Wiley Rein LLP

EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | January 2014

ALSO IN THIS ISSUE

Side A Insurers Not Required to Drop Down to Provide Coverage to Claims Deemed First Made in Prior Policy Period

The Superior Court of Arizona has held that two Side A insurers did not have an obligation to drop down and provide coverage for underlying litigation deemed related to litigation filed in a prior policy period. *SP Syntax LLC v. National Union Fire Ins. Co.*, CV 2011-019071 (Ariz. Super. Ct. Jan. 7, 2014). In an earlier decision, the court held that a specific litigation exclusion in an underlying primary and two follow-form insurance policies barred coverage under the later policy period, but allowed the plaintiffs, as the assignees of the insureds, to conduct discovery to determine whether there was any extrinsic evidence to support the plaintiffs' contention that the parties mutually intended for two Side A/Difference in Condition policies to drop down in the circumstances presented. Wiley Rein represented one of the Side A insurers.

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Allegations of Violations of the California Labor Code Fall Outside the Definition of "Loss" Under Policy

The Superior Court of California, San Diego County, has held that a policy's wage, hour, and payroll policies exclusion precludes coverage for a claim based on violations of the California Labor Code. *M Bar C Constr. Inc. v. Continental Cas. Co. Inc.,* No. 37-2012-00088258-CU-IC-CTL07-P-1180 (Cal. Super. Ct. Jan. 3, 2014). The court also held that the claim fell within categories that were carved out of the definition of "loss." Wiley Rein represented the insurer.

The policyholder sued, seeking coverage under a liability insurance policy for a putative class action complaint brought against the policyholder on behalf of a class of former employees alleging violations of the California Labor Code. The insurer moved for summary judgment on the grounds that the policy's "wage, hour and payroll policies" exclusion barred coverage and that the underlying claim did not seek covered "loss." The "wage, hour and payroll policies" exclusion provided that "[t]he Insurer shall not be liable to pay any Loss under this Coverage Part in connection with any Claim made against any Insured: [¶] ... [¶] b. based upon or arising out of any actual or alleged violation of: the Fair Labor Standards Act (except the

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Failure to Obtain Consent Negates Coverage for Settlement

The United States Court of Appeals for the Fourth Circuit, looking both to Maryland law and Tennessee law, has held that an insured's breach of a policy provision requiring it to obtain the insurer's consent before settling any claim negates coverage without regard to whether the insurer was prejudiced by the breach. *Perini/ Tompkins Joint Venture v. ACE Am. Ins. Co.*, 2013 WL 6570947 (4th Cir. Dec. 16, 2013).

The case involved primary and excess commercial general liability policies issued by the same insurer to a construction company hired to build a hotel. During the course of the project, part of the building collapsed, causing significant property damage and delaying completion of the hotel. The owner of the hotel subsequently sued the construction company. Without providing notice of the suit to its insurer and without seeking or obtaining consent from its insurer, the insured settled the claim and agreed to credit the hotel owner approximately $26 million toward the balance due under the parties' original contract.

More than six months later, the insured sought to recover the settlement amount under its policies. The insurer denied coverage, taking the position that the insured breached the "voluntary payment clause" in the policies, which provided that "[n]o insured will, except at that insured's own cost, voluntarily make a payment, assume an obligation, or incur any expense . . . without [the insurer's] consent." The insurer also relied on the policies' "no-action clause," which provided that an insured may sue to recover on a settlement only if the settlement is one agreed to and signed by the insurer.

In the coverage litigation that followed, the parties did not dispute that the insured failed to seek and to obtain the insurer's consent to the settlement. The construction company did, however, argue that regardless of whether the court followed the law of Maryland or Tennessee, a showing of prejudice was required to support a denial

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"Innocent Insured" Doctrine Prevents Rescission

The Appellate Court of Illinois, applying Illinois law, has held that an insurer could rescind coverage for an insured who made material misrepresentations on the policy application. *Ill. State Bar Assn. Mut. Ins. Co. v. Law Office of Tuzzolino & Terpinas*, 2013 WL 6157417 (Ill. App. Ct. Nov. 22, 2013). However, the court also ruled that the insurer could not rescind coverage for other insureds who did not make misrepresentations, citing both the policy's severability provision and the "innocent insured" doctrine.

A client of one partner in the insured law firm sued the partner for malpractice in handling litigation with the client's former partners in a business venture. The partner convinced the client to file suit against the business's bankruptcy attorney rather than pursue the case against him, but the partner failed to file the complaint within the time required by the statute of repose. The partner then led the client to believe that the bankruptcy malpractice suit was still pending for the next 18 months. When the client learned that the suit had been dismissed, the partner offered to settle any claims the client might have against him.

Shortly thereafter, the partner completed a renewal form for the firm's malpractice insurance policy. The partner failed to disclose any of the circumstances surrounding the settlement with the client. After the policy was issued, the firm's other partner learned of the malpractice claims and alerted the firm's insurer. The insurer then filed suit to rescind the policy on the grounds that the partner's withholding of information on the application was a material misrepresentation that voided the policy *ab initio*. The trial court granted summary judgment in favor of the insurer, and the partners appealed. In particular, the other partner argued that the policy should provide coverage for him because he was unaware of the events at issue or his partner's misrepresentation.

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No Coverage for Class Action Where All Claims Were First Made or Related Back to Claims First Made Prior to the Policy Period

Applying Michigan law, the United States District Court for the Eastern District of Michigan has held that an art gallery's professional liability insurance policy does not afford coverage for a multi-district class action litigation because some of the claims asserted were first made before the policy period and the remaining claims related back to those uncovered claims. *Park West Galleries, Inc. v. Ill. Nat'l Ins. Co.*, 2013 WL 6095482 (E.D. Mich. Nov. 20, 2013).

The art gallery purchased a miscellaneous professional liability policy for the claims-made-and-reported policy period of October 31, 2008 to October 31, 2009, with a retroactive date of October 31, 2008. Prior to the policy's inception, the art gallery had been named as a defendant in four separate class actions alleging that the gallery acted wrongfully in connection with the sale and appraisal of certain artwork. After the policy incepted, customers filed several additional class actions lawsuits against the gallery based on similar allegations. Ultimately, six of the class actions were consolidated into a multi-district class action litigation. Following a settlement of the multi-district litigation, the art gallery sought defense and indemnity coverage for the six consolidated cases from the carrier.

In the coverage litigation that followed, the court first considered the applicability of an exclusion in the policy for claims "arising out of any wrongful act which occurred prior to the retroactive date." The insurer argued that the exclusion applied because the named plaintiffs in each of the six underlying class actions alleged wrongful acts that occurred prior to October 31, 2008. The court rejected this argument, reasoning that putative class members other than the named plaintiffs could have alleged wrongful acts that occurred after the retroactive date, such that the exclusion did not relieve the insurer of its duty to defend.

The court nonetheless held that a number of other terms and conditions in the policy barred coverage for the six consolidated cases. First, the court concluded that two of the consolidated cases were filed prior to the policy's inception date and therefore were not first made within the policy period. Second, the court held that, although the named plaintiffs in the third action did not file suit until after the policy incepted, the same group of plaintiffs had sent pre-inception correspondence to the art gallery

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No Coverage for Late Notice of Claim Filed with Banking Authorities

The United States District Court for the Eastern District of Louisiana, applying Louisiana law, has held that no coverage was available for a lawsuit filed by a bank customer because the claim was first made when the customer filed complaints with federal and state banking authorities and because the bank provided late notice of the claim. *Grubaugh v. Central Progressive Bank*, 2013 WL 6709887 (E.D. La. Dec. 18, 2013). The court also held that the insurer's coverage defense of late notice applied to the bank customer and held that the insurer did not waive the coverage defense.

In June 2008, the customer of an insured bank filed complaints with state and federal banking authorities in which he alleged unauthorized withdrawals from his bank accounts and demanded reimbursement of the withdrawals. The banking authorities notified the bank of the complaints, and the bank responded to the complaints. In June 2009, the customer filed a lawsuit against the bank in Louisiana state court, and several days later, the bank tendered the lawsuit to its insurer, which provided D&O and professional liability coverage to the bank from February 1, 2007 to November 15, 2009. In June 2011, the customer amended the complaint to name the bank's insurer as a defendant under Louisiana's direct action statute. The insurer

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Concealment of Criminal Conspiracy Is Grounds for Rescission of Professional Liability Policy

Applying Florida law, a federal district court has held that an insurer may rescind a title agent's E&O policy on account of the insured's failure to disclose in the application for coverage her participation in an ongoing criminal conspiracy. *Zurich Am. Ins. Co. v. Diamond Title of Sarasota, Inc.*, 2013 WL 6283684 (M.D. Fla. Dec. 4, 2013).

In 2009, the owner and president of a title agency company pleaded guilty to various crimes relating to a mortgage fraud scheme. As part of her plea agreement, the insured admitted to participating in a conspiracy that involved making materially false and misleading statements to federally insured banks between 2002 and 2008. Meanwhile, in 2007, the insured had completed an application for professional liability coverage and responded "no" to Question No. 21, which asked whether "the Applicant or any prospective Insured kn[ew] of any circumstances, acts, errors or omissions that could result in a professional liability claim against the Applicant." In light of the admitted ongoing conspiracy at the time, the insurer took the position that this answer constituted a material misrepresentation that warranted rescission of the policy.

In the litigation that followed, pointing to the phrase "professional liability claim," the insured argued that Question No. 21 was limited to a potential claim for negligence, and therefore its negative response was truthful because the conspiracy involved intentional acts that would not result in such a claim. The court rejected the argument on the grounds that "[a] single act [could] be the basis for both professional and criminal liability." The court also rejected the insured's reliance on the fact that the policy expressly excluded coverage for claims arising out of intentional or criminal conduct, finding that the insured "was not relieved of [its] duty in the application to report acts that *could* result in a professional liability claim simply because the policy may not have covered those acts."

The court additionally held that rescission did not require the insurer to prove an intentional misrepresentation. The court noted that this holding was consistent with applicable law, as well as the language in the policy providing that the "discovery of any fraud, intentional concealment, or misrepresentation of material fact" renders the policy "void at inception." As the court explained, under this provision, the policy was void at inception "not just for fraud and intentional concealment, but also for misrepresentation of material fact."

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No Coverage for Claim Deemed First Made Prior to Policy Period

The United States Circuit Court for the Eleventh Circuit, applying Florida law, affirmed a trial court's dismissal of a complaint against an insurer after determining that the underlying lawsuit was deemed a claim first made prior to the inception of the insured's professional liability policy. *Zodiac Group, Inc. v. AXIS Surplus Ins. Co.*, 2013 WL 5718439 (Oct. 22, 2013).

An insurer issued a claims-made professional liability policy to a company that offered psychic hotline telephone services. The policy was issued for the policy period of October 1, 2008 to October 1, 2009, and the insurer issued a renewal policy for the following year. Both policies provided that "all Claims arising from the same Wrongful Act" were deemed to have been made on the same date and that wrongful acts "related by common facts, circumstances, transactions, events and/or decisions" were to be treated as "one Wrongful Act."

In April 2008, a putative psychic sued the insured company and alleged that the company improperly used her name and likeness to imply falsely that she supported the company after her endorsement agreement with the

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Application Exclusion Bars Coverage for Wrongful Termination Suit by Would-Be Whistleblower

The United States Court of Appeals for the Ninth Circuit, applying California law, held that a broker-dealer's professional liability policy barred coverage for claims arising from circumstances known but not disclosed on the policy's application. *Endurance Am. Specialty Ins. Co. v. Nommensen*, 2013 WL 6623869 (9th Cir. Dec. 4, 2013). At the time the broker-dealer submitted the application, it was aware that an affiliate's employee had sent a "tip" to the Financial Industry Regulatory Authority (FINRA) regarding unregistered employees and that the broker-dealer had reprimanded the employee's supervisor and requested that the employee be terminated for violating FINRA rules. The court held that the employee's subsequent wrongful termination action "arose from" those circumstances, which were required to be disclosed on the application but were not. The court therefore concluded that the application's exclusion for any claim "arising from" a fact or circumstance required to be disclosed in the application barred coverage for the wrongful termination action, which arose from the same circumstances as the FINRA tip. ■

Exclusion for Violation of Licensure Laws Inapplicable to Medical Malpractice Action

Applying Kentucky law, a Kentucky intermediate appellate court has held that an exclusion for liability resulting from a violation of professional licensure laws does not bar coverage for a lawsuit against a doctor based on his alleged negligence that also resulted in the medical licensure board taking action that affected the doctor's license. *Healthcare Underwriters Grp. v. Strange*, 2013 WL 6571799 (Ky. Ct. App. Dec. 13, 2013).

A doctor was performing surgery on a patient when the doctor suddenly collapsed. He later tested positive for opiates. Consequently, the medical licensure board began an investigation and ultimately concluded that the doctor's medical license would be affected. When the patient filed an action against the doctor for professional negligence, the doctor sought coverage under his professional liability policy. The insurer denied coverage and filed a coverage action seeking a declaration that there was no coverage for the malpractice lawsuit based on an exclusion for "liability resulting from any violation of any law, including but not limited to, antitrust, unfair competition, consumer protection or professional licensure laws." The insurer asserted that the exclusion barred coverage for medical negligence if that negligence also resulted in a violation of professional licensure laws.

The court disagreed with the insurer. The court found the exclusion ambiguous and thus rejected the insurer's interpretation, holding instead that the exclusion barred coverage only for liability directly resulting from a violation of the professional licensure laws. According to the court, in a medical malpractice action, an insured's liability results from his or her negligence, not from a violation of professional licensure laws, and thus the exclusion does not apply every time an insured commits a tort of medical negligence that also happens to be a violation of a licensure law. As such, the court held that the exclusion did not bar coverage for the patient's lawsuit against the doctor. ■

Side A Insurers Not Required to Drop Down to Provide Coverage to Claims Deemed First Made in Prior Policy Period *continued from page 1*

At issue were two successive towers of claims-made D&O insurance issued to a company for the policy periods of November 30, 2006 to November 30, 2007 (Tower 1) and November 30, 2007 to November 30, 2008 (Tower 2). Tower 1 was comprised of four policies, each with $5 million limits of liability, and Tower 2 was comprised of five policies, each with $5 million limits of liability. Tower 2 included a primary policy, two policies that followed form to the primary policy, and two Side A policies that did not follow form and provided "drop down/difference in condition" coverage.

Shortly before the expiration of the Tower 1 policy period, investors brought suit against certain of the company's D&Os for securities fraud (the Securities Action), and the officers tendered the Securities Action to the Tower 1 insurers. In light of the Securities Action, the Tower 2 primary and follow-form carriers added a specific litigation exclusion to their policies that identified the Securities Action by name. The specific litigation exclusion provided that all Claims arising out of or related to the Securities Action were deemed made during the Tower 1 policy period and excluded from coverage under Tower 2. The Side A insurers did not adopt the specific litigation exclusion, but their policies contained related claims provisions and prior notice exclusions.

The Securities Action was followed by additional litigation filed during the Tower 2 policy period, including a lawsuit by two private entities that had loaned money to the insured company during the Tower 1 policy period (the Underlying Action). After the Underlying Action was tendered to the Tower 1 and Tower 2 insurers, all of the insurers determined that the Underlying Action arose out of the same facts and circumstances as the Securities Action and therefore related back to Tower 1.

The D&Os and the claimants settled the Underlying Action for a stipulated judgment of $26.47 million and an assignment of rights under the Tower 2 policies, and the Tower 1 insurers paid $1.47 million of the settlement in accordance with the stipulated judgment. The claimants then brought a coverage action seeking the remaining $25 million of the stipulated judgment from the Tower 2 insurers.

On motions to dismiss filed by the insurers, the court dismissed the primary and follow-form insurers on the basis that, applying the plain language of the specific litigation exclusion, the Securities Action and the Underlying Action were related, and the Underlying Action was therefore excluded from coverage under Tower 2. The court further determined, however, that discovery was appropriate to determine whether the Side A insurers were required to drop down in the circumstances presented because the Side A insurers had not adopted the specific litigation exclusion and the related claims and prior notice exclusions did not reference the Securities Action by name.

Following the completion of discovery, the Side A insurers and the claimants filed cross-motions for summary judgment. The court concluded that the related claims and prior notice provisions in the Side A policies applied to relate the Underlying Action back to the Securities Action under Tower 1. The court rejected the claimants' arguments that the parties mutually intended for the Tower 2 Side A policies to drop down and afford coverage for a Claim related to the Securities Action and that the insureds reasonably expected the Tower 2 Side A policies to do so. Instead, the court agreed with the insurers that the D&Os' tender under the Tower 1 policies and the claimants' receipt of settlement funds paid under a Tower 1 Side A policy belied the claimants' arguments in the coverage litigation.

The court also rejected the claimants' argument that the date in prior or pending litigation exclusions in the Tower 2 policies, which barred coverage for all Claims pending as of or prior to November 30, 2006, controlled the operation of the related claims and prior notice provisions and impliedly afforded coverage for the Underlying Action in Tower 2 because it was not pending before that date. The court observed that it "simply cannot be the case" that the date in a prior or pending litigation exclusion mandated coverage for the Underlying Action and expressly rejected the claimants' reliance on *Gastar Exploration Ltd. v. U.S. Specialty Insurance Co.*, 412 S.W.3d 577 (Tex. App. 2013). The court noted that the prior or pending date did not "override the related claims and prior notice

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Side A Insurers Not Required to Drop Down to Provide Coverage to Claims Deemed First Made in Prior Policy Period *continued from page 6*

provisions, which make no reference to a pending and/or prior date and operate independently of it."

The court also rejected the claimants' argument that the premiums charged for the Side A policies "cannot be reconciled with an interpretation that excludes coverage for all claims regarding [the insured company's] financial statements or business relationships . . . ." In this regard, the court noted that the "related claims and prior notice provisions do not foreclose coverage," but merely "specify which policy period and corresponding tower of coverage will respond to a claim."

The court therefore granted summary judgment in favor of the Side A insurers. ■

"Innocent Insured" Doctrine Prevents Rescission *continued from page 2*

On appeal, the court first considered what it referred to as the policy's "innocent insured" clause. That provision stated:

> Whenever coverage under this policy will be excluded or lost because of the insured's failure to provide timely notice, the company agrees that such insurance as would otherwise be afforded under this policy, should be applicable with respect to any insured who do not personally fail to give timely notice after having knowledge of the conduct that forms the basis of the claim. All insureds covered by this provision must immediately comply with all policy provisions regarding reporting the claim upon learning of the unreported claim.

The other partner argued that he had lost coverage because his partner had failed to report the client's claim, but the court found that this ignored the distinction between reporting a claim under an existing policy and failing to disclose a claim on an application for a new policy and rejected that argument.

The court then considered whether the common law "innocent insured" doctrine would prevent rescission of the policy as to the other partner. The court held that the common law "innocent insured" doctrine, which preserves coverage for an "innocent insured" where a reasonable person would not understand that the wrongdoing of a co-insured would prevent recovery, applied to these circumstances. The court rejected the insurer's argument that the doctrine should apply only to coverage questions and not to whether the policy was void from its formation. The court held that, under Illinois law, the partner's material misrepresentation merely rendered the policy voidable, not void *ab initio*, and therefore the "innocent insured" doctrine could protect an innocent co-insured where a material misrepresentation was made during the formation of a policy. In addition, the court observed that the Illinois rescission statute demonstrates a public policy disfavoring rescission.

Although the court noted that the "innocent insured" doctrine did not require a divisible contract, the court also examined the policy's severability clause, which stated that the information contained in the application could be construed "as a separate agreement with and binding on each insured." Because the misrepresentation did not void the policy *ab initio*, the court found that the severability clause created separate contracts with each insured, allowing partial rescission of the policy as to the culpable insured. ■

Failure to Obtain Consent Negates Coverage for Settlement *continued from page 2*

of coverage based on the voluntary payment and no-action clauses. The court disagreed, first pointing out that the prejudice requirement imposed by Section 19-110 of the Maryland Code is limited to instances in which coverage is denied based on late notice or lack of cooperation. The court noted that the state intermediate appellate court has held that the statute should not be read "to be applicable to any defense raised by the insurer" and that it is "inapplicable when an insurer defends on the basis that its insured failed to meet the condition precedent set forth in a no-action clause." The court further read the same state court decision as holding that "an insured's failure to obtain the insurer's prior consent to a settlement does not *ever* require prejudice," even under the common law of Maryland, because an insurer would always have "the impossible burden . . . of showing collusion or demonstrating, after the fact, the true worth of a settled claim." Based on this logic, the court also predicted that the highest court in Tennessee likewise would conclude that an insurer presented with a settlement as a *fait accompli* need not demonstrate prejudice to disclaim coverage.

Additionally, the court concluded that, even if a showing of prejudice was required, the result would be the same here because an insurer is prejudiced as a matter of law when an insured delays notifying the insurer of a claim until after its resolution. In this regard, according to the court, the delay vitiates the insurer's rights under the policies, including the insurer's rights to investigate, defend, control, and settle the suit against its insured. ■

No Coverage for Class Action Where All Claims Were First Made or Related Back to Claims First Made Prior to the Policy Period *continued from page 3*

stating that (1) they were not able to resell the paintings they had purchased from the gallery "at a good price"; (2) that they wanted to settle the matter "in a fair way"; and (3) that they had retained attorneys and would likely be suing the gallery for damages. Because the court determined that this correspondence constituted a "claim"—defined by the policy as a "demand for money or services, including a suit, arising from your wrongful act"—the court likewise concluded that the third case asserted a claim that was first made before the policy period.

Finally, the court held that the three remaining cases fell within an exclusion in the policy barring coverage for any claim "first made against you prior to, or pending as of, the first inception date, or relating to the essential facts, circumstances or situation underlying such claim." The court observed that the term "relating to" is generally "interpreted very broadly in this context." Applying this broad definition, the court determined that the three remaining cases involve "similar issues of fact and law" as the other, uncovered cases—as is required for consolidation into a multi-district proceeding. Accordingly, the court held that the related claims exclusion precluded coverage for the final three cases. ■

Concealment of Criminal Conspiracy Is Grounds for Rescission of Professional Liability Policy *continued from page 4*

Finally, the court concluded that the insured's misrepresentation was material. The court cited Florida Statute § 627.409 for the proposition that a misrepresentation was material if it "[did] not enable an insurer to adequately estimate the nature of a risk in determining whether to issue the policy." The court noted that "[a]n objective insurer" with knowledge that the insured was engaged in an ongoing scheme to commit mortgage fraud may "not have issued a policy at all" and "certainly" would not have issued it "under the same terms and pricing" as it did without such knowledge. ■

No Coverage for Late Notice of Claim Filed with Banking Authorities *continued from page 3*

moved for summary judgment because the bank did not provide timely notice of the claim.

The court held that no coverage was available under the policy for the customer's lawsuit. First, the court held that the complaints filed with banking authorities constituted a "claim" that was first made in June 2008. The policy defined "claim," in relevant part, as a "written demand for monetary damages" and, with respect to the policy's professional liability coverage, required that the demand be brought "by or on behalf of a customer." The court held that the complaints filed by the customer with the banking authorities and served on the bank constituted written demands for monetary relief because the customer demanded reimbursement of allegedly unauthorized withdrawals from his bank account.

Second, the court held that the bank provided untimely notice of the June 2008 claim. As a condition precedent to coverage, the policy required that the insured provide notice of a claim "as soon as practicable, but in no event later than … sixty (60) days after which the insured first becomes aware that the Claim has been made." No coverage was available for the 2008 complaints filed with the banking authorities or the subsequent lawsuit because the bank did not provide notice to the insurer within 60 days of receiving notice of the 2008 complaints. The court also held that it was irrelevant that the customer did not provide the complaints directly to the bank because the bank received notice of the complaints from the banking authorities.

In addition, the court held that the bank's failure to provide timely notice of the claim barred the customer, as a third-party claimant, from maintaining a direct action against the insurer because there was no potential coverage for the claimant's lawsuit.

Finally, the court held that the insurer did not waive its right to rely on the late notice defense. The customer contended that the insurer waited too long to invoke the late notice defense. But the court held that the insurer had not waived the coverage defense because the insurer issued a reservation of rights letter for the lawsuit and raised late notice as an affirmative defense in the customer's direct action against the insurer. ■

No Coverage for Claim Deemed First Made Prior to Policy Period *continued from page 4*

company had ended. This complaint, filed in state court, was dismissed in November 2009 for lack of prosecution, and the insured never provided notice of the action to the carrier. In January 2010, the psychic filed a lawsuit in federal court against the company and two individual insureds. She again alleged that the insureds improperly used her name and likeness to promote the company. The insured gave its insurer notice of this later action, and the insurer denied coverage.

In the ensuing coverage litigation, the insurer moved to dismiss the insured's complaint, which motion was granted. On appeal, the court agreed that the alleged "wrongful acts" in the state and federal complaints were "clearly related by common facts, circumstances, transactions, events and/or decisions" and thus were "one Wrongful Act." The court rejected the insured's argument that the inclusion of additional defendants in the later action resulted in allegations of a "new wrongful act" because the policy did not limit its broad relation language "to only those acts committed by a single actor." As such, under the policy language, the claim for the single wrongful act was treated as if it were made at the time of the earlier lawsuit in April 2008 and therefore prior to the policy period. Accordingly, the court reasoned that a condition precedent to coverage was not met because the claim was not first made during the policy period. The court therefore affirmed the lower court's dismissal of the action against the insurer. ■

Allegations of Violations of the California Labor Code Fall Outside the Definition of "Loss" Under Policy *continued from page 1*

Equal Pay Act), as amended, or any other federal, state or local statutory law or common law anywhere in the world."

The court agreed with the insurer that the policy's "wage, hour and payroll policies" exclusion clearly excluded violations of the California Labor Code. The court further ruled that because an exclusion applied, it need not address a bad faith claim against the insurer or the issue whether any categories of relief sought qualified as a "loss" within the meaning of the policy. However, without providing its analysis, the court found that all of the relief sought in the underlying action fell within categories that were carved out of the definition of "loss" and that the "genuine dispute doctrine" warranted summary judgment in favor of the insurer with respect to the bad faith claim. ■

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