February 2004

The Executive Summary

Developments Affecting Professional Liability Insurers

Court Holds Insurer Properly Rescinded D&O Policy Based on Intentional Misrepresentations

A United States district court ruled on summary judgment that an insurer properly rescinded a directors and officers liability insurance policy. *Cutter & Buck, Inc. v. Genesis Ins. Co.*, No. C02-2569P (W.D. Wash. Feb. 11, 2004). The court also held that the insurer did not waive its right to rescind and did not breach its duty of good faith to its insured. Wiley Rein & Fielding LLP represented the insurer in the case.

The insured company is a clothing designer and manufacturer. In April 2000, the company shipped merchandise to three distributors and accounted for the shipments as sales. In reality, the distributors merely stored the goods until the company found actual buyers. The distributor transactions were designed to allow the company to meet Wall Street's projections and were hidden from the company's board and outside auditors. When the distributors subsequently returned the unsold product, the company's CFO attempted to cover up the returns.

The company's D&O insurance was set to expire in August 2001. In a meeting with the insurer, the company's CFO stated that the company had a very conservative revenue recognition and product return policy. He did not mention the distributor transactions. The company submitted a written application signed by the CFO along with various other required documents, including its annual report, CPA letter regarding internal controls and latest 10-K and 10-Q. Based on these materials, the insurer agreed to renew the company's insurance for another year.

In August 2002, the company again discussed renewal of its D&O insurance. The company's new CEO disclosed that the company would restate its financials because revenue had been recognized from sales in 2000 although the company's product was later returned. The CFO represented that there was no right of return for the company's product and the company would not have booked the revenue in question if it knew the product could be returned. The CFO did not mention that intentional misconduct was causing the company to restate its financials. The insurer agreed to extend the policy for another year.

On August 12, 2002, the company issued a press release announcing that it would restate its financials and suggesting intentional wrongdoing had occurred. The insurer did not immediately rescind the policy, but on August 14, sent the insured a letter requesting additional information regarding the company's accounting irregularities. In late October 2002, after various shareholder lawsuits had been filed against the company, the company gave the insurer documents that showed that the company's CFO had engaged in intentional misconduct in connection with the distributor transactions. The insurer rescinded the policy in December 2002. Shortly thereafter, the company filed suit alleging breach of contract and bad faith. In August 2003, the company entered into a consent decree with the SEC admitting that the recognition of revenue from the distributor transactions was improper. In addition, the

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Collateral Consequences Cannot Be Used to Justify Reasonableness

The Arizona Supreme Court has held that in evaluating the reasonableness of a settlement between an insured and an underlying plaintiff, a court may not consider any collateral consequences the insured would have faced by failing to settle. *Parking Concepts, Inc. v. Tenney*, 2004 WL 61153 (Ariz. Jan. 14, 2004).

The insured was a real estate broker who purchased an E&O policy that excluded coverage for fraudulent acts. A party to a real estate transaction sued the broker for allegedly misrepresenting the tax liability associated with a property. The complaint alleged fraud, negligent misrepresentation and breach of contract. The insurer defended the broker subject to a reservation of rights based on the fraud exclusion in the policy.

Two years into the litigation, the broker demanded that the insurer settle the case or withdraw its reservation of rights. The insurer refused. (The court explained that, under Arizona law, the insurer's refusal precluded it from arguing that any settlement the broker and claimant reached without the insurer's consent breached the cooperation clause of the policy.) The broker and the underlying plaintiff agreed to settle the lawsuit for $430,000. The broker assigned his rights under the insurance policy to the underlying plaintiff in return for the plaintiff's covenant not to execute the settlement against the broker.

The plaintiff then sued the insurer to collect the settlement amount. The insurer contended that the settlement was the product of fraud and collusion and that the amount of the settlement was unreasonable. The broker argued (and the trial court had found) that the settlement was reasonable because the broker risked losing his license had the claimant ultimately prevailed on its fraud claim.

The Arizona Supreme Court rejected the broker's argument, holding that consideration of collateral consequences to the broker was improper because the insurer never agreed to cover such loss. The court reasoned that, under the terms of the policy, the insurer contracted to cover amounts the insured "became legally obligated to pay as damages" as a result of covered conduct, and that "[n]othing in the policy suggests that [the broker] purchased insurance against any consequences of their covered conduct other than the imposition of money damages." The court explained that the only proper considerations in determining the reasonableness of the settlement were facts bearing on the broker's liability and damages in the underlying litigation. ✦

Loss of Jury Verdict Does Not Automatically Create Foreseeable Claim

A federal district court in Maine, applying Maine law, held that the prior knowledge exclusion in a legal malpractice policy did not exclude coverage for a legal malpractice claim, even though the insured law firm lost a substantial verdict at a trial during a prior policy period. *Westport Ins. Corp. v. Lilley*, No. 03-36-P-K (D. Me. Nov. 13, 2003).

An insurer issued three annual claims-made professional liability policies to a law firm from 2000-2003. Each policy excluded coverage for "any act, error, omission [or] circumstances…occurring prior to the effective date of this policy if any insured at the effective date knew or could have reasonably foreseen that such act, error, omission [or] circumstance…might be the basis of a claim."

During the 2000-2001 policy period, the law firm represented a client in a medical malpractice claim against a physician and a hospital after the client's husband had died from post-operative infection. At trial, a jury awarded the client a verdict of approximately $1.5 million. However, the jury also found that the client's husband had been comparatively negligent and reduced the award to $32,000. The attorneys from the law firm did not request that the jury be polled after it returned the verdict; however, at a later stage of the case, the attorneys questioned whether the jurors had intended to reduce the amount *by* $32,000 instead of *to* $32,000. In part because of questions about the jury's handling of the verdict form, the trial court ordered a new trial, which took place during the 2001-2002 policy period and resulted in a verdict for the defense.

In May 2002, after an adverse ruling in the new trial, the client informed the law firm that it would file suit for legal malpractice, and the law firm provided notice

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Absent Duty to Defend, Insurer Does Not Have to Determine Coverage Until after Judgment or Settlement

A Texas appellate court has held that an errors and omissions insurer who did not have a duty to defend, but only a right to defend, was not required to decide coverage under the policy until a reasonable time after settlement, rather than within a reasonable time after tender of the claim. *Comsys Info. Tech. Svcs., Inc. v. Twin City Fire Ins. Co.*, 2003 WL 22901017 (Tex. App. Ct. Dec. 4, 2003). The court also held that where parts of the underlying settlement were covered by the policy, and parts were not, the policyholder had the burden of segregating damages.

The insured computer contractor purchased an E&O policy that had a limit of $5 million and a retention of $250,000. The policy provided that the insurer would pay "all sums which the insured shall become legally obligated to pay as damages." Further, the policy provided that:

- The "insured against whom a 'claim' is made shall have the duty to defend any 'suit' seeking damages;"
- The "insured will…have the obligation of paying any defense counsel selected by or on behalf of the insured and all defense costs" and
- The insurer "shall not be obligated to assume charge of, participate in, or pay for the investigation or defense of any 'claim' or 'suit.'"

However, the policy also provided that if the suit is "reasonably likely" to result in damages in excess of the retention, the insurer has "the right but not the duty to assume control of the defense."

A company that had retained the contractor to develop and implement a project sued the contractor in 1997 for negligence and negligent misrepresentation in failing to properly perform and supervise work on its computer system. The contractor filed a counterclaim against the company for unpaid work. In 2000, the parties settled the lawsuit for $275,000, plus forgiveness of the $114,000 in unpaid work. A month and a half after the contractor tendered the claim to the insurer for $139,000 (the amount of settlement in excess of the retention), the insurer denied coverage because the contractor had settled the suit without first obtaining the insurer's consent and because coverage was barred by certain exclusions in the policy. Coverage litigation ensued and, in that litigation, the contractor sought to recover both the settlement amount, as well as additional damages, including loss of good will and the additional costs it incurred in completing the project.

As an initial matter, the court rejected the contractor's argument that the insurer had waived the settlement-without-consent provision in the policy by waiting a month and a half to deny coverage or, alternatively, that it was estopped from doing so. The court reasoned that because the policy did not require the insurer to defend and the insurer did not exercise its right to defend, the insurer was only obligated to determine whether the suit was covered within a reasonable time after judgment or settlement and therefore did not waive its right to deny coverage by waiting two years to determine coverage.

However, the court also reasoned that because the insurer had been invited to the mediation more than a week before it occurred and declined to attend, a factual question existed as to whether the delay in deciding to consent to the settlement or assume the defense was reasonable once the insurer was invited to the mediation. Nevertheless, the court held that even if the delay was reasonable, the insurer would need to demonstrate that it had been prejudiced by not being given the opportunity to consent to the settlement. The court therefore remanded for a determination as to whether the insurer had waived its right to rely on the consent provision and, if so, whether it had been prejudiced.

The court then evaluated a number of exclusions on which the insurer had relied to deny coverage. Among other things, the court held that allegations of overcharging by the contractor were excluded by the provision in the policy precluding coverage for "[a]ny injury or damage arising out of the failure to…[m]eet the terms of cost estimates or guarantees, or any delays in the performance of any contract or agreement…." The court held that the policy precluded coverage for loss of goodwill on the part of the contractor, noting that the policy contained an exclusion barring coverage for "[a]ny injury or damage arising out of loss of customer faith or acceptance or any cost incurred to regain customer approval." The court also agreed that the contractor was not entitled to recover $100,000 it spent to repair the computer system, reasoning that the expense was

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Legal Fees for Pursuit of Cross-Claim Are "Defense Costs" Under Policy

The United States District Court for the District of South Dakota, applying South Dakota law, has held that legal fees and expenses incurred in pursuing a cross-claim constituted "defense costs" under a D&O policy because the cross-claim could be viewed as the policyholder's answer to a complaint filed against it in a different forum. *IBP, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 2003 WL 23175427 (D.S.D. Dec. 3, 2003).

The insurer issued a D&O policy to a company. The policy defined "defense costs" as "[r]easonable and necessary fees, costs and expenses consented to by the Insurer…resulting solely from the investigation, adjustment, defense and appeal of a Claim against the Insured, but excluding salaries of Officers or employees of the Company." The policy defined "claim" to include "a civil, criminal or administrative proceeding for monetary or non-monetary relief which is commenced by…service of a complaint or similar pleading."

The company entered into a merger agreement with a purchasing company. Shortly thereafter, the purchasing company sued the policyholder in the Arkansas court for rescission of the agreement on the grounds that the policyholder had fraudulently induced the purchaser's acceptance. Rather than responding in the Arkansas court, however, the policyholder filed a cross-claim against the purchasing company in a pending securities action in Delaware court where both companies had been named as defendants. In the cross-claim, the policyholder sought, among other things, specific performance of the merger agreement.

The company sought coverage from the insurer for the legal costs it incurred in both the Arkansas and Delaware actions. Although the insurer acknowledged that it was required to pay the costs in connection with the Arkansas litigation, it took the position that the legal fees and expenses incurred in the Delaware action were not "defense costs" because the company had sought affirmative relief by requesting specific performance rather than merely defending itself.

The district court granted summary judgment for the company, holding that the fees and expenses it incurred in connection with the Delaware litigation were "defense costs" resulting from a "claim." The court opined that it was "clear" from the Delaware court's opinion in the underlying litigation "that neither [the policyholder nor the purchasing company] believed the issue of specific performance was a significant issue in the Delaware litigation." In the court's opinion, the parties were "nearly exclusively litigating" the fraudulent inducement issue first raised in Arkansas, and the company's attorneys "would have spent a limited amount of time" on specific performance. The court asserted that other district courts have held that an insured's initiation of a lawsuit "does not automatically preclude coverage for defense-type legal fees and expenses where the insured is

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Parties in Shareholder Lawsuit Enjoined from Collecting on D&O Policy

A federal district court in Illinois has held that a bankruptcy court can preliminarily enjoin the parties in separate securities actions from collecting any judgment or settlement from the proceeds of the debtor's D&O liability policies, where the debtor was pursuing an adversary proceeding against one of the same directors or officers in the bankruptcy court. *Keywell v. HA-LO Indus., Inc.*, No. 03-C-5538 (N.D. Ill. Dec. 22, 2003) (minute order). The district court ruled that the bankruptcy court had jurisdiction to enter the injunction because the securities action was "related to" the bankruptcy proceeding for purposes of Section 105(a) of the Bankruptcy Code. The court reasoned that although the proceeds from the D&O policies are not property of the bankruptcy estate, the bankruptcy court has authority to enjoin actions that "may affect the amount of property in the bankrupt estate, or the allocation of property among creditors." That possibility existed here, the court held, because the debtor could make a claim on the policies if it prevailed in the adversary action.

In so holding, the court rejected the argument that the public interest would be undermined by restricting the securities plaintiffs' ability to pursue their case, noting that although the shareholders could not collect any judgment from policy proceeds, they could still pursue their action against the directors and officers. The court also rejected the directors and officers' argument that the injunction undermined the public interest in providing professional liability coverage, explaining that one of the defendant directors and officers in the shareholder action was also a defendant in the adversary and thus benefited from the injunction. ✦

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Insurer Can Challenge Reasonableness of Settlement Even if It Refuses to Defend or Indemnify

In an unpublished decision, a California appellate court has held that an insurer is entitled to challenge the reasonableness of an underlying settlement by its insured even though the insurer had previously refused to defend or indemnify its insured. *Morris v. Employers Reinsurance Corp.*, 2004 WL 25243 (Cal. Ct. App. Jan. 5, 2004).

The insurer issued an E&O policy to a real estate broker. One of the broker's clients sued for breach of fiduciary duty and fraud in connection with the purchase of property. After the insurer refused to defend or indemnify the broker, the broker settled with the clients and assigned them rights under the insurance policy to the clients, who then sued the insurer.

The appellate court held that the insurer was entitled to present evidence that the settlement was unreasonable, notwithstanding its refusal to defend or indemnify. The court explained that, under California law, a policyholder seeking to collect on an insurance policy in these circumstances has the initial burden of proving that: (1) the insurer wrongfully denied coverage; (2) the policyholder settled without the insurer's consent and (3) the settlement was reasonable "in the sense that it reflected an informed and good faith effort by the insured to resolve the claim." The court explained that "[i]f the plaintiff insured (or its assignee) produces evidence of these foundational facts, then the burden of proof will shift to the defendant insurers to persuade the trier of fact, by a preponderance of the evidence, that [the underlying] settlement did not represent a reasonable resolution of plaintiff's claim or that the settlement was the product of fraud or collusion."

The appellate court also explained that, in evaluating reasonableness, the trial court must consider the reasonableness of the settlement at the time it was made, not retrospectively. The court explained that in this case the trial court should consider the facts known at the time of the settlement, the probability of success at trial, damages exposure, other potential causes of action and the valuation of the property. Finally, the court noted that while the existence of a good faith settlement was not binding on the insurer, that determination would have "some evidentiary value." ✦

No Coverage for Claim Based on Prior Acts that Insured Could Reasonably Foresee Would Result in Claim

In an unreported decision, the United States Court of Appeals for the Third Circuit has held that a 1999 claims-made legal malpractice policy did not afford coverage for claims based on a 1995 lawsuit where the insured attorneys could reasonably have foreseen that a claim might be brought as a result of the attorney's handling of the matter. *Westport Ins. Corp. v. Mirsky*, 2003 WL 23002528 (3rd Cir. Dec. 23, 2003).

In 1995, two attorneys represented a plaintiff in a medical malpractice suit. In that suit, the plaintiff was precluded from presenting expert testimony as a sanction for the insured attorneys' discovery violations. As a result, the suit was dismissed on summary judgment for lack of evidence.

In February and July of 1999, an insurer issued two professional liability claims-made policies to the attorneys. Both policies excluded from coverage "any Claim based upon, arising out of, attributable to, or directly or indirectly resulting from…any act, error, omission, circumstance or Personal Injury occurring prior to the effective date of this Policy if any Insured at the effective date knew or should have reasonably foreseen that such act, error, omission circumstance or Personal Injury might be the basis of a claim." In November 1999, the plaintiff in the 1995 lawsuit notified the attorneys that she was suing them for malpractice. The attorneys notified the insurer, which filed a declaratory judgment action based on the prior knowledge exclusion of the policy. The Third Circuit held that the prior knowledge exclusion precluded coverage because the defendant attorneys "should have reasonably known" of the plaintiffs malpractice claim in 1998, prior to the inception of the policy. ✦

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Loss of Jury Verdict Does Not Automatically Create Foreseeable Claim

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of the potential claim to its insurer. The insurer filed this action seeking a declaratory judgment that it had no duty to defend or indemnify, arguing that the claim was excluded since the law firm knew prior to the effective date of the 2002-2003 policy that an error in the jury verdict form had occurred and therefore could have foreseen that a claim could result.

After first finding the language of the prior notice exclusion to be unambiguous, the court considered when the law firm could have reasonably foreseen that its client would pursue a claim for legal malpractice. The court noted that the test had both an objective component—what a reasonable attorney would foresee—and a subjective component—what the attorney knew. The court held that the claim was not foreseeable, noting that medical malpractice cases always involve difficult issues and the outcomes vary dramatically. The court explained that under the insurer's approach, "any trial attorney who loses a substantial jury verdict, whether representing plaintiff or defendant, should put his carrier on notice that the client may ultimately seek compensation from the lawyer." The court acknowledged that it was possible that, had the jurors been polled, the jurors would have explained that the award was only to be reduced by $32,000, rather than changed to $32,000, and the original verdict might have been unchanged. However, the court concluded that the "touchstone here is reasonableness, not conceivability" and explained that while it was conceivable that a claim would result before the inception of the policy, the law firm did not have "constructive knowledge of an impending claims prior to the policy period." ✦

Absent Duty to Defend, Insurer Does Not Have to Determine Coverage Until after Judgment or Settlement

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part of the cost of doing business and was precluded by the policy provision precluding coverage for "your costs of doing business. This includes the costs or expenses of performing additional services to correct deficiencies in the original services you performed."

The court found that there was a factual issue as to whether the allegations of loss of revenue by the company for whom the contractor was performing work were excluded by the policy provision precluding coverage for "[a]ny injury or damage 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 [your product, work, or any property of which your product or work forms a part] 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 court reasoned that it was unclear from the record whether the losses of revenue were caused by system downtime or delays when the system was running. The court found that the allegations of breach of express and implied warranties were not excluded by the policy because the exclusion for breach of warranties carved out "representations made at any time with respect to fitness, quality, durability, performance or use of 'your work' or 'your product'" and the allegations at issue were for breach of warranties concerning its services, goods, or workmanship.

The court then explained that because some of the allegations were covered and others were not, it would be necessary to segregate the damages in order to determine if the retention had been exceeded. The court explained that, under the doctrine of concurrent causation, "when covered and non-covered perils combine to create a loss, the insured is entitled to recover that portion of the damage caused solely by the covered peril." It also explained that the policyholder has the burden of proof on this issue. The court remanded for a factual determination as to the appropriate segregation of damages. ✦

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Court Holds Insurer Properly Rescinded D&O Policy Based on Intentional Misrepresentations

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company's CFO pled guilty to federal criminal charges in connection with the attempted cover-up of the transactions.

The court held that the insurer properly rescinded the policy. Under Washington law, the insurer was required to prove that the company had made material misrepresentations in the underwriting process with the intent to deceive the insurer.

First, the court held that the materials submitted with the company's 2001 application for insurance and its oral statements regarding its revenue recognition policy during the 2001 and 2002 underwriting processes contained misrepresentations. The court rejected the company's argument that it had never represented the materials it submitted with its application were "true and correct" because the application notified the company that the insurer would rely on the accuracy of the materials. The court held that while the materials were not physically attached to the issued policy, they were incorporated by reference and therefore complied with Washington's "attachment statute," which required application materials to be "attached to or otherwise made a part of" the issued policy. The court also rejected the company's argument that oral representations made outside a written application for insurance could not form the basis for rescission, citing a Washington statute that explicitly contemplated rescission based on oral misrepresentations.

Second, the court held, and the company did not contest, that the company's misrepresentations were material to the underwriting process.

Third, the court held that the company possessed the requisite intent to deceive its insurer because the company's CFO made knowingly false statements to the insurer and the company had failed to offer any evidence to rebut this presumptive intent to deceive.

The court held that the insurer was entitled to rescind the policy in its entirety based on the policy's severability provision. Under the provision, the policy would be considered void if the application and materials submitted therewith contained material misrepresentations made with the intent to deceive "provided, however, that no knowledge possessed by any director or officer shall be imputed to any other director or officer except for material information known to the person or persons who signed the Application. In the event that any of the particulars or statements in the Application is untrue, this Policy will be voided with respect to any director or officer who knew of such untruth." The court held the policy was void in its entirety because the knowledge of the CFO, who signed the application, was imputed to all insureds.

The court also rejected the argument that the insurer waived its right to rescind by failing to rescind immediately after the company's August 12, 2002 press release. First, the court held that the insurer did not possess full knowledge of its right to rescind until October 2002, when it received key documents showing that the company's CFO acknowledged wrongdoing in connection with the distributor transactions. Second, in response to the company's argument that the insurer possessed "constructive" knowledge of its right to rescind after the August 12, 2002 press release, the court held that by requesting additional information on August 14, 2002, the insurer commenced an investigation into its ability to rescind and demonstrated that it did not knowingly and voluntarily waive its right to rescind. The court held that an insurer must be allowed a reasonable time to investigate and determine whether rescission is warranted.

The court dismissed the company's bad faith claims because the claims all rested on the premise that the insurer had wrongfully rescinded the policy. ✦

Legal Fees for Pursuit of Cross-Claim Are "Defense Costs" Under Policy

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resisting a contention of liability for damages." The court reasoned that the allegations in the purchasing company's counterclaim in Delaware court were "nearly identical" to the allegations in its Arkansas complaint. Accordingly, the court concluded that the company's cross-claim in Delaware was "in essence" an answer to the complaint filed in Arkansas and, as a result, the legal fees and expenses were covered "defense costs."

The court also held that the insurer was entitled to a jury trial on the question of whether the fees and expenses paid by the policyholder were "reasonable and necessary" because the inadequate descriptions of work performed by the policyholder's lawyers prevented the court from ruling on the reasonableness of the charges as a matter of law. ✦

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WRF Continues to Expand Its Insurance Practice

Kenneth E. Ryan
202.719.7028
kryan@wrf.com

Wiley Rein & Fielding LLP is pleased to announce the arrival of Kenneth E. Ryan as a partner. Mr. Ryan, an experienced insurance litigator, represents insurers in coverage matters involving general liability—particularly environmental, toxic torts and other product liability claims—directors & officers liability, professional liability and employment liability. He also represents insurers in bankruptcy proceedings and related coverage issues.

Mr. Ryan has extensive experience in commercial litigation matters including telecommunication issues and whistleblower litigation. He regularly assists insurance clients to develop practices, procedures and policy language to avoid future coverage disputes and bad faith claims. ✦

Contributors

Name	Phone	Email
Joseph A. Bailey III	202.719.4554	jbailey@wrf.com
Nicholas A. Bonarrigo*	202.719.7410	nbonarrigo@wrf.com
Mary E. Borja	202.719.4252	mborja@wrf.com
Thomas W. Brunner	202.719.7225	tbrunner@wrf.com
Deborah Chandler**	202.719.7414	dchandler@wrf.com
Jason P. Cronic	202.719.7175	jcronic@wrf.com
Paul A. Dame*	202.719.7415	pdame@wrf.com
Stephanie M. Denton	202.719.4612	sdenton@wrf.com
Cara Tseng Duffield	202.719.7407	cduffield@wrf.com
Valerie E. Green	202.719.7516	vgreen@wrf.com
Paul J. Haase	202.719.3434	phaase@wrf.com
Dale E. Hausman	202.719.7005	dhausman@wrf.com
Kimberly M. Melvin	202.719.7403	kmelvin@wrf.com
Karalee C. Morell	202.719.7520	kmorell@wrf.com
Leslie A. Platt	202.719.3174	lplatt@wrf.com
Kenneth E. Ryan	202.719.7028	kryan@wrf.com
William E. Smith	202.719.7350	wsmith@wrf.com
Daniel J. Standish	202.719.7130	dstandish@wrf.com
Sandra Tvarian Stevens	202.719.3229	sstevens@wrf.com
David H. Topol	202.719.7214	dtopol@wrf.com
Jonathan S. Woodruff*	202.719.7426	jwoodruff@wrf.com

* Member, Virginia Bar. District of Columbia Bar membership pending. Supervised by the principals of the firm.

** Member, Massachusetts Bar. District of Columbia Bar membership pending. Supervised by the principals of the firm.

1776 K Street NW ✦ Washington, DC 20006 ✦ (ph) 202.719.7000 ✦ (fax) 202.719.7049

7925 Jones Branch Drive ✦ Suite 6200 ✦ McLean, VA 22102 ✦ (ph) 703.905.2800 ✦ (fax) 703.905.2820

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