Wiley Rein LLP

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Guilty Pleas Bar Coverage and Entitle Insurer to Recoupment

Applying Virginia law, a federal district court has held that guilty pleas and criminal convictions of officers of the insured company trigger fraud, profit, and prior knowledge exclusions and entitle the insurer to recoup all defense costs. *Protection Strategies, Inc. v. Starr Indem. & Liab. Co.*, No. 1:13-CV-00763 (E.D. Va. Apr. 23, 2014). Wiley Rein LLP represented the insurer.

An insurer issued a D&O policy to a defense contractor. The company received a subpoena and a search and seizure warrant from the NASA Office of Inspector General as well as notification from the U.S. Department of Justice that it was the target of an investigation regarding federal contracting preferences. The insurer advanced defense costs to the company and its officers, who also were identified as targets of the investigation. After the officers pleaded guilty to fraud and conspiracy charges and were sentenced, the insurer asserted that fraud, profit, prior

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Joint Lawsuit by Four Siblings Constitutes a Single Claim Because It Alleged Interrelated Wrongful Acts

The United States Court of Appeals for the Eighth Circuit, applying Minnesota law, has held that a lawsuit by four siblings against their financial advisor for negligent investment advice alleged "Interrelated Wrongful Acts" and constituted a single claim. *Kilcher v. Continental Cas. Co.*, 2014 WL 1317296 (8th Cir. Apr. 3, 2014). Wiley Rein represented the insurer in the appeal.

The insured, a financial advisor, provided investment advice to four siblings, who were members of the Shakopee Mdewakanton Sioux Community, and were each introduced to the financial advisor by the siblings' mother. Between 1999 and 2003, each sibling,

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No Coverage for Lawyer's Alleged Self-Dealing

A federal district court in Nevada has granted an insurer's motion for summary judgment, holding that the business enterprise, trust, and investment advice exclusions in a lawyers professional liability policy barred coverage for a suit alleging self-dealing by the insured attorney and his firm. *Christensen v. Darwin Nat'l Assurance Co.*, No. 2:13-CV-00956-APG-VCF (D. Nev. Apr. 14, 2014). Wiley Rein represented the insurer.

A corporate client, which owned property on the Las Vegas Strip, retained a law firm and its named partner in connection with an eminent domain matter. During the course of that representation, the attorney purchased a 50% stake in the client through a trust, of which the attorney was the trustee and both he and his family members were beneficiaries. In time, parties associated with the client's original owner sued the attorney and his firm, alleging that they had misrepresented the value of the business in order to acquire the 50% stake at a discount. In addition, the claimants alleged that the attorney used the trust's stake in the business to engage in transactions that benefitted his firm, his family, and himself at the expense of the business. Among other things, the claimants asserted that the law firm and the attorney's family occupied client-owned real estate without

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Insured v. Insured Exclusion Bars Coverage for Claim by FDIC as Receiver

An exclusion from a failed bank's D&O liability policy for any claim brought by the insured bank—or any receiver of the bank—barred coverage for a claim by the Federal Deposit Insurance Corporation (FDIC), as receiver of the bank, according to a summary judgment ruling by the United States District Court for the Eastern District of California. *Hawker v. BancInsure, Inc.*, 2014 WL 1366201 (E.D. Cal. Apr. 7, 2014).

The FDIC sued the bank's former officers for alleged negligence and breach of fiduciary duty. The insurer denied coverage for the FDIC lawsuit under the policy's insured v. insured exclusion, which barred coverage for any claim "by or on behalf of, or at the behest of, any other insured person, the company, or any successor, trustee, assignee or receiver of the company."

The FDIC made numerous arguments that this exclusion did not apply to its lawsuit. The FDIC first argued that "receiver" must refer to a court-appointed receiver because some dictionary definitions of the term reference appointment by courts. The district court rejected that argument, finding that the Black's Law Dictionary definition—which does not limit the term "receiver" to those appointed by courts—is representative of the "ordinary and popular" meaning of the term. The court concluded that the FDIC meets the definition of "receiver" as used in the exclusion.

The FDIC also contended that the fact that the insurer offered a separate regulatory exclusion that specifically barred claims by the FDIC in

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Statutory Damages Under Louisiana PPO Act Do Not Constitute Fines or Penalties

A Louisiana appellate court has held that statutory damages awarded under the Louisiana Preferred Provider Organization Act do not constitute a fine or penalty and were covered under E&O policies. *Williams v. SIF Consultants of Louisiana, Inc.*, 2014 WL 718060 (La. App. Feb. 26, 2014).

The insurers issued E&O policies over several policy periods to the insured, a preferred provider organization. The claimant medical providers filed a class action lawsuit against both the insured and the insurers under Louisiana's direct action statute, alleging that the insured failed to comply with the mandatory notice provisions of billing discounts in the Louisiana Preferred Provider Organization (PPO) Act. In the event of noncompliance, the Louisiana PPO Act provides for "damages payable to the medical provider of double the fair market value of the medical services provided, but in no event less than the greater of fifty dollars per day of noncompliance or two thousand dollars, together with attorney fees." The insurers contended that no coverage existed under the policies in part because the statutory damages constituted a fine or penalty, and the policies carved out of the definition of covered "Loss" "fines, penalties, taxes, and punitive, exemplary or multiplied damages."

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Fraud Exclusion in D&O Policy Triggered by Employee's Misconduct; But Fidelity Bond Responds to the Resulting Judgment Against Insured Bank

Applying Minnesota law, a federal district court has held that a fraud exclusion bars coverage under a D&O policy for a judgment against a bank arising out of its employee's participation in an "advance-fee scheme." *Avon State Bank v. BancInsure, Inc.*, 2014 WL 1048503 (D. Minn. Mar. 18, 2014). The court, however, also concluded that the bank's fidelity bond issued by the same insurer afforded coverage for the resulting loss.

A bank employee became involved in a scam in which individuals were promised portions of a fictional estate if the individuals wired money to help transfer the fictional estate from Senegal to the United States. The employee wired his own funds, but received no return on his investment. He then recruited others to invest in an attempt to cover his losses when he began to doubt the legitimacy of the scheme. The individuals he recruited wrote checks to the bank, and the employee used the bank to wire the funds to offshore accounts. When the individuals received no return on their investments, they demanded that the bank return their money and threatened litigation. The individuals subsequently brought suit against the bank for fraudulent misrepresentation, contending that the bank was vicariously liable for the misconduct of its employee.

The insurer denied coverage under the D&O policy based on an exclusion for losses resulting from fraudulent acts. In the coverage litigation that followed, the court agreed with this position and rejected the bank's reliance on the policy's severability clause for the argument that the exclusion applied only to the extent that the bank itself acted fraudulently. The severability clause provided that "[n]o fact pertaining to any Insured Person shall be imputed to any other Insured Person for the purposes of applying the exclusions." The court held that the bank's interpretation would render the fraudulent acts exclusion meaningless because the bank could only act through its employees, officers, and

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Class Action Suit Against Insured Mortgage Broker Deemed First Made at Time of Prior Suit Alleging Common Course of Conduct

The Florida District Court of Appeals has held that a class action lawsuit filed after the expiration of a claims-made policy was deemed made during the policy period because the class action suit and an earlier action filed during the policy period alleged a common course of conduct by the insured. *Gidney v. Axis Surplus Ins. Co.*, 2014 WL 1386168 (Fla. Dist. Ct. App. Apr. 9, 2014). The court held that the alleged wrongful acts were sufficiently related even though the individual class members were involved in different transactions and had unique financial positions.

In October 2007, a private investor filed suit against an insured mortgage broker alleging that it negligently brokered and serviced mortgages by failing to determine the viability of projects, to follow appropriate accounting practices, and to disclose superior encumbrances on properties. In May 2009, another investor filed a putative class action lawsuit against the insured's officers on behalf of "similarly situated investors who had financed mortgages brokered by [the insured]." The class action alleged that the insured "negligently brokered and serviced 41 named projects" by failing to engage in due diligence, to ensure that appropriate accounting standards were in place, and to advise the plaintiffs of

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Independent Counsel's Settlement Report Inadmissible in Subsequent Litigation Under Different Policy

Applying California law, a federal court in California has held that an insurer that issued two primary policies to a policyholder may not use a confidential settlement memorandum prepared by independent counsel retained under one policy in subsequent coverage litigation related to the other policy. *Fidelity Nat'l Financial, Inc. v. Nat'l Union Fire Ins. Co.,* 2014 WL 1393743 (S.D. Cal. Apr. 9, 2014).

An insurer issued two primary policies to a financial institution: an E&O policy with a duty to defend and a financial institution bond (FIB) policy that applied to first-party loss but provided no duty to defend. When the institution faced multiple lawsuits arising out of an alleged Ponzi scheme, the insurer accepted its tender of the claims for a defense under the E&O policy subject to a reservation of rights, and it reserved its right to contest coverage under the FIB policy. Because it reserved its rights under the E&O policy, the insurer retained independent counsel to defend the matter. The institution asked the insurer to erect a "firewall" between the E&O and FIB claims departments, but the insurer declined to do so, promising only to make its "best efforts" in that regard.

During the pendency of the underlying lawsuits and at the behest of the insurer, the independent counsel provided his assessment of the settlement value of the case in a detailed memorandum to the E&O claims department. The insurer eventually contributed to a settlement under the E&O policy but refused to indemnify the insured under the FIB policy. The institution sued the insurer, and it questioned some of the insurer's executives about the E&O file in the course of discovery. However, in doing so, it did not use the independent counsel's memorandum. Nonetheless, the insurer provided the memorandum to its expert witness and otherwise relied on it as a basis for denying coverage under the FIB policy.

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Broad Allegations in Complaint Against Investment Adviser Trigger Duty to Defend

The United States District Court for the Southern District of California has held that an insurer breached its duty to defend when a complaint alleged that an insured provided investment advice that "includ[ed]," but was not specifically limited to, investments not covered under the policy, and where the insurer failed to investigate whether the allegations could have encompassed covered investments. *Isaacs v. Chartis Spec. Ins. Co.*, 2014 WL 1286565 (S.D. Cal. Mar. 31, 2014).

An insurer issued an E&O policy to a broker/dealer. The policy classified a registered investment adviser and its principal as insureds and "Registered Representatives" under the policy. The insuring agreement provided specified coverage to the investment adviser only for professional services rendered "in connection with an Approved Activity." "Approved Activit[ies]" required prior approval by the broker/dealer.

The investment adviser allegedly recommended investments to a customer in two business entities controlled by the adviser without disclosing the adviser's interest in those companies. The investment adviser did not have approval from the broker/dealer to recommend investments in either of the two business entities. The customer

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Continuity Dates and Discovery Period Do Not Expand Coverage for Claim Made Before the Policy Period

The United States District Court for the Eastern District of Louisiana has held that neither continuity dates nor the discovery period of a claims-made policy altered the conclusion that a lawsuit was not covered because the claim was first made prior to the policy period. *XL Spec. Ins. Co. v. Bollinger Shipyards, Inc.*, 2014 WL 994665 (E.D. La. Mar. 13, 2014).

In a prior summary judgment ruling, the court had held that a lawsuit against the insured was not covered under a claims-made policy because the "claim" was first made three years earlier, when the insured entered into a tolling agreement with the claimant. The insured moved for reconsideration on the basis that the court failed to consider the "continuity dates" of the policy. The insured argued that the claim should be covered because it was made "between the Continuity Dates and the end of the D&O Policy." The court rejected this argument, noting that the policy, by its plain terms, limits coverage to claims first made during the policy period. The purpose of the continuity dates, reasoned the court, is to delimit the scope of the policy's prior and pending litigation exclusion, not to change the policy period or the policy's requirement that a claim must be first made during the policy period in order for the policy to afford coverage.

The court also determined that the policy's discovery period was irrelevant to the coverage case. First, the court noted that the period was never triggered because the insured renewed its policy year after year. Second, in any event, the discovery period operates to extend coverage after the applicable policy period, and has no application where a claim was made before the policy period. ■

Emails Demanding to Be "Made Whole" Constitute "Claims"

Applying California law, a California federal district court has held that emails to a wealth manager from his clients constituted "claims" within the meaning of a claims-made management liability policy because the emails insisted that the insured take curative action. *Presidio Wealth Mgt., LLC v. Columbia Cas. Co.*, 2014 WL 1341696 (N.D. Cal. Apr. 3, 2014). The court also held that, because the emails and a later-filed arbitration and lawsuit against the insured involved "interrelated wrongful acts," the later proceedings related back and were deemed to have been first made at the time of the emails, prior to the inception of the policy.

In 2007, a couple hired the insured wealth management firm and deposited $10 million into the firm's custodial account. The firm allegedly used the clients' funds to purchase illiquid securities. Between September 2009 and January 2010, the husband sent a series of emails requesting that the firm solve the illiquidity situation so as to "make whole" the clients. Around the same time, the husband orally advised the firm's executive chairman that "I'm not trying to sue you." In February 2010, the couple moved their investments to a separate entity, seemingly resolving the situation. Then, in October 2010 and November 2010, the clients filed an arbitration claim and a civil action against the firm. The firm's insurer denied coverage for both matters under a claims-made investment management policy that incepted on July 1, 2010, concluding that the prior emails constituted "claims" to which the civil suit and arbitration related back, meaning that the policy's insuring agreement was not implicated.

In the coverage litigation that followed, the court agreed with the insurer's position. First, the

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Duty to Defend Triggered by Insured's Alleged Knowledge That Third Party Would Rely on Services

Applying Illinois law, an intermediate state appellate court has held that, for purposes of evaluating the duty to defend under an E&O policy, the "for a third party" component of the definition of professional was satisfied by allegations that the insured knew that third parties would rely on the services that the insured performed for its subsidiary. *Hilco Trading, LLC v. Liberty Surplus Ins. Corp.*, 2014 WL 1028536 (Ill. App. Ct. Mar. 17, 2014).

An insured asset valuation company and its subsidiary, an asset lending company, were sued by two financial institutions. The asset lending company was in the business of borrowing funds from financial institutions and loaning the funds to its own borrowers. The insured's loans to borrowers were then secured by collateral, and the asset valuation company conducted appraisals of the collateral. The asset valuation company performed the appraisals for the asset lending company, but it allegedly had knowledge that the appraisals would be provided to and relied upon by the financial institutions lending to its subsidiary. In the lawsuits, the financial institutions alleged, among other things, negligence in connection with the performance of the collateral appraisals.

The insureds tendered the suits to their E&O insurer, which declined coverage on the grounds that the claims did not allege wrongful acts in the performance of professional services. The policy defined "professional services" to mean "valuation opinions in support of asset-based lending which are provided by the Insured to a third party for a monetary fee." According to the insurer, the appraisals at issue here did not constitute covered professional services because the appraisals were performed and provided by

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Insurer Not Liable for Ponzi Scheme Losses

The United States District Court for the Northern District of California, applying California law, has granted an insurer's motion for summary judgment, finding that state insurance law precludes coverage for a policyholder's own fraudulent conduct. *Dillon v. Continental Casualty Co.*, No. 5:10-cv-05238 (N.D. Cal. Mar. 26, 2014).

In 2008, a 1031 exchange company, which held funds to shelter clients transacting in real estate from capital gains tax liability, collapsed and was unable to repay clients due to fraudulent transfers made by the company's manager and CEO. The individuals subsequently pled guilty to wire fraud, money laundering, and conspiracy in connection with the transfers. Thereafter, a victim of the Ponzi-like real estate embezzlement scheme sought coverage, as a court-appointed receiver of the insured, under four employee dishonesty policies. In relevant part, the policies covered losses "resulting from employee dishonesty" and losses to "client property" but notably only benefitted the policyholder, not third parties, and provided "no rights to any other person or organization."

In resolving the cross motions for summary judgment, the court first addressed whether the conduct at issue was insurable under California Insurance Code Section 533, which states that an insurer is "not liable for a loss caused by the wilful acts of the insured." The court found "overwhelming evidence" that the policyholders' conduct was "willful, and thus not insurable within the meaning of Section 533." The court imputed the actions of the individuals to the company because they were plainly "acting within the course of their employment and moreover were using the corporation to perpetuate their fraudulent scheme."

Finding no exception to the state insurance law provision, the court rejected the receiver's alternate argument that Section 533 should not

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Former Employee Not an "Insured Member"

The United States District Court for the District of Columbia has held that a former employee was not an "Insured Member" under District of Columbia law. *Silver v. Am. Safety Indem. Co.*, 2014 WL 1233034 (D.D.C. Mar. 26, 2014).

The insurer issued a Federal Employee Professional Liability Policy (the Policy) to a federal employee for the policy period March 11, 2011 to March 11, 2012. The Policy afforded coverage for administrative and criminal claims against "Insured Members," a term that was defined as "any full or part time civilian federal employee." The coverage ceased when the "Insured Member" no longer met the definition of "Insured Member" (Condition B). In October 2011, the employee left his position at the federal government. In November 2011, the FBI requested to interview the employee regarding his conduct while employed at the federal government. On or about December 20, 2011, the employee gave notice to the insurer. The insurer denied coverage on the grounds that the employee's resignation from government employment in October 2011—before he became involved in any disciplinary proceedings or criminal proceedings—rendered him ineligible for coverage under the criminal section of the Policy.

The court agreed with the insurer's argument that, read together, Condition B and the definition of "Insured Member" unambiguously state that coverage under the administrative claims section of the Policy ends when an individual ceases to

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Insurer's Underwriting Guideline Does Not Violate Montana Public Policy

Applying Montana law, the United States District Court for the District of Montana has held that an insurer's underwriting guideline does not violate Montana public policy where the guideline prohibits the insurer from writing lawyers' professional liability coverage where the intended insured's law practice includes more than 10% of plaintiff's side insurance bad faith work. *Angel, P.C. v. Darwin Nat'l Assurance Co.*, 2014 WL 991905 (D. Mont. Mar. 13, 2014).

A law firm had professional liability insurance policies with the same insurer for several years. During the renewal process for the fifth consecutive year, the law firm indicated on its renewal application that 20% of its practice involved plaintiff's side insurance litigation. Based on this statement, the insurer issued a notice of non-renewal on the grounds that the law firm's practice is outside of the insurer's underwriting guidelines. In that regard, the insurer had an underwriting guideline that expressly prohibited it from issuing a lawyers' professional liability policy to any intended insured that spends 10% or more of its time on plaintiff's side insurance bad faith work.

The law firm filed suit for breach of contract, bad faith, and for a declaratory judgment that the insurer's underwriting guideline violates Montana public policy by improperly distinguishing between counsel who represent plaintiffs and counsel who represent insurers in bad faith cases. With respect to the declaratory judgment count, the law firm argued that certain Montana statutes govern an insurer's conduct with respect to cancellation and renewal of policies and unfair trade practices, and the insurer's guideline violates the public policy behind these statutes. The court disagreed, holding that, because professional liability insurance is not mandatory in Montana, the insurer is free to create any guidelines regulating the types of attorneys to whom it issues policies. In addition, the court found that nothing in the Montana statutes that the law firm cited would prohibit the insurer from applying the underwriting guideline. As such, the court ruled in favor of the insurer with respect to the law firm's declaratory judgment count. ■

Ninth Circuit Confirms That Former Employee's Suit for Unlawful Termination Is Not a Claim for "Wrongful Acts"

The United States Court of Appeals for the Ninth Circuit, applying California law, has affirmed a district court's ruling that claims for unlawful termination based on military service are not covered as "wrongful acts" under the insured entity's D&O liability insurance policy. *Forest Meadows Owners Ass'n v. State Farm Gen. Ins. Co.*, 2014 WL 1425299 (9th Cir. Apr. 15, 2014).

Alleging that she had been fired as a result of her time commitments to the Air Force Reserve in violation of state and federal law, a former employee sued the policyholder. After its insurer denied coverage on the grounds that the claim did not allege a "wrongful act" necessary to trigger the policy's insuring agreement, the policyholder filed a declaratory judgment action against the insurer. The California federal district court granted the insurer's motion for summary judgment.

On appeal, the Ninth Circuit affirmed the district court's holding. In so doing, the court held that, under established California law, "wrongful acts," defined as "any negligent acts, errors, omissions or breach of duty directly related to the operations of the [insured]," "reaches only negligent conduct." In this regard, the court found that "the firing of an employee is an intentional act [that] cannot qualify as negligence and does not fall within the policy." Because the policy was not implicated, the court rejected the insured's bad faith claim. ■

Exclusion for "Violation of Consumer Protection Laws" Bars Suit Alleging Violations of the TCPA

According to a New York federal district court, coverage for a suit alleging violations of the Telephone Consumer Protection Act, 47 U.S.C. § 227 (TCPA), is barred by a "violation of consumer protection laws" exclusion in a technology, media, and professional liability insurance policy. *Certain Underwriters at Lloyd's, London v. Convergys Corp.*, No. 1:12-cv-08968-CRK (S.D.N.Y. Mar. 25, 2014).

The insured was sued for violations of the TCPA by allegedly making "improper and unsolicited autodialed calls to plaintiff's cellular telephone." The insurer reserved rights and filed a declaratory judgment action seeking a declaration that the policy did not respond to the suit by operation of an exclusion "[f]or, arising out of or resulting from any actual or alleged . . . violation of consumer protection laws (except for consumer privacy protection laws under Insuring Clause I.C.)[.]" Insuring Clause I.C. provided coverage for "Damages and Claims Expenses . . . for . . . failure by the Insured to comply with that part of a Privacy Policy that specifically . . . provides a person with the ability to assent to or withhold assent for (*e.g.* opt-in or opt-out) the Insured Organization's collection or use his or her Personally Identifiable Non-Public Information. . . ."

The court first held that the suit fell within the scope of the exclusion because the TCPA is a consumer protection law. Second, the court rejected the insured's argument that the exclusion's exception applied because the TCPA is a "consumer privacy protection law." The court ruled that the exception must be read in conjunction with the coverage afforded under the referenced insuring clause and found that the suit did not trigger Insuring Clause I.C. because the suit did not actually allege injury flowing from the insured's violation of any privacy policy since it was based exclusively on alleged violations of the TCPA. As such the suit was not "for" the violation of any privacy policy, as required by the policy provisions. According to the court, the insured's position "ask[ed] too much of the word 'for.'" ■

Statutory Damages Under Louisiana PPO Act Do Not Constitute Fines or Penalties *continued from page 3*

The Louisiana appellate court concluded that the damages assessed under the Louisiana PPO Act were properly subject to coverage under the policies. The appellate court noted that, although the policies carved out coverage for penalties and fines, "[i]t is equally clear that the policy does not exclude statutory damages." According to the court, the amounts assessed pursuant to the Louisiana PPO Act are not properly considered penalties because the statute "denotes that a violator is subject to pay 'damages' and includes no language regarding penalties." As such, the appellate court rejected the insurers' argument that no coverage existed for the amounts awarded. The appellate court also rejected the insurers' contention that no claim was made during the requisite policy period, concluding that a demand letter sent to the insured from the state of Louisiana during the policy period constituted a claim as defined by the policies. ■

Joint Lawsuit by Four Siblings Constitutes a Single Claim Because It Alleged Interrelated Wrongful Acts *continued from page 1*

upon turning 18, received an annual distribution from the community, and the financial advisor recommended that each sibling purchase a $10 million whole life insurance policy. For the siblings with spouses and children, the financial advisor recommended that the siblings purchase whole life insurance policies for their spouses and children. The insured also recommended that the siblings invest in fixed annuities with surrender charges if the siblings withdrew funds before an annuity's maturity.

In 2007, the siblings commenced separate arbitrations alleging that the financial advisor had breached her duties to the siblings by making misrepresentations concerning the investments and selling unsuitable investments. Subsequently, the siblings dismissed the arbitration and, in 2009, filed a single lawsuit against the advisor in Minnesota state court. The insurer paid the policy's $1 million per claim limit, and the parties agreed to litigate whether the policy's $2 million aggregate limit of liability, rather than the per claim limit, applied. The United States District Court for the District of Minnesota held that the $2 million aggregate limit of liability applied because the siblings' lawsuit alleged multiple claims and because the claims did not allege "Interrelated Wrongful Acts."

The Eighth Circuit reversed, holding that the siblings' claims in the lawsuit alleged "Interrelated Wrongful Acts" and were subject to the policy's $1 million per claim limit of liability. The policy defined "Interrelated Wrongful Acts" as "any Wrongful Acts which are logically or causally connected by reason of any common fact, circumstance, situation, transaction or event," and provided that "more than one Claim involving . . . Interrelated Wrongful Acts shall be considered one Claim[.]" Although the court declined to hold that each plaintiff made only a single claim, the court held that the siblings' claims alleged Interrelated Wrongful Acts because the allegations were logically or causally related.

The court held that "[a]lthough [the financial advisor] made different alleged misstatements, omissions, and promises on different dates to each [sibling], there nonetheless exists a logical connection between her wrongful acts" and that the financial advisor harmed each sibling "individually and uniquely is not enough to overcome the Policy's broad language." The acts were committed by a single financial advisor with the alleged motive to generate commissions. The court also reasoned that each alleged wrongful act was logically related because each sibling was introduced to the financial advisor by the siblings' mother; each sibling was a young, unsophisticated investor with a significant income when the financial advisor began providing advice; and the financial advisor recommended that each sibling purchase whole life insurance policies and fixed investments. The court also held that the siblings alleged that the financial advisor breached her fiduciary duty to each sibling in the same manner. ■

Class Action Suit Against Insured Mortgage Broker Deemed First Made at Time of Prior Suit Alleging Common Course of Conduct *continued from page 4*

superior liens. The broker's insurer sought a declaration that the class action was not covered under the claims-made professional liability policy it issued for the May 2007 to 2008 policy period.

The Florida District Court of Appeals held that the class action and original investor action alleged the "same Wrongful Act" under the policy's "Multiple Claims" provision. The class action was thus deemed to be a claim first made in October 2007, during the policy period. The policy provided that all wrongful acts "related by common facts, circumstances, transactions, events and/or decisions . . . will be treated as one Wrongful Act." According to the court, the class action and the prior action were "based on the same course of conduct by the insured . . . [the insured's] allegedly negligent brokering and servicing of mortgages. The fact that individual class members may have been involved in separate mortgage transactions does not negate the fact that each claim is based on [the insured's] negligence in this regard." The court further noted that the class members were investors "in the same situation" as the plaintiff in the prior action, who was also a member of the putative class. "Acts can be 'related' under the policy's definition of 'Wrongful [A]ct' even if the resulting claims differ in magnitude, such as the amount of damages or number of claimants, so long as the basis of those claims are 'common facts, circumstances, transactions, events and/or decisions.'"

In reaching its decision, the appellate court rejected the trial court's decision to treat the original action as a notice of wrongful act under the policy's "Reported Wrongful Acts" provision. The trial court had held that because the original claim did not meet the strict notice requirements of this provision, the subsequent class action based on the noticed wrongful act was not covered under the policy. The appellate court held that this was not relevant in light of the "Multiple Claims" provision, "which deals with when and how . . . later-filed claims relate back to a previously-filed claim." ■

Broad Allegations in Complaint Against Investment Adviser Trigger Duty to Defend *continued from page 5*

eventually brought suit against the investment adviser for breach of his fiduciary duties "to provide competent and accurate financial advice and services related to his estate plan, including his investments in" the two business entities. The investment adviser sought coverage from the insurer, which denied coverage on the grounds that the complaint arose out of investments for which the investment advisor did not have approval from the broker/dealer.

In the ensuing coverage litigation, the court held that the insurer breached its duty to defend the investment adviser. The court focused on the broad language of the allegations of the complaint, which sought damages for breach of duty for services "related to [the claimant's] estate plan, including [the claimant's] investments in" the two entities. The court found that the word "including" indicated that the allegations were not limited to investments in these two entities and could be read to encompass approved activities. Because the allegations were so broad, the burden shifted to the insurer, and it was not sufficient for the insurer to rely on the "narrow reasoning" that it had no duty to defend because the two specified entities were not approved by the broker/dealer. ■

Guilty Pleas Bar Coverage and Entitle Insurer to Recoupment *continued from page 1*

knowledge, and warranty exclusions barred coverage for the investigations and criminal proceedings and that its policy entitled it to recoup all amounts it had paid.

The court agreed that all four exclusions barred coverage and that the insurer was entitled to recoup all defense costs. The court first rejected the insured's attempt to trigger coverage under two successive policies, noting that under the claims-made policies a claim can only be "first made" one time. The court next held that the statements of fact in the officers' guilty pleas and the judgments against those individuals triggered the fraud, profit, prior knowledge, and warranty exclusions. The court disagreed that a "100% preset allocation" provision in the policy applied. The company argued that the investigations included company employees who had not pleaded guilty, but the court held that there were no "Claims" against those fact witnesses, and the exclusions barred coverage for the entirety of the investigations and criminal proceedings. Finally, the court held that the policy's recoupment provision entitled the insurer to repayment of all defense costs advanced. The court disagreed that the insurer's "duty to defend" negated the plain language of the recoupment provision, noting that the duty to defend is contractual in nature. The court also held that once the exclusions were triggered, they barred coverage for the investigations from inception, and therefore the insurer was entitled to recoup all defense payments and not simply defense costs incurred after the guilty pleas were entered. ■

Insured v. Insured Exclusion Bars Coverage for Claim by FDIC as Receiver *continued from page 2*

any capacity meant that the insured v. insured exclusion should not apply to the FDIC, lest the regulatory exclusion be rendered meaningless. The court rejected this argument as well, finding that any overlap between the exclusions did not negate the reach of the insured v. insured exclusion to claims by the FDIC as a receiver where the broader regulatory exclusion would also exclude claims by the FDIC as a regulator.

The FDIC further asserted that, based on the purpose of the insured v. insured exclusion to prevent collusive lawsuits, and the fact that the FDIC's claims clearly are not collusive, the application of the exclusion defied "reasonable expectations." The court rejected this argument, noting that it is flawed because it would apply to any receiver in any context and therefore cannot be conclusive if the term "receiver" is to be given meaning within the exclusion, as it must under California law. The court observed in addition that claims by the FDIC against insureds who are also creditors of the failed bank may well be collusive because "the directors and officers benefit by having their uninsured investment and loans paid from the insurance proceeds." Finally, the court examined proffered extrinsic evidence concerning the alleged intent of the parties during the underwriting process for the policy, and concluded that the emails and deposition testimony did not render the exclusion reasonably susceptible to the FDIC's interpretation. Because the FDIC acted as a receiver within the meaning of the insured v. insured exclusion, its claim against the former bank officers was excluded from coverage. ■

Emails Demanding to Be "Made Whole" Constitute "Claims" *continued from page 6*

court held that the emails constituted "claims," a term that the policy defined to include a "written demand for monetary damages or non-monetary relief." The court reasoned that each email insisted that the firm take some course of action—namely, to cure the illiquidity problem. Thus, each email constituted a "demand" that the firm provide "non-monetary relief" to the clients in the form of liquidity. The court rejected the firm's argument that the emails were not "claims" because they did not put the firm on notice of the clients' intent to file a lawsuit, noting that the definition of "claim" did not require such notice. The court also rejected the argument that it was reasonable for the firm to infer that the clients were not actually demanding action based on the "nuance in tone" of the husband's communications. The court observed that the "reasonable expectations" doctrine cannot be used to avoid unambiguous provisions in a policy.

Next, the court held that the emails, the arbitration, and the civil lawsuit against the firm each involved "interrelated wrongful acts," a term defined to mean any wrongful acts "which are logically or causally connected by reason of any common fact, circumstance situation, transaction or event." The court rejected the insured's argument that the civil action and the arbitration could not relate back to the emails because the husband had, subsequent to the emails, made clear that "he was not seeking to pursue a legal claim." The court reasoned that the husband's communications with the firm after sending the emails could not possibly "break the interrelatedness of otherwise interrelated claims." ■

Duty to Defend Triggered by Insured's Alleged Knowledge That Third Party Would Rely on Services *continued from page 6*

the asset valuation company for its subsidiary, and not a third party.

In the coverage litigation that followed, the court rejected the insurer's position and pointed out that the suits alleged that the asset valuation company knew that third parties—namely, the financial institutions—would rely on its appraisals. According to the court, these allegations were sufficient to trigger the duty to defend under the policy. ■

Former Employee Not an "Insured Member" *continued from page 7*

be a federal employee. In doing so, the court rejected the employee's argument that Condition B should be interpreted to bar coverage only for prospective acts that occur after the former employee leaves government service, finding such an interpretation inconsistent with the coverage grant that extends coverage solely to acts undertaken in an Insured Member's capacity as a federal employee.

The employee also contended that the insurer's interpretation of Condition B would render coverage illusory because it would preclude coverage for covered claims made after the employee left government employment but before the expiration of the policy period. The court disagreed, finding ample examples of coverage afforded under the Policy. ■

paying full rent and that the attorney caused the client to purchase various assets owned by the attorney and his family under unfair terms.

In the coverage litigation that followed the insurer's denial of coverage, the court granted summary judgment in favor of the insurer, holding that the suit did not trigger the duty to defend. The court first determined that coverage was barred by the policy's "Business Enterprise Exclusion," which applied to "any claim . . . based on, arising out of, directly or indirectly resulting from, in consequence of, or in any way involving . . . the Insured's capacity or status as . . . an officer, director, partner, trustee, shareholder, manager or employee of a business enterprise." In this regard, the court pointed out that the complaint focused on the attorney's position as a trustee of the trust and member of the law firm when engaging in transactions between the client and those entities. The court also found that the trust's 50% membership stake in the client necessarily involved the attorney's capacity as a "shareholder." Moreover, the court determined that, while the claimants' suit was based in part on the attorney's conduct as a lawyer, the "arising out of" and "in any way involving" language in the policy's exclusion was broad enough to bar coverage for the attorney's conduct in a "dual capacity."

Next, the court found that the "Trust Exclusion" applied as well. This provision barred coverage for "any claim . . . based on, arising out of, directly or indirectly resulting from, in consequence of, or in any other way involving … any act whatsoever of an Insured in connection with a trust or estate when an Insured is a beneficiary . . . of the trust." The court reasoned that the attorney's conduct was at least in part intended to benefit his family's trust, and it pointed out that the attorney's continued involvement in the management of the client was necessarily in connection with his family's trust since that trust owned a 50% stake in the client. The court also rejected the insureds' argument that the exclusion was too broad to be given effect, concluding instead that "parties are free to contract for broad exclusions resulting in narrow coverage."

The court also rejected the insureds' argument that the exclusion was too broad to be given effect, concluding instead that "parties are free to contract for broad exclusions resulting in narrow coverage."

Finally, the court found that the allegations by the claimants triggered the policy's "Investment Advice Exclusion." This provision precluded coverage for "any claim . . . based on, arising out of, directly or indirectly resulting from, in consequence of, or in any other way involving . . . the alleged rendering of investment advice. . . ." The court found that a number of the allegations in the underlying complaint involved the attorney's alleged advice for the client to make particular investments. According to the court, the claims based on such purported conduct were "excluded . . . by the unambiguous language of the [p]olicy." ■

Fraud Exclusion in D&O Policy Triggered by Employee's Misconduct; But Fidelity Bond Responds to the Resulting Judgment Against Insured Bank *continued from page 3*

directors. Here, according to court, because the employee was acting within the scope of his employment with respect to the fraudulent scheme, his fraudulent misrepresentations were attributable to the bank.

The bank's fidelity bond provided certain specified coverage for loss resulting from the misconduct of an employee in connection with property of a third party held by the bank. In this regard, the court concluded that the bank held the property of the individuals who invested in the fraudulent scheme because the employee represented that the bank would be handling the funds. The court also rejected the insurer's argument that the bank should have provided notice under the bond when the bank president first learned of the scheme and the possibility of employee's involvement. According to the court, because the notice provision in the bond did not identify a specific recipient for notice, it was sufficient that the bank provided timely notice to the insurer in connection with reporting the circumstances under the D&O policy. The court also found, in any event, that the insurer waived the notice requirement when the insurer initially agreed to defend the suit under the D&O policy pursuant to a reservation of rights because the insurer caused the bank to believe that the matter was covered under that policy and therefore it was futile to pursue coverage under the bond. ■

Independent Counsel's Settlement Report Inadmissible in Subsequent Litigation Under Different Policy *continued from page 4*

The court concluded that there was no enforceable firewall agreement, but nonetheless held that the insurer could not use the confidential memorandum prepared for the E&O file in the subsequent FIB dispute. The court determined that the insured's disclosure of the memorandum was not a waiver of the attorney-client privilege because California law expressly required the policyholder to cooperate with its insurer by providing all information relevant to the defense of the action. Because an evaluation of whether to settle was directly relevant to the defense of the action and was unrelated to the coverage issues, the court concluded that its disclosure in connection with the E&O claim was compelled by law and did not waive the policyholder's rights. The court also rejected the insurer's argument that, because the California statute provides that the disclosure of defense information to the insurer "is not a waiver of the privilege as to any other party," and because the insurer was the same corporate entity under both policies, it could rely on confidential information gleaned under one policy to deny coverage under the other policy. The court held that, for all practical purposes, the FIB department should be treated as a different entity from the E&O department so as not to disadvantage policyholders with multiple policies issued by the same insurer. ■

Insurer Not Liable for Ponzi Scheme Losses *continued from page 7*

apply because the insurance proceeds would be paid to the client's victims rather than to the wrongdoing policyholder. Instead, it found that the statute applied "even where the recovery from the insurance company would be primarily for the benefit of the victim rather than the insured." Section 533 would not permit "corrupt corporate officers to take out criminal liability insurance, willfully violate the law, and then, in the event that the wrongdoing is discovered, cover any losses to the victims with the insurance proceeds." The court reasoned that to find otherwise could create an incentive for the wrongdoer and its victims to collude in pursuit of recovery from an insurer. ■

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