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EXECUTIVE SUMMARY

Developments Affecting Professional Liability Insurers | April 2012

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Excess Policy Triggered Even Though Underlying Insurers Paid Less Than Their Policy Limits

Applying Virginia law, a federal district court has dismissed an excess insurer's complaint for a declaratory judgment that, by settling with underlying carriers for less than their policy limits, the policyholder had not complied with the excess policy's requirement to exhaust underlying insurance. *Maximus, Inc. v. Axis Reinsurance Co.*, No. 11-cv-1231 (E.D. Va. Mar. 12, 2012). The court distinguished cases reaching the opposite conclusion principally on the basis that the policies at issue in such cases specified that payment of the underlying limits had to be by the underlying insurers.

The excess policy in question provided that it "shall apply only after all applicable Underlying Insurance with respect to an Insurance Product has been exhausted by actual payment under such Underlying Insurance, and shall only pay excess of any retention or

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Violation of Consent to Settle Clause Precludes Coverage for Consent Judgment

Applying Louisiana law, the United States Court of Appeals for the Fifth Circuit has held that a consent judgment entered into between an insured and a claimant is not enforceable by the claimant against an insurer because the parties violated the policy's "no action" clause by failing to comply with the "consent to settle" clause. *New England Ins. Co. v. Barnett*, 2012 WL 715261 (5th Cir. Mar. 6, 2012). In addition, the court held that a bad faith action cannot lie in the absence of an excess judgment.

A claimant brought an action against his former business partner, whose insurer agreed to provide a defense of the claim subject to a reservation of rights. The claimant later amended the suit to add claims for legal malpractice and additional defendants, including the insurer. The parties, including the insurer, initially engaged in settlement negotiations, which proved unsuccessful. The claimant and the insured business partner later settled the matter without the insurer's involvement and agreed to the entry of a consent judgment, whereby the insured assigned his rights against the insurer to the claimant upon the claimant's agreement not to

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I-v-I Exclusion Held Not to Preclude Coverage for Claims Brought by Chapter 7 Trustee

The United States Bankruptcy Court for the Western District of Louisiana has held that an insured versus insured exclusion does not apply to preclude coverage for claims brought by a duly appointed bankruptcy trustee against an insolvent corporation's directors and officers. *Central La. Grain Coop. v. Vanderlick*, 2012 WL 293173 (Bankr. W.D. La. Jan. 31, 2012).

The insurer issued a directors and officers liability policy to the insured, a Louisiana agricultural cooperative association. The insured filed for relief under Chapter 7 of the Bankruptcy Code, and a trustee of the bankruptcy estate was appointed. The bankruptcy trustee commenced a proceeding against several of the insured's former directors and officers, alleging breaches of various fiduciary duties. The trustee also named the insurer as a defendant in the action under Louisiana's direct action statute. The insurer moved for summary judgment, contending that coverage for the action was precluded by the policy's insured versus insured exclusion.

The policy excluded coverage for any claim made against the insureds "by, on behalf of, or in the right of the Insured Entity in any capacity." The policy defined "Insured Entity" to include the insured corporation and its subsidiaries.

The court held that the insured versus insured exclusion did not operate to bar coverage. According to the court, the trustee acts on behalf of the bankruptcy estate and not on behalf of the insured entity in discharging his duties under the bankruptcy code. As such, the court concluded that the claims brought by the trustee do not fall within the confines of the exclusion because the trustee "is a distinct legal entity with different duties and functions, and the language of the exclusion does not sweep the trustee into the definition of 'Insured Entity.'" In so holding, the court noted that claims brought by a duly appointed bankruptcy trustee do not present the potential for collusion that it viewed as underlying

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Judgment Creditor Asserting Statutory Bad Faith Claim Entitled to Discover Other Bad Faith Allegations Against Insurers

A federal district court, applying Connecticut law, has held that a judgment creditor with a judgment against her insured former employer was entitled to seek discovery from the employer's insurers regarding any allegations that the insurers had committed bad faith claims handling practices because such evidence would support the judgment creditor's cause of action asserting that the insurers had a "general business practice" of unfair claims settlement in violation of the Connecticut Unfair Insurance Practices Act (CUIPA). *Tucker v. Am. Int'l Group, Inc.*, 2012 WL 685461 (D. Conn. Mar. 2, 2012).

After the judgment creditor obtained a $4 million judgment against her former employer, the insured, she sued the employer's insurers seeking to recover the judgment. The judgment creditor also alleged that the insurers had a "general business practice" of unfair claims settlement that violated the CUIPA. The judgment creditor then sought to depose several witnesses for the insurers on the subject of "[a]ny allegations of bad faith or reckless claims handling practices against [the insurer] and/or its subsidiaries prompting any internal review of claims handling practices at any time from 2004 to the present." After a discovery dispute, the court granted discovery on the topic.

In a motion for reconsideration of the court's discovery order, the insurers argued that allegations of bad faith claims handling were insufficient to prove that the insurers had a general business practice that violated the CUIPA. To support their position, the insurers asserted that courts had struck allegations in a complaint that referred to bad faith allegations in other lawsuits where those lawsuits were not resolved on the merits. The court rejected the

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Misappropriation and Personal Profit Exclusions Do Not Preclude Duty to Defend Negligent Supervision Claim

A federal district court in New York has held that an insurer has a duty to defend negligent supervision claims against an insured employer even though the alleged damages arise out of the intentional and fraudulent conduct of the insured's employee. *Am. Automobile Ins. Co. v. Sec. Income Planners & Co., LLC*, 2012 WL 957528 (E.D.N.Y. Mar. 22, 2012).

An employee of the insured, an investment consulting firm, was sued by two clients, alleging that the employee had engaged in a systematic scheme by which he defrauded the clients out of their investment funds. The employee also was prosecuted and ultimately pleaded guilty to criminal charges relating to the fraud. Meanwhile, the clients filed an amended complaint, naming the firm as a defendant and asserting claims against the firm for negligent supervision. The insurer denied coverage for these claims on the grounds that the clients sought to recover from the firm the amounts misappropriated by the employee and from which the employee illegally profited. In taking this position, the insurer relied on two policy exclusions that precluded coverage for claims "based upon, arising out of . . . [a]ny commingling, misappropriation or conversion of funds" and for claims "based upon, arising out of any Insured gaining in fact any personal profit or advantage to which such Insured was not legally entitled."

In the coverage litigation that followed, the court rejected the insurer's position and concluded that the exclusions did not apply to the negligent supervision claims against the firm because neither improper personal profit nor misappropriation was an element of those claims. The court also pointed out that although the employee's conduct was intentional and fraudulent, the claims against the firm did not allege that the firm gained any improper personal profit through its failure to supervise or that the firm improperly commingled, misappropriated or converted funds. ■

Coverage Triggered by Claim for Failure to Pay Wages Under Fair Labor Standards Act

Applying Virginia law, the United States Court of Appeals for the Fourth Circuit has held that a school board's alleged failure to pay wages as required by the Fair Labor Standards Act (FLSA) constitutes a "wrongful act" and that the liquidated damages and attorneys' fees recoverable under the FLSA constitute loss within the meaning of the school board's liability policy. *Republic Franklin Ins. Co. v. Albemarle County School Bd.*, 670 F.3d 563 (4th Cir. Feb. 24, 2012).

Employees of the school board brought suit alleging that they were not paid for all of the time that they worked and that they were not paid at the premium overtime rate when they worked more than 40 hours in a week. The employees demanded from the school board, among other things, unpaid wages and overtime pay, liquidated damages as authorized by the FLSA and attorneys' fees. The school board tendered the suit to its liability insurer, which took the position that it had no obligation to defend the school board or to provide indemnification on the grounds that the failure to pay wages in accordance with the FLSA was not a "wrongful act" covered by the policy because the board had a preexisting duty to pay its employees in compliance with the law.

In the coverage litigation that followed, the court rejected the notion that the failure to abide by a pre-existing obligation or duty cannot be a wrongful act. According to the court, "[e]very duty breached or violated is necessarily a preexisting duty, and it is the breach or violation of that duty which constitutes a wrongful act." In this regard, the court noted that the policy defined the term to include "any breach of duty" and held therefore that the school board's purported breach of the duty imposed by the FLSA to pay certain wages constituted a "wrongful act" within the meaning of the policy.

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Claims Made After Policy Period Involving Different Wrongful Acts Not Related; No Duty to Defend Based on Untimely Notice, Failure to Request Defense and Lack of Damages

Applying California law, the California Court of Appeal has held, in an unpublished opinion, that an insured cannot rely on "related claims" language in a professional liability policy to obtain coverage for claims made after the expiration of the policy and further that, regardless, the claims involved different and unrelated wrongful acts. *NovaPro Risk Solutions, L.P. v. TIG Ins. Co.*, 2012 WL 913243 (Cal. Ct. App. Mar. 16, 2012). The court also held that the insurer had no duty to defend because the insured did not provide timely notice of the claims against it, did not request a defense and did not suffer damages because the insured was completely defended by an insurer for a subsequent policy period.

A third-party administrator that handled claims for property and casualty insurance companies (P&Cs) was insured under consecutive claims-made professional liability policies issued by different insurers. In 2001, the administrator provided notice to its insurer (the first insurer) of a potential claim against it by one P&C arising out of a default judgment against the P&C's insured due to a filing error by an administrator file clerk (the 2001 claim). The potential claim ripened into an actual claim in 2002, and the first insurer entered into a settlement agreement with the P&C that released the administrator from liability for future related claims. Thereafter, in 2005, the same P&C, along with other plaintiffs, filed suit against the administrator alleging that it had mishandled numerous claims under a particular insurance services program (the 2005 claims). The administrator's insurer for that policy period (the second insurer) provided the administrator with a defense, but filed a declaratory judgment action against the administrator. The administrator filed a cross-complaint against the first insurer, asserting that the 2005 claims related back to the 2001 claim.

Relying on the case *Homestead Insurance. Co. v. American Empire Surplus Lines Ins. Co.*, 44 Cal. App. 4th 1297 (1996), the court held that the administrator could not rely on the first policy's "related claims" language, which provided that "[a]ll Claims made by the same person and arising out of the same error, omission or negligent act or series of errors, omissions or negligent acts will be deemed to have been made at the time

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Letter From Insured's Receiver Noting Intent to Assert Claims Constituted Notice of Circumstances

The United States District Court for the Northern District of Florida, applying Florida law, has granted summary judgment in favor of a receiver of an insured, holding that a letter sent to the insurer during the policy period of a claims-made-and-reported directors and officers liability policy that advised of the receiver's intention to assert claims for breach of fiduciary duty against the insured constituted proper notice of circumstances under the policy, such that a later-filed complaint was deemed a claim first made under the policy. *Fla. Dep't of Fin. Svcs. v. Nat'l Union Fire Ins. Co.*, 2012 WL 760606 (N.D. Fla. Mar. 7, 2012).

The plaintiff petitioned a Florida Circuit Court to be the receiver of the insured. Shortly thereafter, it provided the insured's D&O carrier with a "general liability notice of occurrence/claim" form notifying the carrier that receivership proceedings had been initiated against the insured. Several weeks later, the receiver sent a letter to the carrier, in which the receiver stated its "intention to assert claims against former officers, directors and shareholders [of the insured] for wrongful acts" and that "[t]his letter shall also serve as a notice of circumstances which may reasonably be expected to give rise to a claim being made against any and all [insureds]." The letter was sent to the carrier during the policy period of the policy at issue. The receiver later filed a complaint alleging breach of fiduciary duty after the policy period ended. The carrier denied coverage, contending that the complaint was

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Coverage Properly Denied Where Insured Sends Notice of Claim to Wrong Address

The United States Court of Appeals for the Third Circuit, applying New Jersey law, has held that an insurer properly denied coverage for an underlying lawsuit brought against the insured where notice of the lawsuit was included in the insured's renewal applications but was not sent to the address designated in the policy's claim and reporting provisions. *Atlantic Health Sys., Inc. v. Nat'l Union Fire Ins. Co.*, 2012 WL 640033 (3d Cir. Feb. 29, 2012).

The insured sought coverage under a claims-made policy for a lawsuit brought against it for alleged antitrust violations. The insurer denied coverage for the lawsuit, claiming that notice of the lawsuit was not provided to the insurer during the policy period or within the policy's 30-day notice period. The insured then brought a coverage action against the insurer, alleging that it had provided the insurer with proper notice of the claim by submitting two renewal applications during the policy period that revealed the insured's involvement in the underlying antitrust lawsuit.

Concluding that the insurer properly denied coverage for the lawsuit, the court first noted that the policy's notice and claim reporting provisions required written notice of a claim to a specified address within a specified time period. Because the insured's renewal applications were sent to a different address than the one specifically designated in the reporting provisions, the court held that the insured failed strictly to comply with the policy's claim and reporting requirements and thus was not entitled to coverage. The court rejected the insured's argument that the policy afforded coverage because the insurer actually received the renewal applications within the time specified by the policy. The court reasoned that the insured must give notice of a purportedly covered claim at the address specified by the insurer to facilitate the claims-handling process, and that it was unreasonable for an insured to insist that its insurer's underwriting department sift through a renewal application and decide what should be forwarded to the claims department on the insured's behalf. ■

Insurers Entitled to Production of Otherwise Privileged Documents From Underlying Case Where Insurers Provided Defense

The United States Court of Appeals for the First Circuit has held that under the Massachusetts common-interest doctrine, an insured cannot assert, in the course of coverage litigation, attorney-client privilege and work product doctrine over documents and communications prepared by defense counsel in the underlying litigation, where defense counsel was paid by and also represented the interest of, the insured's primary and excess level insurers. *Vicor Corp. v. Vigilant Ins. Co.*, 2012 WL 883198 (1st Cir. March 16, 2012).

In the underlying action, a purchaser of power converters sued the insured manufacturer in connection with cell phone network outages allegedly caused by the converters' failure. Subject to a reservation of rights, the primary and excess general liability insurers provided a defense for the insured in the underlying action, and the insured ultimately settled with the purchaser. The insured sued its primary and excess general liability insurers for coverage, and after a jury verdict and partial judgment as a matter of law in the insured's favor, the insurers appealed. One of the issues on appeal was the district court's denial of the insurers' motion to compel documents related to the underlying litigation, which were withheld by the insured on the basis of attorney-client privilege and work product doctrine.

The court held that, under the Massachusetts common-interest doctrine, the insured's defense counsel, paid for by the primary insurer, represented both the insured and the insurers, and the communications between the lawyer and any one or more of the clients was privileged as to outsiders, but not as between the insurer and its insured. The court held that

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Improper Use of Funds Exclusion Did Not Render Coverage for Escrow Agent Illusory

Applying Illinois law, a federal district court has held that a professional liability policy issued to an escrow agent did not afford coverage for claims alleging that the agent mishandled escrow funds by failing to disburse the funds to pay claimants' property taxes and insurance premiums or to return the funds to claimants. *Hawks v. Am. Escrow, LLC*, 2012 WL 966059 (N.D. Ill. Mar. 16, 2012). The court concluded that the allegations fell squarely within the policy's exclusion barring coverage for claims "alleging, based upon, arising out of, or attributable to the commingling or improper use of, or failure to properly segregate or safeguard funds." In reaching this conclusion, the court rejected the insured's argument that because its business is escrow services, reading the exclusion to apply to such services renders the coverage purchased illusory. The court pointed out that the policy named as insureds additional affiliated entities that provided other services. The court also noted that the definition of covered professional services in the policy went beyond simply the collection and disbursement of funds. ■

Excess Policy Triggered by Exhaustion of Primary Policy Even Though Insured Paid Deductible to Primary Insurer

The United States District Court for the Southern District of California has found that an excess errors and omissions insurer was required to defend an underlying claim because the primary policy was exhausted by the primary insurer's payment of its full limit of liability, even though the policyholder paid the deductible amount to the primary insurer and not for settlement or defense expenses. *Liberty Mut. Ins. Co. v. Indian Harbor Ins. Co.*, 2012 WL 642890 (S.D. Cal. Feb. 28, 2012). The court found further that, because the excess policy was specifically excess of the relevant primary policy, the excess insurer was required to defend without requiring exhaustion of a potentially applicable run-off policy.

The underlying claimant sued the insured, a third-party claims administrator, alleging negligence in claims handling during a period covered by both primary and excess E&O policies and previously issued run-off policies. The issuer of the primary policy had contributed its full $5 million limit of liability toward settlement of the personal injury claim from which the allegedly negligent claims handling arose. The insured had not, however, paid the $75,000 deductible under the primary policy until after the personal injury settlement. At that time, the insured paid the amount of the deductible to the primary insurer. Accordingly, the excess insurer contended that it was not obligated to defend the negligence action because the primary policy was not exhausted. Moreover, the excess insurer argued that its policy was not triggered until both the primary policy and the primary run-off policy were exhausted because both potentially afforded coverage for the pending claim.

The court disagreed with the excess insurer. The primary policy provided that the primary insurer was "not obligated to pay any damages or claims after the applicable limit of liability has been exhausted by the payment of damages or claim expenses." The court determined that "whether [the insured] paid its $75,000 deductible is not indicative of whether the [primary] policy was properly exhausted." Because the primary insurer paid its full limit in settlement of the earlier claim, the court found that it was exhausted.

With respect to exhaustion of the run-off policy, the court determined that "horizontal exhaustion" of both the primary policy and the primary run-off policy was not required. "Vertical exhaustion" applies, the court found "if, and only if, the excess policy provides that it is excess to a *specified* primary policy. This is true even when the primary policies apply to different policy periods." The excess policy provided that it was specifically excess of the primary policy, which the court had found to be exhausted. Accordingly, vertical exhaustion applied, and the excess policy was triggered. ■

Court Holds that Property Damage Exclusion Does Not Bar Claim for Title-Search Malpractice

Applying Connecticut law, the Appellate Court of Connecticut held that a professional liability policy's exclusion for claims for destruction of "tangible property" did not bar a plaintiff's claim that her attorney's alleged negligence resulted in her acquiring title to property subject to encumbrances that required it to be demolished by the city. *Shaw v. Freeman*, 2012 WL 653821 (Conn. App. Ct. Mar. 6, 2012).

The plaintiff retained the insured attorney to represent her in the purchase of a parcel of real property. The attorney obtained a title insurance policy identifying certain encumbrances placed on the property by the city in which it was located, which required that the building on the property be destroyed, but did not advise the plaintiff of the encumbrances. After the plaintiff purchased the property, the city demolished the building and billed the plaintiff, as owner, for the costs of the demolition. The plaintiff sued the attorney for negligence, recklessness and emotional distress, seeking as damages the costs of the demolition, the resulting diminution in the property's value, and compensation for emotional distress.

The insurer denied coverage based on policy exclusions for claims arising from (i) the destruction of tangible personal property, and (ii) bodily injury, including emotional injury, except for emotional injury resulting from "personal injury." The policy defined "personal injury" as injury resulting from certain specified wrongful acts, which did not include negligence or recklessness.

The court agreed with the plaintiff that her negligence claim was not barred by the exclusion for destruction of tangible personal property because, while she sought damages related to the destruction of property, her claim "emanate[d], not from destruction of property by the defendant, but rather from the defendant's failure to adequately review the title policy and search the land records in preparation for the transfer of the property." The court also held that the emotional distress claims were excluded by the bodily injury exclusion because the plaintiff did not allege a wrongful act that fell within the policy's definition of personal injury. ■

No Coverage for Claim Not Reported Within 30 Days After Notice to the Insured

The United States Court of Appeals for the Ninth Circuit has held that an insured failed to provide timely notice to an insurer by reporting a claim to the insurer two months after the policy's 30-day reporting period expired. *Re/Max Mega Group v. Maxum Indemnity Co.*, 2012 WL 767417 (9th Cir. Mar. 12, 2012). The court further held that the insurer did not waive the policy's reporting requirement and was not estopped from denying coverage based on late notice even though it did not rely on that point in its initial denial.

The court held that a third party made a claim, which the court explained was defined in the policy as "a written demand for money or services," when the third party sent letters to the insured alleging negligence and fraud, threatening to file a lawsuit, requesting mediation, and enclosing a copy of a civil complaint for damages. The court further held that the policy provision requiring the insured to provide notice of claims "as soon as practicable, but in no event later than thirty days after notice to the insured" was unambiguous and that the insured failed to provide timely notice by reporting the claim three months after the insured received the third party's letters. In addition, the court held that the insurer did not waive the reporting requirement by failing to mention untimely notice in its initial coverage disclaimer because the insurer was unaware of the letters at the time the coverage disclaimer was provided and the insurer expressly stated in the coverage disclaimer that it was not waiving any rights under the policy. The court also held that the insurer was not estopped from denying coverage for the claim because the insured was not induced belatedly to report the claim and did not detrimentally rely on the insurer's initial grounds for denying coverage for the claim. ■

Violation of Consent to Settle Clause Precludes Coverage for Consent Judgment *continued from page 1*

execute the full amount of the judgment against the insured. The insurer subsequently filed suit seeking a declaratory judgment that it was not liable to the claimant for the consent judgment, and the claimant filed a counterclaim against the insurer under Louisiana's direct action statute alleging bad faith and seeking damages in excess of the consent judgment.

The court held first that the consent judgment was not enforceable against the insurer pursuant to the policy's "no action" clause, which stated that "no action shall lie against the Company unless . . . the Insured shall have fully complied with all the terms of this policy." The policy contained a "consent to settle" clause, which prohibited the insured from entering into a settlement without the insurer's consent, except at the insured's own cost. Here, because the insurer had not consented to the settlement between the insured and the claimant, the court held that the "no action" clause precluded enforcement of the consent judgment. In so holding, the court rejected the claimant's argument that the "consent to settle" clause violates Louisiana public policy, finding instead that Louisiana courts enforce such provisions unless an insurer wrongfully denies coverage or refuses to participate in settlement negotiations. Here, the insurer agreed to provide a defense of the claim and had made a settlement offer, which the court deemed not unreasonable. Accordingly, the court concluded that the provision was consistent with public policy, and thus the insured's violation of the provision barred enforcement of the consent judgment pursuant to the policy's "no action" clause.

Finally, the court addressed the claimant's bad faith claim. Under Louisiana law, an insurer cannot be liable for bad faith failure to settle in the absence of an adjudicated excess judgment. Here, no such judgment existed. The claimant argued that an excess judgment was still possible because the insured's liability was not tried. The court rejected this argument, finding that the settlement between the claimant and the insured meant that the claims against the insured would never be tried. Thus, because there was no possibility of an excess judgment, the insurer could not be held liable for bad faith. ■

Claims Made After Policy Period Involving Different Wrongful Acts Not Related, and No Duty to Defend Based on Untimely Notice, Failure to Request Defense, and Lack of Damages *continued from page 4*

the first of those Claims is made against any Insured," to bring the 2005 claims within the first policy period. The court further held that, even if the related claims language could be construed to create coverage, the 2001 and 2005 claims arose out of different and unrelated wrongful acts. The court explained that the gravamen of the 2005 claims was the administrator's alleged understaffing and inadequate training—which purportedly resulted in the negligent practices of numerous claims adjusters in hundreds of claims—whereas the 2001 claim arose out of a single default judgment due to a clerical filing error. According to the court, the only factual nexus between the 2001 and 2005 claims was that the same P&C was the claimant in the former and one of the plaintiffs in the latter.

The court also held that the first insurer did not have a duty to defend the 2005 claims because the administrator did not provide the first insurer with notice of the 2005 claims until 2008, did not request a defense and did not suffer damages because the second insurer provided it with a complete defense. With respect to the issue of notice, the court held that the first insurer did not waive the right to assert untimely notice as a defense to coverage by merely failing to cite that defense when it denied the claim. ■

Insurers Entitled to Production of Otherwise Privileged Documents From Underlying Case Where Insurers Provided Defense *continued from page 5*

the insured could not use the common interest exception to the attorney-client privilege to protect disclosure of communications to third parties and then turn around and assert the privilege against its insurers. The court also held that, in order for documents to be subject to protection under the work product doctrine, the insured must demonstrate that its defense counsel prepared the documents in anticipation of a lawsuit with the insurer. The court held that the district court therefore abused its discretion in denying the insurers' motion to compel, and remanded the matter to the district court for further consideration. ■

Judgment Creditor Asserting Statutory Bad Faith Claim Entitled to Discover Other Bad Faith Allegations Against Insurers *continued from page 2*

argument, reasoning that evidence of allegations of bad faith conduct against the insurers in handling other claims was reasonably calculated to lead to evidence of the insurers' actual business practices for purposes of proving a CUIPA violation. The court therefore affirmed the order granting the judgment creditor the requested discovery. ■

Excess Policy Triggered Even Though Underlying Insurers Paid Less Than Their Policy Limits *continued from page 1*

deductible amounts provided in the Primary Policy and other exhausted Underlying Insurance." The policyholder settled certain claims and sought coverage from its insurance carriers, and settled with the primary carrier and first two excess carriers. The third excess carrier disclaimed coverage. In subsequent coverage litigation, the third excess carrier filed a counterclaim for declaratory relief on the exhaustion issue, but the court granted the policyholder's motion to dismiss.

The court found that the applicable policy term "actual payment" was ambiguous under Virginia law, citing for that proposition *Zeig v. Massachussets Bonding & Insurance Co.,* 23 F.2d 665 (2d Cir. 1928). The court distinguished contrary authorities cited by the carrier on the basis that several such cases—including *Comerica Inc. v. Zurich Am. Ins. Co.*, 498 F. Supp. 2d 1019, 1032 (E.D. Mich. 2007), *Great American Ins. Co. v. Bally Total Fitness Holding Corp.*, No. 06C4554, 2010 U.S. Dist. Lexis 61553 (N.D. Ill. June 22, 2010), *Citigroup Inc. v. Fed. Ins. Co.*, 649 F.3d 367 (5th Cir. 2011), and *Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London*, 73 Cal. Rptr. 3d 770, 778 (Cal. Ct. App. 2008)—interpreted exhaustion provisions that specified that the underlying insurers had to pay the full underlying limits. The court stated that it did not need to follow the sole case relied upon by the carrier that applied materially identical policy language because that case—*JP Morgan Chase & Co. v. Indian Harbor Ins. Co.*, 930 N.Y.S.2d 175 (N.Y. Sup. Ct. May 26, 2011)—applied Illinois rather than Virginia law.

The court cited a case applying Virginia law—*The Mills, Ltd. v. Liberty Mutual Ins. Co.*, 2010 Del. Super. Lexis 563 (Del. Super. Ct. Nov. 5, 2010)—which had held for a policyholder on the exhaustion question in similar circumstances. The court elected to follow that precedent, holding that the exhaustion provision was ambiguous. And, accordingly, the court granted the insured's motion to dismiss the carrier's counterclaim. ■

Letter From Insured's Receiver Noting Intent to Assert Claims Constituted Notice of Circumstances *continued from page 4*

filed after the policy period expired. The receiver filed a declaratory judgment action, seeking a declaration that the receivership petition, the claim form and the letter to the carrier constituted "claims" under the policy or a notice of circumstances such that the complaint fell within the policy's coverage.

The court first rejected the receiver's contention that the petition for receivership constituted a claim. The court noted that, while "claim" is defined to include a demand for non-monetary relief, "the petition for receivership does not allege that wrongful acts occurred" as required by the terms of the policy. The court further held that the claim form sent to the carrier "does not raise a claim for a wrongful act."

Addressing the letter sent by the receiver to the carrier, the court determined that the "letter is not a claim as defined by the policy . . . . [as i]t makes no present demand for any action from [the carrier], such as tendering the policy limit." The court, however, stated that the letter satisfied the policy's notice of circumstances provision. The court noted that "the letter specifically states that it is giving 'notice of circumstances' pursuant to Paragraph 7 of the policy. It expresses [the receiver's] intention to assert claims resulting in injuries in excess of $5 million. The letter identifies a list of wrongful acts committed by officers and/or directors for which it may seek relief." The court also rejected the carrier's argument that the letter was "boilerplate" and did not identify the required "full particulars" of the potential claim, stating that "[b]y its very nature, a notice of circumstances will be less specific than an actual claim." Accordingly, the court granted the receiver's summary judgment motion. ■

I-v-I Exclusion Held Not to Preclude Coverage for Claims Brought by Chapter 7 Trustee

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the insured versus insured exclusion. Finally, the court rejected the insurer's contention that the exclusion applied because the trustee's claims were brought "in the right of" the insured entity. The court determined that the insured entity had no rights or ownership interests in the trustee's claims because they were brought solely on behalf of the bankruptcy estate. ■

Coverage Triggered by Claim for Failure to Pay Wages Under Fair Labor Standards Act

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Turning to the issue of "loss," the court recognized that coverage was limited to loss resulting from a wrongful act. In this regard, while the breach of a preexisting duty to pay is a wrongful act, the obligation to pay back wages is not necessarily a loss resulting from that wrongful act. Such loss, according to the court, could only arise if the failure to fullfill the preexisting duty to pay wages caused damages apart from the back wages not paid. The court found that liquidated damages and attorneys' fees recoverable under the act were not payable because of any preexisting duty, and thus met the policy's requirement that they result from a wrongful act. The court also found that liquidated damages and attorneys' fees were not fines or penalties, but rather represented compensatory damages within the scope of covered loss under the policy. ■

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