudice is usually an issue of fact for which summary judgment is inappropriate. In contrast, the time a claim was made or reported is easier to determine. While the issues may require litigation, the matters almost invariably resolve on summary judgment or on motions to dismiss. Therefore, not only is there less litigation, the litigation is more defined and therefore less costly to both insurer and insured.

## II. WHAT IS A CLAIM?

### A. Claims-Made Policies Do Not Always Define "Claim"

1. The majority of courts find that lack of a definition of "claim" does *not* render the policy ambiguous. See Oakland-Alameda County Coliseum, Inc. v. Nat'l Union Fire Ins. Co., 480 F. Supp. 2d 1182, 1194 (N.D. Cal. 2007); Safeco Title Ins. Co. v. Gannon, 774 P.2d 30 (Wash. 1989); Evanston Ins. Co. v. Security Assurance Co., 715 F. Supp. 1405 (N.D. Ill. 1989).
2. Very few courts have ruled that a policy that did not define "claim" was ambiguous.



But see Andy Warhol Foundation for Visual Arts, Inc. v. Federal Ins. Co., 189 F.3d 208 (2d Cir. 1999) (claims-made policy containing no definition of "claim" ruled ambiguous for purpose of deciding when copyright infringement claim were first asserted; insured asserted "claim" made when suit was brought, and insurer argued that pre-action letter from counsel constituted "claim"); Clarendon Am. Ins. Co. v. N. Am. Cap. Ins. Co., 112 Cal. Rptr. 3d 339, 351(Cal. App. 2010) (where policy did not define "claim", the term was susceptible to both the insured's and the insurer's proffered meanings); Walker v. Larson & St. Paul Fire & Marine Ins. Co., 727 P.2d 321(Mont. 1986).

**B. Courts Have Interpreted the Word "Claim" Consistently, Giving the Word Its Ordinary Meaning**

1. A demand on the insured for damages resulting from the insured's alleged negligent act or omission. Gannon, supra.
2. A demand for something as of right. National Cas. Co. v. Great Southwest Ins., 833 P.2d 741(Colo. 1992).
3. Assertion of legally cognizable damage that must be a type of demand that can be defended, settled and paid by the insurer. Evanston Ins. Co. v. GAB Business Services, 132 A.D.2d 180, 521N.Y.S.2d 692 (1987).
4. An effort by a third party to recover money from the insured. CIPS v. American Empire Surplus Lines, 642 N.E.2d 723 (Ill. App. 1994).
5. Applying the definition in the California Insurance Code, claim means an "assertion, demand or challenge of something as a right; the assertion of a liability to the party making it to do some service or pay a sum of money." Oakland-Alameda County Coliseum, Inc. v. Nat'l Union Fire Ins. Co., 480 F. Supp. 2d 1182, 1194 (N.D. Cal. 2007).

**C. In Few Cases, Courts Apply a More Restrictive Interpretation**

In relatively few situations, courts apply a more restrictive interpretation of "claim," requiring a demand be made *in court*. See, e.g., Hyde v. Fidelity and Deposit Co. of Md., 23 F. Supp. 2d 630 (D. Md. 1998).

**III. ENFORCEMENT OF THE REPORTING REQUIREMENT**

**A. Virtually All Jurisdictions Enforce Reporting Requirements**

- Even when resulting in harsh consequences, "claims-made" policies, and their reporting provisions, are enforceable. Pizzini v. Am. Int'l Specialty Lines Ins. Co., 210 F. Supp. 2d 658, 668 (E.D. Pa. 2002).
- "[R]eporting requirements in claims-made policies are strictly construed and enforced; if an

insured does not give notice within the required time, there is simply no coverage under the policy." Nations First Mortg. LLC v. Tudor Ins. Co., 2009 U.S. Dist. LEXIS 90343, \*17 (M.D. Pa. Sept. 30, 2009).

- Though the result may be harsh, “[e]xceptions to the requirement of strict compliance with notice-of-claim provisions in claims-made policies are not favored because they would defeat the fundamental concept on which claims-made policies are premised.” Farm Bureau Life Ins. Co. v. Chubb Custom Ins. Co., 780 N.W.2d 735, 741 (Iowa 2010) (internal quotations omitted).
- “The notice provision of a 'claims made' policy is not simply the part of the insured's duty to cooperate, it defines the limits of the insurer's obligation... If the insured does not give notice within the contractually required time period, there is simply no coverage under the policy.” Pantropic Power Prods. v. Fireman's Fund Ins. Co., 141F. Supp. 2d 1366,1370 (D. Fla. 2001)
- “The notice provision of a claims made policy is just as important to coverage as the requirement that the claim be asserted during the policy period. If the insured does not give notice during the contractually required time period ...there is simply no coverage under the policy.” Burns v. International Ins. Co., 709 F. Supp. 187,190 (D. Cal. 1989).

#### **B. In Isolated Cases, Unique Facts May Require an Equitable Result**

- In Root v. American Equity Specialty Ins. Co., 130 Cal. App. 4th 926, 30 Cal. Rptr. 3d 631(June 28, 2005), the court excused the reporting requirement in a claims-made and reported policy on equitable considerations. The Root court reached this conclusion in the face of a claim made against the insured in the last days of the policy period. The insured reported the claim virtually immediately, yet after the last day of the policy period. Because the policy did not provide for an automatic or extended reporting period, coverage would have been unavailable without the *court's* exercise of its equitable powers. More dangerously, however, the Root court interpreted the reporting requirement as a condition, not an element of coverage, despite the fact that the requirement was contained in both the insuring agreement and the conditions section of the policy. Id. at 943-944.

#### **C. In Direct Action States, the Reporting Requirement May Violate State Statute**

- Hood v. Cotter, 978 So.2d 988 (La. App. 2007) illustrates the unique challenges presented to insurers in direct action jurisdictions. In that *case*, the policy at issue was claims-made and reported. The underlying malpractice claim was filed against the doctor during the policy period, but the complaint against the insurer was not. The insurer denied coverage on the basis of the reporting requirement. The court held that the reporting period violated state statute prohibiting the limiting of a right of action against an insurer to less than one year.

Citing Hedgepath v. Guerin, 691So. 2d 1355 (La. App. 1997), writ denied 701So. 2d 9 83 (La. 1997), the Hood court held, "[t]hat portion of [the] claims-made policy which limited its liability to those claims that occurred and were reported while the policy was in *force*, is unenforceable and without effect as to those acts of malpractice that occurred during the policy period for which a claim was filed within one year from accrual of the cause of action and was also reported to the insurer within such time."

But see Guthrie v. Louisiana Med. Mut. Ins. Co., No. 42, 974-CA (La. Ct. App. Feb. 13, 2008), which held that the claims-made policy did not violate the Louisiana statute providing that insurance contracts cannot limit the right of action against the insurer to a period of less than one year from the time the action accrues. The court reasoned that claims- made policies "do not limit the time in which a plaintiff has to file suit following an alleged act of malpractice." Id. Rather, the "policy contractually limits the risk insured" and "sets forth the parameters of the contractual agreement between the insured and the insurer." Id. It noted that the plaintiff "may file within the time limits set forth under the law." Id.

#### IV. RECURRING LITIGATION ISSUES

##### A. Definition of "Claim" Issues

Litigation over the definition of "claim" has resulted in a few common rules:

1. While a demand for money is certainly a claim, the demand for relief does not have to be in the form of a lawsuit. Dalton, Brown & Long Inc. v. Executive Risk Indem., Inc., 73 Fed. Appx. 229 (9th Cir. 2003) (letter from insured's attorney to real estate agent alleging breach of fiduciary duty and demanding compensation was "claim" under California law); City of Shawnee, Kansas v. Argonaut Ins. Co., 546 F. Supp. 2d 1163 (D. Kan. 2008) (finding that correspondence stating, among other things, that claimant "hereby notifies you of its claim for damages on this project" was a "claim for damages" under the policy); Westrec Marina Mgmt., Inc. v. Arrowood Indem. Co., No. B195047 (Cal. Ct. App. June 16, 2008) (holding that letter from claimant's attorney, which stated that the claimant had been subjected to employment discrimination and which stated the insured might prefer to resolve or mediate the matter, was a "claim" in that it was a "Settlement demand seeking monetary compensation for the alleged wrongdoing" even though it did not expressly demand payment or refer to a specific amount).
2. To constitute a "claim," a demand upon the insured need not be for a specific dollar amount and, in appropriate cases, does not have to include a demand for money if specific performance is involved (i.e., some form of corrective action is demanded). Home Ins. Co.

v. Spectrum Info. Techs., 930 F. Supp. 825 (E.D.N.Y. 1996) (stating that a claim is a demand for money damages or "other relief owed").

3. The circumstance that the insurer is aware of an alleged *injury* is generally not enough to constitute a claim, Richardson Electronics, Ltd. v. Federal Ins. Co., 120 F. Supp. 2d 698 (N.D. Ill. 2000) (under Illinois law, mere fact that insured reasonably concludes that claim is inevitable is insufficient to trigger coverage under claims-made policy); Insurance Corp. of Am. v. Dillon, Hardamon & Cohen, 725 F. Supp. 1461 (N.D. Ind. 1988) ("Awareness is not a demand and the use of the word claim, unless modified by other language, requires that a demand be made").
4. A mere assertion by a third party that a wrongful act has occurred is not a "claim." California Union Ins. Co. v. American Diversified Sav. Bank, 914 F.2d 1271 (9th Cir. 1990) (assertion that wrong took place is "not the same thing as a claim for payment"); In re Ambassador Group, Inc. Litig., 830 F. Supp. 147 (E.D.N.Y. 1993) ("It is clear that a claim is something more than the threat of a lawsuit"; in addition, the insured's expectation of a lawsuit based upon his knowledge of an occurrence does not constitute a claim).
5. A demand for regulatory compliance generally does not constitute a "claim." See FDIC v. Mijalis, 15 F.3d 1314 (5<sup>th</sup> Cir. 1994) (cease and desist letter from FDIC to bank's directors and officers regarding unsafe lending practices did not constitute a claim).
6. A mere "request for information" generally does not constitute a claim. In the widely discussed case of Hoyt v. St. Paul Fire & Marine Ins. Co., 607 F.2d 864 (9th Cir. 1979), an attorney insured under a claims-made professional liability policy could not allege a "claim" for purposes of insurance coverage where the injured third party simply wrote to the insured attorney requesting information as to why he had drafted a will provision with adverse tax consequences. The court stated: "In our judgment...the letter did not constitute a claim. It was a request for information and explanation...In our view, an inquiry cannot be transformed into a claim or demand depending in each case on the reasonable expectations of the insured...". See also Myers v. Interstate Fire & Cas. Co., No. 08-CV-2347, 2008 U.S. Dist. LEXIS 7053 (M.D. Fla. Jan. 30, 2008) (holding that a letter from the claimant's attorney advising that he had been retained in connection with a claim for damages arising from the insured's negligence and requiring a copy of any statements taken from the claimant, as well as the insured's insurance information, was a "close case" but was not a claim because it made no demand for money and did not advise the insured to forward the letter to his insurance carrier; instead it was merely a notice of a potential claim).
7. Where "claim" was defined as the commencement of a civil proceeding, courts have held that an amended complaint adding new theories of recovery does not constitute a new

"claim." The claim should have been reported when the original complaint was commenced. National Union v. Willis, 296 F.3d 336 (5th Cir. 2002). See also, Community Foundation for Jewish Educ. v. Federal Ins. Co., 16 Fed. Appx. 462 (7th Cir. 2001).

8. Letter on behalf of local governments to regional planning commission, containing demand for repayment of allegedly over-billed amount in connection with government services, was not a "claim" within meaning of claims-made policy where letter did not initiate a proceeding against regional planning commission before a governmental body empowered to render an enforceable judgment or order money damages. Area 15 Regional Planning Comm'n v. Cinn. Ins. Co., 2011 U.S. Dist. LEXIS 6676, \*23 (S.D. Iowa June 6, 2011).
9. Termination of legal representation, hiring counsel to investigate former counsel's alleged wrongdoing, and asserting that former counsel misappropriated property constituted a "claim" under professional liability policy. Simpson & Creasy, P.C. v. Cont. Cas. Co., 770 F.Supp.2d 1351, 1357 (S.D. Ga. 2011).
10. Letter to former counsel demanding counsel rectify problems created for plaintiffs constituted a "claim" under professional liability policy even though plaintiffs did not request monetary damages. McCabe v. St. Paul Fire & Marine Ins. Co., 79 A.D.3d 1612, 1614 (N.Y. App. 2010).

## **B. Proper Reporting of Claims Issues (The "Who" Issue)**

### **1. Timely Report Must Be Received by the Insurer**

In order for a report of a claim to satisfy a particular policy, the insured must report the claim within the designated period to the insurer that issued the policy. Reporting the claim to the broker does not suffice. See Southern New Jersey Rail Group, LLC v. Lumbermens Mut. Cas. Co., 2007 U.S. Dist. LEXIS 58510 (S.D.N.Y. 2007) (Maj. opinion), adopted by Southern New Jersey Rail Group, LLC v. Lumbermens Mut. Cas. Co., 2007 U.S. Dist. LEXIS 67889 (S.D.N.Y. 2007) (court held that notice to the insurer was untimely under a claims-made and reported policy, despite insured's timely report of the claim to its broker); Raby v. Am. Int'l Specialty Lines Ins. Co., No. 06-15742, 2008 U.S. App. LEXIS 4688 (9th Cir. Feb. 28, 2008) (applying Nevada law and holding that the insured's notice to the insurance agent was not sufficient and, therefore, the insureds did not give the required notice of the claim to the insurer within the period allowed by the claims-made policy); Countryside Cooperative, et al. v. Harry A. Koch Co., 280 Neb. 795 (2010) (insured reported to broker, but broker delayed report to insurer until 3 days after the extended reporting period concluded); Farm Bureau Life Ins. Co. v. Chubb Custom Ins. Co., et al., No. 07-0958, 2010 Iowa Sup. LEXIS 27 (Iowa April 9, 2010).

Typical policy language requires the *insured* to report a claim to the insurer, though at least one court has permitted notice by the underlying plaintiffs to preserve coverage. Ashby, et al. v. Davidson, Jr., et al., 930 N.E. 2d 53 (Ind. App. 2010). A lawyer abandoned his practice to go on a multi-state bank-robbing and crime spree, leaving his cases unattended. Certain clients sued the lawyer for malpractice, and provided actual, written notice of these claims to the lawyer's insurer. The court found that because the purpose of the notice provisions in claims-made policies is to permit the insurer to investigate and defend promptly, the report by the clients was sufficient for purposes of coverage.

- a) For a contrary result, see 4th Street Investors LLC, et al. v. Dowdell, et al., No. 06-536, 2007 U.S. Dist. LEXIS 99670 (W.D. Pa. Dec. 3, 2007) (holding that underlying plaintiff's report of claim to insurer did not satisfy policy's requirement that the insured report a claim).

## 2. **Excess Claims-Made Policies Require *Separate Reporting***

Under virtually all occurrence-based policies, an insured's duty to provide notice to an excess carrier arises when the insured has reason to believe that the occurrence is likely to involve the excess layer. Whether an insured could reasonably conclude that an occurrence is likely to reach an excess policy is judged by an objective standard, generally presenting a question of fact.

These considerations do not apply to an excess policy that is claims-made and reported, unless otherwise written into the policy.

- a) Because reporting a claim is an element of coverage, an insured seeking coverage under an excess policy must provide separate reporting to an excess carrier that issued a claims-made and reported policy. Old Republic Ins. Co. v. Ness, Motley, Loadholt, Richardson & Poole, P.A., 2006 U.S. Dist. LEXIS 900 (N.D. Ill. Jan. 11, 2006) (examining excess carrier's defense to coverage based on failure to report claim under excess claims-made policy).
- b) Even if following form, reporting to the primary alone does not suffice. Lexington Ins. Co. v. Western Pa. Hosp., 423 F.3d 318 (3d Cir. 2005) (where excess policy follows form to underlying claims-made and reported primary policy, insured's failure to report claim to excess carrier within policy period defeats coverage under the excess policy).
- c) Excess insurers cannot require more than the policy terms. JPMorgan Chase and Co., et al. v. Travelers Indem. Co., et al., 2010 N.Y. App. Div. LEXIS

2006 (N.Y. App. Div. March 18, 2010) (insured sufficiently reported a claim because the policy only required notice of a “Wrongful act” that could give rise to a claim under the policy, with no additional details).

## C. Sequential Policies Do Not Create Seamless Coverage

### 1. No Seamless Claims-Made Coverage

Numerous courts have ruled that successive claims-made and reported policies do not create “Seamless” coverage. These courts recognize that each policy stands on its own and lasts for a finite period of time, providing coverage only for those claims that are made against the insured and reported to the insurance carrier during the designated time period. The reporting provisions define the scope of coverage and are strictly construed.

- a) See, e.g., Pizzini v. American International Specialty Lines, 210 F. Supp. 2d 658, 666 (E.D. Pa. 2002) (no coverage because claim was not first made and reported during a single policy period); Westport Ins. Co. v. Mirsky, 2002 U.S. Dist. LEXIS 16967, \*31 (E.D. Pa. 2002) (“renewal of claims-made policies does not create a single policy for purposes of reporting”). See also, Quinones v. Jimenez & Ruiz, S.E., 261 F. Supp. 2d 87,91 (D.P.R. 2003) (court rejected insured’s argument that seamless coverage was created under a series of successive one-year “claims-made” policies issued by the same insurance company, and held that where a policy clearly stated that it terminated at the end of the policy period, a new contract with a new effective date was created each time the policy was renewed); Checkrite Limited, Inc. v. Illinois National Ins. Co., 95 F. Supp. 2d 180,193 (S.D.N.Y. 2000) (“[N]o where in the contract does it say that renewal creates a continuing period of coverage during which the insured may report claims without regard to the policy period in which they were first made.”)
- b) For cases reaching the contrary result, see Cast Steel Products, Inc. v. Admiral Ins. Co., 348 F.3d 1298 {11th Cir. 2003} (court refused to recognize the time parameters of each policy and, instead, interpreted the two policies as a single multi-year policy creating “seamless” coverage); New England Environmental Technologies v. American Safety Risk Retention Group, Inc. No.09-10632, 2010 U.S. Dist. LEXIS 96547 (D. Mass. Sept. 15, 2010) (relying on Cast Steel and noting that the renewal of the claims- made policy was “intended to provide seamless, identical coverage from one year to the next”); AIG Domestic Claims, Inc. v. Tussey, No. 2008-CA-001248, 2010 WL 3603844 (Ky. App. Sept. 17, 2010)

(holding that consecutive claims-made policies "create[] seamless coverage over the two-year period"); Helberg v. National Union Fire Ins. Co., 657 N.E.2d 832 {Ohio App. 1995}.

**2. No Continuous Trigger Under Claims-Made Coverage**

Because the claim is made at one identifiable point in time and, if required, reported at one identifiable point in time, a single claim cannot trigger more than one claims-made policy.

**D. The Notice Condition Does Not Create Ambiguity with the Reporting Requirement**

Courts consistently recognize the difference between notice provisions and reporting requirements, and hold that their incorporation into a policy does not render either provision ambiguous. See, e.g., Pension Trust Fund for Operating Engineers v. Federal Ins. Co., 307 F.3d 944 (9th Cir. 2002) (applying California law) (recognizing difference between reporting requirement and notice condition, and applying notice-prejudice rule to claims-made policy only because it was *not* subject to a reporting requirement); Slater v. Lawyers' Mutual Ins. Co., 227 Cal. App. 3d 1415 (Cal. App. 1991) ("we conclude that the reporting and notice provisions are not ambiguous and do not render the coverage language ambiguous."); ACE American Ins. Co. v. Underwriters at Lloyds, 939 A. 2d 935 (Pa. Super. 2007) (affirming trial court holding that more stringent reporting provision did not create ambiguity with policy's general reporting requirement), aff'd without opinion 601Pa. 95 (Pa. 2009).

1. In United States of American v. A.C. Strip, et al., 868 F.2d 181, 186-87 (6<sup>th</sup> Cir. 1989), the Sixth Circuit held:

The "as soon as practicable" language is intended to preclude an insured who has knowledge of a claim near the beginning of the policy period, from waiting many months until near the end of the policy period to notify the insurer of the existence of the claim, when such delay would cause prejudice to the insurer. It does not excuse, modify, or render ambiguous the claim reporting requirement that is recited in paragraph I as a condition of coverage.

2. In Liberty Mutual Ins. Co. v. The Black & Decker Corp., 2004 U.S. Dist. LEXIS (D. Mass. 2004), the insured argued that the reporting requirement was not a substantive limit on coverage, by virtue of the notice condition. The court rejected the insured's argument, holding:

[N]otice provisions differ fundamentally from reporting requirements. Notice provisions, which are typically found in occurrence and claims-made policies, usually require that notice be "reasonable" or "as soon as practicable" and serves



simply to help the insurer to investigate the claim while events are reliably fresh... . Reporting provisions, which are only found in claims-made-and-reported policies, require reporting within a fixed period of time, because they actually trigger the scope of coverage; the coverage-triggering event is not the occurrence or the claim, but the reporting of the claim.

3. In XL Specialty Ins. Co. v. Fin. Indus. Corp., No. 06-51683, 2007 U.S. App. LEXIS 29373 (5th Cir. Dec. 19, 2007), the Fifth Circuit certified the following question to the Texas Supreme Court: "Must an insurer show prejudice to deny payment on a claims-made policy, when the denial is based upon the insured's breach of the policy's prompt-notice provision, but the notice is nevertheless given within the policy's coverage period?" The Texas Supreme Court answered the question in the affirmative, finding that even if the notice is not given "as soon as practicable", if it is within the policy period, the insurer must demonstrate prejudice. Fin. Indust. Corp. v. XL Specialty Ins. Co., 285 S.W.3d 877 (Tx. 2009); see also Prodigy Communications Corp. v. Agricultural Excess and Surplus Ins. Co., 288 S.W.3d 374 (Tx. 2009) (finding if notice not given as soon as practicable but is within the policy period or extended reporting period, the insurer must demonstrate prejudice to deny coverage); Fulton Bellows, LLC v. Federal Ins. Co., 662 F. Supp. 2d 976 (E.D. Tenn. 2009) (applying Tennessee law, and adopting reasoning of Texas Supreme Court in XL Specialty and Prodigy Communications).

## V. THE RETROACTIVE DATE AND EXTENDED REPORTING PERIOD

Most claims-made policies contemplate certain events that can lock in the available coverage. The retroactive date, automatic reporting period and extended reporting period, and awareness provision, along with the policy period, establish the policy's time parameters.

### A. Automatic and Extended Reporting Periods

Some policies allow a claim to be reported within an "automatic" period of time after policy expiration, usually 30 or 60 days. Particularly if the policy is claims-made and reported, this additional period of time eliminates the concern raised by claims that are made near the end of a policy period. See Root, supra. Typically, however, this additional time is only for *reporting* claims-made within the policy period. It does not extend coverage to claims first made within the additional 30 or 60 days.

In contrast, an "Extended Reporting Period" may allow coverage for claims made after policy expiration, as well as reporting of claims. An insured changing insurers is the typical candidate for an "Extended Reporting Period," typically referred to as an "ERP." Depending on the policy language,

an ERP may allow the insured to extend coverage for claims reporting during a fairly long period of time, even years. The additional time is set forth in the policy or ERP endorsement, as is the premium charge for purchasing the coverage.

1. In Emissions Technology, Inc. v. Twin City Fire Ins. Co., No. CV10-0393, 2010 U.S. Dist. LEXIS 117926 (D. Az. Nov. 4, 2010), the insured, ETI, procured a claims-made policy with a 60 day extended reporting period. ETI reported the claim to Twin City two years after ETI had notice of the underlying lawsuit, and 18 months after the policy expired. Twin City denied coverage, and ETI brought suit. ETI argued that because it purchased a "claims-made" policy, Twin City should have to demonstrate prejudice in order to deny based upon late reporting. The Court found that the 60 day extended reporting period rendered the policy a "claims- made and reported" policy, and therefore did not reach the question. The Court did not address the fact that the 60 day extension should only apply to the *report* of the claim, and not when the claim was *made*.

## **B. Retroactive Dates**

Another problem that can arise when an insured is switching carriers relates to the retroactive date. Most claims-made policies provide for a "retroactive date" which provides that any occurrence which takes place before the retroactive date is not covered by the claims-made policy even if the claim is made during the policy period.

1. Policyholders have argued that claims-made policies which do not provide retroactive coverage are unenforceable as violative of public policy. This concern motivated the New Jersey Supreme Court's decision in Sparks v. St. Paul Insurance Co., 100 N.J. 325, 495 A.2d 406 (1985). In Sparks, the court was faced with a legal malpractice policy where the retroactive date was the inception date of the first in a series of four policies. Relying on the reasonable expectations doctrine, the court held that because of the absence of retroactive coverage, the St. Paul policy at issue combined "the worst features of 'occurrence' and 'claims-made' policies and the best of neither. It provides neither the prospective coverage typical of an 'occurrence' policy, nor the 'retroactive' coverage typical of 'claims-made' coverage." On this reasoning, the court refused to enforce the time parameters of the claims-made coverage.
2. Sparks does not represent the majority rule and, even in New Jersey, is limited to its specific facts. See, e.g., President v. Jenkins, 357 N.J. Super. 28, 814 A.2d 1173 (2003) (a policy providing no retroactive coverage enforced according to its terms where insured failed to renew his existing occurrence policy, did not make sure the new claims-made policy inceptioned on the expiration of the existing occurrence policy, so that the resulting gap in coverage was due to his own negligence, not to any fault on the part of the carrier). See also, Yancey v.

Floyd West & Company, 755 S.W. 2d 914 (Tex. App. 1988} (retroactive date provision of claim-made policy enforce in accordance with its terms; insurance contract did not violate public policy of Texas); General Insurance Company of America v. McManus, Inc., 272 Ill. App. 3d 510, 650 N.E. 2d 1080, 209 Ill. Dec. 107 (1995) (Sparks represents a minority view); Edwards v. Lexington Ins. Co., 507 F.3d 35 (1<sup>st</sup> Cir. 2007) (noting that even Sparks recognized there are situations where claims made policies with no retroactive coverage are appropriate, such as where an insured's earlier occurrence policy will provide coverage).

### C. Awareness Provisions and "Deemer" Clauses

1. Claims made and reported policies are typically subject to language that clarifies when a claim is deemed made.
2. Most claims-made and reported policies contain an "awareness provision" that allows the insured to report potential claims or events that the insured reasonably believes may give rise to a claim in the future. See, e.g., United States Liability Ins. Co. v. Johnson & Lindberg, P.A., 617 F. Supp. 968 (D. Minn. 1985). The "awareness clause" is a mechanism for "locking in" coverage for a claim that is actually made after the policy period ends, where the insured reports facts and circumstances that might give rise to a claim, but no claim has yet been asserted. The awareness provision "is the notice that turns potential future claims ... into actual claims made during the policy's term." Stewart Title Guar. Co. v. Kiefer, 1997 U.S. Dist. LEXIS 3562 (D. La. 1997).
3. Likewise, a claim made against the insured that is an outgrowth of a prior claim, even if pursued by different claimants, will be deemed made at the time the related claim was made. See e.g., Seneca Ins. Co. v. Kemper Ins. Co., No. 02-Civ-10088, 2004 U.S. Dist. LEXIS 9159 (S.D.N.Y. May 21, 2004); Greenburgh Eleven Union Free Sch. Dist. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, 304 A.D.2d 334 (N.Y. App. Div. 2003).

Chapter Two:

## **Whose Line is It: When Is a Claim a General Liability Claim Or a Professional Liability Claim?**

**Kathryn M. Rutigliano, Esquire**  
Cozen O'Connor  
Philadelphia



## **Whose Line Is It?**

### **When Is a Claim a General Liability Claim Or a Professional Liability Claim?**

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Professionals, like other business owners, face a wide variety of liability risks, some ordinary and common to all businesses, and others extraordinary. These risks include bodily injury, property damage, and financial losses suffered by clients and non-clients; bodily injury, wrongful termination, harassment and retaliation suffered by employees; defamation claims; copyright, patent and trademark infringement claims; civil rights claims; and in the case of public companies, securities claims. Because claims involving professional services are typically *excluded* under general liability policies, it is common for certain professionals to purchase separate professional liability coverage.

Although general liability and professional liability policies are designed to insure different risks, it is sometimes difficult to determine whether a particular claim implicates the general liability coverage or the professional liability coverage. On rare occasions, some claims conceivably trigger coverage under both general liability and professional liability policies. Whether a claim is covered under a professional's general liability policy, professional liability policy, or both, may have significant implications for the insured and the insurer(s). Often, the two types of coverage are subject to different coverage triggers. Moreover, one policy may offer broader coverage terms than the other.

General liability policies are typically "occurrence" based, and are triggered by an accident that results in bodily injury or property damage that occurs during the policy period. In contrast, professional liability policies are often "claims-made" and are triggered by a claim that is first made against the insured during the policy period. Thus, an insured's negligence causing an injury in year one, resulting in a lawsuit filed against the insured in year two, could trigger the general liability policy in force in year one. That same claim, however, would most likely trigger coverage under the claims-made professional liability policy in force during year two. In addition, while a continuing injury or progressive loss claim may trigger multiple general

liability policies in force during multiple policy years, that same claim may trigger only the professional liability policy in force during the policy year in which the claim was first made.

Notably, even when the two policies' limits are identical, one policy may provide a greater benefit to the insured over the other. The general liability policy may offer the insured greater coverage in terms of defense costs. It is not uncommon for a general liability policy to cover defense costs as supplementary payments paid by the insurer in addition to the limit of liability stated in the policy declarations. In contrast, professional liability policies often treat defense costs as part of the loss and, as such, defense costs erode the limit available to pay claims. Accordingly, whether a claim falls within the scope of a general liability policy versus a professional liability policy could have significant impact on the limits available to pay indemnity.

#### **A. Commercial General Liability Insurance**

Commercial general liability insurance forms the backbone of liability protection for business owners. It promises to defend and indemnify the business/business owner from liability for accidental bodily injury and property damage to third parties, subject to certain exclusions. General liability coverage may be tailored in many ways with a multitude of optional forms and endorsements to expand, delete, or restrict core coverages, forming a contract specifically designed for the individual insured. Nevertheless, the basic areas covered under general liability policies include the insured's ownership and use of the premises; coverage for insured contractual agreements; coverage for products manufactured, sold or distributed by the insured; completed operations of the insured; personal injury and advertising injury liability of the insured; and medical payments coverage.

The standard general liability policy form has been amended several times since it was first introduced in 1940, and there are currently a number of versions in use. Despite the changes

over the years, the core coverages have not changed significantly. The coverage form typically includes four parts:

COVERAGE A—Bodily Injury and Property Damage Liability  
COVERAGE B—Personal and Advertising Liability  
COVERAGE C—Medical Payments Coverage  
SUPPLEMENTARY PAYMENTS—Coverages A and B

General liability coverage forms typically begin with an insuring agreement, broadly expressing what the policy covers. By way of example, a typical general liability insuring clause may read:

We will pay those sums that the insured becomes legally obligated to pay as damages because of “bodily injury” or “property damage” to which this insurance applies . . . .

As noted above, business insureds can incur some extraordinary risks. The general liability policy is designed to cover *ordinary* business risks – those common to most businesses. For that reason, general liability policies contain certain exclusions in attempt to reign in *extraordinary* exposures. One such exclusion is the “professional services” exclusion. The professional services exclusion, although not a part of the standard general liability policy, is often added by endorsement when the policyholder is a professional and/or engages in the rendering of services that can be deemed to require special skill or knowledge.

There are different professional services exclusion endorsements for different professions. A generic professional services exclusion endorsement may state:

This insurance does not apply to “bodily injury,” “property damage,” or “personal and advertising injury” due to the rendering of or the failure to render any professional service.

Alternatively, the policy may include a profession-specific exclusion. For example, a pharmacy may be issued a general liability policy containing a professional services exclusion stating:

This insurance does not apply to “bodily injury,” “property damage” or “personal and advertising injury” arising out of the rendering or failure to render professional health care services as a pharmacist.



As discussed below, even when the exclusion is profession-specific, it may still be deemed ambiguous by the court interpreting it.

## **B. Professional Liability Insurance**

Professional liability insurance is designed, in part, to fill the gap created by the professional services exclusion in a general liability policy. This insurance provides coverage for the defense and indemnification of claims alleging errors and omissions in the rendering of professional services. Additionally, professional liability insurance provides coverage for damages not otherwise covered by general liability policies. General liability policies will only respond to bodily injury, property damage, personal injury or advertising injury claims. Often times, the rendering of a professional service by accountants, investment advisors, and corporate directors and officers can result in *financial* losses. While such losses are not normally covered under general liability policies, they are typically covered under professional liability policies.

Unlike general liability policies, the vast majority of professional liability policies are issued on a “claims-made” basis. Under a claims-made policy, coverage is triggered by a claim made against the insured during the policy period alleging a wrongful act, error, or omission. Some claims-made policies include the additional requirement that the claim be reported to the insurer during the policy period or during an extended reporting period. Additionally, many claims-made policies include a retroactive date which requires that the wrongful act, error, or omission which forms the subject of the claim take place on or after the retroactive date.

Professional liability insurance is necessary for anyone engaged in the rendering of professional services, including lawyers, accountants, appraisers, architects, engineers and other designers, medical doctors, nurses, dentists, psychologists, hospitals, clinics and nursing homes, agents and brokers, directors and officers, bankers, underwriters, and investment fund managers.

## 1. The Policy Definition of Professional Services Is Often Superficial

What constitutes a professional service has been the subject of much litigation across the country. Many general liability and professional liability policies make little effort to define the term *professional services*. Even where the term is defined in a policy, the definition is little more than a statement to the effect that professional services means “any services of a recognized profession,” such as medical services, or “includes but is not limited to” a list of services, such as medical, surgical, dental or nursing services to a patient. The lack of an adequate definition within the policy can be problematic because today people often use the term professional to refer to a wide array of occupations. Further, professionals are often assisted by non-professionals and/or paraprofessional personnel, who sometimes perform services requiring no particular technical expertise. As a result, it is often left for the courts to determine whether or not a particular claim constitutes a professional service.

The landmark case discussing the definition of professional services is *Marx v. Hartford Accident and Indemnity Co.*,<sup>1</sup> a 1968 decision issued by the Nebraska Supreme Court. *Marx* involved a fire damage claim that occurred when the insured’s employee accidentally put benzene, rather than water, into a sterilization container. The issue in that case was whether the claim was covered under the insured’s professional liability policy. In determining whether the insured’s employee was engaged in a professional service, the Nebraska Supreme Court determined that the term ‘professional’ in the context used in the policy meant “something more than mere proficiency in the performance of a task and implies intellectual skill as contrasted with that used in an occupation for production or sale of commodities.” The court stated that:

A ‘professional’ act or service is one arising out of a vocation, calling, occupation, or employment involving specialized knowledge, labor, or skill, and the labor or skill involved is predominantly mental or intellectual, rather than physical or manual. . . . In determining whether a particular act is of a professional nature or a ‘professional service’ we must look not to

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<sup>1</sup> 157 N.W.2d 870 (Neb. 1968).

the title or character of the party performing the act, but to the act itself.”<sup>2</sup>

The court then held that the act of boiling water for sterilization, by itself, did not constitute an act necessitating professional knowledge or training because any unskilled person could perform the routine cleaning of equipment. Accordingly, there was no coverage under the insured’s professional liability policy.

Although the *Marx* case involved the scope of coverage under a professional liability policy, the decision has been consistently cited and relied upon by many courts in connection with determining whether a claim is *excluded* from coverage under the professional liability exclusion in general liability policies.<sup>3</sup> This, however, does not mean that the professional services exclusion in a general liability policy has precisely the same scope as the coverage afforded for professional services under a professional liability policy. Courts typically construe insuring agreements broadly, in a manner that broadens coverage. Exclusions, on the other hand, are usually construed narrowly and strictly, again in a way calculated to broaden coverage. This means that the court may well apply the term professional services differently, depending on the term’s location and function in the policy.

## **2. The Term Professional Services May Be Ambiguous**

Similarly, as ambiguities in the contract are generally construed against the insurer, courts have determined that the term professional services is ambiguous, allowing for inconsistent results depending on the term’s location in the policy. Thus, the court may hold that a particular claim involves a professional service if the ambiguous term is contained in the insuring clause of a professional liability policy. But, where the professional services exclusion

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<sup>2</sup> *Id.* at 871.

<sup>3</sup> See, e.g., *Harad v. Aetna Cas. & Sur. Co.*, 839 F.2d 979, 984 (3d Cir. 1988) (adopting *Marx* definition of professional services in the context of a professional services exclusion in a general liability policy issued to an attorney); *W. Nat’l Mut. Ins. Co. v. Structural Restoration, Inc.*, No. A09-1598, 2010 Minn. App. Unpub. LEXIS 406 (Minn. Ct. App. May 4, 2010).

in a general liability policy is determined to be ambiguous, that same claim may be viewed by the court as not constituting a professional service.

For example, in *URS Corp. v. Tristate Environmental Management Services, Inc.*,<sup>4</sup> the claimant asserted negligent supervision claims against URS in connection with a drilling project that caused damage to underground cables. URS was an additional insured under a liability policy issued to its subcontractor which provided coverage for general liability, professional liability, and contractor's pollution liability. URS was only covered under the general liability portion of the policy. The general liability form included a broadly worded professional services exclusion which precluded coverage for property damage arising out of the rendering or failure to render any professional service, including but not limited to "supervision, inspection, construction or project management, and quality control or engineering services." But the policy also included a number of endorsements which appeared to have been specifically negotiated for the project at issue, including an endorsement which defined professional services more narrowly as "environmental consulting services." The insurer argued that the claim against URS was excluded by the broadly worded professional liability exclusion, and that the definition of professional services in the endorsement was inapplicable because it applied only to the "contractors pollution legal liability coverage."

The court determined that the policy definition of professional services was ambiguous and construed the provisions against the insurer. The court held that the professional liability exclusion in the general liability coverage form was modified by the endorsement which defined professional services as "environmental consulting services." The court, therefore, held that the exclusion was inapplicable to the claims against URS which alleged negligence in the maintenance, operation and supervision of the drilling project that caused damage to the underground cables.

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<sup>4</sup> No. 08-154, 2008 U.S. Dist. LEXIS 57049 (E.D. Pa. July 28, 2008).

Similarly, in *State Farm & Cas. Co. v. Lorrick Pac., LLC*,<sup>5</sup> the owner of a building sued the general contractor, asserting various claims including faulty workmanship and improper coordination of subcontractors. The general contractor's insurer filed a declaratory judgment action, arguing that the professional services exclusion in its contractors insurance policy barred coverage for the claim. The professional services exclusion set forth examples of "professional services," including legal, accounting, engineering, architectural, "supervisory or inspection," medical, and veterinary services. Although "professional services" included "supervisory" services, it did not specifically include "coordinating" services, including coordinating the work of subcontractors. In light of the specific list of services, the court found that absence of coordinating services to be significant.

On the other hand, the professional services exclusion in a general liability policy may sometimes exclude a broader range of activities than those that are included within the basic coverage of a professional liability policy. For example, the general liability exclusion may preclude coverage for conduct relating to *any* professional services, while the professional liability policy may only offer coverage for a specific type of professional service, *e.g.*, "medical professional services." At times, a broadly worded exclusion can be problematic.

In *Admiral Insurance Co. v. Ford*,<sup>6</sup> for example, a consultant was retained to develop a drilling plan for an oil well and asked to assist with the drilling of the well. During drilling, the oil well had a blowout. The insured consultant was sued for damages and sought covered under a professional liability policy and general liability policy issued by Admiral. Admiral paid under the professional liability policy, but denied coverage under the general liability policy citing to the professional services exclusion. The insured countered that because the professional services exclusion purported to apply to "all operations of the insured," the exclusion destroyed any grant of general liability coverage and, therefore, should not be given effect. The district court agreed

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<sup>5</sup> 2012 WL 1432603 (D. Or. Apr. 24, 2012).

<sup>6</sup> 607 F.3d 420 (5th Cir. 2010).

with the insured's argument, rendering the exclusion illusory, and held that the "broad description of professional services obliterated the entire insurance policy, and gave the exclusion no effect."

On appeal, the Fifth Circuit reversed, holding that, although the exclusion was "confusingly worded," the only reasonable interpretation was to apply the legal definition of professional services which excluded coverage for professional services in any of the insured's operations. Although some of the claims against the insured were based on the insured's failure to properly perform menial tasks, the insured was retained for its specialized knowledge and training, and, therefore, the claims asserted against it were excluded from general liability coverage as professional services.

### **C. Administrative Activities**

It is somewhat common for claims arising out of basic, administrative activities to be asserted against professionals. Courts have generally held that policies covering professional services reach only those acts committed by the insured in his or her capacity as a professional. Thus, professional services do not include general administrative activities that occur in all types of businesses.<sup>7</sup> For example, courts have uniformly held that allegations arising from the billing practices of a professional office are not professional services.<sup>8</sup> Similarly, employment decisions relating to non-professionals generally do not constitute professional services.<sup>9</sup> Likewise, a

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<sup>7</sup> See, e.g., *Massamont Ins. Agency, Inc. v. Utica Mut. Ins. Co.*, 489 F.3d 71 (1st Cir. 2007) (holding that the rendering of a business decision does not constitute a professional service, even if done by a professional).

<sup>8</sup> See *Cont'l Cas. Co. v. Donald T. Bertucci, Ltd.*, 926 N.E.2d 833 (Ill. App. Ct. 2010) (attorney's wrongful retention of money is a business practice independent of the lawyer-client relationship and is therefore not a professional service); *Zurich Am. Ins. Co. v. O'Hara Reg'l Ctr. for Rehab*, 529 F.3d 916 (10th Cir. 2008) (holding that false and fraudulent billing practices of a rehabilitation facility do not trigger professional liability coverage because billing does not constitute a professional service); *Med. Records Assocs., Inc. v. Empire Surplus Lines Ins. Co.*, 142 F.3d 512, 514 (1st Cir. 1998) (holding that medical records processing company's alleged conduct in overcharging its clients was not covered by its professional liability policy).

<sup>9</sup> See *Inglewood Radiology Med. Grp., Inc. v. Hosp. Shared Servs., Inc.*, 266 Cal.Rptr. 501, 503 (Ct. App. 1989) (holding that professional liability policy did not cover a lawsuit concerning a physician's decision to fire employee, even though the physician's medical knowledge was required to make employment evaluations).

professional's failure to pay for services rendered is not a professional service.<sup>10</sup> Nor is the renting of an office or the engagement of employees a professional service.<sup>11</sup>

Professional services do not include acts by professionals that do not require technical expertise. For example, in *Thermo Terratech v. GDC Enviro-Solutions, Inc.*,<sup>12</sup> an engineer caused a fire when he disconnected the control panel of an incinerator. The court held that the professional services exclusion in the general liability policy did not apply. The court reasoned that the removal of the control panel, although performed by an engineer, "could have been performed by individuals who had neither engineering training nor the ability to exercise special judgment unique to the field of engineering."

Similarly, in *American Casualty Co. v. Hartford Insurance Co.*,<sup>13</sup> a 76 year-old patient was injured in a fall after an EKG technician instructed him to enter the EKG examination room, remove his shirt and place himself on the examination table. In holding that the claim was properly covered by the insured's general liability insurer rather than its professional liability insurer, the court stated that the actions of the EKG technician were purely mechanical and administrative in nature, did not require the exercise of any special training, and could be performed by any unskilled or untrained employee.<sup>14</sup>

Sometimes, however, an act which may appear to be administrative or ministerial can be held to constitute a professional service if the court deems that the seemingly administrative act arises from the performance of professional services. For example, in *American Economy Insurance Co. v. Jackson*,<sup>15</sup> the administrator of a nursing home facility allegedly failed to engage the facility's air conditioning system during a heat wave. As a result of this decision,

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<sup>10</sup> See *Cohen v. Empire Cas. Co.*, 771 P.2d 29 (Col. Ct. App. 1989) (holding that one attorney's failure to pay another for services rendered was not covered by a professional liability policy).

<sup>11</sup> See *Hampton Med. Grp. v. Med. Inter-Ins. Exch. of NJ*, 366 N.J. Super. 165, 840 A.2d 915 (2004).

<sup>12</sup> 265 F.3d 329 (5th Cir. 2001).

<sup>13</sup> 479 So.2d 577 (La. Ct. App. 1985).

<sup>14</sup> See also *D'Antonio v. Sara Mayo Hosp.*, 144 So.2d 643 (La. Ct. App. 1962) (the raising of a bed side rail was a purely mechanical act that could be performed by any unskilled person).

<sup>15</sup> 476 F.3d 620 (8th Cir. 2007).

four nursing home residents died from heat exposure. The court held that the claims were excluded under the general liability policy by the professional services exclusion. The court explained that “although the failure to engage the HVAC system’s air conditioning could be considered a ministerial or administrative act,” the facts in that case showed that the administrator’s decisions “are all decisions that were made using specialized training, skill, experience, and knowledge . . . and the action or inaction involved in regulating the temperature was a ‘nursing’ or ‘health’ service.”

Likewise, in *Duncanville Diagnostic Center, Inc. v. Atlantic Lloyd’s Insurance Co. of Texas*,<sup>16</sup> a patient died after receiving an incorrect dosage of medicine at a diagnostic center. The insured argued that the professional services exclusion in its general liability policy was not applicable because the allegedly negligent acts, such as documenting drug dosages, required only clerical skills. The court held that the professional services exclusion applied because the administration of drugs requires the exercise of trained medical judgment. Furthermore, the skills involved in rendering these medical services are predominantly intellectual as opposed to physical.

Sometimes a professional’s employment related decisions and supervisory role will be held to constitute professional services because the selection and supervision of one’s own employees is a component of a professional’s job. For example in *Millers Casualty Insurance Co. of Texas v. Flores*,<sup>17</sup> a patient suffered a debilitating stroke when an unsupervised and untrained physician’s assistant injected her with estrogen which was contraindicated. Here, the assistant was the employee of a professional and was not herself a professional. Nonetheless, the court held that the “professional services” exclusion applied to preclude coverage under the general liability policy because the insured physician was “in the business of providing medical services to patients,” which included hiring and supervising his non-professional employees.

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<sup>16</sup> 875 S.W.2d 788 (Tex. App. 1994).

<sup>17</sup> 876 P.2d 227 (N.M. 1994).



Likewise, in *National Fire Insurance Co. of Hartford v. Briseis Kilfoy*,<sup>18</sup> the plaintiff filed a negligent hiring suit against a professional who had previously hired physicians to work at his clinic. The court held that the professional services exclusion in the general liability policy applied to the professional's action of hiring professional employees because "unlike performing an administrative act, the determination of whether a physician is qualified to render professional services requires specialized knowledge and skill." In essence, the court distinguished between hiring procedures that involve administrative reviews (which do not constitute professional services) and hiring procedures that are an intellectual endeavor and involve the application of specialized knowledge (thereby constituting professional services).<sup>19</sup>

Similarly, in *Lansing Community College v. National Union Fire Ins. Co.*,<sup>20</sup> an individual was wrongly convicted of murder. Upon exoneration, he sued various defendants, including the investigating police force. The general liability insurer denied coverage, citing the professional services exclusion in the liability policy, and the court agreed with the insurer's position, holding that police services constitute professional services because police require specialized training and education. Moreover, the court also held that any clerical errors in organizing or maintaining the files are professional services, because they arose out of the professional services, namely the criminal investigation and prosecution.

#### **D. Sexual Assaults Committed by Professionals**

Sexual assaults committed by a professional are generally not professional services.<sup>21</sup> Instead, they are performed merely to satisfy the professional's prurient interests. Often,

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<sup>18</sup> 874 N.E.2d 196 (Ill. App. Ct. 2007).

<sup>19</sup> See also, *Colony Ins. Co. v. Suncoast Med. Clinic, LLC*, 726 F. Supp.2d 1369 (M.D. Fla. 2010) (holding that professional services exclusion applied because complaint alleged a failure to have in place adequate policies, procedures, staff and assistive technology to ensure performance of diagnostic tests and communication between medical personnel, which was an intricate part of the medical services provided by the center).

<sup>20</sup> 2010 U.S. Dist. LEXIS 17696 (W.D. Mich. March 1, 2010).

<sup>21</sup> See *Smith v. St. Paul Fire & Marine Ins. Co.*, 353 N.W.2d 130 (Minn. 1984); *Hirst v. St. Paul Fire & Marine Ins. Co.*, 683 P.2d 440 (Idaho Ct. App. 1984); *Standard Fire Ins. Co. v. Blakeslee*, 771 P.2d 1172, review denied, 781 P.2d 1320 (Wash. 1989). But see *St. Paul Fire & Marine Ins. Co. v. Shernow*, 610

however, a different standard applies to psychologists and psychiatrists where it is alleged that the therapist mishandled the patient's transference. The transference phenomenon is the process by which a patient's emotions and desires for one person, such as a spouse, are unconsciously shifted to another person, usually the analyst. Numerous courts have held that a therapist is engaged in a professional service where the claim alleges an improper sexual relationship with a patient suffering from the transference phenomenon, because the sexual conduct is related to the therapy and the transference phenomenon renders the patient particularly vulnerable.

For example, in *L.L. v. Medical Protective Co.*,<sup>22</sup> a psychiatrist engaged in sexual acts with a patient during therapy sessions. The court held that the professional liability policy covered the doctor's conduct because "a sexual relationship between therapist and patient [suffering from the transference phenomenon] cannot be viewed separately from the therapeutic relationship that has developed between them." Thus, the sexual conduct had such a strong tie to the therapy that it was covered by the doctor's professional liability policy. Similarly, in *St. Paul Fire & Marine Insurance Co. v. Love*,<sup>23</sup> a psychologist and his patient engaged in a two-month long sexual relationship. The court held that the doctor's actions were covered under the professional liability policy because the "sexual conduct between the therapist and patient arising from the transference phenomenon may be viewed as the consequence of a failure to provide proper treatment of the transference."

#### **E. Professional Services Performed by Non-Professionals**

Sometimes actions of *non*-professionals are held to constitute professional services. This is because the nature of the conduct (and not the employment position of the actor) ultimately controls the outcome. In *Utica Lloyd's of Texas v. Sitech Engineering Corp.*,<sup>24</sup> engineering and

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A.2d 1281 (Conn. 1992) (holding that coverage under professional liability policy extended to injuries sustained by patient when dentist, in the course of treatment, sexually assaulted her, having overcome her ability to resist through misuse of anesthesia).

<sup>22</sup> 362 N.W.2d 174 (Wis. Ct. App. 1984).

<sup>23</sup> 459 N.W.2d 698 (Minn. 1990).

<sup>24</sup> 38 S.W.3d 260 (Tex. App. 2001).

non-engineering personnel were working together in an excavation project when a trench caved, killing an employee. The court held that the professional services exclusion in a general liability policy applied to both the engineering and non-engineering personnel because the corporation, as a unit, was engaged in the professional service of excavation.

On the other hand, in *Duke University v. St. Paul Fire & Marine Insurance Co.*,<sup>25</sup> a patient at a dialysis center suffered fatal injuries when employees dropped her on the floor while attempting to move her from a dialysis chair to her wheelchair. The court held that stabilizing the patient and securing the dialysis chair did not constitute a professional service because “these tasks are purely manual” and their performance “would not require any special skills or training.”

Similarly in *Cochran v. B.J. Services Co. U.S.A.*,<sup>26</sup> a non-professional employee was injured while removing a cement head from a casing on the top of a drilling rig. The employee alleged that the contractor’s failure to adequately supervise his employees caused the injury. The court held that the routine task of removing a cement head was not a professional service and the court stated that the contractor’s supervisory role would only be classified as a professional service if he were to supervise an action which necessitated the employee’s specialized expertise or skill.

#### **F. Professional Services Rendered to Non-Clients**

In certain circumstances, coverage may extend to claims of non-clients where it is established that the claim arises from the insured’s rendering or failure to render professional services. This arises often in the context of financial lines coverage such as directors and officers liability insurance and professional liability insurance to investment bankers and underwriters. In some policies, however, the professional services definition may limit coverage to claims asserted by clients. Where the definition does not limit coverage to clients’ claims,

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<sup>25</sup> 386 S.E.2d 762 (N.C. Ct. App. 1990).

<sup>26</sup> 302 F.3d 499 (5th Cir. 2002).

however, it is likely there will be coverage for non-client claims. *Harad v. Aetna Casualty & Surety Co.*<sup>27</sup> involved a malicious prosecution claim filed against an attorney by a non-client. The court held that the claim constituted a professional services claim because the policy definition did not limit coverage to claims of clients and because the claim arose from the attorney's rendering of professional legal services.

### **G. Claims That Potentially Trigger Both General Liability and Professional Liability Coverage**

Sometimes an insured will hold both a general liability policy and professional liability policy, but the general liability policy does not contain a professional services exclusion. In this situation, a problem arises if the policyholder files a claim that could lead to coverage under both policies. The outcome of such situations may depend on the court's interpretation of the language in both policies and other clauses, such as anti-stacking provisions, that may be contained in the policies.

In *U.S. Fire Insurance Co. v. Scottsdale Insurance Co.*,<sup>28</sup> U.S. Fire issued the insured nursing home a liability policy containing both a general liability coverage form and a professional liability coverage form. The general liability coverage form, however, provided liability limits of \$2 million, while the professional liability coverage form provided liability limits of only \$1 million. The general liability coverage form did not include a professional services exclusion. After a wrongful death claim was commenced against the nursing home, U.S. Fire paid only its \$1 million limits under the professional liability portion of the policy. In the coverage action that ensued, U.S. Fire argued that it would be unreasonable to afford general liability coverage to a professional liability claim because that would render the entire professional liability coverage form superfluous. Scottsdale, the excess insurer, argued that the

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<sup>27</sup> 839 F.2d 979, 984 (3d Cir. 1988). See also *Navigators Specialty Ins. Co. v. Scarinci and Hollenbeck, LLC*, 2010 U.S. Dist. LEXIS 47124 (D. N.J. 2010) (finding lawyers' professional liability policy extended to claims by non-clients because the insuring agreement did "not require that those...who were the direct recipients of professional services, be the parties who bring the claims.").

<sup>28</sup> 2008 Tex. App. LEXIS 64 (Tex. App. 2008).

wrongful death claim triggered both coverage parts and that therefore, the claim was subject to the \$2 million general liability limit.

The court rejected U.S. Fire's contention that the professional liability coverage alone should apply to the underlying claim. First, the court observed that the underlying claim fell within the literal terms of both the general liability and the professional liability coverage parts. Second, the court reasoned that the general liability policy did not render the professional liability coverage superfluous. To bolster its point, the court cited examples of certain claims that would fall under the professional liability coverage, but not the general liability coverage. Third, the court declined to insert an exclusion into the general liability coverage that simply was not present. Finally, the court held that the anti-stacking provision in the professional liability coverage part clearly indicated an awareness by the parties that the coverage provided under the professional liability coverage form could overlap with coverage provided by other forms within the same policy.

In *S.T. Hudson Engineers, Inc. v. Pennsylvania National Mutual Casualty Co.*,<sup>29</sup> an engineering firm was named in several lawsuits resulting from the collapse of a pier the firm was retained to repair and monitor. The firm tendered its defense and indemnity to its professional liability carrier, as well as to its general liability carrier. After the professional liability carrier settled, the New Jersey Appellate Division explored the relationship between three clauses commonly contained in policies issued to professionals: (1) the professional services exclusion in a general liability policy, (2) the products-completed operations coverage in that same general liability policy, and (3) the exclusion of products-completed operations coverage in a professional indemnity policy. The court was asked to determine whether the general liability policy was triggered by the failure to warn and misrepresentation regarding a known danger claims that accompanied numerous professional negligence claims.

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<sup>29</sup> 909 A.2d 1156 (N.J. Super. Ct. App. Div. 2006).

The court determined that the professional services exclusion in the general liability policy spoke in terms of the various professional services actually performed by the insured. By contrast, the products-completed operations coverage for the failure to provide warnings did not emanate from the performance or failure to perform actual professional services but the giving or failure to provide information. Because it was the nature of the act or omission, and not the resulting damage, that was determinative of coverage, the court held that the claims (1) clearly fell within the products-completed operations coverage of the general liability policy, (2) were not excluded by the professional services exclusion in the general liability policy, and, indeed (3) would not have been excluded by the professional services exclusion even absent the products-completed operations provision. According to the court, any other interpretation of the general liability policy would not have met the insured's reasonable expectation of coverage for this class of liability.

#### **H. Take-Away Points**

What general points can we take from these cases?

First, insurance professionals should not focus exclusively on the title of the person who committed the act or omission when determining whether a professional service is implicated because: (1) there is room for argument over who is or who is not a professional; and (2) the identity of the actor matters, but is not, by itself, determinative because not everything a professional does is a professional service.

Second, when determining whether conduct constitutes a professional service, most courts focus on the nature of the conduct. That is, the question of coverage usually turns on the nature and context of the alleged conduct.

Third, professional services involve the use of specialized training or knowledge and do not typically involve physical endeavors that do not require a specific skill.

Fourth, conduct may be a professional service even if performed by non-professionals, paraprofessionals, or independent contractors.

Fifth, the location within the policy of the term professional services may influence how a court interprets and applies it. Courts usually read insuring agreements broadly and exclusions narrowly so as to broaden the coverage afforded under the policy.

Finally, the definition of professional services, if any, will likely have an impact.

While sometimes the decisions in these general liability versus professional liability cases are result-oriented, these factors provide claims professionals with some guidance in resolving the question of whether a particular claim is a general liability claim or a professional liability claim.

Kathryn M. Rutigliano, Esq.  
Cozen O'Connor  
1900 Market Street  
Philadelphia, PA 19103

Chapter Two:

## **Appendix A: PowerPoint: Whose Line Is It?**

**Kathryn M. Rutigliano, Esquire**  
Cozen O'Connor  
Philadelphia





# Whose Line Is It?

Pennsylvania Bar Institute  
Claims Made and Professional  
Liability Insurance Coverage

Spring 2014

Kathryn Rutigliano, Global Insurance Department  
Cozen O'Connor, 1900 Market St., Philadelphia, PA 19103  
(215) 665-2090



## PROFESSIONALS FACE WIDE VARIETY OF LIABILITY RISKS

Professionals face a wide variety of liability risks, including:

- Bodily injury, property damage, and financial losses suffered by clients arising out of the rendering or failure to render professional services
- Bodily injury and property damage suffered by clients and non-clients unrelated to the rendering or failure to render professional services
- Bodily injury suffered by employees
- Wrongful termination, harassment and retaliation suffered by employees
- Libel and slander suffered by third parties
- Copyright, patent and trademark infringement suffered by third parties



## **PROFESSIONAL LIABILITY IS OFTEN EXCLUDED FROM GENERAL LIABILITY POLICIES**

- Claims involving professional services are typically excluded under CGL policies, so most professionals purchase separate professional liability coverage.
- Though general and professional liability policies are designed to cover different risks, it can be difficult to determine which coverage a claim implicates; some claims may trigger both coverages.
- Whether a claim triggers coverage under a professional's general liability or professional liability policy, or both, may have significant implications for both the insured and the insurer(s) since one or the other policy may offer broader coverage terms.



## **GENERAL LIABILITY POLICIES AND PROFESSIONAL LIABILITY POLICIES ARE OFTEN SUBJECT TO DIFFERENT TRIGGER**

- General Liability policies: typically occurrence-based, triggered by "bodily injury" or "property" damage that occurs during the policy period.
- Professional Liability policies: typically claims-made, triggered by a claim made against the insured during the policy period.
- An insured's negligence causing an injury in year one resulting in a lawsuit filed against the insured in year two could trigger a general liability policy in force in year one. That same claim would most likely trigger coverage under a professional liability policy in force during year two.



## **TRIGGER: CONTINUING INJURIES**

While a continuing injury or progressive loss claim may trigger multiple general liability policies in force during multiple policy years, that same injury may only trigger one professional liability policy in force during the policy year in which the claim is made.

- Bodily injury claim against nursing home
- Claim contains allegations of pressure sores that developed during years one and two. A lawsuit is filed against the insured in year two.
- Under a professional liability policy, the triggering event—the filing of a claim—occurred in year two and triggers only the professional liability policy in effect during year two.
- In contrast, under a general liability policy, the triggering event—the development of pressure sores—occurred during year one and year two. Therefore, the general liability policies in effect during both coverage years could be triggered and subject to allocation.



## **LIMITS AVAILABLE FOR DEFENSE**

- Professional Liability: defense costs are typically not payable by the insurer in addition to the limit of liability stated in the policy declarations. Defense costs are part of loss and as such are subject to the limit of liability for the loss.
- General Liability: defense costs are typically supplementary payments paid by the insurer in addition to the limit of liability stated in the policy declarations.



## COMMERCIAL GENERAL LIABILITY INSURANCE

- Commercial General Liability (“CGL”) promises to defend and indemnify business owners from liability for accidental bodily injury and property damage to third parties, with certain exclusions.
- Examples of claims typically covered under CGL:
  - a slip and fall on the business premises
  - food poisoning from a meal
  - water damage to another tenant’s property caused by an employee’s failure to shut off a faucet
  - misappropriation of advertising ideas or infringement of a copyright
  - an injury to someone’s reputation caused by defamatory statements
  - damage caused by a component part manufactured by the business
  - negligent supervision of discrimination by employees
  - wrongful eviction of a tenant
  - civil rights claims against security personnel



## INSURING AGREEMENT

General Liability coverage forms typically begin broadly expressing what the policy covers, and then listing exclusions from that coverage. By way of example, the 1986 ISO policy form insuring agreement for coverage A reads, in pertinent part:

We will pay those sums that the insured becomes legally obligated to pay as damages because of “bodily injury” or “property damage” to which this insurance applies. We will have the right and duty to defend the insured against any “suit” seeking those damages...



## **PROFESSIONAL SERVICES EXCLUSION**

- General liability policies are designed to cover ordinary business risks. For that reason, general liability policies contain certain exclusions in attempt to reign in extraordinary exposures. One such exclusion is the “Professional Services” exclusion.
- The professional services exclusion is not a part of the standard general liability policy. Instead, it is often added by endorsement when the policyholder is a professional. There are different endorsements for different professions.



## **STANDARD PROFESSIONAL LIABILITY EXCLUSION**

ISO has a generic 1998 professional services exclusion endorsement, which states in relevant part:

“This insurance does not apply to ‘bodily injury,’ ‘property damage,’ or ‘personal and advertising injury’ due to the rendering of or the failure to render any professional service.”



## **PROFESSIONAL LIABILITY INSURANCE**

- Professional Liability Insurance “fills the gap” created by the professional services exclusion in the general liability policy.
- General liability insurance policies only respond to bodily injury, property damage, personal injury or advertising injury claims.
  - The rendering of a professional service can result in financial losses which are not covered under a general liability policy.



## **WHO IS COVERED**

Anyone engaged in a profession is subject to professional exposures including:

- Lawyers
- Accountants
- Appraisers
- Architects
- Engineers and other designers
- Medical doctors, Dentists, Psychologists
- Hospitals, clinics and nursing homes
- Agents and Brokers
- Directors and Officers
- Bankers, Underwriters, & Investment Fund Managers



## WHAT IS COVERED

Professional liability insurance protects professional practitioners against certain claims made by their clients. This insurance provides coverage for the defense and indemnification of claims alleging errors and omissions in the rendering of professional services.



## COVERAGE TRIGGER

- Professional liability policies are often, but not always, “claims-made” policies. Under a claims-made policy, coverage is triggered by a “claim” made against the insured during the policy period alleging a wrongful act, error, or omission.
- Some claims-made policies include the additional requirement that the claim be reported to the insurer during the policy period or during an “Extended Reporting Period.”
- Additionally, many claims made policies include a “Retroactive Date” which requires that the wrongful act, error, or omission which is the subject of the claim take place on or after the Retroactive Date.





## PROFESSIONAL SERVICE DEFINED

- Many policies make little effort to define the phrase *professional services*, and even when defined, it is often merely a statement that *professional services* means “any services of a recognized profession” or “includes but is not limited to” a list of services.
- The lack of an adequate definition can be problematic, because today people often use the term professional to refer to a wide array of callings, vocations, occupations, and jobs.
- Further, professionals are often assisted by non-professionals or paraprofessional personnel, who sometimes perform services requiring no particular technical expertise.



## ***Marx v. Hartford Accident and Indemnity Co., 157 N.W.2d 870, 871 (Neb. 1968)***

- Landmark case defining the scope of professional services.
- Fire damage occurred when insured's employee accidentally put benzene, rather than water, into a sterilization container when refilling the host water sterilizer.
- The court held that the act of boiling water for sterilization by itself did not constitute an act necessitating professional knowledge or training because any unskilled person could conduct the routine of cleaning of equipment. Accordingly, there was no coverage under the professional liability policy.



### ***Marx v. Hartford Accident and Indemnity Co.*, 157 N.W.2d 870, 871 (Neb. 1968)**

- Nebraska Supreme Court: “professional” means something more than mere proficiency in the performance of a task and implies intellectual skill, as contrasted with that used in an occupation for production or sale of commodities.
- “A ‘professional’ act or service is one arising out of a vocation, calling, occupation, or employment involving specialized knowledge, labor, or skill, and the labor or skill involved is predominantly mental or intellectual, rather than physical or manual. ... In determining whether a particular act is of a professional nature or a ‘professional service’ we must look not to the title or character of the party performing the act, but to the act itself.”



### **APPLICATION OF *MARX* TO PROFESSIONAL LIABILITY EXCLUSION IN GENERAL LIABILITY POLICY**

- *Marx*: decided the scope of a professional liability policy, but is cited by courts determining whether coverage is excluded under a professional liability exclusion in a general liability policy.
- Scope of professional services exclusion is not the same as coverage afforded by a professional liability policy, as the term can appear in either an insuring agreement or an exclusion.
  - Courts usually read insuring agreements broadly.
  - Exclusions are usually read narrowly.
- This means the same court may well read a phrase like *professional services* differently in different cases, depending on its location and function in the policy.



## PROFESSIONAL SERVICES EXCLUSION WHERE TERM IS UNDEFINED

- Where a professional services exclusion in a general liability policy does not define “professional services,” courts examine the nature of the conduct and not the title of the actor, as well as whether the acts required special acumen and training.
- *David Lerner Assocs., Inc. v. Phila. Indem. Ins. Co.*, 934 F. Supp. 2d 533 (E.D. N.Y. 2013), *aff'd*, 2013 WL 6124329 (2d Cir. Nov. 21, 2013) (rejecting argument that undefined term “professional services” is ambiguous and holding that individuals engaged in the due diligence and sale of financial products are engaged in professional services).



## AMBIGUITIES CONSTRUED AGAINST INSURER

- *URS Corporation v. Tristate Environmental Management Services, Inc.*, 2008 U.S. Dist. LEXIS 57049 (E.D.Pa. 2008): URS was sued because it was allegedly negligent in supervising a drilling project which caused damage to underground cables.
- URS was an additional insured for general liability coverage under a policy issued to subcontractor which provided coverage for general liability, professional liability and contractor’s pollution legal liability.
- GL form subject to a professional liability exclusion which precluded coverage for property damage arising out of the rendering or failure to render any professional service, including but not limited to... supervision, inspection, construction or project management, quality control or engineering services.
- A specifically negotiated policy endorsement defined professional services as “environmental consulting services.”



- The insurer argued the claim was excluded by the broadly-worded professional liability exclusion and that the definition of professional services in the endorsement was inapplicable because it applied only to the “contractors pollution legal liability coverage.”
- The court determined that the policy definition of professional services was ambiguous and construed the provisions against the insurer.
- The court held that the professional liability exclusion in the general liability coverage form was modified by the endorsement which defined professional services as “environmental consulting services.” The court held that the exclusion was inapplicable to the claims against URS which alleged negligence in the maintenance, operation and supervision of the drilling project that caused damage to the underground cables.
- See also *State Farm & Cas. Co. v. Lorrick Pac., LLC*, 2012 WL 1432603 (D. Or. Apr. 24, 2012).



## **GL EXCLUSION MAY BE BROADER**

- On the other hand, sometimes the professional services exclusion in a general liability policy may exclude a broader range of activities than are included within the basic coverage of a malpractice policy. For example, the general liability exclusion may preclude coverage for conduct relating to any professional services while the professional liability policy only offers coverage for a specific type of professional service, i.e., “*medical professional services.*”



## PROFESSIONAL SERVICES DO NOT INCLUDE ADMINISTRATIVE SERVICES

- Policies covering “professional services” reach only those acts committed by the insured in his or her capacity as a professional, and do not include general administrative activities incidental to business, such as the billing practices of a professional office.
  - *Cont'l Cas. Co. v. Donald T. Bertucci, Ltd.*, 926 N.E.2d 833 (Ill. App. Ct. 2010) (attorney’s wrongful retention of money is a business practice independent of the lawyer-client relationship and is therefore not a professional service).
  - *Zurich Am. Ins. Co. v. O’Hara Reg’l Ctr. for Rehab.*, 529 F.3d 916 (10th Cir. 2008) (billing practices are incidental to nursing facility, and are not professional services).
  - *Medical Records Associates, Inc. v. Empire Surplus Lines Ins. Co.*, 142 F.3d 512, 514 (1st Cir. 1998) (holding that medical records processing company’s alleged conduct in overcharging its clients was not covered by its errors and omissions policy).
  - *National Union Fire Ins. Co. v. Shane & Shane Co.*, 605 N.E.2d 1325 (Ohio Ct. App. 1992) (holding that an attorney’s overcharging of a personal injury client was not covered by the attorney’s professional liability policy).



- Similarly the employment decisions relating to non-professionals do not generally constitute professional services.
  - *See Inglewood Radiology Medical Group, Inc. v. Hospital Shared Services, Inc.*, 266 Cal.Rptr. 501, 503 (Ct. App. 1989) (holding that professional malpractice insurance does not cover a lawsuit concerning a physician’s decision to fire employee, even though the physician’s medical knowledge was required to make employment evaluations).
- Likewise, a professional’s failure to pay for services rendered is not a professional service.
  - *See Cohen v. Empire Casualty Co.*, 771 P.2d 29 (Colo. Ct. App. 1989) (holding that one attorney’s failure to pay another for services rendered was not covered by a professional liability policy).
- Nor is the renting of an office or the engagement of employees a professional service.
  - *Hampton Medical Group v. Medical Inter-Insurance Exchange of NJ*, 366 N.J. Super. 165 (2004).



## ADMINISTRATIVE ACTS AS PROFESSIONAL SERVICES

An act which may appear to be administrative or ministerial can constitute a professional service if the seemingly administrative act arises from the performance of professional services.

- *American Economy Ins. Co. v. Jackson*, 476 F.3d 620 (8th Cir. 2007) (nursing home administrator's failure to turn on air conditioning system during a heat wave, killing four residents, used specialized training to provide a health services, thus claims were barred by the general liability policy's "professional services" exclusion).
- *Duncanville Diagnostic Ctr., Inc. v. Atlantic Lloyd's Ins. Co. of Texas*, 875 S.W.2d 788 (Tex. App. 1994) (patient dies after receiving an incorrect dosage of medicine at a diagnostic center, and professional services exclusion barred coverage for the claim because administering of drugs requires the exercise of trained medical judgment, and the skills involved in rendering medical services are predominantly intellectual rather than physical).



## PROFESSIONAL SERVICE EXCLUSION BARS COVERAGE

- An individual was wrongly convicted of murder. Upon exoneration, he sued various defendants, including the investigating police force.
- The general liability insurer denied coverage, citing the professional services exclusion in the liability policy, and the court agreed with the insurer's position.
- The court held that police services constitute professional services because police require specialized training and education.
- The court also held that any clerical errors in organizing or maintaining the files are professional services, because they arose out of the professional services, namely the criminal investigation and prosecution.
- *Lansing Cmty. College v. Nat'l Union Fire Ins. Co.*, 2010 U.S. Dist. LEXIS 17696 (W.D. Mich. March 1, 2010).



## **PROFESSIONAL SERVICES EXCLUSION DOES NOT BAR COVERAGE FOR PURELY MECHANICAL OR ADMINISTRATIVE ACTS**

- In contrast, in *American Casualty Company v. Hartford Insurance Company*, 479 So.2d 577 (La.App. 1985), the court held that instructing a patient to remove his clothing and climb onto an examination table did not constitute a professional service.
  - 76-year-old patient fell and sustained injuries after an EKG technician employed by the insured medical clinic instructed the patient to enter the EKG examination room, remove his shirt, and place himself on the examination table.
  - The claim was properly covered by the insured's CGL insurer rather than its PL insurer, because the actions of the technician were purely mechanical and administrative in nature, did not require the exercise of any special training, and could be performed by any unskilled or untrained employee.
- *D'Antonio v. Sara Mayo Hospital*, 144 So.2d 643 (La.App. 4<sup>th</sup> Cir. 1962) (holding that the raising of a bed side rail was a purely mechanical act that could be performed by any unskilled person).



## **PROFESSIONAL SERVICES REQUIRE EXPERTISE**

- *Hartford Fire Ins. Co. v. St. Paul Fire and Marine Ins. Co.*, 606 F. Supp. 2d 602 (E.D. N.C. 2009) (therapist driving patient to a medically-indicated event is not a professional service; service could have been rendered by any licensed driver, and thus was not covered by the healthcare facility professional liability policy).
- *Westfield Ins. Co. v. D & G Dollar Zone*, 2013 WL 951086 (Mich. Ct. App. Feb. 28, 2013) (the retail sale of cosmetic contact lenses was a routine act flowing from mere employment; sale did not involve "the rendering or failure to render any professional service" within the meaning of the exclusion).
- *Feszchak v. Pawtucket Mut. Ins. Co.*, 316 Fed. Appx. 181 (3d Cir. 2009) (failure to maintain exercise bike was manual or physical, thus the professional services exclusion did not bar coverage).
- *Thermo Terratech v. GDC Enviro-Solutions, Inc.*, 265 F.3d 329 (5th Cir. 2001) (fire caused by engineer removing incinerator's control panel not a professional service because removal of panel did not require engineering training).



## EMPLOYMENT-RELATED DECISIONS

- Sometimes employment-related decisions constitute “professional services” because the selection and supervision of employees is a component of a professional’s job.
- *Millers Cas. Ins. Co. of Texas v. Flores*, 876 P.2d 227 (N.M. 1994): a patient suffered a stroke when an unsupervised and untrained physician’s assistant injected her with estrogen which was contraindicated.
- The assistant was the employee of a professional and was not herself a professional.
- The “professional services” exclusion applied because the defendant physician was “in the business of providing medical services to patients,” which included hiring and supervising non-professional employees.
- See also *National Fire Ins. Co. of Hartford v. Briseis Kilfoy*, 874 N.E.2d 196 (Ill. App. 2007) (professional services exclusion applied to negligent hiring of physicians because “the determination of whether a physician is qualified to render professional services requires specialized knowledge and skill”).



## IMPROPER SEXUAL ACTS COMMITTED BY PROFESSIONALS

Sexual assaults committed by a professional are generally not professional services.

- In *Smith v. St. Paul Fire and Marine Ins. Co.*, 353 N.W.2d 130 (Minn. 1984), a physician sexually assaulted three minor patients during the course of a medical examination at his clinic. The court held that the professional liability policy did not cover the doctor’s conduct because his “acts of sexual contact were not part of medical treatment and involved neither the providing nor withholding of professional services.”
- See also *Hirst v. St. Paul Fire and Marine Ins. Co.*, 106 Idaho 792, 683 P.2d 440 (1984).





## EXCEPTION: TRANSFERENCE PHENOMENON

- Often a different standard applies when a psychologist or psychiatrist mishandles a patient's transference, because the sexual conduct is related to the therapy and the transference phenomenon renders the patient particularly vulnerable.
- *L.L. v. Medical Protective Co.*, 362 N.W.2d 174 (Wis. Ct. App. 1984): a psychiatrist's sex acts with a patient during therapy sessions were covered by the professional liability policy because "a sexual relationship between therapist and patient [suffering from transference] cannot be viewed separately from the therapeutic relationship that has developed between them."
- *St. Paul Fire & Marine Ins. Co. v. Love*, 459 N.W.2d 698 (Minn. 1990): claims arising from a psychologist's two-month sexual relationship with his patient were covered under the professional liability policy because the "sexual conduct between the therapist and patient arising from the transference phenomenon may be viewed as the consequence of a failure to provide proper treatment of the transference."



## SEXUAL ACT EXCLUSION

- Many insurers now include "sexual act" exclusions in professional liability policies, which courts generally enforce. Cases hold that a professional liability policy does not apply to claims arising from sex acts between a psychologist/ psychiatrist and his patient.
- *Govar v. Chicago Ins. Co.*, 879 F.2d 1581 (8th Cir. 1989): a psychologist had a sexual relationship with his patient during the course of her treatment. The psychologist's professional liability policy contained an exclusion for claims arising out of sexual acts and the court, applying Arkansas law, held that the policy did not provide coverage.
- *National Union Fire Ins. Co. v. Northwest Youth Services*, 983 P.2d 1144 (Wash. 1999): a patient alleged that her therapist had an improper sexual relationship with her. The therapist's professional liability policy contained an exclusion for "licentious, immoral or sexual behavior intended to lead to or culminating in any sexual act." The court held that this exclusion barred coverage under the policy.



## ACTS OF NON-PROFESSIONALS

Sometimes actions of *non*-professionals are held to constitute professional services. This is because the nature of the conduct (and not the job position of the actor) ultimately controls the outcome.

- In *Utica Lloyd's of Texas v. Sitech Engineering Corp.*, 38 S.W.3d 260 (Tex. App. 2001), engineering and non-engineering personnel were working together on an excavation site when a trench caved, killing an employee. The court held that the "professional services" exclusion in a general liability policy applied to both the engineering and non-engineering personnel because the corporation, as a unit, was engaged in the "professional service" of excavation.



## NON-PROFESSIONAL ACTS BY EMPLOYEES OF PROFESSIONALS

- *Duke University v. St. Paul Fire & Marine Ins. Co.*, 386 S.E.2d 762 (N.C. Ct. App. 1990): a dialysis center patient suffered fatal injuries when employees dropped her while moving her from a dialysis chair to a wheelchair. The court held that stabilizing the patient and securing the dialysis chair did not constitute a "professional service" because the tasks were purely manual and would not require any special skills or training.
- *Cochran v. B.J. Svcs. Co. U.S.A.*, 302 F.3d 499 (5th Cir. 2002): a non-professional employee was injured while removing a cement head from a casing on the top of a drilling rig. The employee alleged that the contractor's failure to adequately supervise his employees caused the injury. The court, applying Louisiana law, held that the routine task of removing a cement head was not a professional service and the court stated that the contractor's supervisory role would only be classified as a "professional service" if he were to supervise an action which necessitated the employee's specialized expertise or skill.



## CLAIMS OF NON-CLIENTS

- Where a professional liability claim against an insured is asserted by a non-client, courts examine the scope of the policy's insuring agreement.
  - Insured lawyers represented certain entities in connection with the foreclosure of a property owned by Bel Air. Bel Air sued the lawyers, claiming that they withheld material information and filed false papers with the court.
  - Professional liability insurer argued that the claims were not covered because they were not asserted by the lawyers' client.
  - The court disagreed, finding that the policy's insuring agreement did "not require that those...who were the direct recipients of professional services[] be the parties who bring the claims."
  - *Navigators Specialty Ins. Co. v. Scarinci and Hollenbeck, LLC*, 2010 U.S. Dist. LEXIS 47124 (D. N.J. 2010).
  - *But see Visiting Nurse Ass'n of Greater Philadelphia v. St. Paul Fire and Marine Ins. Co.*, 65 F.3d 1097 (3d Cir. 1995) (holding that professional liability coverage did not apply to a competitor's antitrust, RICO and state interference claims).



## CLAIM COVERED BY BOTH THE GENERAL AND PROFESSIONAL LIABILITY POLICIES

- In *U.S. Fire Ins. Co. v. Scottsdale Ins. Co.*, 2008 Tex. App. LEXIS 64 (Tex. App. 2008), U.S. Fire issued the insured nursing home a liability policy containing both a general liability coverage form and a professional liability coverage form. The general liability coverage form, however, provided liability limits of \$2 million, while the professional liability coverage form provided liability limits of only \$1 million. The general liability coverage form didn't include a "professional services" exclusion.
- A coverage dispute arose in the context of a wrongful death claim filed against the insured after U.S. Fire paid only its \$1 million limits under the professional liability portion of the policy. U.S. Fire argued that it would be unreasonable to afford general liability coverage to a professional liability claim because that would render the entire professional liability coverage form superfluous. Scottsdale, the excess insurer, argued that the wrongful death claim triggered both coverage parts and that therefore, the claim was subject to the \$2 million general liability limit.



- The court rejected U.S. Fire's contention that the professional liability coverage alone should apply to the underlying claim.
- First, the underlying claims fell within the literal terms of both the general liability and the professional liability coverage parts.
- Second, the general liability policy did not render the professional liability coverage superfluous. The court cited examples of certain claims that would fall under the professional liability coverage, but not the general liability coverage.
- Third, the court declined to insert an exclusion into the general liability coverage that simply wasn't present.
- And fourth, the anti-stacking provision in the professional liability coverage part clearly indicated an awareness by the parties that the coverage provided by the professional liability coverage form could overlap with coverage provided by other forms within the same policy.



## GENERAL PRINCIPLES

- The title of the person who committed the act or omission is not outcome determinative with respect to whether a *professional service* is implicated because: (1) there is room for argument over who a professional; and (2) it is not how the courts decide this issue.
- Not everything a professional does is a *professional service*.
- When determining whether something constitutes a *professional service*, the question of coverage usually turns on the nature and context of the alleged conduct.
- Professional services involve the use of specialized training or knowledge and do not typically involve physical endeavors.



## GENERAL PRINCIPLES

- Conduct may be a professional service even if performed by non-professionals, paraprofessionals, or independent contractors
- The context in which the policy uses the phrase *professional services* can make a difference in how a court interprets and applies it.
  - Insuring agreements are read broadly.
  - Exclusions are read narrowly.
- The precise definition of professional services makes a difference.
  - Does the policy define professional services broadly or does it limit its scope to acts performed in a certain profession?
  - Does the definition limit its application to claims by clients or does its scope also apply to claims of non-clients?



## Contact Information

**Kathryn M. Rutigliano**  
Associate, Global Insurance Department  
215-665-2090 | [krutigliano@cozen.com](mailto:krutigliano@cozen.com)  
[www.cozen.com](http://www.cozen.com)



Chapter Three:

## **PowerPoint: Selected Issues About D&O Insurance**

**Thomas M. Reiter, Esquire**  
K&L Gates LLP  
Pittsburgh



## Selected Issues About D&O Insurance

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### I. The Basics



## Selected Issues About D&O Insurance

- A. Liability Coverage (Not Property)
  - 1. Claims
  - 2. Cost of Defense, Settlement & Judgments
- B. Three Types of Coverage
  - 1. Claims Against Individuals That the Company **Does Not** Indemnify (“Side A”)

## Selected Issues About D&O Insurance

- 2. Claims Against Individuals That the Company **Does** Indemnify (“Side B”)
- 3. Claims Against the Company Itself (Side C)
  - a. Public Company (Securities Claims)
  - b. Private Company/Non-Profit (All Claims)

## Selected Issues About D&O Insurance

- C. Policy Are Claims-Made (Not Occurrence-Based)
  - 1. Was Claim Made Against Insured During the Policy Period?
  - 2. Timing of Wrongful Act Typically Not Relevant
- D. Which Individuals Are Covered?
  - 1. Varies
  - 2. Directors
  - 3. Officers
  - 4. Non-Officer Employees
  - 5. In-House Attorneys

## Selected Issues About D&O Insurance

- E. Basic Requirements for Claim to Be Covered
  - 1. "Claim"
  - 2. "First Made" During the Policy Period
  - 3. Against Covered "Insured"
  - 4. Based On A "Wrongful Act"
  - 5. Committed Within An Insured "Capacity"
  - 6. Exclusions Do Not Apply
  - 7. Conditions Complied With

## Selected Issues About D&O Insurance

### F. Miscellaneous Other Basic Points

1. "Loss"
2. Defense Costs Erode Limits
3. Programs Typically Layered (Primary and Excess)
4. Other Sources of Protection for Individuals
  - a. Company Indemnity

## Selected Issues About D&O Insurance

- b. Other Forms of Potential Insurance
  - i. General Liability
  - ii. E&O
  - iii. Personal Umbrella
  - iv. Outside Directorship Coverage

## Selected Issues About D&O Insurance

4. The Players
  - a. Company Personnel
    - i. Insurance
    - ii. Finance
    - iii. Legal
  - b. Broker-Intermediary
  - c. Outside Coverage Counsel
  - d. Insurer Underwriter/Counsel

## Selected Issues About D&O Insurance

- G. Why the Questions Matter
  1. Unlike Some Types of Insurance, Terms of D&O Insurance Contracts Vary Enormously
  2. Positive Effect of Heightened Interest on the Part of Boards/Senior Management
  3. Insurer "Willingness" to Change Terms/Endorsements
  4. Importance of Policy Wording
  5. Particular Importance of Policy Wording for Side A Claims

## II. Selected Issues

### **Selected Issues About D&O Insurance**

*No. 10. What Are the Terms of Indemnity Protection Available to Director Or Officer?*

- A. By-laws/Charter
- B. Contract
- C. Select Issues
  - 1. Mandatory vs. Permissive
  - 2. No Changes to Individual's Detriment

## Selected Issues About D&O Insurance

*No. 10. (Cont'd)*

3. "Fees On Fees"
4. Process Issues
5. Parent vs. Subsidiary
6. Potential Concerns Over Breadth

## Selected Issues About D&O Insurance

*No. 9. Does the Client Get to Choose Its Own Lawyer/Law Firm?*

- A. Duty to Defend
- B. Consent
- C. Panel Counsel
- D. Conflicts/Potential Conflicts

## Selected Issues About D&O Insurance

*No. 8. How Does the Client Know That It Has Enough Insurance/Not Too Much?*

- A. Surveys
- B. Models
- C. Defense Costs
- D. Side A DIC Limits
- E. Issues of Erosion/Depletion of Limits
- F. Benefits of Purchasing Limits Sooner Rather Than Later/Application
- G. The Problem of “Too Much”

## Selected Issues About D&O Insurance

*No. 7. What Steps Can the Client Take to Deal With Risk of Insurer Insolvency?*

- A. Process for Evaluating Financial Strength of Insurers
  - 1. Best's
  - 2. S&P
  - 3. Other
- B. Provisions in Insurance Program
  - 1. Ratings Endorsements
  - 2. Cut-Through Clause
  - 3. Drop-Down Provisions/In-Fill
  - 4. Diversification of Carriers

## Selected Issues About D&O Insurance

*No. 6. In What Respects (If Any) Is the Client's Excess Policies More Restrictive Than the Coverage Provided by the Primary Policy?*

- A. Following Form
- B. Differences
  - 1. Exclusions
  - 2. Conditions
- C. Shaving of Limits
  - 1. Large Claim
  - 2. Impacts Multiple Layers

## Selected Issues About D&O Insurance

*No. 6. (Cont'd)*

- 3. Coverage Issues
  - a. The Exhaustion Problem If Underlying Carrier Insists On Discount/Implications
  - b. "Shaving of Limits" Wording/Variations



## Selected Issues About D&O Insurance

### *No. 5. How Favorable Are the Client's D&O Program's "Conduct" Exclusions?*

- A. Fraud/Dishonesty
- B. Personal Profit
- C. Illegal Remuneration
- D. Key Concepts
  - 1. Type of Conduct – "Deliberate Fraud"

## Selected Issues About D&O Insurance

### *No. 5. (Cont'd)*

- 2. The Trigger: "In Fact;" Final Adjudication (Coverage Actions vs. Underlying Proceeding)
- 3. Defense Costs
- 4. Carve-Outs
  - a. Independent Directors?

## Selected Issues About D&O Insurance

*No. 4. How Favorable Is the Client's D&O Program's "Insured v. Insured" Exclusion?*

- A. Original Purpose (Collusion)
- B. Extensions/AIG/ACE
- C. Carve-Outs
- D. Bankruptcy
- E. "Assistance" of Insured

## Selected Issues About D&O Insurance

*No. 3. How Favorable Is the Client's D&O Program's Rescission Wording?*

- A. The Problem:
  - 1. Underlying Claim Based on Misstatement in Filings
  - 2. The Law of the Misrepresentation
    - a. Materiality
    - b. Scierter
    - c. "Innocents" Potentially Affected

## **Selected Issues About D&O Insurance**

*No. 3. (Cont'd)*

- B. “Severability” Clauses
  - 1. Materiality
  - 2. Scierter
  - 3. Hidden Exclusions

## **Selected Issues About D&O Insurance**

*No. 2. When Will the Client Get the Policy?*

- A. Binders
- B. Uncertainty

## Selected Issues About D&O Insurance

*No. 1. Does the Client Have (Enough) Side A Difference-In-Conditions Coverage?*

- A. What Is Side A DIC Coverage?
  - 1. Side A Only (Subgroups)
  - 2. Drop Down
    - a. Insurer Insolvency
    - b. Claim Not Covered by Underlying
    - c. Failure/Delay in Covering
    - d. Company Insolvency

## Selected Issues About D&O Insurance

*No. 1. (Cont'd)*

- B. Why Is Side A DIC Coverage So Attractive?
  - 1. Dedicated Limits
  - 2. Breadth of Coverage
  - 3. Drop Down Features
  - 4. Bankruptcy Scenario



Chapter Four:

## **Employment Practices Liability Insurance in an Evolving Economic and Legal Landscape**

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**Caitlin R. Garber, Esquire**  
Reed Smith  
Pittsburgh

**Courtney C.T. Horrigan, Esquire**  
Reed Smith  
Pittsburgh

**Kate M.K. Owen, Esquire**  
Reed Smith  
Pittsburgh



**EMPLOYMENT PRACTICES LIABILITY INSURANCE  
IN AN EVOLVING ECONOMIC AND LEGAL LANDSCAPE**

Courtney C.T. Horrigan, Kate M. K. Owen, and Caitlin R. Garber  
Reed Smith LLP<sup>1</sup>

Employment Practices Liability (“EPL”) Insurance provides financial protection to companies looking to protect their balance sheets against the costs of employment-related claims. In recent years, a combination of factors, fueled by the recession, caused the volume of employment-related lawsuits to reach record highs.<sup>2</sup> Even as the nation slowly recovers from the recession, employers continue to face the ever-present threat of expensive litigation and proceedings before the U.S. Equal Employment Opportunity Commission (“EEOC”) and state Fair Employment Practices Agencies.<sup>3</sup> Indeed, the risk of a sizeable jury award remains a constant and the EEOC reported record-high recoveries of \$372.1 million in fiscal year 2013.<sup>4</sup> To bring the threat into further perspective, the total amount of the top ten largest settlements of private employment discrimination class action lawsuits in 2013 reached a combined total of \$234.1 million.<sup>5</sup>

Additionally, recoveries for wage and hour lawsuits filed against employers remain at record highs.<sup>6</sup> Adding to the evolving landscape, EEOC opinions have extended protection from

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<sup>1</sup> Courtney Horrigan is a Partner, Kate Owen is a Senior Associate, and Caitlin Garber is an Associate in the Insurance Recovery Group at Reed Smith LLP.

<sup>2</sup> Seyfarth Shaw LLP, *Annual Workplace Class Action Litigation Report*, Jan. 2014 at 2, 5.

<sup>3</sup> EEOC, *EEOC Releases FY 2013 Enforcement and Litigation Data*, Feb. 5, 2014, available at <http://www.eeoc.gov/eeoc/newsroom/release/2-5-14.cfm>. “The Equal Employment Opportunity Commission (EEOC or Commission) is the federal agency responsible for enforcing federal laws prohibiting employment discrimination on the basis of race, color, religion, sex (including pregnancy), national origin, age (40 or older), disability, or genetic information.” EEOC, *Administrative Enforcement and Litigation*, available at [http://www.eeoc.gov/eeoc/enforcement\\_litigation.cfm](http://www.eeoc.gov/eeoc/enforcement_litigation.cfm).

<sup>4</sup> While the total amount of charges filed with the EEOC decreased slightly in FY 2013, by 5.7 percent, “the agency obtained the highest monetary recovery in agency history through its administrative process, increasing by \$6.7 million to \$372.1 million.” *EEOC Releases FY 2013 Enforcement and Litigation Data*, *supra* note 3.

<sup>5</sup> Seyfarth, *supra* note 2.

<sup>6</sup> Marsh & McLennan, *Wage and Hour Preferred Solution*, Jan. 15, 2013, available at <http://usa.marsh.com/ProductsServices/MarshSolutions/ID/28195/Wage-and-Hour-Preferred-Solution.aspx>.



discrimination under Title VII of the Civil Rights Act (“CRA”)<sup>7</sup> to include individuals who have been discriminated against on the basis of sexual orientation and gender identity.<sup>8</sup> Many states are also considering proposed legislation that would create a cause of action to specifically protect employees from workplace bullying.<sup>9</sup>

As the legal landscape changes more employers are considering the benefits and detriments of purchasing insurance coverage tailored specifically for employment-related claims. The employment practices liability insurance market is also evolving as carriers develop specialty policies to address the wage and hour claims that are typically excluded from coverage under traditional EPL policy forms.

## **I. History of Employment Practices Liability Insurance**

To appreciate the current state of EPL insurance, it is helpful to understand its roots. The first EPL policies insuring liability against employee claims became available in the early 1990’s following the passage of the 1991 amendments to the CRA<sup>10</sup> and the EEOC’s issuance of guidelines addressing sexual harassment in the workplace.<sup>11</sup> The 1991 Amendments to the CRA expanded the remedies available under Title VII by granting employees the right to jury trials as well as the ability to recover compensatory and punitive damages. The same year that the CRA was amended much of the nation was consumed with the explosive confirmation hearings for

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<sup>7</sup> Title VII of the Civil Rights Act of 1964 (Title VII), as amended, 42 U.S.C. §2000e *et. seq.*

<sup>8</sup> See Section II(C) below.

<sup>9</sup> The following states currently have healthy workplace bills pending: Florida, Hawaii, Massachusetts, New Hampshire, New Jersey, New Mexico, New York, Pennsylvania, Tennessee, Vermont, West Virginia, and Wisconsin. *Healthy Workplace Bill*, Workplace Bullying Institute (2013), available at <http://www.healthyworkplacebill.org/faq.php>.

<sup>10</sup> David L. Leitner, Reagan W. Simpson, and John M. Bjorkman, *Employment Practices Liability Insurance*, 5 LAW & PRAC. OF INS. COVERAGE LITIG. § 56:2 (updated July 2011).

<sup>11</sup> EEOC, *Policy Guidance on Current Issues of Sexual Harassment*, EEOC Enforcement Guidance (March 19, 1990), available at <http://www.eeoc.gov/policy/docs/currentissues.html>.

Supreme Court Justice Clarence Thomas, during which Anita Hill testified that Justice Thomas had sexually harassed her during his tenure as head of the EEOC.

Since 1991, employment litigation claims have been on the rise and news coverage of large verdicts in employment suits are “a constant reminder that employers must search for ways to limit their liability and avoid potentially crippling jury verdicts.”<sup>12</sup> Many believe that the attention that sexual harassment and employment practices received during the early 1990’s caused the number of employee claims to significantly increase.<sup>13</sup> Beyond the spike in claims caused by this increased attention, continuing developments in employment liability law have made it easier for employees to bring claims. For example, the Americans with Disabilities Act Amendments Act of 2008 emphasized that the definition of disability should be construed broadly.<sup>14</sup> The Lilly Ledbetter Fair Pay Act of 2009 clarified that each paycheck that delivered discriminatory compensation was actionable, regardless of when the discrimination first began.<sup>15</sup> The Lilly Ledbetter Fair Pay Act superseded the Supreme Court’s decision in *Ledbetter v. Goodyear Tire & Rubber Co., Inc.*, which required that a charge of compensation discrimination be filed within 180 days of a discriminatory pay-setting decision (or 300 days in jurisdictions with local or state laws prohibiting the same forms of compensation discrimination).<sup>16</sup>

The insurance market developed EPL policies to provide coverage for these employment practices claims, which were typically excluded by traditional types of insurance policies, such

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<sup>12</sup> Nancy H. Van der Verr, *Employment Practices Liability Insurance: Are EPLI Policies a License to Discriminate, Or Are They a Necessary Reality Check for Employers?* 12 CONN. INS. L.J. 173, 175 (2005).

<sup>13</sup> *Id.* at 186; Gary Lockwood, *Business Risk and Insurance Coverage*, 2 ADVISING SMALL BUS. § 27:21 (2013).

<sup>14</sup> EEOC, *The Americans with Disabilities Act Amendments Act of 2008*, available at [http://www.eeoc.gov/laws/statutes/adaaa\\_info.cfm](http://www.eeoc.gov/laws/statutes/adaaa_info.cfm); see also German A. Gomez, *Employment Practices Liability Insurance & The Perfect Storm*, 811 PLI/LIT 235 (2010).

<sup>15</sup> EEOC, *Notice Concerning the Lilly Ledbetter Fair Pay Act of 2009*, available at [http://www.eeoc.gov/laws/statutes/epa\\_ledbetter.cfm](http://www.eeoc.gov/laws/statutes/epa_ledbetter.cfm).

<sup>16</sup> 550 U.S. 618 (2007).

as Commercial General Liability (CGL), Workers' Compensation, and Directors and Officers Liability (D&O).<sup>17</sup>

## **II. Recent Developments in Employment-Related Claims**

While the overall volume of employment-related lawsuits dropped slightly in 2013, employers faced an increased number of retaliation charges and record high recoveries.<sup>18</sup>

According to EEOC statistics for fiscal year 2013, the number of individual charge filings for discrimination against private sector employees last year totaled 93,727, a decrease of 5.7% from the 99,412 charges filed in fiscal year 2012.<sup>19</sup> However, despite a decline in the total number of charges, a government furlough and budget cuts, the EEOC obtained the highest monetary recoveries in agency history at \$372.1 million, a \$6.7 million increase from the prior year.<sup>20</sup>

### **A. Wage and Hour Claims**

Wage and hour claims continued to dominate headlines in 2013.<sup>21</sup> Wage and hour claims arise under the Fair Labor Standards Act or state law equivalent, and the claims generally seek to address issues such as the alleged improper classification of workers as exempt, or violations of meal and rest periods by employers.<sup>22</sup> When all potentially affected employees are taken into consideration, the cases can become very large and defense costs alone can be very expensive.<sup>23</sup> In fact, coverage for wage and hour claims is the biggest concern reported among employers,

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<sup>17</sup> Leitner, *supra* note 10 at § 56:12.

<sup>18</sup> *EEOC Releases FY 2013 Enforcement and Litigation Data*, *supra* note 3.

<sup>19</sup> *Id.* See also German A. Gomez, *Employment Practices Liability Insurance & The Perfect Storm*, 811 PLI/LIT 235 (2010).

<sup>20</sup> *EEOC Releases FY 2013 Enforcement and Litigation Data*, *supra* note 3.

<sup>21</sup> *Id.*

<sup>22</sup> United States Department of Labor, *Handy Reference Guide to the Fair Labor Standards Act* (April 2011), available at <http://www.dol.gov/whd/regs/compliance/hrg.htm>.

<sup>23</sup> Seyfarth, *supra* note 2 at 3.

alongside the large legal bills they may experience when targeted with prominent class action lawsuits.<sup>24</sup>

Fiscal year 2013 saw an increase in the number of wage and hour cases which resulted in more judicial opinions on wage and hour issues than any other area of employment class action litigation.<sup>25</sup> Indeed, wage and hour litigation has outpaced discrimination actions, and represents “the most predominant type of workplace class action pursued against corporate America.”<sup>26</sup> For example, Wal-Mart, the world’s largest retailer, has been a frequent target of wage and hour lawsuits.<sup>27</sup> In *Braun v. Wal-Mart*, the court upheld the vast majority of a \$187 million verdict rendered against Wal-Mart in a case where it was accused of denying meal and rest breaks to Pennsylvania workers.<sup>28</sup> While not disputing that attorneys’ fees should be included in the total verdict, the court remanded the case to the lower court for a recalculation of the attorneys’ fees awarded, finding that the lower court erred in the reasoning of its initial calculation.<sup>29</sup>

Wage and hour lawsuits are not only being filed at the federal level, but an increase in class actions being filed in state courts is an increasing part of this trend.<sup>30</sup> States with the highest number of filings included California, Florida, Massachusetts, New Jersey, New York

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<sup>24</sup> *Id.* at 10.

<sup>25</sup> *Id.* at 3.

<sup>26</sup> *Id.* at 9; see also Marsh & McLennan, *supra* note 6. In 2013, the top ten wage and hour claims settled for a combined total of \$248.45 million, and the number was \$292 million in 2012. Seyfarth, *supra* note 2 at 2.

<sup>27</sup> Sophia Pearson, *Wal-Mart Loses Appeal of \$187 Million Verdict in Worker Lawsuit*, Bloomberg News, June 13, 2011, available at <http://www.bloomberg.com/news/2011-06-13/wal-mart-losses-appeal-of-187-million-verdict-in-worker-lawsuit.html>; Jonathan Stempel, Brad Dorfman, Dave Zimmerman, *Wal-Mart in \$86 million settlement of wage lawsuit*, Reuters, May 12, 2010, available at <http://www.reuters.com/article/2010/05/12/us-walmart-lawsuit-settlement-idUSTRE64B3MG20100512>.

<sup>28</sup> *Id.* See also *Braun v. Wal-Mart Stores, Inc.*, 24 A.3d 875 (Pa. Super. Ct. 2011) (finding that there was sufficient evidence to conclude Wal-Mart violated state law wage requirements but the trial court was ordered to recalculate the attorneys' fees), *appeal granted in part*, 47 A.3d 1174 (Pa. 2012) (granting appeal to determine “whether, in a purported class action tried to verdict, it violates Pennsylvania law (including the Pennsylvania Rules of Civil Procedure) to subject Wal-Mart to a ‘Trial by Formula’ that relieves plaintiffs of their burden to produce classwide ‘common’ evidence on key elements of their claims”).

<sup>29</sup> *Braun*, 24 A.3d at 883.

<sup>30</sup> Seyfarth, *supra* note 2 at 4.

and Pennsylvania.<sup>31</sup> The wave of wage and hour filings is expected to continue into 2014 with a consistent level of significant litigation activity.<sup>32</sup>

Because EPL insurance is a defined-risk coverage, providing coverage for the alleged wrongful acts specified within the policy itself, it may not provide coverage for all employment claims that a company may face. Wage and hour claims are a key example. Without a wage and hour coverage endorsement, EPL policies generally do not insure against these claims.<sup>33</sup>

Insurance coverage for wage and hour claims is available in the EPL market, but most EPL Policies contain some form of exclusion for the following:<sup>34</sup>

the Fair Labor Standards Act (except the Equal Pay Act) and any other law concerning wage and hour practices, including, but not limited to any Claim for off-the-clock work, failure to provide rest or meal periods, failure to reimburse expenses, improper classification of employees as exempt or non-exempt, failure to timely pay wages, conversions, unjust enrichment, or unfair business practices<sup>35</sup>

Historically, the wage and hour insurance coverage available in the market generally covered defense costs only, and explicitly disclaimed any obligation to cover any settlement or judgment. Moreover, any coverage for wage and hour claims was typically subject to a sub-limit of liability. The market, however, is slowly changing. Brokers have begun to market wage and hour insurance programs with limits as high as \$50 and \$100 million.<sup>36</sup>

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<sup>31</sup> *Id.*

<sup>32</sup> *Id.* at 9.

<sup>33</sup> Richard S. Betterley, *Employment Practices Liability Insurance Market Survey 2013: Rates and Deductibles Up as Carriers Cope with Losses*, THE BETTERLEY REP., Dec. 2013, at 10.

<sup>34</sup> *Id.*

<sup>35</sup> Zurich EPL Policy form U-EPL-1171-A CW (01/09), § IV(4)(c).

<sup>36</sup> Chad Hemenway, *Keep Your Shirts On: Wage & Hour Coverage Arriving Just in Time*, Property Casualty 360, Mar. 29, 2013, available at <http://www.propertycasualty360.com/2013/03/29/keep-your-shirts-on-wage-hour-coverage-arriving>; see also Marsh & McLennan, *supra* note 6.

## B. Workplace Bullying

While bullying in schools has grabbed headlines and been a frequent topic of conversation on national news programs for years, bullying in the workplace is only recently being recognized. In the fall of 2013, workplace bullying made national headlines after an NFL lineman accused a teammate of hazing and bullying and walked off the Miami Dolphins football team in the middle of the 2013 NFL season.<sup>37</sup>

On February 14, 2014, independent investigators hired by the NFL issued a 140-page report detailing a pattern of harassment by Dolphins' lineman Richie Incognito, and two other football players, against their teammate Jonathan Martin.<sup>38</sup> The report concluded that Martin was "taunted on a persistent basis with sexually explicit remarks about his sister and his mother and at times ridiculed with racial insults and other offensive comments."<sup>39</sup> After Martin walked out of the Dolphins' facility and into mental health treatment, Martin was placed on the Non-Football Injury List, ending his 2013 season.<sup>40</sup> Incognito was suspended from the team (with pay).<sup>41</sup> The investigators concluded that these events were consistent with a case of workplace bullying and contributed to Jonathan Martin's mental health issues.<sup>42</sup> The investigators concluded that the Miami Dolphins should create and enforce a new set of workplace conduct

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<sup>37</sup> Robin Abcarian, *Just as we thought: Richie Incognito bullied Jonathan Martin*, LOS ANGELES TIMES, Feb. 14, 2014, available at <http://www.latimes.com/local/abcarian/la-me-ra-report-miami-dolphins-jonathan-martin-bullied-by-richie-incognito--20140214,0,7766892.story#axzz2tahbonAQ>.

<sup>38</sup> Theodore V. Wells, Jr., Bruce S. Karp, Bruce Birenboim, David W. Brown, *Report to the National Football League Concerning Issues of Workplace Conduct at the Miami Dolphins*, Feb. 14, 2014, available at <http://documents.latimes.com/nfl-report-workplace-conduct-miami-dolphins/>. The report also detailed bullying endured by a fellow football player, referred to only as "Player A" and an assistant trainer. *Id.*

<sup>39</sup> *Id.* at 1.

<sup>40</sup> *Id.* at 139.

<sup>41</sup> *Id.* at 139. There is a dispute regarding Incognito's pay in connection with the first two weeks of his suspension and "Incognito has filed a grievance in connection with that decision." *Id.*

<sup>42</sup> *Id.* at 5, 13, 17.

rules and guidelines.<sup>43</sup> The investigators also recognized in their report that there is currently no law against workplace bullying in any state.<sup>44</sup>

Indeed, while there is presently no cause of action for workplace bullying, multiple states have attempted to introduce “healthy workplace” legislation, with bills currently pending in twelve states.<sup>45</sup> The proposed state legislation often seeks to provide the employee with a private cause of action against the bully, as well as against his or her employer.<sup>46</sup> As awareness of this issue increases, and legislative efforts continue, claims for workplace bullying are likely to follow, further adding to the volume of employment-related claims.

### **C. Discrimination on the Basis of Sexual Orientation or Gender Identity**

While protection from discrimination based on sexual orientation and gender identity, including transgender status, is available in some states,<sup>47</sup> there is currently no federal law extending such protections to all workers. The EEOC, however, has recently issued decisions confirming protections under Title VII of the CRA on the basis of sexual orientation and transgender status<sup>48</sup> and has specifically identified in its Strategic Enforcement Plan for FY

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<sup>43</sup> *Id.* at 49, 140.

<sup>44</sup> *Id.* at 17, 140. At least 26 states have tried to introduce “healthy workplace” legislation to provide legal protection for victims of workplace bullying and 12 states currently have healthy workplace bills pending. *Healthy Workplace Bill*, Workplace Bullying Institute (2013), available at <http://www.healthyworkplacebill.org/faq.php>.

<sup>45</sup> *Healthy Workplace Bill*, *supra* note 44.

<sup>46</sup> *Id.* Proposed legislation requires “evidence of serious health harm, or a pattern of negative employment decisions against the individual.” *Id.*

<sup>47</sup> The following states have a non-discrimination law that covers sexual orientation and gender identity: California, Colorado, Connecticut, Delaware, District of Columbia, Illinois, Iowa, Maine, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Vermont and Washington. American Civil Liberties Union, *Non-Discrimination Laws: State by State Information – Map*, available at <https://www.aclu.org/maps/non-discrimination-laws-state-state-information-map>. The following states have non-discrimination laws that cover only sexual orientation (not gender identity): Maryland, New Hampshire, New York, and Wisconsin. *Id.*

<sup>48</sup> *See, e.g., Couch v. Department of Energy*, Appeal No. 0120131136, 2013 EEO PUB LEXIS 2613 (EEOC Aug. 13, 2013). *See also Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 844 (1984) (acknowledging courts’ deference to administrative interpretations and decisions).

2013-2016 that “coverage of lesbian, gay, bisexual and transgender individuals under Title VII’s sex discrimination provisions” is an emerging and developing issue that it will closely monitor.<sup>49</sup>

Recent EEOC decisions shed light on the type of allegations that may be seen with such claims of discrimination and for which employers may be seeking coverage. In *Baker v. Social Security Admin*, the complainant, Mr. Baker, alleged sexual discrimination including on the basis of his sexual orientation where co-workers made “snide remarks about his sexual orientation, ... singled him out and chastised him for socializing with co-workers, ... [and] falsely accused him of making inappropriate comments about religion and his sex life.”<sup>50</sup> The EEOC found that Baker’s allegations set forth a claim for sex discrimination, reasoning that “as long as the allegations state a viable claim of sex discrimination, the fact that a Complainant has characterized the basis of discrimination as sexual orientation does not defeat an otherwise valid sex discrimination claim.”<sup>51</sup> The court further explained that Baker “alleged that he was mocked as effeminate and told that his ‘flamboyant’ mannerisms were unsuited to his work place. Such allegations are sufficient to state a claim that [Baker] was discriminated against for failure to match gender-conforming behavior and thus state a claim based on sex discrimination.”<sup>52</sup>

More recently, in *Couch v. Department of Energy*, the EEOC found that the complainant, Mr. Couch, was subjected to a hostile work environment on the basis of his perceived sexual orientation, a form of gender discrimination.<sup>53</sup> Couch alleged that he was subjected to offensive and degrading language by his co-workers, including the use of epithets historically used against

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<sup>49</sup> EEOC, *Strategic Enforcement Plan FY 2013-2016*, available at <http://www.eeoc.gov/eeoc/plan/sep.cfm>.

<sup>50</sup> *Baker v. Social Security Admin.*, EEOC Appeal No. 0120110008, 2013 WL 1182258, at \*2 (EEOC Jan. 11, 2013).

<sup>51</sup> *Id.* at \*5 (“Title VII does not explicitly include sexual orientation as a basis for protection under the law. Nevertheless, the law’s broad prohibition of discrimination ‘on the basis of...sex’ will offer coverage to gay individuals in certain circumstances”).

<sup>52</sup> *Id.* at \*6.

<sup>53</sup> *Couch*, 2013 EEO PUB LEXIS 2613, at \*23.



gay men.<sup>54</sup> In addition to being subjected to anti-gay slurs and other offensive incidents, Couch alleged that he was told “he was going to be fired because of his sexual orientation, that he was unwelcome at the organization, and that he should find another job.”<sup>55</sup> The EEOC found that Couch’s “claim of harassment based on his ‘perceived sexual orientation’ is a claim of discrimination based on the perception that he does not conform to gender stereotypes of masculinity, and therefore states a viable claim under Title VII’s sex discrimination prohibition.”<sup>56</sup>

In 2013, the EEOC also affirmed its position that discrimination on the basis of transgender status is cognizable under Title VII. In *Day v. Donahoe*, Ms. Day, a transgender woman, was attending new employee orientation prior to starting her job with the U.S. Postal Service.<sup>57</sup> At the orientation, Day alleged that she was called into the hallway and asked if she had been drinking because she smelled of alcohol.<sup>58</sup> Day explained that the smell was from the solution she used for her psoriasis, and offered to take a breathalyzer test.<sup>59</sup> Despite her explanation, and offer, she was sent home and the job offer was subsequently withdrawn.<sup>60</sup> The EEOC found that Day had stated a claim under Title VII for discrimination based on her transgender status and remanded the case for further proceedings.<sup>61</sup>

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<sup>54</sup> *Id.* at \*20.

<sup>55</sup> *Id.* at \*1-2.

<sup>56</sup> *Id.* at \*22.

<sup>57</sup> EEOC Appeal No. 0120122376, 2013 WL 783235, at \*1 (EEOC Feb. 19, 2013).

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> *Id.*

<sup>61</sup> *Id.* See also *Macy v. Dept. of Justice*, 2012 WL 1435995 (EEOC April 20, 2012) (finding that discrimination based on gender identity, change of sex and/or transgender status is cognizable under Title VII).

#### **D. Punitive Damages**

It is estimated that punitive damages are awarded in 20% of EPL cases that go to trial.<sup>62</sup> Whether punitive damages are covered under an EPL policy is a function of the policy language at issue, as well as the applicable law in the governing jurisdiction.<sup>63</sup> In 2010, a federal jury in New York awarded \$250 million in punitive damages in a gender discrimination class action lawsuit brought on behalf of 5600 current and former female employees of a pharmaceutical company.<sup>64</sup> This award remains the largest such award in the history of employment discrimination cases. While this case ultimately settled for over \$175 million a few months later, none of which was directly attributed to punitive damages, coverage for potential punitive damages remains an important consideration.<sup>65</sup> To increase the likelihood that punitive damages may be covered under a policy, some insurers agree to include language specifying that punitive damages are covered if permitted under the applicable law that most favors coverage, referred to as “most favorable venue” wording.<sup>66</sup> In Pennsylvania, coverage for punitive damages is permitted where the insured’s liability for such damages is only vicarious.<sup>67</sup>

#### **III. Evolution of the EPL Policy**

Commercial General Liability, Workers’ Compensation, and Directors & Officers Liability insurance policies typically exclude employment claims from coverage. EPL policies were designed to “fill the gaps” left by these other forms of insurance. The earliest EPL policies

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<sup>62</sup> Marsh & McLennan, *Novartis \$250 Million Punitive Damages Award: Why Employment Practices Liability Insurance Matters* (June 15, 2010), available at <http://usa.marsh.com/NewsInsights/ThoughtLeadership/Articles/ID/5082/Novartis-250-Million-Punitive-Damages-Award-Why-Employment-Practices-Liability-Insurance-Matters.aspx>.

<sup>63</sup> John H. Mathias, Jr., John D. Shugrue, and Thomas A. Marrinson, *Insurance Coverage Disputes*, Law Journal Press (2014) § 9.02[3] (providing a 50 state survey of the insurability of punitive damages).

<sup>64</sup> *Velez v. Novartis Pharm. Corp.*, No. 04 Civ. 09194, 2010 WL 4877852 (S.D.N.Y. Nov. 30, 2010).

<sup>65</sup> *Id.* See also Marsh & McLennan, *supra* note 6.

<sup>66</sup> Betterly, *supra* note 33 at 10.

<sup>67</sup> *Butterfield v. Giuntoli*, 670 A.2d 646 (Pa. Super. Ct. 1995).

had noteworthy shortcomings: They were very expensive and restrictive; filled with exclusions and pitfalls; and, came with huge deductibles and premiums.<sup>68</sup> However, as the market for EPL policies has become more established, many of the deficiencies in the early EPL policies have been remedied.

EPL policies are not standard-form, and therefore the actual coverage provided is subject to negotiation between insurers and policyholders. Generally, carriers that write Directors & Officers Liability insurance also offer EPL policies. EPL policies may be written as stand-alone policies, or coverage may be provided by endorsement or as a coverage part within a blended policy that includes Directors & Officers Liability, Professional Liability and/or Fiduciary Liability coverages.

As insurers have faced an increased total of claims and defense costs in recent years, carriers have responded by increasing rates and deductibles, as well as implementing further controls on defense costs.<sup>69</sup> This trend is expected to continue into 2014.<sup>70</sup>

#### **IV. The Application Process**

Prior to offering coverage, EPL insurers may require employers to demonstrate that they have taken steps to minimize their exposure to employee claims. For example, an EPL insurer may review an employer's human resources systems and standard documents (*e.g.*, the employee handbook, job applications and other forms) and require that employers follow specified procedures to minimize the likelihood of viable employee complaints. Furthermore, many insurers scrutinize the employer's recent employment-related claims history and their cultural

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<sup>68</sup> Merrick T. Rossein, *Insurance Coverage for Employment Practices Liability*, 2 EMP. L. DESKBOOK HUM. RESOURCES PROF. § 40:7 (updated Nov. 2013).

<sup>69</sup> Betterly, *supra* note 33 at 4, 7, 15 (noting that increases were more aggressive than in most other lines, and that the increases were indicated by a lack of profits).

<sup>70</sup> *Id.* at 4.

diversity policies. The volume of information reviewed during the underwriting process may make the underwriting for EPL coverage more complex than the underwriting for other commercial business policies.

## V. General Structure of EPL Policies

### A. “Claim” and “Notice”

EPL policies are written on a “Claims-Made” basis, meaning that the coverage trigger is a “Claim” filed against the policyholder during the policy period. Claims-made policies often require as a condition precedent to coverage that the policyholder report the claim to the insurer during the policy period or within a specified period of time thereafter. Human Resources Managers and other key employees should understand how their EPL policy has defined the term “Claim,”<sup>71</sup> so that events falling within the definition are recognized internally and reported to the appropriate insurer promptly.

In general, the term “Claim” may be defined in an EPL policy to include civil and criminal proceedings, written demands for monetary or non-monetary relief, requests to toll a statute of limitations, arbitration or alternative dispute resolution proceedings, and formal administrative, regulatory, or mediatory proceedings or investigations, which would include EEOC notices of charges or notices from any equivalent state or local organizations. The most favorable versions of the definition of “Claim” will provide that the “Claim” doesn’t arise until

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<sup>71</sup> The importance of the definition of the term “Claim” was highlighted by the decision in *Cracker Barrel Old Country Store, Inc. v. Cincinnati Ins. Co.*, No. 3:07-cv-00303, 2011 WL 5208369 (M.D. Tenn. Sept. 21, 2011). The court in *Cracker Barrel* ruled that the policy in question did not provide coverage for claims brought by the EEOC, only claims brought by employees, based upon the restrictive definition of the term “Claim” in the policy. *Id.* at \*1. The policy at issue defined a “Claim” as “a civil, administrative or arbitration proceeding commenced by the service of a complaint or charge, which is brought by any past, present or prospective ‘employee(s)’ of the ‘insured entity’ against any ‘insured’ for any of the following twelve listed causes.” *Id.* However, this interpretation was reversed on appeal, where the court held that the definition of “Claim” was susceptible to more than one reasonable interpretation. The court, however, affirmed the district court opinion, finding that the initial administrative charges were filed with the EEOC prior to the inception of the claims-made policy period. *Cracker Barrel Old Country Store, Inc. v. Cincinnati Ins. Co.*, 499 Fed.Appx. 559, 563 (6th Cir. 2012).

the insured has received actual notice of a triggering event, whether through service of a complaint, receipt of a demand, or through other means. Given the size of many employers, an employer should seek coverage that requires reporting “as soon as practicable” after a specified individual, such as the General Counsel, Human Resources Director, or Risk Manager, becomes aware of the “Claim.”

Issues often arise when an insurer is not promptly placed on notice of charges filed against an insured. This frequently occurs where a complaint is filed with the EEOC but the policyholder fails to notify its insurer until a subsequent lawsuit is filed, by which time the policyholder is in a new policy period. For example, in *City of Maplewood, Missouri v. Northland Casualty Company*, the policyholder, the City of Maplewood, failed to provide notice to its insurers of a charge of discrimination that was filed against it with the EEOC until two years after the applicable reporting periods had expired.<sup>72</sup> In 2003, a female police officer, Ms. Wallingsford, filed a complaint with the EEOC that alleged she was suspended by the City due to her gender and was subjected to sex discrimination.<sup>73</sup> After the EEOC issued a right to sue letter, in 2004 Wallingsford filed a federal lawsuit against the City for gender discrimination that was dismissed a few months later.<sup>74</sup> Fast forward two years, and Wallingsford had filed a second charge of discrimination with the EEOC and then instituted a second lawsuit against the City, this time in state court.<sup>75</sup> The City first reported the claim involving Wallingsford to its insurers in 2006. After its insurers denied coverage due to their respective policies’ reporting

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<sup>72</sup> *City of Maplewood, Missouri v. Northland Cas. Co.*, No. 4:11-cv-564, 2012 U.S. Dist. LEXIS 95088 (E.D. Mo. July 10, 2012).

<sup>73</sup> *Id.* at \*7.

<sup>74</sup> *Id.* at \*8.

<sup>75</sup> *Id.* at \*9-10.

requirements, the City brought a coverage action against its insurers claiming the insurers were not prejudiced by any delay in notice of Wallingsford's claims.<sup>76</sup>

With respect to the City's policy that had a reporting period ending on July 1, 2004, the court held that "[b]ecause the City did not provide notice of Wallingsford's claim within the reporting period of the claims made policy, [the insurer] is entitled to summary judgment without a showing of prejudice."<sup>77</sup> The court further held that no coverage was available under the City's 2005 policy because the prior and pending exclusion in the policy precludes coverage for a claim involving the same or substantially related wrongful acts alleged in litigation filed in a prior policy period.<sup>78</sup>

Many policies also allow an employer to report a circumstance that has not yet met the policy's definition of a "Claim," but may give rise to a claim after the policy has expired. In those circumstances, any claim later arising from the reported circumstances should be subject to coverage under the policy that was in effect when the notice of circumstances was given.

#### **B. Categories of Claims Covered**

EPL policies generally cover three broad categories of claims: wrongful discharge or failure to employ, discrimination, and sexual harassment. Coverage for wage and hour claims is more limited as noted above. Within this framework, some of the most common claims that may be covered by EPL policies include any actual, alleged or constructive wrongful dismissal, discharge or termination of employment; employment-related misrepresentation; violation of any federal, state or local statute, regulation, ordinance, common law or public policy concerning employment or discrimination in employment; sexual or other illegal workplace harassment;

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<sup>76</sup> *Id.* at \*2.

<sup>77</sup> *Id.* at \*16.

<sup>78</sup> *Id.* at \*24.

wrongful failure to employ or promote; wrongful discipline; wrongful deprivation of a career opportunity; wrongful demotion or other adverse change in terms, conditions or status of employment; failure to grant tenure; failure to adopt adequate workplace or employment policies and procedures; illegal retaliatory treatment of employees; negligent hiring; negligent evaluation of employees, wrongful reference; employment-related invasion of privacy; employment-related defamation; employment-related wrongful infliction of emotional distress; and other employment-related torts.

Some policies will specifically include coverage for workplace bullying within the definition of “workplace harassment.” Likewise, some policies will specifically include coverage for discrimination on the basis of sexual orientation or gender identity within the definition of “discrimination.” While broad coverage for “workplace harassment” and “discrimination” generally may be sufficient to provide coverage for these claims without an accompanying list of specifics, depending on the particulars of the policy language and applicable law, employers may desire to negotiate the specific inclusion of such terms within the grant of coverage if not already provided.

### **C. Third-Party Coverage**

Many EPL policies also protect an insured entity from allegations that its employees discriminated against or harassed a third party. Businesses with employees who deal with clients, customers or vendors on a regular basis, such as real estate agents, medical offices, law firms, restaurants, and other entertainment venues, may be more likely to experience third-party claims.<sup>79</sup> The expansiveness of the “third-party” coverage available, or desired, may vary

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<sup>79</sup> Wayne E. Bernstein, *Third-party Coverage Can be an Important Part of EPL Policies*, AM. AGENT & BROKER, Nov. 1, 2006, available at <http://www.propertycasualty360.com/2006/11/01/third-party-coverage-can-be-an-important-part-of-epli-policies>.

depending upon the policyholder's industry and the perceived risk of significant third-party liability.

**D. Coverage for Defense Counsel**

While not a new or novel issue, selection of counsel remains a hot topic with clients when it comes to EPL coverage, with many clients preferring to select counsel of their choosing. However, stand-alone EPL policies generally are written as "duty to defend" policies, where the insurer has the right and obligation to control the defense of a claim by hiring counsel directly.<sup>80</sup> Policyholders should review the defense provisions of their EPL policies to determine whether the insurer will appoint counsel or require the policyholder to select counsel from a list of pre-qualified "panel counsel." If the policyholder has outside counsel that it wishes to use on employment practices cases, and that law firm does not appear on the insurer's panel counsel list, the policyholder should discuss with the underwriter whether the EPL policy can be endorsed to allow that law firm to represent the policyholder in employment practices liability matters. Some policies are written to allow the policyholder to choose its own counsel for most individual claims, but will require the policyholder to use the insurer's panel counsel for class actions and claims alleging certain specific wrongful acts, such as discrimination.

Alternatively, the policyholder may seek to have the panel counsel requirement deleted. It is generally easier to address these issues during the underwriting phase rather than attempt to negotiate control of defense issues with the insurer after the claim has arisen. Policyholders should note that as insurers trim their panel counsel lists to control costs, many carriers have been unwilling to cede selection of counsel to the employer. Struggles between insurers and policyholders over the control of defense often arise in the EPL context. If an employer desires

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<sup>80</sup> Lockwood, *supra* note 13.



absolute discretion in investigating, defending and settling EPL claims, the employer should carefully consider whether an EPL policy will meet its business needs.

**E. Approval of Settlements**

While the insurer has both an obligation and monetary incentive to settle employment claims quickly, the policyholder generally must consent to any such agreement. Should the insured refuse to consent to a settlement recommended by the insurer, the insured may assume some risk. If the policyholder's EPL policy has a "hammer provision" and the policyholder refuses to agree to a proposed settlement agreement, the EPL policy may cap the insurer's liability at the amount the claim could have been settled for if the policyholder had given consent (the "Settlement Opportunity Amount").<sup>81</sup> Some EPL policies contain a so-called "soft hammer clause," which calls for the insurer and policyholder to share a specified percentage of any liability assessed in excess of the Settlement Opportunity Amount. These soft-hammer clauses generally require the policyholder to assume 25-50 percent of any additional liability.<sup>82</sup>

The issue of settlement control becomes more complicated when it is the insured that desires to settle a case but the insurer will not agree to a settlement demand. In *Babcock & Wilcox v. American Nuclear Insurance*, the Superior Court of Pennsylvania held that a policyholder is limited to two options in this situation when an insurer tenders a defense subject to a reservation of rights.<sup>83</sup> First, the policyholder may accept the defense.<sup>84</sup> In accepting the defense, the policyholder is bound to the terms of the consent to settlement provision of the

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<sup>81</sup> Ed E. Duncan, *Insurance Coverage for Sexual Harassment in the Workplace*, NO. 2 PRAC. LAW 51, 60 (Apr. 2005).

<sup>82</sup> *Id.* at 60.

<sup>83</sup> 76 A.3d 1, 22 (Pa. Super. Ct. 2013), *appeal granted in part*, 2014 WL 373715 (Pa. Jan. 24, 2014).

<sup>84</sup> *Id.*

policy, and therefore bound by the insurer's decision regarding whether to settle.<sup>85</sup> The policyholder's only recourse from any injuries arising from the insurer's conduct in deciding whether to settle lies within the bad faith standard.<sup>86</sup> Alternatively, the policyholder may choose to defend itself and decline defense by the insurer.<sup>87</sup> In so choosing, the policyholder retains full control of its defense, including whether or not to settle and for how much.<sup>88</sup> "Should the insured select this path, and should coverage be found, the insured may recover from the insurer the insured's defense costs and the costs of settlement, to the extent that these costs are deemed fair, reasonable, and non-collusive."<sup>89</sup>

#### **F. General Policy Exclusions**

Most EPL policies contain a series of exclusions and coverage limitations. Exclusions may appear within the pre-printed policy form or be added to the policy through an endorsement. Common exclusions include those for: (1) claims noticed to prior insurers; (2) claims relating to litigation or EEOC proceedings commencing prior to the policy's inception date; (3) claims involving deliberately fraudulent, dishonest or criminal conduct; (4) claims for personal profit or advantage to which the insured was not legally entitled; (5) claims arising from circumstances that the policyholder knew, prior to policy inception, could lead to a claim; (6) liability assumed by contract, unless the liability alleged would also have arisen in the absence of the contract; (7) acts committed with the intent to cause harm; (8) claims covered by other insurance, such as CGL or Fiduciary Liability coverage; (9) claims for violations of the Employee Retirement Income Security Act of 1974 (ERISA); (10) securities claims; (11) claims for bodily injury (not

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<sup>85</sup> *Id.*

<sup>86</sup> *Id.*

<sup>87</sup> *Id.*

<sup>88</sup> *Id.*

<sup>89</sup> *Id.*

including emotional distress or mental anguish); (12) claims for property damages; (13) claims concerning benefits, such as Social Security benefits, unemployment insurance, workers' compensation, disability insurance, etc.; and (14) claims for wage and hour violations, including violations of the FLSA (Fair Labor Standards Act) and state law equivalents but excluding the Equal Pay Act.<sup>90</sup> In addition, EPL policies tend not to cover equitable relief such as job reinstatement or an injunction against future wrongful employment practices (*e.g.*, EEOC proceedings seeking injunctive relief against an employer).<sup>91</sup>

Policyholders may have the ability to narrow or delete problematic exclusions in the policy. During negotiations regarding exclusions, one of the first issues to address is whether the EPL policy will provide the insureds with a defense against claims alleging excluded conduct. Another area of attention should be the introductory language used in each exclusion, which will influence how broadly or narrowly a particular exclusion is construed. For example, an exclusion that restricts coverage "for" a claim alleging bodily injury will be read more narrowly than an exclusion that applies to any claim "based upon, arising out of, directly or indirectly resulting from or in consequence of, or in any way involving" a bodily injury claim.

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<sup>90</sup> See, *e.g.*, Lockwood, *supra* note 13. See also Chartis Employment Edge Employment Practices Liability Insurance Policy Form 105997 (7/10), available at [http://www.aig.com/employment-liability\\_295\\_392469.html](http://www.aig.com/employment-liability_295_392469.html), and Traveler's Wrap + Employment Practices Liability Form EPL-3001 (07-05), available at <https://www.travelers.com/business-insurance/management-professional-liability/private-non-profit/employment-practices.aspx>.

<sup>91</sup> Hon. Ming W. Chin, Hon. Rebecca A. Wiseman, Hon. Consuelo Maria Callahan and Alan B. Exelrod, *Insurance and Indemnification*, CAL. PRAC. GUIDE EMPLOYMENT LITIG. Ch. 3-C (2007) at 3:181.

## **VI. Conclusion**

Employers in 2014 continue to face record high claims, with wage and hour claims dominating the concerns of many employers. The legal landscape is also evolving as new laws are being proposed to provide remedies to employees who claim to have experienced workplace bullying and the EEOC is recognizing claims of discrimination on the basis of sexual orientation and gender identity. In this shifting economic and legal climate, it may be beneficial for employers to evaluate the scope of EPL insurance available in the market, including wage and hour coverage, to determine whether coverage makes sense for their individual business needs.



Chapter Five:

## **Legal Malpractice Insurance Coverage: Survey of Recent Cases and Issues**

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**Jay M. Levin, Esquire**  
Reed Smith LLP  
Philadelphia



## **LEGAL MALPRACTICE INSURANCE COVERAGE: SURVEY OF RECENT CASES AND ISSUES**

**By: Jay M. Levin  
Reed Smith, LLP  
1650 Market Street  
Philadelphia, PA 19103  
(215) 851-8126  
jmlevin@reedsmith.com**

### **I. INTRODUCTION**

Legal malpractice insurance provides important protections to lawyers and their firms in the event of claims by clients and others for loss arising out of alleged acts or omissions by lawyers. However, malpractice coverage loses all of its value if it is forfeited by failure to comply with the terms and conditions of the applicable policy, and loses much of its value if lawyers are not familiar with limitations on the coverage provided.

This paper reviews opinions issued over the last ten years addressing legal malpractice insurance coverage, specifically disputes between legal malpractice insurers and either their insureds, or those suing their insureds. This paper focuses primarily on Pennsylvania, because the seminar is being given in both Pittsburgh and Philadelphia, although it also discusses cases from other jurisdictions (primarily New Jersey, New York and Ohio). The cases discussed below illustrate several important points. First, the importance of recognizing circumstances which may lead to a claim. Because malpractice policies are issued on a claims-made basis, insurers almost invariably ask policyholders if they are aware of circumstances which may give rise to a future claim and the policies usually exclude claims when, before the inception of the policy, the lawyer was aware of facts or circumstances which might result in a claim. Failure to properly identify and report potential claims leads to a loss of coverage. In addition, the failure to properly and timely report an actual claim in accordance with the terms and conditions of the policy will almost invariably lead to a forfeiture of coverage.

These cases also demonstrate that lawyers should be very careful to consider whether, in any given circumstance, they are acting as a lawyer providing professional services, or in some other capacity. To the extent lawyers serve as officers and directors of other business entities, their legal malpractice policies may provide no coverage whatsoever. This may militate in favor of purchasing separate coverage for any such activities. However, unless lawyers review and understand their policies, they may not be aware of this need, which could expose them to potentially serious uninsured liability.

Finally, malpractice carriers are not in the business of providing windfalls to their policyholders. Therefore, to the extent lawyers take advantage of their clients or others to obtain personal profit to which lawyers are not entitled, insurers will not indemnify against those liabilities and, if their policies are written properly, may not even have a duty to defend such claims.



## II. CASE DISCUSSION

### A. Notice Issues

Lawyers seem to have difficulty recognizing potential claims. This can be problematic because most malpractice policies contain “prior knowledge” exclusions which preclude coverage for claims made during the policy period when the lawyer was aware of facts or circumstances which could give rise to a claim before the policy inception. While these cases all turn on their specific facts, they illustrate the importance of recognizing and dealing with potential claims in a realistic and timely fashion.

*Chiera et al. v. Liberty Insurance Underwriters, Inc., et al.*, 873 N.Y.S.2d 232 (N.Y. Sup. Ct. 2008), discusses what constitutes a “claim” and “potential claim” under New York law. In this case, Randall J. Chiera and his law firm, Chiera & Associates were sued by Patria Warren for alleged malpractice in handling her medical malpractice case. Ms. Warren retained Chiera & Brady on March 19, 2001 to represent her in a medical malpractice case against her ophthalmologist. That law firm dissolved and Warren then was represented by Chiera & Associates. More than two years after she retained Chiera’s prior firm, on May 20, 2003, Chiera Associates filed an action on her behalf.

The defendant doctor never responded to the complaint and, in February 2004, Chiera Associates filed a motion for default judgment on behalf of Patricia Warren. In response, the doctor stated that he had not been served with process and that the first time he learned of the suit was when he received the motion for a default judgment. The doctor filed a motion to dismiss for lack of personal jurisdiction. Chiera Associates filed a motion for extension of time to serve. The court heard evidence regarding the allegedly defective service of process and subsequently granted the doctor’s motion to dismiss with prejudice and denied Chiera Associates’ motion for an extension of time to serve. Since the statute of limitations for Warren’s claim had expired in July 2003, Warren could no longer assert her claim. On January 26, 2006, she filed a malpractice action against Chiera and Chiera and Associates.

The firm’s malpractice carrier, Liberty Insurance Underwriters, Inc., denied coverage based on late notice. Liberty argued that Chiera was on notice of a potential claim as early as March 2004 when the doctor moved to dismiss the medical malpractice action and not later than April 28, 2004, when the judge dismissed the action and refused to extend the time of service. Liberty filed a lawsuit seeking a declaratory judgment that there was no coverage under the policy.

The policy defined a claim as “a demand received by you for money or services, including the service of suit or institution of arbitration proceedings against you, or a disciplinary proceeding.” The policy stated that the insured “must give us written notice of any claim(s) or potential claim(s) made against you as soon as practicable.” Relying upon these definitions, the court ruled in favor of the policyholder on summary judgment, finding that:

The phrase “potential claim” is intended to prevent an insured from not giving notice of a real, concrete claim simply because the claimant did not articulate an explicit demand. Thus, the Court reads the entire phrase “potential claim made against you” as

meaning a demand for money or services which, though not actually yet asserted, has been impliedly articulated by a third party, such as by a letter from the client indicating that a claim might be forthcoming, a letter expressing dissatisfaction with the insured's performance, a letter inquiring as to the attorney's insurance coverage, or other, similar circumstances.

The court found that, since the client never communicated any express or implied demand for money until she filed suit, Chiera and Chiera Associates had satisfied the notice requirement by forwarding the suit papers to Liberty promptly after Warren filed suit on January 26, 2006.

A case from the District Court of New Jersey illustrates what type of communication constitutes a claim. In *Russoniello v. Twin City Fire Ins. Co., et al.*, No. 09-452 (PGS), 2010 WL 2024048 (D.N.J. May 20, 2010), the client sent a letter to his attorney which contained a demand for money and alleged "completely inadequate" representation which "may well be considered malpractice." The attorney, however, did not notify his insurer because he believed that the letter from the client "amounted to nothing more than a 'shake down' which negated his obligation to notify his insurer." *Id.* at \*6. The court noted that the definition of "claim" did not include a "subjective component." The court ultimately held that there was no coverage because the "notice requirements of a claims made policy are strictly enforced without regard to an insured's subjective assessment of the merits." *Id.* See also *Abood et al. v. Gulf Group Lloyds, et al.*, No. 2007-299, 2008 WL 2641310 at \*8 (W.D. Pa. July 1, 2008) ("The plaintiffs' subjective belief that they would not be sued has no bearing on the analysis of whether or not they should have reasonably expected to be sued.")

*Minnesota Lawyers Mut. Ins. Co. v. Terrence Raymond Batzli; Batzli Wood & Stiles, P.C.*, No. 10-1684, 10-1839, 10-1910, 2011 WL 3347849 (4th Cir. August 4, 2011), reaches a more pro-policyholder result. In this case, the court held that the jury had a sufficient evidentiary basis to support its conclusion that Minnesota Mutual breached its insurance contract by refusing to defend Batzli and the law firm of Batzli Wood against a suit filed by their client, Richard Chasen. Chasen advised Batzli that he wanted to obtain Karen Chasen's interest in Chasen Properties during divorce settlement negotiations. Nonetheless, the agreement was drafted without this provision. The agreement was signed on January 11, 2006. After realizing this error and at the client's direction, Batzli filed a motion in the Circuit Court of the City of Richmond, Virginia, seeking correction of a scrivener's error on August 24, 2006. The court denied the motion to correct the alleged scrivener's error, finding that there was no evidence that Ms. Chasen ever agreed to transfer her interest in Chasen Properties. Thereafter, the Court of Appeals of Virginia affirmed this order.

On January 8, 2009, Richard Chasen filed a malpractice suit against Batzli and Batzli Wood. Batzli gave notice to his insurer after receiving a copy of the complaint. The policy provided that the duty to notify Minnesota Mutual arose whenever the insured "did something that he knew, or reasonably should have known, would support a demand for damages." Minnesota Mutual denied coverage because Batzli failed to comply with the policy's notice requirement, claiming that Batzli knew or reasonably should have known that his failure to include Ms. Chasen's interest in Chasen Properties would support a demand for damages. The court disagreed and granted declaratory judgment to Batzli. It was uncontested that Ms. Chasen

would not have agreed to transfer her interest to Richard Chasen and that, if this provision had been part of the agreement, she would not have signed it. The court found that this fact, “combined with Richard Chasen’s apparent overall satisfaction with the Agreement, was enough to support the jury’s conclusion that a reasonable person in Batzli’s position would not have thought that his drafting omission would support a demand for damages.” *Id.* at \*5. The court concluded that “[a] reasonable jury therefore could have determined that Batzli could not have anticipated a demand for damages for failing to procure that which was unprocurable.” *Id.* at \*8.

In another case, the court found that a Verified Petition that only sought equitable relief was not a claim because it did not demand damages. *Popovitch & Popovitch, LLC, et al. v. Evanston Ins. Co.*, No. 07-2225, 2009 WL 2568090 (D.N.J. August 17, 2009). In *Popovitch*, the attorney failed to serve answers to interrogatories and, as a result, the matter was dismissed with prejudice. The client’s new lawyer served a Verified Petition on Popovitch. That Petition sought an order requiring Popovitch to provide information about the dismissed case. It did not seek any damages. Popovitch provided the Petition to his insurer, which accepted it as a notice of circumstances which could give rise to a claim. Popovitch failed to send the insurer the malpractice complaint until after his answer was stricken for failing to provide discovery. Because Popovitch failed to provide additional information, the insurer “was prejudiced and unable to evaluate whether the policy required it to provide coverage and whether it would defend and participate in settlement discussions.” *Id.* at \*8.

The characterization of the requested relief by the underlying plaintiff is not dispositive of whether there is coverage. In *Post v. St. Paul Travelers Ins. Co.*, 593 F. Supp. 2d 766, 752 F. Supp. 2d 499 (E.D. Pa. 2009), *aff’d* 2011 WL 2489738, (3d Cir. 2012), the court held that coverage was owed for sanctions proceedings initiated by a client against his attorney even though there was a “sanctions exclusion” in the professional liability insurance policy. The court noted that the term “sanctions” under the commonly understood definition referred to a sanctions motion brought by opposing counsel. In this case, there was an attorney client relationship between the attorney and that relationship indicated that the requested damages were actually malpractice damages. The court held that a professional liability insurance carrier cannot avoid coverage for what is essentially a malpractice claim simply because of how an attorney’s former client chooses to term the requested relief.

*Brownstein & Washko v. Westport Insurance Corp.*, No. CIV.A. 01-4026, 2002 WL 1745910 (E.D. Pa. July 24, 2002), is an example of losing insurance coverage because the lawyer allowed hope to overcome reality and did not properly identify a potential malpractice claim. Washko represented Mary Lou Maxwell in a state criminal proceeding where she was convicted at trial. On April 8, 1998, Maxwell fired Washko and retained new counsel, who filed a motion for post-verdict relief alleging (not surprisingly) ineffective assistance of counsel, prosecutorial misconduct, and trial court error. Washko testified extensively about his representation of Maxwell at an October 22, 1998 hearing. He was aware that one purpose of the hearing was to evaluate ineffective assistance of counsel. Washko claimed that Maxwell’s new lawyer told him after the hearing that Washko was “out of the woods” regarding the case. He learned several months after the hearing that Maxwell had been granted a new trial. In fact, on November 6, 1998, the trial court issued an opinion granting a new trial based solely on the Washko’s ineffective assistance. While Washko admitted that he had been informed that a new trial had been granted, he claimed that he was not aware of the grounds for the trial court’s decision until

after May 1, 1999, the effective date of his policy with Westport. The federal court hearing the declaratory judgment action assumed that fact was true.

On December 21, 1999, Washko was advised that Maxwell had retained separate counsel to sue him for legal malpractice and Brownstein & Washko notified Westport on December 22, 1999. Westport denied coverage based on the following exclusion:

This policy shall not apply to any claim based upon, arising out of, attributable to, or directly or indirectly resulting from:

\* \* \*

B. any act, error, omission, circumstance or personal injury occurring prior to the effective date of this policy if any insured at the effective date knew or could have reasonably foreseen that such act, error, omission, circumstance or personal injury might be the basis of a claim.

In ruling on cross-motions for summary judgment, the district court applied existing Third Circuit law holding that whether a lawyer believes, on the basis of his relationship with the client or his impression of the client's reaction to a particular situation, that the client would not make a claim, is not the relevant inquiry. Instead, the relevant inquiry is whether an attorney has a basis to believe that he has breached a professional duty or was aware of other facts which, when viewed by a reasonable person, could give rise to a malpractice claim.<sup>1</sup>

The court held that Washko knew as of May 1, 1999, the effective date of the policy, that: (1) Maxwell had fired him and retained new counsel; (2) one of the bases on which Maxwell sought to overturn the conviction was ineffective assistance of counsel (Washko); (3) Washko testified extensively at the post-conviction hearing; and (4) the motion for relief was granted and a new trial ordered. The court held that a reasonable lawyer in possession of these facts would have had reason to believe that they might form the basis of a future malpractice claim. The court rejected Washko's argument that he had no reason to believe there might be a malpractice claim given new counsel's comments and given the fact that he did not learn of the basis for the grant of the new trial until after his Westport policy inception. The court held that those were purely subjective factors which were insufficient to avoid application of the exclusion.

In *Fishman v. Hartford*, the court held that "[a] reasonable attorney could foresee that failure to file a claim prior to the running of the statute of limitations would be the basis for a subsequent malpractice suit against him. No. 12-3779, 2013 WL 5429272 at \*6 (E.D.Pa. Sept. 27, 2013). An inmate, Abdul Murray, contacted Brian Fishman of David S. Nenner & Associates, P.C. seeking representation for a civil suit against a correctional officer for assault. Murray faced assault charges from the incident. Between January 25, 2007 and December 22, 2008, Murray and Fishman communicated via letter about the potential civil suit. While interested in

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<sup>1</sup> The court cited *Selko v. Home Ins. Co.*, 139 F.3d 146 (3d Cir. 1998); *Coregis Ins. Co. v. Barrata & Fenerty, Ltd.*, 264 F.3d 302 (3d Cir. 2001), *Coregis Ins. Co. v. Wheeler* 24 F. Supp. 2d 475 (E.D.Pa. 1998), *Mount Arie Ins. Co. v. Thomas*, 954 F.Supp. 1073 (W.D.Pa. 1997).

representing Murray, Fishman advised Murray that he did not want to proceed with a civil rights suit until the criminal assault case was resolved. On August 26, 2008, Murray asked Fishman whether the delay in his assault case would impact the two-year statute of limitations for his civil rights case and Fishman allegedly did not respond. In October 2007, Murray wrote to Fishman again asking him to proceed with the civil rights suit, since the statute of limitations would run in December 2008. Again, he allegedly received no response. On December 22, 2008, Fishman informed Murray that he would not pursue a civil rights case on his behalf, because of the pending assault case and that the statute of limitations had run on his civil rights case. In May 2009, Fishman received a letter from the Disciplinary Board of the Supreme Court of Pennsylvania regarding a complaint filed by Murray in response to how Fishman handled his case, but this complaint was later dismissed. Murray ultimately filed a malpractice suit against Fishman. Hartford, Fishman's malpractice carrier was notified, and Hartford denied coverage based on a prior knowledge exclusion. The policy was a one-year claims made policy purchased in August 2010.

In upholding the denial of coverage, the court held that the prior knowledge provision of the Policy unambiguously precluded coverage "if the insured, as of August 24, 2010, the effective date of the Policy, 'knew or could have foreseen that [an] act, error, omission, or 'personal injury' could result in a 'claim.''" The court held that Fishman should have been able to foresee a malpractice suit as early as December 2008 based on the running of the statute of limitations, and at the latest in May 2009 when Murray filed his complaint with the Disciplinary Board. The court concluded that Fishman was aware of an act, error, or omission which he could have foreseen would result in a claim, and therefore, violated the prior knowledge exclusion. Consequently, Hartford did not have to defend or indemnify Fishman. *See, also Pelagatti v. Minnesota Lawyers Mut. Ins. Co.*, 2013 WL 3213796, at \*7 (E.D.Pa. 2013) (denying malpractice coverage for failure to report potential claim on insurance application).

Another example of courts upholding coverage based on a prior knowledge exclusion is *Javitch Block Eisen & Rathbone, PLL v. Target Capital Partners, Inc.*, 2006 WL 1781095 (Ohio App. Ct. June 29, 2006). In *Javitch Block*, the firm had filed four lawsuits on behalf of the Berrys and, in the summer of 1999, withdrew as counsel in one of the suits. The Berrys retained another law firm to both handle the four suits and to review Javitch Block's performance in handling their claims. After reviewing the claims, the new lawyer sent a letter to Javitch Block advising that it had committed multiple violations of the code of professional responsibility and that the Berrys could prove a *prima facie* case of legal malpractice against Javitch Block. In addition, the new lawyer asked Javitch Block to put its malpractice carrier on notice and demanded \$200,000 to settle the malpractice case. After receiving the letter, Javitch Block obtained a claims-made and reported legal malpractice policy from Legion which specifically excluded claims based on wrongful acts which occurred before the inception date of the policy if the insured was aware that its conduct constituted a wrongful act. When the Berrys sued Javitch Block, Legion originally provided a defense under reservation of rights, but later withdrew the defense. Javitch Block thereafter settled with the Berrys and sued Legion and its third-party administrator for defense costs and the settlement payment. Javitch Block argued that the allegations in the Berrys' malpractice complaint were not sufficiently specific to determine whether some or all of the alleged "wrongful acts" took place before the effective date of the policy. The court rejected that argument out of hand, and affirmed judgment in favor of the carrier.

In *Goodman v. Medmarc Ins.*, an Ohio court found that an insurance company had to provide coverage despite the policyholder failing to list a potential claim against it on the insurance application. 977 N.E.2d 128, 133 (Ohio Ct. App. 2012). Here the actual claim was filed in the policy period, but Medmarc argued that Goodman should have reasonably known that he could have been potentially sued when he filled out his application. The court held that, because the answers in the application were representations and not warranties, even if misrepresentations were made, they did not render the policy void *ab initio*. Under Ohio law, an insurer may cancel a voidable policy, but a representation “may not be used to avoid liability arising under the policy after such liability has been incurred.”

New York also enforces prior knowledge exclusions. Thus, in *Citak & Citak v. St. Paul Travelers Cos.*, No. 07 Civ. 5459(WHP), 2008 WL 1882660 (S.D.N.Y. April 28, 2008), the insured received a disciplinary complaint no later than January 27, 2006. The disciplinary complaint was based in part on dismissal of the client’s arbitration claim against a contractor, and other related acts and omissions. The malpractice policy issued by St. Paul had an inception date of April 2006. After the insureds were sued for malpractice, they sought a defense from St. Paul under the April 2006 policy and St. Paul denied coverage based on a prior knowledge exclusion. The court held that, where an attorney’s errors result in dismissal of the client’s arbitration claim, the attorney is on notice of a potential claim and receipt of a disciplinary complaint is a relevant factor in determining whether an attorney is on notice of a potential claim. In this case, because: (1) the client’s action against his contractor had been dismissed because the lawyers failed to bring the case to arbitration; (2) the lawyer never informed the client that a subsequent arbitration filing had been rejected by the AAA; (3) the lawyers failed to respond to the client’s repeated inquiries about the status of the action; and (4) the lawyers failed to pursue the action in court after it was rejected by the AAA, once the lawyers received the disciplinary complaint, they should have reasonably foreseen a malpractice claim. Therefore, the denial of coverage was proper and the prior knowledge exclusion was enforced by the court. *See also United Nat. Ins. Co. v. Granoff, Walker & Forlenza, P.C.*, 598 F.Supp.2d 540, 549 (S.D.N.Y. 2009) (When an attorney is asked by a carrier whether he is aware of any legal work that might reasonably be expected to lead to a claim, he is expected to answer “yes” only as to matters that involve a clear breach of duty, such as the failure to comply with the statute of limitations, attorney neglect, criticism by the court or disciplinary proceeding, or explicit threats of litigation).

Still another case enforcing a prior knowledge exclusion is *Westport Ins. Corp. v. Mirsky*, 84 Fed. Appx. 199, 2003 WL 23002528 (3d. Cir. 2003). In *Mirsky*, the lawyers represented Kaston in a medical malpractice case. The trial court in the medical malpractice barred Kaston’s expert witnesses from testifying as a sanction for alleged discovery violations and ordered Mirsky to pay \$800 in sanctions to defendants. Without expert testimony, Kaston lost the medical malpractice case on summary judgment on September 19, 1998. After summary judgment was granted, Mirsky and his co-counsel Hepps renewed their malpractice policies with Westport. Mirsky’s policy incepted on February 13, 1999 and Hepps’ policy incepted on July 19, 1999. Neither Hepps nor Mirsky reported any potential claim by Kaston to Westport before policy inception. In November of 1999, Kaston notified Hepps and Mirsky that she was suing them for malpractice. Hepps and Mirsky notified Westport, which filed a declaratory judgment action seeking to avoid coverage. The prior knowledge exclusion precluded coverage for:

Any CLAIM based upon, or arising out of, attributable to,  
or directly or indirectly resulting from:

\* \* \*

B. Any act, error, omission, circumstance or PERSONAL INJURY occurring prior to the effective date of this POLICY if any INSURED at the effective date knew or could have reasonably foreseen that such act, error, omission, circumstance or PERSONAL INJURY might be the basis of an CLAIM.

The Third Circuit affirmed the trial court's decision in favor of Westport. The trial court had cited prior Third Circuit law holding that, when an attorney has a basis to believe he has breached a professional duty, he has a basis to foresee that the breach might lead to a professional liability claim. Here, Hepps and Mirsky should have reasonably known of the potential claim by September 19, 1998, the date summary judgment was granted against Kaston or, certainly, by October 23, 1998, the date they filed an appeal in the medical malpractice case. Because both of these dates pre-dated the inception of their Westport policies, the prior knowledge exclusion applied and Westport owed neither a duty to defend nor indemnify.

In *Westport Ins. Corp. v. Law Offices of Marvin Lundy*, No. Civ.A. 03-CV-3229, 2004 WL 555415 (E.D. Pa. March 19, 2004), the court held that the claim was made before the policy inception and, therefore, the court did not need to reach the prior knowledge exclusion. The undisputed material facts showed that Christopher Worrall retained the Lundy firm to prosecute a slip and fall case against the Atlantic City Convention Center and other entities. In July of 2000, Worrall retained a new lawyer who gave Tort Claim Act notices to various defendants. On November 28, 2000, another lawyer acting on behalf of Worrall sent a letter to the Lundy firm asserting that he would be seeking monetary damages from the Lundy firm's malpractice carrier or from the firm itself, and asking the firm to forward the letter to its malpractice carrier. The letter referenced Worrall's "prospective legal malpractice claim" against the Lundy firm for the firm's failure to serve the proper notices on the culpable public entities. In the subsequent declaratory judgment action, the Lundy firm asserted that the firm believed the allegations in the November 28<sup>th</sup> letter to be in error because the firm had filed the appropriate tort claim notices. A firm lawyer e-mailed Worrall's lawyer on December 20, 2000 and April 16, 2001 seeking an explanation of the basis for the malpractice claim. In the latter e-mail, the firm lawyer stated that, given the lack of response, the firm assumed no malpractice claim would be forthcoming.

On October 10, 2001, the Lundy firm applied for malpractice insurance with Westport, but made no mention of Worrall's claim, even though it identified certain other potential claims which might be asserted against the firm. The policy went into effect October 8, 2001. On January 30, 2002, Worrall filed a malpractice suit against the Lundy firm in New Jersey state court.

The declaratory judgment court noted that the November 28, 2000 letter constituted a "claim" for loss under the policy because it specifically made a demand on an insured for money. Therefore, Worrall's claim was made before the inception date of the policy and, as the policy

was a claims-made policy, was not covered. Whether the insured believed the letter was a viable claim, or a claim at all, was not relevant. The policy definition of “claim” was clear and unambiguous and must be enforced as written. In a footnote, the declaratory judgment court also noted that he would not have granted summary judgment on the prior knowledge exclusion because Worrall’s malpractice counsel did not respond to two e-mails asking for the basis of the claim, and the second e-mail noted that the Lundy firm was closing its file. The court held that whether the insured’s belief that the claim was no longer outstanding was reasonable was an issue of fact. That holding was *dicta* because the court ruled that an actual claim had been made before the inception date of the policy.

It is interesting to compare *Brownstein & Washko* with *Lundy*. In the former, being told that you “are out of the woods” is not sufficient to avoid a prior notice exclusion, while in the latter whether it is reasonable to believe there will be no claim based on the former client’s lawyer’s silence creates an issue of fact. One potentially distinguishing feature may be that, in *Brownstein & Washko*, the lawyer made no effort to find out what happened to the former client’s case, while in *Lundy*, the lawyer was positively responding to a notice letter. The difference may be that a belief that no claim will be made is more reasonable if one is actually pursuing information, as opposed to effectively ignoring the problem.

In two more recent cases applying the prior knowledge exclusion, the courts held that in certain situations a reasonable attorney should know that a legal malpractice claim is possible. For example, in *Westport Insurance Corp. v. Jacobs & Barbone, P.A.*, No. 08-0801, 2009 WL 922023 (D.N.J. March 31, 2009), the court held that the prior knowledge exclusion barred coverage for a malpractice claim. The client’s medical malpractice case was dismissed because of Barbone’s failure to serve a proper summons on the defendant. The court applied the Third Circuit’s test: (1) “[t]he first condition in the exclusion is satisfied if the insured had knowledge of the relevant suit, act, error, or omission, and (2) [t]he second condition in the exclusion, in contrast, is satisfied if the suit, act, error, or omission might reasonably be expected to result in a claim or suit.” *Id.* at \*4. The court found that, as a matter of law, “a reasonable professional in Barbone’s position would have expected that a claim for malpractice was possible” since Barbone failed to serve a proper summons and, as a direct result, Beese-Munoz’s complaint was dismissed. *Id.* at \*5. Other recent cases applying this exclusion include *Malcolm Blum v. The Travelers Indemnity Co.*, No. 06-916 (JAG), 2008, 2008 WL 2557538 (D.N.J. June 23, 2008); *Executive Risk Indem. Inc. v. Pepper Hamilton LLP*, 13 N.Y.3d 313, 322 (N.Y. App. Div. 2010).

## **B. Other Issues**

Moving away from notice issues, as lawyers move from firm to firm ever more frequently, it is increasingly important to consider the implications of the change of firm for malpractice coverage. This lesson was brought home in *Jolley v. Marquess*, 393 N.J. Super. 255, 923 A.2d 264 (App. Div. 2007). Marquess was a former partner and former employee of Marquess, Morrison and Trimble, P.A. While Marquess was still a partner, the firm was retained by American Independent Insurance Company (AIIC) to defend AIIC’s insured, Barbara Gorna, in an automobile negligence action filed by Jolley. AIIC was actually Morrison’s client and the file was originally sent to Morrison, who was designated as trial counsel in Gorna’s answer to the complaint in the underlying action. Morrison later asked Marquess to handle pretrial discovery and motions, which he did. Jolley’s lawyer sent several *Rova Farms* letters to both the



firm and AIIC.<sup>2</sup> All letters sent to the firm were addressed to Morrison. The letters were dated March 4, 1998, November 18, 1998, and December 16, 1998. The last letter notified the firm that Jolley would no longer accept policy limits (\$30,000) to settle the claim. On December 22, 1998, Marquess finally advised Jolley's counsel that AIIC had authorized a policy limit settlement. On January 4, 1999, Jolley's counsel responded that it was too late. Counsel advised that Jolley intended to pursue all of her claims for damages without any limitation, and would look to AIIC for payment of any damages in excess of policy limits.

On November 2, 1999, Marquess, Morrison and Trimble decided to dissolve the firm. From November 2, 1999 until April 30, 2000, Marquess was a "senior trial attorney", not a partner, with the firm. Marquess went out on his own effective May 1, 2000. Marquess took neither AIIC nor Gorna with him as clients when he left the firm. Less than one week before the scheduled May 15, 2000 trial of the Jolley case, Morrison asked Marquess to try the case. Marquess agreed to do so, but only if Morrison agreed to let Marquess bill AIIC directly, and Morrison agreed. The May 15, 2000 trial date was adjourned and trial began August 8, 2000. On August 9, 2000, the jury rendered a verdict finding Gorna 100% responsible for the accident. That same day, Marquess entered into an agreement that Gorna would pay Jolley stipulated damages in the amount of \$750,000, plus pre-judgment interest. Gorna was never asked to consent to the stipulation. On September 5, 2000, a judgment in the amount of \$878,475 was entered in favor of Jolley and against Gorna. Marquess had written to Gorna advising that she would not be personally responsible to pay any portion of the judgment, which was not reflected in the September 5, 2000 judgment order. Gorna and Jolley sued AIIC, Marquess, and Morrison, Morrison and Trimble on October 31, 2001. After Marquess was sued in the malpractice action, he filed a third-party complaint against Zurich (the firm's malpractice carrier up until the time Marquess left the firm) seeking defense and indemnity from Zurich. Zurich specifically denied having a duty to defend or indemnify Marquess, claiming that he was not a member of the firm or a named insured under the policy, particularly at the time that Marquess stipulated to damages.

Zurich and Marquess filed cross-motions for summary judgment. While there were some disputed facts, the lower court found that none were material. Both sides agreed that no substitution of attorney was ever filed and that Marquess, Morrison and Trimble was counsel of record for Gorna during trial. Both Marquess and Zurich agreed that Marquess billed AIIC directly for his work on the Gorna file after he left the firm, and further agreed that when Marquess left the firm, he did not forward a Counsel Selection form to AIIC. Marquess testified in the lower court that Morrison asked him to try the case as a favor to Morrison, and Morrison agreed that, as of April 30, 2000, he was not in a position to defend the Gorna case. Other undisputed facts the trial court found relevant included that Marquess sent a letter to AIIC with a blind carbon to Morrison after every day of trial and that Morrison remained involved in the handling of the file even after Marquess left the firm. Based on these facts, Marquess argued that he had been hired by the firm of Morrison & Trimble to try the case on its behalf and that the file remained a Morrison & Trimble file even after Marquess left the firm.

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<sup>2</sup> See *Rova Farms Resort, Inc. v. Investors Ins. Co. of America*, 65 N.J. 474, 484, 328 A.2d 495 (1974) (holding that an insurer which violates its fiduciary duty to settle a case within policy limits is liable for any excess verdict).

The Appellate Division looked carefully at the policy definition of insured, which read as follows:

1. *The Insured*: The unqualified word “insured,” whenever used in this policy means:

(a) the Named Insured firm or predecessor firm set forth in the Declarations;

(b) any partner of the Named Insured firm or predecessor firm, including any incorporated partners and their shareholders, but solely while acting in [a] professional capacity on behalf of such firm or firms;

(c) any person who is not defined as Named Insured, but was, is now, or hereinafter becomes an employed lawyer or another employee of the firm or predecessor firms named in the Declarations *solely while acting in a professional capacity on behalf of such firm or firms*;

(d) any former partner, officer, director or stockholder employee of the firm or predecessor firms named in the Declarations *while acting solely in a professional capacity on behalf of such firms*;

(e) any partner, officer, director or stockholder employee of the firm or predecessor firms named in the Declarations who have retired from the practice of law, but only for those professional services rendered prior to the date of retirement from the Insured firm;

\* \* \*

(g) Lawyers acting as “of Counsel,” but only while acting in a professional capacity on behalf of the Named Insured.

393 N.J. Super. at 267 (emphasis added).

The court focused on sub-sections (c) and (d), and noted that the language of those sub-sections was neither clear nor straightforward. Indeed, the court characterized it as “vague and uncertain.” The court held that sub-sections (c) and (d) intended to limit coverage to those instances where a former associate or former partner represented a party who remained a client of the insured firm, as opposed to a successor firm. The court noted that sub-section (e), which applied to retired partners, provided that they were insured, “but only for those professional services rendered prior to the date of retirement from the insured firm.” Because Zurich did not use similar language for sub-sections (c) and (d), and because Zurich could have used the same language in those sub-sections, the mere fact that any malpractice by Marquess took place after he left the firm did not mean he was not entitled to coverage under the Zurich policy. The

Appellate Division affirmed the trial court's holding that, under the circumstances of this case, Marquess was acting solely in a professional capacity on behalf of Morrison & Trimble and the predecessor firm, Marquess, Morrison & Trimble.

The Appellate Division then reviewed the trial court's conclusion that the malpractice complaint was worded broadly enough to include malpractice committed by Marquess both before and after he left the firm. Because the malpractice claims could encompass both the failure to respond to the *Rova Farms* letters and the stipulation to damages, and because the complaint did not specify specific time frames for each specific alleged act of malpractice, Zurich was obligated to cover Marquess for acts or omissions occurring both before and after he left the firm.

Turning to some of the other exclusions frequently found in medical malpractice policies, another key issue is whether a lawyer is acting solely in his capacity as a lawyer providing professional services, or in a capacity as an officer, director, partner, manager, employee of any other business entity, triggering some version of the exclusion for other entity activities. *Westport Ins. Corp. v. Bayer*, 284 F.3d 489 (3d Cir. 2002), highlights both the need to carefully explore precisely what a lawyer is doing at the time of the alleged breach of duty and the importance of complete answers in insurance applications.

In *Bayer*, Keith Fryer claimed to be running a secondary mortgage business in England and used that claim to collect substantial amounts of money in investments. In a classic Ponzi scheme, he used the money from the later investors to pay off the early investors. Brown was an early investor and negotiated a deal with Fryer that gave Brown a business commission for bringing in new investors. Brown retained Bayer as his attorney to negotiate the commission arrangement with Fryer. Bayer received one-third of Brown's commissions and himself invested heavily with Fryer. Bayer attended meetings hosted by Brown for prospective investors and generally promoted the investment. The Lakens ultimately invested almost \$700,000 in this venture. In 1996, an audit discovered the fraud and the Lakens sued Bayer, Fryer and several other defendants for misrepresentation and fraud. All of the defendants were either fictitious, bankrupt or judgment proof, including Bayer. The Lakens eventually obtained an order allowing them to proceed against Bayer to the extent of his malpractice policy with Westport. Westport thereafter filed a declaratory judgment action seeking a ruling that it had no duty to defend or indemnify Bayer.

The trial court found for the Lakens and against Bayer in the underlying litigation, finding that Bayer was Fryer's point of contact in America, introducing Fryer to potential investors. Bayer endorsed the investment opportunity, received funds from American investors and forwarded them to Fryer in England. Bayer received one-third of the commissions and was authorized to draw checks on Fryer's American business account in emergencies. The court also found that the Lakens had never retained Bayer as their attorney, but that Bayer created the impression that he was "looking out for" the Lakens' interest. He permitted the Lakens to believe that he had checked out Fryer's activities and claimed to have performed a due diligence investigation. The Lakens relied on the information they received from Bayer. The trial court in the underlying action therefore held that Bayer had an obligation to make clear that he was not protecting the Lakens' interest and that they should seek legal advice elsewhere, or to exercise

reasonable care to avoid misrepresentations. He also found that the Lakens justifiably relied on Bayer.

As far as the coverage case, when Bayer applied for his legal malpractice policy, he answered “no” to questions asking whether he was involved in money management activities or recommending investments and specific securities. However, in an addendum he attached to his application, he specifically identified his precise involvement with Fryer’s operations. The insuring agreement of the policy provided coverage for claims against Bayer “arising out of services rendered or which should have been rendered by any insured . . . and arising out of the conduct of the insured’s profession as a lawyer. 284 F.3d at 494-95. The policy contained an exclusion for “any claim arising out of any insured’s activities as an officer, director, partner, manager or employee of any company, corporation, operation, organization or association other than [the] named insured.” 284 F.3d at 495. It also contained an exclusion for claims “arising out of or in connection with the conduct of any business enterprise other than the named insured . . . which is owned by any insured or in which any insured is a partner, or which is directly or indirectly controlled, operated or managed by any insured either individually or in a fiduciary capacity.” *Id.*

The trial court in the declaratory judgment action found that Bayer considered himself to be practicing law as an attorney representing Fryer in the United States, that the Lakens thought Bayer was performing legal services as an attorney, that Bayer held himself out to the Lakens a practicing lawyer and the Lakens dealt with him on that basis, and that Bayer was never an officer, director, partner, manager or employee of any of Fryer’s businesses. Westport argued that the Lakens’ claims did not arise out of Bayer’s conduct as a lawyer and, therefore, the policy provided no coverage. The Third Circuit noted that professional liability can arise out of an attorney’s activities with those other than an actual client. The language “arise out of” is very broad and “may well give rise to a finding of ambiguity in an insurance policy.” 284 F.3d at 497 (citing *Biborosch v. Transamerica Ins. Co.*, 412 Pa. Super. 505, 603 A.3d 1050, 1056 (1992)). The “arising out of” language requires that coverage be broadly construed. *Id.* The court held that, under a broad construction of the coverage grant in Bayer’s policy, reasonably intelligent people could differ as to whether the coverage grant included Bayer’s actions in connection with Fryer’s Ponzi scheme. Therefore, the policy was ambiguous and, particularly in light of the addendum Bayer attached to his application for coverage, Bayer had a reasonable expectation that his work in connection with Fryer’s activities would be covered. Consequently, the Third Circuit held that Bayer had met his burden of proving that the claim fell within the policy’s coverage grant.

The Third Circuit rejected application of the other business entity exclusions because the district court found that Bayer had never served as an officer, director, partner, manager or employee of any entity other than his own firm, and that Bayer neither directly nor indirectly controlled nor operated any other business entity. The Third Circuit explicitly rejected the argument that Bayer’s involvement with Fryer’s enterprises was control or operation. Therefore, the exclusions did not apply and Bayer was entitled to defense and indemnity. *But see Rissman, Barrett, Hurt, Donahue & McClain, P.A. v. Westport Ins. Corp.*, 477 Fed.Appx. 639, 641 (11th Cir. 2012) (denying coverage under legal malpractice policy where complaint alleged that lawyer was acting as an unlicensed real estate broker).

Policyholders do not fare as well when there is a specific exclusion for any claim “arising out of the solicitation or sale of...specific investments.” For example, in *Minnesota Lawyers Mut. Ins. Co. v. Thomas J. Ahrens, et al.*, Nos. 10-2779 and 10-2780, 3d Cir., 2011 WL 2489738 (3d Cir. June 23, 2011), the Third Circuit found that the District Court did not err in finding that there was no coverage for \$8.7 million in client losses arising from investments in gold and commodities futures. The insured lawyer argued that, because the transactions were sometimes called “loans,” they were not investments. The Third Circuit found that the District Court did not err in finding that, even though the clients sometimes called the transactions “loans” and their expected returns “interest,” this did not end the inquiry. *Id.* at \*4. The facts as pleaded in the complaint “indicated that the clients expected to profit” and “that their expected returns depended upon that success, not on an interest rate.” *Id.* Even though “some of them sought mortgages to further secure their investments, that did not convert their speculative investments into loans.” *Id.*

The importance of giving notice properly is illustrated in *Ohio Bar Liability Ins. Co. v. Hunt*, 152 Ohio App. 3d 224, 787 N.E. 2d 82 (Ohio App. 2 Dist. 2003). In *OBLIC*, the Pollards fired Hunt after he failed to timely appeal from an adverse judgment in their daughter’s personal injury suit. Hunt claims he then called OBLIC, his malpractice carrier, to advise of a potential claim. The Pollards eventually sued Hunt for malpractice in 1996, but Hunt did not forward a copy of the complaint against him, or provide written notice of the complaint, until four years later, when his defense attorney finally wrote to OBLIC. OBLIC ultimately denied coverage. After Hunt and the Pollards alerted OBLIC that they would enter into a consent judgment if OBLIC failed to defend and indemnify, the trial judge approved a \$750,000 settlement and entered judgment against Hunt in that amount. Hunt paid only \$4,000, but assigned his bad faith claim against OBLIC to the Pollards in exchange for their agreement to satisfy the judgment only against OBLIC. The Pollards then sued OBLIC. The trial court found that the policy required written notice of a claim, which was not given. Therefore, there was no coverage.

The policy contained several different notice requirements, which were quoted by the court as follows:

#### 1) NOTICE

Except to such extent as may otherwise be provided herein, the coverage of this policy is limited to liability for only those claims that are first made against the insured and reported to the Company while the policy is in force.

#### 2) I. COVERAGE

To pay on behalf of the Insured all sums which the Insured shall be legally obligated to pay as money damages because of any claim first made against the Insured and *reported to the Company during the policy period \* \* \**” (Emphasis added by the court).

#### 3) V. POLICY PERIOD AND TERRITORY

A Claim is first made during the Policy Period or Extended Reporting Period if:

(a) during the Policy Period or Extended Reporting Period, the Insured shall have knowledge or become aware of any act, error, or omission which could reasonably be expected to give rise to a Claim under this policy, and shall, during the Policy Period or Extended Reporting Period, give written notice thereof to the Company in accordance with Condition VI.

\* \* \* A Claim shall be considered to be first made when the Company first receives written notice of the Claim or of any event which could reasonably be expected to give rise to a Claim.

#### 4) VI. NOTICE OF CLAIM OR SUIT

Upon the Insured's becoming aware of any act, error, or omission which would reasonably be expected to be the basis of a Claim or suit covered hereby, *written notice shall be given* by or on behalf of the Insured to the Company or any of its authorized agents as soon as practicable, together with the fullest information obtainable. If 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." (Emphasis added by the court).

#### 5) WHAT TO DO IN CASE OF A CLAIM

In the event you directly or indirectly become involved in any situation which you believe may result in a claim, you should immediately report it to your OBLIC claims representative.

Telephone: \* \* \*

Mailing Address: \* \* \*.

The court held that the first and last provisions did not specify written notice, and the last specifically implied that telephone notice was adequate by including a telephone number. Although the other provisions required written notice, the court held that the provisions conflicted, creating an ambiguity. However, although the appellate court reversed the grant of summary judgment against the Pollards, it found an issue of fact as to precisely when Hunt gave oral notice to OBLIC. It, therefore, remanded for determination of that issue. Interestingly, the court did not address whether OBLIC was entitled to deny coverage based on the four-year delay in sending the complaint to OBLIC, which prevented OBLIC from defending the case.

This case teaches the importance of reviewing notice provisions in malpractice policies because the entire problem could have been avoided had Hunt simply reviewed the policy and either given written notice, or asked OBLIC whether written notice was required.<sup>3</sup>

Federal courts, in particular, have no problem supporting a coverage denial even in the face of sympathetic plaintiffs. In *Westport Ins. Corp. v Hanft & Knight, P.C.*, 523 F. Supp. 2d 444 (M.D. Pa. 2007), the Diehls engaged Michael Hanft as their lawyer before 1997. Beginning in 1997, Hanft convinced the Diehls to loan him large sums of money, often on an unsecured basis, and always on terms unfavorable to the Diehls. The Diehls placed their trust in Hanft and relied on Hanft's status as their lawyer. By January 2003, Hanft owed the Diehls almost \$800,000 and, acting as both borrower and attorney for the Diehls, Hanft prepared a promissory note to evidence this debt. The Diehls later learned that Hanft had misrepresented the purpose of the loans and had actually used the money to satisfy gambling debts. In the meantime, on January 1, 2002, Hanft and Gregory Knight formed the law firm Hanft & Knight, P.C., with Hanft holding 75% of the shares. Hanft committed suicide August 11, 2004.

The Diehls sued, asserting four claims against Hanft's estate, including rescission of the note, breach of the note, breach of contract, and breach of contract on two of the loans. The Diehls also asserted three claims against the firm, including breach of its duty of care, breach of fiduciary duty, and violation of Pennsylvania's Unfair Trade Practices and Consumer Protection Law.

Hanft & Knight was insured under a Westport policy for the period December 31, 2003-2004. The named insured was Hanft & Knight, P.C. "Insured" included "any lawyer who is a past or present partner, officer, director, stockholder, shareholder, employee, or 'of counsel' of the Named Insured, but only as respects legal services rendered on behalf of the Named Insured." The policy was a claims made policy which obligated Westport to:

pay on behalf of any Insured Loss in excess of the deductible which any Insured becomes legally obligated to pay as a result of Claims first made against any Insured during the Policy Period . . . by reason of any Wrongful Act occurring on or after the Retroactive Date, if any.

"Loss" included "the monetary and compensatory portion of any judgment, award or settlement" but did not include civil or criminal fines, penalties, fees or sanctions or punitive or exemplary damages. Wrongful Act included "any act, error, omission, circumstances Personal Injury or breach of duty in the rendition of legal services for others, either for a fee or pro bono in the Insured's capacity as a lawyer . . .".

In a comprehensive opinion, the court addressed several issues under the insuring agreement and the applicability of various exclusions. Westport first argued that Diehls' claims for principal and interest on their loans sought restitution, not compensatory damages. The court held that the various claims included claims for damages for breach of duty which sought

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<sup>3</sup> Of course, all good lawyers know that any important oral communication should be confirmed in writing.

damages falling within the policy definition of “ Loss.” Because the professional malpractice claims were separate, viable claims seeking compensatory damages other than pure restitution, they fell within the scope of the policy’s coverage and Westport could not avoid its duty to defend on that basis.

Westport also argued that Pennsylvania public policy precluded insurance coverage because paying the loss would allow the insureds to benefit from their wrongdoing. The court noted that, while the Hanft estate might receive a windfall if Westport indemnified a judgment against it, Hanft & Knight would not because there was no evidence that the firm benefited from the loans provided by the Diehls. The court, therefore, rejected Westport’s arguments that indemnifying against this loss would be contrary to Pennsylvania public policy.

The court then turned to various exclusions. The personal profit exclusion provided that the policy “shall not apply to any Claim based upon, arising out of, attributable to, or directly or indirectly resulting from any Insured having gained in fact any personal profit or advantage which he or she was not legally entitled.” The court held that the exclusion applied because the Diehls alleged that Hanft fraudulently induced the Diehls to loan him the money, abused his attorney-client relationship, used the money to satisfy gambling debts, and that the Diehls received nothing of value for their loans, which Hanft never intended to repay. According to the court, these allegations established that Hanft gained personal profit to which he was not legally entitled through the wrongful acts out of which the Diehls’ claims arose. The court rejected the Diehls’ argument that, because the loans were debts to be repaid, Hanft did not profit. The allegations in the underlying action that Hanft never intended, and made no serious effort, to repay the loans gutted that defense. The court also held that, because the loans were procured through fraud and misrepresentation, Hanft was not legally entitled to the money at any time and, therefore, the jury could not find that Hanft was legally entitled to the loan money, but simply committed malpractice in failing to properly secure the Diehls’ interest.

Turning to the prior knowledge exclusion, which is identical to the one quoted above with regard to the *Brownstein & Washko* case, the court also relied on *Selko* and *Baratta & Fenerty* in holding that the Third Circuit applies a mixed subjective/objective standard to determine when claims fall within this exclusion. The court held that the circumstances of this case (*i.e.*, Hanft securing money through fraudulent misrepresentation, using the money for gambling debts, and drafting illusory promissory notes) provided any reasonable attorney with a basis to believe that he had breached his professional duty.

The Westport policy also had a dishonesty exclusion which stated that the policy:

shall not apply to any Claim based upon, arising out of, attributable to, or directly or indirectly resulting from any criminal, dishonest, malicious or fraudulent act, error, omission, or Personal Injury committed by an Insured. This exclusion does not apply to any Insured who is not so adjudged.



The court held that the allegations of the Diehls' complaint fell within the dishonest acts portion of the exclusion and supported Westport's denial on this basis. The court also applied a conversion/misappropriation exclusion, finding that Hanft had converted the Diehls' funds.<sup>4</sup>

Finally, the Diehls argued that, even if the underlying claims against Hanft were excluded, the claims against Hanft & Knight were potentially covered because the firm was an innocent co-insured. The court noted that the personal profit and prior knowledge exclusions applied to "any Insured." Because Hanft was clearly an insured, at least those two exclusions applied to preclude coverage for the firm.

One would think that in this day and age lawyers would understand that they should not represent adverse parties in transactions in which they themselves have a direct interest. For example, one would hope that a lawyer would understand that if he is selling his own house, he should not represent the buyers. Surprisingly, however, that is exactly the allegation in *Milgrub v. Continental Casualty Co.*, 2007 WL 625039 (W.D. Pa.). On September 9, 2003, Milgrub and his wife entered into a contract with the Browns to sell their home. The Browns alleged that Milgrub acted as both the seller and the Browns' attorney in the transaction. In November of 2004, the Browns sued Milgrub and his wife alleging fraudulent misrepresentation and claims under various Pennsylvania statutes. Counts IV and V of the complaint stated claims against Milgrub individually for fiduciary duty and professional negligence arising out of his conduct as the Browns' lawyer. Milgrub forwarded the complaint to Continental, which had issued him a malpractice policy with effective dates of August 1, 2003-2004. That policy contained an exclusion for any claim "based on or arising out of Insured's alleged liability under any oral or written contract or agreement . . ." unless liability "would have attached to the Insured in the absence of " the oral or written agreement or contract. Continental denied coverage based on this contractual liability exclusion.

The court held that the claim against Milgrub for conflict of interest and depriving the Browns of effective representation in the real estate transaction fell within the exclusion because Milgrub's liability under those claims was solely a product of the contract with the Browns. However, the court also held that some of the breach of fiduciary duty claims depended solely on the conflict of interest, and were outside of the agreement of sale. The court held Milgrub's failure to disclose negative conditions and failure to demand that the Browns close without compensation for defects were breaches of fiduciary duty not tied to the contract of sale. Therefore, the exclusion did not apply to those allegations and Continental was required to provide coverage for at least those claims.

In *Gladstein and Isaac v. Philadelphia Indemnity Insurance Company*, No. 601014/07, 2009 WL 4728827 (N.Y. Sup. Ct. November 30, 2009), a client alleged that Allen H. Isaac had "caused offensive sexual bodily contact, verbally abused, verbally sexually abused, verbally demeaned, and sexually harassed her" during trial preparation. The client, Luisa Esposito, sued

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<sup>4</sup> The exclusion provided that the policy did not apply to "any Claim based upon, arising out of, attributable to, or directly or indirectly resulting from any conversion, misappropriation or improper comingling of client funds. This exclusion does not apply to any Injured who is not so adjudged."

Allen H. Isaac, Harvey Goldstein and Goldstein & Isaac. The firm's malpractice insurer, Philadelphia Indemnity Insurance Company, denied coverage on the basis that the allegations against Allen H. Isaac were "intentional acts" for which the company owed no defense. The Court held that, although the insurer owed no duty to defend Allen H. Isaac against allegations of intentional torts, the insurer did owe a duty to defend Harvey Goldstein and Goldstein & Isaac to the extent that Goldstein and the firm "may be held liable for the negligent hiring, training, supervising, and retaining control over Allen H. Isaac."

The outcomes of other recent cases interpreting fraud exclusions have also depended on the allegations in the underlying complaint. *Compare Minnesota Lawyers Mut. Ins. Co. v. Christopher Mazullo*, No. 09-830, 2010 WL 1568465 (E.D. Pa. April 19, 2010) (excluding coverage for complaint that alleged "dishonesty, fraud and maliciousness") *with Boccone v. Eichen Levinson LLP*, 301 Fed. Appx. 162 (3d Cir. 2008) (finding that, although ex-husband couched claim against law firm in terms of fraud and deceit, the claim against the ex-wife's law firm was essentially one for breach of duty imposed by the New Jersey child support judgment lien statute and was covered under the policy).

### **III. CONCLUSION**

The cases discussed above reflect two unsurprising concepts for legal malpractice insurance coverage: (1) insurance companies do not want to pay for liability arising out of fraud or non-legal businesses which the carrier is not insuring; and (2) lawyers should pay very careful attention to the terms and conditions of their malpractice policies, especially notice provisions. The limited availability of coverage for fraud is neither surprising nor distressing because it is generally against public policy to allow insurance coverage for criminal activity. It is also not surprising that insurers do not want to pay claims arising out of business entities other than the lawyers and law firms who are named in the policy. Outside entities can and do have unknown risks and exposures for which the insurer is not collecting a premium. To the extent a lawyer or law firm wants coverage for those activities, they should be disclosed to the insurer so that an appropriate risk evaluation can be made. Alternatively, lawyers should get separate coverage for outside business entities.

Finally, the importance of reviewing and understanding malpractice coverage cannot be understated. Even in a large law firm, lawyers should understand the basic scope of their malpractice coverage and their obligations to give notice of actual and potential claims to both management and their carriers.







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<input type="checkbox"/> I am an attorney employed full time by a local, state, or federal government agency or a nonprofit legal services office, as opposed to an independent contractor. Your Signature _____	
Type of Practice	<input type="checkbox"/> Private <input type="checkbox"/> Government <input type="checkbox"/> Corporate
Area(s) of Specialization _____	
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(or) Date Admitted _____ in County of _____	
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## EARLIEST ADMIT DATE TO ANY STATE BAR

On or before 10/07/10

## PRORATED SCHEDULE

## DUES

## GOV'T ATTY.\*

Nov.–March .....	\$305.00	\$244.00
April–June .....	229.00	183.00
July–Sept. ....	153.00	122.00
Oct.–Dec. ....	77.00	61.00

10/08/09 thru 9/19/11

Nov.–March .....	\$244.00	\$196.00
April–June .....	183.00	147.00
July–Sept. ....	122.00	98.00
Oct.–Dec. ....	61.00	49.00

9/20/10 thru 9/19/12

Nov.–March .....	\$183.00	\$147.00
April–June .....	138.00	111.00
July–Sept. ....	92.00	74.00
Oct.–Dec. ....	46.00	37.00

9/20/11 thru 9/19/13

Nov.–March .....	\$122.00	\$98.00
April–June .....	92.00	74.00
July–Sept. ....	61.00	49.00
Oct.–Dec. ....	31.00	25.00

On or after 9/20/13

FREE

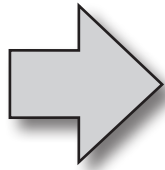
## Lawyers not admitted to practice in PA (Associate Membership)

Nov.–May.....	\$175.00	N/A
June–Dec. ....	88.00	N/A

Not Admitted to PA Bar

\* A government attorney is defined as an attorney who is employed full time by a local, state, or federal government agency or a nonprofit legal services agency, as opposed to an independent contractor.

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- |  |         |  |         |
|--|---------|--|---------|
| <input type="checkbox"/> Administrative Law .....        | \$25.00 | <input type="checkbox"/> Intellectual Property Law.....          | \$35.00 |
| <input type="checkbox"/> Aeronautical & Space Law .....  | 20.00   | <input type="checkbox"/> International & Comparative Law .....   | 15.00   |
| <input type="checkbox"/> Business Law.....               | 25.00   | <input type="checkbox"/> Labor & Employment Law.....             | 40.00   |
| <input type="checkbox"/> Civil Litigation.....           | 45.00   | <input type="checkbox"/> Municipal Law .....                     | 15.00   |
| <input type="checkbox"/> Criminal Justice.....           | 35.00   | <input type="checkbox"/> Public Utility Law.....                 | 25.00   |
| <input type="checkbox"/> Education Law .....             | 15.00   | <input type="checkbox"/> Real Property, Probate & Trust Law..... | 35.00   |
| <input type="checkbox"/> Elder Law.....                  | 35.00   | <input type="checkbox"/> Solo & Small Firm Practice.....         | 35.00   |
| <input type="checkbox"/> Environmental & Energy Law..... | 25.00   | <input type="checkbox"/> Tax Law.....                            | 15.00   |
| <input type="checkbox"/> Family Law.....                 | 65.00   | <input type="checkbox"/> Workers' Compensation Law .....         | 30.00   |

Check here if you are a new section member or you have not belonged to the selected section for five years or longer. You will receive a free, one-year section membership! (Limited to one free section membership.)

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City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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# *PBA Working Rules of Professionalism*

**T**he practice of law is a profession, a genuine calling inspired with service to the system of justice, not a common business enterprise. The quality of the profession is only as worthy as the character of the people who practice it.

Self-esteem, shared respect for each other, the clients we serve, the judges and the officers with whom we work, are essential to it.

Civility is a virtue, not a shortcoming. Willingness to temper zeal with respect for society's interest in preserving responsible judicial process will help to preserve it.

Unwritten rules of professional courtesy have long sustained us. Since they are sometimes forgotten, we should set them down again and conscientiously observe them.

- 1** Treat with civility the lawyers, clients, opposing parties, the Court, and all the officials with whom we work. Professional courtesy is compatible with vigorous advocacy and zealous representation.
- 2** Communications are lifelines. Keep the lines open. Telephone calls and correspondence are a two-way channel; respond to them promptly.
- 3** Respect other lawyers' schedules as your own. Seek agreement on meetings, depositions, hearings and trial dates. A reasonable request for a scheduling accommodation should never be unreasonably refused.
- 4** Be punctual in appointments, communications and in honoring scheduled appearances. Neglect and tardiness are demeaning to others and the judicial system.
- 5** Procedural rules are necessary to judicial order and decorum. Be mindful that pleadings, discovery processes and motions cost time and money. They should not be heedlessly used. If an adversary is entitled to something, provide it without unnecessary formalities.
- 6** Grant extensions of time when they are reasonable and when they will not have a material, adverse effect on your client's interest.
- 7** Resolve differences through negotiation, expeditiously and without needless expense.
- 8** Enjoy what you are doing and the company you keep. You and the world will be better for it.

*Beyond all this, the respect of our peers and the society which we serve is the ultimate measure of responsible professional conduct.*