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EMPLOYMENT LAW CLAIMS: TRIGGERING COVERAGE UNDER "CLAIMS MADE" POLICIES

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INTRODUCTION

Employment law liability claims can give rise to some unusual coverage issues and present some practical claims handling problems for both risk managers and insurers. This Article will discuss the particular problems that arise when the relevant liability policy is a "claims made" or "claims made and reported" policy. This often is the case when an employer seeks coverage under a Director's and Officer's ("D&O") policy or an Errors and Omissions ("E&O") policy. These issues promise to grow in significance due to the fact that the Employment Practices Liability Policies now emerging in the insurance market generally are nearly always written only on a "claims made" basis as well.

First and foremost, this Article analyzes what constitutes a claim. In particular, this Article will discuss whether the filing of a "charge" with the Equal Employment Opportunity Commission ("EEOC") or a state human rights agency amounts to a "claim" for insurance coverage purposes. Additionally, this Article describes the reporting and notice requirements in a "claims made" policy governing the information that must be provided to the insurer subsequent to the assertion of a claim. This Article discusses this issue especially with respect to an employer's duties when it receives or makes an offer to pay a nominal severance or settlement payment to a terminated employee. Finally, the strategic importance of pro-

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viding a "laundry list" of information relative to possible claims will be reviewed.

I. EMPLOYMENT LITIGATION: WHAT IS A "CLAIM"?

An initial and fundamental question in the arena of employment law liability is what constitutes a "claim" for insurance coverage purposes. Although litigated extensively in other contexts, the issue is probably more difficult and problematic in the employment law arena, given the variety of administrative and litigation venues. There is, of course, no question that a legal action filed in court and served on the employer constitutes a "claim" under virtually any "claims made" liability policy. Coverage issues often arise, however, relating to all the facts and circumstances that lead up to the filing of a suit. For example, an employee unhappy with his annual performance review might orally threaten to quit and file suit but take no further action immediately. The employee may pursue the matter by filing a "charge" or a grievance with the EEOC, alleging unlawful discriminatory conduct by the employer. The EEOC may then, on its own initiative, refer the charge to a state agency or human rights commission for review. Alternatively, the employee may go directly to the state agency and file a "charge" that, in turn, may be referred to the EEOC for handling. Significant uncertainty exists as to which, if any, of these circumstances would be a claim within the meaning of the "claims made" policy.

A. *Policy Definition of "Claim"*

The first step in answering the question of what constitutes a claim is to review the particular insurance policy to determine whether it defines the word "claim." As a result of past uncertainty, many "claims made" policies now contain a definition for the word "claim," but the definitions vary and may or may not include "administrative proceedings." A typical endorsement to a widely used "claims made" policy from a Director and Officer insurer contains the following definition: "The term 'Claim' shall mean any judicial or administrative proceeding *or* specific written demand initiated against a Director or Officer by a third party in which such Director or Officer *may be* subjected to a binding adjudication of liability for damages or other relief."¹ This definition makes clear that a "claim" includes an administrative proceeding

1. See, e.g., Directors' and Officers' Liability Policy issued by Reliance Insurance Company (on file with authors) (emphasis added).

before a state or federal agency, depending on the authority exercised by the agency. Therefore, in order to interpret this definition, it is necessary to understand the substantive powers exercised by the administrative agencies involved in the case.

State human rights agencies that are empowered to award damages and demand services from individuals against whom charges have been filed are said to have "coercive authority." Agencies that cannot award damages and demand services are said to have only "powers of conciliation." When the state agency has powers of conciliation only and no powers of coercion, the agency generally does have the power to refer the charge to a state court for adjudication. Thus, it might appear at first glance that a charge filed with such an agency may ultimately lead to an adjudication that a named director or officer is liable for damages or other relief. However, in this situation, it is only *the court* that can award damages and compel relief. Therefore, a filing with such an agency does not meet the full definition of a "claim." Of course, once the charge is referred to the court and the employer is served with notice of such referral, the charge or potential claim becomes a "claim" under the policy definition, thereby triggering coverage.

The federal EEOC, which is an agency with powers of conciliation only, is empowered to commence suit on its own initiative or on behalf of an aggrieved party who has followed appropriate administrative procedures. However, this power alone also fails to give rise to true coercive authority. The filing transfers the power to the court, much as the state agency's referral would do, and the court, not the agency, has coercive authority in these instances. Due to the agency's lack of power, it can only call upon the court to pick up where the agency leaves off. Once the EEOC has made the decision to file suit, it becomes a litigant, and it is the filing of the suit and service of the complaint which constitutes the actual claim. For this reason, a mere filing with the EEOC may not constitute a claim while a suit filed by the EEOC on behalf of the aggrieved party clearly would constitute the making of a "claim" for insurance coverage purposes.

In summary, when the policy defines the term "claim" to include such things as administrative proceedings that "may" result in an adjudication of liability, the insured will likely be able to establish that it is entitled to coverage if the agency exercises coercive authority. Such coverage normally would include payment or reimbursement of counsel's fees for responding to the claim. On the other hand, with regard to an administrative proceeding before an

agency *without* coercive authority, the insurer will likely be able to establish that no "claim" exists yet. This is true because the responding party can only be subjected to a binding adjudication of liability in a court, not through an administrative proceeding before an agency.

However, it is important to remember that when policy language is subject to interpretation in coverage disputes, courts generally adopt an interpretation that favors the interests of the insured if there is a reasonable basis for doing so. Should a court determine that the term "claim" is ambiguous, and that the policy engenders a reasonable expectation that a non-coercive administrative proceeding constitutes a claim, the court might decide to honor this expectation by finding that coverage is afforded under the policy. Given the interpretation preference for protecting the reasonable expectations of insureds, many insurers decide to provide no definition in the policy.² The insured will often insist that a definition of claim is provided by endorsement, thereby exposing the insurer to the risk that the definition will be interpreted in an unintended manner.

B. *Analysis when the Policy is Silent*

1. Charges Filed with the EEOC

If the policy in question does not contain a definition of the word "claim," courts generally have held that the filing of a charge with the EEOC does nothing more than initiate an investigative proceeding since the EEOC lacks coercive authority. In *Bensalem Township v. Western World Insurance Co.*,³ the underlying dispute involved an age discrimination action brought against a township by the widow of a township police officer. Prior to filing her lawsuit, the widow had filed a complaint with the EEOC. The EEOC subsequently corresponded with the township to advise it of the discrimination charge.

The court determined that the EEOC correspondence was not a "claim" within the meaning of the policy. The court reasoned:

2. In one recent case, however, it was held that the mere absence of a definition for the term "claim" in the policy rendered the determination of what was or was not a claim *inherently* ambiguous. *Resolution Trust Corp. v. Walke*, No. 92-0430, 1994 U.S. Dist. LEXIS 8919 (C.D. La., Feb. 25, 1994). If this becomes a trend, insurers will do well to provide more definitions of terms in the policy. This, of course, will lead to longer and more complex policies, and more words lend greater potential for ambiguity.

3. 609 F. Supp. 1343 (E.D. Pa. 1985).

[T]he EEOC letter of September 1981 was at most a notice that Mrs. Johnson intended to hold plaintiff responsible for a wrongful act. Neither the letter nor the attached charge of discrimination requested money or other relief; neither document stated that a lawsuit was to follow. The closest the letter comes to any such formal demand is the statement that, upon receiving a charge of discrimination, the EEOC is required to notify the prospective defendant and try to eliminate any alleged unlawful practice by informal conciliation, conference and persuasion. . . . This statement does indeed suggest that a formal lawsuit may follow (hence the term "prospective defendant"), but it also suggests that any such formal proceeding will be preceded by EEOC efforts to resolve the matter informally. The letter thus informed plaintiff that a demand for relief, based on a legal right, might well follow. Neither the letter nor the charge, however, purported to be such a demand.⁴

A number of other cases have established that it is not so much the content of EEOC correspondence that is determinative as it is the nature of the EEOC as a conciliating agency. In *Campbell Soup Co. v. Liberty Mutual Insurance Co.*,⁵ twenty-two insurance companies obtained summary judgment on the issue of whether they were required to defend and indemnify Campbell Soup Company against a discrimination claim pending before the EEOC. The *Campbell Soup* case arose as a consequence of a charge filed by the EEOC commissioner on September 29, 1980. On May 6, 1986, the EEOC found reasonable cause to believe that Campbell had engaged in substantial discriminatory hiring and employment practices. The reasonable cause determination issued by the EEOC alleged that Campbell had discriminated against blacks and women because of their race and/or sex with respect to recruitment, hiring, assignment, promotion, training, policies and practices, and other terms and conditions of employment. Campbell contended that the reasonable cause determination was the functional equivalent of a suit because it initiated an administrative procedure that was coercive in nature. The insurers countered that the EEOC reasonable cause determination merely sought to place the plaintiff in a conciliation mode pursuant to 42 U.S.C. § 2000(e)-5(b).

The narrow issue resolved by the court was whether a reasonable cause determination by the EEOC compels insurers, pursuant to the terms of their liability policies, to defend insureds in EEOC

4. *Id.* at 1348 (citation omitted).

5. 239 N.J. Super. 403, 571 A.2d 969 (N.J. Super Ct. App. Div. 1990).

proceedings, where such proceedings are conducted in response to charges of discriminatory hiring and employment practices. In finding for the insurers, the court held that the EEOC's reasonable cause determination was not "the functional equivalent of a suit" so as to require the insurers to defend the insureds. The court agreed with the decision of the trial court that the duty to defend is triggered when the insured is involved in an adversarial proceeding, a consequence of which is the factual determination that legal liability may or may not be imposed upon the insured. The court noted that even though an EEOC probable cause determination was admissible in a subsequent federal action instituted by the EEOC or the aggrieved party, this admissibility does not transform the EEOC conciliation process into a coercive, adversarial proceeding tantamount to a suit, for which a duty to defend is owed. The court similarly found that there was no obligation of indemnification under any of the policies.⁶

2. Charges Filed with State Agencies

The question of whether an administrative action constitutes a claim in the absence of a policy definition is much more complex with respect to filings with state agencies. Almost every state, with the notable exceptions of Mississippi and Alabama, has its own state agency or human rights commission. The powers of these agencies vary in a number of respects. In many states, the human rights agency has essentially the same conciliatory powers and authorities as the EEOC. Hence, for the reasons discussed in the preceding section, the filing of a "charge" with a human rights agency in those jurisdictions likely will not constitute a "claim." Other state agencies, however, are empowered to do much more than simply investigate charges of discrimination. Many state agencies are empowered to award damages, including back pay, front pay, punitive, and compensatory damages. Hence, in these jurisdictions, the filing of a "charge" with a state agency likely would constitute the making of a "claim" within the meaning of a "claims made" policy.

Texas is an example of a state whose anti-discrimination laws are substantially identical to the federal statutes and the EEOC regulations. For example, Texas makes it an unlawful employment

6. See also *Abifadel v. Cigna Ins. Co.*, 9 Cal. Rptr. 2d 910 (Cal. Ct. App. 1992) (cease and desist order, examination report, and various other regulatory agency communications, taken together or separately, do not constitute claims absent specific demands for services or payments).

practice for an employer to: (1) fail or refuse to hire an individual, or otherwise discriminate against an individual with respect to compensation or the terms, conditions, or privileges of employment because of race, color, disability, religion, sex, national origin, or age; or (2) to limit, segregate, or classify an employee or applicant for employment in a way that would deprive or tend to deprive the individual of employment opportunities.⁷ The state agency charged with enforcement of Texas' anti-discrimination laws is empowered to investigate complaints and determine whether there is a "reasonable cause to believe" that an employer who is alleged to have violated the anti-discrimination statute did in fact engage in unlawful employment practices as alleged by the aggrieved party.⁸

Texas Labor Code sections 21.206 and 21.207 provide that where there is reasonable cause to believe an employer has engaged in an unlawful employment practice, a written determination to that effect shall be issued and provided to the aggrieved party, the employer, and other agencies as required by Texas law. This section further provides that the agency must *endeavor to eliminate* alleged unlawful employment practices by informal methods of conference, conciliation, and persuasion. Barring the successful conciliation of the claim, the commission and/or the aggrieved party's only recourse is to the courts. The commission cannot compel services or award damages of its own accord.⁹ Because any filing of a discrimination claim with the Texas Commission on Human Rights would not, therefore, be a demand for money or services, it would not constitute a claim any more than the same filing with the EEOC. To the extent the Texas Commission retains the power to initiate suit on behalf of an insured or to enforce its holdings, it is the court, not the commission, whose powers give rise to a claim at that time.

The laws of Texas contrast with those of other states such as New York. In New York, if the New York State Division on Human Rights finds that an employer has committed any unlawful discriminatory practice, it may require that the offending employer: cease and desist from such practice;¹⁰ take affirmative action;¹¹ or

7. TEX. CODE ANN. § 21.051 (West 1995).

8. §§ 21.002, 21.201-04.

9. §§ 21.210, 21.208, 21.251-56.

10. N.Y. EXEC. LAW § 297.4(c)(i) (McKinney 1995).

11. This power includes, but is not limited to hiring, reinstatement, or upgrading of employees, with or without back pay, restoration to membership in any respondent labor organization, admission to or participation in a guidance program, apprenticeship training program, on the job training program, or other occupational training or retaining program. § 297.4(c)(ii).

pay compensatory damages;¹² and may report on the adequacy and manner of the offending employer's compliance with any mandates issued by the Division.¹³ The New York State Division on Human Rights also has extensive discretion in fashioning other remedies, as long as these remedies bear a reasonable relation to the particular discriminatory practice that has been found to exist, and to the public policies giving rise to the particular anti-discrimination statute that has been violated.¹⁴ Therefore, because the New York State Division on Human Rights can award damages and compel services from employers who violate New York Anti-Discrimination provisions, any filing with that agency by an allegedly aggrieved party likely would constitute a claim for the purposes of coverage.

In summary, in order to determine whether an administrative filing constitutes a claim, the employee's attorney must examine the policy for relevant definitions, and then must examine state law to determine whether the state agency has true coercive powers. An EEOC charge, under established case law, does not constitute the making of a claim. An insured should be aware, however, that recourse to the courts almost always amounts to a claim for purposes of insurance coverage.

II. FAILURE TO GIVE PROMPT NOTICE

An insured's failure to give prompt notice of a "claim" constitutes a breach of contract and may result in forfeiture of coverage. However, in many jurisdictions coverage is not forfeited unless the insured's failure to give timely notice results in significant prejudice to the insurer, thereby easing the burden on the insured considerably. The problem of late notice is particularly complex in the employment litigation setting.

If a terminated employee files a charge with a state agency that has coercive authority, and the insured fails to give notice until a year or two later after the resolution of the administrative proceeding and the filing of a lawsuit by the same employee, the insurer would undoubtedly argue that coverage should be denied, based upon late notice and resulting prejudice. However, under the notice-prejudice rule adopted in many states, the prejudice threshold is quite high. Generally, an insurer is not able to deny coverage absent a showing that the claim no longer is defensible as a result of

12. § 297.4(c)(iii).

13. § 297.4(c)(v).

14. *See, e.g.,* Holland v. Edwards, 307 N.Y. 38, 119 N.E.2d 581 (1954).

the untimely notice by the insured.¹⁵

A very different scenario arises under the more narrow "claims made and reported" insurance policy. Under the terms of this type of policy, the claim not only must be made during the policy period, it also must be reported during the same policy period. Due to this more explicit language regarding the reporting obligation, the reporting aspect of the "claims made and reported" policy is generally considered to be a condition precedent to coverage and is enforceable irrespective of any prejudice to the insurer. Thus, it is imperative that an insured carefully consider the question of what constitutes a claim and, where appropriate, give prompt notice of that claim to its insurer. For example, in *Burns v. International Insurance Co.*,¹⁶ the United States Court of Appeals for the Ninth Circuit held that the reporting requirement in a "claims made and reported policy" was a condition precedent to the insured's right to coverage.¹⁷ Therefore, the notice-prejudice rule did not apply.¹⁸ The courts in California¹⁹ and other jurisdictions²⁰ have followed, finding that the notice-prejudice rule does not apply to claims made and reported policies.

The result of this kind of interpretation can be harsh. For example, in *National Union Fire Insurance Co. v. Bauman*,²¹ the court held that a claim made during one policy period, but not reported

15. See, e.g., *Twin City Fire Ins. Co. v. King County*, 749 F. Supp. 230 (W.D. Wash. 1990). See also ROBERT E. KEETON & ALAN I. WIDISS, *INSURANCE LAW* § 4.8(a) (1988).

16. 929 F.2d 1422 (9th Cir. 1991).

17. *Id.* at 1423.

18. *Id.* at 1425. See also *Pacific Employers Ins. Co. v. Superior Court (Rausch)*, 270 Cal. Rptr. 779 (Cal. Ct. App. 1990).

19. *Slater v. Lawyers' Mut. Ins. Co.*, 278 Cal. Rptr. 479 (Cal. Ct. App. 1991) (a claim filed during the policy period, but not served on the insured nor reported to the insurer until after expiration of the policy, was not covered under a claims made and reported policy); *Merrill & Seeley, Inc. v. Admiral Ins. Co.*, 275 Cal. Rptr. 280 (Cal. Ct. App. 1990) (a claims-made policy's requirement that the insured's negligent act, the claim, and the reporting of the claim to the insurer all occur during the policy period did not violate public policy); *Industrial Indem. v. Superior Court*, 275 Cal. Rptr. 218 (Cal. Ct. App. 1990) (trial court improperly required a claims made liability insurer to prove it was prejudiced by the insured's failure to report a claim within the policy's one-year extended reporting period).

20. *Esmailzadeh v. Johnson & Speakman*, 869 F.2d 422 (8th Cir. 1989); *National Union Fire Ins. Co. v. Bauman*, No. 90 C 0340, 1992 WL 1738 (N.D. Ill. Jan. 2, 1992), *aff'd*, 997 F.2d 305 (1993); *Jefferson Guar. Bank v. Westbank-Marrero Cab Co.*, 570 So. 2d 498 (La. Ct. App. 1990); *Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.*, 406 Mass. 862, 551 N.E.2d 28 (1990); *Continental Casualty Co. v. Maxwell*, 799 S.W.2d 882 (Mo. Ct. App. 1990); *Safeco Title Ins. Co. v. Gannon*, 774 P.2d 30 (Wash. Ct. App. 1989).

21. *Bauman*, 1992 WL 1738.

until the renewal policy's period, did not comply with either policy's "claims made and reported" requirement. In *Bauman*, the court specifically noted that the reporting requirement relates to a *single* policy period, and an insured cannot utilize the renewal period to satisfy the reporting requirement for claims first made during the initial policy period.

In addition to the provision that makes it a condition precedent to coverage that a claim be first made *and reported* during the policy period, many policies' notice provisions place a duty on the insured to provide notice of the claim to the insurer "as soon as practicable during the policy period." This places an additional obligation on the insured to provide timely notice of a claim. To illustrate the distinctive obligation of the notice provision, consider a claim against an insured that is made on the first day of the policy period. If the insured *reports* the claim on the last day of the policy period (just short of a year later), the policy's reporting requirement will be satisfied. There could be a question of late notice, however, because the insured arguably failed to provide *notice* of the claim "as soon as practicable." Under this example, although the reporting requirement was satisfied, coverage may not be available based upon untimely notice, particularly if the jurisdiction is one following the notice-prejudice rule. When evaluating whether the reporting provisions of a "claims made and reported" policy has been satisfied, it is important to note any policy terms that specify the requirements for reporting claims. For example, the policy may provide that a claim is deemed reported when mailed to the insurer.

Of course, a prudent insured may want to err on the side of caution and report to its insurer any employment situation that might ultimately result in a claim. The insured has little to lose and much to gain by adopting this strategy. If a particular fact or circumstance is not reported, and it ultimately turns out that it is deemed to be a "claim," the insurer might be within its rights to deny coverage, assuming that the reporting period has expired.

Furthermore, notice of facts or circumstances that the insurer does not consider to be a claim may be accepted as notice of facts or circumstances "likely to give rise to a claim." Most "claims made" policies contain language that will relate a claim back to the time at which notice of its facts or circumstances was provided. The insurers avoid an avalanche of potential notices under these provisions by requiring "full particulars" with respect to names of witnesses, potential allegations and parties involved. If there is insufficient information provided, the insurer may reject the notice

of potential claim as insufficient, which will mean simply that any claim ultimately arising will not relate back. Actual claims arising from such inadequately described facts or circumstances may still be covered if they are made within the same policy period or they may be covered under a subsequent period.

III. HANDLING THE EMPLOYEE PROBLEM: AVOIDING PREJUDICE TO THE INSURER

It has become somewhat routine for employees, soon-to-be-terminated employees, and former employees to seek out settlements at the time of their discharge from employment. This can arise under different circumstances, but the common theme is that the employee demands, either orally or in writing, that he or she receive additional compensation above that for which the employment contract or the severance plan provides. The insured employer is faced with the dilemma of whether to give notice of each and every instance in which a terminated (or about-to-be-terminated) employee seeks this additional compensation.

From one standpoint, the foregoing situation may present an early and relatively inexpensive opportunity for the employer to avert a larger liability problem in subsequent litigation. Thus, the employer may regard the settlement demand as the assertion of a claim against it. Consequently, the employer may seek to resolve the dispute before it escalates into litigation. On the other hand, the employer likely will be loathe to settle such "disputes," for fear that all departing employees will seek such extraordinary compensation. From this perspective, the employee's demands do not amount to a true claim as much as an effort to negotiate additional benefits at termination.

Depending upon the wording of the policy at issue, an oral demand for severance pay may or may not constitute a "claim." If the circumstances do not constitute a "claim," then the employer should be free to try to compromise the demand. An issue arises, however, if the employer attempts to settle an employee demand without providing notice to the relevant insurers. If such efforts are unsuccessful, resulting in litigation with a demand for damages significantly greater than the original demand, the insurer may balk at providing coverage. Therefore, it is in the insured employers' best interest to promptly give notice of facts and circumstances—as well as full-blown claims—as they arise.

This strategy may pose some practical difficulties, however, for

both the insured and the insurer. From the insured's standpoint, reporting each and every incident in which an employee seeks additional compensation could result in an increased premium at renewal, based upon the number of reported incidents. An increased premium might result even if the incidents ultimately are resolved for nominal amounts of money. From the insurer's standpoint, the reporting of an incident necessitates the opening of a file and claim-handling expenses on a matter that may never implicate the policy.

For these and other reasons, there is no perfect strategy for reporting potential employment litigation, although the insured clearly has an interest in acting in a manner that avoids forfeiture of coverage. Any demand for compensation or severance pay from a terminated employee could well escalate into a "claim" or litigation. Failure to give prompt notice of these occurrences or incidents could cause some prejudice to the insurer in the event that the insured's handling of the matter prior to notice to the insurer is unsuccessful.

The case law is rather clear that an insured who settles a claim without the insurer's written consent, where such written consent is required under the policy, will defeat coverage altogether.²² In addition, the insurer may raise the issue of prejudice and late notice, as described above. The insurer also may take the position that the insured's handling of the incident rendered litigation more likely and more serious, resulting in increased exposure to the insurer. As a general rule, insurers will not complain if these types of incidents are resolved by the insureds without notice to the insurer. The moment that an unreported incident results in a claim or litigation, however, the insurer may raise a policy defense that would not have otherwise been available otherwise and that arises solely from the conduct of the insured.

An example of these complexities is provided by *Edinburg Consolidated, I.S.D. v. INA a/k/a Pacific Employers Insurance Co.*²³ In *Edinburg*, a teacher requested a review before the state's education agency, challenging his termination by the school district for which he previously worked. The district was empowered to award damages, back pay, reinstatement, and costs.

The review took place prior to the policy period of the school

22. *Central Bank v. St. Paul Fire & Marine Ins. Co.*, 929 F.2d 431 (8th Cir. 1991); *Beck v. American Casualty Co.*, No. MO-88-CA-303, 1990 U.S. Dist. LEXIS 13756 (W.D. Tex. Apr. 12, 1990).

23. 806 S.W.2d 910 (Tex. Ct. App. 1991).

district's E&O insurance policy. The school district did not give notice of the teacher's grievances until a suit was subsequently filed in federal court. The suit plainly was premised on the same facts and circumstances that gave rise to the grievance. The insurer in *Edinburg* took the position that, although the suit was filed during the policy period, the claim was not covered by the policies because the insured had notice of it prior to the policy period and alternatively because the administrative hearing was a claim outside the policy period. The court found for the insurer, holding that any reasonable interpretation of the term "claim" encompassed the administrative proceeding at issue, especially in light of the fact that back-pay and damages were sought.

Similarly, in *Marion v. National Casualty Co.*,²⁴ a federal action was filed by Marion, Illinois police officers alleging improper employment practices by the city. The city sought coverage under a "claims made and reported" E&O policy. Although the federal action was filed within the policy period, administrative disciplinary proceedings had been going on for years prior to the actual litigation, and most of the administrative proceedings took place outside the policy period.

The officers had made repeated threats to file suit during the course of the administrative proceedings, but settlement negotiations continually convinced the officers to refrain. It was not until the dispute reached its final administrative appeal that litigation was commenced. The insurer refused coverage on the grounds that the claim made at the time the administrative proceedings were being conducted was made outside the policy period.

Although the trial court found for the city, the Iowa Supreme Court reversed, holding that the term "claim" connotes *the assertion of a legal right*, rather than the recognition of that right. The Iowa Supreme Court felt that the multiple demands, threats of litigation, and continuing settlement negotiations during the administrative proceedings were clear evidence a claim had been made, notwithstanding the officers' failure to actually file litigation.

Consequently, employers must be aware of the insurance coverage implications of dealing with employee grievances in the early stages. The costs of an aggressive reporting strategy include administrative efforts and probably higher premiums, but the cost of lax reporting may well be a loss of coverage altogether for the claim in question.

24. 431 N.W.2d 370 (Iowa 1988).

IV. MISREPRESENTATION AT THE TIME OF UNDERWRITING

The issues of what constitutes a claim and whether the insured may seek to compromise an employee grievance in its early stages without affecting coverage are relevant also to the application and underwriting processes. An employer applying for coverage under one of the new employment practices liability policies will be required to answer a long list of questions concerning EEOC filings, state agency filings, and more generally, known employee problems. To the extent that other coverage may be implicated by employment law claims, however, the applications likely will be much less specific regarding facts and circumstances about employment-related problems that are known by the insured.

For example, an application for D&O liability coverage may not ask about EEOC filings specifically. However, the application undoubtedly will ask about the insured's knowledge of facts and circumstances which might give rise to a claim. In this regard, one court very recently has confirmed that failure to give notice of anticipated employment litigation at the time of application can result in loss of coverage.²⁵

When completing an application or renewal application an insured must carefully consider all events that have transpired that may fall into the category of facts or circumstances that "might give rise to a claim." If the employer fails to disclose employee grievances that might give rise to a claim for which it will demand coverage, many jurisdictions will rescind an insurance policy issued on incorrect applications. This rule, often dictated by statute, provides that when an insured has made incorrect statements in an insurance application, coverage can be barred where the statements are material to the risk insured, or where the insurer can show that it would not have issued the policy under the same terms had it been in possession of accurate information.²⁶ There is no intent requirement under many such statutes; unintentional or unknowing misstatements in an insurance policy application can bar coverage if they alter the risk or the likelihood of a demand for coverage.²⁷

Returning to the example of the recently terminated employee who demands payments in addition to those provided by the employers' severance plan, the employer should be aware that if it fails

25. See *Association for Retarded Citizens v. North Am. Specialty Ins. Co.*, No. CV 94-46-02 LGB (C.D. Cal. Nov. 23, 1994).

26. *National Union Fire Ins. Co. v. Sahlen*, 999 F.2d 1532 (11th Cir. 1993).

27. *Id.* at 1536.

to disclose this common employee demand at the time of the application, the insurer will have a potential coverage defense if the application requested information about such circumstances, and they are not disclosed. Although it may not appear important to the employer at the time, the insurer who has already seen many such informal demands escalate into litigation may be able to prove to a court's satisfaction that it would have issued the policy under different terms had it been aware of the demand. The employer risks little in reporting such demands as a matter of course, and in fact, making it a standard practice to do so at the time of renewal applications would serve to keep the insurer abreast of the frequency of such demands and thus facilitate more efficient risk management.

V. LAUNDRY LIST ISSUES

Based upon the foregoing, an insured employer might deem it wise to provide a "laundry list" of facts and circumstances that may give rise to a claim when it is getting off risk at the end of the reporting period. The term "laundry list" refers to a submission by an insured to its insurer—usually towards the end of the policy period—of a list of "circumstances" purporting to be notice of potential claims under the policy.

A typical strategy for taking advantage of the policy's notice provision, this amounts to an effort by an insured to keep the expiring policy alive. As stated above, the notice provision allows the insured to report circumstances that might result in a claim being made during the policy period. If the insured provides "notice" properly, then any claims subsequently arising from the reported circumstances—even if the claims are not first made until after the expiration of the policy—will be deemed to have been made during the policy period. Thus, the insured is motivated to provide a list of any circumstances that could conceivably result in a claim at some point in the future.

The issue then arises: do the "circumstances" described in the insured's submission sufficiently provide "particulars" so as to constitute a proper notice of claim under the terms of the policy? Particularity is required in order to allow the insurer to investigate the potential claim. Although research reveals no cases involving employment-practices allegations specifically, there are many cases involving banking, securities and fiduciary-type claims as potential claims. The discussion that follows likely will apply equally to the employment-practices field.

The insured must take care to provide notice that is specific and informative enough to apprise the insurer of the nature and potential exposure posed by the facts or circumstances at issue. Case law holds that mere recitation of the policy language does not constitute adequate notice under a "claims made and reported" policy. In *FDIC v. Marvin L. Caplan*,²⁸ the court noted that the insured, in attempting to provide notice of a potential claim against directors and officers,

did no more than recite the language of the policy's notice provision and identify the FDIC as the source of potential claims. . . . The letter said nothing of the types of practices alleged to constitute "wrongful acts," the agents, officers, or directors alleged to be involved in wrongdoing, or the time period during which the allegedly wrongful act took place.

On that basis, the court held that, although notice was timely, it was insufficient under a "claims made and reported" policy. The court stated: "In a claims made policy . . . the exact peril insured against is the insured's discovery and notice of claims. Notice to the insurer, under such a policy, is not merely a technical defense, . . . it defines the insurer's obligation, and thus the injured party's rights, under the law" ²⁹

In *United Association Local 38 Pension Trust Fund v. Aetna Casualty & Surety Co.*,³⁰ the United States Court of Appeals for the Ninth Circuit denied an insured's motion for summary judgment, finding that the issue of whether the insured's submission of "everyday financial data" constituted proper notice of facts or circumstances likely to give rise to a claim was a question of fact for a jury. The insureds, trustees of an employees' benefit trust, submitted a renewal application to the insurer during the policy period together with a "5500" form. The 5500 form is a document that benefit plans must file with the Department of Labor. After the expiration of the policy, the Department of Labor asserted a claim against the insureds. The 5500 form contained information that eventually became the subject of the Department of Labor claim.

The insureds sued for coverage under the expired policy for expenses arising from the claim, arguing that the 5500 form provided the insurer with notice of a claim during the policy period. The insurer argued that the 5500 form merely contained "everyday

28. 838 F. Supp. 1125 (W.D. La. 1994).

29. *Id.* at 1131 (citation omitted).

30. 790 F.2d 1428 (9th Cir. 1986), *opinion amended*, 811 F.2d 500 (9th Cir. 1987).

financial data" and could not therefore constitute notice under the policy. Even though the subject policy did not have the "full particulars" language contained in many claims made and reported policies, the court found that the issue was at least deserving of jury consideration.

The cases are qualified to some extent by the holding in *Federal Savings & Loan Insurance Corp. v. Burdette*.³¹ In *Burdette*, a federal district court held that a D&O insurer's failure to object to the sufficiency of its insured's notice of facts and circumstances "likely to give rise to a claim" waived its right to do so later. The insured had sent the D&O carrier two letters describing potential claims that it thought might be asserted against the insured's directors and officers. The D&O insurer acknowledged receipt of the letters but did not question or challenge the sufficiency of the detail contained therein.

In a subsequent declaratory judgment action filed by the insured, the D&O insurer argued that the two letters did not comply with the policy's notice provision and therefore did not constitute proper notice under the policy. The court rejected this argument, noting as follows:

[The D&O carrier] did not in any way question the sufficiency of the notice, nor did [it] attempt to obtain any more specific information relating to the identification of the officers and directors to be sued. If notice provided to an insurer is considered by the insurer to be defective, good faith requires the insurer to notify the insured of its objections within a reasonable time, and if the insurer fails to do so or proceeds to act as though notice was satisfactory, it has waived any right to assert notice as a defense at a later date.³²

On the substantive issue of whether the claims ultimately asserted against the directors and officers were described in the notice letters previously forwarded to the D&O carrier, the court noted that:

[n]otification as to one loss or claim does not constitute notification as to another . . . and it would certainly turn the notice provision in this policy into a nullity to permit notice as to the action of one director on a certain date to constitute notice as to another director's unrelated action on a different date.³³

31. 718 F. Supp. 649 (E.D. Tenn. 1989).

32. *Id.*

33. *Id.* at 654 (citation omitted).

Hence, the court held that although the insurer waived its right to contest the sufficiency of the notice, the insurer was not required to afford coverage with respect to claims that were not described in the notice letters provided.

In the context of employment issues, the "laundry list" might indicate simply that several employees were terminated. Those individuals might conceivably make a claim arising from their employment against the insured at some future date. The question then arises: what sort of notice will be adequate under an insurance policy such that coverage will be available under the policy after expiration of the reporting period?

In this regard, the general rule is that the adequacy of notice of facts and circumstances prior to policy termination will turn on the language of the policy. Some policies require that the insured provide the identity of the claimant, the nature of the wrongful acts, the damages alleged, and the circumstances by which the insured became aware of the potential claim. As a general principal, if the insured is able to articulate the reasons for expecting a claim and to otherwise provide the particulars as required by the policy, it is more likely that coverage will be afforded at some future date based upon the prior notice of a potential claim. Where the "laundry list" looks more like a prophylactic measure, merely giving the names of terminated employees with a suggestion that claims and litigation might follow, the likelihood of coverage becomes more remote.

Insureds who fail to provide satisfactory information and detail regarding potential claims during the policy period often attempt to characterize "notice of potential claim" provisions as ambiguous, thereby triggering an interpretation that favors their interest. This ambiguity often is difficult to establish given the clear and specific language employed by most insurers to set forth notice requirements. Courts have consistently rejected, however, insureds' attempts to characterize "notice of potential claims" provisions as ambiguous.³⁴

Insureds sometimes take the position that the insurer has not been prejudiced by the lack of detail in a laundry list letter. However, courts consistently hold that an alleged absence of prejudice

34. See, e.g., *American Casualty Co. v. Wilkinson*, No. CIV-89-1609-W, 1990 WL 302175 (W.D. Ok. 1990), *aff'd* 958 F.2d 324 (10th Cir. 1992); *American Casualty Co. v. FDIC*, 944 F. 2d 455, 460 (8th Cir. 1991); *FDIC v. Continental Casualty Co.*, 796 F. Supp. 1344, 1352 (D. Or. 1991).

to an insurer based upon insufficient notice is irrelevant in the context of "claims made" policies.³⁵ As the court stated in *American Casualty Co. v. Wilkinson*, "the critical and distinguishing feature of a 'claims made' policy is notice in accordance with the terms of the policy: absent notice during the policy period, there is no coverage."³⁶

CONCLUSION

As has been illustrated, employment-practices claims and their surrounding circumstances give rise to many difficult coverage issues under "claims made" policies. The threshold issue, of course, is what constitutes a claim. The resolution of this issue often depends on the specific language of the policy at issue and also on the jurisdiction within which an employee resides. Some certainty is gained where a policy provides a definition of what constitutes a claim. If the insured's policy has no such definition, then the insured and the insurer need a clear understanding as to what should and should not be reported as a claim.

In those instances where the policy provides no guidance, the common law definition of "claim" may be no more than a demand for money or services. A filing with an administrative agency that is not empowered to award damages or compel other relief services generally is not considered a claim. Many state agencies and the EEOC fall into this category. When such an agency resorts to the additional power of the courts, however, a claim generally will be considered to have been made. Many state agencies can award damages and compel relief, and insureds and insurers should be cognizant of the powers of each particular agency.

Even where no claim has been made, it is prudent to be aware of when policies require or allow notice of facts or circumstances "likely to give rise to a claim." Most insurance applications and some renewal applications will inquire about facts or circumstances likely to give rise to a claim as a condition to issuing a policy. A failure to address questions fully from an insurer in this regard can result in a coverage denial in the future. On the other hand, a prudent policy of providing notice of appropriate facts or circumstances to insurers will avoid such unexpected coverage denials and may not materially affect premiums. Both insurers and insureds

35. *Wilkinson*, 1990 WL 302175.

36. *Id.* at *5.

can benefit from a greater knowledge of what may or may not constitute a claim under policies in effect between them.

Insureds and insurers should be aware of their rights and obligations under any insurance policy. Because the law is unsettled regarding the extent to which demands for extraordinary severance by terminated or soon-to-be-terminated employees might constitute a claim and the extent to which negotiations in that regard might constitute settlement without an insurer's authority, an insured should take care to notice all such incidents for which coverage may ultimately be desired. The law is well settled that settlement without authority, where such authority is required under the policy, will support a coverage denial.

Finally, an insured should be aware of the nature of the particular policy they purchased. "Claims made" and "claims made and reported" policies are not the same, and the "claims made and reported" policy provides coverage only for claims both made *and* reported within the same policy period, usually one year. Most courts have strictly upheld the claims made and reported provisions of these policies. Particular care should therefore be taken by an insured to stay current on policy renewals, and especially prompt notice should be given to claims made near the end of a policy period.