EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | February 2016

Court Holds Insurer Can Allocate Settlements

A federal district court in Pennsylvania has upheld an insurer's right to allocate settlements between covered and non-covered amounts and affirmed the insurer's substantive allocation of two settlements. *United Nat'l Ins. Co. v. Indian Harbor Ins. Co.*, No. 14-6425 (E.D. Pa.). Wiley Rein represented the insurer.

The insured, an insurance company, purchased an E&O policy that contained a provision for allocating between "Loss covered by this Policy and Loss not covered by this Policy." The insured sought coverage from its E&O carrier for two underlying claims, both of which the insured settled without admitting any liability. In one of the two underlying claims, the E&O carrier contributed $1.5 million to the insured's settlement but declined to cover the entire settlement, allocating a portion of the settlement to non-covered contractual liability. In the other claim, the E&O carrier declined to contribute to the settlement because, subtracting amounts allocated to non-covered punitive damages, the covered portion of the settlement did not exceed the retention. The insured brought the present coverage action against the E&O carrier, seeking to recover the entire amount of the two settlements and asserting a bad faith claim.

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Wiley Rein Overturns Adverse Verdict Against Insurance Broker

A New York federal court has granted an insurance broker's motion for a new trial, which vacates a jury verdict and judgment of over $23 million on the ground that an erroneous jury instruction was given to the jury. Wiley Rein represented the insurance broker for purposes of post-trial motions and possible appeal. *Cammeby's Mgmt. Co., LLC v. Affiliated FM Ins. Co.,* 2016 WL 316023 (S.D.N.Y. Jan 26, 2016).

The plaintiff real estate management company hired an insurance broker to procure a property insurance policy with $30 million in flood insurance coverage. Three weeks later, the broker arranged to reduce the limits of flood insurance coverage from $30 million to $10 million.

After Hurricane Sandy damaged property owned by the real estate management company, the insurance broker was sued for negligence in arranging for the reduction in flood coverage. The real estate management company argued that it never wanted the limits reduced from $30 million to $10 million. Among other things, the broker argued that it was asked to reduce the limits and, in any event, the real estate management company ratified the reduction in flood limits given that it was aware of the reduced limits and accepted a substantial amount in returned premium.

During deliberations following an eight-day trial, the jury sent out two notes relevant to the insurance broker's ratification defense. The court's response to the jury indicated that the real estate management

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Prior Knowledge Condition Could Apply to Bar Coverage

In a victory for Wiley Rein's client, a New Jersey federal court has held that a prior knowledge condition could apply to bar coverage for an underlying claim arising out of a breach of professional duty known to the insured prior to the inception date of the policy, even where the policy at issue was the first and last policy issued to the firm. *Darwin Nat'l Assurance Co. v. Fahy Choi, LLC*, No. 13-7197 (D.N.J. Dec. 18, 2015).

A lawyers' professional liability insurer issued a claims-made-and-reported malpractice liability policy to a law firm for the period of August 1, 2012 to August 1, 2013. The insurer had not previously issued an insurance policy to that firm. During the policy period, a former client sued the firm. The underlying complaint alleged that the firm made misrepresentations to the client about the status of a lawsuit filed by the firm on behalf of the client. The conduct alleged in the lawsuit occurred between 2010 and 2012.

The firm reported the suit to its insurer during the policy period and sought defense and indemnity coverage. The insurer denied coverage, citing a prior knowledge condition in the policy. The prior knowledge condition was written directly into the insuring agreement of the policy and provided that it was a condition precedent to coverage that "no Insured had any basis . . . to believe that any Insured had breached a professional duty" for a "Claim" based on a "Wrongful Act" that occurred "prior to the inception date of the first policy issued by the Insurer if continuously renewed."

In the ensuing coverage litigation, the parties cross-moved for summary judgment. The court granted the insurer's cross motion for summary judgment, holding that the prior knowledge condition could apply if the insurer showed that the insured had a basis to believe that any insured breached a professional duty prior to the policy's inception date. The insurer argued that the policy was the "first policy issued by the Insurer" and therefore that the condition applied. The firm argued that because the policy was

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Court Dismisses Coverage Action Where Claims Were Made Before Policy Period and Barred by Prior and Pending Litigation Exclusion

A California federal court has held that a professional liability policy does not afford coverage for claims against an insured individual, who was serving as executor of his father's estate, by his stepmother because those claims related to earlier claims by the stepmother before the policy period. *Cove Partners, LLC v. XL Specialty Ins. Co.*, 2016 WL 461918 (C.D. Cal. Feb. 2, 2016). Wiley Rein represented the insurer. The court dismissed claims of breach of contract, bad faith, fraud, and reformation with prejudice.

The professional liability policy provided coverage to the insured company for professional services wrongful acts, which were defined to include services as a trustee and executor. The principal of the insured had been sued by his stepmother prior to the policy period in connection with his administration of his father's estate, and the insured disclosed these suits on its application for the policy. After the policy incepted, the principal sought coverage for three additional claims by the stepmother. The insurer denied coverage on the basis that the claims were related to the claims made before the policy period. Accordingly, the claims were deemed made before the policy incepted and, in any event, coverage was barred by the policy's prior and pending litigation and prior knowledge exclusions. The insured brought this coverage action, alleging breach of contract, bad faith, fraud, and reformation.

The court granted the insurer's motion to dismiss with prejudice. The court held that the insured had failed to state a claim for breach of contract because the policy "clearly and unequivocally" excluded from coverage claims "based upon, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving any fact, circumstance, situation, transaction, event, Wrongful Act underlying or alleged in any prior and/or pending litigation," which the court determined included the stepmother's earlier suits. Because the insurer had a reasonable basis

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Ninth Circuit Finds "Related Wrongful Acts" Term is Unambiguous and Encompasses a Broad Range of Acts

The United States Court of Appeals for the Ninth Circuit, applying California law, has held that a trial court properly interpreted a D&O policy's "Related Wrongful Acts" provision in concluding that an insured was not entitled to coverage under two policies for twenty-seven lawsuits that followed the first claim noticed to the insurer. *Previti v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA* (no. 13-56368) (9th Cir. Jan. 22, 2016).

In November 2008, the insured tendered to its insurer a motion for entry of order that converted Chapter 11 bankruptcy cases to Chapter 7, alleging preferential and fraudulent transfers of money from the debtor companies to non-debtor affiliates. The insurer accepted this motion as a notice of circumstances under the 2007-2009 policy—the first of three consecutive policies it had issued to the insured.

Six months later, the Chapter 7 trustee sued the insured, and the insurer advanced $10 million in defense costs to the insured under the 2007-2009 policy. Twenty-seven lawsuits later filed against the insured included allegations of misrepresentations of the financial condition of the company and improper transfers. The insured sought an additional $20 million in defense costs for these suits, arguing that they triggered coverage under the two subsequent policies. The insurer disagreed on the basis that only the 2007-2009 was triggered because all 28 suits were "related" to the first motion. In response, the insured sued its insurer for breach of contract, bad faith, and a declaratory judgment that the insurer had a duty to defend all of the underlying claims under three separate policies.

The trial court granted the insurer's motion for partial summary judgment, concluding that all of the 28 underlying claims arose under one policy and were subject to the $10 million limit of liability. On the insured's appeal to the Ninth Circuit, the insured argued, among other things, that the trial court applied the incorrect burden of proof,

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Fourth Circuit Holds that Rescission is Not Available to Innocent Co-Insureds

The United States Court of Appeals for the Fourth Circuit, applying South Carolina law, has affirmed a trial court's determination that a professional liability insurance policy afforded coverage to innocent co-insureds despite fraudulent misrepresentations in the application submitted by an individual applicant posing as a doctor. *Evanston Ins. Co. v. Agape Senior Primary Care, Inc.*, 2016 WL 192748 (4th Cir. Jan. 15, 2016). The court found that the insurer could have limited coverage in the face of fraud in drafting the policy, the co-insureds had no knowledge of the fraud, and public policy would not be served by rescission.

The insurer issued a medical malpractice liability policy to a company employing doctors and nurses. The company hired an individual who falsely held himself out to be a licensed doctor. Prior to the discovery of the fraud, the company and all individual physicians, including the imposter, submitted separate renewal applications to the insurer, and the insurer accepted. After discovery of the fraud, several lawsuits were filed against the company. The insurer filed a declaratory judgment action, seeking to rescind the entire policy as issued to the company and its employees. The trial court invalidated coverage as to the imposter, but it left coverage for the company and its innocent employees intact.

On the insurer's appeal, the Fourth Circuit affirmed, holding that principles of law and equity required that coverage for the innocent co-insureds remain in place. The court observed that three factors weighed in favor of maintaining coverage for the innocent co-insureds: 1) the insurer, as the drafter of the policy, could have included forfeiture language in the policy to address fraudulent misrepresentations by one applicant, 2) neither the company nor any of its employees had any knowledge of the fraud, and 3) public interest would not be served by rescission. The court observed that pursuant to South Carolina statutory law and policy, the fraudulent actions of one insured cannot deprive the other innocent insureds of the benefits of their respective contracts. ■

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Policy Rescinded And Voided *Ab Initio* For Failure to Disclose Professional Responsibility Grievance Investigation of Insured Officer

Applying Connecticut law, a Connecticut federal court held that an insured's E&O policy must be rescinded and voided *ab initio* after finding that the insured knowingly made misrepresentations regarding an investigation of one of its officers, which were material to the insurer's decision to insure the applicant. *Zurich Am. Ins. Co. v. Expedient Title, Inc.*, 2015 WL 9165875 (D. Conn. Dec. 16, 2015). In so holding, the court rejected the insured's argument that the question at issue in the renewal application was limited only to investigations concerning the operation of the insured's business. The court also ordered the insured to reimburse defense costs paid by the insurer.

The insured, a title agent company for title insurance companies, renewed its "Title Agents, Abstractors and Escrow Agents Error and Omissions Liability Insurance Policy," from its insurer for the policy period of May 27, 2008 to May 27, 2009. In October 2008, the insured tendered a complaint against it and a title insurance company concerning the alleged failure to record the deed of conveyance of a particular property. The insurer provided a defense to the insured subject to a reservation of all of its rights and defenses under the E&O policy, including the right to recover expenses incurred in connection with the defense of the matter if it was determined that coverage was inapplicable.

In 2011, the insurer filed a declaratory judgment action against its insured seeking rescission and a determination that the E&O Policy was void *ab initio* because of the insured's alleged misrepresentations on its insurance renewal application. The insurer explained that in the insured's renewal application, the insured answered "no" to the question that asked "[h]as the Applicant or any prospective Insured been involved in or have knowledge of any inquiry, investigation, complaint or notice from any State or Federal Authority regarding the activities, procedures, or practices of the Applicant or any proposed insured in the past (1) year?"

The insurer argued that the answer "no" was a material misrepresentation that voided the policy in light of the fact that the insured was aware that for several years one of the insured's officers, an

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Insurer Could Face Bad Faith Liability Even Though It Has No Duty To Defend

Applying Utah law, the United States District Court for the District of Utah held that an insurer could potentially face bad faith liability even though the insurer had no duty to defend the insured against an underlying lawsuit. *Travelers Prop. Cas. Co. of Am. v. Fed. Recovery Serv., Inc.*, 2016 WL 156453 (D. Utah Jan. 12, 2016).

The insureds, related businesses providing processing, storage, transmission, and other handling of electronic data for their customers, were hired by an owner/operator of fitness centers to manage payments and automatic debits for its customers. A dispute between the owner/operator and the insureds later ensued, and the owner/operator alleged that the insureds failed to provide certain customer information "until [the owner/operator] satisfied several vague demands for significant compensation." The insureds provided notice to the insurer of the owner/operator's lawsuit, but the insurer advised the insureds not to provide notice until the lawsuit was served on the insureds. When the lawsuit was served on the insureds, the insureds tendered it to the insurer, which denied coverage under a "Technology Errors and Omissions Liability" policy providing coverage for "any error, omission or negligent act," and sought a judicial determination that no coverage was available for the lawsuit.

In a prior decision, the court had held that the insurer had no duty to defend the lawsuit because it alleged that the insureds knowingly withheld information, which was not an "error, omission, or negligence."

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Exclusion For Certain Communications Narrowly Construed Not To Apply To Alleged Improper Publishing of DNA Test Results

The Unites States District Court for the Southern District of Texas, applying Texas law, has held that an exclusion barring coverage for certain communications, including violations of the Telephone Consumer Protection Act and "any other statute . . . prohibit[ing] or limit[ing] the . . . communication or distribution of information or other material" does not apply to bar coverage for alleged improper publishing of DNA test results in violation of Alaska's Genetic Privacy Act. *Evanston Ins. Co. v. Gene by Gene, Ltd.*, 2016 WL 102294 (S.D. Tex. Jan. 6, 2016)

The insured, the owner and operator of genealogy website, was sued for allegedly improperly publishing DNA test results on its website without the claimant's consent in violation of Alaska's Genetic Privacy Act, which prohibits the disclosure of a person's DNA analysis without written and informed consent. The insured sought coverage under the Personal Injury and Advertising Injury Liability coverage part of its professional liability policies. The insurer denied coverage pursuant to an Electronic Data and Distribution of Material in Violation of Statutes Exclusion. Sections A through C of the exclusion preclude coverage for claims based upon or arising out of any violation of the TCPA (Section A), the CAN–SPAM Act of 2003 (Section B) or "any other statute, law, rule, ordinance, or regulation that prohibits or limits the sending, transmitting, communication or distribution of information or other material" (Section C).

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Pre-Tender Defense Costs are Uncovered Voluntary Payments

A federal district court, applying California law, has held that a "no voluntary payment" provision precluded coverage for defense expenses voluntarily incurred by an insured pursuant to its agreement to indemnify its directors and officers prior to providing notice to the insurer of its indemnity obligation. *Corthera, Inc. v. Scottsdale Ins. Co.*, 2016 WL 270951 (C.D. Cal. Jan. 22, 2016).

The insured sought coverage under its business and management indemnity liability policy—which imposed a duty to defend on the insurer—in connection with its obligation to indemnify its officers and directors as a result of a lawsuit alleging violations of a competitor's intellectual property rights. The amended complaint named two additional insured directors as defendants, one of whom had a conflict with counsel previously consented to by the insurer. That director selected separate counsel, who then requested indemnification from the insured. The insured agreed to indemnify the director and notified the insurer of this additional obligation.

Upon receiving an invoice from the director's separate counsel, the insurer advised the insured that it had not consented to separate counsel's retention, believed the amount of the invoice did not appear reasonable, and would not recognize separate counsel's fees incurred without its consent. While the insurer and the insured continued to negotiate regarding separate counsel, the court granted the motion to dismiss filed by separate counsel in the underlying action, which was then appealed. The insurer appointed new counsel in connection with the appeal, but the director would not permit appointed counsel to assume his defense. The insured then asserted that the insurer's prior reservation of rights letter accepting coverage for the matter and consenting to counsel for the other insured defendants in the litigation created a conflict of interest that entitled the remaining director to separate counsel of his choosing. When the insurer disagreed, the insured initiated coverage litigation, and the parties filed cross-motions for partial summary judgment.

The court enforced the policy's "no voluntary payment" provision as to those defense expenses incurred voluntarily by the insured prior to providing the insurer notice of the additional director's claim. In doing so, the court

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Court Holds Insurer Can Allocate Settlements *continued from page 1*

On the parties' cross-motions for summary judgment, the court granted summary judgment in favor of the E&O carrier, holding that the carrier had the right to allocate the settlements between covered and non-covered amounts pursuant to the unambiguous allocation provision in the E&O policy. The court held that, under Pennsylvania law, the insured has the burden to prove what portion of each settlement is covered under the policy. According to the court, the insured had not carried its summary judgment burden to put forth evidence supporting its position that the entire amount of each settlement should be covered. The court also granted summary judgment to the E&O carrier on the insured's bad faith claims, holding that the insured had not identified acts constituting bad faith and that the applicable statutes of limitation precluded the claims.

Finally, the court rejected the insured's argument that the E&O carrier breached the policy's insuring agreement, which stated that the carrier would pay amounts "on behalf of" the insured, when the E&O carrier paid covered settlement amounts to the insured rather than the claimant. The insured had directed the carrier where to pay its $1.5 million settlement contribution and had therefore waived any argument that the carrier should have paid the settlement to another party.■

Wiley Rein Overturns Adverse Verdict Against Insurance Broker *continued from page 1*

company could ratify the reduced premium only through "some writing or conversation or other conduct that [an employee or agent of the real estate management company] intentionally approved of what [the insurance broker] had done in obtaining a reduction." The jury found the broker liable on the negligence claim, meaning that it did not credit the broker's ratification defense.

The insurance broker filed a motion for judgment and for a new trial, arguing in relevant part that the court gave erroneous instructions to the jury with regard to the insurance broker's defense of ratification of the reduction in limits of flood coverage. The trial court agreed that an erroneous instruction was given, holding that the most reasonable inference to the trial court's response the jury's questions was that ratification could be demonstrated only if the real estate management company took an affirmative step to communicate its intent to ratify. However, the court determined that, under New York law, ratification may result from silence or inaction. Because an erroneous response was given to the jury, the court ordered a new trial. ■

Court Dismisses Coverage Action Where Claims Were Made Before Policy Period and Barred by Prior and Pending Litigation Exclusion *continued from page 2*

for denying coverage, the court also dismissed the insured's bad faith claim.

The court dismissed the insured's fraud claims because the insured failed to allege any misrepresentations by the insurer and made only conclusory allegations that were insufficient to meet the heightened pleading standard required by Federal Rule of Civil Procedure 9(b). The court further held that, even if the insured could amend its pleadings to include additional factual allegations, it could not establish justifiable reliance as a matter of law. Specifically, the insured alleged that it had requested on its application that the policy cover "all liability associated with being executor and trustee" and that the insurer had not refuted this statement. The court held that the insured could not rely on its own statement in the application; that statement directly conflicted with the policy ultimately agreed to by the parties, which, like all insurance contracts, contained limitations and exclusions that defined the scope of the parties' relationship.

Likewise, the court rejected the insured's allegation that the policy should be construed in its favor because the insurer had failed to address the scope of the policy's exclusionary provisions, including the prior and pending litigation exclusion. The court noted that the insured alleged that the terms of the policy were reached through "extensive negotiations," and therefore as a "manuscript" policy, any ambiguities need not be strictly construed against the insurer.

Finally, because the insured had failed to sufficiently allege fraud or either unilateral or bilateral mistake, the court also dismissed the insured's reformation claim. ■

Prior Knowledge Condition Could Apply to Bar Coverage *continued from page 2*

not renewed, the condition would not apply in any circumstance, focusing on the phrase "if continuously renewed." The court accepted the insurer's proposed construction, stating that the condition was not ambiguous, and that the firm's interpretation would lead to absurd results. The court noted that it would not make sense to have a condition that did not apply if an insurer issued only one policy to an insured.

In addition, the court held that abstention under *Burford v. Sun Oil Co.*, 319 U.S. 315 (1943), was inappropriate as the case dealt with standard issues of contract interpretation. The court also rejected an argument by the firm asserting that New Jersey public policy would bar the application of the prior knowledge condition because an "innocent" third-party purchaser of legal services sued the insured. The court noted that accepting the firm's argument would result in the prohibition of most contract-based denials of coverage, as a third-party purchaser of legal services would nearly always be "innocent." ■

Ninth Circuit Finds "Related Wrongful Acts" Term is Unambiguous and Encompasses a Broad Range of Acts *continued from page 3*

the incorrect interpretation of "related wrongful acts," and incorrectly concluded that the notice of circumstances constituted sufficient notice as to all the underlying suits.

The Ninth Circuit concluded that none of the insured's arguments withstood scrutiny. After concluding that the trial court applied the appropriate burden of proof for the insurer, the court then turned to the interpretation of the term "Related Wrongful Acts." According to the court, the unambiguous language of the insurance contract foreclosed an alternate interpretation. The court explained that, when construed with the other contract provisions, the term "Related Wrongful Acts" "encompasses a broad range of acts clearly extending to all [twenty-eight actions]." Finally, the court explained that the notice of circumstances served as a notice for all 28 actions "as it alleged a broad fraudulent scheme involving both debtor insiders and non-debtor affiliates, as well as questionable pre- and post-petition transfers." ■

Exclusion For Certain Communications Narrowly Construed Not To Apply To Alleged Improper Publishing of DNA Test Results *continued from page 5*

In the ensuing coverage litigation, the court granted the insured's motion for summary judgment, finding that coverage was triggered under the policy and that the exclusion at issue did not apply. The court found that that the allegations contained in the complaint fell within the Personal Injury and Advertising Injury Liability coverage part because the allegations met the definition of personal injury, defined as "oral or written publication of material that violates a person's right of privacy."

The court then found that the Electronic Data and Distribution of Material in Violation of Statutes Exclusion did not apply to preclude coverage. The court held that "[i]t is reasonable to construe [the exclusion's] language as meaning any similar or related statutes or laws that govern communication over the phone or fax machine (Section A) or email (Section B), while Section C covers other, similarly unsolicited forms of communication that may be regulated by statute, law, rule, ordinance, or regulation." The court reasoned that because Clauses A and B of the exclusion preclude coverage for claims arising out of violations of two specific consumer protection statutes that regulate the use of unsolicited communication to consumers, Clause C should likewise be construed to refer to unsolicited forms of communication to consumers that may be regulated by statute, law, rule, ordinance, or regulation. Because the Genetic Privacy Act does not involve unsolicited communication to consumers, but rather regulates the disclosure of a person's DNA analysis, and the allegations in the complaint solely concerned the improper disclosure of DNA test results on a public website and to third-parties, the court held that the underlying complaint did not fall within the exclusion and that the insurer had a duty to defend and indemnify the insured. ■

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Insurer Could Face Bad Faith Liability Even Though It Has No Duty To Defend continued from page 4

In this most recent decision, the court held that the insureds could not re-litigate the issue of whether the insurer had a duty to defend the lawsuit brought by the owner/operator. The court determined that the insurer had no duty to defend based on the policy and complaint, and the court held that, under Utah law, the insureds could not use extrinsic evidence to show a duty to defend because the policy provided that the insurer's duty to defend depended solely on the allegation in the suit. Because there was no duty to defend, the court held that the insurer did not breach any fiduciary duty owed to the insureds.

The court also held that it could not determine as a matter of law that the insurer did not breach the policy's implied covenant of good faith and fair dealing. Even though the court held that the insurer had no duty to defend the lawsuit, it held that the insurer could face bad faith liability because it required the insured to receive service of the lawsuit before tendering the claim for coverage and allegedly did not "diligently investigate, fairly evaluate, and promptly and reasonably communicate" with the insured. However, the court held that the insured could not face bad faith liability for any actions "root[ed]" in the denial of coverage or for threatening to seek reimbursement of defense costs paid under a reservation of rights while litigating coverage for the lawsuit. ■

Policy Rescinded And Voided Ab Initio For Failure to Disclose Professional Responsibility Grievance Investigation of Insured Officer continued from page 4

insured under the policy, was being investigated by the Grievance Committee for the 9th Judicial District of New York for multiple alleged violations of the Code of Professional Responsibility related to his activities as an attorney and with work for a company connected to the named insured.

Ruling on the insurer's motion for summary judgment as to rescission, the court explained that the insurer must prove (1) a misrepresentation (or untrue statement) (2) that was knowingly made, and (3) material to its decision whether to insure.

As to the first two prongs, the court found that there was a false statement in light of the insured's "no" answer to the question at issue and that there was no basis, as argued by the insured, to limit the scope of the question to investigations related to the title insurance business. The court then found that the insured's false response to the question was made knowingly as the officer who was subject to the grievance investigation was aware of the grievance since 2004, as was the President who signed the application. In doing so, the court rejected the argument that the insurer should not be awarded the drastic remedy of recision based upon the officer and the insured's ignorance, mistake, or neglect in reporting matters that they did not believe that they were obligated to report. According to the court, "where, as here, the question on the application is written in clear terms, allowing an insured to stave off rescission by asserting that he or she was laboring under an erroneous interpretation of the question would be tantamount to excusing the insured for not reading the application at all – something that Connecticut courts have refused to do."

As to the final element in its analysis, the court found that the answer to the question at issue was material under Connecticut law and under the E&O Policy for three reasons. First, according to the court, Connecticut case law strongly suggests that an answer to an insurance application is presumptively material. Second, the court provided that an insured's answer to a question on an insurance application is also considered material where, as was the case here, the application itself states that it "shall become the basis of any coverage and a party of any policy that may be issued by the [insurance] Company." Finally, after review of the underwriter's affidavit, the court concluded that the insured's "no" answer satisfied the traditional test of finding a misrepresentation material where "in the judgment of reasonably careful and intelligent persons, it would so increase the degree or character of the risk of insurance as to substantially influence its issuance, or substantially affect the rate of premium."

Because the E&O policy was found to be void at inception and because the insurer expressly reserved its right to reimbursement for the costs of defending the underlying action, the court also granted the insurer's request for reimbursement of defense costs. ■

Pre-Tender Defense Costs are Uncovered Voluntary Payments _continued from page 5_

first discounted the insured's argument that its indemnification obligations were "incompatible" with the indemnity coverage provided by the policy. The court disagreed, explaining that the insured's inability to control the defense of its officers and directors is separate and apart from its obligation to inform the insurer of the matter prior to incurring any defense expenses. According to the court, the insured's bylaws cannot unilaterally enlarge the coverage provided by the policy.

The court then determined that the insured incurred the defense expenses at issue "when the task [was] performed because this is when the obligation to pay is created," and not when the insured actually paid separate counsel's invoices. The court also found that the defense expenses incurred from the time the insured received notice of the director's retention of separate counsel until the insured provided notice to the insurer were incurred voluntarily, and, as a result, the "no voluntary payment" provision applied to preclude coverage for those amounts.

The court also denied the insurer's motion for summary judgment on the insured's bad faith claim because the court determined that the insurer's request that its appointed counsel prepare a budget for filing a motion to dismiss similar to that filed by the director's separate counsel "could have created a conflict of interest and thus demonstrate bad faith." According to the court, a jury could find that the insurer had no reason to ask for such information other than to defeat coverage, particularly when the insurer made the request after the motion had been filed and granted. Finally, the court granted the insurer's motion for summary judgment as to the insured's claim for punitive damages because, according to the court, the insurer's actions "do not rise to the level of being 'evil, criminal, recklessly indifferent to the rights of the insured, or with a vexatious intention to injure.'" ■

SPEECHES/UPCOMING EVENTS

ACI's ERISA Litigation Conference
KIMBERLY M. MELVIN, Speaker
• Fiduciary Insurance and Claims: Perspectives from Underwriting, Claims, Organization and Coverage Counsel
March 2, 2016 | Chicago, IL

ABA's 2016 Insurance Coverage Litigation Committee CLE Seminar
LAURA A. FOGGAN, Speaker
• Hack That Thing: Physical Harms from Cyber Perils - Are They Covered?
March 3, 2016 | Tucson, AZ

ABA's 2016 Insurance Coverage Litigation Committee CLE Seminar
MARY E. BORJA, Speaker
• Battling for the Forum: Strategies Employed by Insurers and Policyholders to Secure and Protect the Most Advantageous Forum for Their Coverage Disputes
March 4, 2016 | Tucson, AZ

ABA's 2016 Insurance Coverage Litigation Committee CLE Seminar
KIMBERLY A. ASHMORE, Speaker
• In the Interests of Time: Exploring Critical Timing Issues Under Claims Made Policies
March 4, 2016 | Tucson, AZ

ABA's 2016 Insurance Coverage Litigation Committee CLE Seminar
CARA TSENG DUFFIELD, Speaker
• Help Me Help You: Tips for Minimizing Insurer/Policyholder Conflict
March 4, 2016 | Tucson, AZ

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