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The ABCs of Analyzing a Liability Insurance Policy

Presented by

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INTRODUCTION

Reading an insurance policy is anything but enjoyable, unless one is a hopeless insomniac. But it is a task that lawyers may be called upon to perform if they work for an insurance company, or if they represent a client whose insurance carrier has disclaimed coverage. Lawyers may also need to analyze the policy's provisions to render advice concerning their client's rights and obligations under the policy.

Analyzing insurance policies can be complex. Most insurance issues, however, can be identified and evaluated based upon a methodical, analytical process and some basic rules of interpretation. This handout, along with a live presentation by attorney, Jeff Bolender, will provide a checklist of five analytical steps, including an explanation as to the context and purpose of each step in the analytical process. Those steps involve answering the following questions:

1. Does the entity or person who is tendering the claim for insurance, hereinafter "tendering party," qualify as an insured under the insurance policy?
2. Do the claims against the tendering party fall within the scope of the insurance policy's insuring agreement?
3. Do any of the claims within the insuring agreement fall within the scope of any exclusionary provisions, and if so, do any exceptions apply to the exclusionary effect of those policy provisions?
4. Did the tendering party satisfy the policy's conditions, and if not, does the failure to satisfy those conditions excuse the insurance carrier's contractual obligations?
5. How must the insurance carrier respond to the claim for insurance benefits or otherwise perform those contractual obligations set forth in the insurance policy,

as well as the covenants implied by law into all insurance policies?

* * * * *

To illustrate the analytical process, this handout and the presentation will focus solely on one of the most common forms of insurance—namely, a Commercial General Liability Occurrence Form, commonly known by its acronym, CGL policy. A 2004 version of a standard CGL policy is attached.

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In analyzing an insurance policy, the first step usually involves asking the question: does the party seeking coverage—referred to herein as the "tendering party"—qualify as an insured under the insurance policy?

Often, the tendering party's status as a qualifying insured is clear from the outset. For example, in the usual situation the tendering party is the entity or person who is identified and scheduled in the declarations of the insurance policy as the named insured. Sometimes, however, the tendering party qualifies as an insured under a policy in which that party is not specifically identified. Rather, the policy's general provisions describe a class of individuals who may qualify under certain circumstances. In such instances, it may be necessary to identify the tendering party's relationship to the named insured, and the extent to which that party is facing liability in the capacity as an insured.

Additionally, a tendering party may be specifically identified as an additional insured via an endorsement that amends the policy. As explained below, liability coverage for additional insureds, who qualify under an additional insured endorsement, is limited by language in the endorsement that restrict the circumstances under which the additional insured will be entitled to coverage.

NAMED INSUREDS

The named insured is the person or entity to whom the policy is issued. The named insured can be a person or business entity. The declarations page of an insurance policy identifies the named insured, including its address, form of business (e.g., corporation), and a general description of the named insured's operations.

In CGL policies, the named insured is specifically identified by the terms "you" and "your." The introductory paragraphs of a CGL policy state:

> Throughout this policy the words “you” and “your” refer to the Named Insured shown in the Declarations, and any other person or organization qualifying as a Named Insured under this policy. The words “we”, “us” and “our” refer to the company providing this insurance.
>
> The word “insured” means any person or organization qualifying as such under Section II Who Is An Insured.
>
> * * * * *

As reflected above, the words “you” and “your” specifically refer to only the named insured, whereas the word “insured” embraces a larger class of qualifying insureds—namely, anyone, including the named insured, who qualifies as an insured under Section II of the CGL policy entitled, Who Is An Insured.

Various provisions in a CGL policy treat the named insured somewhat differently than other insureds.

For example, one of the exclusionary provisions in a CGL policy provides that “This insurance does not apply ... to ‘Property damage’ to ... Property you own, rent or occupy...” In this instance, the exclusion would only apply to property owned by the named insured, not property owned by an insured who is not the named insured. Stated differently, “property you own” refers to property owned by the named insured, not property own by anyone else who qualifies as an insured.

In contrast, another exclusion provides that “This insurance does not apply ... to ‘Property damage’ to ... personal property in the care, custody or control of the insured[.]” Unlike the exclusion for owned property, which is limited to property owned by the named insured, the “care, custody, or control” exclusion applies to any insured. This is because the term “insured” means anyone, including the named insured, who qualifies under Section II.

In summary, it is critical to begin the analysis of a CGL policy, or any type of insurance policy, by first identifying the named insured in order to distinguish between the various classes of qualifying insureds.

AUTOMATIC INSUREDS

Some entities and persons may qualify as insureds by virtue of their relationship with the named insured. In recent years, some lawyers and insurance professionals have begun to use the phrase, "automatic insured," to describe such qualifying insureds. Apparently, the reason this phrase was created is to distinguish between additional insureds, who are added via a policy endorsement, from those who qualify as an insureds by virtue of their relationship to a CGL policy's named insured.

Determining whether a tendering party qualifies as an automatic insured involves a two step process. First, one must determine the form of the named insured's business, which is indicated on the policy's declarations page. Second, one must then determine if the tendering party's relationship with the named insured meets any of the qualifying language, and if so, whether the tendering party faces liability in its capacity as an automatic insured.

For example, if the named insured is a corporation, one would begin by reviewing the first paragraph of Section II of the CGL policy, which states as follows:

> **1.** If you are designated in the Declarations as:
>
> > **a.** An individual, you and your spouse are insureds, but only with respect to the conduct of a business of which you are the sole owner.
> >
> > **b.** A partnership or joint venture, you are an insured. Your members, partners, and their spouses are also insureds, but only with respect to the conduct of your business.

c. A limited liability company, you are an insured. Your members are also insureds, but only with respect to the conduct of your business. Your managers are insureds, but only with respect to their duties as your managers.

d. An organization other than a partnership, joint venture or limited liability company, you are an insured. Your "executive officers" and directors are insureds, but only with respect to their duties as your officers and directors. Your shareholders are insureds, but only with respect to their liability as your stockholders.

* * * *

Thus, if the named insured is a corporation, subparagraph **d**. would be the pertinent policy provisions to begin the analysis, because it is an organization other than a partnership, joint venture or limited liability company.

As reflected above, the corporation's executive officers and directors qualify as insureds, "but only with respect to their duties as the named insured's officers or directors." If, for example, the tendering party claims to be a director of the named insured corporation, that director may qualify as an insured; however, one must further analyze whether the director is actually being sued in his or her capacity as the named insured's director, i.e., for liability-producing acts or omissions committed within the scope of the director's corporate duties. Milazo v. Gulf Ins. Co. (1990) 224 Cal.App.3d 1528, 1538 (named insured partnership sues one partner for usurping a partnership opportunity and other fiduciary wrongdoings; held, defendant partner not entitled to coverage for wrongful acts committed outside scope of his partnership capacity); accord Lomes v. Hartford Fin'l Services Group, Inc. (2001) 88 Cal.App.4th 127, 133; but see Barnett v. Fireman's Fund Ins. Co. (2001) 90 Cal.App.4th 500, 510 (named insured corporation sues former officers for defamation of corporation while still employed as officers; held, former officers

entitled to a defense because complaint alleges officers were seeking to further corporate interests when they criticized named insured's business practices).

ADDITIONAL INSURED

The phrase "additional insured" is often used in the general sense to describe any entity or person, other than the named insured, who also qualifies as an insured under an insurance policy. In fact, the phrase has been overused to the point that "additional insured" often lacks a commonly understood, definitive meaning among many who use that phrase. For example, some lawyers, insurance professionals, and judges will use the term generally to include those who may qualify as "automatic insureds" (discussed above).

Here, however, the use of the phrase "additional insured" is limited to situations in which an entity or person whose status as an insured is pursuant to an additional insured endorsement. An additional insured endorsement is an amendment to a liability policy. It amends Section II of a standard form CGL policy. Section II is the part of the CGL policy that describes those entities and persons who qualify as insureds. Typically, the endorsement specifically schedules a particular entity or person, along with language that describes the extent of coverage available to that scheduled entity or person.

Additional insured endorsements, or "AIE's," usually are pre-printed forms; however, many different versions exists, and each must be separately analyzed based on the specific language therein.

Recently, the Nevada Supreme Court addressed various issues relating to an additional insured endorsement. Fed. Ins. Co. v. Am. Hardware Mut. Ins. Co., 184 P.3d 390 (Nev. 2008).

In Federal Insurance, an employee of a maintenance company sued his employer's customer for injuries sustained on the customer's premises. The customer was scheduled as an additional

insured pursuant to an additional insured endorsement on the maintenance company's CGL policy. The endorsement provided that the customer was an insured "but only with respect to liability arising out of the [named insured's] ongoing operations performed for that [additional insured]." The carrier refused to defend the customer on the grounds that the endorsement's coverage did not extend to the additional insured's direct acts of negligence. The carrier argued that the endorsement's coverage was only triggered when the alleged negligence could be imputed to the additional insured through the named insured's operations.

The Nevada Supreme Court, however, held that an additional insured endorsement provides coverage without regard to fault unless it provides explicit limiting language clearly providing otherwise. Because the endorsement's terms did not allocate fault, it does not preclude coverage for the additional insured's own negligent acts, so long as those acts are connected to the named insured's operations and causally linked to the injury.

SEPARATION RULE

One of the conditions of a CGL policy states that "this insurance applies separately to each insured against whom…suit is brought."

Case law has interpreted this to mean that an insurance carrier must perform a separate analysis as to each entity or person who tenders a claim. This is because a CGL policy's insurance protection may be different depending upon the identity of the tendering party.

Consider the following example: plaintiff, an employee of Acme Corp., sues Acme Corp. and Bob, a co-employee, for injuries sustained on the job (and outside the scope of the exclusive-remedy rule of the workers compensation laws). Acme Corp. and the co-employee each tender the lawsuit to the general liability carrier for Acme Corp. In evaluating the tender of defense, the insurance carrier will determine whether the exclusion for employer's liability ap-

plies. That exclusion is set forth at Section I.A.2.e. of the CGL policy, and states in pertinent part:

> This insurance does not apply to:
>
> **e. Employer's Liability**
>
> "Bodily injury" to:
>
> **(1)** An "employee" of the insured arising out of and in the course of:
>
> **(a)** Employment by the insured; or
>
> **(b)** Performing duties related to the conduct of the insured's business[.]
>
> * * * *

As to the named insured corporation, the above-quoted exclusion would apply, because the plaintiff is an employee of "the insured" Acme Corp. however, the exclusion would not apply to "the insured" co-employee Bob, because the plaintiff is not employed by a co-employee. Tri-S Corp. v. Western World Ins. Co., 135 P.3d 82 (Ha. 2006). The Hawai'i Supreme Court in Tri-S Corp. explained that "the insured" refers to the insured seeking coverage, and that consequently, each tendering party's tender must be separately analyzed. Notably, the analysis would be different if the exclusion stated "employee of *an* insured." There, the exclusion would apply to all qualifying insureds if the plaintiff was employed by any insured.

"You're denied coverage because of your pre-existing condition of having lousy health insurance."

After determining that the tendering party qualifies as an insured, the next step is to determine whether the allegations against the tendering party fall within one or more insuring agreements under the policy.

A CGL policy contains three insuring agreements. Coverage A provides insurance protection for bodily injury liability and property damage liability. Coverage B provides insurance protection for personal and advertising injury liability. And Coverage C provides coverage directly to a third party claimant for certain medical payments, regardless of fault.

For purposes of this booklet and presentation, we focus solely upon Coverage A, which is the insurance protection most commonly associated with lawsuits involving construction defects. Also, in analyzing an insuring agreement, it is important to apply the correct standards of interpretation. Under Nevada law, courts broadly interpret insuring agreements to afford a qualifying insured the greatest possible coverage. Fed. Ins. Co. v. Am. Hardware Mut. Ins. Co., 184 P.3d 390 (Nev. 2008).

The insuring agreement for Coverage A, Bodily Injury and Property Damage Liability, provides in pertinent part as follows:

> **1. Insuring Agreement**
>
> **a.** 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 the insured against any "suit" seeking those damages. However, we will have no duty to defend the insured against any "suit" seeking damages for "bodily injury" or "property damage" to which this insurance does not apply. We may, at our discretion, investigate any "occurrence" and settle any claim or "suit" that may result…

b. This insurance applies to "bodily injury" and "property damage" only if:

(1) The "bodily injury" or "property damage" is caused by an "occurrence" that takes place in the "coverage territory";

(2) The "bodily injury" or "property damage" occurs during the policy period...

* * * *

As explained below, analyzing a CGL policy's insuring agreement under Coverage A involves the following analytical steps:

1. Does the claim seek money damages because of a physical injury to tangible property or an injury to the body?
2. Was each particular item of property damage or bodily injury sustained during the policy period?
3. Was the property damage or bodily injury caused by an "occurrence" that is potentially attributable to the tendering party?
4. Is the tendering party facing liability in the context of a "suit" as defined in the policy?

* * * *

MONEY DAMAGES

For purposes of liability insurance, the term "damages," which is not defined in the insurance policy, is limited to monetary awards issued by a court of law to compensate a third-party claimant for a past loss.

The term "damages" does not include other forms of judicial relief, such as restitutionary relief, declaratory relief, or most forms of injunctive relief. The term "damages" also does not include a monetary award intended to prevent future losses. Crystal Bay Gen. v. AETNA Cas. & Sur. Co., No. 90-16417, 1992 WL 98269 (9th Cir. Apr. 7, 1992) (holding that construction of sewer bypass does not constitute "damages" because "there was no evidence that it would remedy damage caused by [the sewage spill]. Rather, the bypass was a prophylactic measure designed to prevent future spills.")

PROPERTY DAMAGE

To constitute "property damage," it must be shown that the damaged property is tangible property. Tangible property generally refers to property that can be seen or touched. "Property damage" does not include damage to intangible property such as goodwill, licenses, leaseholds, easements, patents, copyrights or trade secrets, and claims for purely economic losses.

Section V of the CGL policy defines "property damage" as follows:

> **17.** "Property damage" means:
>
> **a.** Physical injury to tangible property, including all resulting loss of use of that property. All such loss of use shall be deemed to occur at the time of the physical injury that caused it; or
>
> **b.** Loss of use of tangible property that is not physically injured. All such loss of use shall be deemed to occur at the time of the "occurrence" that caused it.
>
> For the purposes of this insurance, electronic data is not tangible property.
>
> As used in this definition, electronic data means information, facts or programs stored as or on, created or used on, or transmitted to or

> from computer software, including systems and applications software, hard or floppy disks, CD-ROMS, tapes, drives, cells, data processing de-vices or any other media which are used with electronically controlled equipment.
>
> * * * *

In some instances, it is necessary to carefully distinguish between an injury to real property and the loss of an intangible right in real property. For example, in one case, the court found that a claim arising out of a neighbor's lawsuit to enforce an easement across the insured's real estate did not constitute a physical injury to tangible property. An easement represents only a nonpossessory right to use another's property and is not tangible property. Rendering the easement unusable by paving, and the ability to recover damages for obstruction, did not change its intangible nature. Kazi v. State Farm Fire & Cas. Co., 24 Cal.4th 871 (2001).

In order to constitute a covered property damage claim, most third party claims must involve a physical injury to tangible property. This generally means the tangible property must sustain some type of observable or measurable harm, degradation, or physical impairment. Intangible economic losses, such as violation of anti-trust laws and breach of contractual obligations or warranties, do not constitute property damage under CGL policies. Any "loss of use" resulting from the physical injury to tangible property is within a liability insurance policy's scope of coverage (unless otherwise excluded).

Property damage may include the loss of use of real or personal property that is not otherwise physically injured.

For example, a strawberry grower suffered property damage when a commercial nursery supplied it with defective strawberries and the grower lost the use of the fields for the entire growing season. Hendrickson v. Zurich Am. Ins. Co. of Ill., 72 Cal.4th 1084, 1091 (1999).

In another case, a manufacturer of scanners suffered property damage when it installed defective circuit boards into its scanners that malfunctioned and caused the scanners to fail. Anthem Electronics, Inc. v. Pacific Employers Ins. Co., 302 F.3d 1049, 1057 (9th Cir. 2002).

BODILY INJURY

For purposes of general liability insurance, a bodily injury is generally limited to a physical injury and its consequences, and such injuries generally do not include emotional distress in the absence of a physical injury. However, emotional distress may constitute a bodily injury in two circumstances: when the emotional distress is a consequence of a physical injury; or when emotional distress manifests itself physically, such as breaking out in hives due to severe anguish.

TRIGGER OF COVERAGE

The term "trigger of coverage" refers to the operative event that must occur during the policy period in order to invoke, or trigger, coverage. The Nevada Supreme Court has held that "a tangible, physical injury" to property must occur during the policy period to trigger coverage under CGL policies. United Nat'l Ins. Co. v. Frontier Ins. Co., 120 Nev. 678 (2008).

It appears, however, that Nevada courts have not yet definitively determined the appropriate trigger for continuous property damage sustained during multiple policy periods. Gary G. Day Constr. Co. v. Clarendon Am. Ins. Co., 459 F.Supp.2d 1039 (D.Nev. 2006) (noting that Nevada courts have not adopted either the manifestation theory or the continuous exposure theory in a progressive loss type of claim).

Determining the appropriate trigger of coverage has a significant impact on construction defect litigation, as well as environmental

contamination and other progressive injury type claims. Consider the following example: water intrusion occurs over the course of three years during which three different CGL policies are in effect. The water causes physical damage to the interior walls, etc., but the property damage does not manifest itself until the third year. Under a manifestation theory, the only triggered policy would be the one in effect during the third year, whereas under the continuous exposure theory, each policy would be triggered because the property sustained physical injury during each policy period.

As noted above, the Nevada Supreme Court has apparently not specifically determined which trigger applies in a progressive loss type claim. Historically, Nevada courts have looked to other states, including California, on unsettled issues relating to insurance law. Accordingly, we discuss below the basic holding of the Montrose case and some of its implication on liability insurance coverage for construction defect lawsuits.

In 1995, the California Supreme Court issued the seminal opinion, Montrose Chemical Corp. of Cal. v. Admiral Ins. Co., 10 Cal.4th 645 (1995). The court held that CGL policies are triggered at the time the plaintiff is actually damaged, not at the time the accident (or negligent act) causing the damage occurred. More importantly, the court held that, if the damage is progressively deteriorating over multiple policy periods, the property damage may trigger coverage under each policy in effect during those periods.

The significance of Montrose to construction defect litigation (or other progressive loss type claims) is that coverage is not limited to the policy in effect at the time when the precipitating event or condition occurred, or to the policy in effect when the property damage first manifested itself. Moreover, the policy's full limit may be exposed, even if the property damage continues after the policy is terminated. As the California Supreme Court later explained in Aerojet-General Corp. v. Transport Indem. Co., 17 Cal.4th 38, 57, (1997), "[i]f specified harm is caused by an included occurrence

and results, at least in part, within the policy period, it perdures to all points of time at which some such harm results thereafter."

OCCURRENCE

In addition to determining whether a claim involves property damage sustained during the policy period, it must be established that the property damage or bodily injury resulted from an "occurrence." CGL policies define "occurrence" to mean an "accident, including continuous or repeated exposure to substantially the same general harmful conditions."

The Nevada Supreme Court has further explained that an "occurrence" is a "happening that is not expected, foreseen or intended." United Nat'l Co. v. Frontier Ins. Co., Inc., 120 Nev. 678 (2004). For example, a sewage spill constitutes an "occurrence" because it is sudden and unexpected. Crystal Bay Gen., 1992 WL 68269. Nevada law, as interpreted by the United States District Court, has found that water intrusion qualifies as an accident and, thus, an occurrence. Gary G. Day Constr. Co. v. Clarendon Am. Ins. Co., 459 F.Supp. 2d 1039 (D.Nev. 2006) (interpreting policy language that differs from standard CGL form's language).

Under recent California case law, the Supreme Court held that "the word 'accident' in the coverage clause of a liability policy refers to the conduct of the insured for which liability is sought to be imposed on the insured." Delgado v. Interinsurance Exchange of Automobile Club of Southern California (2009) 47 Cal.4th 302, 314-315. The Delgado court explained that "an injury-producing event is not an 'accident' within the policy's coverage language when all of the acts, the manner in which they were done, and the objective accomplished occurred as intended by the actor." The Delgado court also noted that courts in a variety of contexts have "rejected the notion that an insured's mistake of fact or law transforms a knowingly and purposefully inflicted harm into an accidental injury."

The "occurrence" requirement is a fundamental issue in the law governing interpretation of liability insurance, but it is often misunderstood. There are thousands of published appellate opinions throughout the state and federal courts interpreting the term "occurrence." And those opinions are far from consistent. The standard definition of "occurrence" has changed over the years, but modern courts will often refer to case opinions interpreting earlier versions of the definition. Also, lawyers, insurance professionals, and courts often confuse the "occurrence"—i.e., as the causative event—with the resulting property damage or bodily injury. The "occurrence" requirement is also confused with those appellate opinions determining whether an insurance policy's per-occurrence limits applies to limit the amount of insurance available in a particular claim.

The concept of "occurrence" in liability insurance is malleable and highly context based. It generally refers to the original causative event—e.g., the liability producing act or omission—and any other events or conditions in the chain of causation that ultimately results in property damage and bodily injury. Although the causative event and the resulting loss are often simultaneous, they should be treated as distinct concepts when performing careful analysis of an insurance policy. Therefore, in performing an analysis of a CGL policy's insuring agreement, it is important in many contexts to distinguish between the causative event and the resulting property damage or bodily injury.

THE "SUIT" REQUIREMENT

Under CGL policies, an insurance carrier's duties are generally not triggered unless the policyholder faces potential liability for covered damages in a "suit." CGL policies define a "suit" as "a civil proceeding in which damages to which this insurance applies are alleged." A "suit" also includes an arbitration proceeding to which the named insured must submit. Also, the "suit" requirement will attach under certain circumstances if the policyholder and insurance car-

rier consent to another form of dispute resolution, such as a mediation.

Generally, however, pre-lawsuit proceedings as well as administrative proceedings are usually not considered a “suit.” In anticipation of the insurance industry taking this position, which is routinely asserted by many liability insurance carriers in the United States, the Nevada Legislature codified a rule requiring an insurer to treat Chapter 40 claims “as if a civil action has been brought against the contractor, subcontractor, supplier or design professional...” NRS 40.649(2).

"I think you misunderstood. The million dollar umbrella policy only covers you for claims involving an umbrella."

If a claim falls within the insuring agreement, the next step is to determine whether coverage is excluded under the policy's exclusionary provisions. An easy way to think about an exclusion is that it "takes away" coverage granted under the insuring agreement. Some exclusionary provisions describe situations in which the exclusion does not apply. Those types of provisions are referred to as exceptions.

Initially, it is important to point out that, unlike insuring agreements, exclusionary provisions are subject to narrow interpretation. Under Nevada law, courts narrowly interpret clauses excluding coverage. If a policy term is ambiguous, i.e., subject to two reasonable interpretations, courts will generally adopt the interpretation providing coverage (or greater coverage) rather than adopt the interpretation that limits or restricts coverage. Fed. Ins. Co. v. Am. Hardware Mut. Ins. Co., 184 P.3d 390 (Nev. 2008).

ANALYTICAL FOCUS

To properly analyze exclusionary provisions, it is critical to identify which policy benefit is at issue—i.e., defense or indemnity—and the analytical focus of each particular exclusion at issue. As explained below, different standards apply to each policy benefit, and depending upon the subject matter of a particular exclusion, the exclusionary effect may apply only to one policy benefit, not both.

As noted above, the two policy benefits are defense and indemnity. The defense benefit is triggered if the claims against the policyholder raise the potential for coverage, even if some claims in the "suit" are not potentially covered, and even if the potentially-covered claim is farfetched, untenable, or fraudulent. In contrast, the indemnity benefit is triggered only where a judgment is entered against a qualifying insured (or in certain other situations) for money damages because of a covered loss, such as property damage. Thus, an insurance carrier's duty to defend is based upon the mere potential for a covered claim, whereas a carrier's duty to indemnify is based upon the existence of actual money damages

for proven losses that are within the insurance policy's scope of coverage.

Understanding the differences between the two policy benefits is important. Certain exclusions may ultimately apply to limit or eliminate the insurance carrier's duty to indemnify, but do not eliminate the carrier's duty to defend. If the analytical focus of an exclusion is subject to a factual or legal dispute, and if that factual dispute will only be resolved in the "suit" against the tendering party, then the potential application of the exclusion may not function to eliminate the carrier's duty to defend.

To illustrate this point, consider the following quoted policy exclusions and hypothetical examples. Section I.A.2. of the CGL policy provides in pertinent part:

> This insurance does not apply to:
>
> **a. Expected Or Intended Injury**
>
> "Bodily injury" or "property damage" expected or intended from the standpoint of the insured. This exclusion does not apply to "bodily injury" resulting from the sue of reasonable force to protect persons or property.
>
> ...
>
> **e. Employer's Liability**
>
> "Bodily injury" to:
>
> **(1)** An "employee" of the insured arising out of and in the course of:
>
> **(a)** Employment by the insured; or
>
> **(b)** Performing duties related to the conduct of the insured's business[.]

k. Damage To Your Product

"Property damage" to "your product" arising out of it or any part of it.

* * * *

If a tendering party seeks defense and indemnification for a lawsuit alleging assault and battery, the exclusion for expected or intended injuries may be relevant to the analysis of available liability coverage. However, it is often questionable at the outset of such a lawsuit whether the exclusion will apply. The analytical focus of the exclusion is a mental state, i.e., intent to injure. Often, issues of fact exists in an assault-and-battery case as to whether the qualifying insured (i) was the aggressor; (ii) was merely defending herself; and (iii) intended to cause injuries to the claimant. In light of the factual disputes concerning the analytical focus of the exclusion, the tendering party could persuasively argue that it is entitled to a defense, even if the evidence ultimately establishes that his proven liability is excluded.

Similarly, the exclusion for employer's liability may not apply in the duty-to-defend context if the status of the claimant is at issue. For example, many times a claimant's injuries are sustained during the course of providing services to the named insured. If the claimant sues, the exclusion for employer's liability may apply to negate the insurance carrier's duty to defend, but only if there is no reasonable dispute as to whether the claimant is employed by the named insured. If, however, a factual dispute exists concerning whether the claimant was an independent contractor versus an employee, the insurance carrier may not be able to enforce the exclusion to negate its duty to defend.

In contrast, sometimes the analytical focus of an exclusion will be an issue that is not subject to a factual dispute. For example, in a lawsuit claiming that the named insured's product is defective due to a physical injury to the product, the exclusion for Damage To Your Product may negate the duty to defend if there are no allega-

tions or other extrinsic indicia that the product caused damage to other property or injury to a person.

"It says our homeowners insurance policy is subject to the following forms and endorsements, Mumbo 1590 and Jumbo 9033."

CGL policies, like all insurance policies, are subject to conditions. A condition in a contract usually refers to contractual language that imposes certain duties upon the entity or person qualifying as an insured. If the insured entity or person does not comply with the condition, such as the duty to provide prompt notice of claim, the insurance carrier's duty to defend and indemnify *may* be excused.

The conditions section of CGL policies contain other provisions, such as how a policy's insurance protection is applied where (i) another insurance policy applies to the claim; (ii) the tendering party has voluntarily incurred a cost or assumed a liability; or (iii) misrepresentations have been made in the process of procuring coverage from the insurance carrier.

NOTICE

Timely notice of a claim or suit is a condition precedent to coverage. States differ on what legal standard applies to the interpretation and application of the notice clause.

Under Nevada law, the policyholder need not show actual prejudice before denying coverage: if prompt notice is a condition precedent to coverage, then failure to comply with the notice provision excuses the insurance company's performance. Las Vegas Star Taxi Inc. v. St. Paul Fire & Marine Ins. Co., 102 Nev. 11 (1986); State Farm Mutual Auto Ins. Co. v. Cassinelli, 67 Nev. 227 (1950).

It appears, however, that Nevada is in the minority of states that do not require a showing of prejudice. In California, for example, the insured cannot deny coverage unless it shows that the delayed notice actually prejudiced its defense and resolution of the claim. Hall v. Travelers Ins. Co., (1971) 15 Cal.App.3d 304, 308 citing Billington v. Interinsurance Exchange, (1969) 71 Cal.2d 728, 737 ("[A]n insurer, in order to establish it was prejudiced by the failure of the insured to cooperate in his defense, must establish…if the cooperation clause had not been breached there was a substantial likelihood the trier of fact would have found in the insured's favor.")

COOPERATION

All liability policies require the insured to cooperate with the insurer in the investigation, defense, and settlement of a claim.

The case law of the states that have addressed the issue are not wholly consistent as to whether the insurance carrier must also show that the policyholder's failure to cooperate substantially prejudiced the insurer before its performance under the policy is excused. For example, in New York, the insurer does not have to suffer actual prejudice before disclaiming coverage for lack of cooperation, whereas in California, the policyholder's lack of cooperation only bars coverage if the insurer shows that, had the policyholder cooperated, there is a "substantial likelihood the trier of fact would have found in the insured's favor." Compare Allstate Ins. Co. v. United Intern. Ins. Co., 792 N.Y.S.2d 549 (N.Y. App. 2005) with Billington v. Interinsurance Exchange of S. Cal., (1969) 71 Cal.2d 728 ("[I]n order to establish it was prejudiced by the failure of the insured to cooperate in his defense, [the insurer] must establish at the very least that if the cooperation clause had not been breached there was a substantial likelihood the trier of fact would have found in the insured's favor.")

Nevada has apparently not yet addressed the issue of whether substantial prejudice must be shown to excuse the insurance carrier's performance for lack of cooperation. However, most states in the Ninth Circuit require substantial prejudice to be shown. See Schmidt v. Allstate Ins. Co., No. CV 05-00480 DAEKSC, 2007 WL 1430341 (D. Hawai'i May 11, 2007); Clark Equip. Co. v. Ariz. Prop. and Cas. Ins. Guar. Fund, 189 Ariz. 433, 442 (Ct. App. 1997); Estes v. Alaska Ins. Guar. Ass'n., 774 P.2d 1315, 1317-19 (1989); Or. Auto. Ins. Co. v. Salzberg, 85 Wash.2d 372, 377 (1975); State Farm Fire & Casualty Co. v. Miller (1970) 5 Cal.App.3d 837, 840; Riggs v. N.J. Fid. & Plate Glass Co. of Newark, N.J., 126 Or. 404, 410-11 (1928).

VOLUNTARY PAYMENTS

The no voluntary payment clause states that the insurer will not reimburse the policyholder for any voluntary payments or liabilities assumed by the insured without the insurance carrier's consent. Under California law, the insurer need not prove the voluntary payment substantially prejudiced it before denying reimbursement on these grounds. The rationale for this clause is twofold: (i) it prevents collusion; and (ii) it invests the insurer with complete control over the investigation, defense and compromise of a suit or claim.

Typically, this clause applies to expenses the policyholder paid prior to tendering the claim to the insurer, such as fees the policyholder pays to its own counsel. However, it may also apply after the claim is tendered as well. For example, the insurer may refuse to reimburse the policyholder for amounts unilaterally paid to settle a claim without notice to the insurer.

Under the laws of some states, the voluntary payment clause does not bar coverage for involuntary payments, or payments by the insured due to circumstances beyond the insured's control. For example, (i) economic necessity (the insured must act immediately to protect its interests); (ii) mistake (the insured is unaware of insurance coverage or of insurer's identity); and (iii) insurer refuses to defend (if insurer denies coverage, insurer may waive "voluntary payment" provision). Insua v. Scottsdale Ins. Co. (2002) 104 Cal.App.4th 737, 743–744 ("[I]f the insured makes no demand to defend, the no-voluntary-payments provision lawfully precludes recovery of pre-tender costs."); Jamestown Builders, Inc. v. General Star Indem. Co. (1999) 77 Cal.App.4th 341, 346; Fiorito v. Sup.Ct. (State Farm Fire & Cas. Co.) (1990) 226 Cal.App.3d 433, 440; Shell Oil Co. v. National Union Fire Ins. Co. (1996) 44 Cal.App.4th 1633, 1648.

OTHER INSURANCE

All policies contain provisions—typically referred to as "other insurance" clauses—that purport to limit the insurance carrier's liability to the extent that other insurance policies are available to the policyholder (i.e., collectible by the policyholder).

Many different versions of "other insurance" clauses exist, but most can be grouped into one of three general categories: pro rata clause, excess clause, and escape clause.

A pro rata clause purports to limit the insurer's liability to the total proportion that its policies bear to the total coverage (i.e., all the policies covering the same risk) available to the insured. An excess clause attempts to limit the insurer's liability to the extent the loss exceeds the policy limits of other insurance covering the same loss. An escape clause attempts to extinguish the insurer's liability if any other insurance policies also cover the loss.

The explicit provisions of the policies' respective "other insurance" clauses determine each insurer's ultimate liability. Problems arise, however, when multiple liability insurance policies covering the same risk at the same level contain conflicting "other insurance" clauses. Historically, courts have resolved conflicting "other insurance" clauses by developing rules as to how each particular type of "other insurance" functions in relation to the same or different types of clauses.

If the insurance policies contain conflicting "excess" clauses, most courts simply ignore the conflicting clauses and prorate the loss among the insurers. Court usually ignore conflicting escape clauses as well, which are highly disfavored by courts.

When a conflict between a pro rata clause and an escape clause arises, most courts rule the escape clause unenforceable and prorate the loss on an equitable basis.

With respect to conflicts between a pro rata clause and excess clause, the case law is inconsistent. Some courts hold that an excess clause prevails over a pro rata clause whereas other courts simply ignore the conflicting clauses and prorate the loss.

In recent years, some states, such as California, have steered away from applying these mechanical conflict rules. Instead, courts in these states determine whether all policies on risk are primary or true excess policies. Generally, coverage afforded under a primary policy attaches immediately upon the happening of an occurrence within the policy's coverage (i.e., "first dollar" insurance). In contrast, liability under a true excess policy only attaches after a predetermined amount of specifically-identified primary coverage has been exhausted.

MISREPRESENTATIONS

It is fundamental to the economic relationship between policyholders and insurance carriers that those who apply for insurance accurately provide requested information, as well as provide any information material to the risks for which insurance protection is sought. If a policyholder omits material information, or misrepresents material information, the insurance carrier may be able to avoid performing its contractual obligations.

Generally, two means exists for an insurance carrier to avoid its contractual obligation when the policyholder has made a material omission or misrepresentation. The first is by rescinding the policy under state laws that permit rescission. Generally, rescission is effected by notifying the policyholder of the rescission, the grounds for rescission, and returning the premium. Case law exists in some states suggesting that, after a third party claimant has sustained a loss, which may be compensable under the tortfeasor's liability policy, that policy can only be rescinded if done so judicially. In any event, rescission voids the policy *ab initio*, meaning that the insurance policy no longer exists.

A second means for an insurance carrier to avoid its contractual obligation is to assert the policyholder's failure to comply with the following condition in the policy:

> **6. Representations**
>
> By accepting this policy, you agree:
>
> **a.** The statements in the Declarations are accurate and complete;
>
> **b.** Those statements are based upon representations you made to us; and
>
> **c.** We have issued this policy in reliance upon your representations.
>
> * * * *

In Nevada, misrepresentations or omissions in the application for insurance bar coverage and justify rescission of any insurance contract if they are material or fraudulent, or if the insurer would not have issued the exact same policy had it known the truth. NRS 687B.110; Morales v. Prudential Ins. Co. of Am., Nos. 48165, 48443, 50181, 2008 WL 6124614 (Nev. Dec. 11, 2008) (intent to deceive need not be shown if the misrepresentation is material.) A representation is material if a truthful response would have affected the insurer's decision to underwrite the risk or what premium to charge.

If the insurer knows that the application contains a material misrepresentation when it issues the policy, it effectively waives its right to rescind the contract after a loss has occurred. An insurer is "'chargeable' with knowledge of the misrepresentation if 'full information about it' is present in its own files." Violin v. Fireman's Fund Ins. Co., 81 Nev. 456, 461 (1965).

For example, in Violin, the insurance application asked, "Has any company ever refused or canceled insurance?" The applicant responded "No" when, in fact, the same insurer that issued the cur-

rent policy had cancelled another policy the insured purchased four years ago. The trial court found the misrepresentation to be both material and intentional. However, the misrepresentation did not bar coverage because information of the cancellation was in Defendant Insurer's own records when it wrote the present policy.

The fact that no one in the new business department checked with the cancellation department was immaterial. Noting "the insurer's ability to promptly discover the misrepresentation after the loss has occurred," the court reasoned that "[i]f it is available at one time, it out to be imputable at the other." Violin, 81 Nev. at 462.

The ultimate goal in analyzing an insurance policy is determining how the insurance carrier must respond to the claim of the tendering party. Thus, after analyzing the issues discussed above, the next step is to determine how the insurance carrier must perform under the language of the insurance policy, as well as duties imposed by law.

INVESTIGATION

An insurance carrier's initial duty is to investigate claims tendered to it under insurance policies.

Many states promulgate regulations that impose various duties upon a liability insurance carrier to respond promptly to the tender of a claim, even if the claim is outside the scope of coverage under the pertinent insurance policy. Additionally, the implied covenant of good faith and fair dealing imposes a duty on the insurance carrier to investigate all properly submitted claims with reasonable diligence. This duty arises immediately upon notification to the carrier of a claim for benefits under the policy. The insurer must investigate all claims, even when it appears from the outset that the claim is frivolous. McCalla v. Royal Maccabees Life Ins. Co., No. 99-15992, 2001 WL 791721 (9th Cir. July 12, 2001).

The adequacy of the insurer's investigation is evaluated objectively in light of the attendant circumstances of the case, but the insurer, at a minimum, must investigate facts material to the issue of liability.

Many states also impose a statutory duty on the insurer to reasonably investigate all properly tendered claims. For example, N.R.S. 686A.310 states that "failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies" constitutes an unfair business practice. Violating this statutorily imposed duty is evidence of the insurer's failure to conduct a reasonably diligent investigation,

but does not conclusively establish it. Hart v. Prudential Prop. & Cas. Ins. Co., 848 F.Supp. 900 (1994).

If the insurer fails to conduct a reasonably diligent investigation of a tendered claim, courts may impute knowledge of the facts it could have discovered had it performed such an investigation. Moreover, the adequacy of the insurer's investigation is a critical factor in determining whether the insurer acted in good faith.

DISCLAIM COVERAGE

If the insurer decides the policy does not cover the tendered claim, it must provide timely written notice to the insured, explaining the basis on which it is disclaiming coverage. The disclaimer notice must include the pertinent policy language, allegations, claims, and facts upon which the decision to disclaim coverage is based.

The Nevada Insurance Code requires the insurer to provide such notice "within a reasonable time after proof of loss requirements have been completed and submitted by the insured." N.R.S. 686A.310. Failing to comply with this notice statute is evidence that the insurer acted in bad faith, but it does not conclusively establish it. Hart v. Prudential Prop. & Cas. Ins. Co., 848 F.Supp.900 (1994).

PAY BENEFITS

If the insurer decides the policy provides coverage for the tendered claim, it must promptly pay policy benefits and take any other action necessary to satisfy its contractual duties to the tendering party.

In the context of a CGL policy, for example, an insurance carrier will owe a duty to defend the tendering party if at least one claim within the complaint raises the potential for covered damages. Satisfying the defense obligation involves hiring a competent law firm to defend against *all* claims in the lawsuit, even those claims that are not potentially covered. The defense obligation also involves ade-

quately funding the appointed defense attorney's efforts to defend the tendering party.

If the carrier elects to defend, but believes that the claims against the tendering party may ultimately be excluded, the carrier has the option of agreeing to defend under a reservation of the right to decline coverage down the road. In such instances, the carrier's agreement to defend under a reservation of rights may create a disqualifying conflict of interest on the part of the defense counsel appointed by the carrier. While Nevada law is not entirely clear on the matter, it appears that under such circumstance, the carrier may be obligated to provide the tendering party with its preferred counsel, i.e., a counsel who is "independent" of the insurance carrier's control over the defense. See Nevada Yellow Cab Corp. v. Dist. Ct., 152 P.3d 737 (Nev. 2007) (holding that both the insurance carrier and policyholder are the clients of the insurer-appointed defense counsel); Jeffrey W. Stempel, The Relationship Between Defense Counsel, Policyholders, and Insurers: Nevada Rides Yellow Cab Toward "Two-Client" Model of Tripartite Relationship. Are Cumis Counsel and Malpractice Claims by Insurer's Next?, Nevada Lawyer, June 2007, at 20 (opining that in light of the holding in Nevada Yellow Cab Corp., "it would appear that Nevada will follow California's lead" with respect to a policyholder's right to independent counsel); compare State Bar of Nevada, Formal Opinion No. 26 (March 21, 2001); see also San Diego Navy Federal Credit Union v. Cumis Insurance Society (1984) 162 Cal.App.3d 358; Cal. Civ. Code § 2860 (codifying, clarifying, and limiting the holding in Cumis).

Additionally, if a judgment is entered against a qualifying insured, the insurer must pay the judgment to the extent that it embraces damages because of a covered loss. Although a CGL policy's duty to indemnify is generally limited to civil judgment (as well as certain other circumstances), courts throughout the United States have found that an insurer may owe a legal duty to accept reasonable, pre-trial settlement offers. Generally, if there is a significant chance that the court or jury will render a verdict for covered damages in

excess of the policy's limits of insurance, the law imposes a legal duty to accept a settlement demand within policy limits.

The implied covenant of good faith and fair dealing enjoins an insurer from refusing "without proper cause" to compensate the insured for a loss covered by the policy. Pemberton v. Farmers Ins. Exchange, 109 Nev. 789 (1993). Unreasonably delaying or refusing to pay benefits due under the policy constitutes bad faith. An insurer is also required to thoroughly investigation its basis for denying benefits before doing so. A refusal to pay benefits because of a genuine dispute of a legal as to the existence of coverage may not bad faith. Carter v. State Farm Mut. Auto. Ins. Co., CV-S-96-142-LDG(RLH) 1996 WL 901286 (D.Nev. Nov. 4, 1996).

SEEK DECLARATORY RELIEF

Often, it is unclear whether an insurance carrier must defend or indemnify a qualifying insured. Under such circumstances, the carrier is usually entitled to file an action for declaratory relief to obtain a judicial declaration of the rights and obligations of the carrier and tendering party.

If the carrier files a declaratory relief action, there is always a possibility the court will stay the action pending resolution of the underlying third party action that gave rise to the coverage dispute, especially when the issues to be adjudicated in both cases overlap. Overlapping issues raise concerns of res judicata: if the declaratory relief action proceeds before the underlying third party action that gave rise to the coverage dispute, the tendering party may be estopped from re-litigating certain issues when it defends the underlying third party action. Courts often avoid placing the insured in this unfair, compromising position by staying the declaratory action whenever both cases require resolution of the same issues of fact. See Great American Ins. Co. v. Sup. Ct. (2009) 178 Cal.App.4th 221 ("When a declaratory relief action regarding a liability insurer's duty to defend depends on coverage issues, and the resolution of those issues might prejudice the insured in the underlying litigation,

the proper course of action is to stay the declaratory relief action until resolution of the underlying action."); Haskel, Inc. v. Sup. Ct. (1995) 33 Cal.App.4th 963, 975.

RESCIND OR REFORM

If the insurer discovers that the policyholder materially misrepresented or omitted information in its insurance application, it may be able to rescind the insurance policy even after the insured has tendered a claim otherwise covered under the policy. However, if "full information about [the misrepresentation] is present in [the insured's] own files," the insurer cannot later rescind the contract after the insured tenders its claim. Violin v. Fireman's Fund Ins. Co., 81 Nev. 456, 461 (1965).

An insurer may seek to reform an insurance contract when there was some kind of mutual mistake in the way the policy was transacted and/or issued that warrants changing the policy to make it consistent with the mutual intentions of the parties at the time the policy was issued.

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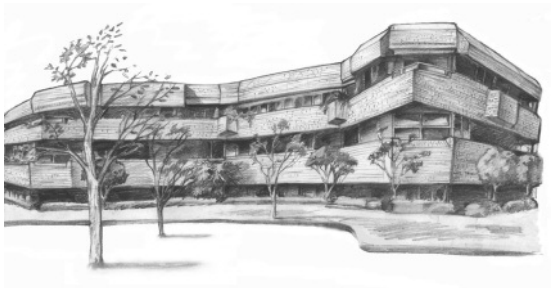
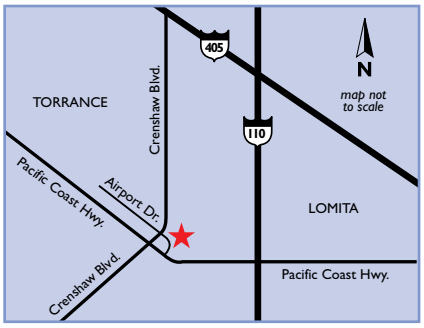


The offices of Bolender & Associates are located in Torrance, California in Southwest Los Angeles County. We are about 20 minutes away from the Los Angeles and Long Beach International Airports. If you would like discuss any legal matters, please do not hesitate to call and make an appointment to speak with Jeffrey S. Bolender.



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