"Let's Call the Whole Thing Off": Pleading, Prosecuting and Defending Rescission Claims[1]

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INTRODUCTION

Although most state's laws discourage policyholders from making misrepresentations to their insurers during the underwriting process, insurers seeking to rescind their policies are often burdened with difficult hurdles — such as proof of the policyholder's intent to deceive — and inflexible notice requirements before they can reap the benefit of that remedy. Courts are also inclined to consider rescission a drastic step and are "ordinarily reluctant to grant it." *Union Ins. Exch., Inc. v. Gaul*, 393 F.2d 151, 154 (7th Cir. 1968).

This paper will explore some of the legal and practical implications of misrepresentations made by policyholders during the underwriting process, surveying statutes, cases, and rules dealing with the remedies available to insurers and the defenses often invoked by insureds.

I. THE UNDERWRITING PROCESS

The potential rescission of an insurance policy will involve a careful review of the underwriting of the policy. Key points to be reviewed include the following.

A. Application Questions

Whether the insurance applicant made any misrepresentations in the application that would merit rescission of the policy will depend on the precise language of the application question(s), the wording of the response, potentially the context for the question based on other parts of the application, and in some instances, any follow up regarding the application by the broker or the insurer. Applications for new business tend to require more detail than applications for renewal policies.

Because the fundamental purpose of insurance is to afford coverage for fortuitous events, applications often ask the applicant to confirm that it is not aware of any claims or potential claims. As an example, an application might ask:

> (a) No person or entities for whom this insurance is being applied have any knowledge of any fact, circumstance, situation, or information of any error, misstatement, act, omission, neglect, breach of duty or other matter that may give rise to a Claim which may fall within the scope of coverage of the proposed insurance.
>
> (b) No person(s) or entity(ies) proposed for whom this insurance is being applied has knowledge of any inquiry, investigation or communication that he/she/it has reason to believe might give rise to a Claim that might fall within the scope of coverage of the proposed insurance.

Applications may also contain an exclusion that bars coverage in the event that the applicant had such knowledge, and a claim arises from the undisclosed facts and circumstances. One such "prior knowledge" exclusion provides:

> It is agreed that with respect to Questions [ ] through [ ] above, if such claim(s), suit(s), investigation(s), action(s), proceeding(s), knowledge, information or involvement exists, then such claim(s), suit(s), investigation(s), action(s) or proceeding(s), and any claim or action arising therefore or arising from such knowledge or information is excluded from the proposed coverage.

In addition to asking for information about knowledge of facts or circumstances that may give rise to a claim, new business applications will often ask about claims history, in addition to requesting a loss run from the former insurer(s). For example, "Have any claims been made during the last 5 years against any person or entity proposed for this insurance in his or her capacity as a director, officer or trustee of any corporation or organization?" If the answer is anything other than an unqualified "No," the application typically must identify and provide further detail regarding those claims.

Applications may also ask for information about the insured's corporate governance and turnover in leadership, financials and projected growth, and standards in human resources. The nature of the questions in the application, understandably, largely tracks the nature of the risk to be insured.

Not infrequently, applications that are submitted to an insurer are incomplete, internally inconsistent, missing referenced attachments, and even unsigned or not signed by the person required by the terms of the application. Applications may be and in some instances must be supplemented after the initial submission. An application will typically require supplementation if any of the responses in the application change between the date of the initial submission and the date of the policy issuance If the information submitted by the applicant by the time of the quote is incomplete or inadequate, a quote may be issued with "subjectivities," which reflect additional information that the applicant must provide for the underwriter's review before any final decision is made to bind on the proposed terms, potentially offer different terms, or even decide not to offer a policy at all.

All of the information that the insurer has requested to underwrite the risk and to decide whether and on what terms to issue any policy will be reviewed during the rescission investigation.

Where an insurer seeks to rescind based on misrepresentations in the application, disputes sometimes arise regarding the specific language in the application question and whether the response fairly answers it. While the Ninth Circuit recently affirmed an insurer's rescission of a professional liability policy based on a misrepresentation in the application, one judge dissented, concluding that one of the application's questions was confusing, even though the insurer and the insured interpreted it in the same way. *W. World Ins. Co. v. Prof. Collection Consultants,* No. 16-55740, 2018 WL 259309 (9th Cir. Jan. 2, 2018). Specifically, the application asked:

> None of the individuals to be insured under any Coverage Part (the "Insured Persons") have a basis to believe that any wrongful act, event, matter, fact, circumstances, situation, or transaction, might reasonably be expected to result in or be the basis of a future claim? __Yes __ No.

The insurer argued that the negative response to the question was a material misrepresentation that entitled the insurer to rescind the policy. The Ninth Circuit agreed, finding that the insured's awareness of a federal criminal investigation was a circumstance that might reasonably be expected to result in or be the basis of a future claim, and the negative response to the question therefore was a material misrepresentation. However, in the dissent, Judge Berzon stated that the "no" answer essentially created a confusing double negative. According to the dissent,

> As a matter of English grammar, the answer checked — 'no' — was accurate. 'No' signified that it was not true that one of the Insured Persons had reasons to expect a claim — in other words, that some Insured persons did have reason to expect a claim.
>
> I recognize that neither [the insurer] nor [the applicant] so read the question initially. But the rules of grammar do not bend because of inaccurate reading, or because of inattention to those rules when drafting an application. Whatever the parties' impressions or intentions, the answer was correct.

Id. at *2.

Similarly, a California Court of Appeal found the following question "utterly ambiguous" such that the insured's interpretation of the question was reasonable:

> Has damage remained unrepaired from previous claim and/or pending claims, and/or known or potential (a) defects, (b) claim disputes, (c) property disputes, and/or (d) lawsuits?

Duarte v. Pac. Specialty Ins. Co., 13 Cal. App. 5th 45, 60 (2017). The insurer in effect asked the Court to interpret the question as requiring "yes" if there were unrepaired damage, or open or pending claims, or known or potential defects, or known or potential claim or potential property disputes, or known or potential lawsuits. In *Duarte*, the Court instead found that the question was missing any form of the verb "to be" and concluded that the insured acted reasonably in interpreting the question "as asking whether the property has unrepaired damage associated in some way with previous or pending claims, known or potential defects, known or potential claim disputes, known or potential property disputes, or known or potential lawsuits." *Id*. at 61. In this way, courts looking to deny rescission may pounce on any ambiguity in the application questions to avoid the "materiality" inquiry altogether.

Because application questions are not standardized or uniform among insurers, each application must be read and answered carefully. Failure to do so can have serious consequences for the insured down the road, which may not come to light until a claim has been presented and it is too late for the applicant to correct its application or seek coverage elsewhere.

B. Knowledge and Belief

The standard of proof for rescission varies both with respect to what the law requires and what various applications require. The laws in different jurisdictions vary whether a misrepresentation must be “willful” to support rescission. *See Infra* Section IV.

In addition to the jurisdiction’s statutory or common law standards, some insurance applications incorporate a “knowledge and belief” standard for the application’s representations, which may increase the burden of proof of misrepresentation in any rescission action. As a result, although certain representations in the application may be determined to be “untruthful,” an insurer seeking to rescind a policy may be required to establish that relevant insureds knew that the representations were untruthful as a result of the application’s requirements, even in a jurisdiction that otherwise would not require that level of proof.

For example:

> The undersigned individuals declare on behalf of the Applicant and its subsidiaries and its directors and officers, as the duly authorized representatives of such parties, that *to the best of their knowledge and belief*, after reasonable inquiry, the information supplied in the Application and other required Underwriting Documents cited in Item 6 is true, accurate and complete and is material to the acceptance of the risk and/or the hazard or liability assumed under the Policy by the Insurer. (emphasis added)

Where an application recites that the answers were correct "to the best" of the applicant’s "knowledge and belief," the burden upon the insurer may rise so that the insurer can rescind only if it can prove that the application answer is *knowingly* false. *See, e.g., Old Republic Life Ins. Co. v. Bales,* 195 S.E.2d 854, 856 (Va. 1973). However, most courts agree that an applicant’s subjective denial cannot be used to evade objective, true facts where the application requires such information. *Fid. Nat’l Title Ins. Co. v. Houston Cas. Co.*, No. 6:11–cv–1438, 2012 WL 4523666 (M.D. Fla. Sept. 30, 2012) (“objective test applies to the ‘might reasonably be expected to give rise to a claim’ component”); *Time Ins. Co. v. Bishop*, 425 S.E.2d 489 (Va. 1993).

In *Time,* an applicant for hospitalization and life insurance answered “no” to the question: "To the best of your knowledge and belief, have you or any family member applying for the insurance: 1. Ever had any indication, diagnosis or treatment for: ... use of alcohol or drugs?" The application form provided above the signature line: “I represent that all statements and answers to the above questions are complete and true to the best of my knowledge and belief.” After receipt of the application, the insurer issued the policy. *Id.* at 490.

After the policyholder died of alcohol-related illness, the insurer investigated the truthfulness of the information in the application and determined that it was false. *Id.* at 491. The insurer sought to rescind the policy. *Id.* The court submitted to the jury the issue whether the putative insured’s alleged misstatements were "knowingly" made. *Id.* The jury returned a verdict in favor of the putative insured. *Id.* The insurer appealed. On appeal, the estate argued that an issue of fact as to whether the decedent “knowingly” made the misrepresentations properly

created a jury issue on the issue of misrepresentation. *Id.* at 492. The estate had adduced expert testimony at trial that alcohol abusers unconsciously use a "defense mechanism" termed "denial," by which they "deny information." *Id.* The estate argued that this testimony gave rise to a question of fact whether the putative insured knowingly misrepresented information in the application. *Id.* Rejecting the proposed subjective test of misrepresentation, even where the application includes the "best of your knowledge and belief" language, the court explained:

> [E]ven though a jury may have accepted [the expert's] testimony of [the policyholder's] probable "denial" or "rationalization" as an indication that he did not believe he had a problem with alcohol, whether he had a problem with alcohol was not the question he was asked in the application. Rather, the question was whether, to the best of his knowledge and belief, he had ever had any indication, diagnosis or treatment for use of alcohol. And, with respect to that question, [the expert's] testimony about [the policyholder's] state of denial was irrelevant. . . . [W]ith the question in the application focused narrowly upon indication, diagnosis, or treatment for the use of alcohol, whether [the applicant] himself or someone else believed he was not an alcoholic was completely beside the point.

Id.

The insurer's stated standard in an application for the relevant knowledge and belief can displace the statutory standard that might otherwise apply. *See, e.g., Travelers Cas. & Sur. Co. of Am. v. Mader Law Grp., LLC*, No. 8:13-cv-2577-T-26TGW (M.D. Fla. Oct. 20, 2014). In *Mader*, the insurer filed suit against a law firm and individual attorney to rescind a professional liability policy based on purportedly material misstatements in the firm's application. The insured argued that the circumstances did not support the heightened standard for rescission required by the policy's misrepresentation clause. Under this clause, the policy could "be considered void if, after the Inception Date… any Principal Insured … intentionally concealed or misrepresented any material fact or circumstance…." The insurer argued that the misrepresentation clause did not apply to representations in the application for coverage or to any actions before the inception date of the policy, and therefore rescission was available to it regardless of whether the insured's responses were made "intentionally" as provided for in the misrepresentation clause. The court ruled that the parties had contracted out of the statutory standard for rescission by their inclusion of the misrepresentation clause in the policy. The court rejected the insurer's arguments to distinguish the provision in its policy based on the phrase "after the Inception Date of the Policy Period…." The court opined that, reading the policy as a whole and resolving any ambiguities in favor of coverage, the added language could be read simply as emphasizing that a policy must exist before it can be void. The court also noted that the policy contained a merger clause but that it never incorporated the application, the application's standard, or the statutory standard. Thus, the court reasoned that the parties had contracted out of the statutory standard, which would have permitted the insurer to rescind the policy even if the insured's inaccurate statements were not made "intentionally."

Where the application did not specify whether a subjective or objective standard for misrepresentation applied, an Ohio court recently adopted a subjective standard. *See Maxum Indem. Co. v. Nat'l Condo & Apartment Ins. Grp.*, 2016 WL 6628490 (S.D. Ohio Nov. 9, 2016)

(applying California law). The insured, a wholesale insurance broker, issued quotes and binders for property insurance coverage to a retail insurance broker, which the retail broker then issued to its own clients. Although the wholesale broker's quotes and binders listed two insurance carriers, those companies had never issued or approved the policies. Upon learning of their lack of insurance, some of the property owners filed suit against the retail broker, which in turn filed claims against the wholesale broker. The E&O carrier sought to rescind the wholesale broker's policy or, alternatively, a declaration that the policy's prior knowledge exclusion barred coverage. It pointed to a cease-and-desist letter sent to the wholesale broker by one of the purported insurance carriers prior to the application date. The E&O insurer also pointed to several additional communications received by the wholesale broker before the policy incepted, including a cease-and desist letter by the other purported insurance carrier and a letter from the Illinois Department of Insurance advising that the wholesale broker had issued binders that may not constitute legally valid insurance. The district court granted summary judgment in favor of the insurer on the prior knowledge exclusion. However, the Sixth Circuit reversed and held that the policy covered the claims as a matter of law because a subjective standard governed the application of the exclusion, and the communications at issue did not give the wholesale broker knowledge of a wrongful act that may result in a claim.

On remand, the insurer argued it was entitled to rescind the policy based on the wholesale broker's failure to disclose the communications in response to an application question which asked if the applicant had "any knowledge of any potential errors or omissions claims." In determining that a subjective standard applied, the court held that "whether an objective or subjective standard is used to evaluate a rescission claim is based upon whether the policy application at issue contained language alerting the applicant to the presence of an objective standard." *Id.* at *6. Here, the court noted that "including the term 'reasonably' in the application language," for example, "are you aware of any facts or circumstances which you reasonably believe . . ." would change this analysis and require the application of an objective test. *Id.* Thus, subtle changes in a policy's application, may have a significant impact on a rescission claim.

C. Materiality

As noted above, to support a rescission claim, a misrepresentation must be material. Contrary to what many policyholders may think, however, when responding to questions in an application about potential claims, "material" and "insurable" are not necessarily the same thing.

For example, in *Hale v. Travelers Cas. & Sur. Co. of Am.*, No. 3-14-1987, 2015 BL 364129 (M.D. Tenn. Nov. 04, 2015), *aff'd* 661 F. App'x 345 (6th Cir. 2016), Don and Dan Hale sued Travelers, their directors and officers insurer, seeking to compel Travelers to defend them against a lawsuit brought by the state of Tennessee. Travelers responded by filing a rescission counterclaim. In their application for coverage, the policyholders responded "no" to a question regarding whether there had been any charges or demands against any applicant in the preceding five years "whether or not such claim or action would be covered." At the time they answered "no," however, the district court found that there had in fact been "customer complaints and demands for refunds (even if those refunds would be less than [the $10,000 deductible])," including complaints lodged with the Better Business Bureau and one customer lawsuit. The Hales argued that it would be "unreasonable to consider the 'statistically miniscule' number of

complaints as falling within the scope of this question." The court disagreed, holding that the terms of the application required the disclosure of "any" claims, whether covered or not, and that the failure to disclose these "statistically miniscule" claims warranted rescission.

Similarly, in *H.J. Heinz Co. v. Starr Surplus Lines*, No. 15-cv-00631, 2016 BL 27088 (W.D. Pa. Feb. 1, 2016), *aff'd* 675 F. App'x 122 (3d Cir. 2017) (applying New York law), Heinz sought coverage from Starr, its contaminated product insurer. Starr counterclaimed, asserting that Heinz failed to disclose prior recalls in its application for coverage, including a prior "silent recall" of baby food contaminated with nitrites. At trial, Heinz argued that the non-disclosure was immaterial because the losses in question did not implicate insurance. The Court disagreed, noting that the application required disclosure of recalls "whether or not insured or insurable," and held that Heinz's non-disclosure of these uninsured losses voided the policies.

D. Knowledge Exclusion

Insurance applications are often incorporated by reference into the policy or physically attached. The application and/or the policy may state that if knowledge or information that is required to be disclosed by the application in fact existed, but was not disclosed, then any claim arising from or in any way related to such matters shall be excluded from the insurance coverage being applied for. By way of example, one prior knowledge exclusion states:

> IT IS AGREED THAT IF ANY SUCH KNOWLEDGE OR INFORMATION EXISTED, ANY CLAIM BASED ON, ARISING FROM, OR IN ANY WAY *RELATING* TO SUCH ERROR, MISSTATEMENT, MISLEADING STATEMENT, ACT, OMISSION, NEGLECT, BREACH OF DUTY OR OTHER MATTER OF WHICH THERE WAS NO KNOWLEDGE OR INFORMATION SHALL BE EXCLUDED FROM COVERAGE REQUESTED.

It is important to understand that the application's prior knowledge exclusion and rescission are based on different contract language and may operate independently to bar coverage for certain claims.

II. THE ROLE OF THE BROKER

One of the principal reasons for using an intermediary for the purchase of insurance is to obtain the benefit of that broker's professional advice and market knowledge. Since the best policy language can be compromised by the application and its potential to be used to rescind the policy, one of the most critical components of the broker's responsibility will be in application review.

Ideally, the broker should have internal resources with direct experience in the client's business. The broker should have internal resources that have either worked in the insured's industry, or have dealt exclusively with the particular kind of insured, so as to have gained an intimate knowledge of them over a period of years. These skills are then implemented in creating the firm's submission to insurers. This function encompasses streamlining, to the greatest extent possible, the application process, assisting the client through it, helping the client gather

documentation for the underwriters and, ultimately packaging materials for appropriate presentation to the underwriters. In addition, the broker assists in the final execution of the transaction and maintains copies of all relevant documentation.

A review and comparison of the information being provided at the current renewal with information provided in prior years is an additional component in the broker's application review and is beneficial in creating accuracy in the information provided by an insured.

As an advocate for the client, the broker should ensure that the application disclosures are either 1) limited to a controlled group (*e.g*., Management Committee, signatory to the application); 2) have a limited, or complete lack of, Prior Knowledge Exclusion; 3) caveated that polling and disclosure are done on a good faith basis, and that the application will not be used to rescind the policy; or 4) limit disclosure to the incumbent insurers (either no claims information, or just information on claims/circumstances that have previously been reported).

For example a Lawyers Professional Liability application may state:

> After inquiry of the firm's Management/Executive Committee, the undersigned declares this information is true and accurate.

Notwithstanding the broker's involvement in the preparation of the application, rescission actions do arise. The broker along with counsel will then be called upon to review the insurance application, supplemental information, and any written correspondence between the broker and the underwriter that would have been provided to aid in the underwriting process. Where possible the broker can act as an intermediary, and attempt to utilize leverage with an underwriter to obtain an interpretation of the application that is favorable to the client.

Due to the nature of the broker's involvement in drafting the insurance submission, there is significant malpractice exposure. In order to mitigate the Errors & Omissions risk arising out of their services relating to application preparation, insurance brokers have implemented Limitation of Liability clauses in their contracts. These clauses state that the client agrees to indemnify the broker for any and all liabilities, costs, damages and expenses, including attorneys' fees, incurred by the broker that exceed the liability limitation.

III. INTERVIEWING THE UNDERWRITERS

As a part of a rescission investigation, the insurer or its counsel will typically interview the primary underwriter for the policy, and potentially other insurer personnel who were substantively involved in the application process. The interview is designed to identify and evaluate how the underwriters viewed the questions that may have been incorrectly answered and what the underwriters would have done if the true facts had been provided. The information might be relevant in isolation, and might also be relevant in the context of a trend of claims or potential claims.

The effort to better understand the true facts in context can also include an evaluation of the risk, if the true facts had been disclosed, under applicable underwriting guidelines. Perhaps the risk would have been ineligible for the insurance program if the true facts had been disclosed. Perhaps the risk would have generated a different premium. The underwriters can also advise

how they would have responded, including whether they would have sought additional information, whether they would have excluded certain aspects of the proposed risk, or what else they might have done if the application had been truthfully completed. The underwriters might have declined even to offer a quote under certain circumstances. On the other hand, it is possible that the underwriter might advise that he or she would have issued the policy on the same terms and at the same premium, even if the application had been truthfully completed. Obviously a careful and thoughtful investigation will help decision-making before an insurer seeks to rescind any policy.

The insurer must anticipate that the underwriters will be deposed in the event of insurance coverage litigation, and that if the matter proceeds to trial, the underwriters will be key witnesses in support of any effort to rescind any policy.

IV. RESCISSION STANDARD

As the party seeking to rescind an insurance policy, the insurer will bear the burden of proof on a rescission claim. *Miller v. Republic Nat'l Life Ins. Co.*, 789 F.2d 1336, 1340 (9th Cir. 1986); *Cont'l Cas. Co. v. Marshall Granger & Co.*, 921 F. Supp. 2d 111, 128 (S.D.N.Y. 2013); *Mann v. New York Life Ins. & Annuity Corp.*, 222 F. Supp. 2d 1151, 1154 (D. Ariz. 2002). To succeed on the claim, the insurer must establish a material misrepresentation in the application for insurance or the failure to disclose material information in procuring insurance (concealment). *See*, *e.g.*, *Scottsdale Ins. Co. v. Priscilla Props.*, LLC, 254 F. Supp. 3d 476, 481 (E.D.N.Y. 2017); *Seidel v. Time Ins. Co.*, 970 P.2d 255, 258 (Or. Ct. App. 1998).

In addition to these requirements, many states either by statute or common law also require an insurer to prove the policyholder intended to deceive its insurer. *E.g.*, Ala. Code § 27-14-28 (requiring proof of an "actual intent to deceive"); *Smith v. Republic Nat'l Life Ins. Co.*, 483 P.2d 527, 530 (Ariz. 1971) ("An insurance company attempting to void a policy must prove that the applicant was guilty of either actual fraud or legal fraud."); *see generally* Masters, Stanzler, and Anderson, Insurance Coverage Litigation § 19.02A (2d ed. 2017) (fifty state survey of right of rescission).

In contrast, other states do not require an insurer to prove intent to deceive. For example, in California, there is no requirement that a material misrepresentation must be accompanied by an intent to deceive for purposes of rescission, even if the material misrepresentation was innocent, negligent, or unintentional. The insurer has a right to know all that the applicant for insurance knows regarding the risk to be assumed. Cal. Ins. Code §§ 331 ("Concealment, whether intentional or unintentional, entitles the injured party to rescind insurance"), 359; *O'Riordan v. Federal Kemper Life Assur.*, 36 Cal. 4th 281, 286-87 (2005); *LA Sound USA*, *Inc. v. St. Paul Fire & Marine Ins. Co.*, 156 Cal. App. 4th 1259, 1270 (2007); *Mitchell v. United Nat'l Ins. Co*., 127 Cal. App. 4th 457, 469 (2005). *See also Coca Cola Bottling Co. v. Columbia Cas. Ins. Co*., 11 Cal. App. 4th 1176, 1189, fn. 4 (1992) (insured's subjective belief that his misrepresentations were unrelated to the insured risk is not a defense to rescission). The reasoning is that an "intent to defraud the insurer is necessarily implied when the misrepresentation is material and the insured willfully makes it with knowledge of its falsity." *TIG Ins. Co. of Michigan v. Homestore*, *Inc*., 137 Cal. App. 4th 749, 763, fn. 15 (2006). In fact, this presumption has been held to apply even where the policy expressly states the insurer may void coverage for intentional misrepresentations, because that language does not abrogate the statutory obligations

to disclose all material facts in the application. *LA Sound,* 156 Cal. App. 4th at 1270; *Atmel Corp. v. St. Paul Fire & Marine Ins. Co*., 426 F. Supp. 2d. 1039, 1048-50 (N.D. Cal. 2005). Similarly, it has also been held to apply to the Standard Form Fire Insurance Policy, which provides that the policy is void if the insured has "willfully concealed or misrepresented any material fact or circumstance concerning the insurance." Cal. Ins. Code. § 2071 (emphasis added). Again, the reasoning is that California Insurance Code section 2071 does not supplant the insured's obligations under sections 331 and 359. *Mitchell v. United Nat'l Ins. Co*., 127 Cal. App. 4th 457, 471 (2005). *See also Breault v. Berkshire Life Ins. Co.*, 821 F. Supp. 410, 416 (E.D. Va. 1993) ("Under Virginia law, an insurer's right to rescind on the ground of an applicant's material, false statement does not depend on a showing that the applicant was aware of the statement's materiality. To permit applicants to recover on policies based on applications they know to contain false information, even if they believe the information not to be material, would undermine the policy interest in encouraging full, accurate, and truthful disclosures on insurance applications."); *In re Worldcom, Inc. Secs. Litig.*, 354 F. Supp. 2d 455, 465 (S.D.N.Y. 2005) ("Even an innocent misrepresentation, if material, will support rescission."); *Delisle v. Cape Mut. Ins. Co*., 675 S.W.2d 97, 100 (Mo. App. 1984) ("The law in Missouri is that a material misrepresentation in an application for insurance is a valid ground for avoiding the policy, even though the misrepresentation is innocently or inadvertently made.") (quoting *Am. Fire & Indem. Co. v. Lancaster*, 415 F.2d 1145, 1146 (8th Cir. 1969)).

A. Burden of Proof

The insurer's burden of proof will vary by state. In some states an insurer can only rescind a policy if it establishes all elements of the claim by clear and convincing evidence. *Northwestern Mut. Life Ins. Co. v. Weiher*, 809 F.3d 394, 398 (8th Cir. 2015) (Wisconsin law); *Carroll v. Metro. Ins. & Annuity Co.*, 166 F.3d 802 (5th Cir. 1999) (Mississippi law); *Batka v. Liberty Mut. Fire Ins. Co.*, 704 F.2d 684, 688 (3d Cir. 1983) (New Jersey law); *Hartford Cas. Ins. Co. v. New Hope Healthcare, Inc.*, 803 F. Supp. 2d 339, 347 (E.D. Pa. 2011) (Pennsylvania law); *Progressive Cas. Ins. Co. v. Luna*, Case No. 05-cv-4194-JPG., 2007 BL 28948 (S.D. Ill. June 07, 2007) (Illinois law); *Primerica Life Ins. Co. v. Ingram*, 365 S.C. 264, 616 S.E.2d 737, 739 (S.C. Ct. App. 2005) (South Carolina law). Other states require only proof by a preponderance of the evidence. *Story v. Safeco Life Ins. Co.*, 40 P.3d 1112, 1116 (Or. Ct. App. 2002).

Notably, the elements of reliance, intent to deceive, and materiality necessarily require proof outside the eight corners of the pleadings and the policy. When considering the duty to defend, however, an insurer is generally not permitted to escape its coverage obligations with resort to extrinsic facts, even to prove the application of an exclusion. *See*, *e.g.*, *Castle Point Nat'l Ins. Co. v. Everado Chuca Lalo, Jr.*, No. 15-10224, 642 F. App'x 329 (5th Cir. March 17, 2016); *Tower Ins. Co. of New York v. All Am. Rigging Co.*, No. H-13-339, 2014 WL 3546295, *3 (S.D. Tex. July 9, 2014). Thus, Texas and some other jurisdictions, have held that a rescission claim can never be used to defeat the duty to defend. *E.g.*, *E&L Chipping Co., Inc. v. Hanover Ins. Co.*, 962 S.W.2d 272, 274 (Tex. App.--Beaumont 1998, no pet.); *Capital City Ins. Co. v. Rick Taylor Timber Co., Inc.*, 918 F. Supp. 1558, 1563 (S.D. Ga. 1995), *aff'd sub nom. Capital City Ins. v. Taylor Timber*, 106 F.3d 417 (11th Cir. 1997) (holding that insured was owed duty to defend, as a matter of law, because the only way the insurer could prove the misrepresentation was through improper extrinsic evidence); *In re HealthSouth Corp.*, 308 F. Supp. 2d 1253, 1281

(N.D. Ala. 2004) (barring D&O insurers from relying on extrinsic evidence to rescind a policy based on alleged misrepresentation).

As the foregoing makes clear, a rescission claim may place a high burden on insurers. For example, under Texas law, an insurer seeking to rescind a policy bears the burden of proving five elements: (1) the making of a representation; (2) the falsity of the representation; (3) reliance thereon by the insurer; (4) the intent to deceive on the part of the insured in making the same; and (5) the materiality of the representation. *Albany Ins. Co. v. Anh Thi Kieu*, 927 F.2d 882, 891 (5th Cir. 1991); *Union Bankers Life Ins. Co. v. Shelton*, 889 S.W.2d 278, 282 (Tex. 1994). In addition to proving these five elements, the Texas Insurance Code requires an insurer seeking to rescind a policy to plead and prove that it gave notice of its intent to rescind the policy to its insured within 90 days of learning of the misrepresentation. *See* Tex. Ins. Code §§ 705.005.

In light of the challenges facing insurers attempting to rescind a policy under Texas law, in recent years some insurers have relied on policy conditions that prohibit misrepresentations in an effort to reframe their rescission claims as breach of contract actions, albeit with limited success. In *Quihong Liu v. Fidelity & Guaranty Life Insurance*, 282 F. App'x 304 (5th Cir. 2008), Fidelity sought to void a life insurance policy arguing that the decedent failed to comply with the Health as Stated Clause because the decedent did not disclose that he had been diagnosed with lung cancer three days before Fidelity issued the policy. Rather than seeking rescission based on a misrepresentation, however, Fidelity argued the policy was void because the breach of the Health as Stated Clause violated a condition precedent.

The district court rejected Fidelity's argument, and the Fifth Circuit affirmed. *Id.* at 308-09. The Fifth Circuit held that Fidelity's treatment of the Health as Stated Clause "purports to do exactly what the Texas Insurance Code and case law prohibit: it provides that untrue or false answers in an insurance application render the policy void." *Id.* at 308. The court acknowledged that the decedent's health was not "as stated" at the time of the delivery of the policy, but concluded that "under Texas law, an insurer must plead the elements of a misrepresentation in order to avoid coverage." *Id.* at 309; *see also Alliance Gen. Ins. Co. v. Club Hospitality, Inc.*, 1999 WL 118798, *4-5 (N.D. Tex. 1999); *Union Bankers Ins. Co. v. Shelton*, 889 S.W.2d 278 (Tex. 1994). Because Fidelity did not plead and prove a rescission claim, it could not escape coverage. *Id.*

B. When Is a False Statement a False Statement

A representation is false "when the facts fail to correspond with its assertions or stipulations" (*e.g.*, Cal. Ins. Code § 358), may be oral or written (*id.*, § 350), and may be made in the application for insurance, or at the time of or before the policy is issued. *Id.*, §351. A statement by the insured made "on information and belief is not a representation that the insured is responsible for unless the statement is made based on a source under the insured's control. *E.g.*, Cal. Ins. Code § 357.

Concealment of a material fact occurs when the insured neglects to communicate a fact which he knows, and ought to communicate to the insurer. *E.g.,* Cal. Ins. Code § 357. An insurance applicant has an obligation to disclose "all facts within his knowledge which are . . . material to the [insurance] contract." *E.g.*, Cal. Ins. Code § 332. This obligation is congruent to the duty of

good faith and fair dealing owed by both sides of an insurance contract. *Lunardi v. Great-West Life Assurance Co*., 37 Cal. App. 4th 807, 826 (1995).

On its face, the requirement of a false statement appears to be straightforward. As a number of recent cases show, however, the requirement of a false statement can create complications for both insureds and their insurers.

For example, in *Illinois State Bar Association Mutual Insurance Co. v. Rex Carr Law Firm*, 2017 IL App (4th) 160365-U, 2017 WL 2805126 (Ill. App. Ct. June 27, 2017), the Illinois Appellate Court considered whether a false statement in the application for a policy can be grounds for rescinding a renewal policy. In *Rex Carr Law*, the insured represented in an application for professional liability insurance that it was unaware of any circumstances in the prior twelve months that might give rise to a claim. In that period, however, the insured had a case involuntarily dismissed for failure to pay court-imposed sanctions (which was a circumstance that the policyholder was required to disclose). The insurer issued the policy, and the policyholder subsequently obtained two renewals of the policy. The policyholder ultimately made a claim under the final renewal policy. After the claim was made, the insurer attempted to rescind the renewal policy on the basis of the misrepresentation in the prior policy's application. The Appellate Court rejected the argument, holding that a "misrepresentation will defeat or avoid a policy only if the misrepresentation is stated in the policy or in a written application for *that* policy." *Id.* at *5 (emphasis in original). The court explained that "in the eyes of the law, each renewal of an insurance policy results in a new contract, a new policy," and "misrepresentations in applications for other policies are irrelevant." *Id.*

While misrepresentations in response to questions in applications for prior policies could not support a rescission claim in *Rex Carr Law*, in 2016 the Second Circuit held that voluntary – but selective – disclosures *could* form the basis of a rescission claim. In *Fireman's Fund v. Great American Insurance Co.*, 822 F.3d 620 (2d Cir. 2016), primary insurers sought contribution from an excess property insurer for property damage to a dry dock when the dock sank. The excess insurer sought to rescind its policy based on misrepresentations made by the policyholder. Critically, the excess property insurer had not actually required the policyholder to complete a standard application. Instead, the policyholder submitted documents it had selected purporting to show the dry dock's value and described the possibility of the dry dock sinking as a "worst case scenario" and "of extremely low probability." *Id.* at 647. The policyholder did not volunteer that multiple engineers had concluded that the dry dock was in need of costly repairs, nearing the end of its useful life, and that the dock was not operating safely. *Id.* at 648.

On these facts, the primary insurers argued that the excess policy could not be voided because the policyholder had not actually provided false or misleading "answers" to questions on an application, and that the policyholder had no obligation to provide further information in the absence of a request from the excess insurer. *Id.* at 646. The district court and the Second Circuit, applying Mississippi law, rejected this argument. The Second Circuit held that "[b]y selectively providing only positive information about the dry dock's condition, while failing to disclose the substantial and multiple sources of information in its possession that called these positive reports into question, [the policyholder's] representations to [the excess insurer] amounted to a misrepresentation of the dry dock's condition." *Id.* at 648. Thus, even where

information is not affirmatively requested, a policyholder's volunteering of accurate but incomplete information, may support a rescission claim.

C. Separate Contracts For Insurance

Courts must also contend with a related problem, "under what circumstances should [they] treat one policy as creating two or more entirely separate contracts of insurance." In *Coca Cola Bottling Co. v. Columbia Cas. Ins. Co*., 11 Cal. App. 4th 1176, 1189 n.4 (1992), the Court was confronted with a complex insurance policy which provided both commercial automobile coverage as well as product liability coverage to "a conglomerate of companies engaged in a myriad of activities." The insurer cross-complained, arguing that the insured's misrepresentations relating to product liability coverage also voided the insured's automobile coverage. The Court held that "the products liability coverage was, in reality, a separate contract for insurance," and any misrepresentations with respect to product liability coverage did not affect the insurer's liability for automobile coverage, explaining that "[u]nless the various coverages can be treated as separate contracts of insurance, [the insureds] would be forced to litigate the truthfulness of statements supplied by each of its subsidiaries when any claim is made on the policy. As a practical matter this possibility would largely deprive [the insureds] of any benefit under the policy." *Id*.

In determining whether coverages constitute separate contracts, a court will consider whether: premiums were apportioned to each coverage; each coverage has a separate policy limit; the misrepresentation in question was material to one or all coverages; and the policy covers multiple business subsidiaries engaged in different activities such that treating all coverages as a single contract would require each subsidiary to defend the truthfulness of its statements upon any claim on the policy. *Id*.

V. RESCISSION DEFENSES

Even where an insurer is able to establish that a material false statement was made in the application for insurance, a policyholder has a number of statutory, equitable, and policy-based defenses available to defeat a rescission claim.

A. Statutory Defenses Based on Delay

First, an insurer's failure to promptly seek rescission after learning of a material misrepresentation may result in a statutory bar to a rescission claim. For example, Texas statute requires that an insurer seeking rescission give notice to the policyholder of its refusal to be bound by the policy within 90 days of its discovery of the misrepresentation and to plead its compliance with this requirement. Tex. Ins. Code § 705.005. This notice requirement is treated an essential element of a rescission claim that the insurer bears the burden of pleading and proving. *See*, *e.g.*, *Sanders v. Jefferson Nat'l Life Ins. Co.*, 510 S.W.2d 407 (Tex. App.--Dallas 1974, no writ) (reversing judgment in favor of insurer on its rescission claim because the insurer failed to prove compliance with the 90-day rule); *Paramount Nat'l Life Ins. Co. v. Williams*, 772 S.W.2d 255, 265 (Tex. App.--Houston [14th Dist.] 1989, writ denied) ("The statutory notice required by [Section 705.005] is an essential element of a defense based on misrepresentation");

Myers v. Mega Life and Health Ins. Co., 2008 WL 1758640, at *3 (Tex. App.--Amarillo April 17, 2008, no pet.).

The insurer tried a creative end-run around the Texas statute in *Thompson v. Diamond State Ins. Co.*, No. 4:06-cv-154, 2008 WL 11344903 (E.D. Tex. May 2, 2008). In that case, the insurer refused to cover a claim under an equine mortality policy based on false representations about the horse's health. Having missed the 90 day notice window under the Texas Insurance Code, the insurer argued that § 705.005 did not apply because it was merely seeking a *denial of coverage* of a particular claim rather than trying to *rescind* the entire policy. The insurer's argument keyed off of the "refusal to be bound by the policy" language in the statute. The *Thompson* court rejected that distinction. According to the court, "[d]enial of a claim that, but for the misrepresentation, would be covered under the policy is a refusal to be bound by the policy." *Id.* at *7.

Statutory notice requirements may come in the form of bright line rules, such as the Texas statute described above. *See also* Utah Code Ann. § 31A-21-105(5) (requiring notice within either 60 or 120 days depending on circumstances). Other states, however, set forth more flexible standards. For example, California's notice statute requires only that the rescinding party give notice "promptly upon discovering the facts which entitle him to rescind." Cal. Civ. Code § 1691. This rule may be further tempered by a general statutory requirement that the party seeking to avoid rescission prove substantial prejudice was caused by the delay. Cal. Civ. Code § 1693.

Even where a statute provides a bright line rule, fact questions may remain as to when the insurer learned the facts that starts the running of the statutory notice period. In *Seneca Ins. Co. v. Alton Coal Dev., LLC*, No. 2:15-cv-761, 2017 BL 124839 (D. Utah Apr. 17, 2017), the policyholder asserted that the insurer failed to comply with Utah's sixty day notice requirement. In support of its motion, the policyholder relied on arguments the insurer made in response to a motion to compel, that the insurer "suspected there was a potential misrepresentation in the claim file" and "was aware of circumstances indicative of fraud or misrepresentation" by March 13, 2015, but failed to notify the policyholder of its intent to assert the rescission defense until October 22, 2015. The district court denied the policyholder's motion for summary judgment, concluding that a reasonable jury could conclude that the insurer had not obtained the facts necessary to assert the defense until it had completed a series of examinations under oath, which the insurer completed just a week before giving notice. *Id.* at *2. The court emphasized that "suspicions and indications are not sufficient" to trigger an insurer's duty under Utah's statute. *Id.* Instead, the triggering point is when the insurer had "knowledge of sufficient facts to constitute a general defense." *Id.*

B. Equitable Defenses

Absent a statutory notice requirement, an insurer's delay in asserting a rescission claim may still give rise to equitable defenses to rescission. "An insurer's failure to rescind a policy promptly after obtaining sufficient knowledge of alleged misrepresentations by an insured constitutes ratification of the policy." *U.S. Life Ins. Co. v. Blumenfeld*, 92 A.D.3d 487, 488-89 (N.Y. App Div, 1st Dept. 2012); *see also Ill. State Bar Assn. Mut. Ins. Co. v. Coregis Ins. Co.*, 3821 N.E.2d 706, 717 (Ill. Ct. App. 1st Dist. 2004).

Thus, in a recent California case, an insurer was found to have waived its rights to rescind coverage where the insurer elected to prospectively cancel a policy but delayed actually asserting a rescission defense until after the policyholder filed a coverage action. *See DuBeck v. California Physicians' Service*, 234 Cal. App. 4th 1254 (2015). In *DuBeck*, the policyholder was diagnosed with breast cancer in February 2005. Five days after her diagnosis she submitted an application for health insurance to Blue Shield, in which she failed to disclose the diagnosis, notwithstanding questions specifically addressing the disclosure of such information. Blue Shield issued the policy, but following an investigation in July and August 2006, it discovered that the insured had been treated for breast cancer prior to completing the policy application. Accordingly, in September 2006, Blue Shield cancelled the policy. However, it did not rescind coverage, and it retained the premiums the insured had already paid (which at that point exceeded the payments Blue Shield had made under the policy). It was not until 2008, when the policyholder filed suit challenging the cancellation, that Blue Shield asserted its right to rescind the policy.

The *DuBeck* trial court granted the insurer's motion for summary judgment on its rescission claim, but the court of appeals reversed, concluding the insurer waived the defense. The court of appeals held that "[i]n waiting over two years to assert a right to rescind, while assuring appellant of her right to coverage during the period the policy was in effect and retaining her premiums for such coverage, Blue Shield engaged in conduct 'so inconsistent with the intent to enforce the right as to induce a reasonable belief that it ha[d] been relinquished.'" *Id.* at 1266 (citations omitted). The court further noted that Blue Shield's receipt of the claim for the policyholder's April 6, 2005 breast cancer surgery, "should have triggered an earlier investigation and resolution of appellant's right to remain insured." *Id.* at 1267.

C. Equitable Ratification of the Policy

In addition to precluding rescission claims based on an insurer's delay in asserting its right to rescind, courts have "precluded rescission if an insurer has acted, subsequent to a breach, in such a way as to recognize the insurance contract as in force." *Cont'l Ins. Co. v. Joseph O. Kingston & D.U. Co.*, 114 P.3d 1158, 1162-63 (Utah. Ct. App. 2005) (citing *Dairyland Ins. Co. v. Kammerer*, 213 Neb. 108, 327 N.W.2d 618, 620 (1982); *McCollum v. Cont'l Cas. Co.*, 728 P.2d 1242, 1245 (Ariz. Ct. App. 1986); *Johnson v. Life Ins. Co.*, 52 So.2d 813, 815 (Fla. 1951)).

The most obvious example of insurer conduct that would preclude rescission is the subsequent acceptance of premiums. "An insurer that accepts premiums after learning of facts that it believes entitles it to rescind the policy has waived the right to rescind." *U.S. Life Ins. Co. v. Blumenfeld*, 92 A.D.3d 487, 488-89 (N.Y. App. Div., 1st Dep't 2012). In *Syncora Guarantee Inc. v. Alinda Capital Partners LLC*, No. 651258/2012, 2017 BL 49253 (N.Y. Sup. Ct. Feb. 14, 2017), a policyholder secured a financial guaranty policy based on representations the insurer later learned to be "grossly misleading" and "based on manipulated data." The insurer, however, continued to accept nearly $10 million in premium payments after learning of the misrepresentations. Because the insurer "continued to receive payments on the policy after [it] learned about the alleged gross misstatements," the trial court held it barred from seeking rescission. *Id.* at *4.

An insurer's acceptance of premiums can even waive a rescission claim when the insurer has already filed a lawsuit seeking a declaration that the policy is void. For example, in *Blumenfeld*, the insured represented in her life insurance application that she had a net worth of $35-$40 million and a household income of $400,000-$500,000. After learning that the insured owned no real estate and resided in a neighborhood where the average median income was $29,625, the insurer notified the policyholder of its intent to rescind and filed a lawsuit seeking a declaration that the policy was void. Notably, however, after filing suit to rescind the policy, the insurer notified the insured that the policy was in its grace period and would terminate unless the insured made an additional premium payment. The insured timely paid this premium amount. The trial court held that the insurer's conduct in soliciting and accepting premium payments, notwithstanding the pending lawsuit, "constituted a ratification of the policy and a waiver of the right to rescind." *Blumenfeld*, 92 A.D.3d at 488-89; *see also U.S. Life Ins. Co. v Grunhut*, 83 AD3d 528, 529 (N.Y. App. Div., 1st Dept. 2011) ("By accepting premium payments for three months after commencing this action to rescind the insurance policies, and doing so apparently intentionally (to 'protect' the insured pending a determination of the action), plaintiff waived its right to rescind the policies.").

D. Innocent Co-Insureds

Where a policy covers multiple individuals or entities, questions arise as to whether an insured's fraud or misrepresentation can be used to support rescission as to an innocent additional insured. "If a policy was procured through a material misrepresentation, the insurer may rescind an insurance policy as to all insureds – even those insureds with no knowledge of any misrepresentation." *Cont'l Cas. Co. v. Marshall Granger & Co.*, 921 F. Supp. 2d 111 (S.D.N.Y. 2013); *Watson v. United Servs. Auto. Ass'n*, 566 N.W.2d 683, 689 (Minn. 1997).

Applying this rule, a federal court in Georgia recently held that a professional liability insurance policy was void as to all members of a law firm where the attorney completing the application falsely warranted that he was not aware of any errors or omissions. *ProAssurance Cas. Co. v. Smith*, No. 4:15-cv-051, 2016 WL 4223666 (S.D. Ga. Aug. 9, 2016). In *ProAssurance*, the attorney who filled out the application had, unbeknownst to his partners, stolen more than $1 million in settlement proceeds from his clients in the 12 month period preceding his representation that he was not aware of any errors or omissions that could result in a professional liability claim. *Id.* at *1. When it learned of the fraud, ProAssurance sought to rescind the policy. The innocent partner opposed rescission, relying on provisions in the policy providing that: (1) the policy "will apply to any Insured who did not participate in, acquiesce in or fail to take appropriate action after having knowledge of such acts, errors or omissions"; and (2) where "a claim has been concealed" the policy "will apply to any Insured who has complied with all policy provisions and did not participate in, acquiesce in or fail to promptly notice the Company of such concealment." *Id.* at *4. The district court, however, held that these policy provisions were not applicable because misrepresentations in the application rendered the policy void *ab initio*, and "[t]herefore, the innocent insured provision is inapplicable because there is and never was a contract for insurance." *Id.*

Not all courts rigidly apply this rule to void coverage for innocent co-insureds. For example, in *Evanston Insurance v. Agape Senior Primary Care*, 636 F. App'x 871 (4th Cir. 2016), Evanston sought to rescind a professional liability policy as to all participants in the policy it had issued to

Agape, a nursing home, when Evanston learned that one of the covered "doctors" at Agape was fraudulently practicing medicine under a stolen identity. On appeal, the Fourth Circuit held that "principles of equity weigh in favor of allowing coverage for the innocent co-insured parties," because (1) Evanston did not include an express provision in the policy voiding coverage as to all insureds for any misrepresentation; (2) the other insureds under the policy had no knowledge of the fraud; and (3) the public interest would not be served by allowing the actions of one corrupt applicant to deprive innocent insureds of the benefit of their contract. *Id.* at 875-76; *see also Nat'l Ins. Assn. v. Peach*, 926 S.W.2d 859, 861-62 (Ky. 1996) (explaining that "without exception" courts hold that rescission will not be effective for automobile insurance as to an injured third party in states mandating automobile insurance coverage).

In addition to these equitable principles, a severability or separation-of-insureds clause may preserve coverage for an innocent co-insured. "The purpose of these separation-of-insureds clauses is to provide each insured with separate coverage, as if each were separately insured with a distinct policy." *Chrysler Ins. Co. v. Greenspoint Dodge of Houston, Inc.*, 297 S.W.3d 248, 253 (Tex. 2009) (citing *Comm. Std. Ins. Co. v. Am. Gen. Ins. Co.*, 455 S.W.2d 714, 721 (Tex. 1970)). "Under such a provision, intent and knowledge for purposes of coverage are determined from the standpoint of the particular insured, uninfluenced by the knowledge of any additional insured." *Id.* (quoting *King v. Dallas Fire Ins. Co.*, 85 S.W.3d 185, 188-89 (Tex. 2002)). Thus, a number of courts have determined that a separation-of-insureds clause will bar rescission of a policy as to innocent co-insureds. *E.g.*, *Atl. Permanent Fed. Savings & Loan Ass'n v. Am. Cas. Co. of Reading, Pa.*, 839 F.2d 212 (4th Cir. 1988); *Northern Security Ins. Co. v. Stanhope*, 14 A.3d 257 (Vt. 2010); *In re HealthSouth Corp. Ins. Litigation*, 308 F. Supp. 2d 1253 (N.D. Ala. 2004); *Wedtech Corp. v. Fed. Ins. Co.*, 740 F. Supp. 214 (S.D.N.Y. 1990); *Shapiro v. Am. Home Ass. Co.*, 616 F.Supp. 900, 903-05 (D. Mass. 1984).

Severability may also be implied in the language used. A policy that voids coverage in the event of fraud by "<u>the</u> insured" instead of "<u>an</u> insured" or "<u>any</u> insured" would allow continued coverage for an innocent coinsured. *Watts v. Farmers Ins. Exch.*, 98 Cal. App. 4th 1246, 1260-61 (2002) (California Standard Form Fire Insurance Policy, which provides "[t]his entire policy shall be void if, whether before or after a loss, <u>the</u> insured has willfully concealed or misrepresented any material fact or circumstance concerning this insurance" is severable as against innocent co-insureds (emphasis added). Principles of agency law may also be used to preserve coverage for innocent co-insureds. In *Everest Nat'l Ins. Co. v. Tri-State Bancshares, Inc.*, No. 5:15-cv-1491, 2016 BL 255812 (W.D. La. Aug. 1, 2016), a federal court in Louisiana held, on facts very similar to *ProAssurance*, that the intent to deceive of an agent who completed an application for insurance could not necessarily be imputed to his principal. In *Tri-State Bancshares*, a bank vice president embezzled nearly two million dollars from a bank. The bank subsequently sought to collect on a financial institution bond, issued by Everest, for which the vice president who had embezzled the money had signed the application representing that the bank was unaware of any fact, circumstance, or situation that "could reasonably be expected to give rise to a future claim." *Id*. at 5. When the bank discovered the embezzlement and reported it to Everest, Everest filed suit seeking to rescind the bond. Everest argued that as the agent of the bank, the vice president's knowledge of his own fraud could be imputed to the bank, warranting rescission of the policy as to the bank for material misrepresentations.

The district court rejected this argument. The court, relying on the adverse interest exception, held that because the vice president "was acting in his own interest in lying on the 2011 Application and 2014 Renewal Application, and because his interests starkly diverged from the best interest of [the bank]" the vice president's knowledge was not imputable to the bank for purposes of determining whether the bank had made a misrepresentation in the policy application. *Id.* at *10-*12.

Often, a severability provision applies only to rescission, and not to the prior knowledge exclusion. A severability provision in an application may be limited to those circumstances in which "this Policy will be *void*." But the prior knowledge exclusion does not void the entire policy, as with rescission. Instead, the exclusion typically operates with respect to particular claims. Thus, while the severability provision could protect a so-called "innocent insured" from the policy being voided *ab initio*, it does not restore coverage otherwise barred by the prior knowledge exclusion.

E. Third Parties

As a general rule, rescission is allowed even where third parties are harmed by the rescission. *Civil Serv. Emps. Ins. Co. v. Blake*, 245 Cal. App. 2d 196, 198 (1966) (policy rescinded due to material misrepresentations in insurance application "notwithstanding the existence of any rights in third parties who were injured by the acts of the insured which occurred before the rescission"). However, some older cases have made narrow exceptions. *Angle v. United States Fid. & Guar. Co.*, 201 Cal. App. 2d 758, 763 (1962) (rescission by insurer based on mutual mistake of fact not allowed because rescission would prejudice a third party's share of the losses); *Beckwith v. Sheldon*, 165 Cal. 319, 324 (1913) ("It is, of course, fundamental that where the rights of others have intervened and circumstances have so far changed that rescission may not be decreed without injury to those parties and their rights, rescission will be denied and the complaining party left to his other remedies.").

VI. ELECTION OF REMEDIES

Whether an insurer seeking to rescind a policy must elect rescission at the expense of an action for breach of contract or fraud is a question determined by applicable state law and statutes governing the procedure for rescission.

Under general contract principles, "[i]f a party has more than one remedy . . . his manifestation of a choice of one of them by bringing suit or otherwise is not a bar to another remedy unless <u>the remedies are inconsistent</u> and <u>the other party materially changes his position in reliance on the manifestation</u>." Restatement (Second) of Contracts § 378; *United States ex rel. Portland Constr. Co. v. Weiss Pollution Control Corp.*, 532 F.2d 1009, 1012 (5th Cir. 1976). Most jurisdictions understand rescission and damages for breach of contract as inherently inconsistent remedies, such that "the election of one bars recovery under the other." *E.g.*, *Akin v. Certain Underwriters at Lloyd's London*, 140 Cal. App. 4th 291, 296 (2006); *Wong v. Stoler*, 237 Cal. App. 4th 1375, 1384 (2015) ("The party may disaffirm the contract, treating it as rescinded, and recover damages resulting from the rescission. Alternatively, the party may affirm the contract, treating it as repudiated, and recover damages for breach of contract or fraud."). Thus, in ordinary contract cases, most jurisdictions will require an election of rescission, based upon a

disaffirmance of the agreement, over damages, based upon an affirmance of the agreement. Ordinarily, courts may not require such election before the case goes to the jury; in some instances, election may be permitted even later. *See Jahn v. Brickey*, 168 Cal. App. 3d 399, 406 (1985) (rescinding party not required to elect a remedy before the case is submitted to the jury but court must strike duplicative recoveries from jury award).

Further, in ordinary contract cases, many jurisdictions interpret narrowly what constitutes "election" of a remedy. Even an overt election of one remedy will not constitute an "election" unless the party allegedly in breach has acted in material reliance upon the election. Put differently, a finding that an election has been made depends on the existence of facts sufficient to create an estoppel. *E.g.*, *Quality Components, Inc. v. Kel-Keef Enters, Inc*., 316 Ill. App. 3d 998, 1010, 738 N.E.2d 524, 533, 250 Ill. Dec. 308 (2000); *Fletcher v. Rodriguez*, 47 Misc. 3d 582, 3 N.Y.S.3d 901 (Sup. Ct. 2015) (election of rescission caused opposing party to suffer some detriment); *PHL Variable Ins. v. Charter Oak Trust*, 2011 Conn. Super. LEXIS 610 (Mar. 9, 2011) (election of rescission caused "the other party [to] materially change[] his position in reliance on the manifestation").

The authors have not found meaningful authority addressing whether the sometimes lenient "election of remedy" standard for business contracts applies to an insurer's attempt to terminate its obligations to a policyholder. Policyholder counsel should be alert to the opportunity to argue that rescission of the protection afforded by insurance coverage is subject to a different standard altogether, and requires an insurer to act early and unequivocally in any rescission attempt.