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December 2, 2022
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INSURANCE FOR NON-INSURANCE LAWYERS

December 2, 2022

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INSURANCE FOR NON-INSURANCE LAWYERS

Agenda

8:30 A.M.	Registration and Coffee
8:55 A.M.	Welcome and Course Objectives *Richard S. Pitts, Program Chair*
9:00 A.M.	Commercial Insurance: The View from an SR-71 Blackbird *Anderson R. White*
9:45 A.M.	Professional Liability Coverage *Richard Mather*
10:30 A.M.	**Break**
10:45 A.M.	The "Top Ten" things to think about if your client has a coverage problem *Michael L. Schultz*
11:30 A.M.	The Benefits of Cyber Insurance *A Roundtable Discussion (White, Weissert, Mather, Pitts)*
12:15 P.M.	**Lunch Break**
1:15 P.M.	Hot Topics in Insurance *Michael Giordano*
2:00 P.M.	Employment Practices Liability Insurance: What happens if your client has a claim? *Gina Moreno*
2:45 P.M.	**Break**
3:00 P.M.	Reinsurance – What it Is and Why it Matters to Your Client *Andrew M. Weissert*
3:45 P.M.	"Exotic" Coverages: Products Recall, Active Assailant, and Political Risk *Richard S. Pitts*
4:30 P.M.	**Adjournment**

December 2, 2022

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December 2, 2022

Richard S. Pitts, Arlington / Roe & Co., Indianapolis

Rick Pitts is vice president and general counsel for Arlington/Roe & Co., a leading Midwest managing general agent and wholesale insurance broker with volume that is approaching $230 million in premium. Rick also serves as general counsel to the Independent Insurance Agents of Indiana, Inc. As counsel to the "Big I," Rick speaks annually at the association's New Laws seminars and teaches various seminars on insurance and employment related matters. Pitts has also presented continuing education seminars to insurance professionals nationally and in Illinois, Kentucky, Michigan, Ohio and Tennessee.

Rick is a 1983 graduate of Wabash College and a 1986 graduate of Indiana University School of Law – Indianapolis. Pitts clerked for the Honorable Patrick D. Sullivan, a judge of the Indiana Court of Appeals in 1986-87. Rick is admitted to practice before Indiana state and federal courts, the United States Supreme Court and the United States Court of Appeals for the Seventh Circuit and is a member of local, state and national bar associations. Pitts has tried cases and participated in over seventy appeals.

Pitts has served as panelist and lecturer on subjects including the Americans with Disabilities Act; "Mold: Issues under the Microscope" for the Indiana Continuing Legal Education Forum (ICLEF); and "Insurance Issues for Builders" for the Indiana Builders Association. He served as chair of several of ICLEF's seminars including "Advanced Corporate Practice," "Privacy Law" and "Insurance Coverage Issues." He has presented seminars on "Insuring Fiduciary Exposures," "Insurance Coverage Disputes" and "Agency Succession and Perpetuation" for the Big I. Pitts has co-authored articles in the Indiana Law Review.

Michael R. Giordano, Lewis Wagner, LLP, Indianapolis

Michael Giordano is a partner in Lewis Wagner's litigation group where he concentrates his practice in insurance coverage defense and bad-faith litigation. Michael evaluates first- and third-party insurance claims in order to assist insurers in resolving coverage-related matters in a prompt and efficient manner. He also defends insurers against bad-faith claims arising under both personal lines and commercial lines policies.

Michael graduated magna cum laude from the University of South Carolina in 2010 with a Bachelor of Arts in criminal justice. He earned his Juris Doctor from the Indiana University Maurer School of Law. Michael is admitted to practice in the State of Indiana and before the United States District Courts for Northern Indiana and Southern Indiana.

Richard Mather, Allied World National Assurance Company, CT

Rich Mather is responsible for claims under Allied World's errors and omissions ("E&O") policies, including insurance agents and brokers, insurance company, technology, privacy and network security, lawyers, contractors professional, media, and miscellaneous professional lines.

Prior to joining Allied World in 2007, Rich spent sixteen years litigating cases in the state and federal courts in Connecticut.

He received his B.A. from the University of Connecticut, his M.A. from Trinity College, and his J.D. from the University of Connecticut School of Law.

Gina Moreno, Ogletree, Deakins, Nash, Smoak & Stewart, P.C., Greenville, SC

Gina Moreno is the Employment Practices Liability Insurance Manager for Ogletree, Deakins, Nash, Smoak & Stewart, P.C. in Greenville, South Carolina.

Michael L. Schultz, Parr Richey Frandsen Patterson Kruse, LLP, Indianapolis

Mike Schultz concentrates his practice on representing commercial and residential policyholders in high risk, high value disputes over insurance claims and claim handling. He frequently litigates large property damage cases involving claims of breach of the insurance agreements and bad faith by insurance companies, as well as claims against third parties for personal injuries and property damage. Mike also has litigated extensively in the areas of employment law, civil rights, toxic torts, unincorporated associations, and general contract disputes. He routinely handles employment related disputes, representing both businesses and employees. Mike is also experienced representing the firm's electric generation and transmission and rural distribution cooperatives and serves as general counsel for the largest rural electric cooperative in the state. Mike lectures frequently on insurance litigation matters and federal employment law compliance. He represents clients in both state and federal appeals and has presented oral arguments before the Seventh Circuit Court of Appeals, the Indiana Supreme Court and the Indiana Court of Appeals.

Mike is admitted to practice before the United States Supreme Court, the United States Court of Appeals for the Seventh Circuit, all federal district courts in Indiana, the Indiana Supreme Court and in all Indiana state courts. He has extensive trial experience, including civil jury trials and bench trials in insurance, employment, civil rights, property damage and business matters.

Andrew M. Weissert, AXIS (Re)Insurance, GA

Andrew M. Weissert is Chief Legal Officer with AXIS (Re)Insurance in Alpharetta, Georgia. Through its various operating subsidiaries and branches, the Company provides a range of insurance and reinsurance products to insureds and reinsureds worldwide with operations in Bermuda, the United States and Europe. Its business consists of two global underwriting platforms: AXIS Insurance and AXIS Re. The Company operates through two business segments: insurance and reinsurance.

Biography

ANDERSON WHITE
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Andy brings almost 20 years of experience as an insurance attorney to the Shepherd team. He has experience with coverage law, fires and explosions, products liability, contractor disputes, construction site accidents, breach of contract and even wrongful death, all in the context of insurance. He is also no stranger to the business of insurance, having worked as a commercial property and casualty producer for a major publicly traded independent insurance broker.

Since joining Shepherd in 2018, he has been heavily involved in reviewing contracts of all types in order to provide advice on how indemnification language may be applied. Additionally, he has assisted all types of clients in claims situations to assist them in recovering money owed because of property damage accidents. His primary focus, as General Counsel for Shepherd, is E&O litigation and avoidance, as well as best-practices creation, review and education. Additionally, he drafts and revises commercial leases and oversees enforcement of confidentiality and non-piracy covenants.

While his prior legal career was limited to insurance-related matters, the scope of his practice as in-house counsel has broadened significantly. He is now involved in matters involving employment law, including the ADA and FMLA on a regular basis. He regularly reviews lease and purchase agreements, and is even involved, from time to time, in probate and estate matters, as well as work with business entity formation and not-for-profit organizations.

Prior to becoming an attorney in 1999, Andy was a video producer, a landscaper and a psychiatric technician on an adolescent psychiatric unit. He's also worked in revenue recovery for United Parcel Service and has been an armed messenger on a Brinks Corporation armored car. So, he brings a substantial amount of varied and diverse life experience to his work at Shepherd Insurance.

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Section One

“Commercial Insurance: The View from an SR-71 Blackbird”

Presented By:

Anderson R. White, General Counsel, Shepherd Insurance, LLC

Shepherd

Commercial
Personal
Benefits
Financial

Section One

"Commercial Insurance: The View From an SR-71 Blackbird"..Anderson R. White

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I. My Insurance Agency: Shepherd Insurance

Insurance agencies come in all shapes and sizes, from single-agent owned and operated captives for carriers like Erie, Allstate and State Farm, to huge, publicly traded independent agencies like Brown & Brown or Aon, and, while it's true that the information I'm presenting in the following pages is not proprietary to any single type of insurance agency, I'd like to give you a brief feel for Shepherd Insurance that may assist you in understanding or contextualizing the information to follow.

Shepherd Insurance, LLC is headquartered in Carmel, Indiana, and was founded in 1977 by Dave Shepherd as a family-owned new business venture. Over the last 45 years, our privately held firm has grown into the largest full-service insurance agency in the state of Indiana. Shepherd provides proactive risk management and property and casualty solutions, as well as a full array of employee benefits solutions, personal insurance products, and financial services. We have more than 450 full-time employees with thirty-one (36) offices in six states (AZ, FL, IL, IN, KY and OH).

We were named one of Inc. Magazine's Fastest 5000 Growing Companies three years in a row and, in June of 2018, identified as one of the Top 100 Independent insurance Agencies in America by Insurance Journal. In 2019, Shepherd was also listed as a Top 50 Elite Agency in the country by Insurance Business America. Shepherd provides solutions to businesses and individuals who have challenging or unique exposure to loss and protects companies and individuals in all 50 states.

Shepherd Insurance is ranked #42 in the country among independent insurance agencies by Insurance Journal. That equates to approximately 68,415 clients protected, 275 carriers represented, 103,830 policies provided with total written premiums at $770,800,000, split roughly between property & casualty and employee benefits.

II. Types of Commercial Insurance

Go outside and take a glance at the first tree that you see. Count the leaves. Now, imagine those leaves are the different types of insurance coverages designed for commercial operations around the world. That's right! There are a HUGE number of different types of commercial insurance coverage.

There's commercial general liability coverage, commercial property coverage, mechanical breakdown coverage, worker's compensation coverage, errors & omissions coverage, manufacturer's E&O coverage, many other types of E&O coverage, directors and officers coverage, inland marine coverage, cargo insurance, ocean cargo insurance, trade credit insurance, accounts receivable coverage, commercial auto coverage, employment practices liability insurance, cyber liability insurance, medical malpractice insurance, stock throughput insurance, commercial umbrella and excess coverage, business income insurance, business identity insurance, bonds, key person insurance, and businessowners policies, just to name a few!

I'm sure you're familiar with someone using the expression "10,000 foot view" or "30,000 foot view." People say that when they're only going to be discussing something in general terms and not providing a huge number of details. That why I referred in my title to the SR-71 Blackbird. This plane is a true marvel of engineering that can fly up to 85,000 feet high (and more) and travel at Mach 3.2. So, as I'm going to tell all of you during the live presentation, listening to me hit the highlights of this material is going to be like going coast-to-coast (2,300 miles) in just 64 minutes and 20 seconds. That's just what the SR-71 Blackbird did in 1990 when it set a record on a flight from Palmdale, California to Dulles airport in Washington, D.C.

In this material, I'm going to focus on just a few of the lines of coverage I referenced above: commercial general liability, commercial property, business auto, and umbrella/excess.

III. <u>COMMERCIAL GENERAL LIABILITY INSURANCE</u>

In a nutshell, this insurance protects the insured company from liability claims arising out of its operations at its premises, its completed operations, or its products. This is the kind of insurance that protects a manufacturer in the event of products liability claims, and the kind of insurance that protects a grocery store against slip and fall claims from the nice old lady who fell in the produce aisle. Additionally, commercial general liability coverage (GCL) protects a contractor in the event of claims by third parties injured at a job site, and claims arising from allegedly defective work after the job is done.

There are two types of CGL forms – “occurrence based” policies and “claims made” policies. Occurrence-based CGL forms are the overwhelming bulk of the policies out there right now, but sometimes the risk is one that will require a claims-made policy – many times a very products liability intensive type of risk. In either case, the coverage provided by a CGL policy is for *non-professional* negligent acts. For example, if a roofing contractor is sued because the roof leaked and personal property inside of the home or business was damaged, a CGL policy will pay for that resulting damage to a third party’s property but will NOT pay for the faulty work itself. To get that kind of coverage, the contractor would have to have *professional* coverage in the form of a contractor’s E&O policy. Thus, doctors, lawyers, CPAs, architects, designers, contractors, etc. ALSO need professional liability coverage because that is an exposure not covered by a CGL policy.

There are three basic types of coverage provided by a CGL policy. Coverage A is for bodily injury and property damage liability. Coverage B is for personal and advertising injury liability, and Coverage C is for no-fault medical payments to third parties.

A. Coverage A

Coverage A, like the rest of the coverage on this form, is third-party coverage. A CGL would not cover injury to a company's own employees or provide coverage for a company's own buildings or business personal property. Those are different policies. Coverage A covers claims of bodily injury or property damage coming from unrelated third parties and made against the insured company.

The bodily injury component of this coverage would respond if someone slipped and fell at a company's store or location, or if the company's product hurt someone or damaged someone's property. This coverage would also protect a company if the company's employee negligently left the water running at a client/customer's home and caused water damage, or if the insured company's work is later responsible for bodily injury or property damage at a site where the company had worked previously. Note that this would only be true if the company maintained "completed operations" coverage in the period between when it turned its work over and the claim was made.

As I've already hinted, there are *lots* of exclusions to Coverage A. Any injuries or damage that were intentional or expected by the insured are excluded. Injuries that should be covered by worker's compensation are excluded. Any claims for employment practices (discrimination, harassment, retaliation) are excluded. In total, there are seventeen (17) major exclusions for this coverage. Anyone purchasing a CGL policy would do themselves, and those depending on them (like employees, board members, family members, etc.) a valuable service by making sure to read the coverage form completely, at least once to familiarize themselves with what is and what is not covered..

B. Coverage B

Coverage B is coverage for personal and advertising injury. What, you may ask, is personal and advertising injury? Well, this coverage provides defense and indemnity in the event of claims of libel,

slander, false arrest, infringing on another's copyright, malicious prosecution, use of another's advertising idea, wrongful eviction, wrongful entry, or invasion of the right of private occupancy.

With this coverage, like Coverage A, the insuring agreement is short, and the list of exclusions is long. There are sixteen (16) major exclusions applicable to this coverage, from the knowing violation of the rights of others, to criminal acts, contractual liability to electronic chatrooms or bulletin boards. Again, for an insured to really know what is covered and what is NOT covered, reading the policy is critical.

In my time selling commercial property and casualty insurance, I saw Coverage B treated largely as a throw-in, not worthy of much conversation, and certainly not worthy of much explanation. Who is really going to need it? When will it ever get used? Well, what about the store owner who decides to detain a suspected shoplifter who turns out to be innocent? Sounds like a possible claim of false arrest and/or imprisonment to me. What about the small "mom and pop" bakery who comes up with its own internet-based advertising and mistakenly uses a copyrighted idea owned by another, larger bakery? Sounds like the use of another's advertising idea in their advertisement to me. Sure, these kinds of claims are not as sensational or "sexy" as the big trucking or wrongful death accidents we see touted by some personal injury lawyers, but the coverage here can end up coming in very handy when circumstances warrant.

C. Coverage C

Coverage C is for medical payments. CGL policies usually come with a default amount of something like $1,000 or $5,000 for this coverage, which is used to help pay for the medical bills of someone injured at an insured's place of business or by something the insured has done or made. I've sometimes heard other professionals call this coverage "goodwill" coverage because, in some instances a business can use this coverage to pay for any medical bills a business invitee may incur because of an injury on the premises and help avoid that same injured invitee deciding to sue the company.

D. CGL – Key Points

One big plus of CGL coverage is that, in almost every instance (read the policy to be sure) defense costs are outside of the limits of insurance. This is critical because, in other types of coverage forms where defense costs are within the limits of insurance, the high cost of litigation means that much of the limit of insurance will be depleted by attorneys' fees and expenses, leaving little left over to pay settlements or judgments.

CGL policies will have a per occurrence and an aggregate limit. Often these are $1M/$1M policies, meaning the policy would pay up to $1 million dollars for a single claim during a policy period, but would only pay a TOTAL of $1M for the entire policy period, no matter how many claims were handled during the term of the policy. So, if you have a $1M claim payout in January, you've got NO liability limits for the rest of the year (if you have no umbrella).

Many times, it is possible for an insured to obtain a "per project" or 'per location" aggregate limit, meaning that, if you have ten (10) locations, each one of those locations has a $1M limit, effectively making your limit jump from $1M to $10M. Likewise, if you are a contractor and do ten (10) projects a year and your CGL aggregate limit is $2M, then you will have that $2M limit for each project. So, your insurer could pay out $1,8000,000 in damages for bodily injury that took place at one of your project sites, and you would still have $2M in limits for each of your other projects.

Completed operations coverage is very important for businesses like contractors. This type of insurance provides coverage for bodily injury or property damage caused by the insured's work that occurs after a job has been completed. In many construction contracts, particularly larger ones, the Owner or the General Contractor will require subcontractors to maintain completed operations coverage for that specific project for a period of years following substantial completion. This is because business

invitees to the completed building may not be injured by something negligently constructed for many months or years after the building is put to its intended use.

Liability coverage for ongoing operations is almost always provided by CGL forms. The difference between ongoing operations and completed operations liability coverage is most important when contractors are being required to add other parties as Additional Insureds onto their policies. Some endorsements doing that ONLY provide AI status for *ongoing ops*, and others are needed if the AI is to be an AI for *completed* operations.

There are, of course, conditions on coverage under CGL policies: notice, cooperation, etc. Late notice of a claim to a carrier can sometimes lead to a claim denial, and sometimes, depending on how the form is worded, notice of a claim can be triggered by the knowledge of almost anyone. It is always prudent for an insured and an insurance agent to try and make sure the policy is endorsed so that the knowledge of a claim for notice purposes is only knowledge by the insureds' leadership or executive class of employee.

Imagine that your client runs a warehouse. The offices are in one corner of the giant building, and the loading dock is on the opposite side of the building. Let's imagine that some workers are standing at an open loading dock door and notice someone walking across a parking lot stumble and fall over a parking block. They go over the make sure the visitor is OK, and are told by a rather embarrassed lady, "Yes, I'm fine. I'm just so clumsy." Since everything seems to have worked out just fine, the loading dock gang tells no one about this event.

Now imagine it's a year and a half later. That same "admittedly clumsy" woman files suit against the company, and it comes out in the CGL carrier's investigation that the men on the loading dock saw the whole thing, but the company never let its carrier know that this potential claim was out there. This could be cause for the carrier to deny coverage. Thus, you want the knowledge of a claim to only be

imputed or imputable to a select few at the company who have actual decision-making power or ability to make an insurance claim.

IV. COMMERCIAL PROPERTY INSURANCE

A. Buildings and BPP

This is the type of policy that provides coverage for direct physical damage or loss to commercial buildings and business personal property (BPP). While the focus of this insurance is often seen as tangible things that can be seen, counted, and touched, we will see shortly that the intangible coverages possible with this type of policy can be just as, if not more important than that provided for tangible things.

The two major tangible things for which this policy provides coverage for direct physical loss are buildings and business personal property. Buildings consist of the structures described in the Declarations, including:

-completed additions;

-fixtures, including outdoor fixtures;

-permanently installed equipment and machinery; and

-personal property used to maintain or service the building (fire extinguishers, outdoor furniture, floor coverings, appliances used for refrigerating, ventilating, cooking, dishwashing or laundering

The following property is considered business personal property if it is located within 100 feet of the building or structure or 100 feet of the premises:

-furniture and fixtures;

-machinery & equipment;

-"stock";

-all personal property owned by the insured and used in the business;

-labor, materials or services furnished or arranged by you on personal property of others;

-insured's interest as tenant in improvements and betterments;

-leased personal property for which the insured has a contractual responsibility to insure; and

-personal property of others that is in the insured's care, custody or control and located in the building or structure or within 100 feet

If you are like me, you look at those two lists of what is considered "building" and what is considered "business personal property," and you wonder in what circle of hell the writers of insurance forms ply their trade[1]. Do you see the phrase "equipment and machinery"? That's right! It's in both the definition of a building and in the definition of business personal property. Did you know that a fire extinguisher is a building? Well, the writers of this form think it is! Do you see the word "fixtures"? Yep, it's in both lists, too.

Needless to say, all of this can create a lot of confusion. For example, will your machinery be covered by your property policy in the event of a loss? Possibly, if the cause of loss is listed in the "Cause of Loss" form that came with the policy. Typically, property is covered for things like fire, explosions, burst pipes, storms, theft and vandalism, as well as earthquakes and floods, if the policy is endorsed properly.

But what about when your $100,000 piece of "equipment" is fried by an electrical surge? Sorry to say, but it is probably not covered by your property policy. In that case, I would certainly hope the insured

[1] To be fair, these forms are written by very, very, very smart people – certainly much smarter than I am. The logic of what is covered, what is not covered and how things are excluded is always, for the most part, there for the explaining. These things are just not always readily apparent to those not familiar with the nuances and complexities of policy drafting and interpretation.

invested in a mechanical breakdown policy, which would, in general, provide for coverage to that same piece of equipment you thought was insured by your property policy, if it was fried by electricity.

In addition to the confusing list of what is covered and what is a building versus what is business personal property, there are also some surprising exclusions on the unendorsed commercial property coverage form. The main items not covered, that most any insured would expect to be, are foundations, underground pipes, flues or drains, retaining walls, and fences. Can you imagine your client suffering a catastrophic fire at their location and learning that (a) the loss would be covered, but (b) there would be no coverage to repair or replace the foundation? I don't know many people who could stay rational in that scenario, and that's especially true since any appraiser or estimator worth your time would include things like foundations and underground pipes in any estimate of the replacement cost of a building. This means that, if the insured is insuring his/her building correctly, it is paying for a limit that would include replacing the foundation, but the unendorsed policy will not provide coverage for that.

The good news is that it is possible to cover the items in that list of items excluded under the property coverage form, but you must ask for that coverage.

B. Business Income Coverage

This type of coverage is sometimes called "business income," and sometimes it is called "business interruption." Regardless of what it is called, it is a type of property coverage that is designed, not to replace a building or a tangible thing, but rather to address the financial impact of an occurrence closing a business for some period of time. As you are all probably aware, the COVID-19 pandemic did more to shine a spotlight on this coverage than anything else in the lifetimes of anyone now selling or servicing insurance.

Typically, business income insurance covers "normal" expenses after a temporary closure – employee wages, leases, loan payments, etc. There are several critical things that an insured and his or

her agent must calculate and come to an agreement on, and none is more important than the “period of restoration.” This is because business income payments end once the insured has returned to “operational capability,” meaning they have reached the end of the “period of restoration.”

In purchasing BI insurance, the insured must select a time limit for the period of restoration, and, at the end of that period, the insurance payments cease, regardless of whether there may or may not be any limits left. So, it is critical for a business owner to calculate this period very carefully and with eyes wide open. It is our experience that many business owners, particularly those who have never experienced a large property loss, drastically underestimate the time it would take to replace a building. However, the danger of not approaching this topic realistically is having BI limits insufficient to see you through this troubling period until you can be profitable again.

C. Extra Expense

If BI insurance covers the “normal” expenses associated with a business shut-down, then it is appropriate to say that extra expense coverage pays for the “abnormal” costs of a business shut-down. The goals of extra expense coverage are to either (1) maintain some level of operational continuity at the insured location, or (2) continue operations somewhere else.

Some of the expenses included within extra expense coverage are the additional cost to speed up real property repairs. These are expediting expenses for real property and MUST reduce the BI loss to be payable. Relocation costs to avoid or minimize the suspension of operations are also covered. These don’t have to reduce the BI loss to be payable. Relocation costs include either temporary or permanent relocation, utility hook-ups, facility rental costs, furniture or equipment rental and advertising costs. Another element of extra expense is the increased operating cost related to a new location. This expense does not have to reduce the BI loss to be payable and includes the same elements as those described for relocation costs.

Property insurance typically features a deductible. This is the amount of the overall value of the insured risk that the insured is retaining. Depending on the value of the building or business personal property being insured, deductibles could be anywhere from $2,500 to $50,000 or more. Sometimes, if the risk is harder to insure (government housing, coastal properties), the only way that an insured can obtain any property coverage is to accept a very high deductible. The key is that the insured must be informed and make decisions related to what deductible to select (assuming there are options). Forewarned is forearmed.

It is important to note that, whether one is considering business income coverage or extra expense coverage, there are also deductibles, but not the traditional kind. The deductibles for BI and extra expense are not stated as dollar amounts, rather, these kinds of coverages feature what are known as “time element” deductibles. In either case, the insured selects or is forced to take BI or extra expense coverage that does not begin to pay until a set period has elapsed from the time of the event giving rise to the claim. One time element deductible that is common is seventy-two (72) hours. It is, however, sometimes possible to purchase a shorter time element deductible for increased premium.

One key issue with time element deductibles was illustrated sharpy in the plethora of BI claims that were made during the COVID-19 pandemic. At least one of the major arguments against insureds’ attempts to argue that their property had been physically, tangibly affected by the virus was that these same insureds admitted to cleaning their businesses almost constantly. So, if the surfaces of a restaurant with a 72-hour time element deductible on its BI coverage are truly physically affected by the COVID-19 virus but are cleaned and made “like new” every day or couple of days, then the 72-hour time element deductible for the BI coverage is never satisfied and the coverage is not triggered.

D. Key Points – Commercial Property Coverage

Building valuation is a critical part of placing property insurance, and we fear that, too often, insureds are not taking the time to get an accurate picture of just how much it would cost to rebuild their structures. Even without considering the crazy new world of supply chain problems and skyrocketing prices for building materials brought on by the COVID-19 pandemic, it is hard to come up with a truly accurate number for what it would cost to rebuild a building.

As we work with our clients, we see them using everything from real estate comparative market analyses (which would only reflect a potential selling price, not a rebuilding price) to property tax valuations to arrive at the limit of insurance they want to buy for their buildings. What insureds really need to do is to engage a builder or contractor who is familiar and experienced in the type of construction that would be needed to rebuild their building and pay for a comprehensive, current estimate of the cost to raise a new building from the ground up.

Let me stress here what we stress to every one of our commercial property clients – INSUREDS CHOOSE LIMITS! It is not our business, as agents, to value our clients' property. It is theirs. If the limits are inadequate in the event of a loss, that is (almost always0 the insured's issue, not the agent's.

Additionally, insureds must understand the concept of coinsurance and how it will affect their loss settlement in the event of a claim. When a coinsurance percentage appears on the Declarations page of a commercial property policy, that means that the insurance carrier expects the insured to purchase limits at least equal to that percentage of the total replacement cost of the structure.

For example, let's say a building would cost $1,000,000 to rebuild, and there is a 90% coinsurance amount on the policy. That means that the carrier expects the insured to purchase at least $900,000 in limits for that building. In the event of a partial loss, the carrier uses the following formula to calculate the potential coinsurance penalty:

$$\frac{\text{Limit Actually Purchased}}{\text{Limit Required}} \times \text{Loss Amount} = \text{Claim Payment}$$

So, let's assume that the true replacement cost of a building is $1,000,000 and there's a 90% coinsurance requirement. Let's further assume that the insured, using limits selected years ago by a previous owner of the company, insures the building with a limit of $500,000. Finally, let's assume that a fire causes $200,000 in damage to the building.

The math would look something like this: $500,000 / $900,000 = .56 ; $200,000 x .56 = $112,000. So, in that case, the insured would only be paid $112,000 on a $200,000 fire loss because it did not buy sufficient limits. Note what would have happened if the insured had purchased the requisite $900,000 in limits: $900,000 / $900,000 = 1 ; 1 x $200,000 = $200,000. In that case, the entire loss would have been paid.

Another issue all insureds need to keep in mind is that, in the event of a loss to a building, debris removal will often become a big factor in the adjustment of the claim. Debris removal, however, is frequently overlooked as a factor in property insurance costs. No matter how extensive the damage is to a building, some debris must always be removed before the site is ready for the rebuilding/repair phase to begin. The cost of removing debris depends on the cause of loss and the degree of damage. For example, in a major fire loss, the fire might actually consume much of the debris, making the removal largely a clean-up expense. If the same amount of damage was due to windstorm (such as a hurricane or tornado), clean-up might entail clearing debris from the building location as well as locating and cleaning debris that the storm carried from the site.

Typically, unendorsed property policies provide some percentage of the coverage limit for debris removal. It's usually 25% of the amount of the loss paid (not the policy limits). Most policies also provide an additional $10,000 as additional debris removal coverage. Let's assume the same $200,000 in

damages used in the coinsurance example above. In that case, the standard, unendorsed policy would provide up to $60,000 in debris removal coverage ($50,000 + $10,000). What if, however, the damage was caused by a tornado, most of the debris is still in situ, and the total debris removal cost is $90,000 (very possible)? The insured now has insufficient coverage to clear all the debris AND repair the damage. The insured is underinsured to the tune of $30,000.

Another issue that insureds MUST consider is purchasing equipment breakdown coverage. Remember, equipment and machinery are defined in the standard commercial property policy as part of the building or as business personal property. So, in some instances, like losses due to fire or wind, there would be coverage for the equipment and machinery under either the building limit or the business personal property limit. However, if the cause of the loss is not one that's encompassed by the Cause of Loss Form attached to the property policy, there would be no coverage. Typically, equipment breakdown polices provide coverage for damages caused by covered internal forces, such as power surges, electrical shorts, mechanical breakdowns, motor burnout or operator error. If the insured's business owns a lot of equipment or machinery, like drill presses, injection molders, generators, etc., the insured needs both a commercial property policy and an equipment breakdown policy.

Finally, I want to stress the importance, for every insured with a business income or extra expense exposure (ALL OF THEM!!), taking the time to prepare a business income worksheet accurately and completely. This six-page form requires an insured to come up with good numbers for the previous 12 months for things like gross sales (deducting finished stock inventory at the beginning and adding finished stock inventory at the end), the gross sales value of production, deductions for things like prepaid freight – outgoing, returns and allowances, discounts, bad debts, and collection expenses. Eventually, the insured can arrive at a figure for net sales (for manufacturing) or the net sales value of production (for non-manufacturing). From there, things like commissions or rents and cash discounts

received are added to come up with total revenues. That figure is what, at least in part, drives the selection of business and extra expense limits.

I have barely scratched the surface of everything involved in a BI worksheet, and, to be honest, filling one out correctly is hard. However, we have never heard clients who have had sufficient BI and extra expense limits in the event of a loss complaining about the time they spent getting the numbers right. The old computer expression "garbage in, garbage out" comes to mind. If the insured cares little about having sufficient BI or extra expense limits in case of a claim that causes the business to shut down temporarily, then the insured is free to throw a dart and pick a number. This, however, is typically a recipe for "much weeping and gnashing of teeth."

V. BUSINESS AUTO POLICIES

The Business Auto Policy (or BAP) combines elements of property coverage, liability coverage and inland marine coverage. At the most basic level, a BAP provides coverage for the clients' covered autos (auto physical damage) while mobile and protects the clients from liability arising from the operation of the autos (damage done to others).

There are eight (8) primary types of coverage that may be provided by a BAP:

1) Liability
2) Personal Injury Protection (PIP)
3) Medical Payments
4) Uninsured Motorists coverage
5) Underinsured Motorists coverage
6) Hired/Borrowed Liability
7) Non-owned Liability
8) Physical damage coverage:
    -comprehensive
    -collision

A. Liability Coverage

Arguably the most important type of coverage provided by a BAP is liability coverage. This coverage provides legal defense and limits of insurance to settle or pay judgments arising from claims of third parties who have been injured by the insured's use and operation of autos in its business.

What autos are covered on the policy is denominated using symbols. The following symbols are used:

Symbol	Description Of Covered Auto Designation Symbols	
1	Any "Auto"	
2	Owned "Autos" Only	Only those "autos" you own (and for Covered Autos Liability Coverage any "trailers" you don't own while attached to power units you own). This includes those private passenger "autos" you acquire ownership of after the policy begins.
3	Owned Private Passenger "Autos" Only	Only the private passenger "autos" you own. This includes those private passenger "autos" you acquire ownership of after the policy begins.
4	Owned "Autos" Other Than Private Passenger "Autos" Only	Only those "autos" you own that are not of the private passenger type (and for Covered Autos Liability Coverage any "trailers" you don't own while attached to power units you own). This includes those "autos" not of the private passenger type you acquire ownership of after the policy begins.
5	Owned "Autos" Subject to No-fault	Only those "autos" you own that are required to have no-fault benefits in the state where they are licensed or principally garaged. This includes those "autos" you acquire ownership of after the policy begins provided they are required to have no-fault benefits in the state where they are licensed or principally garaged.
6	Owned "Autos" Subject To A Compulsory Uninsured Motorists Law	Only those "autos" you own that because of the law in the state where they are licensed or principally garaged are required to have and cannot reject Uninsured Motorists Coverage. This includes those "autos" you acquire ownership of after the policy begins provided they are subject to the same state uninsured motorists requirement.
7	Specifically Described "Autos"	Only those "autos" described in Item Three of the Declarations for which a premium charge is shown (and for Covered Autos Liability Coverage any "trailers" you don't own while attached to any power unit described in Item Three).
8	Hired "Autos" Only	Only those "autos" you lease, hire, rent or borrow. This does not include any "auto" you lease, hire, rent or borrow from any of your "employees", partners (if you are a partnership), members (if you are a limited liability company) or members of their households.
9	Non-owned "Autos" Only	Only those "autos" you do not own, lease, hire, rent or borrow that are used in connection with your business. This includes "autos" owned by your "employees", partners (if you are a partnership), members (if you are a limited liability company) or members of their households.
19	Mobile Equipment Subject To	Only those "autos" that are land vehicles and that would qualify under the definition of "mobile equipment" under this policy if they were not

	Compulsory Or Financial Responsibility Or Other Motor Vehicle Insurance Law Only	subject to a compulsory or financial responsibility law or other motor vehicle insurance law where they are licensed or principally garaged.

As is (hopefully) apparent from the preceding table, the very best symbol to obtain is symbol 1. It could be said that symbol 1 encompasses all the other symbols. There is less guess work, paperwork and legwork involved with symbol 1. The use of many of the other symbols is going to require someone at the insured business to keep a schedule of vehicles updated frequently with the insurance carrier, and the use of some symbols would result in potentially uncovered claims, depending on the promptness with which the insured notifies the carrier of changes in vehicle ownership.

Using symbol 1 means that any auto in existence could conceivably be a covered auto, depending on the facts of a particular claim. Contrast that with symbol 7, which is for "specifically described autos." Using that symbol, the insured will only have coverage for autos for which they have provided the carrier with information and requested coverage. Sometimes, there's no avoiding using a symbol *other* than symbol 1, but extra care must always be taken if symbol 1 is ***not*** being used.

B. Personal Injury Protection (PIP) Coverage

PIP, or Personal Injury Protection, is no-fault coverage, providing medical payments to the insured's drivers for injuries sustained, regardless of fault. PIP coverage is part of specific states' compulsory auto or financial responsibility laws. Each state that requires PIP has its own required limits. Indiana is an at-fault state, so it does NOT require PIP on business auto policies. As such, I will say no more about it in these pages.

C. Medical Payments Coverage

Just like PIP, medical payments coverage provides first-party medical benefits to the agents of the legal entity/named insured. Medical payments coverage is not required in all states, but it is required in some states instead of PIP. Just as Indiana is not a PIP state, it is also not a "medical payments" state. So, I will move on to the next topic.

D. Uninsured/Underinsured Motorists Coverage

This type of coverage, just like its twin found on some personal auto policies, is meant to protect insured, not-at-fault drivers who are injured by a driver who either has NO insurance or insurance limits that are insufficient to pay for the innocent driver's injuries/damages.

For example, let's assume a driver in Indiana has the state mandated minimum legal auto insurance coverage of $25,000 per person and $50,000 per accident. Let's further assume that another, innocent driver is t-boned by Mr. Minimum and suffers injuries requiring $100,000 in treatment. In that case, Mr. Minimum's insurer would pay its policy limits of $25,000, but that would leave the innocent driver with $75,000 in uncompensated-medical bills. That's where UM/UIM coverage could come into play. If the innocent driver had something like $100,000 in UM/UIM limits, his/her carrier would pay the remaining $75,000 after Minimum's carrier paid its limits.

In practice, UM/UIM coverage can be much, much more complicated than that, and I find that, each year when I attend the Indiana Law Update CLE class in September, the bulk of the insurance law cases discussed seem to be UM/UIM cases. For the sake of this class, however, UM/UIM issues are fairly simple. I am a firm proponent of *individuals* buying as much UM/UIM insurance as they can on their ***personal*** auto policies. However, as it pertains to businesses, workers' compensation is the exclusive means whereby an employee injured in the course and scope of his/her job is to receive payments for medical bills and lost wages. As such, I would almost always recommend that businesses buy as little

UM/UIM insurance as possible. If it is possible to purchase ZERO UM/UIM, that is what I would counsel Indiana *businesses* to buy. They are already paying work comp premiums to assure that their valued workers are protected in the event of a work-related injury. Why are they going to spend extra money on other insurance that is designed to do the same thing?

E. Hired/Borrowed Liability Coverage

Purchasing this type of coverage means that the Named Insured is making the owner of a leased/rented/borrowed vehicle an insured under its own policy. When our insured borrows a vehicle, they will be responsible (rental car legal agreement/contract) or may wish to be responsible to protect that owner of the needed vehicles.

This type of insurance is providing coverage for another entity as an Additional Insured for the acts of our Named Insured in using a vehicle it hires/rents/borrows but ONLY with respect to our Named Insured's use of the vehicles for our Named Insured's business operations.

Look at the example of a business renting a U-Haul truck to move some boxes to storage. If the business's driver is in an at-fault accident with another vehicle, the injured, innocent driver is going to sue everyone possible: the at-fault driver, the business for which the at-fault driver works, and U-Haul, because their name is in huge letters on the side of the truck. When U-Haul gets sued, they are going to expect that the business that rented the truck from them will defend the suit and provide indemnification. That's the kind of scenario covered by hired/borrowed coverage. Additionally, if a business purchases hired/borrowed physical damage, it will have coverage to repair that U-Haul truck after the accident.

F. Non-Owned Liability Coverage

This is one of my favorite types of auto coverage. I know, I know. ***Who*** has a favorite auto insurance coverage? The reason I like this coverage so much is because it is often not well understood but is vitally necessary for almost 100% of all businesses.

We sometimes have business clients that tell us they have no auto liability exposure because they have no vehicles. However, this is the exact kind of coverage a business like that needs. This coverage is the coverage that's needed if any of a company's employees ever run errands for the business using their own personal vehicles, or if companies have employees who regularly use their own vehicles for business travel or sales functions.

Non-Owned autos are autos which not leased, rented, borrowed, or hired or owned by the Named Insured. Non-owned coverage is for autos owned by the Named Insured's employees, partners, members and/or members of their households, and others but only while used for business purposes or personal affairs of the Named Insured. If a company's employee, using her own vehicle, gets into an accident in her personal auto while on company business and the company gets sued, this coverage will protect the company.

But what about the employee? How are they covered? Well, there is an endorsement called Employees as Insured. This endorsement makes any employee a covered insured for any auto they are operating on company business which is not owned, hired, or borrowed by the Named Insured. This is a critical endorsement for any company, particularly ones who don't think they have any auto exposure.

When a claim occurs, the insurance carrier for the insured business will want the driver of the auto in question on their side of the table/defense. Without this endorsement, the company will be protected, but, since the employee/driver will have to rely on any personal auto policy he/she has, the company and the employee/driver may end up adverse to each other in court proceedings – an eventuality that most companies would like to avoid.

G. Comprehensive & Collision Coverage

This coverage provides funds to pay for repairs to insured vehicles which occurs as the result of either crash or non-crash damage. Crash damage is just what it sounds like. If an employee is driving an

insured vehicle and the vehicle is damaged, collision insurance will pay to repair the damages. Comprehensive coverage, on the other hand, covers any damage that is not crash-related, like fire damage or a tree limb falling on the vehicle.

H. Key Points – Business Auto Coverage

Close attention must be paid to who is an insured, what vehicles are covered and what things are excluded. Coverage will ONLY extend to those who are (1) Insureds, (2) for Covered Autos, and (3) otherwise not excluded. When a commercial auto claim occurs, there are three entities which will need liability coverage: (1) the business, (2) the owner of the auto, and (3) the driver. Sometimes the business is the owner of the auto, and the driver is an insured by virtue of being an employee driving a covered auto on company business, but sometimes this is not the case.

Even if a business has no vehicles, it should ALWAYS have hired/borrowed/non-owned liability coverage, because one can never be certain what scenarios may arise. Rather than try and imagine a business that would never have an auto risk, it is more prudent to consider that, on any given day, things tend to happen which we do not consider possible. An employee (Agent of the Named Insured) is sent to pick up company mail, drop off papers or plans, run to the courthouse to file something, go pick up lunch for fellow employees or the boss, or take a cash deposit to the bank. These are just some of the examples of when an employee, as an Agent of the Named Insured, may use their personally owned (Non-Owned by the Named Insured) autos and create a liability for themselves (the human owners of the vehicles) and the Named Insured who is responsible for the conduct of its employees and Agents.

When it comes to liability coverage, the best symbol that affords the most vehicles coverage is symbol 1. That is the symbol we always try to obtain for every insured client. With symbol 1, there is no need to keep track of vehicle schedules or the buying and selling of new or used vehicles. On the flip side of that statement is the warning that, if an insured is <u>not</u> able to obtain symbol 1 for liability

coverage, it is imperative that the insured keep its agent and carrier absolutely up to date regarding the purchase of new vehicles, the sale of previously insured vehicles and what vehicles should and should not be a part of any schedule required by the carrier. If this is not done, it could easily result in a significant uninsured loss for the insured.

VI. COMMERCIAL UMBRELLA / EXCESS POLICIES

Just as an umbrella is put in place over a person to shield them from rain or sun, these policies are meant to "sit over" certain liability policies like general liability insurance, commercial auto insurance and employer's liability insurance (part of a work comp policy). Think of a raincoat as analogous to the insured's primary, underlying policies. They are the insured's primary means of protection. Sometimes, if the rain is light, no umbrella is even needed. However, if it's pouring buckets, the umbrella/excess policy is like the insured's physical umbrella – an extra layer of protection for when the raincoat just isn't enough.

It is important to keep in mind that many in the insurance industry, including agents and (most unfortunately) carriers, use the words "umbrella" and "excess" interchangeably. This may be understandable, as both types of policies provide an extra or excess layer of protection over and above primary liability policies. However, it is also unfortunate because umbrella policies and excess policies, while sharing many traits, are different animals.

A. Umbrella Policies / Coverage

This coverage serves three purposes:

1) It provides excess limits when the limits of underlying policies are exhausted by the payment of a claim;

2) It "drops down" and picks up where the underlying policy leaves off when the aggregate limit of the underlying policy in question is exhausted; and

3) It provides protection against some claims not covered by underlying policies, subject to the assumption by the insured of a self-insured retention (SIR).

This coverage is protection against one very large judgment or settlement in an amount over the total underlying limit of insurance, or against the erosion of underlying limits by multiple claims in a given policy year.

For example, let's assume a CGL policy with $1M per occurrence and $1M aggregate limits. Someone is gravely injured in a fall at the insured location, and the eventual settlement of the claim costs $1,500,000. If the full underlying aggregate limit of $1M was intact, the underlying policy would pay $1M of the settlement, and the umbrella carrier would pay the remaining $500,000.

Now, let's assume the same CGL policy with the same limits. This unfortunate insured has three (3) $250,000 claims that are settled by its underlying GL carrier in the first half of the year. That leaves the insured with only $250,000 in underlying GL limits for the remaining six (6) months of the policy term. If, during that six (6) months, there's another claim that takes $500K to settle, the underlying carrier would pay its remaining limits of $250,000, and the umbrella carrier would pay the remaining $250,000.

One unique aspect of an umbrella policy is that it sometimes provides "broader" coverage than an underlying policy. Put another way, there are limited instances where an umbrella policy may provide coverage for a claim in a situation where the underlying policy does not. This is typically when the exclusions on the underlying policy are more restrictive than those on the umbrella policy. For example, something may be excluded under Coverage B – Personal and Advertising Injury in the underlying CGL policy which is NOT excluded on the umbrella form. If a claim is made that triggers the underlying

exclusion, but there is no corresponding exclusion on the umbrella coverage for the same claim, the umbrella carrier may be required to provide the insured with access to its limits of insurance, even though the underlying limits have not been exhausted or even triggered.

One indicator that a policy is an umbrella policy, as opposed to an excess policy, is the presence of an SIR (self-insured retention) on the umbrella Declarations page. This SIR is an amount that an insured is typically required to pay on its own before the umbrella carrier will agree to provide coverage in these instances where coverage for a claim is excluded in the underlying policy but not in the umbrella.

B. Excess Policies / Coverage

Unlike umbrella policies, the ONLY purpose for an excess policy is to provide additional funds to settle claim after underlying liability limits have been exhausted. These policies are NEVER broader than their corresponding underlying liability policies. Therefore, one will sometime see a true excess policy sitting over an umbrella policy, which is, in turn, sitting over multiple underlying policies.

C. Larger Programs

For many small to medium-sized businesses, having commercial general liability, commercial auto, and worker's compensation policies, with a single umbrella policy sitting over them all, is enough insurance to protect them from the vast majority of claims they may face. However, larger businesses, or those with operations or products that are inherently more prone to produce claims, sometimes have entire umbrella/excess "programs."

For example, a national supplier of home protection equipment and services may have a $10M umbrella with a $10K SIR sitting over its auto, general liability, and work comp policies, and a $10M excess policy sitting over the umbrella, for a potential combined total of $22,000,000 when including the $2M aggregate limits on the underlying policies. Alternatively, a national provider of "professional"

services may have an underlying professional liability limit of $10M, with a $15M umbrella sitting over the primary E&O policy, and a $15M excess policy over the umbrella, for a combined potential total policy limit of $40M.

It is also worth noting that, in the case of larger, more sophisticated businesses, there may be "towers" of coverage of different sizes and make-ups in different parts of the program. Take the national home security example above. It may have the "tower" described above for its standard liability policies (auto, GL, work comp), but may have a totally different kind of tower over its Directors & Officers and fiduciary liability policies. What I have learned in my time at Shepherd is that, when it comes to putting together a program of umbrella and excess coverage for a client, the "science" is most about getting the client to commit to the need for a certain level of coverage. Once that question is answered by the client, the "art" in the umbrella/excess world is working with one or many carriers to get the program fleshed out.

D. A Warning from the "Real World"

Please note here that, as I've been writing this section of the materials, I've used phrases like "the underlying carrier will pay" or "the umbrella carrier will pay." This is as good a time as any to put in writing for *this* audience something I tell our employees so often that it may end up someday on my tombstone – CARRIERS MAKE THE DETERMINATION AS TO WHETHER THERE IS COVERAGE. AGENTS DO NOT. In this context, what that means is that everything I've included in the preceding examples is correct, as far as the math goes and the theory goes. However, the fact of the matter is that no one at Shepherd Insurance, or any other agency, has any part in determining whether there is or is not coverage for any given claim. That is the obligation and responsibility of the insurance carriers. So, while we can give our opinions, as insurance professionals, about what would be or what would NOT be covered, our words will always be just that – opinions. For the purposes of this section of the materials, it is appropriate to state that it is never a foregone conclusion that an umbrella or excess carrier will

automatically pay a claim over and above underlying limits if the underlying carrier agrees to provide coverage.

All carriers, ones that sell underlying or primary liability policies as well as those who sell umbrella policies, have various terms and conditions in their forms or endorsements that can affect coverage. One of the big ones in the world of umbrella coverage is the requirement of prompt notice. If someone loses both legs in an auto accident, there's little doubt that the claim is ultimately going to be valued in excess of $1M. So, in that case, it's easy to see that the umbrella carrier on the risk should be notified right away.

But what about an injured plaintiff who initially does not seem to be seriously injured but suffers significant complications? In that case, those initially working on a claim may not ever suspect that the claim could cost more than the low six figures and may not end up providing notice to an umbrella carrier of the incident. Then, years later, when it's become apparent that the plaintiff's damages will end up in excess of $1M and the umbrella carrier is finally noticed, the carrier cites the notice provisions in its policy and (probably correctly) claims to have been prejudiced by not being involved in the matter all along.

So, while any insurance professional may be willing to offer an opinion or conjecture about whether a given claim may be covered by underlying or umbrella/excess policies, those opinions and/or conjecture are never any substitute for the carrier's letter outlining either why there IS or IS NOT coverage for a given claim. Anything an agent says in this regard could potentially be characterized as "mere surplusage."

E. Key Points – Umbrella / Excess Coverage

Remember, even though insurance professionals use the words "umbrella" and "excess" carelessly and make them seem interchangeable to the lay person, they are not. An umbrella policy is

different from an excess policy. While it is true that both can provide coverage in excess of the limits of their underlying policies, excess policies will NEVER provide coverage where an underlying policy does not, and an umbrella policy sometimes will. For this reason, the following is a good picture of the relationships here:

“No Umbrella/Excess” < “Excess” < “Umbrella”

“Running bare” is never a good idea, for any commercial insured, or personal insured, for that matter. If, because of pricing or some other factor, a business cannot purchase a true umbrella policy, then having an excess policy is still important protection for catastrophic single claims or bad claims years. Overall, an insured will obtain the most protection by purchasing a true umbrella policy if one is available.

When it comes to umbrella/excess policies, notice is, again, a very important factor. As mentioned previously, when considering some claims it would seem easy to tell whether they could ever impact an umbrella/excess carrier. Fatalities are those kinds of claims. However, other claims that do not seem, at first blush, to be candidates to eat into an umbrella/excess layer can do just that. In those situations, we never want to give an umbrella/excess carrier any ammunition to argue that it was not provided notice in a sufficiently timely manner. The safest bet, of course, would be to notice an umbrella/excess carrier anytime personal injury was involved in a claim, but that would probably seem excessive to most of us. A better rule might be that, when the reserves on any given claim are increased to a certain level (i.e.- $200,000, $250,000, $500,000) they umbrella/excess carrier is put on notice.

VII. <u>WORKERS’ COMPENSATION INSURANCE</u>

Workers’ compensation (“WC”) is a type of insurance that protects the employees of businesses, and the businesses themselves, in the event of workplace injuries. WC is designed to cover medical bills and lost wages and will also pay in the event of a worker’s death or permanent disability. Any business that employs full or part-time employees or has temporary workers will likely have to purchase WC.

A. Eligibility

In general, all businesses are required to purchase WC insurance for their employees. This is mandated by statute. In certain instances that vary by state, owners, officers, and certain others may choose to include or exclude themselves from coverage. In Indiana, sole proprietors, LLC managers and partners are not covered unless they “opt in.” Also, agricultural employees performing traditional types of farm labor directly related to the tending of crops and livestock are not included in the work comp statute, however, coverage can be purchased for them.

B. Benefits

WC starts by paying for the medical treatment required for an employee injured in the course and scope of his/her employment. These payments can be triggered almost immediately. As soon a medical bill is incurred due to a work-related injury, WC benefits will begin to pay for that treatment. Common medical expenses may include doctor and hospital visits, surgical procedures, ambulance transportation, medical devices, and equipment, physical or occupational therapy, and prescription medication.

Additionally, if an employee must miss work for more than seven (7) days, that employee will be eligible to receive payments for his/her lost wages at 2/3 of the regular weekly rate. These payments are called temporary total disability (TTD) benefits and are paid when the employee cannot do any work because of the injury. These benefits last for a maximum of 500 weeks or until the worker reaches maximum medical improvement (MMI).

If the injured worker returns for light-duty work for fewer hours than he/she worked prior to the injury, he/she may be paid temporary partial disability (TPD). TPD benefits will cover the difference between the worker’s pre-injury and post-injury wages, up to the maximum set for TTD, and these benefits last for a maximum of 300 weeks.

Once a doctor determines that the injured worker has reached MMI, he/she will be evaluated to determine whether there is any permanent impairment of some degree. This is referred to as permanent partial impairment (PPI). This rating represents the percentage of the worker's body that has been permanently damaged. The PPI is converted into a dollar amount of benefits using a formula found in Indiana's WC statutes.

If the worker is prevented from performing any reasonable work in the future, he/she is entitled to receive a payment for permanent total disability, which will be the amount of the PPI calculation or a permanent total disability award (500 weeks at the TTD rate), whichever is higher. Finally, if the worker was killed in the work-related accident, WC will provide death benefits to his/her beneficiaries in the amount of two-thirds of the worker's average weekly wage paid over 500 weeks.

C. Premium Calculation

WC premiums are calculated using several criteria. The first factor considered is the "class code" of the employees. There are class codes for just about any type of worker in any type of job. As you can imagine, if a business has several employees in a dangerous class code like blasting or excavation, the premium generated will be higher than a business full of office clerks and employees. This is because the likelihood that a blaster/excavator is injured is so much greater than is the case for someone sitting at a desk all day using a computer and answering phones.

Another important factor that goes into the calculation of WC premium is the payroll associated with each class code reported by an employer. Take any class code you like and assume a business has ten (10) employees in that class code. If you increase the number of employees by ten times so there are now 100, you have just increased the risk the insurer is insuring by a factor of ten (10). This will obviously increase the premium.

Once all the class codes and numbers of employees and payroll associated with each have been reported, something called a “manual premium” is generated. This number is basically a preliminary premium. To calculate manual premium, the payroll for each class code is multiplied by the established WC rate for each class code. That manual premium is then modified by the insured’s experience modification factor (mod). Depending on the state, this is a number computed by the state’s WC ratings bureau or the NCCI (National Council on Compensation Insurance).

A business in any given area of work (retail store, restaurant, gas station, oil drilling, mining, etc.) that is *average* in terms of employee injuries/costs will have a 1.0 mod. That’s a grade of “C.” If a business is better than average, its mod will be below 1.0, and, if it’s worse than average, its mod will be above 1.0. This means that two businesses that have identical numbers of employees in identical class codes and the same payroll associated with each of them may pay vastly different premiums for WC insurance. Any mod rating over 1.0 means that the insured is paying a “surcharge” for its insurance because of negative claim history because an insured’s final premium is calculated by multiplying the manual premium by the experience mod number.

The mod is derived using the claims experience for the insured business for a rolling 36-month period. So, a catastrophic injury with a huge payout in both medical expenses and lost time will continue to affect the insured business for three (3) years. However, since there are caps on the mod penalty created by any individual claim, one catastrophic WC claim will not be as detrimental to the insured’s mod number as frequent smaller claims. The reasoning here is that single, catastrophic claims are almost always outliers and unexpected, while frequent small claims could be controlled through risk management and loss control.

D. Importance of Return to Work

It is important to note here that employers have a significant motivation to adopt "return to work" programs and do everything possible to assure that an injured employee does not have to miss more than that seven (7) days of work that causes lost wages payments to kick in. This is because an insured's mod is calculated based on the financial impact of claims, and a "lost wages" claim is hugely more impactful than a "medical only" claim. Consider the very same claim for a broken arm. The medical bills are identical. The only difference is that one employee can return to work before the seven (7) days when lost wages would become part of the claim payments. The other misses enough work to trigger lost wages payments.

The penalty on the mod number for the "medical only" broken arm claim will be <u>70% less</u> than the penalty for the "lost wages" broken arm claim. Same exact injury, but vastly different penalties – penalties with which the insured will have to live for the next three (3) years! Sometimes, employers avoid these "lost wages" claims by allowing employees to come back to do light-duty work, or clerical kinds of tasks until they are released to resume their normal jobs. In some instances when an employee is not going to be able to return to work by that seven (7) day mark, an employer will make the decision to continue paying them <u>even while they are off work</u> to avoid the penalty that comes from having a "lost wages" claim.

E. What States Does the Insured Need?

On key question that any insured needs to answer when considering its WC insurance program is for what states it needs to purchase coverage? For some insureds with only localized operations in a single state, the answer to this question will be simple. However, what about businesses that are located or headquartered on or near the border between two or more states? What happens then?

Employees may have the opportunity to choose the highest available benefits from one of four jurisdictions:

1) benefits available from the employee's state of residence;
2) benefits extended from the state in which they primarily work;
3) benefits available in the state in which the injury occurred; or
4) benefits prescribed by the state in which the employer's workers' compensation coverage is provided.

The selection of what state's WC benefits laws will apply in this kind of situation is governed by the related principals of extraterritoriality and reciprocity. Extraterritoriality refers to the WC coverage provided where the employer's operation is located, and the employee's work is primarily based. Every state provides extraterritoriality, meaning that the WC policy in one state will FOLLOW the employee going into another state to work temporarily. However, the bad news is that the *application* of extraterritoriality is not consistent from state to state. Put another way, every state extends its WC protection to other states differently.

The concept of reciprocity is the flip-side of extraterritoriality. Does the receiving state where the employee goes to work temporarily recognize and accept the sending state's WC coverage? The answer is not consistent. It varies greatly from state to state. Based on the particular facts surrounding the extraterritorial exposure, out-of-state employees are covered by one of three methods:

1) extraterritorial coverage from the sending state;
2) as an additional "primary" state, also known as a "3.A" state by the sending state's WC policy;
3) as an "Other" state, also known as a "3.C" state or secondary state.

There are two tests applied with the intention of narrowing the available benefits: the “significant contact” test and the “contract for hire” test. The “significant contact” test attempts to narrow the number of states that could potentially provide the rules for WC coverage by looking at the state with which the injured employee has the most significant contact. That state would, then, be considered the “primary” state. The “contract for hire” test focuses on making the primary state the one in which the employee entered the contract of hire.

While those two tests are meant to try and narrow the choice of benefits available to an injured employee, state-to-state reciprocity may widen the injured employee’s jurisdictional options. There are three levels of reciprocity:

1) No reciprocity: These states are not concerned with the laws of any other state. This is common. Lots of states have no reciprocity;

2) Full reciprocity: States in this class maintain a list of states with which they have a reciprocity agreement and fully recognize the other jurisdiction’s laws – without limitation. This is the LEAST common type;

3) Limited reciprocity: These are states that DO reciprocate, but not in full, refusing reciprocation for several reasons, including class of business, number of employees, length of time in the state.

So, an employer’s WC policy will usually list all the states in which the employer does business as “3.A” states. That’s the “highest and best” classification of state. Sometimes, when the true extent of a given insured’s exposure is unknown, the agent also selects “3.C,” which means “Other states,” and is another way of saying the insured wants WC coverage in its 3.A states and any “other states” in which its workers might be found.

Typically, if a state should have been listed as a 3.A state in the WC policy and is not, there is a penalty. . . and it’s a big one. The penalty for failing to include a 3.A state on a WC policy is the likelihood of “no coverage” if the state should have been listed but wasn’t. The actual policy language goes something like this, “If you have work on the effective date of this policy in any state not listed in Item 3.A of the Information Page, coverage will not be afforded for that state unless we are notified within thirty days.”

COMMERCIAL INSURANCE:
THE VIEW FROM AN SR-71 BLACKBIRD

12/2/2022

WHO IS SHEPHERD INSURANCE?

WHO IS SHEPHERD INSURANCE?

Largest Full-Service Insurance Agency in Indiana

-Founded in 1977 by Dave Shepherd
-Personal Lines, Commercial Lines, Property & Casualty, Employee Benefits

Accolades

-2018: Insurance Journal's Top 100 Independent Insurance Agencies
-2019: Insurance Business America's Top Elite Agency
-Inc. Magazine's 5,000 Fastest Growing Companies three years in a row

Bottom Line

-450 employees in 36 offices in six states (AZ, IL, IN, OH, KY, FL)
-Representing over 275 carriers
-Protecting approx. 68,000 clients
-More than 100,000 insurance policies
-42nd largest independent agency in U.S. - combined P&C and EB premium of almost $771,000,000

TYPES OF COMMERCIAL INSURANCE

Like leaves on a tree, commercial insurance types are numerous. . .

-General Liability
-Property
-Mechanical Breakdown
-Worker's Compensation
-Errors & Omissions
-Manufacturer's E&O
-Professional Liability
-Inland Marine
-Cargo
-Ocean Cargo
-Trade Credit
-Accounts Receivable
-Business Auto
-Employment Practices Liability
-Cyber Liability
-Medical Malpractice
-Stock Throughput
-Umbrella/Excess
-Business Income
-Business Identity
-Bonds & Surety
-Key Person
-Businessowners

MY PRESENTATION

Commercial Insurance: The View From An SR-71 Blackbird

Talking about any one of the policies in this presentation could fill a whole day, and MORE.

Some may talk about the 10,000 foot view, or even the 30,000 view.

Today, however, you get the view from 85,000 feet, going Mach 3.2

COMMERCIAL GENERAL LIABILITY INSURANCE

Provides liability coverage to commercial insureds for non-professional negligent acts

-Professionals (doctors, lawyers, CPAs) need additional coverage.

-A GL policy will protect a doctor for a slip & fall, but not a botched surgery

Coverage for an insured's (1) premises (2) operations (3) products and (4) completed operations

Occurrence-based and Claims-based (occurrence-based is most common)

-Three types of coverage: (A) Bodily Injury/Property Damage, (B) Personal & Advertising injury, (C) Medical Payments

COMMERCIAL GENERAL LIABILITY INSURANCE

Coverage A – Bodily Injury & Property Damage

-Third-party coverage for people who are injured or property that is damaged or destroyed.

-Premises coverage: slip & falls in the office or plant
-Operations: contractor injures third-party at a job site while working on project
-Products: toaster malfunctions and burns a house down
-Completed Operations: glass falls out of a frame in an office that’s completed and occupied by a tenant

-Note that premises/operations and products/completed operations coverage are provided by every GL policy, UNLESS SPECIFICALLY EXCLUDED

COMMERCIAL GENERAL LIABILITY INSURANCE

Coverage B – Personal & Advertising Injury

-Third-party coverage for:

-libel
-slander
-false arrest
-infringing copyright
-malicious prosecution
-use of another's advertising idea
-wrongful eviction, entry
-invasion of privacy

-16 exclusions here

COMMERCIAL GENERAL LIABILITY INSURANCE

Coverage C – Medical Payments

-Third-party medical expense coverage for injured customers, visitors, invitees.

-Typically a set amount of $1,000 or $5,000, but can be increased via endorsement.

-We often call this “lawsuit prevention” coverage.

-As you all know well, sometimes nothing can keep someone from filing a lawsuit, but sometimes all it takes is being nice to the injured person and keeping the promise to pay for their ER visit and x-rays.

COMMERCIAL GENERAL LIABILITY INSURANCE

KEY POINTS

-Defense Costs almost always outside of the limits

-Per Project and Per Location Limits Endorsements are CRUCIAL

-Completed Operations coverage is important for contractors.

-Completed Operations for AIs takes a special form.

-Notice provisions are important

COMMERCIAL PROPERTY INSURANCE

Provides first-party coverage for an insured buildings and business personal property

Can provide coverage for Business Income and Extra Expense in the event of a shut-down

What are buildings?

-structures described in the Declarations, including
- -completed additions;
- -fixtures, including outdoor fixtures;
- -permanently installed equipment & machinery; and
- -personal property used to maintain or service the building (fire extinguishers, outdoor furniture, floor coverings, appliances used for refrigeration, ventilating, cooking, dishwashing or laundering)

What is BPP?

-furniture & fixtures; machinery & equipment; stock, personal property owned by insured & used in business; labor & materials; insured's interest in tenant's betterments & improvements

COMMERCIAL PROPERTY INSURANCE

All Property policies are subject to a Cause of Loss form. This says what causes of loss are covered.

There are “Named Peril” policies that ONLY cover the things listed (fire, lightning, explosion, etc.)

Then, there are “Cause of Loss – Special” forms. These cover “everything” unless it’s specifically excluded.

In a Named Peril policy, the burden is on the Insured to prove the loss is covered.

In an Open Perils policy (one with a Cause of Loss – Special form) the burden is on the carrier to prove the loss ISN’T covered, if it’s not specifically excluded.

COMMERCIAL PROPERTY INSURANCE

So, why is there a problem with equipment & machinery being listed as both Building and BPP?

-What happens of you have a limits loss to the building, but not the contents?

-That equipment was likely NOT included in the calculation of the limit for the Building, but probably WAS included in the calculation of the limit for the BPP.

-So, in a limits loss to the building, all policy proceeds could be paid out for the building and there might be nothing left for the machinery & equipment, if it's considered "Building" and not BPP.

COMMERCIAL PROPERTY INSURANCE

Surprising Exclusions:

-Foundations

-Underground Pipes, Flues or Drains

-Retaining Walls

-Fences

COMMERCIAL PROPERTY INSURANCE

Business Income Coverage:

-Addresses financial impact of an occurrence that forces the closure of a business for a period of time.

-Covers "normal" expenses after a temporary closure:

-employee wages
-leases
-loan payments, etc.

-Only paid during the "Period of Restoration," which is calculated by the Insured.

-Possible to get "Extended Business Income"

COMMERCIAL PROPERTY INSURANCE

Extra Expense Coverage:

-Covers "abnormal" expenses after a temporary closure

-Goals of Extra Expense coverage are to:

(1) maintain some level of operational continuity at insured location; or
(2) continue operations somewhere else

-Some items covered:

-additional costs to speed up real property repairs
-relocation costs to avoid or minimize suspension of operations
-increased operating costs at new location

COMMERCIAL PROPERTY INSURANCE

Key Points:

-Building Limits are chosen by the insured, and too often they're not doing a good job.

-Co-insurance Provisions can be killers when buildings are not sufficiently insured.

-Debris Removal is an often forgotten BIG factor.

-For some insureds, Equipment Breakdown coverage is a MUST.

-Well thought out, thorough BI Worksheet is CRUCIAL!

BUSINESS AUTO INSURANCE

Business Auto Policies (BAPs) combine elements of property coverage, liability coverage and inland marine coverage.

At the most BASIC level, a BAP provides:

-coverage for an Insured's covered autos (auto physical damage) while mobile

-coverage for liability arising from the operation of the autos (damage done to others)

BUSINESS AUTO INSURANCE

Eight Types of Coverage Provided by a BAP:

1) Liability
2) Personal Injury Protection (PIP)
3) Medical Payments
4) Uninsured Motorists Coverage
5) Underinsured Motorists Coverage
6) Hired/Borrowed Liability
7) Non-owned Liability
8) Physical Damage
   -comprehensive
   -collision

BUSINESS AUTO INSURANCE – LIABILITY COVERAGE

Arguably, the most important type of coverage provided by BAP is liability coverage.

This coverage provides legal defense and limits of insurance to settle or pay judgments arising from claims of third parties who have been injured by the Insured's use and operations of autos in its business.

On a BAP, liability coverage is ALL about symbols . . .

BUSINESS AUTO INSURANCE – LIABILITY COVERAGE

Symbol	Description Of Covered Auto Designation Symbols	
1	Any "Auto"	
2	Owned "Autos" Only	Only those "autos" you own (and for Covered Autos Liability Coverage any "trailers" you don't own while attached to power units you own). This includes those "autos" you acquire ownership of after the policy begins.
3	Owned Private Passenger "Autos" Only	Only the private passenger "autos" you own. This includes those private passenger "autos" you acquire ownership of after the policy begins.
4	Owned "Autos" Other Than Private Passenger "Autos" Only	Only those "autos" you own that are not of the private passenger type (and for Covered Autos Liability Coverage any "trailers" you don't own while attached to power units you own). This includes those "autos" not of the private passenger type you acquire ownership of after the policy begins.
5	Owned "Autos" Subject To No-fault	Only those "autos" you own that are required to have no-fault benefits in the state where they are licensed or principally garaged. This includes those "autos" you acquire ownership of after the policy begins provided they are required to have no-fault benefits in the state where they are licensed or principally garaged.
6	Owned "Autos" Subject To A Compulsory Uninsured Motorists Law	Only those "autos" you own that because of the law in the state where they are licensed or principally garaged are required to have and cannot reject Uninsured Motorists Coverage. This includes those "autos" you acquire ownership of after the policy begins provided they are subject to the same state uninsured motorists requirement.
7	Specifically Described "Autos"	Only those "autos" described in Item Three of the Declarations for which a premium charge is shown (and for Covered Autos Liability Coverage any "trailers" you don't own while attached to any power unit described in Item Three).
8	Hired "Autos" Only	Only those "autos" you lease, hire, rent or borrow. This does not include any "auto" you lease, hire, rent or borrow from any of your "employees", partners (if you are a partnership), members (if you are a limited liability company) or members of their households.
9	Non-owned "Autos" Only	Only those "autos" you do not own, lease, hire, rent or borrow that are used in connection with your business. This includes "autos" owned by your "employees", partners (if you are a partnership), members (if you are a limited liability company) or members of their households but only while used in your business or your personal affairs.

BUSINESS AUTO INSURANCE – LIABILITY COVERAGE

19	Mobile Equipment Subject To Compulsory Or Financial Responsibility Or Other Motor Vehicle Insurance Law Only	Only those "autos" that are land vehicles and that would qualify under the definition of "mobile equipment" under this policy if they were not subject to a compulsory or financial responsibility law or other motor vehicle insurance law where they are licensed or principally garaged.

BUSINESS AUTO INSURANCE – PIP & MEDICAL PAYMENTS

Personal Injury Protection (PIP):

-No-fault coverage, providing medical payments to the insured's drivers for injuries sustained, regardless of fault.
-Part of specific states' auto or financial responsibility laws.
-Each state that requires PIP sets its own limits.
-Indiana doesn't have PIP. It's an "at-fault" state.

Medical Payments:

-No-fault coverage, providing first-party medical benefits to the agents of the legal entity/named insured.
-Not required in all states, but states that DO require do so in lieu of PIP.
-Again, Indiana doesn't require Medical Payments

BUSINESS AUTO INSURANCE – UM/UIM COVERAGE

Uninsured / Underinsured Motorists Coverage:

-Provides coverage to an innocent victim of an uninsured motorist.

-Provides coverage to an innocent victim of an underinsured motorist.

-This coverage is ALL ABOUT protecting people, not a business.

-So, since commercial insureds ALREADY buy worker’s compensation to protect their employees, it is not unreasonable for a business to decline to purchase UM/UIM.

BUSINESS AUTO INSURANCE – HIRED/BORROWED LIABILITY

Hired / Borrowed Coverage:

-This means that the Named Insured / Legal Entity is making the owner of a leased, or rented, or borrowed vehicle an Insured under its policy.

-This type of insurance is providing coverage for ANOTHER ENTITY as an Additional Insured for the acts of our Named Insured in using a vehicle it hires/rents/borrows. . .

-but ONLY with respect to our Named Insured's use of the vehicles for our Named Insured's business operations.

BUSINESS AUTO INSURANCE – NON-OWNED LIABILITY

Non-Owned Liability:

-ALL BUSINESSES NEED THIS!!!

-This is for when your secretary runs out to pick up lunch for the participants in that morning meeting that ran long.

-If he/she gets into an accident, that's company business and the business is going to get sued. This is the coverage that will protect the business for its employee's use of his/her own vehicle in business pursuits.

MAKE SURE TO ENDORSE "EMPLOYEES AS INSUREDS"

BUSINESS AUTO INSURANCE – COMPREHENSIVE & COLLISON

Collision:

- **-Damage occurring when the vehicle is being driven**

Comprehensive:

- **-Damage caused by something *other* than operation of vehicle:**
  - **-tree limb falling on car**
  - **-fire damage / wind damage**

BUSINESS AUTO INSURANCE – KEY POINTS

Key Points:

-Coverage will ONLY be extended to those who are (1) Insureds, (2) Covered Autos, and (3) otherwise not excluded;

-Even if a business has no autos, it should ALWAYS have hired/non-owned coverage;

-When it comes to liability coverage, you should ALWAYS try to get symbol 1, which provides liability coverage for "all autos" without having to schedule them or keep track of them.

COMMERCIAL UMBRELLA / EXCESS COVERAGE

Most unfortunate thing about this coverage is that agents and carriers have historically used these words interchangeably.

These coverages are, indeed, similar, but they are NOT THE SAME!

They can typically "sit over" GL policies, BAPs and Employer's Liability policies

Think of an underlying policy as a raincoat.

The umbrella/excess policy is the insured's extra protection, over and above, their raincoat. It's kind of like an *umbrella*.

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Section
Two

Professional Liability Policies

Richard Mather
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Section Two

Professional Liability Policies………………………………….. Richard Mather

PowerPoint Presentation

Professional Liability policies

General characteristics

- Primarily Third Party Liability policies.
- Generally, third party liability coverage for acts, errors or omissions in the performance of "Professional Services."
- Think of this as coverage for things that are excluded in CGL policies.
- Can include some "first party" coverage, such as for Cyber. However, that is likely to be a sublimited coverage that is not as comprehensive as a stand-alone cyber policy. In some cases if may actually serve to limit the insurers exposure.

General Characteristics

Two main types:

I. Miscellaneous Professional Liability.

Broad range of "professions" that could be covered, from crop dusters to land surveyors to nursing home managers. Lower limits, higher volume. Not extensive underwriting.

II. Policies written for specific professions.

Legal mal. Med Mal. IAE&O. Contractors Professional. Likely higher limits, and coverage elements tailored to specific needs of the profession in question. More extensive underwriting process.

Likely to have some coverages that are specific to the type of professions. Disciplinary and licensing. Subpoena response. Mitigation.

General Characteristics

- Generally speaking, all of these policies are written on a Claims Made & Reported basis.
- Occurrence: looks to when the act, error or omission occurred. Generally, claim could be brought whenever. Even decades after the policy period. E.g. revived abuse claims.
- Claims made: looks to when the claim was "made." Allows underwriters to understand the exposure with some confidence on a policy period, since they will generally know what claims have been made and most likely will be made.
- Reported: claims must be reported during the policy period or any extended reporting period.
- Retroactive Date: No coverage for acts, errors or omissions occurring prior to this date.

Common provisions

Insureds: Who is covered under the Policy

- Owners, partners, employees.
- Former owners, partners, employees.
- Predecessor firms.
- Subsidiaries.
- Independent contractors.

Common Provisions

- **Claim**: Need not be a suit. When made triggers reporting obligations.
    - Written demand for monetary, non-monetary, or injunctive relief
    - Written request to toll as statute of limitations
    - Civil proceeding in a court of law or equity commenced by filing a complaint
    - Administrative, regulatory proceeding or investigation
    - Arbitration proceeding.
- **Disciplinary proceedings** often handled separately under sublimit.
- **Related Claim**. Works with the definition of a claim to define what policy period a claim is deemed to have been "made in." Can determine number of limits and retentions that apply. Can also operate to preclude coverage if an earlier communication constitutes a relate claim and was not timely reported.

Common Provisions

Professional Services:

- What activity is covered under the policy.
- In the case of miscellaneous professional polices, will be defined in the declarations or endorsements. May not be everything the Insured does as part of its business.
- "Services performed in the usual and customary conduct of the Profession set forth in item "x" in the Declarations
- "for a fee or other business consideration inuring to the benefit of the Named Insured or any Subsidiary."
- In the case of the policies geared toward specific professions, definition will be in the policy form itself, but may be modified by endorsement.

Common Provisions

Professional Services Wrongful Act:

- Negligent act, error, omission, misstatement, neglect or breach of duty or
- Personal injury
- by an Insured, in the performance of or failure to perform Professional Services

Common Provisions

Covered Loss.

What does the policy pay by way of indemnity, and what does it exclude?

- Monetary damages.
- Injunctive relief.
- Punitive or exemplary damages.
- Statutory multiple damages or penalties.
- Matters deemed uninsurable under applicable law. Choice of law provision?
- Disgorgement, return of fees, unjust enrichment
- Fine, taxes, penalties

Common Provisions

Reporting provisions.

- As noted above, these are usually "claims made and reported" policies.
- The Policy will usually provide that the claim is to be reported as soon as practical after it is "made" and in any event within the policy period or no later than the end of the applicable extended reporting period (if any).
- The Policy will specify where and how the claim is to be reported. It is common to have both a physical address and an email box.
- Notices of circumstances: notices of "Wrongful Acts" that may lead to claims.
- Typically, must be reported in the same policy period in which the insured becomes aware of it.
- If properly reported, if it later develops into a claim, the claim will be "deemed" made within the policy period in which it was reported.

Common Exclusions

- "For" exclusions. More limited.
- "In any way involving" exclusions. Broader.

- Fraudulent or intentional acts. Carveback for uninvolved insureds?
- Insured vs. insured.
- Disgorgement.
- Liability assumed under contract. (Unless duplicative of tort liabiity)
- Loss of assets in the care, custody and control of an Insured.
- Employment type losses, pollution, telephone solicitation, civil rights, securities law violation, anti-trust, fair housing).

Defense related provisions

- Usually Insurer "duty to defend" policies.
- Selection of defense counsel. Who gets to choose?
- Defense inside or outside the policy limits?
- Reimbursement for insureds defense costs?
- Pre-tender defense expenses.
- Duty to defend vs. duty to indemnify.
- Separate defense counsel where there is a conflict between insureds? But see retention discussion.

Indemnity: What is covered (and what is not?)

- Monetary damages.
- Injunctive relief.
- Punitive or exemplary damages.
- Statutory multiple damages or penalties.
- Matters deemed uninsurable under applicable law.

Retentions

- A retention is not the same as a deductible.
- What does the retention apply to?
- Who is responsible for paying the retention?
- What happens if it is not paid?

Common exclusions

- Fraudulent or intentional acts.
- Insured vs. insured.
- Disgorgement.
- Liability assumed under contract.
- Loss of assets in the care, custody and control of an Insured.

“Other Insurance” clause

- Two or more insurers provide concurrent coverage at the same level
- Pro-rata, Excess, No coverage at all.

Section Three

INSURANCE FOR NON-INSURANCE LAWYERS

Richard S. Pitts, Chair

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ICLEF – Indianapolis, Indiana

The "Top Ten" Things to Think About

If Your Client has a Coverage Problem

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Section Three

The “Top Ten” Things to Think About If Your Client has a Coverage Problem……………………..Michael L. Schultz

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I. Introduction

What is the purpose of insurance?

The answer to that question various depending on who you ask. My answer is always the same: the purpose of insurance is the transfer of risk. On the one hand, you have a person, a homeowner, or a business that can reasonably foresee something unwanted may happen and they want protection from that risk. You might say a homeowner who purchases a typical insurance policy is hedging against the risk of fires or thefts or some other loss. On the other hand is someone willing to accept that risk (something bad happening in the future) in exchange for payment now. When the policy is issued, the risk is supposed to be transferred from, in this example, the homeowner to the insurer. This transfer in routine examples works amazingly well in most circumstances – the risk is successfully transferred. When the homeowner suffers a loss, the insurance company accepts, adjusts, and pays the claim.

But this is where Murphy's Law comes into play. In its simplest form, Murphy's Law states that if anything can go wrong, it will. The transfer of risk is no exception, and in many cases there are forces that frustrate the central purpose of insurance, *i.e.,* the transfer of risk. Ask anyone who has had a claim denied, or a policy that had lapsed, or an endorsement limiting coverage they were unaware of, or any agent who has had to report a claim under their own errors and omissions policy.

I've been asked to present on the "top ten" things to think about if your client has a coverage problem. Since I think about coverage problems every day, I thought that listing ten "things" should be easy. It is, but the nature of top ten lists (thanks to David Letterman I suppose) is to place things in a logical order. That, it turns out, is exceedingly difficult. The order

in which to place the “things” to think about is different depending on the specific facts of the coverage problem. And no two coverage problems are ever quite the same.

So this introduction is really a disclaimer. These top ten “things” are not in any particular meaningful order. They all matter, but how much they matter will vary greatly from one client’s problem to another’s. The first two listed are of relatively paramount importance in any case so perhaps they always top the list, but the rest – who knows? It depends. So, with that disclaimer, here is my actual “top ten” list, followed by a more in depth discussion of some of the coverage-related issues on the list.

1. Is there a policy?

2. Is the policy *in force*?

3. What is the nature of the loss or claim, and is it a first party or third party claim?

4. What was the nature of the *risk* that was insured (or should have been insured)?

5. If there are coverage limits, are they adequate?

6. What duties must the insured perform and what duties does the insurer have?

7. Who are all of the potentially interested parties or other insureds, and did the insured have an “insurable interest”?

8. Who is the insurer, and is there more than one insurer that may provide coverage?

9. If there is a dispute, where or how should it be resolved?

10. Who will pay for resolving the coverage dispute?

With that general list in mind, what follows are some materials that may help guide how to think about these issues.

II. In the Beginning: Issues Regarding Failure of Agent to Procure Coverage

On the subject of "is there a policy", the discussion often starts with how the insured went about obtaining coverage in the first place. Many people, perhaps most, think of obtaining insurance in terms of getting a policy. Agents get policies for insureds. Often, that process is not particularly difficult. But in a great many cases that cross my desk, something that should have happened in the process of obtaining coverage didn't go quite the way it should have. The seeds of a big disagreement or serious misunderstanding were often planted early, when the policy "incepted". This impacts whether there is a policy at all in some cases, or it may impact some of the other topics on the "top ten" list in different ways. For example, there may be a policy, and it may be in force at the time of the loss, but it does not actually provide coverage for the *risk* that the insured intended. A great many homeowners have told me that they thought their policy covered them if flood waters filled their basement. The vast majority of them were mistaken. The question may become who is to blame for this – the homeowner for not understanding their policy? The agent for not explaining the limitations of coverage? The answer varies based on the particular facts of the case.

Insurance agents and brokers sometimes find themselves named as defendants in cases where the policyholder, following a loss, claims the agent failed to procure the correct policy form(s) for their needs, or failed to obtain a policy providing sufficient limits for the type of risk involved. In bringing such claims, policyholders may rely on a theory of simple negligence. Depending on the facts of the case, they may also be able to assert the existence of a "special relationship" giving rise to a heighted duty of care owed by the agent or broker to the

policyholder. And, in appropriate circumstances, the policyholder may be able to recover damages based on a theory of breach of contract.

"All insurance agents who undertake to procure coverage owe their clients a general duty of reasonable care and skill in obtaining insurance and following their clients' instructions." *Ind. Restorative* at 264 (Ind. 2015) (citing *Filip* at 1085). "An insured may allege a breach of the duty to procure as either a claim for negligence or breach of contract." *Id.* (citing *Stockberger v. Meridian Mut. Ins. Co.*, 395 N.E.2d 1272, 1279 (Ind. 1979). "Indiana courts have consistently held that agents 'may be liable for breach of contract or for negligent default in the performance of a duty imposed by contract' when they fail to procure insurance requested by the insured." *Id*. "To use tort terminology, 'one who agrees to procure insurance on behalf of another becomes the agent of the proposed insured and incurs a duty to use reasonable care to procure the desired insurance.'" *Id*. (citing *Anderson Mattress Co., Inc. v. First State Ins. Co.*, 617 N.E.2d 932, 939 (Ind. Ct. App. 1993). "Under a contract theory, the agent and the insured may come to a 'meeting of the minds' on a particular policy and mutually assent to the agent procuring that policy on behalf of the insured—the contract 'is not binding if negotiations are incomplete in any material particular [element], or assent of either party is lacking.'" *Id*. (citing *Stockberger* at 1279). "In Indiana, an oral or written contract of insurance requires a meeting of the minds of the parties upon the following essential elements of a contract: (1) the subject of the insurance; (2) the risk or peril insured against; (3) the amount of coverage; (4) the limit and duration of the risk; and (5) the amount of the premium to be paid." *Stockberger* at 1279.

The duty to advise, arising from a "special relationship" with the insured or prospective insured, requires proof of different facts. "An agent's duty to procure is distinct from the duty to advise their clients about the adequacy of coverage or any alternative coverage." *Ind.*

Restorative Dentistry, P.C. v. Laven Ins. Agency, Inc., 27 N.E.3d 260, 264 (Ind. 2015). "There is no duty to advise the principal concerning the procurement of insurance absent a showing of an intimate long term relationship between the parties or some other special circumstance." *Wyrick v. Hartfield*, 654 N.E.2d 913, 914 (Ind. Ct. App. 1995). "It is the nature of the relationship, not merely its length, that invokes the duty to advise." *Ind. Restorative* at 265 (citing *American Family Mut. Ins. Co. v. Dye*, 634 N.E.2d 844, 848 (Ind. Ct. App. 1994). "Some of the relevant factors which manifest a special relationship include: (1) exercising broad discretion to service the insured's needs; (2) counseling the insured concerning specialized insurance coverage; (3) holding oneself out as a highly-skilled insurance expert, coupled with the insured's reliance upon the expertise; and (4) receiving compensation, above the customary premium paid, for the expert advice provided." *Dye* at 848. "These factors are not exhaustive, nor is any particular factor dispositive." *Ind. Restorative* at 265. "All of these factors illuminate a single issue: the nature of the agent-insured relationship." *Id.*

Many prospective insureds, perhaps most, rely to a large extent on their agent or broker to help them obtain the correct types and amounts of coverage for the risk of loss to their homes or businesses. They may request "full coverage" for their auto or home or business. The knowledge or experience of a prospective insured varies greatly, and in litigation regarding policy selection or inception these facts matter. The likelihood of the agent or broker being found liable for improper or insufficient insurance depends, in many cases, on details that may not have seemed critical at the time the risk was being evaluated or the policy issued. How was the decision made about coverage limits for the home? Did the insured request "full coverage" and the agent set the limits based on replacement cost estimator software? Did the insured ask questions and the broker give answers? Did the insured raise an issue about coverage for a very

specific risk and, if so, did the agent provide assurances that coverage would be available for that risk? How, if at all, was the insurer involved in evaluating the risk, and what communications were recorded about the process? There are as many factual scenarios as there are policies or policyholders, and all of these details may become critically important in the event of a loss.

III. Underwriting Issues

If the risk was not fully understood when the policyholder first sought insurance, problems can easily result that frustrate the transfer of risk. Because of this, going "back to the beginning" to understand how the risk was underwritten is very often critical to solving a coverage problem. This is especially true in cases where an insurer is denying a claim or declaring a policy void *ab initio* (like the policy never existed) because the investigation of a claim reveals that something on the insurance application was misrepresented and, but for this misrepresentation, the policy would not have been issued.

Indiana law provides that a carrier may be deemed to have had actual knowledge of facts about which it should have known or could have known had it conducted a reasonable investigation upon an application for insurance. *See, e.g.*, *Colonial Penn Ins. Co. v. Guzorek*, 690 N.E.2d 664 (Ind. 1997). If red flags are present at the time of an application, there is likely to be a question of fact regarding whether the carrier was in notice to inquire further. *Id.*

Indiana law has long held such and the Indiana Supreme Court outlined these principles as follows:

> Although there is little Indiana precedent on the point, the general rule appears to be that the insurer may rely on representations of fact in the application without investigating their truthfulness, unless there is some reason to believe the representations are false. *Price,* 181 Ind.App. at 260-

> 61, 396 N.E.2d at 137; Lee R. Russ & Thomas F. Segalla, 6 Couch on Insurance 3d § 82:17 (1996) (collecting cases). Therefore, Colonial Penn had no duty to look beneath the surface of Dorothy's representations to determine whether she had shaded the truth or left out any material information in her application in 1990.
>
> However, an insurer cannot avoid coverage where it had knowledge of the facts notwithstanding the material misrepresentations, <u>or where a reasonable person would have investigated further and the investigation would have uncovered the truth</u>. *Johnson v. Payne,* 549 N.E.2d 48, 51-52 (Ind.Ct.App.1990) (citing *Price* and other cases dealing with inquiry notice). Thus, when the insurer had sufficient information to place it on inquiry notice of possible falsity, whatever facts a reasonably diligent investigation would have discovered are imputed to the insurer. *Id.* For example, the insurer's independent knowledge of the spouse's driving record has been held to waive the right to avoid coverage. *American Family Mut. Ins. Co. v. Kivela,* 408 N.E.2d 805 (Ind.Ct.App.1980).

Colonial Penn Ins. Co. v. Guzorek, 690 N.E.2d 664, 674 (Ind. 1997) (emphasis added).

Decades ago, the Seventh Circuit succinctly described how Indiana law imposes a duty on insurance companies to be chargeable with knowledge of facts they should have known:

> As explained in Columbian National Life Insurance Co. of Boston, mass. v. Rodgers, 116 F.2d 705 (10th Cir. 1940), certiorari denied, 313 U.S. 561, 61 S.Ct. 838, 85 L.Ed. 1521, ***an insurance company is chargeable with knowledge of facts which it ought to have known***. As the court there explained (at p. 707):
>
>> 'Knowledge which is sufficient to lead a prudent person to inquire about the matter, when it could have been ascertained conveniently, constitutes notice of whatever the inquiry would have disclosed, and will be regarded as knowledge of the facts.'
>
> Here we hold that this Insurer and its agent had sufficient information in their possession to awaken further inquiry. Indiana recognizes such a duty. As stated in *Travelers Insurance Co. v. Eviston*, 110 Ind.App. 143, 37 N.E.2d 310, 316 (1941):
>
>> 'The rule that whatever puts a person on inquiry amounts, in law, to notice of such facts as an inquiry pursued with ordinary diligence and understanding would have disclosed, is applicable to

> charge an insurer with notice. This is in line with the general rule * * * that the principal is charged with the knowledge of that which his agent, by ordinary care, could have known, where the agent has received sufficient information to awaken inquiry.' If 'proper inquiry' had been made [footnote reference omitted], plaintiff would have learned of the falsity of Gaul's representations as to his driver's license and moving traffic violations. Since the plaintiff is charged with notice of what that inquiry would have disclosed, it is estopped from asserting Gaul's false statements as ground for cancelling the policy. Apperson v. United States Fidelity and Guaranty Co., 318 F.2d 438, 441 (5th Cir. 1963). In the Apperson case, the insured's reaffirmance of his misrepresentations made it unnecessary to decide whether the facts previously disclosed to the insurer would have put a prudent person on further inquiry [footnote reference omitted], but here the facts already in Insurer's and its agent's possession required it to make a further investigation. Cf. Provident Life & Accident Insurance Co. v. Hawley, 123 F.2d 479, 483 (4th Cir. 1941); Gallagher v. New England Mutual Life Insurance Co. of Boston, 19 N.J. 14, 114 A.2d 857, 862 (1955); Bailey v. American Marine & General Insurance Co., 249 La. 98, 185 So.2d 214, 217 (1966); Johnson v. Life Insurance Co. of Georgia, 52 So.2d 813, 815-816 (Fla. 1951); 29 Am.Jur. Insurance § 706, p. 967. The issuance of the policy without making such inquiry waived the misrepresentations in the second and third answers in the box of the application. 7 Couch on Insurance 2d, §§ 35:252, 35:-254; 16 Appleman, Insurance Law and Practice, § 9086, pp. 618-619.
>
> Since we conclude that the Insurer did not have the right to rely upon Gaul's false representations when this policy issued, the judgment of rescission must be reversed.

Union Ins. Exch., Inc. v. Gaul, 393 F.2d 151, 155 (7th Cir. 1968).

Our Indiana Supreme Court has shown in *Aetna Ins. C. of the Midwest v. Rodriguez* how an insurer is under a duty to inquire further, and how the insurer will be deemed to know certain facts it should have inquired about:

> We have a prospective insured, Rodriguez, without a high school education (although he has made more money than most Judges will ever

see) buying a product in a highly technical field. He knows he wants fire insurance to protect his property and knows that he must have insurance to protect the former owner of the property to whom he still owes money. He contacts an insurance broker-agent who under the specific facts of this case, is the agent of the company and not that of the prospective insured.

The only facts in the record show that the prospective insured, Rodriguez, tells the broker-agent that he is buying this property from Shaver Chevy and making payments; that he wants insurance and wants Shaver Chevy protected on it.

The prospective insured does not know the difference between contracts and mortgages, much less the legal differences between the defenses of an insurance company as to contract sellers, loss payees, and mortgagees. I proffer the thought that, although others may know the distinction between the actual terms, only insurance attorneys and underwriters know the distinction as to company defenses which may be invoked against each of the above three classes of insureds, and I further suggest that many agents do not understand same or know there is a difference between the defenses.

No one asked the proposed insured: 'Are you buying this real estate on a long term conditional sale contract or did you get a deed then in return sign a promissory note and a real estate mortgage?' Neither did anyone check the Recorder's Office to determine any correct facts. No one even checked the correct names of the parties, but simply used the street vernacular.

The broker-agent and company were faced with a situation in which the words used by the prospective insured, Rodriguez, were susceptible of two or more meanings or interpretations. They did nothing to determine the correct interpretation or facts, but simply adopted the interpretation and wrote the insurance policy in the manner most legally advantageous to the company. <u>When a company is faced with facts susceptible of many interpretations, said company is then under a duty to determine the correct interpretations and not simply adopt the one most advantageous to themselve[s] to the detriment of all others</u>.

This is not a situation in which the proposed insured committed an intentional fraud by withholding information. He specifically made it known that someone else had an interest in this property and that he wanted them protected. He did not withhold any requested information,

> nor deliberately mislead the company. Neither is this a situation where the company is entitled to rely upon the application for insurance. There is no evidence there was ever any application.
>
> Neither is this a case where Shaver was not a mortgagee, but was listed as one and after a loss, it tried to claim the proceeds as a mortgagee. Shaver was an actual mortgagee and had recorded their mortgage which is notice to any dealing with this property. Under the particular facts of this case, Aetna is estopped to deny coverage to Shaver as a mortgagee.
>
> Shaver should collect the amount of the principal secured by their mortgage together with pre-judgment interest at the same rate as the promissory note of Rodriguez to Shaver.
>
> Shaver has asked for punitive damages. Shaver, prior to the loss, had a receipt showing that Rodriguez had purchased insurance. Shaver did not contact Aetna and object to their listing as a 'contract seller'. Thus, there is a legitimate controversy for trial and in as much as Shaver could also have prevented the conflict, it is now estopped to claim punitive damages.
>
> * * *
>
> It is our view that Judge McLaughlin is correct in his observations. We quote his judgment here because we feel we cannot improve upon his language.
>
> * * *
>
> The fact that Aetna's agent did not ascertain the true situation is Aetna's responsibility.

Aetna Ins. Co. of the Midwest v. Rodriguez, 517 N.E.2d 386, 386-88 (Ind. 1988) (emphasis added).

The primary point is simple: policyholders will seek to establish that the carrier is, or may be, estopped from voiding a policy based on a material representation where the information was known or knowable or obvious to the insurer. For example, in *Callis v. State Auto Ins. Co.*, the court held:

> Turning to the question of Callis's coverage, we think the principles enunciated in *Property Owners Ins. Co. v. Hack* (1990), Ind.App., 559 N.E.2d 396, *trans. denied* are controlling. In *Property Owners,* the plaintiff was the contract seller of a piece of real estate, which the contract buyer destroyed through arson. The insurance policy at issue had been written at the seller's instigation: the seller informed a broker/agent of the contract of sale, and of the existence of the three separate interests, i.e., seller, seller's mortgagee, and buyer. The seller also told the broker/agent that he wanted his (the seller's) interest on the policy to be protected. When the policy was issued, the seller was listed as contract holder, but no contract of sale clause was attached to the policy.
>
> After the arson, the insurer paid off the seller's mortgage and denied any further recovery to the seller when the seller demanded payment of the lesser of the balance of his contract price or the policy limit. Relying on *Aetna Ins. Co. of the Midwest, supra,* and the "reasonable expectation" test laid down by Judge Cardozo in *Bird v. St. Paul Fire & Marine Ins.* (1920), 224 N.Y. 47, 120 N.E. 86, we held the seller's unrefuted affidavit attesting to the facts disclosed to the broker/agent was a sufficient showing of the absence of a genuine issue of material fact to warrant judgment for the seller [Plaintiff].
>
> In the present case, Mr. Callis's affidavit in response to State Auto's summary judgment motion reveals that he, like the seller in *Property Owners,* informed Wren of the details of the sale arrangement. ***132** *Record* at 200-01. Moreover, the policy states the truck was garaged in Callis's home town. *Record* at 185. Finally, the evidence most favorable to Callis reveals he paid for all the premiums through his freight fee retention arrangement with Architectural Brick.

Callis v. State Auto. Ins. Co., 579 N.E.2d 129, 131-32 (Ind. Ct. App. 1991).

In litigation concerning bad faith for claim denials, a focal point in decision making pertains to the reasonableness of the insurer in denying a claim. *Shade Foods, Inc. v. Innovative Products Sales & Marketing, Inc.*, 78 Cal. App. 4th 847, 93 Cal. Rptr. 2d 364 (Cal. App. 1st Dist. 2000). In examining how and why a claim was denied, it should not be overlooked whether or not an underwriter or agent knew of a condition had by the insured which would have precluded coverage at the outset. This circumstance might be a game changer in terms of bad

faith liability, and would certainly contribute to the discussion of reasonableness in rendering a decision on a claim.

IV. What If There Was A Mutual Mistake When The Policy Was Obtained?

Sometimes the policy is written on the wrong form, or doesn’t quite fit the risk that was supposed to be insured. When this happens, it almost invariable causes a “coverage problem” your client may be facing. Part of the importance of going back to the beginning is to see if, perhaps, there was a mutual mistake. If so, there may be remedy.

Mutual mistake exists “where both parties share a common assumption about a vital fact upon which they based their bargain, and that assumption is false, the transaction may be avoided if because of the mistake a quite different exchange of values occurs from the exchange of values contemplated by the parties." *Perfect v. McAndrew*, 798 N.E.2d 470 (Ind. Ct. App. 2003); *see also Jackson v. Blanchard*, 601 N.E.2d 411, 416 (Ind. Ct. App. 1992).

> Courts may reform written documents in only two well-defined situations: (1) where there is a mutual mistake – meaning there has been a meeting of the minds, an agreement actually entered into, but the document in its written form does not express what the parties actually intended; or (2) where there has been a mistake by one party, accompanied by fraud or inequitable conduct by the remaining party.

Monroe Guar. Ins. Co. v. Langreck, 816 N.E.2d 485, 490 (Ind. Ct. App. 2004) (citing *Plumlee v. Monroe Guar. Ins. Co.*, 655 N.E.2d 350, 356 (Ind. Ct. App. 1995)). “Resolution of this issue is fact-based; i.e., whether there is any designated evidence to support [a] claim of mutual mistake.” *Id.* A determination that there was a mutual mistake at inception may help solve the coverage problem by replacing the incorrect policy with one that was, in fact, actually intended by the parties.

V. Issues About the Claim Itself or Claims Handling

Often the existence of the policy, its limits, the fact that it was in force at the time of the loss, and the fact that it actually provides coverage for the loss are not the issue. Often you may find the client in your office is complaining principally about not being treated "fairly" – that the insurer seems to be discounting the value of their claim too much, or some similar complaint. Or, perhaps your client is a business and the problem is a claim being made against them – perhaps they are accused of negligent work on a construction project, or of a wrongful termination of an employee. In this context, item number 6 on the top ten list should be top of mind – what duties must the insured perform and what duties does the insurer have? The insured's duties are typically easy to find. For example, in a typical homeowner's policy, they may look like this:

SECTION I – CONDITIONS

1. **Insurable Interest and Limit of Liability.** Even if more than one person has an insurable interest in the property covered, ***we*** will not be liable:
   a. to the ***insured*** for an amount greater than the ***insured's*** interest; or
   b. for more than the applicable limit of liability.
2. **Your Duties After Loss.** After a loss to which this insurance may apply, ***you*** must cooperate with ***us*** in the investigation of the claim and also see that the following duties are performed:
   a. give immediate notice to ***us*** or ***our*** agent and also notify:
      (1) the police if the loss is caused by theft, vandalism, or any other criminal act; and
      (2) the credit card company or bank if the loss involves a credit card or bank fund transfer card;
   b. protect the property from further damage or loss and also:
      (1) make reasonable and necessary temporary repairs required to protect the property; and
      (2) keep an accurate record of repair expenses;
   c. prepare an inventory of damaged or stolen personal property:
      (1) showing in detail the quantity, description, age, replacement cost, and amount of loss; and
      (2) attaching all bills, receipts, and related documents that substantiate the figures in the inventory;
   d. as often as ***we*** reasonably require:
      (1) exhibit the damaged property;
      (2) provide ***us*** with any requested records and documents and allow ***us*** to make copies;
      (3) while not in the presence of any other ***insured***:
         (a) give statements; and
         (b) submit to examinations under oath; and
      (4) produce employees, members of the ***insured's*** household, or others for examination under oath to the extent it is within the ***insured's*** power to do so; and
   e. submit to ***us***, within 60 days after the loss, ***your*** signed, sworn proof of loss that sets forth, to the best of ***your*** knowledge and belief:
      (1) the time and cause of loss;

Insured should comply with these duties. For an example of what may happen if they refuse, *See Morris v. Economy Fire and Cas. Co.*, 848 N.E.2d 663 (Ind. 2006) (summary judgment entered

in favor of insurance company because insureds refused to submit to examination under oath unless and until insurer provided transcript of prior recorded statements, thereby breaching their policy contract." There are many other examples that can be given of bad things happening to insureds who do not comply or substantially comply with their duties as set forth in the policy.

The insurer has duties too, the most important of which is the duty of good faith and fair dealing. An insurer has a duty to deal with its insureds in good faith, and a cause of action exists for the breach of that duty. *Erie Ins. Co. v. Hickman*, 622 N.E.2d 515, 519 (Ind. 1993); *County Line Towing, Inc. v. Cincinnati Ins. Co.*, 714 N.E.2d 285, 291 (Ind. Ct. App. 1999), *trans. denied*. This duty to deal in good faith with insureds ". . . includes an obligation to refrain from causing an unfounded delay in making payment; making an unfounded refusal to pay policy proceeds; exercising an unfair advantage to pressure an insured into settlement of his claim; and deceiving the insured." *Id.* ". . . [A]n insurer which denies liability knowing that there is no rational, principled basis for doing so has breached its duty." *Becker v. American Family Ins. Group*, 697 N.E.2d 106, 108 (Ind. Ct. App. 1998). In order to find that an insurer has committed bad faith in any particular case, a jury ultimately must find from the evidence that the insurer (or its adjusters) had "a state of mind reflecting dishonest purpose, moral obliquity, furtive design, or ill will." *Colley v. Indiana Farmers Mut. Ins. Group*, 691 N.E.2d 1259, 1261 (Ind. Ct. App. 1998).

Referring back to the underwriting issues discussed above, you can see how this duty of good faith may come into play in a case where significant underwriting issues have caused a coverage problem. Insurers can't just ignore what they know and, in appropriate cases, the same is true for what they *should have known*. To illustrate this, consider the situation where the carrier is denying coverage or voiding a policy based on a misrepresentation in an application.

"[A]n insurance contract is not rendered absolutely void by reason of false answers to questions contained in the application which materially affect the risk undertaken by the insurer, but in such a case, the contract is voidable at the election of the insurer." *American Family Mut. Ins. Co. v. Kivela*, 408 N.E.2d 805, 810 (Ind. Ct. App. 1980) (citing *Ind. Ins. Co. v. Knoll*, 236 N.E.2d 63, 71 (Ind. Ct. App. 1968). "A representation is material if the fact or facts represented reasonably enter into and influence the insurer's decision whether to issue the policy or to charge a higher premium." *Id.* "Whether a misrepresentation is material is normally a question of fact for the finder, unless the evidence is such that there can be no reasonable difference of opinion." *Id.* When an insurer claims concealment of a material fact for which an insured would have a duty to disclose, "the contract is voidable at the insurer's option." *Knoll*, 236 N.E.2d at 70. Furthermore, Indiana has long required an insurer to "take proper steps to exercise its election to avoid and rescind [an insurance contract], and that tendering back the premiums received is one of the necessary steps in making the election to rescind." *Commercial Life Ins. Co. v. Schroyer*, 95 N.E. 1004, 1005 (Ind. 1911).

"However, an insurer cannot avoid coverage where it had knowledge of the facts notwithstanding the material misrepresentations, or where a reasonable person would have investigated further and the investigation would have uncovered the truth." *Colonial Penn Ins. Co. v. Guzorek*, 690 N.E.2d 664, 674 (Ind. 1997); *see also Schmidt v. Ind. Ins. Co.*, 24 N.E.3d 516 (Ind. Ct. App. 2015) *trans. granted*, *aff'd in part, rev'd in part*, 45 N.E.3d 781 (Ind. 2015). "Thus, when the insurer had sufficient information to place it on inquiry notice of possible falsity, whatever facts a reasonably diligent investigation would have discovered are imputed to the insurer." *Id.* Crucially, "[w]hen a company is faced with facts susceptible of many interpretations, said company is then under a duty to determine the correct interpretations and not

simply adopt the one most advantageous to themselve[s] to the detriment of all others." *Aetna Ins. Co. of the Midwest v. Rodriguez*, 517 N.E.2d 386, 387 (Ind. 1988). If an insurer has a duty to act in good faith, that duty must necessarily include a duty to be cognizant of the law and how it applies to their claim handling decisions.

Not every coverage dispute or denial of coverage supports a claim for breach of the duty of good faith and fair dealing. There are many cases where courts have considered and rejected arguments by policyholders about some perceived unfairness, or where courts have found that it was the policyholder that breached the contract. *See generally, Nat'l Ath. Sportswear, Inc. v. Westfield Ins. Co*., 528 F.3d 508 (7th Cir. 2008) (insured breached insurance contract by refusing to sit for a second EUO); *Freidline v. Shelby Ins. Co.*, 774 N.E.2d 37 (Ind. 2002) (insurer did not act in bad faith by denying a claim based on interpreting the policy language); *Becker v. American Family Ins. Group*, 697 N.E.2d 106 (Ind. Ct. App. 1998) (insurer did not act in bad faith by determining insured was more than 50% at fault and denying a UIM claim); *Morris v. Econ. Fire & Cas. Co*., 848 N.E.2d 663 (Ind. 2006) (insured breached insurance contract by refusing to sit for an EUO until the insurer sent a copy of recorded statements to the insured's attorney); *Allstate Ins. Co. v. Fields*, 885 N.E.2d 728 (Ind. Ct. App. 2008) (insured failed to submit a Proof of Loss form for his uninsured motorist claim and instead sued insurer, alleging bad faith in failing to pay the policy limit). The lesson is clear: the facts matter, and no two claim situations are alike.

VI. Claims Against the Insured and the Duty to Defend

In some cases, the claim at issue is one for defense. Someone is suing, or threatening to sue, your client, and your client looks to an insurer to provide counsel and defend the suit. In

Indiana, the duty to defend is broader than coverage liability. *Trisler v. Indiana Ins. Co.*, 575 N.E.2d 1021, 1023 (Ind. Ct. App. 1991) (citing *Cincinnati Ins. Co. v. Mallon*, 409 N.E.2d 1100, 1105 (Ind. Ct. App. 1980)). The nature of the claim, not the claim's merit, establishes the insurer's duty to defend. *Id.* If it is determined that an insurer has a contractual duty to defend a suit based upon the risks it has insured, the insurer will not be relieved of that obligation regardless of the merits of the claim. *Id.* An insurer's duty to defend is broader than its duty to indemnify. *Liberty Mut. Ins. Co. v. OSI Indus., Inc.*, 831 N.E.2d 192, 198 (Ind. Ct. App. 2005). An insurer's duty to defend is determined from the allegations contained within the complaint and from those facts known or ascertainable by the insurer after reasonable investigation. *Id.* An insurer who concludes that a claim is "patently outside the risks covered by the policy" and elects not to defend an insured in the underlying tort action under a reservation of rights does so at his peril. *Knight v. Ind. Ins. Co..*, 871 N.E.2d 357, 362 (Ind. Ct. App. 2007) (quoting *State Farm Fire & Cas. Co. v. T.B. ex rel. Bruce*, 762 N.E.2d 1227, 1230 (Ind. 2002)). This is because the insurer will be "bound at least to the matters necessarily determined in the lawsuit." *Id.*

In the event of a claim, it is important to give prompt notice to the insurer. Insurance policies contain notice requirements so the insurance company is not prejudiced by a delay in filing the claim and has an opportunity to complete a timely and adequate claim investigation. *Ind. Ins. Co. v. Williams*, 463 N.E.2d 257, 265 (Ind. 1984). After that notice is provided, the carrier must deal promptly and fairly with the insured. An insurance contract contains a promise implied in law that the insurer will deal fairly with its insureds in the settlement of any claim. *Liberty Mutual Insurance Co. v. Parkinson*, 487 N.E.2d 162 (Ind. Ct. App. 1985) (holding that the insured could recover damages beyond the policy limits due to the insurer's breach of

contract and delay in settling her claim). Further, a business owner purchases a commercial insurance policy with the expectation of prompt payment in the event of a loss so he can "rebuild and continue his business". *Indiana Ins. Co. v. Plummer Power Mower & Tool Rental, Inc*. 590 N.E.2d 1085, 1092 (Ind. Ct. App. 1992). Indeed, "[d]elayed payment, whether as a result of good or bad faith, will undoubtedly result in the failure of the owner's business. He cannot generate sufficient income to pay his bills because he has no business. The damages incurred from such inability to pay bills flow directly, and are proximately caused by, the insurer's failure to pay". *Id*.

Issues arise when the carrier says "no" and refuses to defend. When this happens, should your client sue its own insurance company to determine coverage for the claim or suit? Should your client proceed to defend the suit and seek recovery from the insurer later? The answer, as usual, is, "it depends."

But one thing is clear: if an insurer refuses to defend and does not seek a judicial determination of coverage, that insurer is operating at great peril to itself, because the insurer will not be permitted to second-guess the decisions made by the insured in defending or settling the claim. This is because "an indemnitor who denies liability on an indemnity contract thereby confers on the indemnitee the right to exercise reasonable judgment in settling the case without further consultation with the indemnitor." *Sink & Edwards, Inc. v. Huber, Hunt & Nichols, Inc.*, 458 N.E.2d 291, 297 (Ind. Ct. App. 1984), *trans. denied*. And because "an indemnitee, who incurs legal expenses through defending an action against him for which he is entitled to indemnification, is entitled to recover the expense of creating his defense, including reasonable attorney's fees. This is especially true where the indemnitor has been notified of the suit and refuses the opportunity to defend it. The indemnitee may recover attorney fees from the

indemnitor incurred through an original action which is settled, *and also for the cost of prosecuting the indemnity clause*." *Bethlehem Steel Corp. v. Sercon Corp*., 654 N.E.2d 163, 1168 (Ind. Ct. App. 1995) (emphasis added).

Given these authorities, and depending on the strength of the argument in favor of indemnity, your client may need to make a strategic decision regarding whether – or not – to litigate the question of coverage earlier or later. Hence the answer above: "it depends."

VII. Resolution of the Dispute – Lawsuit or Appraisal?

Property insurance policies often have an "appraisal clause." They are not all the same. Here is one example:

> 7. **Appraisal.** If you and we do not agree on the amount of the loss, including the amount of ***actual cash value*** or ***replacement cost,*** then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within 20 days of such demand. The appraisers shall first select a competent and disinterested umpire; and failing for 15 days to agree upon such umpire, then, on request of you or the company, such umpire shall be selected by a judge of a court of record in the state in which the property covered is located. The appraisers shall then appraise the loss, stating separately the ***actual cash value*** or ***replacement cost*** of each item, and, failing to agree, shall submit their differences, only, to the umpire. An award in writing, so itemized, of any two of these three, when filed with the company shall determine the amount of loss.
>
> Each party will:
>
> **a.** pay its own appraiser; and
>
> **b.** bear the other expenses of the appraisal and umpire equally.
>
> In no event will an appraisal be used for the purpose of interpreting any policy provision, determining causation or determining whether any item or loss is covered under this policy. If there is an appraisal, we still retain the right to deny the claim.

Keeping this language in mind, consider a hypothetical "coverage problem" your client may have: assume a home's roof has been impacted by a storm, and a dispute arises whether that storm has caused "damage" as the parties intended that word in the policy. Assume in this hypothetical situation that the insurer engages a licensed engineer to examine the roof and prepare a report. From a policyholder's perspective, the use of an engineer to determine whether

or not a roof has been damaged should always raise a red flag. The policy does not say "we will pay for loss of or damage to structures *only if an engineer says the structure suffered damage*"; rather, it says something like "we will pay for sudden and accidental direct physical loss." Why should an engineer ever be needed to determine whether "loss or damage" has occurred? And, is it fair to require an insured to feel forced to hire (and pay) their own engineer to give such an opinion as a condition of being paid for the loss? These are the questions that frequently result in litigation.

In that hypothetical situation, assume further that the storm resulted in visible cosmetic changes to the appearance of the roof in various locations, and assume further that the roof was old and the shingles are no longer available. Finally, assume the policy contained the following Loss Settlement provision:

5. **Loss Settlement.** Covered property losses are settled as follows:

   a. **Replacement Cost.** Property under Coverage A or B at ***replacement cost,*** not including those items listed in **5.b.(2)** and **(3)** below subject to the following:

      (1) We will pay the full cost of repair or replacement, but not exceeding the smallest of the following amounts:

         (a) the limit of liability under the policy applying to Coverage A or B;

         (b) the ***replacement cost*** of that part of the damaged building for equivalent construction and use on the same premises as determined shortly following the loss;

         (c) the full amount actually and necessarily incurred to repair or replace the damaged building as determined shortly following the loss;

         (d) the direct financial loss you incur; or

         (e) our pro rata share of any loss when divided with any other valid and collectible insurance applying to the covered property at the time of loss.

      (2) When more than one layer of siding or roofing exists for **Building Property We Cover,** we will pay for the replacement of one layer only. The layer to be replaced will be at your option. The payment will be subject to all other policy conditions relating to loss payment.

This language raises a number of important questions. First, what is meant by "that part" of the damaged building? Is a shingle a part of a building? Is a roof a part of a building? A roof is composed of many parts, including many shingles; walls and roofs are parts of houses.

Reasonable minds could differ, so the construction must be against the drafter. And this language says the "layer to be replaced will be at your option." It does not say the shingles to be replaced; it says the layer to be replaced. A reasonable insured arguably would not read this policy to provide coverage only for individual damaged shingles. Yet this issue arises in a great many wind and hail claims.

Sometimes the parties turn to the appraisal process to resolve disputes like this. However, in certain cases, that process is ill-suited to the task because a dispute about what the policy covers, or does not cover, is by definition a *coverage question* and the appraisal process is not designed or intended to resolve coverage disputes. Using the same hypothetical claim situation discussed above, the central question is one of contract interpretation. Appraisal is not a good option in this case.

"An appraiser's authority is generally limited by the language of the provision to determine the value of the property and the amount of the 'loss.' Courts have construed this language as a limitation on an appraiser's authority which precludes her from resolving issues of law such as those pertaining to coverage, liability, causation, and exclusions." Johnny C. Parker, *Understanding the Insurance Policy Appraisal Clause: A Four-Step Program*, 37 U. TOL. L. REV. 931, 946 (2006) (citing *St. Paul Fire & Marine Ins. Co. v. Wright*, 629 P.2d 1202, 1203 (Nev. 1981); *Hanson v. Commercial Union Ins. Co.*, 723 P.2d 101, 104 (Ariz. Ct. App. 1986); *Holt v. State Farm Lloyds*, No. CA 3:98- CV-1076-R, 1999 U.S. Dist. LEXIS 6257, at 9 (N.D. Tex. Apr. 21, 1999); *Munn v. Nat'l Fire Ins. Co.*, 115 So. 2d 54, 54 (Miss. 1959); *Auto-Owners Ins. Co. v. Kwaiser*, 476 N.W.2d 467, 468-69 (Mich. Ct. App. 1991); *Feinbloom v. Camden Fire Ins. Co.*, 149 A.2d 616, 620 (N.J. Super. Ct. App. Div. 1959); *Jefferson Ins. Co. v. Superior*

Court of Alameda, 475 P.2d 880, 883 (Cal. 1970); *Opar v. Allstate Ins. Co.*, 751 So. 2d 758, 759 (Fla. Ct. App. 2000)).

In *Advanced Radiant Sys. v. Peerless Indem. Ins. Co.*, the U.S. District Court for the Southern District of Indiana held that "the scope of coverage at issue herein 'is a purely legal issue that cannot be determined by an appraisal, which is limited to factual disputes over the amount of loss for which an insurer is liable.'" 2016 U.S. Dist. LEXIS 36619, *31 (citing *Duane Reade, Inc. v. St. Paul Fire & Marine Ins. Co.*, 411 F.3d 384, 389 (2d Cir. 2005) (collecting cases); *Indian Chef, Inc. v. Fire & Cas. Ins. Co.*, 2003 U.S. Dist. LEXIS 2199, 2003 WL 329054, *3 (S.D.N.Y. 2003) ("A dispute between the parties that goes to coverage under the policy and can only be resolved by analysis and application of the policy is not appropriate for appraisal."); *Turnstone Consulting Corp. v. U.S. Fid. & Guar. Co.*, 2007 U.S. Dist. LEXIS 38053, 2007 WL 1430033, *4 (N.D. Cal. 2007) ("The appraisal panel's role is only to determine the monetary value of the interruption to plaintiff's business. The panel's role is not to determine whether the policy covers that interruption."). For these reasons, in the example above, the dispute should be resolved by a court. If we change the facts – say the dispute is really over *how much depreciation* was applied in one of the estimates, resulting in a dispute over how to calculate the "actual cash value" of the loss, then appraisal may be the best way, and least expensive way, to resolve the dispute.

VIII. Conclusion

When clients consult their counsel about coverage problems, there is no definitive list of issues to consider. I like to think of it the way Gene Kranz (portrayed in a memorable performance by Ed Harris in *Apollo 13*) thought about the problem with the Apollo spacecraft

("Houston, we have a problem!"). At least in the movie, Gene Kranz is credited with asking, "What have we got on the spacecraft that's good?" That's a good place to start in an insurance coverage problem. If the policy is good, then look for the problem with the claim. If the claim is good, look for the problem with the policy. If neither the policy nor the claim are good, look for the door!

Section Four

The Basics of Cyber Insurance

Panel Discussion

Section Four

The Basics of Cyber Insurance……………………………………Panel Discussion

PowerPoint Presentation

The Basics of Cyber Insurance

AN INTRODUCTION FOR OUR PANEL DISCUSSION

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Where We Were 20 and 30 Years Ago

- 88% of Americans are "concerned about general threats to their privacy."
- 82% feel a loss of control over data collection.
- 78% believe businesses ask for too much information.
- 78% have refused to give information as too personal or unnecessary, *up from 42% in 1990*.

Source: Givens, Privacy Expectations in a High Tech World, *Symposium on Internet Privacy, Computer and High Technology Law Journal* (2000)

History: ChoicePoint

NEWSDAY, April 28, 2005: "[ChoicePoint] announced in February that the personal information of 145,000 Americans may have been compromised when thieves posing as legitimate small business customers gained access to its database. Authorities say at least 750 people were defrauded in the scam."

Ten Years Later, State Data Breach Notification Laws

According to the National Conference of State Legislators (1/21/14):

"Forty-six states, the District of Columbia, Guam, Puerto Rico and the Virgin Islands have enacted legislation requiring private or government entities to notify individuals of security breaches of information involving personally identifiable information."

So, We Talked About Privacy Laws and Compliance Concepts in General

- HIPAA (Health Insurance Portability & Accountability Act)
- GLB (Gramm-Leach-Bliley Act)
- FTC Act (Federal Trade Commission)
- FCRA (Fair Credit Reporting Act)
- Disclosure Guidance on Cyber Security

NOW? Cybersecurity: Eight Key Cyber Risk Trends (2022 Marsh and Microsoft Cyber Risk Survey)

Cyber-specific enterprise-wide goals – including cybersecurity measures, insurance, data and analytics, and incident response plans – should be aligned to building cyber resilience versus simply preventing incidents, **as every organization can expect a cyber attack**

Ransomware is considered the top cyber threat faced by companies, but not the only one. (Others: phishing/social engineering, privacy breaches, business interruption due to external supplier being attacked.

Cybersecurity in 2022 – A Fresh Look at Some Very Alarming Statistics (Forbes)

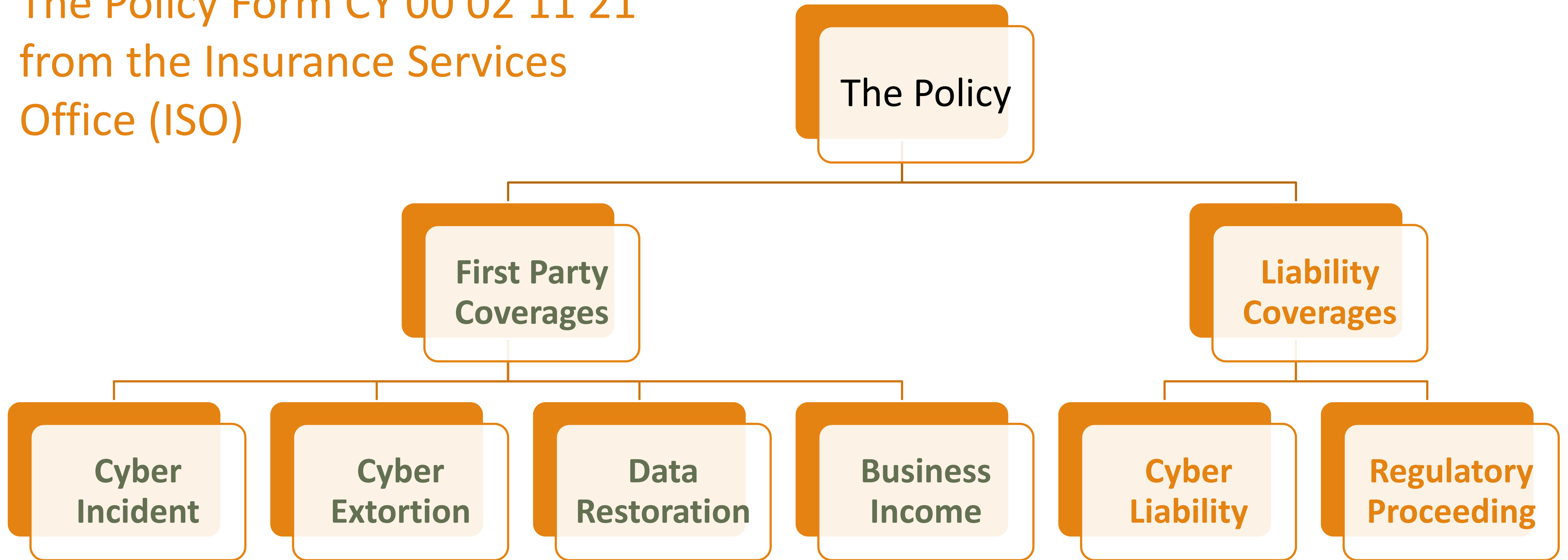
43% of cyber attacks are aimed at small businesses, but only 14% are prepared to defend themselves. A cyber attack doesn't just disrupt normal operations, but may cause damage to important IT assets and infrastructure that may be impossible to recover from without the budget or resources to do so

61% of all small businesses have reported at least one cyber attack during the previous year

83% of small and medium sized businesses are not financially prepared to recover

91% don't have cyber liability insurance

The Policy Form CY 00 02 11 21 from the Insurance Services Office (ISO)



Some Important Definitions:

"Cyber incident" means any:

1. Unauthorized access to or use of the "organization's computer system" (including the "organization's" "electronic data").

2. Malicious code, virus or any other harmful code that is directed at, enacted upon or introduced into the "organization's computer system" (including the "organization's" "electronic data") and is designed to access, alter, corrupt, damage, delete, destroy, disrupt, encrypt, exploit, use or prevent or restrict access to or the use of any part of the "organization's computer system" (including the "organization's" "electronic data") or otherwise disrupt its normal functioning or operation.

Some Important Definitions:

"Cyber extortion event" means **a demand for ransom payments** made to the "organization" in connection with the actual or threatened:

1. Perpetration of a "cyber incident" or "information security breach" or

2. Theft, disclosure, destruction, publication or use of the "organization's" confidential corporate or proprietary information that is stored on the "organization's computer system" or on a "third party computer system".

Some Important Definitions:

"Data restoration expenses":

1. Means the cost to replace or restore the "organization's" "electronic data" or "computer programs" stored within the "organization's computer system" as well as the cost of data entry, reprogramming and computer consultation services. To the extent that any of the "organization's" "electronic data" cannot be replaced or restored, we will pay the cost to replace the media on which such "electronic data" was stored with blank media of substantially identical type.

2. Does not include:

a. The cost to duplicate research that led to the development of the "organization's" "electronic data" or "computer programs"

b. Any costs or expenses associated with upgrading, maintaining, repairing, remediating or improving "electronic data" or any "computer program" to a level beyond the condition in which it existed immediately preceding the "cyber incident" or

c. Any costs or expenses associated with upgrading, maintaining, repairing, remediating, replacing or improving any "computer system".

And a Crucial Condition:

The provisions contained within this section apply only to First Party Insuring Agreements:

The "insured" must give us written notice of any "cyber incident", "cyber extortion event", "information security breach" or "interruption" that is "discovered" within the "policy period" as soon as practicable, **but in no event later than 60 days after the end of the "policy period"**. If an Extended Discovery Period applies, the "insured" must provide us written notice of any "cyber incident", "cyber extortion event", "information security breach" or "interruption" that is "discovered" within the Extended Discovery Period as soon as practicable, but in no event later than 60 days after the end of the Extended Discovery Period. **The "insured" must also cooperate with us in the investigation and settlement of the "loss".**

And a Crucial Condition:

The provisions contained within this section apply only to First Party Insuring Agreements:

2. Additionally, under Insuring Agreement A.2. Cyber Extortion Events and Insuring Agreement A.3. Replacement Or Restoration Of Electronic Data, the "insured" must:

a. Notify local law enforcement officials;

b. Submit to examination under oath at our request and give us a signed statement of the "insured's" answers; and

c. Give us a detailed, sworn proof of loss within 120 days.

And a Crucial Condition:

d. In addition, under Insuring Agreement A.2. Cyber Extortion Events, the "insured" must:

(1) Determine that the "cyber extortion event" has actually occurred;

(2) Make every **reasonable effort to access** the "organization's" "electronic data" from **backup**, if any, and to remediate the cause of the ransomware;

(3) Make every reasonable effort to **immediately notify us before making any ransom payment** based upon the "cyber extortion event" and

(4) Approve any ransom payment based upon the "cyber extortion event".

Section Five

Additional Insured Coverage 101

Michael R. Giordano
Lewis Wagner, LLP
Indianapolis, Indiana

Section Five

Additional Insured Coverage 101…………………………..... Michael R. Giordano

PowerPoint Presentation

Additional Insured Coverage 101

ICLEF
Insurance For Non-Insurance Lawyers
Friday, December 2, 2022
Indianapolis, Indiana

Michael R. Giordano
Lewis Wagner, LLP
Indianapolis, Indiana
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What It Is and What It Is Not

A Hypothetical

Key Features of Common Endorsements

Practice Suggestions and Considerations

Q&A

Tiny Print Disclaimer

This presentation is intended solely for the education and information of the audience. The information presented is not, nor is intended to be, legal advice or a legal opinion and thus should not be regarded as either. There are no representations or warranties made about the accuracy or substantive adequacy of any information presented. You should contact your own attorney for advice on specific legal issues.

Why Should A Non-Insurance Lawyer Care About Additional Insured Coverage?

It's everywhere.

Your business clients likely have active contracts that require them to obtain or entitle them to receive additional insured coverage, such as:

- Property management agreements;
- Residential and commercial leases;
- Equipment leases and rental agreements;
- Franchise and distribution agreements; and
- Construction contracts and subcontract agreements; and
- Service contracts.

An important but overlooked and misunderstood tool of contractual risk management.

An Additional Insured Is Not A Named Insured

A "named insured" is a person or organization "specifically designated in the policy as the one protected and, commonly, it is the person with whom the contract of insurance has been made." Black's Law Dictionary 1023 (6th ed. 1990).

- Usually named on the first pages of the policy—the declarations.
- Receives all the protections of the policy.
- Can make changes to the policy, such as adding coverage for an "additional insured."

What Is An Additional Insured?

A person or organization added to the policy at the named insured's request.

The additional insured does not have the same rights or coverage as the named insured but doesn't have to pay premiums.

Added by one of two types of endorsements:

- A scheduled endorsement specifically names the person or entity.
- A "blanket" endorsement automatically extends coverage to certain classes of persons or entities.

Scheduled Additional Insured Endorsement

Require the named insured to identify the additional insured by name.

Excerpt of Scheduled Endorsement:

“**Section II – Who Is An Insured** is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule…” (ISO Form CG 20 10 07 04).

Blanket or "Automatic" Additional Insured Endorsement

Usually requires a written contact between the named insured and additional insured.

Excerpt of Blanket Endorsement:

"**Section II – Who Is An Insured** is amended to include as an additional insured any person or organization for whom you are performing operations when you and such person organization have agreed in writing in a contract or agreement that such person or organization be added as an additional insured on your policy…" (ISO CG 20 33 12 19).

Additional Insured Coverage & Indemnification

Complimentary tools of contractual risk management

Contractual Indemnification – Duty to Indemnify

- "In general, an indemnity agreement involves a promise by one party (indemnitor) to reimburse another party (the indemnitee) for the indemnitee's loss, damage, or liability." *Henthorne v. Legacy Healthcare, Inc.*, 764 N.E.2d 751, 756 (Ind. Ct. App. 2002).

Additional Insured Coverage – Duty to Obtain Insurance

- Requirement for one party to a contract to obtain a certain type of insurance policy with certain limits and naming the other party as an "additional insured."
- May apply to property insurance, liability insurance, or both.

Duties to indemnify and to obtain insurance are usually placed on party with less bargaining power or those having greater control over the potential risks involved (such as a tenant or subcontractor).

A Contractual Indemnitee Is Not An Additional Insured

The "additional insured" and "indemnification" requirements are separate and independent and must be analyzed that way.

A contractual indemnitee is not a third-party beneficiary of the indemnitor's insurance policy.

A contractual indemnitee is not (necessarily) an additional insured under the indemnitor's insurance policy.

A contractual indemnitee has no standing to sue the insurer directly or to bring a bad faith claim against the indemnitee's insurer.

Why Would A Party Want To Be An Additional Insured?

Additional Insured

- Direct relationship with indemnitor's insurer (contractual privity)
- Right to immediate defense
- Right to indemnification, often even for own negligence
- Owed a duty of good faith
- Required to provide notice of accident, claim, or suit
- Required to cooperate with insurer
- Prevents depletion of own liability insurance to defend claims and limits the chance of increased premiums.

Indemnitee

- No direct relationship with indemnitor's insurer
- Right to defense depends on proving enforceable promise in contract
- No right to indemnification for own negligence unless contract says so explicitly
- The promise of indemnification may be limited by indemnitor's bank account

The Case of Ayman Pain

Mega Mall contracts with Garbage Guru to empty the trash dumpsters in the mall's parking lot.

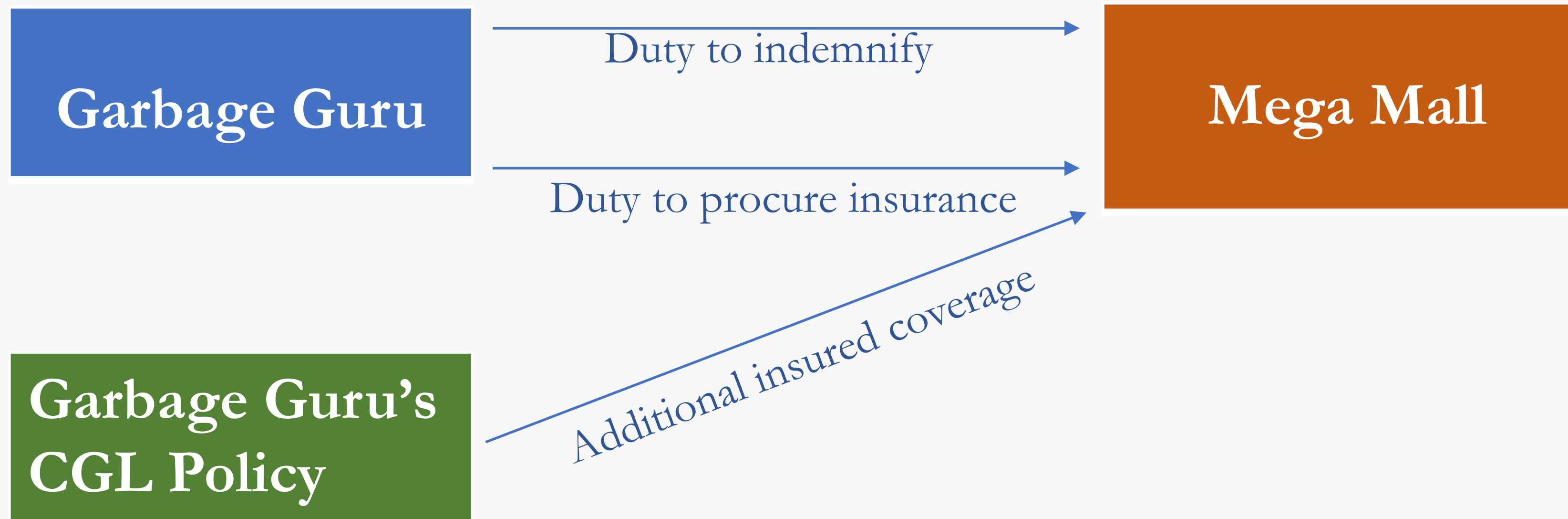
An employee of Garbage Guru, Ayman Pain, gets out of the garbage truck to pick up loose trash but he slips and falls on black ice next to the dumpster and breaks his wrist.

Ayman Pain sues Mega Mall for negligence in failing to keep the parking lot reasonably safe and clear of ice.

- The contract has an "indemnification" clause that requires Garbage Guru to indemnify Mega Mall for claims arising out of Garbage Guru's work under the contract (duty to indemnify).
- The contract has an "insurance" clause that requires Garbage Guru to name Mega Mall as an additional insured on its liability policy (duty to procure coverage).

Garbage Guru's Duty to Indemnify and its Duty to Procure Insurance

Garbage Guru's duty to indemnify and its duty to procure additional insured coverage for Mega Mall are separate and must be analyzed that way.



Mega Mall Tenders to Garbage Guru

Mega Mall tenders to Garbage Guru under the contract's "Indemnification" clause:

Indemnification Clause

To the fullest extent permitted by law, Garbage Guru shall indemnify Mega Mall from and against any and all liability, claims, suits, losses, costs and expenses (including without limitation attorney fees), fines or penalties to the extent arising in any way, directly or indirectly, from entry onto the property by Garbage Guru, its employees, and subcontractors, or to the extent otherwise arising from Garbage Guru's negligent performance of trash-removal services or other operations under this contract. This indemnity shall survive the termination or expiration of this contract.

Does Garbage Guru accept Mega Mall's tender?

Who said Garbage Guru even responds?

WARNING: Anecdotal Experience

Tenders for contractual indemnification, no matter their merit, are often ignored or denied, possibly because:

- The indemnitor relies on its insurer to respond, but its insurer addresses only the tender for additional insured coverage;
- The indemnitor fails to appreciate that it may have a duty to indemnify not covered by its insurance;
- The indemnitor simply believes it did nothing wrong.

Is Mega Mall entitled to indemnification from Garbage Guru?

Probably not. The "Indemnification" clause does not explicitly state that Garage Guru's will indemnify Mega Mall for its own negligence:

> **Indemnification/Insurance Clause**
>
> To the fullest extent permitted by law, Garbage Guru shall indemnify Mega Mall from and against any and all liability, claims, suits, losses, costs and expenses (including without limitation attorney fees), fines or penalties to the extent arising in any way, directly or indirectly, from entry onto the property by Garbage Guru, its employees, and subcontractors, or to the extent otherwise arising from Garbage Guru's negligent performance of trash-removal services or other operations under this contract. This indemnity shall survive the termination or expiration of this contract.

Ayman's complaint alleges negligence against Mega Mall only. It does not assert that Mega Mall is vicariously liable for the acts or omissions of Garbage Guru.

Because Mega Mall has been sued for its own negligence, Garbage Guru should have no duty under Indiana law to indemnify Mega Mall. Any potential counterarguments?

Analyzing Garbage Guru's Duty to Indemnify

Was the written contract signed before the loss, covering this location, this date and this kind of claim?

What does it say about indemnity?

Are the indemnity provisions enforceable under your state's law?

Is there a choice of law clause? Which state's law applies?

Mega Mall Reviews the "Insurance" Clause

All hope is not lost for Mega Mall, because the contract required Garbage Guru to name Mega Mall as an "additional insured" on its liability policy:

Insurance Clause
During the term of this contract, Garbage Guru will maintain a Commercial General Liability Policy with a limit of $1,000,000 per occurrence. Mega Mall must be listed as an Additional Insured. Garbage Guru shall provide Mega Mall with a Certificate of Insurance evidencing such coverage before beginning work.

Garbage Guru's Certificate of Insurance with Infallible Insurer

Certificate of Liability Insurance (COI)

DATE (MM/DD/YYYY): 11/01/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER: Honest Abe's Insurance Agency

CONTACT NAME:
PHONE (A/C, No, Ext):
FAX (A/C, No):
E-MAIL ADDRESS:

INSURED: Garbage Guru

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Infallible Insurance Company	123456
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

COVERAGES | CERTIFICATE NUMBER: | REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE / OCCUR Broad Form Property Damage Blanket Contractual GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC	x		CGL 123456	11/01/2022	11/01/2023	EACH OCCURRENCE	$ 2,000,000
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 500,000
							MED EXP (Any one person)	$ 25,000
							PERSONAL & ADV INJURY	$ 2,000,000
							GENERAL AGGREGATE	$ 2,000,000
							PRODUCTS - COMP/OP AGG	$ 2,000,000
								$
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS HIRED AUTOS NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR EXCESS LIAB / CLAIMS-MADE DED / RETENTION $						EACH OCCURRENCE	$
							AGGREGATE	$
								$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N / A					WC STATU-TORY LIMITS / OTH-ER	
							E.L. EACH ACCIDENT	$
							E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

Mega Mall is listed as an additional insured for Garbage Guru's ongoing and completed operations.

CERTIFICATE HOLDER: Mega Mall

CANCELLATION: SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Infallible Insurance Company	123456
INSURER B :	
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

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CANCELLATION: SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Does Mega Mall Even Need to Tender to Infallible, Which Already Received Notice from Garbage Guru?

YES.

Depending on the applicable law, Infallible might not have a duty to defend until it receives a tender from Mega Mall.

Even if Mega Mall told Garbage Guru to forward the tender to Infallible, Mega Mall should tender directly to Infallible.

Most common CGL policy forms impose duties on additional insureds, including duties to provide notice of accidents, claims, and suits, and to immediately forward copies of any legal papers received in connection with any accident, claim, or suit.

Is Mega Mall entitled to coverage as an additional insured under Garbage Guru's CGL policy with Infallible?

It depends.

The Insurance Services Office (ISO) publishes more than 30 different additional insured endorsements. Many insurers create their own endorsements.

The coverage provided by additional insured endorsements varies.

The certificate of insurance does not specify the endorsement in Garbage Guru's policy.

Whether Mega Mall is entitled to coverage under Garbage Guru's CGL policy depends on the endorsement.

AI Endorsement Language: The named insured and additional insured have "agreed in writing"

"Who is an Insured (Section II) is amended to include as an insured any person or organization for whom you are performing operations ***when you and such person or organization have agreed in writing in a contract or agreement*** that such person or organization be added as an additional insured on your policy. Such person or organization is an additional insured only with respect to liability arising out of your ongoing operations performed for that insured. A person's or organization's status as an insured under this endorsement ends when your operations for that insured are completed." ISO Form CG 20 33 (03/97).

Mega Mall would be entitled to coverage under this scheduled endorsement.

Variation: What if Ayman Pain was an employee of Garbage Guru's subcontractor, Trash Titan, and Mega Mall did not sign subcontract with Trash Titan?

AI Endorsement Language: Injury or Damage "Caused in Whole or in Part"

"Section II – Who Is An Insured is amended to include as an insured the person or organization shown in the Schedule, but only with respect to liability for 'bodily injury', 'property damage' or 'personal and advertising injury' caused, in whole or in part, by:

1. Your acts or omissions; or
2. The acts or omissions of those acting on your behalf; in the performance of your ongoing operations for the additional insured(s) at the location(s) designated above.

ISO Form CG 2010 (07/04).

Meant to narrow coverage and avoid overbroad interpretation that was given to "liability arising out of" language in earlier endorsements.

Under this scheduled endorsement, Mega Mall should be entitled to a defense against Ayman Pain's lawsuit. If any fault is assigned to Garbage Guru/Ayman Pain (even just 1%), Mega Mall should be entitled to indemnification as an additional insured.

Additional Insured Endorsement Language: "Liability Arising Out of"

"WHO IS AN INSURED (Section II) is amended to include as an insured the person or organization shown in the Schedule, but only with respect to liability arising out of your ongoing operations performed for that insured." ISO Form CG 20 10 (10/93)

Broad protection. Indiana courts have interpreted this "liability arising out of" language to provide the additional insured with coverage even for its sole negligence. *See Peabody Energy Corp. v. Roark*, 973 N.E.2d 636, 642 (Ind. Ct. App. 2012).

Under the above scheduled endorsement, Mega Mall would be entitled to coverage as an additional insured under Garbage Guru's liability policy.

AI Endorsement Language: Coverage Limited by Law and Contract

"The insurance afforded to such additional insured applies only to the extent permitted by law."

"[T]he insurance afforded to such additional insured will not be broader than that which you are required by the contract or agreement to provide for such additional insured."

"[T]he most we will pay on behalf of the additional insured is the amount of insurance: 1. Required by the contract or agreement; or 2. Available under the applicable Limits of Insurance shown in the Declarations; whichever is less." ISO Form No. CG 20 10 04 13

Is Mega Mall covered under this language? The contract does not specify the scope of required additional insured coverage:

> Garbage Guru will maintain a Commercial General Liability Policy with a limit of $1,000,000 per occurrence. Mega Mall must be listed as an Additional Insured. Garbage Guru shall provide Mega Mall with a Certificate of Insurance evidencing such coverage before beginning work.

AI Endorsement Language: Vicarious Negligence Only

Some rare endorsements limit the additional insured's coverage to its vicarious liability for the acts or omissions of the named insured.

Setting aside the defense aspect, the right to contractual indemnification seems illusory in that the additional insured has a claim for common-law indemnification.

Under this endorsement, Mega Mall would not be entitled to coverage.

What can Mega Mall do if it believes Garbage Guru and Infallible wrongly denies its tender?

Mega Mall could bring a claim against Garbage Guru for breach of its contractual duty to indemnify and breach of its duty to procure additional insured coverage for Mega Mall (assuming it is determined that Infallible's denial is correct).

Mega Mall could also bring a claim against Infallible for breach of contract in failing to defend and indemnify Mega Mall as an additional insured (assuming it is determined that Garbage Guru procured the contractually required coverage).

If Mega Mall believes that Infallible had no rational basis for denying coverage, Mega Mall might also bring a claim against Infallible for bad faith. But Mega Mall should voluntarily dismiss that claim if I appear for Infallible.

Practice Tip: Keep Indemnification and Insurance Requirements Separate

Having separate "Indemnification" and "Insurance" clauses helps avoid ambiguity, particularly if scope of duties to indemnify and to procure additional insured coverage are meant to be different:

- Indemnification is meant to be limited to vicarious negligence.
- Additional insured coverage is meant to extend to comparative negligence.

If the duties are combined in one clause, another party or a court may construe them to have the same scope or limits. Assume the duties in Mega Mall's contract were lumped together:

Indemnification/Insurance Clause

To the fullest extent permitted by law, Garbage Guru shall indemnify Mega Mall from and against any and all liability, claims, suits, losses, costs and expenses (including without limitation attorney fees), fines or penalties to the extent arising in any way, directly or indirectly, from entry onto the property by Garbage Guru, its employees, and subcontractors, or to the extent otherwise arising from Garbage Guru's negligent performance of trash-removal services or other operations under this contract. This indemnity shall survive the termination or expiration of this contract. Additionally, Garbage Guru will maintain a Commercial General Liability Policy with a limit of $1,000,000 per occurrence. Mega Mall must be listed as an Additional Insured. Garbage Guru shall provide Mega Mall with a Certificate of Insurance evidencing such coverage before beginning work.

Practice Suggestion: Require Specific Additional Insured Endorsements

Example: "Garbage Guru must name Mega Mall as an additional insured on the Commercial General Liability Policy using ISO Additional Insured Endorsement CG 20 10 (11/85) or an endorsement providing equivalent or broader coverage."

Should the coverage apply to the additional insured's vicarious negligence, comparative negligence, or sole negligence?

Should the coverage apply to the additional insured's ongoing operations, completed operations, or both?

If the contract does not specify the scope of coverage owed to the additional insured, disputes will likely arise.

Practice Suggestion: Don't Rely on a Certificate of Insurance

Verify your client's status as an additional insured when the contract is signed, not after an accident happens or a lawsuit is filed.

A certificate of insurance alone cannot create coverage or alter the terms of an insurance policy. *See Am. Family Ins. Co. v. Globe Am. Cas. Co.*, 774 N.E.2d 932, 939 (Ind. Ct. App. 2002).

Ideally you would require the party procuring insurance to provide a copy of the policy, but many entities and risk managers are unlikely to agree to this requirement.

At the least, require the relevant declarations (with appropriate redactions) and a copy of the applicable endorsement: "Before beginning its work, Garbage Guru will provide to Mega Mall a copy of commercial general liability declarations (premiums redacted) and the required additional insured endorsement(s) affording coverage to Mega Mall."

Practice Suggestion: Address the Priority, Limits, and Duration of Coverage

Most likely the coverage afforded to the additional insured will be excess *unless* the contract explicitly requires otherwise.

> "The coverage afforded to Mega Mall as an additional insured shall apply on a primary and non-contributory basis."

Specify the amount of coverage required for the additional insured but consider addressing potential impact on coverage that may be afforded to additional insured under CGL and any excess policies.

- Example: The contract requires $1 million in liability coverage, but the named insured's CGL policy has a $2 million limit. What happens? Can the additional insured receive coverage under the named insured's excess policy?

Specify how long the named insured needs to maintain the additional insured coverage. Consider the duration of the additional insured's exposure to completed operations (statute of limitations or statute of repose).

Other Considerations: Subrogation, Deductibles and Self-Insured Retentions, and Notice of Cancellation

Is a waiver-of-subrogation provision is needed to prevent the insurer from seeking subrogation, or does an anti-subrogation rule protect the additional insured?

Who is responsible for paying premiums and any applicable deductible or self-insured retention in order to trigger coverage?

Does the additional insured should have the right to obtain the contractually required coverage if the named insured fails to do so?

Is the named insured or the insurer required to provide notice (usually 30 days) to the additional insured before the policy is cancelled?

Conclusion: Be Proactive

Don't wait until things go wrong.

Identify all potentially relevant contractual obligations to indemnify and to procure additional insured coverage.

Review the additional insured endorsements in policies and determine whether they satisfy the contractual obligations to procure coverage.

Review all relevant contractual obligations to indemnify (particularly older contracts) and determine whether they need to amended or renegotiated.

- Watch out for overbroad or vague "indemnification" and "insurance" clauses. Be specific.
- Know the applicable laws that might impact the enforceability of the "indemnification" clauses.
- Understand the interplay between the "indemnification" and "insurance" requirements. A party may believe its insurance will cover any liable assumed under the "indemnification" clause, but the coverage may have gaps or exclusions that leave the contractor on the hook for a loss.

The End

QUESTIONS?

QUESTIONS? QUESTIONS?

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Section Six

EPLI and You

Gina Moreno
EPLI Program Manager
Ogletree, Deakins, Nash, Smoak & Stewart, P.C.
Greenville, South Carolina

Section Six

EPLI and You…………………………………………………………Gina Moreno

PowerPoint Presentation

EPLI AND YOU

Gina Moreno
EPLI Programs Manager
Ogletree Deakins
December 2, 2022

What is EPLI?

For any demand, administrative action, or lawsuit, a client may have Employment Practices Liability Insurance (EPLI)

- insurance for claims that "arise out of and in the course of the injured employee's employment by you" or "**wrongful acts arising from the employment process**"
- not required insurance and not governed by state law
- for example, wrongful termination, discrimination, sexual harassment, retaliation, defamation, invasion or privacy, negligent evaluation
- Wage and hour claims may not be covered and/or defense costs only

What Changes?

First, rates are not standard. Your firm may be approved “panel” counsel for many insurance companies and rates are already negotiated. For all other insurance companies, rates are determined on a case-by-case basis.

What Changes?

First, rates are not standard. Your firm may be approved “panel” counsel for many insurance companies and rates are already negotiated. For all other insurance companies, rates are determined on a case-by-case basis.

Second, in order to bill your time correctly you will need some additional information from the insurance company.

Information You Will Need To Properly Set Up The Matter

What Changes?

First, rates are not standard. Your firm may be approved “panel” counsel for many insurance companies and rates are already negotiated. For all other insurance companies, rates are determined on a case-by-case basis.

Second, in order to bill your time correctly you will need some additional information from the insurance company.

Third, the attorney will communicate with both the client and the insurance company representative. For example, insurance companies require a budget, status reports, a litigation plan, copies of all invoices, etc.

What Changes?

First, rates are not standard. Your firm may be approved “panel” counsel for many insurance companies and rates are already negotiated. For all other insurance companies, rates are determined on a case-by-case basis.

Second, in order to bill your time correctly you will need some additional information from the insurance company.

Third, the attorney will communicate with both the client and the insurance company representative. For example, insurance companies require a budget, status reports, a litigation plan, copies of all invoices, etc.

Fourth, the insurance company publishes special Billing Guidelines that you must follow or risk reductions to time and expenses.

What Changes?

First, rates are not standard. Your firm may be approved “panel” counsel for many insurance companies and rates are already negotiated. For all other insurance companies, rates are determined on a case-by-case basis.

Second, in order to bill your time correctly you will need some additional information from the insurance company.

Third, the attorney will communicate with both the client and the insurance company representative. For example, insurance companies require a budget, status reports, a litigation plan, copies of all invoices, etc.

Fourth, the insurance company publishes special Billing Guidelines that you must follow or risk reductions to time and expenses.

Fifth, in most cases, the insurance company contributes to legal fees or settlement only after the client’s deductible or self-insured retention is met.

Terminology

- Self-insured retention
- Deductible
- Bordereau
- Defense only coverage
- Defense and indemnity coverage
- Coverage Start Date
- Late reporting
- Shared Defense

Guideline Highlights

- Staffing
- Timeliness of bills (monthly, quarterly)
- Due dates for status reports and litigation plans
- What activities and expenses are not reimbursed
- List of approved vendors
- Expectations for time entries

Block-billed entries are not acceptable

- “Prepare for, travel to, and attend deposition of John Smith.” (8.0)

- “Prepare for deposition of John Smith by reviewing employment file, pleadings to date, plaintiff’s interrogatory responses (1.3)”

- “Travel to deposition of John Smith (.70); conduct deposition of John Smith (6.0)”

Avoid Vague entries

- “Prepare for mediation (1.50)”
- “Prepare for mediation by reviewing mediation brief (23 pages), reviewing the plaintiff’s deposition (150 pages), and reviewing plaintiff’s employment file (75 pages) (1.50)”

Provide Requested Detail for ALL Communications

- "Telephone conversation with plaintiff's counsel (.40)"
- "Telephone conversation with plaintiff's counsel regarding potential settlement (.40)"

Provide Requested Detail for ALL Document Reviews

- “Review documents forwarded by ABC Company for responsiveness to plaintiff’s Request for Production” (2.0)

- “Analyze documents forwarded by Acme Co. including plaintiff’s employment file, the employee handbook, and e-mails for response to plaintiff’s Request for Production (150 pages)” (2.0)

Questions?

Section Seven

Reinsurance 101
Reinsurance – What it is and Why it Matters to Your Client

Andrew M. Weissert
Chief Legal Officer
AXIS (Re)Insurance
Alpharetta, Georgia

Section Seven

Reinsurance 101
Reinsurance – What it is and
Why it Matters to Your Client…………………………….. Andrew M. Weissert

PowerPoint Presentation

Reinsurance 101

Reinsurance – What it Is and Why it Matters to Your Client

ICLEF – December 2, 2022

Andrew M. Weissert

Table of content

1. Purpose of Reinsurance contracts
2. Brief history of Reinsurance
3. General commercial law
4. Reinsurance law specifics
5. Types of Reinsurance relationships
6. Clause types
7. Drill-down menu

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1. Purpose of Reinsurance Contracts

AXIS

Purpose of contracts

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2. Brief history of Reinsurance

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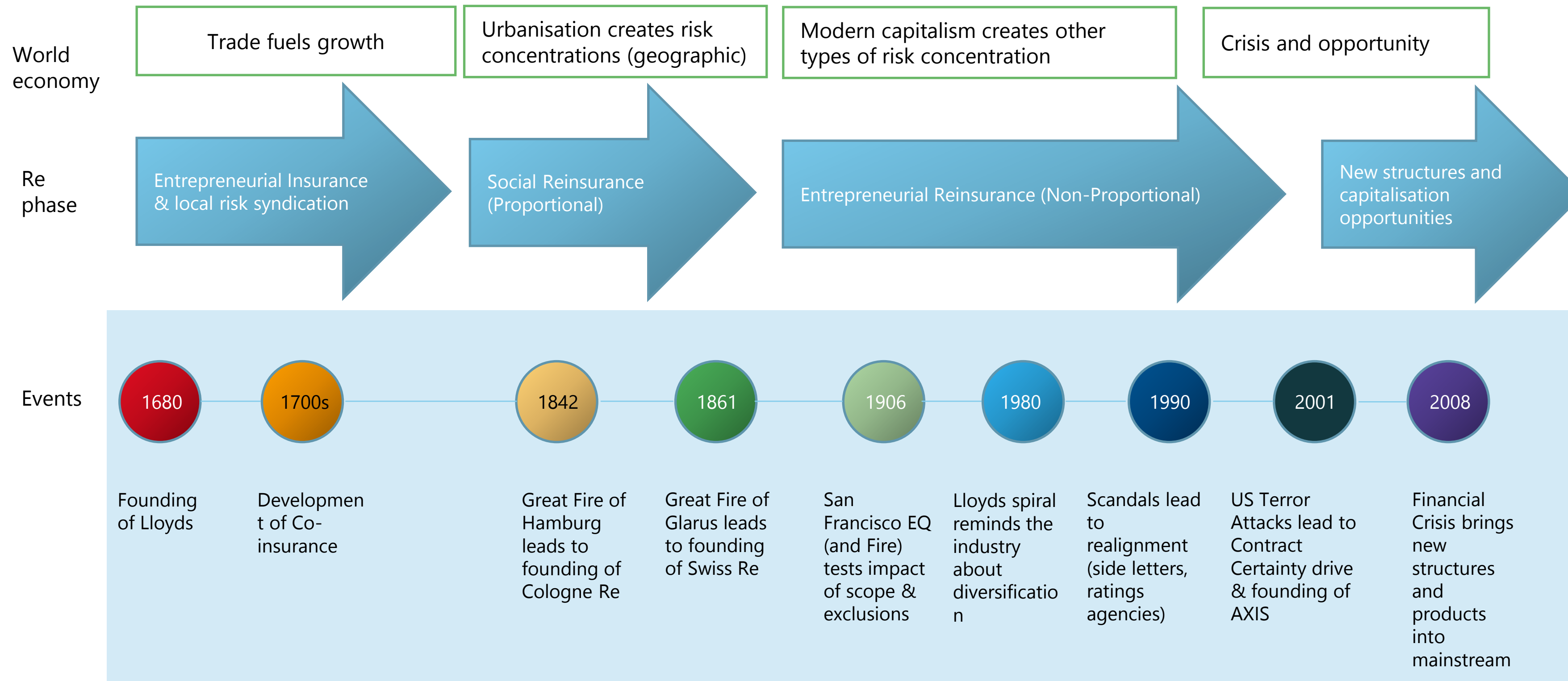
Brief History of Reinsurance



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3. General Commercial Law

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The law of Reinsurance is mostly General Commercial Law

- Consideration
- Oral, written contracts
- Contract execution, modification
- Signatures (including electronic)
- Off-set
- Applicable law
- Enforcement: Lugano Convention
- Data Protection: GDPR etc.
- Trade Sanctions
- Etc.

4. Reinsurance Law Specifics

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Specifics

Concept	Detail	Related clauses
Indemnity	No recovery without **net loss**. No part of a claim that is not **reasonable**. Unless otherwise stated, **(Re)insured proves each loss** – hence, Follow the Settlements.	UNL, ECO/XPL, ALE, Reinsuring clause, Follow the Settlements, TRIA exclusion
Utmost Good Faith	Game theory requires parties to be re-aligned: this is protected by law	Incorrect or Incomplete Information; Utmost Good Faith and Due Diligence; Loss Reporting; Access to Records
Offer and Acceptance	Special Rules in London Market due to Marathon messenger role of brokers	Subscription Agreement
Leading/ Following	Allows & regulates syndication without creating solidarity	Claims Settlements; Special Acceptances; Form of Alteration
Follow: Fortunes/ Settlements	''What **happens to** the Reinsured'' (limits on sharing the unexpected) vs. ''What the Reinsured **does**'' - (limits on sharing consequences of conduct)	Follow the Fortunes; Claim Settlement; Ex Gratia; ECO/XPL; Change of Law; Scope; Exclusions
Arbitration	Technical nature of disputes explains lack of law and precedents	Customs & Choice of Law; Dispute Resolution
Regulation	Policyholder protection via solvency and security & closing legal loopholes	Collateral; Deposits; Sanctions; Special Termination & Downgrading; Entire Agreement
Path dependency	Annually renewable business, set 'Seasons', non-standard wordings and data complexity	Commencement & Duration; Borderaux

5. Types of Reinsurance Relationships

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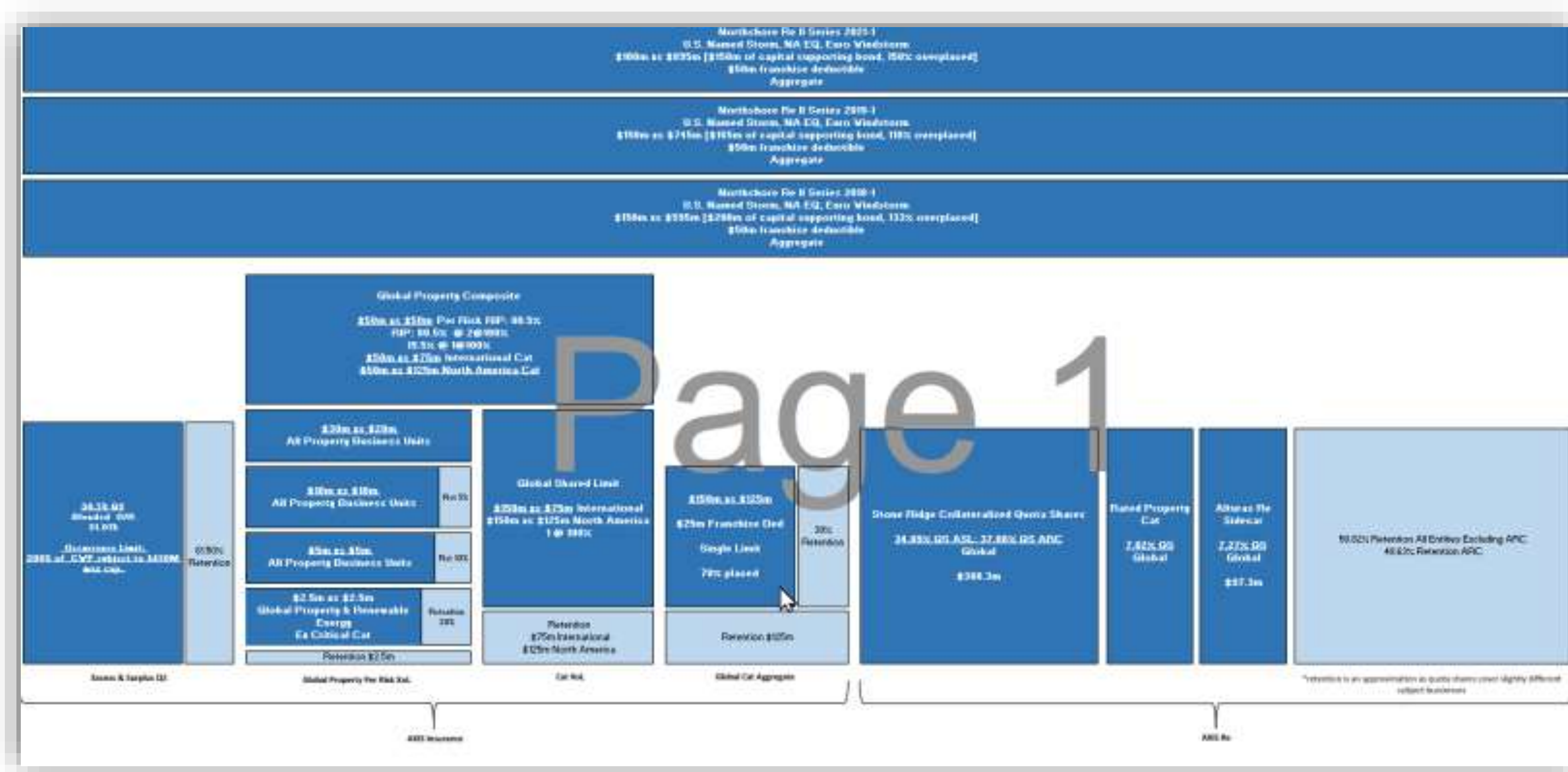
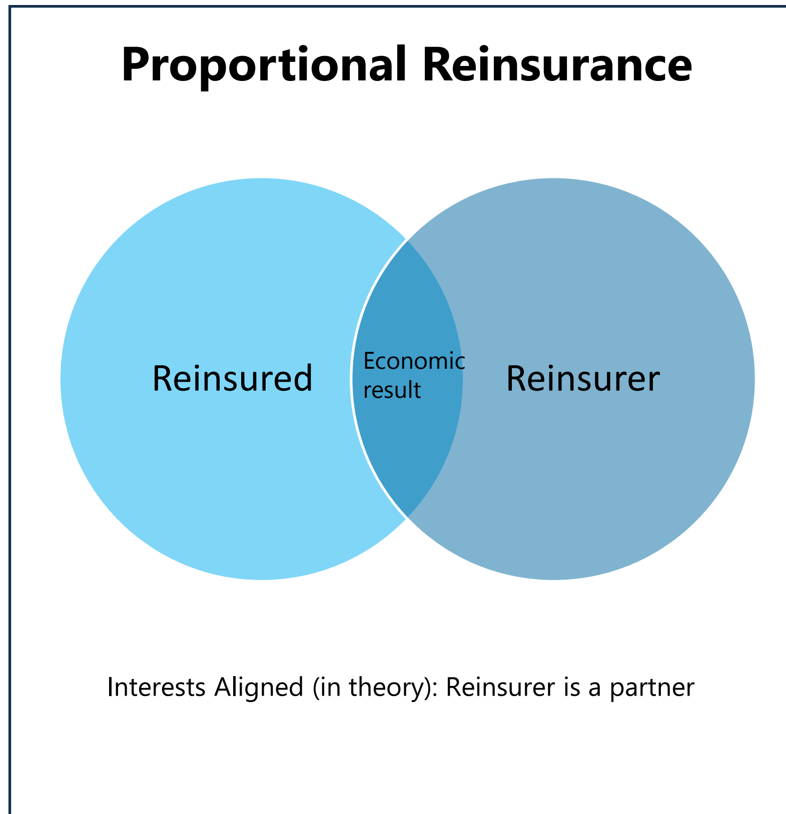
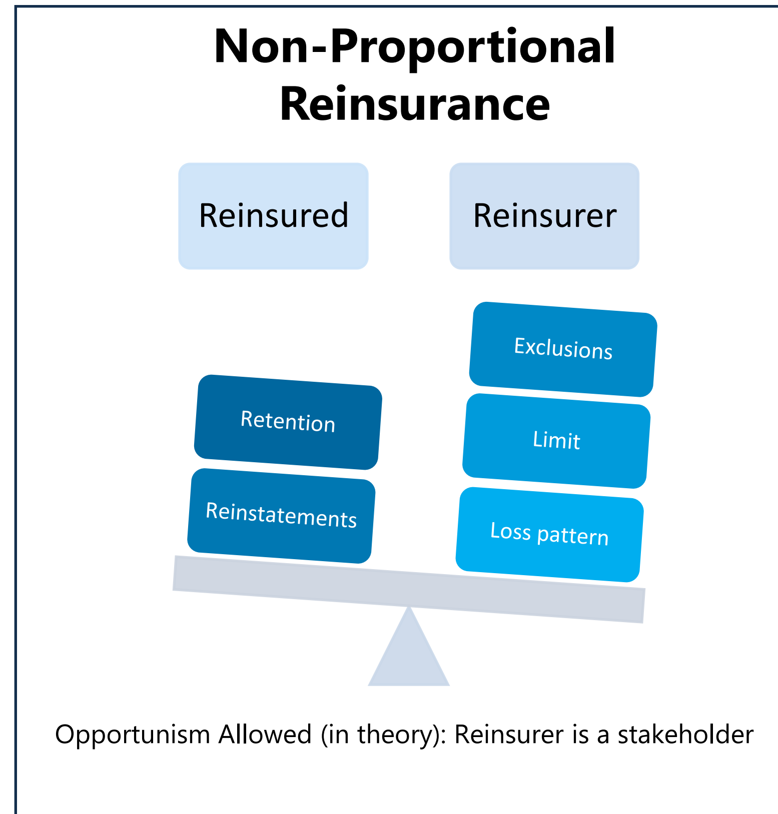
Reinsurance is usually a suite of interlocking products.



Types of Reinsurance Products: building blocks of a relationship





Types of Cover

Proportional Reinsurance

- Quota Share
- Surplus

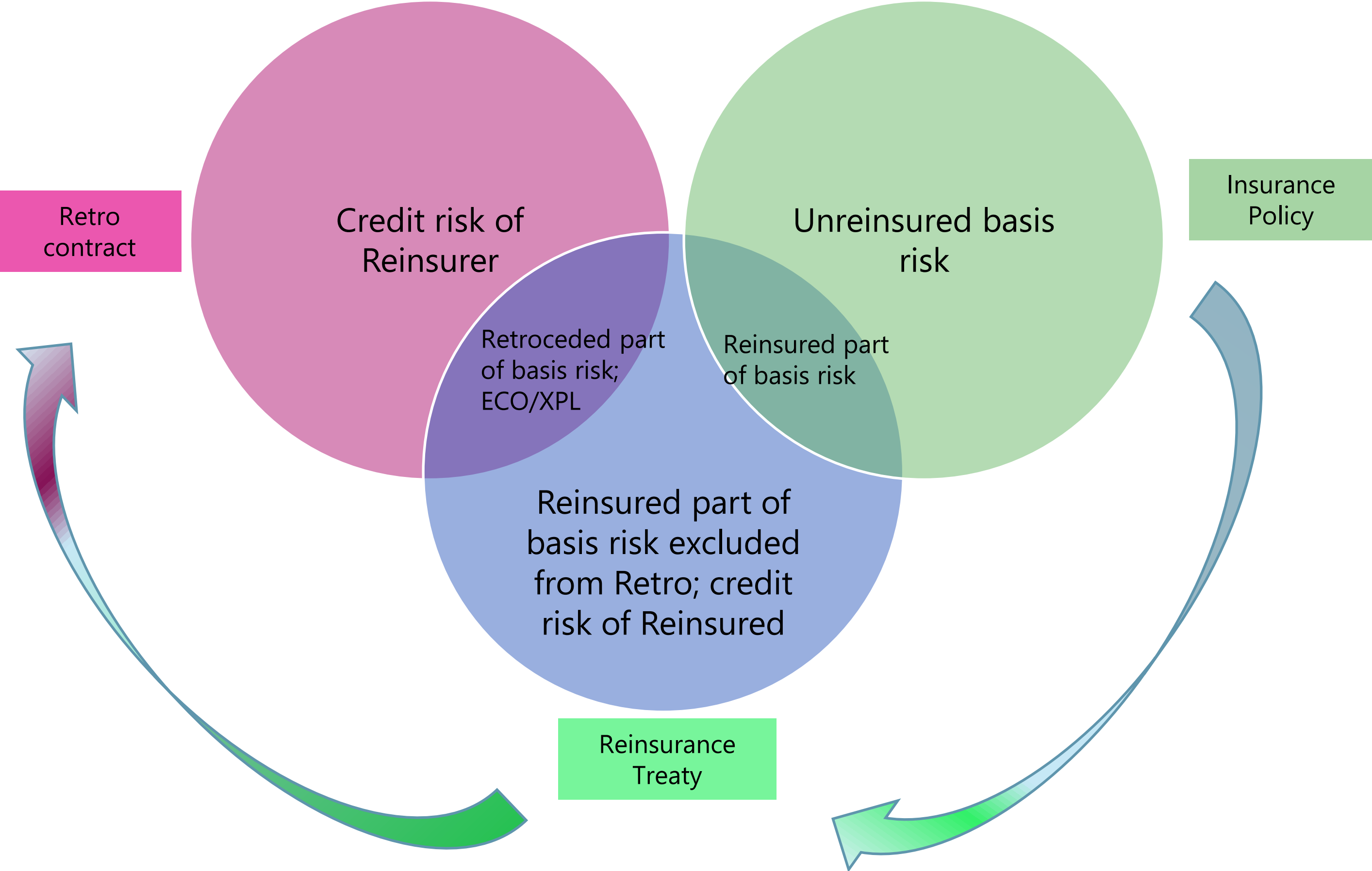
Non-Proportional Reinsurance

- Risk XoL
- 'Working' per Event XoL
- Cat XoL
- Clash XoL
- Stop Loss

Other

- Structured Reinsurance
- Adverse Development Cover
- Loss Portfolio Transfer
- ILW
- ILS/Cat Bonds
- Parametric
- Sidecars

Risk Sharing



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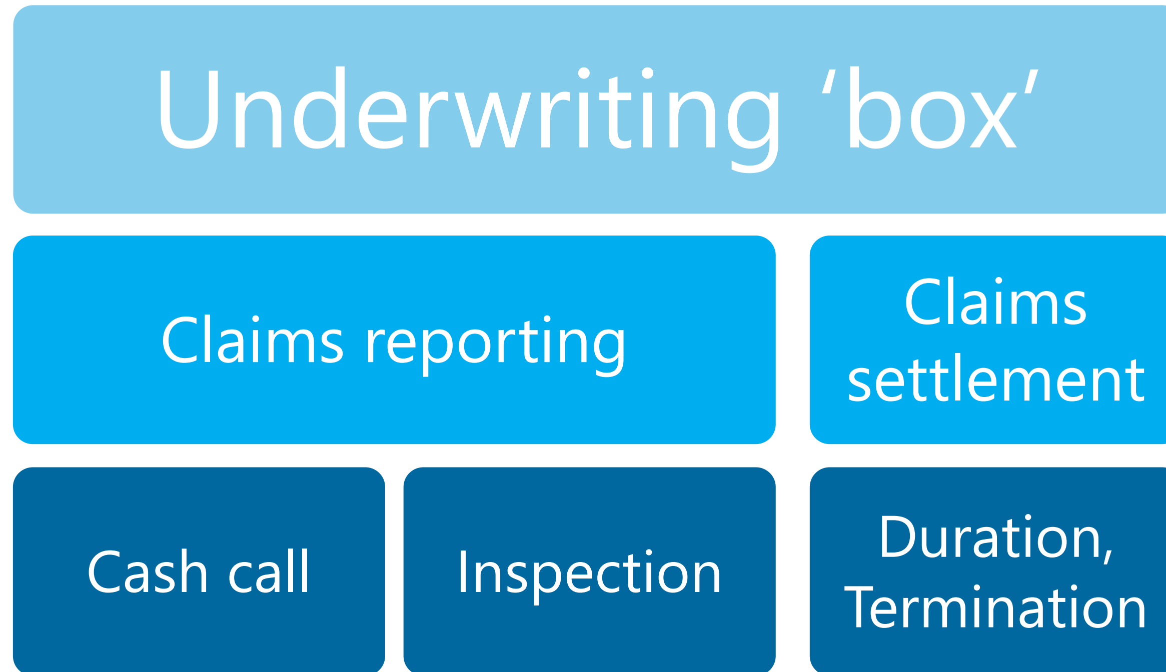
Cooperation: The main non-technical battle grounds



6. Clause Types

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Clause categories and ownership

Category	Owner
Administrative	• TA, Claims, Legal
Aggregation	• UW
Claims	• TA, Claims
Compliance	• Legal
Credit Protection	• Legal, Finance
Data	• IT
Duration	• UW, Legal
Financial Risk	• Legal, Finance
Legal Certainty	• Legal
Limits	• UW, Legal
Loss Contributions	• UW, TA, Claims
Premium	• UW, TA
Relationship	• UW, Global Markets
Risks/Perils Covered	• UW
Other	• Various

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Clause types

Topic	Administrative	Aggregation	Claims	Compliance	Credit Protection	Data	Duration	Financial Risk	Legal Certainty	Limits	Loss Contributions	Premium	Relationship	Risks/Pe	Co
Account	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Accounting System	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗
Cash Call	✓	✗	✓	✗	✓	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗
Change in Law	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✓	✗	✗
Claims Notification	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Claims Settlement	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗
Collateral	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗
Confidentiality	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Currency	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗
Currency Conversion	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗
Customs & Choice of Law	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗
Data Protection	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗
Definitions	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓
Delay in Payment	✗	✗	✗	✗	✓	✗	✗	✓	✗	✗	✗	✓	✗	✗	✗
Dispute Resolution	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗
Downgrading	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
E&O	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Entire Agreement	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗
Event Definition	✗	✓	✗	✗	✗	✗	✗	✗	✗	✓	✓	✗	✗	✗	✗
Exclusions	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓
Follow the Fortunes	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗
Follow the Settlements	✓	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗
Form of Alteration	✓	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗
Incorrect or Incomplete Informa	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗	✓	✗	✗
Indexation	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗
Inspection of Records	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗
Interlocking	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗
Intermediary	✓	✗	✗	✓	✓	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗
Inuring Reinsurance	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✓	✗	✗	✗
Leading Reinsurer	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗
Limits	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗
Loss Payment	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Losses Outstanding at Terminat	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗	✓	✗
Net Retained Lines	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗
Obligatory Reinsurance	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✓	✓	✗	✗
Off-set	✗	✗	✗	✗	✓	✗	✗	✓	✗	✗	✗	✗	✓	✗	✗
Period	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗
Premium	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗
Reinstatement	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗
Reinstatement Premium	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗
Reinsurance Compensation	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✓	✗	✗	✗	✗
Risk Definition	✗	✓	✓	✗	✗	✗	✗	✗	✗	✓	✓	✗	✗	✗	✗
Run-off	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗	✓	✗
Run-off Reinsurer	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗
Sanctions	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗
Scope of Agreement	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗
Special Termination	✗	✗	✗	✗	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗
Term	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✗	✗	✗
Ultimate Net Loss	✓	✗	✓	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗
Unauthorised Reinsurer	✗	✗	✗	✗	✓	✗	✗	✗	✗	✗	✓	✗	✗	✗	✗
Underwriting Policy	✗	✗	✓	✗	✗	✗	✗	✗	✗	✓	✗	✗	✓	✓	✗
Utmost Good Faith	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✓	✗	✗

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7. Drill-down Menu

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Options

Hot topics

- Cyber
- Communicable Disease

Gatekeeping topics

- War
- NBCR/Terrorism
- Pollution
- Risk/Event Definitions

Other standard clause types

- Collateral
- Special Termination
- Arbitration
- Applicable Law
- Right of Information/Access to Records
- Accounting items and Rules / Balance Settlement
- Notification of Claims
- Loss Settlements
- Follow Fortunes
- Sanctions
- Obligatory Treaty Reinsurance and Retrocession
- Pool, Syndicate or Association
- Cut Through
- Interlocking

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Gatekeeping Topics

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War Exclusion Clause (Property)

What does it do?	• Specifically excludes coverage for acts of war or warlike actions. • Excludes damage to property by or under the order of any government or public or local authority, which is a differentiator to terrorism losses. • War exclusions were expanded and became standard after the attack on the World Trade Centre.
Alternate names	War and Civil War Exclusion Clause (NMA464), Terrorism, War and Terrorism Exclusion Endorsement (Reinsurance) NMA2918
Why included ?	• Usually considered uninsurable catastrophic risk. • War losses not measurable, not due to chance, not predictable. • Hence, impossible to estimate premium for war.
Advantage/Risk for counterparty	• Advantage: Protect the solvency of the insurance companies (for covered risks). • Advantage: Should be a market standard and part of original policies. • Risk: In case there are policies without war exclusion in their portfolio.
Advantage/Risk for reinsurer	• Advantage: Even though this being a standard exclusion in original insurance policies, we avoid exemptions and special coverages given by the insured without our consent. • Risk: If there is no War exclusion, we do not have the guarantee that there is a war exclusion clause in the original insurance policies.
Best practice	1. Ensure that **active war** is excluded. 2. Coverage of old munition is acceptable ("... munitions does not result from a state of war current at the time of damage")

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Sample: War and Civil War Exclusion

War and Civil War Exclusion Clause

(Approved by Lloyd's Underwriters' Non-Marine Association)

Notwithstanding anything to the contrary contained herein this Policy does not cover loss or damage directly or indirectly occasioned by, happening through or in consequence of war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition or destruction of or damage to property by or under the order of any government or public or local authority.

1/1/38

N.M.A. 464

WAR AND CIVIL WAR EXCLUSION CLAUSE NMA 464 IN RESPECT OF NON-MARINE BUSINESS ONLY

Notwithstanding anything to the contrary contained herein this Reinsurance does not cover loss or damage directly or indirectly occasioned by happening through or in consequence of war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition or destruction of or damage to property by or under the order of any government or public or local authority.

However, it is agreed and understood that this exclusion does not apply to damage (except for damage by nuclear devices and radioactive contamination losses or damage following the release of chemical or biological substances) from or occasioned by detonation of old munitions or parts thereof in or about the vicinity of an insured Risk provided that the presence of such munitions does not result from a state of war current at the time of damage.

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Terrorism/ NBCR Exclusion (Property)

What does it do?	• Terrorism Exclusion: • Specifically excludes an act of terrorism. • Defines terrorism to influence government and put public in fear. • NBCR (Nuclear, Biological, Chemical and Radiological) are seldom/never covered. If terrorism is covered, NBCR is usually excluded in a separate clause. There will be no coverage of damage to insured property when nuclear materials, chemical or biological materials and poisonous or disease causing chemicals or biological materials are released /used in the terrorist attack.
Alternate names	Terrorism Exclusion Endorsement NMA 2921; Radioactive Contamination Exclusion Clause
Why included ?	• Prior to the World Trade Centre attack, standard commercial insurance policies included terrorism coverage as part of the package, effectively free of charge. • Today, terrorism coverage is generally offered separately at a price that more adequately reflects the current risk. • NBCR represents manmade catastrophic events that are viewed to be uninsurable.
Advantage/Risk for counterparty	Terrorism Exclusion • Advantage: Defines and channels the terrorism risk into a structured treaty/pool etc. • Advantage: Makes terrorism risks better assessable and easier to reinsure • Risk: Too little coverage available.
Advantage/Risk for reinsurer	• Advantage: Defines and channels the terrorism risk into a structured treaty/pool etc. • Advantage: Makes terrorism risk better assessable for the reinsurer and limit allocated capital for terrorism. • Risk: Application of terrorism clauses in warlike cases, e.g., Turkey 2016.
Best practice	1. Exclude NBCR in conjunction with terrorism cover.

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Sample: Terrorism / NBCR

Terrorism Exclusion Endorsement NMA 2921:

Notwithstanding any provision to the contrary within this reinsurance or any endorsement thereto it is agreed that this reinsurance excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any act of terrorism regardless of any other cause or event contributing concurrently or in any other sequence to the loss.

For the purpose of this endorsement an act of terrorism means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

This endorsement also excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any action taken in controlling, preventing, suppressing or in any way relating to any act of terrorism. If the Reinsurers allege that by reason of this exclusion, any loss, damage, cost or expense is not covered by this reinsurance the burden of proving the contrary shall be upon the Reassured.

In the event any portion of this endorsement is found to be invalid or unenforceable, the remainder shall remain in full force and effect.

Radioactive Contamination Exclusion Clause

Unless specifically agreed for an insured loss involving nuclear material under determined circumstances, this Agreement does not cover loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss:

a) ionising radiations from or contamination by radioactivity from any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel;
b) the radioactive, toxic, explosive or other hazardous or contaminating properties of any
b) nuclear installation, reactor or other nuclear assembly or nuclear component thereof any weapon or device employing atomic or nuclear fission and/or fusion or other like reaction or radioactive force or matter;
c) the radioactive, toxic, explosive or other hazardous or contaminating properties of any radioactive matter. The exclusion in this sub-clause does not extend to radioactive isotopes, other than nuclear fuel, when such isotopes are being prepared, carried, stored, or used for commercial, agricultural, medical, scientific or other similar peaceful purposes.
d) any chemical, biological, bio-chemical, or electromagnetic weapon

a) Pollution Exclusion b) Pollution Clause (Property)

What does it do?	• The pollution exclusion removes any loss arising from seepage, pollution and contamination. • The Pollution Clause might cover on a sudden and accidental basis contingent resulting from an unexpected (insured?) happening during the period of this contract. • Excludes liability in resulting from gradual pollution, disposal and dumping.
Example of Names	INDUSTRIES, SEEPAGE, POLLUTION AND CONTAMINATION **EXCLUSION** CLAUSE No.4 ; INDUSTRIES, SEEPAGE, POLLUTION AND CONTAMINATION **CLAUSE** – NMA 1685
Why included ?	• Seepage, pollution and contamination insurance could reduce incentive to act responsively (Moral hazard). • Gradual pollution is not a sudden event. Diligent maintenance is a condition. Lack of maintenance and/or gradual damage ("wear and tear") is not an insured peril, the same way as maintaining a home and its content is the duty of the owners.
Advantage/Risk for counterparty	• Advantage: The pollution exclusion is a total exclusion, whereas the pollution clause rules out gradual pollution. • Risk: The pollution clause could trigger discussion about the root cause of a loss.
Advantage/Risk for reinsurer	Same as above: • Advantage: The pollution exclusion is a total exclusion, whereas the pollution clause rules out gradual pollution. • Risk: The pollution clause could trigger discussion about the root cause of a loss.
Best practice	1. Exclude gradual pollution. 2. Cover for sudden events is acceptable.

AXIS

Sample: Pollution Exclusion and Clause

INDUSTRIES, SEEPAGE, POLLUTION AND CONTAMINATION EXCLUSION CLAUSE No.4

This Insurance does not cover any liability for:

1. Personal Injury or Bodily Injury or loss of, damage to or loss of use of property directly or indirectly caused by seepage, pollution or contamination.
2. The cost of removing, nullifying or cleaning-up seeping, polluting or contaminating substances.
3. Fines, penalties, punitive or exemplary damages.

22/1/70
NMA1686

INDUSTRIES, SEEPAGE, POLLUTION AND CONTAMINATION CLAUSE – NMA 1685

This contract does not cover any liability for:

Personal Injury or Bodily Injury or loss of, damage to, or loss of use of property directly or indirectly caused by seepage, pollution or contamination, provided always that this paragraph (1) shall not apply to liability for Personal Injury or Bodily Injury or loss of or physical damage to or destruction of tangible property, or loss or use of such property damaged or destroyed, where such seepage, pollution or contamination is caused by a sudden, unintended and unexpected happening during the period of this Contract.

The cost of removing, nullifying or cleaning-up seeping, polluting or contaminating substances unless the seepage, pollution or contamination is caused by sudden, unintended and unexpected happening during the period of this Contract.

Fines, penalties, punitive or exemplary damages.

This Clause shall not extend this Contract to cover any liability which would not have been covered under this Contract had this Clause not been attached.

Risk and Event Definition

What do they do?	• Defines what constitutes one risk and one loss occurrence. • This constitutes the cession basis reimbursement from the cedent's reinsurance protection. • Per Risk Cover: Reimburses losses sustained for one risk. What constitutes one risk is fundamental for the collection from a per risk treaty. One risk definition is also influential on per event accumulations. • Per Event Cover: Aggregates all losses from a defined event. Typically per event losses picks up losses from the retention of the cedent. If the per risk treaty inures to the benefit of the per event treaty, there is a relief for the per event treaty for that particular risk(s).
Possible Names	Definition of any risk clause, Definition of each risk, Definition of Loss Occurrence Clause
Why included ?	• Define the principle of cession before a loss happens. • Endeavour to create transparency of what constitutes one risk. • Avoid discussions at the time of a loss. However, the strive for upfront clarity is often diminished by "sole judge"-language.
Advantage/Risk for counterparty	• Advantage: The insurer must consider what constitutes one risk at the time of underwriting. This is also related to his maximum capacity considerations, if available. • Risk: Difficult to foresee all possible accumulations to their risk at the time of underwriting. Notable are accumulations from other policies, be it unknown accumulation at one location or discussions around whether CBI-losses from other policies may be added per risk.
Advantage/Risk for reinsurer	• Advantage: Expectation to create transparency of cession before a loss happens. • Risk: The reinsurer is still on the weaker side with respect to what constitutes one risk but defining one risk implies that this demands some considerations upfront, and that the cedents stringent process should apply
Best practice	1. Make sure there is risk and/or loss occurrence definition in the treaty **2. Risk definition** will always leave space for some judgement from the cedent, but we should try to get as much clarity as possible with respect to their definition of risk. 3. In cases where information is too vague or not consistent, we hold down that definition of one risk has to happen at the time of underwriting, not at the time of loss. 4. The Event definition should be based on clear and objective criteria, allowing logical, pre-programmed aggregation of losses.

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Sample: Risk and Event Definition

DEFINITION OF ANY ONE RISK CLAUSE

Any One Risk: Shall be defined as all values at one location including all business interruption and/or time element exposures whether by way of Contingent Business Interruption, Suppliers or Customers extensions.

DEFINITION OF EACH RISK

The Reinsured shall be the sole judge as to what constitutes any one risk.

DEFINITION OF LOSS OCCURRENCE CLAUSE (LPO98A)

The words "loss occurrence" shall mean all individual losses arising out of and directly occasioned by one catastrophe. However, the duration and extent of any "loss occurrence" so defined shall be limited to:

- 72 consecutive hours as regards hurricane, typhoon, windstorm, rainstorm, hailstorm and/or tornado
- 72 consecutive hours as regards earthquake, seaquake, tidal wave and/or volcanic eruption
- 72 consecutive hours and within the limits of one City, Town or Village as regards riots, civil commotions and malicious damage
- 72 consecutive hours as regards any "loss occurrence" which includes individual loss or losses from any of the perils mentioned in (a), (b) and (c) above
- 504 consecutive hours as regards any "loss occurrence" of whatsoever nature which does not include individual loss or losses from any of the perils mentioned in (a), (b) and (c) above

and no individual loss from whatever insured peril, which occurs outside these periods or areas, shall be included in that "Loss Occurrence".

The Reinsured may choose the date and time when any such period of consecutive hours commences and if any catastrophe is of greater duration than the above periods, the Reinsured may divide that catastrophe into two or more "Loss Occurrences", provided no two periods overlap and provided no period commences earlier than the date and time of the happening of the first recorded individual loss to the Reinsured in that catastrophe

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Other standard clause types

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Special Termination

What does it do?	• Defines the situations in which one or both of the parties can bring the Reinsurance contract to an early end. • Defines how that right can be exercised (usually by written notice). • Defines the mechanics of termination (e.g. notice periods, treatment of premium and run-off etc.).
Alternate names	Immediate Termination; Special Cancellation
Why included ?	By agreeing to a reinsurance contract, the parties take risks on each other as well as on the basis risk. Some events (e.g. insolvency of one of the parties, repeated non-compliance, war) change the nature of that risk so much that it is better for the 'innocent' party to have the right to walk away. The clause sets out that right, and how it works. It also provides other protections to the Reinsured if the Reinsurer goes into run-off.
Advantage/Risk for counterparty	• Advantage: manages credit and cooperation risk for a Reinsurer that has become unreliable • Advantage: allows the Reinsured to seek replacement security • Risk: if the clause is bilateral, a Reinsured experiencing difficulties can find their reinsurers exiting the program, potentially hastening demise.
Advantage/Risk for reinsurer	• Advantage: allows it not to expose itself further and deeper to a Reinsured that continues to write business and to pay claims, despite the various proofs of changed circumstances. • Advantage: allows the Reinsurer to calculate the debt it is owed by the Reinsured, to make a claim against the liquidator (if relevant) • Risk: depending on the consequences of termination (e.g. loss of business, repayment of unearned premium, need to post collateral or to pay commutation amount) can lead to treasury strain, potentially hastening demise.
Best practice	1. Where Reinsurer downgrading is a trigger to Special Termination, ensure that the downgrading is to less than A-. 2. Ensure that there are no special consequences to Special Termination, such as the need to post collateral or to enter a 'forced' commutation process. The consequences of this have been disastrous for some companies when accumulated across the portfolio.

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Sample: Special Termination

Notwithstanding the provisions of paragraph A above, the Company may terminate a Subscribing Reinsurer's percentage share in this Contract at any time by giving written notice to the Subscribing Reinsurer in the event any of the following circumstances occur:

1. Either the Subscribing Reinsurer's or the Subscribing Reinsurer's group or holding company's policyholders' surplus (or its equivalent under the Subscribing Reinsurer's or the Subscribing Reinsurer's group or holding company's accounting system) at any time during the Term of This Contract has been reduced by 20.0% or more of the amount of surplus (or the applicable equivalent) 12 months prior to that date;
2. Either the Subscribing Reinsurer's or the Subscribing Reinsurer's group or holding company's policyholders' surplus (or its equivalent under the Subscribing Reinsurer's or the Subscribing Reinsurer's group or holding company's accounting system) at any time during the Term of this Contract has been reduced by 20.0% or more of the amount of surplus (or the applicable equivalent) at the date of the Subscribing Reinsurer's or the Subscribing Reinsurer's group or holding company's most recent financial statement available to the public as of the inception of this Contract;
3. The Subscribing Reinsurer's A.M. Best's or S&P Global Ratings' financial strength rating has been assigned or downgraded below the rating it had at the inception of this agreement;
4. The Subscribing Reinsurer has become, or has entered into a definitive agreement to become, merged with, acquired by or controlled by any other entity or individual(s) not controlling the Subscribing Reinsurer's operations at the inception of this Contract;
5. A State Insurance Department or other legal authority has ordered the Subscribing Reinsurer to cease writing business;
6. The Subscribing Reinsurer has become insolvent or has been placed into liquidation, receivership, supervision, administration, winding-up or under a scheme of arrangement, or similar proceeding (whether voluntary or involuntary) or proceedings have been instituted against the Subscribing Reinsurer for the appointment of a receiver, liquidator, rehabilitator, supervisor, administrator, conservator or trustee in bankruptcy, or other agent known by whatever name, to take possession of its assets or control of its operations;
7. The Subscribing Reinsurer has reinsured its entire liability under this Contract without the Company's prior written consent;
8. The Subscribing Reinsurer has ceased assuming new or renewal property or casualty treaty reinsurance business;
9. The Subscribing Reinsurer has transferred its claims-paying authority to an unaffiliated entity; or
10. The Subscribing Reinsurer has failed to comply with the funding requirements set forth in the Funding Article; or
11. There is a severance or obstruction of free and unfettered communication and/or normal commercial and/or financial intercourse between the United States of America and the country in which the Subscribing Reinsurer is incorporated or has its principal office, as a result of war, currency regulations or any circumstances arising out of political, financial or economic uncertainty; or
12. The Subscribing Reinsurer utilizes a regulatorily-permitted novation or a regulatorily-permitted commutation without the Company's consent.

A Subscribing Reinsurer that is rated below A+ by S&P Global Ratings' financial strength rating at the effective time and date of this Contract and experiences one or more of the circumstances set forth above shall also hereinafter be referred to as a "Qualified Reinsurer."

D. Unless the Company elects that the Reinsurer shall have no liability for losses arising out of Occurrences commencing or claims made at or after the effective time and date of termination or expiration (except for extended reporting coverage attaching to Policies
that expired prior to the effective time and date of expiration), reassumes the ceded unearned premium in force at the effective time and date of termination or expiration, and so notifies the Reinsurer prior to the effective time and date of termination or expiration (hereinafter "Cut-off Basis"), reinsurance hereunder on Policies in force at the effective time and date of termination or expiration shall remain in full force and effect until expiration, cancellation or next premium anniversary of such business, whichever first occurs.

E. The Company shall have the option to commute a Qualified Reinsurer's liability under this Contract. In the event the Company and the Qualified Reinsurer cannot agree on the commutation amount, they shall appoint an independent actuary that is a Fellow of the Casualty Actuarial Society to assess such amount and shall share equally any expense of the actuary. If the Company and the Qualified Reinsurer cannot agree on an actuary, the Company and the Qualified Reinsurer shall each appoint one individual of such qualifications, the two so appointed will choose a third actuary of such qualifications. If a third actuary or appraiser cannot be agreed, an arbitrator shall be chosen by the Company and the Qualified Reinsurer and the expense of such arbitrator shall be equally shared. Any amount determined by such actuary or appraiser shall be final and binding. Payment by the Qualified Reinsurer of the amount of liability ascertained shall constitute a complete and final release of both parties in respect of liability arising from the Qualified Reinsurer's participation under this Contract. The Company's option to require commutation under this Article shall survive the termination or expiration of this Contract.

F. Notwithstanding the provisions of paragraph D above, in the event that any Policy subject to this Contract is required by statute, regulation or by order of an insurance department to be continued in force, the Reinsurer, at the option of the Company, agrees to extend reinsurance coverage hereunder with respect to such Policy until such Policy may be canceled or non-renewed by the Company.

Cut Through

What does it do?	Allows a third party to claim under the reinsurance contract.
Alternate names	Direct Proceeds Loss Payee Alternate Payee
Why included ?	Reinsureds or their stakeholders sometimes want Reinsurers to pay to someone else, either for administrative efficiency or (more like) to avoid taking credit risk on the Reinsured. In this way it is often used to pay the lenders in infrastructure projects, or to pay Managing Agents who are using the Reinsured's paper.
Advantage/Risk for counterparty	Satisfies lenders or Managing Agents.
Advantage/Risk for reinsurer	Creates a credit risk. A reinsurer agreeing to pay certain claims monies or premium refunds to a third party may be deemed, in the event of Reinsured insolvency, to have created a preference for the third party it has paid to. The liquidator or insolvency practitioner could then turn back to the Reinsurer for payment to the estate, for the money to be redistributed to ordinary creditors. In that way the Reinsurer is exposing itself to double payment risk – payment once to the beneficiary of the Cut Through clause, and a second time to the liquidator of the Reinsured.
Best practice	Avoid clauses which go in this direction – under no circumstances do we need a Cut Through 'exclusion'. Where the Reinsurance contract does not contain a specific provision on this topic, that is ideal. Referrals are attached to contracts containing such clauses.

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Sample: Cut Through

A. This Article shall be subject to policies, certificates, contracts, binders, agreements or other proposals or evidences of insurance, new and renewal policies, binders, and contracts of insurance issued by or on
behalf of Markel Insurance Company, State National Insurance Company, Inc. and United Specialty Insurance Company (collectively, "Markel") on behalf of the Company (the "Markel Business").

B. To the extent that Markel becomes obligated to make payment on any Markel Business, Markel shall be substituted for the Company as payee of any reinsurance recoverable hereunder in respect of such payment, and the Reinsurer, upon notice from Markel shall make payment thereof directly to Markel in lieu of payment to the Company, or its liquidator, receiver, or statutory successor.

C. In the event that the Reinsurer makes payment to Markel instead of the Company, or its liquidator, receiver, or statutory successor, in accordance with Paragraph B of this Article, the Reinsurer shall be credited with any amount equal to such payment and shall be relieved of its corresponding responsibility and liability to the Company, or its liquidator, receiver, or statutory successor under the Insolvency Article herein for the amount of such payment for any sum or sums owed or owing under this Contract, as such payment, by the Reinsurer to Markel shall be, to the extent of said payment, in substitution, satisfaction and discharge of the Reinsurer's obligation to the Company. In no event shall the Reinsurer be subject to duplicate liability to the Company, or its liquidator, receiver, or statutory successor.

D. In the event that the Reinsurer is required to post collateral pursuant to the Unauthorized Reinsurance Article with respect to any Markel Business, Markel shall be substituted for the Company for purposes of the Unauthorized Reinsurance Article, and the Reinsurer shall post such collateral directly to Markel.

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Loss Settlements

What does it do?	Delegates claims handling to the Reinsured and establishes the limits of that delegation, if any.
Alternate names	Follow the Settlements Claims Cooperation Claims, Losses and Loss Expense
Why included ?	Without such a clause, the Reinsured has to prove each of its individual losses to the Reinsurer, which can be administratively cumbersome for both parties.
Advantage/Risk for counterparty	- Avoids it having to prove for each loss. - Where there are no, or few limits to the delegation of claims authority, allows the Reinsured freedom to settle claims and cede them to the Reinsurer.
Advantage/Risk for reinsurer	- Where the freedom is too broad, can lead to automatic coverage of non-covered primary losses (so-called ex gratia payments). - Can create a healthy triage between the 'flow' cases and the more important ones where the Reinsurer would like some oversight. - According to some legal systems, if it is too broad it can imply that the Reinsurer is acting as Insurer, creating licensing problems and allowing claims by the Policyholder directly against the Reinsurer, e.g. for ECO/XPL.
Best practice	- AXIS Re's preference is to make decisions with respect to claims coverage and settlements and would prefer not to be bound by the decision of the Lead and/or majority of the Reinsurers on the placement (eg LMA 9150 – Single Claims Agreement Party Arrangements). Any deviation from this preference needs to be referred. - Avoid "unconditional " language and automatic coverage of ex gratia claims by including an ex gratia exclusion OR using language like 'if covered by the terms of the Policy as well as of this Reinsurance contract'. - Amounts due to the Reinsured have actually been paid. - Retain claims handling influence where AXIS has a significant share (i.e. >10%) and/or a significant amount of exposed capacity (i.e. >20m MPL). - Avoid full claims control in most cases.

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Sample: Follow Settlements

EXAMPLE 1: The Company shall investigate and settle or defend all claims and losses, including those involving the extension of credit or the advancement of money. All payment of claims, losses, or loss adjustment expenses by the Company, within the amount of reinsurance set forth in the RETENTION AND LIMIT and EXTRA CONTRACTUAL OBLIGATIONS ARTICLES, shall be binding on the Reinsurer, subject to the terms of this Contract. If the Company becomes insolvent, the liability of the Reinsurer shall be modified to the extent set forth in the INSOLVENCY ARTICLE.

EXAMPLE 2: Notwithstanding the Proof of Loss provision above, at the request of the Company the Reinsurer shall pay any amount with regard to a loss settlement or settlements hereunder which are scheduled to be paid by the Company within twenty business days, provided that the Company shall support its request for payment with confirmation that a loss report has been received and a declaration that payment will be made. The Reinsurer will make payment of the sum so requested within ten business days of receipt by it of the request supported by the required confirmation and declaration subject always to such scheduled payments falling within the terms and conditions of this Agreement.

Collateral

What does it do?	Obliges the Reinsurer to set aside secured funds which are earmarked for a specific transaction, such as a reinsurance treaty. This can be done in various ways, e.g. by pledging assets to the Reinsured, or putting cash into an escrow account. The obligation is driven by market norms, and the exact nature of the obligation on the Reinsurer depends on the requirements of the agreed clause.
Alternate names	Funds Withheld; Security; Unauthorized Reinsurance.
Why included ?	Protects credit exposure of the Reinsured against the risk of Reinsurer default, particularly where the Reinsurer is insolvent or bankrupt. In some countries, Regulators do not allow Reinsureds to take full credit for their reinsurance if collateral is not provided. Taking credit for reinsurance (i.e. reducing the capital which Reinsureds must set aside for the risk/portfolio) is a key benefit of reinsurance. Some regulators allow no credit for reinsurance if there is no collateral, others insist on a 'haircut', being a reduction in credit for reinsurance. In most US States, for example, a Reinsured cannot take full credit for reinsurance from a non-domiciled or 'Unauthorized Reinsurer' unless collateral is secured.
Advantage/Risk for counterparty	1.Ensures that if the Reinsurer does not pay (e.g. because it is insolvent) the Reinsured has direct access to the Reinsurer's part of the claims burden from the collateral it has access to, without needing to wait for a liquidation or other tutelary process to be completed (timing risk). 2.Avoids the Reinsured having to rank as an 'ordinary creditor' in a liquidation and seeing a reduction in its recoveries (quantum risk). 3.Where the collateral takes the form of withheld premium, provides the Reinsured with a 'fighting fund' out of which it can pay claims.
Advantage/Risk for reinsurer	1.Blocks assets: Limits a Reinsurer's freedom to deal with the collateralized assets as it wishes to (e.g. by investing them as it wishes to). When cash is set aside, it deprives the Reinsurer of the 'time value of money'. 2.Administrative cost and burden: Setting up a collateral fund has an associated cost for the Reinsurer which reduces the technical margin, above and beyond the opportunity cost described above. Some clauses allow freedom for the Reinsured to select its preferred form of collateral, so if the Reinsured changes its mind during the course of the agreement, the administrative fees are doubled. The cost of a Letter of Credit varies over time, but always amounts to a percentage of the committed funds, which can be expensive. 3.Credit risk: If the Reinsured goes into liquidation, the amounts pledged as collateral may exceed the eventual claims burden, resulting in a credit for the Reinsurers. Typically, the Reinsurer will only retrieve a part of that excess since it ranks as an 'ordinary creditor' of the Reinsured. In these situations the Reinsurer would effectively have paid more than the technical loss. 4.Liquidity spirals: Can hasten the downfall of a Reinsurer in financial difficulty. Some clauses provide that collateral is only required in response to an event like a downgrading – this is referred to as 'contingent collateral'. If a Reinsurer has agreed to provide contingent collateral on multiple contracts and is suddenly downgraded, it may be asked to find a lot of cash or other funds at the worst time possible.
Best practice	1.Agree collateral clauses if required by Regulation, or if it is a precondition to market entry. 2.Resist voluntary collateral (i.e. collateral not provided because of Regulatory or market norms). 3.Where possible, insist on clauses that provide the most freedom for the Reinsurer to choose the form of collateral it sets aside. 4.Avoid posting collateral for IBNRs. 5.Do not post collateral to parties other than the Reinsured (see Cut Through).

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Sample: Collateral

EXAMPLE 1: This Condition will apply only to a Reinsurer for which the Company or any of its cedants on Policies reinsured hereunder would incur a financial statement penalty for all or any portion of the reinsurance ceded to such Reinsurer under the rules of the jurisdiction authorised to regulate each entity comprising the Company or its cedants. With respect to Policies issued by the Company coming within the scope of this Agreement, the Company agrees that when it files with the insurance department or sets up on its books reserves for loss, Loss Expenses and unearned premiums ceded hereunder which it is required to set up by law, it will forward to the Reinsurer a statement showing the proportion of such loss, Loss Expenses and unearned premium reserves which is applicable to the Reinsurer. The Reinsurer shall (1) apply for and secure delivery of a Letter of Credit on the terms and conditions set forth herein, (2) enter into a Trust Agreement on the terms and conditions set forth herein, or (3) secure its Obligations under applicable laws and regulations via any other method permitted under the credit for reinsurance law of the state of domicile of the Company, as determined by the Company. Any method of collateralizing such Reinsurer’s Obligations hereunder shall comply with the applicable state’s law to enable the Company to take reserve credit for the reinsurance ceded hereunder. The Reinsurer shall be responsible for any fees, costs, or expenses incurred in connection with collateralizing its Obligations as set forth in this Condition.

French Market: Le Réassureur s’engage à constituer une garantie au bénéfice de la Cédante au titre des sinistres en suspens qui affectent le présent traité. A la fin de chaque exercice, la Cédante fournit au Réassureur une liste des sinistres en suspens indiquant le montant à hauteur duquel la garantie doit être constituée. Le Réassureur s’engage à ce titre à ajuster à tout moment en cours d’année sa garantie, afin qu’elle constitue le parfait reflet du montant actualisé des sinistres en suspens de la Cédante. La garantie devra être constituée au plus tard dans les 15 jours suivant la demande de la Cédante. Le Réassureur constituera sa garantie sous forme de nantissement de comptes-titres, une « déclaration de nantissement de compte de titres financiers » soumise aux dispositions du code monétaire et financier français sera régularisée d’un commun accord entre les parties. L’obligation du Réassureur de fournir une telle garantie est maintenue jusqu’à ce que la Cédante confirme que les obligations incombant au Réassureur aux termes du présent traité sont définitivement satisfaites. La garantie ainsi constituée est soumise au droit français.

Right of Information/ Access to Records

What does it do?	Gives the reinsurer the right to inspect documents relevant to the covered business. There is always a misalignment of information between Reinsurer and Reinsured as to risks, claims and accounting. In the event of any controversy between the parties it is important for the reinsurer to have access to all relevant documentation, by means of a physical inspection.
Alternate names	Inspection of Records
Why included ?	Evens out – to a certain extent – the considerable information advantage which the Reinsured has over the Reinsurer Re by allowing the Reinsurer to check 'with its own eyes'. .
Advantage/Risk for counterparty	None.
Advantage/Risk for reinsurer	Allows the Reinsurer to investigate and comment on claims and operations which it has reason to believe are suboptimal.
Best practice	- Always include this clause in the wording. - Avoid broad carve-outs of 'privileged documents' where the Reinsured is sole judge of what is privileged and what is not: privilege is a legal question, not a question of opinion. - Allow inspection by authorized representatives of Reinsurer as well as Reinsurer. - Avoid requirement on Reinsurer to provide Reinsured with report after inspection. - No limitation of right after termination.

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Notification of Claims

What does it do?	Allows the Reinsurer to have information about claims which are or may be particularly large or of a certain type.
Alternate names	Claims Notification; Loss Notification; Loss Reporting.
Why included ?	Allows the Reinsurer to assess reserves and to decide whether or not it needs to be involved in the more important claims, per the claims handling/ claims control article.
Advantage/Risk for counterparty	- A Reinsurer may give value as an active participant in claims handling. Generally, Reinsurers have a more global view of some claims topics.
Advantage/Risk for reinsurer	- Risk: Excess notifications. - Risk: If clause is missing, there will be blind spots and reserving will be a less accurate process.
Best practice	- Include a clause in every treaty. - Cover the following items in the clause: • Timing of notice requirement • Type/estimated amount of claims to be notified (different for Motor/ Casualty from other lines) • Form of notice • Contents of notice • Treatment of Privileged and Confidential information • Continuing reporting duties after initial notification

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Follow Fortunes

What does it do?	• Obliges the Reinsurer to follow the technical reinsurance fortunes of the Reinsured.
Alternate names	None
Why included ?	Reminds the parties – specifically in Proportional reinsurance – of the spirit of a reinsurance contract, whose purpose is to compensate the Reinsured whatever fate befalls the risk.
Advantage/Risk for counterparty	• Non-US: ensures that the reinsurer takes its part in the fate of the risk (e.g. in the case of unexpected court decisions or legal changes). • US: limits Reinsurer's right to challenge the decisions of the Reinsured.
Advantage/Risk for reinsurer	• Ambiguous outside of Proportional Reinsurance. • Judicially unstable, with courts over the years using it in various ways to achieve what they view as a desirable result. • US: limits Reinsurer's right to challenge the decisions of the Reinsured.
Best practice	1. Except in US, do not mix separate concepts of Follow Fortunes and Follow Settlements. 2. Avoid language that requires «unconditional» following.

AXIS

Sample: Follow Fortunes

Reinsurer's liability shall attach as of the Effective Date and commence obligatorily and simultaneously with that of Everspan under the Policies. Subject to the terms and conditions of this Reinsurance Agreement, all reinsurance for which Reinsurer shall be liable by virtue of this Reinsurance Agreement shall be subject, in all respects, to the same rates, terms, conditions, interpretations, assessments, waivers, and premium adjustments, and to the same modifications, alterations, and cancellations applicable or deemed applicable to the Policies, as the Covered Liabilities, the true intent of this Reinsurance Agreement being that Reinsurer will, in every case to which this Reinsurance Agreement applies, follow Everspan's fortunes, and Reinsurer shall be bound, without limitation, by all payments and settlements entered into by or on behalf of Everspan.

Interlocking

What does it do?	• Where a loss event causes losses in two or more sections of the same treaty, or in policies covering two or more years of account of a Risks Attaching treaty, an interlocking clause ensures fair allocation of the losses from the event to the various sections and treaties • , taking into account the retentions and limits of the affected sections or • inuring effect of reinsurance contracts applying on a Losses Occurring During basis to a reinsurance contract writen on a UW year or «Risks Attaching» basis.
Alternate names	None
Why included ?	Contained in Non-Proportional covers only Risks Attaching covers, it proposes a methodology to allow the reinsured to apportion its retention across two or more reinsurance agreement periods, i.e., when one loss affects policies assigned to different reinsurance periods, so that the company will have one retention and one recovery for the loss involving the two reinsurance periods.
Advantage/Risk for counterparty	
Advantage/Risk for reinsurer	
Best practice	

AXIS

Sample: Interlocking

- TRADE CREDIT: Notwithstanding anything contained herein to the contrary in the event of the Reinsured being involved in a loss on one risk under two or more policies and/or Agreements issued in the period covered herein and other periods, then it is understood that, at the option of the Reinsured, the amount of the excess to be retained by the Reinsured under this Agreement in respect of that risk shall be reduced to the percentage of the excess which the Reinsured's settled losses from those policies and/or Agreements issued in the period covered hereon bears to the total of the Reinsured's settled losses arising out of all policies and/or Agreements from that risk contributing to the loss. The Indemnity and/or Recovery hereunder shall likewise be arrived at in the same manner.

MOTOR OWN DAMAGE XoL

INTERLOCKING

In the event of the Reinsured being involved in a loss under two or more Policies which incept in different periods of reinsurance, then it is understood and agreed that the amount of the excess to be retained by the Reinsured in respect of such loss shall be reduced to that percentage of the excess which the Reinsured's settled losses on the Policies incepting during the period of reinsurance bears to the total of the Reinsured's settled losses arising out of all Policies contributing to the Loss Occurrence. The Limit and Deductible hereunder shall be arrived at in the same manner.

Interlocking Clause

Notwithstanding anything contained herein to the contrary in the event of the Reinsured being involved in a loss on one risk or Obligor under two or more policies and/or Agreements issued in the period covered herein and other periods, then it is understood that, at the option of the Reinsured, the amount of the excess to be retained by the Reinsured under this Agreement in respect of that risk or Obligor shall be reduced to the percentage of the excess which the Reinsured's settled losses from those policies and/or Agreements issued in the period covered hereon bears to the total of the Reinsured's settled losses arising out of all policies and/or Agreements from that risk contributing to the loss. The Indemnity and/or Recovery hereunder shall likewise be arrived at in the same manner.

Q & A

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Section Eight

“Exotic” Coverages

Richard S. Pitts
Vice-President and General Counsel
Arlington/Roe & Co., Inc.
Indianapolis, Indiana

Section Eight

“Exotic” Coverages………………………………………………..... Richard S. Pitts

PowerPoint Presentation

“Exotic” Coverages

Insurance for Non-Insurance Lawyers

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Three Coverages

Products Recall

Active Assailant

Political Risk Insurance

A Side Note: The Excess and Surplus Lines Market

"Excess & Surplus" is a class of insurance designed generally for large, unusual and difficult to place insurance risks.

E&S market frequently has coverage capacities above or beyond the admitted market.

Simpson, Van Buren and Stephan, *Surplus Lines Fundamentals* (2009)

Products Recall

Why Talk About Product Recall?

Product	Date	Agency
Strollers	Nov. 10, 2022	CPSC
Mini Crumb Cakes	Nov. 14, 2022	FDA / Voluntary
Generators	Nov. 10, 2022	CPSC
Hand Sanitizer	Nov. 7, 2022	FDA
Frozen Beef	Nov. 9, 2022	USDA
Vehicle Running Lights	Nov. 11, 2022	NHTSA / Voluntary

The CGL and Products Recall:

According to FC&S:

"It was in 1966 that insurance companies began to add to the standard form CGL liability policy exclusions such as the sistership exclusion, which sought to eliminate coverage for activities insurance professionals believed to be **risks of developing and marketing a product**."

The CGL and Products Recall:

“Sistership” is believed to be derived from a historical accident in the airplane industry…

…in which a plane crashed and its “sister ships” were grounded to fix the common defect that had caused the crash.

The CGL and Products Recall:

Exclusion (n) in the ISO CGL carves out:

"[d]amages claimed for any loss, cost or expense incurred by you or others for the loss of use, withdrawal, recall, inspection, repair, replacement, adjustment, removal or disposal of" the named insured's ‘product,’ ‘work’ or ‘impaired property’…

The CGL and Products Recall:

Exclusion (n) continued:

"if such product, work, or property is **withdrawn or recalled** from the market or from use **by any person or organization** because of a known or suspected defect, deficiency, inadequacy or dangerous condition in it."

The CGL and Products Recall:

- The language of “withdrawn or recalled” and the language of “by any person or organization” are both significant.
- The “withdrawn or recalled” is generally construed as a limitation on the exclusion, while
- The “by any person or organization” is a broadening of the exclusion.

The CGL and Products Recall:

<u>As to "withdrawn or recalled," according to FC&S</u>:

"Typically, the exclusion bars coverage for the cost incurred when a product is recalled due to a known or suspected defect or deficiency that may cause injury or damage; and it applies only to **costs incurred in order to prevent future damage/injury, not to damage/injury that has already taken place…"**

The CGL and Products Recall:

As to “withdrawn or recalled,” according to FC&S:

“If the exclusion is applicable, it does not eliminate coverage for all damage incurred because of the need to replace a product. Rather, it eliminates coverage only for damages incurred for the replacement.”

The CGL and Products Recall:

As to "by any person or organization":

- The language dates from 1986 and
- Is designed to combat court cases that held the exclusion applicable only to situations in which the insured recalled or withdrew the product, because
- Courts have been generally hostile to a broad reading of the exclusion.

Moving Toward a Solution:

Prior to 2004, endorsements were available in the ISO family

These were limited in coverage, even though they were broader than their predecessors.

In 2004, ISO created a stand-alone form for products recall coverage.

The form currently is the ISO CG 00 66 04 13.

Moving Toward a Solution:

According to FC&S:

- Coverage grants and forms vary tremendously among insurers.
- Coverage is expensive
- Companies are reluctant to buy it, but should consider:
  - Size
  - Financial resources
  - Are they high profile
  - The likelihood of tampering or contamination
  - Confidence levels in internal research and development

The ISO CG 00 66 04 13:

Insuring Clause (A):

"We will reimburse you for 'product withdrawal expenses' incurred by you because of a 'product withdrawal' …

Insuring Clause (B):

"We will pay those sums that the insured becomes legally obligated to pay as damages for 'product withdrawal expenses' incurred because of a 'product withdrawal' …

The ISO CG 00 66 04 13:

"**Product withdrawal**" means the recall or withdrawal:

a. From the market; or

b. From use by any other person or organization;

of "your products", or products which contain "your products", because of known or suspected "defects" in "your product", or known or suspected "product tampering", **which has caused or is reasonably expected to cause "bodily injury" or physical injury to tangible property** other than "your product".

The ISO CG 00 66 04 13:

"Product withdrawal expenses" means

a. Cost of replacing "your product", repairing the "defect" in "your product" or repurchasing "your product" for your initial purchase price, whichever is less;

b. Costs of notification;

c. Costs of stationery, envelopes, production of announcements and postage or facsimiles;

d. Costs of overtime paid to regular non-salaried employees and costs incurred by such employees, including costs of transportation and accommodations;

The ISO CG 00 66 04 13:

"Product withdrawal expenses" means

e. Costs of computer time;

f. Costs of hiring independent contractors and other temporary employees;

g. Costs of transportation, shipping or packaging;

h. Costs of warehouse or storage space; or

i. Costs of proper disposal of "your products", or products that contain "your products", that can not be reused, not exceeding your initial purchase price or your cost to produce the products.

The ISO CG 00 66 04 13:

Conditions to Coverage A:

This insurance applies to a "product withdrawal" only if the "product withdrawal" is initiated in the "coverage territory" during the policy period because:

(1) You determine that the "product withdrawal" is necessary; or

(2) An authorized government entity has ordered you to conduct a "product withdrawal"…

The ISO CG 00 66 04 13:

Conditions to Coverage A:

c. We will reimburse "product withdrawal expenses" only if:

(1) The expenses are incurred within one year of the date the "product withdrawal" was initiated;

(2) The expenses are reported to us within one year of the date the expenses were incurred; and

(3) The product that is the subject of the "product withdrawal" was produced after the Cut-Off Date designated in the Declarations.

The ISO CG 00 66 04 13:

Supplemental Payments under Coverage B:

We will pay, with respect to any claim we investigate or settle, or any "suit" against an insured we defend:

1. All expenses we incur.

2. All reasonable expenses incurred by the insured at our request to assist us in the investigation or defense of the claim or "suit", including actual loss of earnings up to $250 a day because of time off from work.

3. All court costs …

4. Prejudgment interest…

5. [Post judgment interest]

These payments will not reduce the limits of insurance.

The ISO CG 00 66 04 13:

Both Coverage A and Coverage B exclude:

1. Breach of Warranty
2. Infringement of Copyright
3. Deterioration or Decomposition
4. Costs of Regaining Goodwill or Market Share
5. Expiration of Shelf Life
6. Known defect
7. Governmental Ban

The ISO CG 00 66 04 13:

Coverage A only exclusions:

1. Defense of Claims
2. Third Party Damages
3. Pollution

Coverage B only exclusions:

1. Intercompany suits
2. Contractual Liability
3. Pollution AND pollution-related loss
4. War
5. Loss of Use

Active Assailant

What is a “Mass Shooting?”

The Gun Violence Archive, which tracks every mass shooting incident in the country, defines a mass shooting as any incident in which at least 4 people are shot, excluding the shooter.

In 2019, there were more mass shootings than days of the year.

Source: CBS News

GVA
GUN VIOLENCE ARCHIVE
MASS SHOOTINGS IN 2022
Ottawa
New York
Washington
United States
Phoenix
Los Angeles
México
The Bahamas
January 1 - November 15, 2022
gunviolencearchive.org

The Basic Liability Premise:

P.M. Lambert of Pessin Katz writes:

"More than seventy-five percent (75%) of individuals who participated in mass violence exhibited signs beforehand. According to reports, statistics have shown that more than seventy-five percent of the perpetrators had, before the attack, made concerning statements or exhibited risky behavior."

Liability For Mass Shootings: Coverage Issues

The Basic Liability Premise:

P.M. Lambert of Pessin Katz writes:

"Once a threat is identified, prevention or risk reduction protocols can be employed. If the venue does not have identification or prevention protocols in place, there is a greater possibility that the venue, business/employer, school board, etc. will be held liable for its failure to protect people from injuries that were deemed '**reasonably foreseeable**.'"

Existing Coverage Questions

A reminder on the CGL:

Sec. 1 – Coverages

- Coverage A – bodily injury and property damage
- Coverage B – personal and advertising injury
- Coverage C – Medical Payments

Sec. 2 – Who is an insured?

Sec. 3 – Limits of Insurance

Sec. 4 – Conditions

Sec. 5 – Definitions

Existing Coverage Questions

Structure of the CGL:

The CGL insuring clause (Coverage A) reads:

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 any "suit" seeking those damages….

Existing Coverage Questions

The Insuring Clause Continues:

"This insurance applies to 'bodily injury' and 'property damage' only if the 'bodily injury' or 'property damage' is **caused by an 'occurrence'** that takes place in the 'coverage territory…'"

An "occurrence" is:

"**[A]n accident**, including continuous or repeated exposure to substantially the same general harmful conditions."

(Side Notes on “Occurrence”)

1. Two police officers seek to obtain a peaceful surrender
2. The shooter hits one officer; one minute later, hits both officers with a second shot; and then 45 seconds later, hits the second officer a second time
3. Is there one occurrence? Two? Three?
4. Carrier said “one;” claimants say “three”

(Side Notes on "Occurrence")

5. Carrier said "insanity" was the one cause
6. Claimants say the shotgun blasts were the cause
7. Court says that it is true the acts would have been intentional and not covered except for the insanity, but
8. There were multiple causes – and NOT a single, uninterrupted continuous cause.
9. **Three occurrences.**

American Indemn. Co. v. McQuaig, 435 So. 2d 414 (Fla. App. 1983)

Existing Coverage Questions

Defense and Limits Relationship

The amount we will pay for damages is limited as described in Section III - Limits Of Insurance and **our right and duty to defend ends when we have used up the applicable limit of insurance** in the payment of judgments or settlements under Coverages A or B or medical expenses under Coverage C…

Existing Coverage Questions

Exclusions Which Might Be at Issue

2(a) – Expected or Intended Injury

2(b) – Contractual Liability

2(d) – Workers' Comp

2(e) – Employer's Liability

2(i) – War

"Bodily injury" or "property damage", however caused, arising, directly or indirectly, out of [war, including]

Warlike action by a military force, including action in hindering or defending against an actual or expected attack, by any government, sovereign or other authority using military personnel or other agents…

Existing Coverage Questions

CG 21 90 01 06 EXCLUSION OF TERRORISM

"Terrorism" is violence with an intent to intimidate, coerce, disrupt, or, a furtherance of ideology

Among others conditions, the exclusion is applicable if an insured suffers:

1. $25,000,000 in property loss or
2. "**Fifty or more** persons sustain death or serious physical injury"

AM BEST SAYS

"Targeted, new insurance solutions are helping these entities develop programs to help protect against and recover from unpredictable and shocking occurrences. Specialized, named-perils active assailant policies are helping…

"In the past, named-perils policies have similarly been developed to help provide protection against storm risk, employment practices liability, and cyber events."

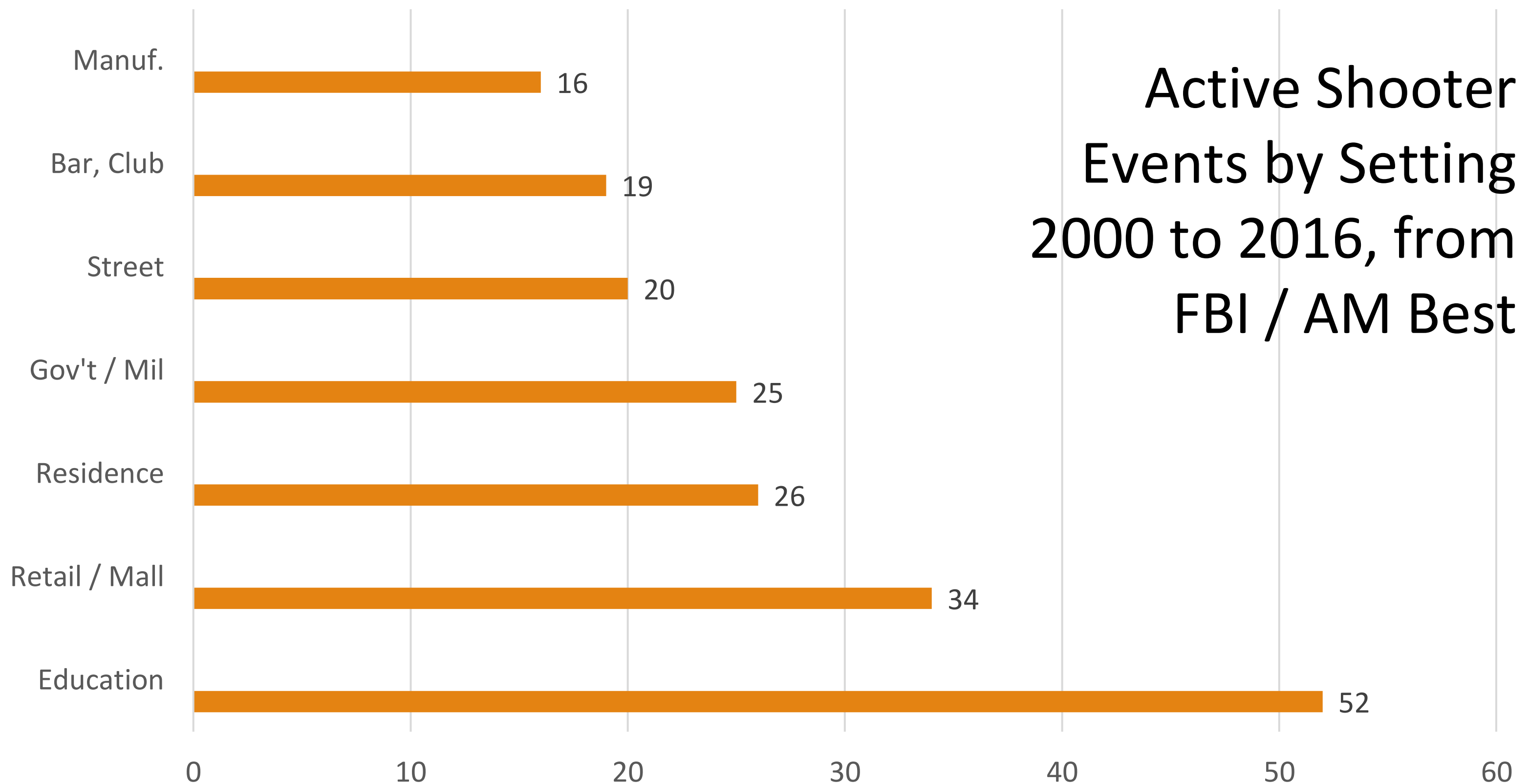
What Are We Seeking to Cover?

"The associated costs will go well beyond General Liability and will often include Business Interruption, Workers Compensation, Brand Impairment and potential lawsuits…"

"All of these issues are coming at the Insured at a time of significant physical and emotional trauma."

Jim Eades of Arlington/Roe in *IIA of IL e-Insight*

Who Should Consider It?



Can We Afford It?

"Fortunately for consumers, more carriers are entering the marketplace and the increased competition seems to be resulting in lower minimum premiums than we saw just a couple of years ago. As time goes on, the availability of better actuarial data should help to focus underwriting and pricing criteria for this coverage."

Angela Cale, CIC, Senior Broker,

Donald Gaddis Co., Inc.

Why Active "Assailant"?

Disagreement in a casino

A disagreement over a card game at a casino results in one of the players drawing a gun and firing at their opponent with bystanders being hit by stray shots.

Syringe rage in a shopping mall

A homeless drug addict who takes exception to being moved on by security personnel in a shopping mall reacts by using a used syringe to attack families passing by.

Why Active "Assailant"?

Acid attack in a bar

A jealous woman throws acid at her ex-boyfriend and new partner on the crowded dance floor of a nightclub soaking those around in the process.

Disgruntled ex-employee

Having been sacked the previous day, a humiliated administrative worker returns to the office brandishing a hunting knife and, in front of his former colleagues, screams a stream of threats at the supervisor.

Why Active "Assailant"?

Automobile rampage at a school

A former pupil who had been bullied while at high school seeks revenge by driving a car at a group of students one morning as they arrive for the start of classes.

beazley

Available Coverages:

Physical damage coverage

"Insureds can get indemnity for physical loss or damage to insured property caused by an active shooter / workplace violence incident. This might include expenses incurred during structural security upgrades along with **building closure, relocation or teardown**."

Insurance Business America, *"What is active shooter insurance coverage?"* by Bethan Moorcraft (12/14/18)

Sample Language of the Coverage:

"[We will]additionally insure the Named Insured against physical loss or physical damage to Insured Property caused by a Deadly Weapon Event, as defined by the Deadly Weapon Protection Policy, occurring at the Location(s) of the Named Insured. In the event that fire or sprinkler leakage ensues from a Deadly Weapon Event, then this Endorsement will also insure physical loss or physical damage to Insured Property caused by that ensuing fire or sprinkler leakage."

Available Coverages:

Legal liability / litigation

"Insureds are legally obligated to pay for certain damages and claim expenses that arise from an active shooter / workplace violence incident. Organizations today are being held to a higher standard of accountability…."

Moorcraft

Available Coverages:

Crisis management

"Insurance carriers will indemnify the insured for specialist crisis response and consultant fees resulting solely and directly from an active shooter or threat event. This might include helping insureds deal with public relations, reassuring families and employees and reinforcing the company branding."

Moorcraft

Sample Language of the Coverage:

- "[We will] pay for expense costs associated with the provision of Crisis Management Services which are reasonably and necessarily incurred by the Named Insured in connection with a Deadly Weapon Event."

- Crisis Management Services can include such things as investigation, crisis management support and temporary security measures

A Second Sample of Coverage:

"Workplace Violence Expenses" means:

1. An independent security consultant for 90 days
2. An independent public relations consultant for 90 days
3. Counseling services to employees on Premises for up to 120 days
4. An independent security guard or security forces for up to 15 days
5. An independent forensics analyst for 120 days

Available Coverages:

- Business interruption coverage
- Medical expenses, funeral expenses, and death benefit
- Loss of attraction

Common Exclusions:

- Terrorism exclusions
- Casualties threshold limit
- Employee exclusions
- Vehicle exclusions
- Mental anguish exclusion

The "Gathering" Clause

A Deadly Weapon Event (or series of Deadly Weapon Events) which occurs at one Location or multiple Locations of the Named Insured within a period of twenty-four (24) consecutive hours and which do have or appear to have a Related Purpose or are coordinated by one or more Assailant(s) will be deemed to be **one** Deadly Weapon Event.

Political Risk Insurance

What is Political Risk Insurance?

Per Investopedia,

Common companies who would purchase:

- Multinational corporations
- Exporters
- Banks
- Infrastructure developers

Can be locked in for extended period of time – up to 15 years – reducing risk of doing business abroad

A Brief History of the Coverage since WWII

Modern PRI began after WWII to promote investment under the Marshall Plan

- Marshall Plan, aka European Recovery Program, was a U.S. program providing aid to Western Europe following the devastation of WWII
- Enacted in 1948 and provided over $15 billion to help finance rebuilding efforts

A Brief History of the Coverage since WWII

For over 40 years, PRI was dominated by bilateral institutions, such as the US Overseas Private Investment Corporation (OPIC), owned and operated by national governments for the benefit of their national private capital.

Since the late 1980s, numerous multilateral institutions have participated in the PRI market

Private insurers appeared in the early 1970s and experienced dramatic growth in the 1990s

What Does PRI Cover?

- Adverse Actions or Inactions by Governments
  - Legislative or regulatory actions or inactions that disproportionately affect foreign investors (selective discrimination)
- Expropriation - Partial or complete government confiscation of property or assets
- Political violence (civil unrest or insurrection)

What Does PRI Cover?

- Acts of terrorism or war
- Inability to convert local currency and repatriate it
- Sovereign debt default (inability for country to pay its debts)

The Private Marketplace

- Private political risk insurers are located primarily in the UK, USA, and Bermuda
- There are around 60 insurers operating globally that offer PRI
- NAIC reports that, “The largest private insurers are Zurich American Insurance, Lloyd’s, AIG, Chubb, and Sovereign.”

The Private marketplace - NAIC

"Having a plethora of active insurers in the PRI market creates significant competition, which gives buyers the ability to choose individualized coverage at a less exorbitant price."

Capacity in the market, according to insurance broker BPL Global, has increased considerably over recent years."

The Private Marketplace - NAIC

"Market capacity has jumped to over $1.5 billion per risk, providing both depth in monetary amounts and increasing breadth in terms of the number of different participating insurers."

"**Over the past three years, overall PRI capacity has increased** across all product lines – with maximum lines for non-payment private obligor risks and public obligor risks rising by 30% to $2.4 billion and $3 billion, respectively. "

HOWEVER…According to Willis Towers Watson

The marketplace continues to experience rate increases, particularly for countries where political risks have risen.

Property carriers are increasingly excluding strikes, riots and civil commotion from policies; the resulting gaps in coverage can be addressed through political risk insurance.

HOWEVER…According to Willis Towers Watson

Capacity for China, Russia, Ukraine, Brazil, Turkey, Peru, Honduras, Haiti, Argentina, Myanmar, Chile and Belarus appears to be tightening.

For multiyear programs in force, underwriters cannot increase rates, and insureds are enjoying the insulation from rate increase for the life of the programs (usually three to five years).

Market conditions are also more challenging in certain sectors, such as technology.