Everything You Need To Know About Professional Liability Insurance You Already Learned from Dr. Seuss (And Other Children's Stories)

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EVERY PROFESSIONAL FACES THE POTENTIAL for unforeseen claims from her clients. Even when those claims are groundless, defending against them can be costly and time consuming. Professional liability insurance is an important risk management tool that may provide protection against many of the claims you face as a provider of professional services, but it is also possible that your insurance policy may contain limiting or exclusionary language that eliminates or reduces the insurance coverage that you thought you purchased.

Fortunately, understanding the ins and outs of professional liability policies, and learning how to avoid some of the common coverage pitfalls, is not as complicated as you may think. In fact, many of the lessons you learned in your favorite childhood stories serve to guide you down the yellow brick road of coverage. In this article, we identify some of the lessons from those childhood stories and explain how they translate into key issues to keep in mind when you are purchasing a professional liability policy or making a claim under one.

I. What is a Professional Service?

"'Speak English!' said the Eaglet. 'I don't know the meaning of half those long words, and, what's more, I don't believe you do either!'"
– Lewis Carroll, Alice's Adventures in Wonderland

We often feel like the Eaglet when reading insurance policies. Is it any wonder that courts have found insurance policy provisions to be "unintelligible" and a virtual "impenetrable thicket of incomprehensible verbosity."[1] Unfortunately, professional liability policies can suffer from the same lack of clarity. A professional liability policy will typically cover liability arising out of an insured's acts, errors or omissions committed while performing, or failing to perform, "professional services." Conversely, general liability and directors & officers policies often contain endorsements excluding "professional services" from coverage. Thus, a threshold determination of what is, or is not, a "professional service" will have significant consequences for an insured. So it may not be surprising that, absent a precise definition of that term in the policy, insureds and insurers often disagree about its meaning.

Texas courts have held that professional services "must arise out of acts particular to the individual's specialized vocation."[2] To constitute a professional service, then, "it must be necessary for the professional to use his specialized knowledge or training."[3] This "legal" definition of "professional services" may even control over contrary policy language.[4]

One area that has generated a fair amount of litigation in this context is whether claims involving billing or fee disputes, or disputes over so-called "administrative" tasks, involve "professional services." Case law suggests that, in such disputes, the policy language preceding the "professional services" term may be even more important than how "professional services" is defined in the policy. For example, although the policy in *Shamoun & Norman, LLP v. Ironshore Indem., Inc.*[5] contained a detailed definition of the term "Professional Legal Services," the court focused instead on the insuring language providing that the insurer must defend any claim "*arising out of the rendering of or failure to render* Professional Legal Services."[6] The court concluded that although non-specialized tasks such as billing and fee-setting did not fall within the definition of "Professional Legal Services," the "arising out of" language in the policy broadened the scope of coverage. The policy covered such non-specialized tasks if they had a "causal connection or relation" to the provision of professional legal services.[7] In cases where the policy does not contain "arising out of" language, courts are more likely to hold that alleged improper billing practices do not constitute "professional services."[8] Like improper billing

practices, courts have also distinguished "administrative" tasks from "professional" tasks.[9]

Here's the take-away: not all services performed by a professional are necessarily covered "professional services." To avoid gaps in coverage, make sure that the definition of "professional services" in your professional liability policy is broad enough—and also sufficiently clear enough—to cover all of the services you provide in your practice. On the flip side, you should seek to eliminate, or at least carefully harmonize, any "professional services" exclusion that may be tucked away in an endorsement in your general liability or directors & officers policies.

II. Conditions, Exclusions and Other Coverage Pitfalls

"Think left and think right and think low and think high.
Oh, the thinks you can think up if only you try!"
– Dr. Seuss, The Lorax

The Lorax was almost certainly describing the myriad of imaginative conditions and exclusions found in many professional liability policies. These coverage pitfalls can be avoided if you pay close attention to the conditions in your policy and work with your broker to narrow the scope of the exclusions.

A. Notice and Reporting Requirements

"How did it get so late so soon?"
– Dr. Seuss, Untitled Poem

Professional liability policies are generally written on a "claims made" basis, which means that the policy only covers claims first made during the policy period, regardless of when the conduct or incident giving rise to the claim occurred. The term "claim" is usually a defined term, and although the definition varies among policies, a "claim" will often include administrative proceedings and demands for damages.[10] Although sometimes the fact of a "claim" is readily apparent, there are other circumstances in which the answer is not as clear. It is important to understand exactly how your policy addresses this term, so you can comply with policy conditions regarding notice of claims and, importantly, provide notice to your insurer under the right policy period.

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A case that underscores this lesson is *Regency Title Co., LLC v. Westchester Fire Ins. Co.*,[11] which involved a lawsuit against a title insurance company for breach of its fiduciary duties. The lawsuit was filed during Westchester's policy period and promptly forwarded to the insurer. As with most professional liability policies, the Westchester policy only provided coverage for claims "first made against the insureds and reported to [Westchester] during the policy period," and excluded claims first made or reported outside of the policy period. However, prior to the filing of the lawsuit and the inception of the Westchester policy, the underlying claimant had filed a complaint with the Texas Department of Insurance (TDI) asserting the same facts that would ultimately become the basis of its lawsuit. The complaint to the TDI also demanded payment by the insured or specific performance.[12]

Westchester denied coverage of the lawsuit on the grounds that the TDI complaint, and not the underlying lawsuit, was the "first made" claim, and that the earlier-asserted claim was not made or reported during the policy period.[13] Westchester relied on the definition of "claim" in its policy. Even though the lawsuit clearly constituted a "claim" under the Westchester policy, a "claim" also included "a written demand against any insured for monetary or non-monetary damages" and any "administrative or regulatory investigation filed against the insured."[14] The *Regency Title* court agreed with Westchester, finding that the complaint filed with the TDI satisfied two subparts of the definition of "claim." Thus, the insured forfeited coverage under its professional liability policy because it failed to understand its reporting requirements and recognize that a complaint filed with an administrative agency might constitute a claim.

An important timing question was not addressed in the *Regency Title* decision: assuming that a claim is first made during the policy period, how can an insured be confident that the notice it provides to its insurer will be timely? What is considered "late" or "timely" can sometimes be puzzling based on policy language alone because most policies simply require notice "as soon as practicable," "promptly" or "immediately." Courts have consistently interpreted such language to require that notice be given within a reasonable time in light of the circumstances involved.[15] While this rule does not leave policyholders or insurers with a hard and fast rule with respect to "timely" notice, one additional factor weighs in

favor of insureds. Even if an insured fails to provide notice within a reasonable period, Texas courts generally require insurers to prove prejudice from such delay in order to sustain a denial of coverage.[16]

But be careful when applying the prejudice rule to a claim under your professional liability policy. If you purchased a claims-made-and-reported policy, which is the most common type of professional liability insurance, the prejudice rule provides you with limited assistance. Courts strictly construe reporting requirements under a claims-made-and-reported policy. If notice is provided outside of the policy period (or any extended reporting period), an insurer may not be required to show prejudice in order to deny coverage.[17] However, when an insured notifies its insurer of a claim within the policy period but not within a reasonable time after the claim has been made, the insured's failure to provide timely notice should not defeat coverage in the absence of prejudice to the insurer.[18]

Although the question of whether and when to give notice to your insurer will depend on the particular facts and circumstances of the claim and your policy language, it is usually a good idea to err on the side of providing notice as soon as you have reasonable grounds to believe that a claim has been made. If in doubt that a claim has been asserted, consider hedging your bets by providing your insurer with a "notice of circumstances" (discussed in the next section).

B. Prior Knowledge Exclusion

> *You can get so confused*
> *that you'll start in to race*
> *down long wiggled roads at a break-necking pace*
> *and grind on for miles across weirdish wild space,*
> *headed, I fear, toward a most useless place.*
> *– Dr. Seuss, Oh! The Places You'll Go*

It is hard to imagine a more wiggled road across weirdish wild space than the one required to decipher and apply the prior knowledge exclusion. You'll find it in virtually every professional liability policy. This exclusion precludes coverage for any act or omission which occurred prior to the policy's inception if an insured knew or could have reasonably foreseen that such act or omission would form the basis of a later claim. Policy language can vary, however. Some insurers attempt to eliminate coverage simply based on the insured's prior knowledge of a wrongful act, regardless of whether the insured knew or could have reasonably foreseen that such act would form the basis of a later claim.[19]

Texas courts apply a subjective-objective test to determine whether a prior knowledge exclusion bars coverage. A good example of how this test is applied to a legal malpractice claim can be found in *Westport Ins. Corp. v. Atchley, Russell, Waldrop & Hlavinka, LLP*.[20] There the court first determined whether the insured "subjectively knew, prior to the policy period, that his client intended to bring a claim."[21] If the insured has subjective knowledge of an impending claim, then the prior-knowledge exclusion bars coverage.[22] Absent such knowledge, the objective part of the test must then be applied: "whether a reasonable attorney, in possession of the facts that the insured possessed at the time he applied for insurance, would reasonably foresee both that a professional breach had occurred and that the breach *would likely* be the basis of a claim against the insured."[23] In a later case, *Westport Ins. Corp. v. Cotton Schmidt LLP*,[24] a different court followed *Atchley*'s subjective-objective test, but criticized *Atchley* for applying a heightened standard with respect to the "objective" prong. Under the *Cotton Schmidt* test, the exclusion is triggered when a reasonable attorney, based on "the subjective knowledge of the actual attorney at issue," would understand that his actions *might* be the basis of a claim.[25] In the most recent application of this test, the court in *OneBeacon Ins. Co. v. T. Wade Welch & Assoc.*[26] formulated its own version of the objective prong, holding that the proper question is whether a reasonable attorney, given the insured's knowledge as of the policy inception date, *could reasonably* have expected the attorney's acts, errors, or omissions to give rise to a malpractice claim.[27]

If these decisions tell us anything it's that the prior knowledge exclusion is fact intensive and subject to an objective reasonableness standard that is not entirely consistent from court to court. Nonetheless, here are a few pointers that apply across the board:

1. Be wary of a prior knowledge exclusion that is triggered by the knowledge of *any* insured, as that language may bar coverage for all insureds if only one insured has the requisite knowledge.[28] On the other hand, a policy limiting a prior knowledge exclusion to *the insured* is more advantageous to an insured organization where the requisite knowledge is confined to a single individual.[29]
2. Check for a "notice of circumstances" provision in your policy, which allows an insured to give notice of a *potential* claim under its present policy in order to preserve coverage under that policy if an actual claim should materialize in the future. Be careful to follow the instructions in the policy for reporting a notice of

circumstance—failure to do so can result in an ineffective notice.[30] Properly reporting a potential claim under a notice of circumstance provision will likely preempt the application of a prior knowledge exclusion.

3. If you end up in a dispute with your professional liability insurer over its duty to defend, be aware that Texas courts adhere to the "eight corners" rule (duty to defend is determined by considering only the four corners of plaintiff's petition and the four corners of the policy) when deciding whether a prior knowledge exclusion bars coverage of the underlying claim.[31] This is not necessarily the rule outside of Texas. Some courts in other states allow parties to introduce extrinsic evidence at the duty to defend stage where the insured's prior knowledge is at issue.[32]

C. Related/Interrelated Claims Provisions

". . . it's no use going back to yesterday, because I was a different person then."
– Lewis Carroll, Alice's Adventures in Wonderland

While it is likely that Alice did not have insurance policies in mind when she made this statement, she did in fact provide a simplistic description of interrelated claims provisions in a professional liability policy. Those provisions—usually in the form of a policy condition or exclusion—serve to group together multiple claims arising out of the same or "related" wrongful acts and deem them to be made at the time that the very first such claim was asserted against the insured. In other words, a claim asserted against an insured years after its policy has expired, but that arises from the same or related facts or circumstances as a claim that was made and reported during that earlier policy period, will be considered part of the originally asserted claim.[33] So, as Alice would likely explain, it's no use going back to a prior policy period if the current claim is *different* from the one made and reported during that earlier time period. However, if the claims are the same or related, then going back to yesterday is not only useful—it's required.

Application of related claims provisions may not always work to the benefit of the insured. The earlier filed claim may have fallen under a policy that has since been exhausted, effectively leaving the insured with no coverage for any subsequent claims that are deemed to be filed under that earlier time period. Timely notice of the original claim may also be an issue.[34] There is also a possibility of a gap in coverage. If the later related claim falls under a policy with a broad interrelated claims *exclusion*, but the earlier claim was reported under a policy that does not recognize coverage for related claims or simply defines them more narrowly, then the insured could conceivably be deprived of coverage under both policies. Confirming that your professional liability policies provide broad coverage for related claims will serve to protect you from the interrelated claims exclusions that will inevitably appear in your future renewals.

D. Personal Profit Exclusions

"One feather is of no use to me, I must have the whole bird."
– Jacob Grimm, The Complete Brothers Grimm Fairy Tales

While most insureds would rather have the whole bird instead of just one feather, insurers are typically not that generous. Professional liability policies often contain a "personal profit" exclusion, which bars coverage for claims "brought about or contributed to by any . . . profit or remuneration gained by any Insured Person to which such Insured Person is not legally entitled." But no need to be so grim. Such exclusions are commonly limited by the inclusion of "final adjudication" or "in fact" language.[35] When that language is included, the exclusion will not apply unless there is a final determination that the insured gained a profit to which she was not entitled.[36] Some professional liability policies also specifically exempt defense costs from this exclusion.[37] If your professional liability policy contains a "personal profit" exclusion, inquire about adding "final adjudication" (or at least "in fact") language and a carve-out for defense costs.

V. Conclusion

"Everything's got a moral, if only you can find it."
– Lewis Carroll, Alice's Adventures in Wonderland

The moral of this article is quite simple: carefully read your professional liability policies when you get them and pay close attention to the conditions of coverage and exclusions. Don't be afraid to ask your broker to explain terms or provisions that you don't understand. Oh, and keep your favorite coverage lawyer on speed dial just in case.

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[1] *See, e.g., Computer Corner, Inc. v. Fireman's Fund Ins. Co.,* 46 P.2d 1264, 1270 (N.M. Ct. App. 2002) ("[The impaired property] exclusion is unintelligible from the standpoint of a hypothetical reasonable insured [and is] too vague and indefinite to be enforceable."); *Universal Underwriters Ins. Co. v. Travelers Ins. Co.,* 451 S.W.2d 616, 622-23 (Ky. App. 1970) ("Ambiguity and incomprehensibility seem to be the favorite tools of the insurance trade in drafting policies. Most are a virtually impenetrable thicket of incomprehensible verbosity.").

[2] *Atlantic Lloyd's Ins. Co. of Tex. v. Susman Godfrey, L.L.P.*, 982 S.W.2d 472, 476–77 (Tex. App.—Dallas 1998, pet. denied).

[3] *Id.* at 477.

[4] *See, e.g., Admiral Ins. Co. v. Ford,* 607 F.3d 420, 422 (5th Cir. 2010) (although the literal interpretation of the professional services exclusion would imply that "all operations" of the insured were excluded, the court applied the legal definition of professional services to only exclude coverage for professional services in any of the insured's operations).

[5] 56 F. Supp. 3d 840 (N.D. Tex. 2014).

[6] *Id.* at 845 (emphasis added).

[7] *Id.* at 847; *see also Shore Chan Bragalone Depumpo LLP v. Greenwich*, 856 F. Supp. 2d 891, 899 (N.D. Tex. 2012) (claim alleging insured's failure to pay third party arose from professional services and thus triggered insurer's duty to defend under professional liability policy).

[8] *See, e.g, John M. O'Quinn P.C. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 33 F. Supp. 3d 756, 773 (S.D. Tex. 2014) (no coverage for claim alleging improper billing practices under policy that did not include "arising out of" language); *see also Utica Nat. Ins. Co. of Texas v. Am. Indem. Co.*, 141 S.W.3d 198, 202-03 (Tex. 2004) (as opposed to broader "arising out of" language, policy excluding injury "due to" the rendition of professional services requires proof of more than simple cause-in-fact).

[9] *See, e.g., Guar. Nat'l Ins. Co. v. N. River Ins. Co.,* 909 F.2d 133, 136 (5th Cir. 1990) (where patient jumped to her death from the window of her fourth floor hospital room, the court distinguished between the hospital's professional judgment about safeguarding its patients and the administrative decision to use screws in the window sashes rather than fixed, protective screens).

[10] When the term "claim" is undefined, courts have found that the term is "ambiguous" and should be construed using an ordinary meaning that is most favorable to the insured. *See Int'l Ins. Co. v. RSR Corp.*, 426 F.3d 281, 292 (5th Cir. 2005) (undefined "claim" means the "assertion of a right" to hold the insured liable).

[11] 5 F. Supp. 3d 836 (E.D. Tex. 2013).

[12] *Id.* at 840.

[13] *Id.* at 845.

[14] *Id.* at 842-44.

[15] *See, e.g., Fed. Ins. Co. v. CompUSA, Inc.*, 319 F.3d 746 (5th Cir. 2003) (construing "as soon as practicable" to mean "within a reasonable time"); *Cont'l Sav. Ass'n v. U.S. Fid. & Guar. Co.,* 762 F.2d 1239 (5th Cir. 1985) (confirming that, under Texas law, "as soon as practicable" or "immediately" require only that notice be given within a reasonable time in light of the circumstances involved); *Ridglea Estate Condo. Ass'n v. Lexington Ins. Co.,* 415 F.3d 474, 478 (5th Cir. 2005), *as amended on reh'g* (Aug. 10, 2005) ("prompt" notice, if undefined, means within a reasonable time); *Travelers Indem. Co. of Connecticut v. Presbyterian Healthcare Res.*, No. CIV.A.3:02-CV-1881-P, 2004 WL 389090, at *8 (N.D. Tex. Feb. 25, 2004) (policy provision requiring notice "immediately" is "construed to mean within a reasonable time in light of the circumstances").

[16] *PAJ, Inc. v. Hanover Ins. Co.,* 243 S.W.3d 630, 632-33 (Tex. 2008) (an insured's failure to timely notify its commercial general liability insurer of a claim or suit does not defeat coverage if the insurer was not prejudiced by the delay); *Alaniz v. Sirius Int'l Ins. Corp.,* No. 15-40497, 2015 WL 5316565 (5th Cir. Sept. 14, 2015) (prejudice rule applied to late notice under commercial property insurance policies).

[17] *See Pennzoil-Quaker State Co. v. Am. Int'l Specialty Lines Ins. Co.*, 653 F. Supp. 2d 690, 698 (S.D. Tex. 2009).

[18] *Prodigy Comms. Corp. v. Agricultural Excess & Surplus Ins. Co.*, 288 S.W.3d 374, 382 (Tex. 2009); *Fin. Indus. Corp. v. XL Specialty Ins. Co.,* 285 S.W.3d 877 (Tex. 2009); *Evanston Ins. Co. v. Keeway America, LLC*, 2010 WL 2652330 (N.D. Tex. 2010) (where insured provided notice 27 days after the expiration of the claims-made policy, but the policy did not expressly require notice during the policy period and insurer had not closed its book on the policy, insurer was required to show prejudice to deny coverage based on late notice). *But see Nicholas Petroleum, Inc. v. Mid-Continent Cas. Co.,* No. 05-13-01106-CV, 2015 WL 4456185 (Tex. App.—Dallas July 21, 2015, no writ) (where insured failed to provide timely notice under a claims-made policy that included a specific time-frame for providing written notice—30 days after receipt of the claim—insurer did not need to show prejudice before denying coverage).

[19] *See, e.g., OneBeacon Ins. Co. v. T. Wade Welch & Assocs.*, Civ. Action No. H-11 3061, 2014 WL 2863701 (S.D. Tex. June 24, 2014) (prior knowledge exclusion that eliminated coverage if the attorney had "a reasonable basis to believe that [he] had committed a wrongful act" was unenforceable as written because it created an unintended gap in coverage and rendered coverage illusory).

[20] 267 F. Supp. 2d 601 (E.D. Tex. 2003).

[21] *Id.* at 608. The policy in *Atchley* provided that it would not apply to "any act, error, omission, circumstance ... 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 [or] circumstance ... might be the basis of a CLAIM".

[22] *Id.* at 611.

[23] *Id.* at 609 (emphasis added).
[24] 605 F. Supp. 2d 796 (N.D. Tex. 2009).
[25] *Id.* at 805 (emphasis added); *see also Darwin Select Ins. Co. v. Laminack, Pirtle & Martines, L.L.P,* No. H–10–5200, 2012 WL 423380 (S.D. Tex. Feb. 8, 2012) (applied an objective test only—based on policy language—and held that the exclusion applied because it was "inconceivable that two experienced, accomplished attorneys, having received notice that . . . they filed a lawsuit outside the statute of limitations, would not have a basis to foresee that missing the filing deadline might reasonably be expected to be the subject of a malpractice claim against them.").
[26] See footnote 19, *supra*.
[27] *Id.* at *12; *see also* Jury Charge and Verdict Form, p. 8 (Prior Knowledge Exclusion), submitted in *OneBeacon Ins. Co. v. T. Wade Welch & Assocs.,* No. H-11-3061, Doc. No. 392 (S.D. Tex. Oct. 17, 2014).
[28] *Coregis Ins. Co. v. Lyford*, 21 F. Supp. 2d 695, 699 (S.D. Tex. 1998).
[29] *Arboretum Nursing & Rehab. Ctr. of Winnie, Inc. v. Homeland Ins. Co. of New York*, No. V-10-69, 2012 WL 6161115, at *5 (S.D. Tex. Dec. 11, 2012); *see also Executive Risk Indem. v. Memorial Health System of East Texas,* No. 9:03–cv–276 (E.D. Tex. June 29, 2004).
[30] *See FDIC v. Barham*, 995 F.2d 600, 604 n.9 (5th Cir. 1993) ("Because notice of a claim or potential claim defines coverage under a claims-made policy, we think that the notice provisions of such a policy should be strictly construed."); *Davis v. BancInsure, Inc.,* 2013 WL 1223696 (N.D. Ga. March 20, 2013) (strictly scrutinizing the insured's compliance with the notice requirements of a potential claim under a D & O policy).
[31] *See Am. Guar. & Liab. Ins. Co. v. Hoeffner,* No. H-08-1181, 2009 WL 130221, at *4 (S.D. Tex. Jan. 16, 2009) (although it appeared "clear" from sources outside of the underlying complaint that the insured knew he was breaching a professional duty or had a basis to foresee that his conduct could result in a claim, the insurer nevertheless had a duty to defend because such allegations were not made in the underlying lawsuit); *see also Darwin Select*, 2012 WL 423380, at *4.
[32] *See, e.g., Westport Insurance Co. v. Albert*, 208 F. App'x 222 (4th Cir. 2006); *Am. Guar. & Liab. Ins. Co. v. Fojanini*, 90 F. Supp. 2d 615 (E.D. Pa. 2000); *Eisenhandler v. Twin City Fire Ins. Co.*, No. CV09-5031716S, 2011 WL 5458180 (Conn. Super. Ct. Oct. 21, 2011).
[33] *Reeves Cty. v. Houston Cas. Co,* 356 S.W.3d 664 (Tex. App.—El Paso 2011, no pet.) (court upheld the insurer's denial of coverage under an interrelated acts provision where the claim bore more than a "slight or attenuated connection" with the previous suit).
[34] *See, e.g., NetSpend Corp. v. AXIS Ins. Co.,* No. A-13-CA-456-SS, 2014 WL 3568355, at *4, n.6 (W.D. Tex. July 18, 2014) *aff'd*, 609 F. App'x 268 (5th Cir. 2015) (because the insured did not provide notice of the original complaint during the policy period of the earlier policy, there was no coverage for the lawsuit).
[35] *See Wintermute v. Kansas Bankers Surety Co.,* 630 F.3d 1063, 1071-72 (8th Cir. 2011) (insurance company cannot rely upon personal profit exclusion to "deny a defense based solely on the allegations in the Complaint unless the facts are uncontested [and] [w]hether an insured in fact gained a personal profit is a fact issue that must be decided by a trier of fact if the relevant evidence is disputed"); *Fed. Ins. Co. v. Cintas Corp.*, 2006 WL 1476206, at *7 (S.D. Ohio May 25, 2006) (insurer must defend lawsuit and potential application of personal profit exclusion must await resolution of underlying litigation); *PMI Mortgage Ins. Co. v. Am. Int'l Specialty Lines Ins. Co.*, 2006 WL 825266, at *6-7 (W.D. Cal. Mar. 29, 2006) (to rely on personal profit exclusion insurer must prove actual receipt of personal profit through final underlying adjudication or other proper evidence); *St. Paul Mercury Ins. Co. v. Foster,* 268 F. Supp. 2d 1035, 1045 (C.D. Ill 2003) (insurance company position that "mere allegations that any insured gained a personal profit to which he was not legally entitled . . . void[s] coverage [is] untenable").
[36] *See Pendergest-Holt v. Certain Underwriters at Lloyd's of London*, 600 F.3d 562, 572-73 (5th Cir. 2010) ("final adjudication" language in the policy requires that the excluded conduct be adjudicated by the factfinder in the underlying proceeding, whereas "in fact" language requires a final decision on the merits in either the underlying case or a separate coverage case, or an admission by the insured).
[37] *See, e.g., Burks v. XL Specialty Ins. Co.*, No. 14-14-00740-CV, 2015 WL 6949610, at *7 (Tex. App.—Houston [14th Dist.] Nov. 10, 2015) ("Under the unambiguous terms of the policy, XL agreed to advance defense expenses until it is 'finally determined' the loss is not covered").