

2009 ANNUAL REVIEW OF CALIFORNIA INSURANCE LAW



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2009 ANNUAL REVIEW OF CALIFORNIA INSURANCE LAW

To Our Clients:

Last year was filled with a number of interesting developments in property and liability insurance law. Below are summaries of the major cases and statutory changes from December 2008 through November 2009 that will impact your California claims next year.

Best wishes for the coming year.

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PENDING BEFORE THE CALIFORNIA SUPREME COURT

The following cases are currently under review by the California Supreme Court:

Ameron International Corp. v. Insurance Co. of the State of Pennsylvania (case no. S153852) - Does a proceeding before the United States Department of the Interior Board of Contract Appeals constitute a "suit" such as to trigger insurance coverage under a commercial general liability policy?

Village Northridge Homeowners Ass'n v. State Farm Fire and Cas. Co. (case no. S16108) - Where an insurer misrepresents the policy limits to induce an insured into settling a disputed insurance claim, may the insured may keep the money paid and sue for fraud?

State of California v. Continental Ins. Co. (case no. S170560) - (1) When continuous property damage occurs during the periods of several successive liability policies, is each insurer liable for all damage both during and outside its period up to the amount of the insurer's policy limits? (2) If so, is the "stacking" of limits - i.e., obtaining the limits of successive policies - permitted?

Minkler v. Safeco Ins. Co. of America (case S174016) - Where a contract of liability insurance covering multiple insureds contains a severability clause, does an exclusion barring coverage for injuries arising out of the intentional acts of "an insured" bar coverage for claims that one insured negligently failed to prevent the intentional acts of another insured?

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PROPERTY INSURANCE

Insurer Properly Denied First-Party Claim Where Contractor's Negligence Damaged Pipe, Which Caused Corrosion, Seepage and Leakage and Mold

The California Court of Appeal has ruled that a homeowners insurer properly denied a first-party claim where a contractor's negligence damaged a plumbing pipe, which then caused corrosion, continuous seepage and leakage and, finally, mold. (*Freedman v. State Farm Ins. Co.* (2009) 173 Cal.App.4th 957)

Facts

Bernard and Gail Freedman hired a contractor to remodel a bathroom in their house. While hanging new drywall, the contractor drove a nail through a plumbing pipe. The nail in the pipe apparently caused no leak at the time and went unnoticed until years later, when corrosion around the nail caused a leak and extensive water damage and mold.

The Freedmans submitted a claim to their insurer, State Farm, which had issued a policy that provided "all-risk" coverage for the dwelling, subject to various exclusions. State Farm denied coverage based on various exclusions. Among other things, the policy provided: "We do not insure for any loss to the property described in Coverage A which is caused by one or more of the items below, regardless of whether the loss occurs suddenly or gradually, involves isolated or widespread damage, arises from natural or external forces, or occurs as a result of any combination of these: ... [g.] wear, tear, marring, scratching, deterioration, inherent vice, latent defect or mechanical breakdown; ... [h.] corrosion, electrolysis or rust."

In addition, the policy provided: "We do not insure under any coverage for any loss which is caused by one or more of the items below, regardless of whether the event occurs suddenly or gradually, involves isolated or widespread

damage, arises from natural or external forces, or occurs as a result of any combination of these: ... Water Damage, meaning ... continuous or repeated seepage or leakage of water or steam from a ... plumbing system...."

Finally, the policy provided: "We do not insure for loss described in paragraphs 2., 3. and 4. immediately above regardless of whether one or more of the following: (a) directly or indirectly cause, contribute to or aggravate the loss; or (b) occur before, at the same time, or after the loss or any other cause of the loss: [a.] conduct, act, failure to act, or decision of any person, group, organization or governmental body whether intentional, wrongful, negligent, or without fault; [b.] defect, weakness, inadequacy, fault or unsoundness in ... design, specifications, workmanship, construction, grading, compaction ... of any property (including land, structures, or improvements of any kind) whether on or off the residence premises...."

The Freedmans filed suit against State Farm, alleging claims for breach of contract, breach of the implied covenant of good faith and fair dealing, and negligence. State Farm answered, and the parties filed cross-motions for summary judgment based on jointly stipulated facts. The superior court denied the Freedmans' motion and granted State Farm's motion, and the Freedmans appealed.

Holding

The Court of Appeal affirmed, ruling that the third-party negligence provisions of the Freedmans' policy clearly excluded third parties' negligent conduct and defective workmanship whenever they interact with excluded perils (such as corrosion and continuous or repeated seepage or leakage of water). Thus, the Freedmans' policy excluded contractor-negligence-induced corrosion and contractor-negligence-induced continuous or repeated seepage or leakage of water.

The Freedmans argued that the "seepage or leakage" exclusion was ambiguous, because the exclusion did not specify how long a leak must

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last in order to be “continuous” or how many times the leak must stop and start in order to be “repeated.” However, the Court concluded that, given the small size of the hole(s) through which the water leaked, and given the extensive amount of water damage, the leak must have lasted a sufficiently long time, or stopped and started sufficiently many times, to count as “continuous” or “repeated” under any reasonable construction of those terms.

In addition, the Freedmans argued that the exclusion applies only to “normal deterioration of the plumbing system,” not to leaks “caused by some force other than deterioration.” The Court disagreed, because the policy excluded “coverage for any loss which is caused by [continuous or repeated seepage or leakage of water from a plumbing system], regardless of whether the event occurs suddenly or gradually, involves isolated or widespread damage, [or] arises from natural or external forces[.]” Therefore, the Court held that the policy expressly excluded continuous or repeated seepage or leakage regardless of whether they are caused by natural forces (such as normal deterioration) or external forces (such as a nail driven through a pipe).

Finally, the Court held there was no coverage for the mold damage. The Court noted that the contractor’s negligence had damaged the pipe, which caused corrosion, which caused seepage and leakage, which caused mold. In short, every link in the chain was an excluded peril.

Comment

This case continues a trend seen in other relatively recent cases involving multiple causes of damage, such as *Julian v. Hartford Underwriters Ins. Co.* (2005) 35 Cal.4th 747 and *De Bruyn v. Superior Court* (2008) 158 Cal.App.4th 1213. More specifically, California courts have demonstrated a willingness to limit the predominant cause (“efficient proximate cause”) doctrine “as long as [a] reasonable insured would readily understand from the policy language which perils are covered and which are not.” In this case, the Court of Appeal ruled that

State Farm’s language clearly eliminated coverage for every cause of damage, including contractor negligence.

Insurer Must Inform First-Party Claimant of Contractual Limitation Period, Even Where Claimant is Represented by Attorney

The California Court of Appeal has held that the Fair Claims Settlement Practices Regulations require an insurer to inform a first-party claimant of a policy’s one-year contractual limitation period even where the claimant is represented by an attorney, and that failure to do so may later estop the insurer from raising the limitation period as a defense. (*Superior Dispatch, Inc. v. Insurance Corp. of New York* (2009) 176 Cal.App.4th 12)

Facts

Superior Dispatch, Inc. (Superior), a trucking company, purchased an insurance policy from Insurance Corporation of New York (Inscorp). The policy included a cargo form that provided all-risk property coverage relating to loss of or damage to cargo in transit. The cargo form included contractual limitations provision that required the insured to file suit within one year of the date of loss.

Matson Navigation Company (Matson) hired Superior to carry freight by truck from one location to another. Superior’s truck struck an overpass, causing damage to the freight on the truck. Thereafter, Matson demanded payment from Superior, and Superior submitted both a first-party claim and a third-party claim to Inscorp.

Ultimately, Inscorp’s claims adjuster sent a letter to Superior stating that Inscorp had denied the claim. However, Inscorp’s adjuster’s letter did not refer to the one-year contractual limitations provision contained in the cargo form.

Superior retained an attorney, who sent a letter to Inscorp challenging the claim denial and

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alleging that the denial was in bad faith. Inscorp then retained an attorney, who sent a letter to Superior's counsel and reiterated the prior denial of coverage. Inscorp's counsel's letter did not refer to the one-year contractual limitations provision contained in the cargo form.

Superior filed a complaint against Inscorp more than one-year after Inscorp's adjuster had given written notice of the denial of the claim and more than one year after Inscorp's counsel had reaffirmed, in writing, the denial of the claim. Inscorp filed a motion for summary judgment, asserting that the one-year contractual limitations period barred the complaint in its entirety. The trial court concluded that the entire action was barred by the one-year contractual limitations period, and Superior appealed.

Holding

The Court of Appeal reversed, relying on the fact that the Fair Claims Settlement Practices Regulations (enacted by the Department of Insurance) require certain disclosures by insurers in connection with claims. Among other things, Section 2695.4, subdivision (a) requires that "[e]very insurer shall disclose to a *first party claimant* or beneficiary, all benefits, coverage, time limits or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant."

In addition, Section 2695.7, subdivision (f) requires an insurer to notify a "*claimant*" of any statute of limitations and any "other time period requirement upon which the insurer may rely to deny a claim, but also provides that "[t]his subsection shall not apply to a claimant represented by counsel on the claim matter." The term "claimant" is defined to include both a "first party claimant" and a "third party claimant."

The Court of Appeal held that Section 2695.7, subdivision (f) – which applies to a "claimant" – exempts the insurer from giving notice of a limitation period if the claimant is represented by counsel. However, the Court held that Section 2695.4, subdivision (a) – which specifically applies to a "first party claimant" –

does *not* exempt the insurer from giving notice of a limitation period if the first-claimant is represented by counsel.

The Court held that triable issues of fact existed as to whether Superior and/or its attorney had actual notice of the policy's one-year contractual limitation period and that, if they could establish that they did not have notice, then Inscorp would be estopped to raise the limitation period as a defense.

Comment

In *Spray, Gould & Bowers v. Associated International Ins. Co.* (1999) 71 Cal.App.4th 1260, the Court of Appeal held that, where an insurer fails to inform the insured that the policy contains a contractual limitation period, and where the insured is not otherwise aware of the shortened limitation period, the insurer may be estopped from raising the limitation period as a defense in litigation.

The *Superior Dispatch* ruling expands somewhat upon the *Spray, Gould & Bowers* ruling and holds that, if the insured is represented by an attorney, the insurer does *not* need to give notice of any *statutory* limitation period but *does* need to give notice of any *contractual* limitation period. Generally, this exception should only apply in the context of first-party insurance.

Although the Court noted that the insured would still need to establish detrimental reliance (i.e., that the insured and the insured's attorney did not have actual knowledge the contractual limitation provision), that typically should be easy for an insured to prove.

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Restitution Order in Criminal Case Does Not Prevent Victim (or Insurer) From Obtaining Separate Civil Judgment

The California Court of Appeal has held that a restitution order in a criminal case does not prevent the victim (or the victim's insurer) from obtaining a separate civil judgment based on the same facts, but any payments made against the restitution order will reduce the amount owed on the civil judgment. (*Vigilant Insurance Company v. Chiu* (2009) 175 Cal.App.4th 438)

Facts

Over a period of time, Robert Chiu stole \$397,085.31 worth of merchandise from his employer, ViewSonic. Ultimately, he was convicted of the crime of grand theft. As a part of his sentence, Chiu was ordered to pay ViewSonic restitution in the amount of \$615,000.00 pursuant to Penal Code section 1202.4. This included the value of the stolen property, as well as lost profits and opportunity costs, and pre-order interest.

Vigilant Insurance Company issued a policy of crime insurance that covered ViewSonic's losses. After applying the policy's \$50,000.00 deductible, Vigilant paid \$347,085.31 to ViewSonic. In turn, ViewSonic provided Vigilant with a written assignment of all rights against Chiu.

Vigilant filed suit against Chiu for fraud, conversion and embezzlement. It sought recovery of the \$347,085.31 paid to ViewSonic, plus the deductible of \$50,000.00. After a bench trial, the court awarded judgment in favor of Vigilant totaling \$504,306.89 which consisted of \$397,085.31 in actual damages, interest of \$105,853.15 and costs in the amount of \$1,368.43.

On appeal, Chiu argued that, by virtue of the restitution order and assignment, ViewSonic, already had what amounted to a judgment against Chiu in the sum of \$615,000.00, and that

the civil judgment would make Chiu liable for the same loss twice.

Holding

The Court of Appeal held that a restitution order is not a civil judgment. The Court also held that a restitution order does not preclude the victim (or the victim's insurer) from pursuing a separate civil action based on the same facts from which the criminal conviction arose. However, the Court also noted that Penal Code section 1202.4 (j) provides that "[r]estitution collected pursuant to this subdivision *shall be credited to any other judgments for the same losses obtained against the defendant arising out of the crime for which the defendant was convicted.*"

The Court held that the statutory provisions, read together, demonstrate legislative recognition of the distinct and separate right of a victim to pursue a civil remedy irrespective of the restitution order, subject only to the requirement that the any amounts paid under the restitution order be credited against the civil judgment.

Comment

It is well established under California law that a victim's insurance company can bring civil actions for reimbursement against the wrongdoer (or against the victim to the extent the wrongdoer already has made restitution). In fact, insurer reimbursement claims are encouraged, since equitable principles would place the loss on the wrongdoing defendant, preclude a windfall recovery by the victim, and reimburse the insurer that honored a claim against a policy.

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GENERAL LIABILITY INSURANCE

"Professional Services" Exclusion Does Not Relieve General Liability Insurer of Duty to Defend Insured Consultant Against Claims Arising From Injury to Worker at Job Site

The California Court of Appeal has held that a "professional services" exclusion did not relieve a general liability insurer of the duty to defend its insured, a consulting firm, against claims arising from injuries to a worker at a jobsite where the insured was providing consulting services. (*Food Pro International, Inc., v. Farmers Ins. Exchange* (2008) 169 Cal.App.4th 976)

Facts

Mariani Packing Company (Mariani), a fruit processing company, decided to move its operations from an old plant in San Jose to a new plant in Vacaville. In order to assist in the relocation, Mariani hired Food Pro International, Inc. (Food Pro), a consulting firm that prepares and implements plans for food processing operations. Among other things, the contract between Mariani and Food Pro required that Food Pro would coordinate the movement of food processing equipment from Mariani's old plant in San Jose to its new plant in Vacaville. The contract did *not* require Food Pro to provide a safe work place for workers.

Mariani itself hired the contractors that physically moved the equipment. In the course of moving a piece of equipment, Mariani's mechanical contractor left a large hole in the second floor of Mariani's old plant in San Jose. Food Pro personnel saw the hole and suggested that Mariani employees cover it, but Mariani employees failed to do so.

One week later, Mariani's electrical contractor sent several employees to Mariani's old plant in San Jose in order to disconnect some equipment. In the process of that work, one of

the electrical contractor's employees, Roy Pettigrew (Pettigrew), fell through the hole in the second floor of the San Jose plant and suffered serious injuries. At the time of Pettigrew's accident, Food Pro personnel were present at Mariani's San Jose plant, supervising the "overall process" of moving the equipment. However, Food Pro personnel did not have a contractual obligation to ensure safety conditions at the site.

The injured worker, Pettigrew, filed a personal injury lawsuit against Food Pro. In addition, Pettigrew's employer's workers compensation insurer, Explorer Insurance Company (Explorer), filed a subrogation lawsuit against Food Pro in order to recover the amount of workers compensation benefits that Explorer had paid to Pettigrew. Pettigrew and Explorer both alleged that Food Pro had negligently failed to cover the hole through which Pettigrew fell and/or negligently allowed Pettigrew to work near the hole.

Food Pro tendered both lawsuits to its general liability insurer, Farmers Insurance Exchange (Farmers). The Farmers general liability policy contained an endorsement labeled "Exclusion - Engineers, Architects or Surveyors Professional Liability." It barred coverage for bodily injury "arising out of the rendering or failure to render any professional services by or for you, including: [1.] the preparing, approving, or failing to prepare or approve maps, drawings, opinions, reports, surveys, change orders, designs, specifications; and [2.] supervisory, inspection or engineering services." Relying on this "professional services" exclusion, Farmers refused to defend Food Pro against the lawsuits filed by Pettigrew and Explorer.

Pettigrew and Explorer later obtained default judgments totaling over \$1.7 million against Food Pro. Food Pro tendered the judgments to Farmers for payment, but Farmers refused to pay.

Food Pro then filed a breach of contract / bad faith lawsuit against Farmers, alleging that Farmers had wrongfully failed to defend and

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indemnify Food Pro in the underlying lawsuits brought by Pettigrew and Explorer. The trial court ruled that Farmers' "professional services" exclusion applied, and that Farmers thus had no duty to defend or indemnify Food Pro in the underlying lawsuits. Food Pro appealed.

Holding

The Court of Appeal reversed, holding that Farmers' "professional services" exclusion did *not* relieve Farmers of a duty to defend Food Pro in the underlying lawsuits. The appellate court agreed that Food Pro, in coordinating the movement of Mariani's equipment, was providing "professional services" to Mariani. However, according to the appellate court, Food Pro's professional services to Mariani "did not extend to the creation of the hole, the safety of the site, or the direction of Pettigrew...." Thus, according to the appellate court, Food Pro's alleged liability in the underlying lawsuits arose from Food Pro's "ordinary negligence," and not from its "professional services." As such, Farmers' "professional services" exclusion did not apply and Farmers was therefore obligated to defend Food Pro in the underlying lawsuits.

Comment

The result in this case seems debatable. The Farmers policy excluded coverage for bodily injury "arising out of" (i.e., flowing from) Food Pro's rendition of "professional services" (i.e., skilled services). "But for" the fact that Food Pro was performing "professional services" for Mariani in the first place, Food Pro would never have had any involvement in the Mariani project, and thus Food Pro would never have faced any liability for the injury to Pettigrew. In this sense, it can be said that Food Pro's alleged liability for Pettigrew's injury did in fact "arise out of" (flow from) Food Pro's rendition of "professional services" (skilled services) for Mariani.

Statutory Attorney Fees Paid to Plaintiffs In Settlement Constitute

Costs "Taxed" Against Insured Under "Supplementary Payments" Provision

The California Court of Appeal has held that when an insured pays statutory attorney fees to plaintiffs as part of a settlement, those statutory attorney fees qualify as costs "taxed" against the insured under a "supplementary payments" provision in a liability policy. (*Employers Mut. Cas. Co. v. Philadelphia Indem. Ins. Co.* (2008) 169 Cal.App.4th 340)

Facts

Louis Simpson owned and operated a mobile home park. In 2003, 188 residents of the mobile home park sued Simpson alleging that he had failed to maintain the mobile park in a habitable condition. The plaintiffs sought damages and statutory attorney fees from Simpson pursuant to California's Mobilehome Residency Law (Civil Code section 798 et seq.).

Simpson tendered defense of the lawsuit to several general liability insurers, including Employers Mutual Insurance Company, Evanston Insurance Company and Philadelphia Indemnity Insurance Company. Employers and Evanston jointly provided a defense to Simpson through two separate "panel" law firms and a third law firm that acted as "independent counsel." Philadelphia, on the other hand, denied coverage and refused to participate in Simpson's defense.

Eventually, the plaintiffs settled their "failure to maintain" lawsuit against Simpson for a total of \$3 million, with \$1.2 million allocated to damages and \$1.8 million allocated to statutory attorney fees. Employers and Evanston funded the entire settlement on behalf of Simpson. In addition, Employers and Evanston paid a total of \$740,000 in defense costs to the two panel law firms and independent counsel that represented Simpson.

Evanston assigned its contribution rights to Employers. Employers then filed a contribution action against the non-participating insurers,

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including Philadelphia. The trial court ruled that Philadelphia did have a duty to defend and indemnify Simpson in the underlying lawsuit. The issue thus became what portion of the defense and indemnity costs should be allocated to Philadelphia.

With respect to plaintiffs' damages of \$1.2 million, the trial court used a "modified" time on the risk method whereby the court multiplied the plaintiffs' damages by Philadelphia's time on the risk (22.2%) *and* the percentage of plaintiffs who resided in the park during Philadelphia's policy period (58%). Thus, Philadelphia was responsible for \$154,000 of the plaintiffs' damages (i.e., \$1.2 million x 22.2% x 58% = \$154,000).

With respect to plaintiffs' statutory attorney fees of \$1.8 million and Simpson's defense costs of \$740,000, the trial court used a "straight" time on risk method whereby the court simply multiplied the plaintiffs' statutory attorney fees and Simpson's defense costs by Philadelphia's time on the risk (22.2%). Thus, Philadelphia was responsible for \$400,000 of the plaintiffs' statutory attorney fees (i.e., \$1.8 million x 22.2% = \$400,000), and \$164,000 of Simpson's defense costs (i.e., \$740,000 x 22.2% = \$164,000). Philadelphia appealed the rulings as to Philadelphia's responsibility for the plaintiffs' statutory attorney fees and Simpson's defense costs.

Holding

The Court of Appeal affirmed.

First, the appellate court held that the trial court properly required Philadelphia to contribute \$400,000 toward the \$1.8 million in statutory attorney fees which Simpson paid as part of the underlying settlement with the plaintiffs. The appellate court noted that the Philadelphia policy contained a "supplementary payments" clause which provided that Philadelphia would pay all costs (including statutory attorney fees) "taxed" against the insured in a lawsuit. Although the underlying lawsuit was settled without a trial, the policy's coverage for costs "taxed" against the

insured was *not* limited only to situations where a court ordered the insured to pay statutory attorney fees to the plaintiff *after trial*. Rather, the word "taxed" could also be construed to include situations where the insured agreed to pay statutory attorney fees to the plaintiff *as part of a settlement*. Further, while only 58% of the plaintiffs lived in Simpson's mobile home park during the Philadelphia policy period, the trial court did not err in requiring Philadelphia to pay a simple 22.2% "time on the risk" share of the statutory attorney fees. The trial court was *not* required to multiply Philadelphia's share of the \$1.8 million in statutory attorney fees by both Philadelphia's time on the risk (22.2%) *and* the percentage of overall plaintiffs who resided in the park during Philadelphia's policy period (58%).

Next, the appellate court held that the trial court properly required Philadelphia to contribute \$164,000 toward the \$740,000 in defense costs which Employers (and its assignor, Evanston) had paid on behalf of Simpson in the underlying lawsuit. Although a portion of the \$740,000 in defense costs was for "independent counsel" fees which were owed because Evanston defended Simpson under a reservation of rights, and although Philadelphia never defended Simpson under any reservation of rights, the court concluded that "Philadelphia stood to gain if Evanston successfully challenged coverage" and thus "it was equitable for Philadelphia to share in the cost of Simpson's *Cumis* counsel." Further, Philadelphia failed to establish that the two "panel" defense firms Employers and Evanston hired in the underlying lawsuit had performed "duplicate" work in defending the insured, Simpson.

Comment

Generally, when one insurer files a contribution action against another insurer, the trial court has broad discretion to allocate defense and indemnity costs in any number of "equitable" ways – e.g., equal shares, time on risk, policy limits, premiums collected, etc. Unless the trial court adopts an allocation approach that is

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manifestly unreasonable, the trial court's decision will be upheld by an appellate court.

The most significant aspect of this case is the appellate court's holding that when an insured (or one of its insurers) agrees to pay costs (including statutory attorney fees) to a plaintiff in *settlement*, those costs are deemed to be "taxed" against the insured for purposes of a "supplementary payments" clause. This ruling allows an insured (or one of its insurers) to settle with the plaintiff and then seek reimbursement of costs (including statutory attorney fees) from a non-participating insurer.

Liability Policy's "First Publication" Exclusion Applies to Infringement Claims

The Ninth Circuit Court of Appeals, applying California law, has held that a liability policy's "first publication" exclusion barred coverage for infringement claims where the insured first published allegedly infringing material before the policy period. (*United Nat. Ins. Co. v. Spectrum Worldwide, Inc.* (9th Cir.) 555 F.3d 772)

Facts

In December 1997, Sunset Health Products, Inc. hired Spectrum Worldwide, Inc. to advertise and distribute Sunset's "Hollywood 48-Hour Miracle Diet" drink ("Miracle Diet"). Soon thereafter, Spectrum developed plans to market and sell a similar product called "The Original Hollywood Celebrity Diet" drink ("Celebrity Diet"). Spectrum then terminated its contract with Sunset and began marketing the Celebrity Diet. Starting in 1999 and continuing through 2001, Spectrum's Celebrity Diet utilized labeling and packaging that bore similarities to the labeling and packaging of Sunset's Miracle Diet.

In April 2001, Spectrum obtained a \$1 million excess policy from United National Insurance Company. The United National policy covered damages that Spectrum became obligated to pay

because of specified "advertising injury" offenses, including "misappropriation of advertising ideas or style of doing business" and "infringement of copyright, title or slogan." However, the United National policy also contained a "first publication" exclusion which barred coverage for advertising injury "arising out of oral or written publication of material whose first publication took place before the beginning of the policy period."

In October 2001, Sunset filed a trade dress infringement claim against Spectrum, alleging that the labeling and packaging of Spectrum's Celebrity Diet was confusingly similar to the labeling and packaging of Sunset's Hollywood Diet. Sunset eventually settled its claims against Spectrum for \$3,220,000, which was funded by Spectrum's insurers. United National contributed \$420,000 to the settlement.

Following the settlement, United National filed an action for declaratory relief / reimbursement against Spectrum in federal district court. United National sought a ruling that the "first publication" exclusion in its policy barred coverage for Spectrum's alleged liability to Sunset in the underlying infringement action, and that Spectrum was thus obligated to reimburse United National for the \$420,000 it had contributed to the underlying settlement. The district court ruled that United National's "first publication" exclusion barred coverage for Spectrum's liability, and ordered Spectrum to reimburse United National \$420,000 plus interest. Spectrum appealed.

Holding

The Ninth Circuit Court of Appeals, applying California law, affirmed. The court began by holding that the "first publication" exclusion applies not only to advertising injury offenses involving defamation and invasion of privacy, but also can apply to advertising injury offenses involving infringement. The court then held that the evidence showed that Spectrum first began publishing infringing material in 1999, *before* the United National policy took effect in April 2001.

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Under such circumstances, the “first publication” exclusion relieved United National of any duty to indemnify Spectrum in connection with the underlying settlement, and Spectrum was thus obligated to reimburse United National for the \$420,000 it had contributed to the underlying settlement.

Comment

The Ninth Circuit’s decision in this case effectively overrules *Arnette Optic Illusions, Inc. v. ITT Hartford Group, Inc.* (C.D.Cal.1998) 43 F.Supp.2d 1088, in which a California federal district court had suggested that the “first publication” exclusion might only apply to advertising injury offenses involving defamation and invasion of privacy. According to the Ninth Circuit, the “first publication” exclusion applies to *all* enumerated advertising injury offenses, including those involving infringement.

Third-Party Claimant Does Not Have Standing to Bring Declaratory Relief Action Against Insured’s Liability Insurer

The California Court of Appeal has held that a third-party claimant did not have standing to bring a declaratory relief action against the insured’s liability insurer to determine the scope of coverage under the insured’s policy. (*Otay Land Company v. Royal Indemnity Company* (2008) 169 Cal.App.4th 556)

Facts

United Enterprises, Inc. (United) owned real property on which it operated a trap and shooting range. Flat Rock Land Company (Flat Rock) eventually acquired the property.

After Flat Rock acquired the property, Flat Rock discovered that the property had become contaminated during the time that United owned the property. Flat Rock thus sued United, seeking recovery of environmental cleanup costs

incurred in connection with the property. United tendered defense of the action to its liability insurer, Royal Indemnity Company (Royal), and Royal agreed to defend United under a reservation of rights.

Royal then filed a declaratory relief action against the insured, United, seeking a determination that Royal did not have any duty to defend or indemnify United in the underlying action brought by Flat Rock. Royal did *not* name the third-party claimant, Flat Rock, as a defendant in the declaratory relief action. Flat Rock filed a motion to intervene in Royal’s declaratory relief action in order to “assist” United in litigating the coverage issues. However, the trial court denied Flat Rock’s motion to intervene, and that ruling was affirmed on appeal. (See *Royal Indemnity Co. v. United Enterprises, Inc.* (2008) 162 Cal. App.4th 194.)

Flat Rock then filed its own separate declaratory relief action against Royal, alleging that Flat Rock had a legitimate interest in making coverage arguments that might affect Flat Rock’s ability to recover damages and cleanup costs from United in the underlying action. The trial court dismissed Flat Rock’s complaint, finding that Flat Rock did not have standing to sue Royal for a declaration as to Royal’s duties to United. Flat Rock appealed.

Holding

The Court of Appeal affirmed the trial court’s dismissal of Flat Rock’s complaint for declaratory relief action against Royal. The appellate court reasoned that Flat Rock was not an “insured” under United’s policy through Royal, and that Flat Rock’s presence in the case was not necessary to resolve the coverage dispute between United and Royal. At most, Flat Rock was merely a “potential” judgment creditor of the insured and thus a “potential” beneficiary of the proceeds in the event coverage was found. Accordingly, the appellate court ruled that Flat Rock lacked standing to sue Royal to resolve coverage questions arising under the policy United had through Royal.

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Comment

If a liability insurer files a declaratory relief action against its insured to determine coverage, the insurer has the option of joining the third-party claimant as a co-defendant. However, as this case suggests, the third-party claimant does not necessarily have an equivalent right to bring a declaratory relief action against the insured's liability insurer. Of course, if the third-party claimant has already obtained a judgment against the insured, or if the third-party claimant has received an assignment of the insured's rights, then the third-party claimant would have sufficient standing to bring an action against the insured's liability insurer.

Insured Can "Stack" Policy Limits Across All Applicable Policy Periods in Cases of Continuous and Progressive Property Damage / Bodily Injury

A California Court of Appeal has held that an insured is entitled to combine or "stack" the policy limits of all applicable policies across all applicable policy periods in cases of continuous and progressive property damage and bodily injury, thus creating a split of authority with the "no-stacking rule" previously adopted by another California appellate panel. (*State v. Continental Casualty Insurance Co.* (2009) 170 Cal.App.4th 160)

Facts

The coverage dispute at issue in this case arose out of claims of groundwater contamination stemming from the 1950s conversion of a quarry in Riverside County into an industrial waste disposal site. A state geologist inspected the quarry for suitability in 1955, and the State of California proceeded to design the site and supervise its construction. Over the next two decades, numerous flaws in the site's design and construction allowed contaminants to escape. In 1998, the State was found liable for all past and

future remediation costs, estimated to be as high as \$700 million.

Seeking indemnification, the State filed suit against its excess liability insurers, each of which covered a two- or three-year period in the 1960s and 1970s. The trial court concluded, among other things, that every policy in effect for any policy period during which the loss was occurring covered the entire loss (subject to the policy limits). However, the trial court also ruled that the State could only recover up to the policy limits of the policies in effect during a *single* period to be selected by the State. This "no-stacking" holding was one of several issues on appeal.

Holding

The Fourth Appellate District reversed the trial court, holding that the State was not limited to a single policy period and that the State could combine or "stack" the policy limits of *all* applicable policies across *all* applicable policy periods. First, the Court examined the language of the policies, noting that they only limit each particular insurer's liability under each particular policy (that is, not in reference to other policies), and that nothing in the policy language expressly prohibits stacking. The Court also noted that, with the exception of uninsured motorist policies, stacking is generally the rule. For example, the fact that California follows the "horizontal exhaustion" rule (whereby excess policies are not triggered until the limits of all underlying primary policies are exhausted) necessarily implies that the insured (like the excess carrier) is entitled to stack primary policies; otherwise, the primary policies could never be exhausted.

The Court then rejected the "no-stacking" rule previously adopted by the Sixth Appellate District in *FMC Corp. v. Plaisted & Cos.* (1998) 61 Cal.App.4th 1132, and identified several arguments against such a rule. First, the policy language is susceptible to the meaning that stacking is allowed and should be construed against the insurer. Second, *FMC's* finding that

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stacking affords the insured more coverage than it paid for is circular: it assumes what it is meant to prove – that the policies do not provide for stacking. Moreover, if an occurrence is continuous across two policy periods, the insured has paid two premiums and can recover up to the combined total of two policy limits – something that is neither unfair nor unexpected. Finally, even if stacking somehow resulted in a windfall to the insured, courts would not be authorized to cure it through “judicial intervention,” as *FMC* suggests, because courts cannot rewrite contracts.

Notably, the *Continental Casualty* holding applies even if there is only a single “occurrence,” but it is limited to cases to where there is continuous and progressive bodily injury or property damage. The Court openly acknowledged that one reason to prohibit stacking is that the insured should not be better off when an occurrence is continuous across multiple policy years. However, the Court also noted that “a continuous loss spanning two or more policy periods is fundamentally different from an instantaneous loss, such that it is appropriate to place a greater contractual obligation on the insurers.”

Comment

As is evident, the *Continental Casualty* decision created a district split with the *FMC* decision regarding the permissibility of “stacking.” In order to resolve the conflicting appellate decisions on this issue, the California Supreme Court has recently granted review in the *Continental Casualty* case. Until the Supreme Court renders its decision in this case (which may not be until sometime in 2010), this will remain an unsettled area of the law.

California Supreme Court Restricts Insurers’ Ability to Rely on “Qualified” Pollution Exclusion

The California Supreme Court has issued a ruling which will significantly restrict the insurance industry’s ability to deny indemnity coverage based on the “qualified” (i.e., “sudden

and accidental”) pollution exclusion. (*State of California v. Allstate Insurance Company* (2009) 45 Cal.4th 1008)

Facts

During the 1950’s, the State of California undertook to design and construct a Class I hazardous waste disposal site (i.e., one capable of accepting all types of liquid wastes). The site later became known as the “Stringfellow Acid Pits.” The facility, located in Riverside County, sat on the floor of a canyon drained by Pyrite Creek. In 1955, a State geologist briefly inspected the Stringfellow site and assumed that there was an impermeable layer of rock, with no water in it, beneath the site. As a result of the State geologist’s investigation of the site, the State concluded that with construction of a watertight barrier dam across the canyon, and with adequate measures to divert runoff, the site would pose no threat of environmental pollution.

Thereafter, the State directed construction of unlined evaporation ponds to contain the hazardous waste; channels to divert rainwater around the site; and a barrier dam at the bottom of the site. In 1956, the State opened the site, and over the next 17 years, various companies deposited more than 30 million gallons of liquid industrial waste in the Stringfellow ponds.

The State’s initial assessment of the Stringfellow site proved inaccurate. In fact, the site was underlain by decomposed granite and fractured bedrock, through which an underground alluvial channel ran. As a result, by 1960, chemical pollution begun seeping into the groundwater through the fractured rock.

In addition to underground leaking, two major overflow episodes occurred at the site. In March 1969, a 50-year rainstorm flooded the site, causing the waste ponds to overflow and send polluted water down the canyon. In March 1978, again following extraordinarily heavy rains, the ponds were near overflowing and the retention dam began to fail; as a result, the State made a series of controlled discharges from the ponds,

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releasing about one million gallons of diluted waste down the Pyrite Creek channel.

Later, the State and the United States filed a federal court action against companies that had disposed of waste at the Stringfellow Acid Pits. The companies counterclaimed against the State. In 1998, the federal district court held the State 100 percent liable for claims under California law, and 65 percent liable for claims under federal law, for past and future costs of remediating contamination of land and groundwater. (The remediation costs are now expected to exceed \$500 million.)

The State requested coverage for the liability imposed in the federal action from several excess insurers, including Allstate Insurance Company, Century Indemnity Company and Westport Insurance Corporation. All three insurers denied coverage based on a “qualified” pollution exclusion which provided as follows: “This policy does not apply to ... property damage arising out of the discharge, dispersal, release or escape of ... pollutants into or upon land or the atmosphere, *but this exclusion does not apply if such discharge, dispersal, release or escape is sudden and accidental.* It is further agreed that the policy does not apply to ... property damage arising out of the discharge, dispersal, release or escape of ... pollutants *into or upon any watercourse or body of water.*”

Following the insurers’ denial of coverage, the State filed a state court action against the insurers for breach of contract and bad faith. After proceedings in both the trial court and the California Court of Appeal, the parties ended up before the California Supreme Court.

Holding

On appeal, the insurers unsuccessfully advanced various arguments as to why the pollution exclusion barred coverage for all – or at least some – of the State’s liability for the costs of cleaning up the pollution.

First, the insurers argued that since the *initial discharges* of pollutants into the containment

ponds were not “sudden and accidental,” the pollution exclusion necessarily barred coverage for *any* liability the State might have. The Supreme Court disagreed, reasoning that in the underlying action, the State was not held liable for polluting *the containment ponds*, but rather for polluting the land and groundwater *outside the containment ponds*. According to the Court, the analysis must focus on the discharge which formed the basis for the insured’s liability. Thus, the pollution exclusion did not necessarily relieve the insurers of the duty to indemnify the State for any property damage arising out of a “sudden and accidental” dispersal, release or escape of pollutants *from* the containment ponds *into* the surrounding soils and groundwater.

Second, the insurers argued that any damages from the 1969 overflow fell within the scope of the pollution exclusion’s *absolute* bar of coverage for damages arising from the “discharge, dispersal, release or escape of ... pollutants into or upon any *watercourse*” The Supreme Court rejected this argument as well, noting that a “watercourse” is usually defined as “a channel through which ... water ... usually or periodically flows.” According to the Court, the insurers had not conclusively established that the 1969 overflow was confined to the Pyrite Creek channel itself, as opposed to land outside the channel.

Third, the insurers argued that since the State intentionally made a series of controlled discharges from the containment ponds in 1978, those discharges were not “accidental” within the meaning of the exception to the pollution exclusion. The Supreme Court disagreed, reasoning that the State made the controlled discharges only to prevent a larger “accidental” discharge which would have occurred if the dam had broken due to the extraordinarily heavy rains. According to the Court, liability policies can “cover damages resulting from an act undertaken to *prevent* a covered source of injury from coming into action, *even if that [preventive] act would not otherwise be covered.*”

Fourth, the insurers argued that the State was barred from recovery because the State could

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not prove what portion of the property damage was caused by the “covered” sudden and accidental discharges in 1969 and 1978, and what portion of the property damage was caused by otherwise “uncovered” gradual or nonaccidental leakage from the containment ponds. The Supreme Court rejected this argument, reasoning that where both covered and uncovered events cause *indivisible* damage, the insurer must indemnify the insured for *all* the damage as long as the covered event was a “substantial factor” in causing the damage. Thus, to the extent the State could prove that covered “sudden and accidental” discharges were a “substantial factor” in causing the contamination of the soils and groundwater, the State would be entitled to *full indemnification* from the insurers.

Comment

One of the more significant aspects of this case is the Supreme Court’s ruling with respect to *indivisible* injuries resulting from both covered and noncovered causes. Relying heavily on its prior decision in *Partridge v. State Farm Fire & Casualty Co.* (1973) 10 Cal.3d 94, the Supreme Court emphasized that if an insured’s *covered* conduct is a “substantial cause” of indivisible injuries suffered by the claimant, that conduct is sufficient to render the insured *fully liable* to the claimant under *tort law*. In that situation, the insured is then entitled to *full indemnification* from the insurer under the *policy* – even if the insured’s *noncovered* conduct also contributed to the claimant’s indivisible injuries. The Supreme Court expressly overruled a prior Court of Appeal decision – *Golden Eagle Refinery Co. v. Associated International Ins. Co.* (2001) 85 Cal.App.4th 1300, which had held that in this situation the insured must prove *how much* of the indivisible amount of damages resulted from covered causes.

Insurer’s Duty of Equitable Contribution for Defense Costs Arises Where, After Notice of Litigation,

Diligent Inquiry Would Reveal Equitable Contribution Exposure

The California Court of Appeal held that an insurer’s obligation of equitable contribution for defense costs arises where, after receiving actual or constructive notice of the lawsuit, a diligent inquiry by the insurer would reveal the potential exposure to a claim for equitable contribution. (*OneBeacon America Insurance Co. v. Fireman’s Fund Insurance Co.* (2009) 175 Cal.App.4th 183)

Facts

OneBeacon America Insurance Company (“OneBeacon”), Insurance Company of the West (“ICW”), and Fireman’s Fund Insurance Company (“FFIC”) were primary coinsurers under liability insurance policies of common insureds. These common insureds — the Mouren-Laurens Oil Company, along with its owners, directors, and officers (collectively “MLOC”) — were sued in 1998 for allegedly contaminating real property with petroleum products from the 1950s onward.

In 1999, OneBeacon agreed to defend MLOC in the underlying action. MLOC also tendered its defense to ICW and FFIC in 1999 under the belief that ICW and FFIC had insured MLOC during the period in question. As of 1999, however, MLOC did not have any physical evidence of the primary policies issued by FFIC and ICW. Thus, in their tender letters and supplementary correspondence, MLOC asked that ICW and FFIC locate and provide all policies they issued to MLOC. Both insurers denied coverage on the grounds that they did not issue any primary policies to MLOC.

Three years later, in 2002, MLOC provided ICW with copies of a number of ICW primary policies that MLOC was able to obtain through an ICW agent. MLOC also sent ICW a declaration from another ICW agent who attested that he sold a primary policy to MLOC in 1978. In 2002, MLOC also provided FFIC with a declaration from one of FFIC’s agents, who attested that he handled

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MLOC's purchase of primary FFIC policies for the 1948-1962 policy years. Using the information from the declaration, FFIC was able to locate evidence of an FFIC primary policy within a matter of weeks. At that point, both ICW and FFIC agreed to defend MLOC under a reservation of rights.

OneBeacon demanded contribution from ICW and FFIC for the costs of defense from 1999 to 2002. ICW and FFIC refused payment, citing defects as to notice and tender. OneBeacon then filed the subject action for equitable contribution against FFIC and ICW. The trial court ruled against OneBeacon, and OneBeacon appealed.

Holding

The Court of Appeal found that OneBeacon was entitled to equitable contribution from 1999 forward. The Court first observed that under California law, tenders can be accomplished through constructive notice, which might be as simple as sending a copy of the complaint to the insurer without any tender letter. The Court then cited a number of public policy reasons for allowing constructive notice (as opposed to requiring formal notice by an insured): constructive notice clarifies the duties of the parties; it takes into account the greater knowledge and sophistication of the insurer; and although it places a burden on the insurer to ask the insured whether it is seeking a defense, that burden is not onerous.

Based on California's recognition of constructive notice and the foregoing public policy considerations, the Court held that an insurer's duty of equitable contribution for defense costs arises where, after receiving notice of the litigation, a diligent inquiry by the insurer would reveal the potential exposure to a claim for equitable contribution. The Court further observed that insurers are charged with knowledge of all information that a diligent inquiry would have revealed.

Applying this rule to ICW and FFIC, the Court then concluded that ICW and FFIC both had an equitable obligation to contribute to the costs of MLOC's defense from 1999 forward. The Court held that neither ICW nor FFIC demonstrated that their search was diligent. In fact, there was no showing that the information available to ICW or FFIC in 2002 was any different from the information that would have been available to them upon a diligent inquiry in 1999. Rather, the record showed that ICW did not conduct any search whatsoever and instead placed the burden of discovering the policies on MLOC. Also, FFIC's search was clearly inadequate, as there was no sufficient explanation for why FFIC was able to locate the policy in 2002 but not in 1999.

Thus, since ICW and FFIC received constructive notice of the lawsuit in 1999, and since a diligent inquiry would have revealed that they had in fact issued primary policies to MLOC exposing them to a claim for equitable contribution, both ICW and FFIC were equitably obligated to contribute to the defense from 1999 onward.

Comment

One of the reasons that the trial court ruled against OneBeacon was that it held that ICW and FFIC had no affirmative obligation to conduct a diligent inquiry into the existence of the policies. The Court of Appeal quickly dispelled with this notion and unequivocally imposed the burden on the insurer to locate policies. Insurers should be mindful of this burden whenever they receive correspondence from insureds or fellow insurers regarding missing policies.

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In Accident Involving Tractor-Trailer Rig, Statute Makes Trailer Lessor's Policy "Excess" To Tractor Owner's Policy

The California Supreme Court has held that, with respect to an accident involving a tractor-trailer rig, California Insurance Code section 11580.9(b) made the trailer lessor's commercial auto policy "excess" to the tractor's owner's commercial auto policy. (*Sentry Select Ins. Co. v. Fidelity & Guaranty Ins. Co.* (2009) 46 Cal.4th 204)

Facts

John's Trucking, Inc. (JTI) was a trucking company that routinely leased nearly three quarters of its commercial fleet of trailers to independent truckers with whom it contracted for hauling jobs. In 1999, JTI entered into a standard "trailer lease agreement" with independent trucker Richard Justice (Justice), whereby JTI leased two trailers to Justice.

In May 1999, Justice was driving his own tractor while pulling the two trailers leased from JTI. The tractor-trailer rig collided with another vehicle, resulting in injuries to April Russo (Russo) and Patricia Nila (Nila). At the time of the accident, Justice had a commercial auto policy listing his tractor through Sentry Select Insurance Company (Sentry), and JTI had a commercial auto policy listing the two trailers through Fidelity & Guaranty Insurance Company (Fidelity).

Russo and Nila brought personal injury actions against both Justice and JTI, but JTI obtained a dismissal. Justice's insurer, Sentry, then settled Justice's alleged liability to Russo and Nila for \$600,000 (an amount within Sentry's policy limit).

Sentry (insurer of Justice and his tractor) subsequently filed a federal court equitable contribution action against Fidelity (insurer of JTI and the leased trailers). (Apparently Sentry's theory was that since Justice was a "permissive user" of the trailers leased from JTI, Justice qualified as an "insured" under the Fidelity

policy.) Fidelity defended the federal court action by arguing that under California Insurance Code section 11580.9(b), the Fidelity policy was conclusively presumed to be "excess" to the Sentry policy, and therefore Fidelity owed nothing to Sentry. However, the United States District Court held that Insurance Code section 11580.9(b) did not apply, and that Sentry and Fidelity thus provided concurrent "primary" coverage for Justice's liability in the underlying personal injury case Fidelity appealed to the Ninth Circuit Court of Appeals. The Ninth Circuit, in turn, asked that the California Supreme Court issue an opinion regarding the proper interpretation of Insurance Code section 11580.9(b).

Holding

The California Supreme Court ruled that under section 11580.9(b), the policy Fidelity had issued to JTI for the leased trailers was conclusively presumed to be "excess" to the policy Sentry had issued to Justice for the tractor. At the time of the accident, section 11580.9(b) provided that if a leased commercial vehicle is involved in an accident, and the lessor of that vehicle is "*engaged in the business of renting or leasing motor vehicles without operators*," then the lessor's policy is conclusively presumed to be excess to any other insurance covering the loss.

The Supreme Court acknowledged that California Courts of Appeal had rendered conflicting decisions as to the meaning of the phrase "engaged in the business of renting or leasing motor vehicles without operators," with some courts focusing on the nature of the insured's primary business, and other courts focusing on the factual circumstances surrounding the lease of the particular commercial vehicle involved in the accident. However, the Supreme Court concluded that it was not necessary to resolve the conflicting appellate court decisions, because under either test, JTI was "engaged in the business of renting or leasing motor vehicles [i.e., the two trailers] without operators." As such,

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under section 11580.9(b), the policy Fidelity had issued to JTI for the leased trailers was conclusively presumed to be “excess” to the policy Sentry had issued to Justice for the tractor. Therefore, Sentry was not entitled to contribution from Fidelity.

Comment

Note that at the time of the accident in this case, section 11580.9(b) applied to an insured who was “engaged in the business of renting or leasing motor vehicles without operators.” Effective January 2007, the Legislature amended the statute, deleting the above phrase and replacing it with the phrase “who in the course of his or her business rents or leases motor vehicles without operators.” This amendment of the statutory language eliminates any ambiguity as to whether the leasing of commercial vehicles must be a regular part of the insured's business in order for the conclusive presumption to apply. As amended, section 11580.9(b) now clearly provides that the renting or leasing of commercial vehicles without operators in the course of *any business* can qualify for the conclusive presumption that the insured's coverage is excess, where all the statutory requirements are otherwise met.

Policies Do Not Cover Damages and Statutory Attorney's Fees Arising from Insureds' False Imprisonment and Exploitation of Domestic Servant

The California Court of Appeal has held that a homeowners and personal umbrella insurer had no duty to indemnify its insureds for compensatory damages and statutory attorney's fees awarded against the insureds after the insureds falsely imprisoned and exploited a domestic servant. (*State Farm General Ins. Co. v. Mintarsih* (2009) 175 Cal.App.4th 274)

Facts

Mimin Mintarsih sued Dennis and Dina Lam, alleging that she had been falsely imprisoned in the Lams' home for seven years and forced to work as a domestic servant. Mintarsih alleged that she had been required to work for the Lams seven days a week, 14 hours a day, without proper breaks and compensation. Mintarsih also claimed that the Lams negligently failed to provide her with proper medical care, which resulted in physical injury to her.

The Lams sought defense and indemnity under homeowners and personal umbrella policies issued by State Farm General Insurance Company. State Farm agreed to defend the Lams subject to a reservation of rights.

Mintarsih's case against the Lams was submitted to the jury on counts for false imprisonment, negligence, negligence per se, fraud, and wage and hour violations under the Labor Code. The jury found in favor of Mintarsih on all counts. It awarded her \$87,000 in damages on the first four counts, \$745,671 in damages and statutory penalties on the wage and hour count, and \$5,000 in punitive damages. Thereafter, the trial court awarded Mintarsih \$733,323 in statutory attorney's fees on the wage and hour claim, plus \$161,591 in “other costs.”

State Farm filed a declaratory relief action against the Lams and Mintarsih. The trial court ruled that State Farm was obligated to indemnify the Lams for some, but not all, of the amounts which had been awarded to Mintarsih in the underlying action. Mintarsih and State Farm both appealed.

Holding

On appeal, the parties agreed that State Farm did *not* have a duty to indemnify the Lams for the \$745,671 in damages and penalties which had been awarded to Mintarsih on the wage and hour count, and did *not* have a duty to indemnify Lams for the \$5,000 in punitive damages which had been awarded to Mintarsih. The parties also

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agreed that State Farm *did* have a duty to indemnify the Lams for the \$161,591 in “other costs” which had been awarded to Mintarsih.

However, the parties disputed whether State Farm had a duty to indemnify the Lams for the \$87,000 in compensatory damages which had been awarded to Mintarsih on the false imprisonment and negligence claims. On that issue, the appellate court ruled in favor of State Farm. The appellate court reasoned that even though the State Farm personal umbrella policy covered the “personal injury” offense of “false imprisonment,” the evidence in the underlying case established that the Lams had intentionally deprived Mintarsih of her freedom, and that constituted a “willful act” under Insurance Code section 533. According to the court, “[s]ection 533 precludes indemnity for the damages awarded for false imprisonment, despite the fact that the umbrella policy expressly promised indemnity for false imprisonment.” Further, section 533 precluded indemnity for the damages which had been awarded as a result of the Lams’ negligence in failing to provide medical care to Mintarsih. According to the appellate court, the Lams’ negligent failure to provide medical care to Mintarsih was “intimately connected with” and “inseparable from” their intentional false imprisonment of her. Thus, section 533 also relieved State Farm of any duty to indemnify the Lams’ for damages awarded on the “negligence” theory.

In addition, the parties disputed whether State Farm had a duty to indemnify the Lams for the \$733,323 in statutory attorney’s fees which had been awarded to Mintarsih on the wage and hour claim. On that issue, the appellate court also ruled in favor of State Farm. The court acknowledged that the State Farm policies’ “supplemental payment” clauses covered “costs taxed against an insured *in suits we defend*,” and that under California law “costs” includes statutory attorney fees awarded to the prevailing party. However, the statutory attorney fees which were awarded as costs in this case arose from the wage and hour claim – a claim that was not even potentially covered under the State Farm policies. According to the court, “the reference in

the supplemental payments provision to ‘suits we defend’ encompasses only those claims that the insurer agreed to defend under the terms of the policy,” and “an insured could not reasonably expect an insurer to pay costs that can be allocated solely to claims that were not even potentially covered.” Thus, since the supplemental payment clauses did not require State Farm to pay costs arising from claims that were not even potentially covered, State Farm was not obligated to pay the statutory attorney’s fees which had been awarded to Mintarsih on the wage and hour claim.

Comment

In an earlier case, *Prichard v. Liberty Mutual Insurance Company* (2000) 84 Cal. App. 4th 890, an Orange County-based appellate panel had concluded that in a mixed action involving both covered and uncovered claims, a standard “supplemental payment” clause *requires* an insurer to pay costs (including statutory attorney’s fees) arising from claims that were *not* potentially covered. However, in the *State Farm v. Mintarsih* case, a different appellate panel, based in Los Angeles County, reached the opposite conclusion. Thus, there is now a “split” in the state appellate courts on this issue. One can expect that, at some point, the California Supreme Court will be asked to review the issue.

Toxic Tort Claims Against Insured Barred by "Seepage / Pollution / Contamination" Exclusion, and Insured Fails to Satisfy Conditions of "Buy Back" Coverage

The California Court of Appeal has held that toxic tort claims against an insured fell within the scope of a general liability policy’s “seepage / pollution / contamination” exclusion, and that the insured failed to satisfy the conditions necessary to trigger coverage under the policy’s “buy back” pollution coverage. (*Venoco Oil Co. v. Gulf Underwriters Ins. Co.* (2009) 175 Cal.App.4th 750)

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Facts

For many years, various oil companies operated an oil and gas production facility near Beverly Hills High School. In 1995, Venoco Oil, Inc. (Venoco) assumed responsibility for operating the facility.

In 1996, Venoco obtained a general liability insurance policy from Gulf Underwriters Insurance Company for the period of April 1, 1996 through April 1, 1997. The Gulf policy contained an exclusion that barred coverage for any claims "directly or indirectly ... arising out of seepage ... pollution and/or contamination..." However, Venoco paid an additional premium in order to "buy back" limited pollution coverage. The "buy back" clause provided the insured with coverage for pollution claims, but only if: (1) the claim stemmed from an accident; (2) the accident began on an identifiable date during the policy period; (3) the insured discovered the accident within seven days after it began; and (4) the insured notified the insurer within 60 days of discovery of the accident.

In 2003 (six years after expiration of the Gulf policy), numerous former students and employees of the High School filed lawsuits against Venoco for personal injuries allegedly caused by long-term exposure to toxic pollution from Venoco's oil and gas operations. Venoco tendered the lawsuits to Gulf for defense. Gulf denied coverage, asserting that the underlying plaintiffs' claims against Venoco were barred by the policy's "seepage / pollution /contamination" exclusion, and that Venoco had not satisfied the conditions necessary to trigger the "buy back" pollution coverage.

Following Gulf's denial of coverage, Venoco sued Gulf for breach of contract and bad faith. The trial court entered summary judgment in favor of Gulf, and Venoco appealed.

Holding

The Court of Appeal affirmed. According to the appellate court, the underlying plaintiffs' claims against Venoco all fell within the scope of the

Gulf policy's "seepage / pollution / contamination" exclusion. The court described the exclusion as "broad and absolute," excluding coverage for "all claims directly or indirectly arising out of seepage and/or pollution and/or contamination."

Further, Venoco had not established the conditions necessary to trigger the "buy back" pollution coverage. Specifically, there was no evidence that the underlying plaintiffs' injuries resulted from an accident occurring on an identifiable date during the Gulf policy period; that Venoco had discovered any such accident within seven days after it began; or that Venoco had notified Gulf of any such accident within 60 days of the accident. The conditions of the "buy back" pollution coverage were "conspicuous, plain and clear," and Venoco's failure to satisfy those conditions precluded Venoco from recovering under that portion of the policy. There was no potential for coverage and, hence, no duty to defend.

Comment

The appellate court spent considerable time discussing the policy condition requiring that the insured notify the insurer of an accident within 60 days of the accident. The insured argued that the insured's failure to comply with the 60-day notice requirement should defeat coverage only if the insurer proved that the late notice caused "actual prejudice" to the insurer. The appellate court disagreed, holding that the 60-day late notice provision was a "condition precedent" to coverage under the policy. Thus, the 60-notice condition was enforceable even without a showing of prejudice.

Insurer Has No Duty to Defend Insured in Assault and Battery Case, Even Though Insured May Negligently Have Believed He Was Acting in "Self-Defense"

The California Supreme Court has held that a homeowners insurer had no duty to defend its insured in an assault and battery case, even though the insured may negligently and

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unreasonably have believed that he was acting in “self-defense.” (*Delgado v. Interinsurance Exchange of the Automobile Club of Southern California* (2009) 47 Cal.4th 302)

Facts

Craig Reid and Jonathan Delgado got into an altercation, during which Reid allegedly hit and kicked Delgado. Delgado later filed a personal injury action against Reid, asserting two causes of action. In the first cause of action for intentional tort, Delgado alleged that Reid “in an unprovoked fashion and without justification physically struck, battered and kicked” Delgado. In the second cause of action for negligence, Delgado alleged that Reid “*negligently and unreasonably believed*” he was engaging in self-defense when he “*negligently and unreasonably physically and violently struck and kicked*” Delgado.

Reid tendered defense of the action to his homeowners insurer, Interinsurance Exchange of the Automobile Club (ACSC), under a policy with liability limits of \$100,000. ACSC denied coverage and refused to defend. ACSC asserted that Reid’s alleged liability (1) did not arise from an “occurrence,” or “accident,” as required by the policy’s insuring clause, and (2) fell within the policy’s exclusion for “intentional acts” committed by an insured.

After ACSC rejected Reid’s tender, Delgado and Reid reached a settlement of the personal injury action. As part of the settlement, Delgado dismissed his intentional tort claim against Reid, and Delgado and Reid stipulated that Reid had *negligently* believed he was acting in self-defense. The trial court then entered a judgment of \$150,000 on Delgado’s negligence claim against Reid. Thereafter, Reid paid Delgado \$25,000 in partial satisfaction of the judgment and assigned to Delgado any rights Reid might have against ACSC for its refusal to defend. In return, Delgado gave Reid a partial satisfaction of judgment and a covenant not to execute on the remainder of the judgment against Reid’s own assets.

Delgado (as assignee) then sued ACSC for declaratory relief, bad faith and enforcement of the underlying judgment. After proceedings in the trial court and the California Court of Appeal, the parties ended up before the California Supreme Court.

Holding

The California Supreme Court held that ACSC did *not* have any duty to defend or indemnify Reid in the underlying action filed by Delgado. As such, Delgado (as Reid’s assignee) could not recover anything in the bad faith action against ACSC.

The Supreme Court reasoned that the ACSC homeowners policy only covered bodily injury caused by an “occurrence,” which the policy defined as an “accident.” According to the Court, in the context of liability insurance, an “accident” is “an unexpected, unforeseen, or undesigned happening or consequence from either a known or an unknown cause.” The Court clarified that the issue of whether there has been an “accident” is determined from the perspective of the *insured*, not from the perspective of the *injured party*. Otherwise, any injury-causing event – including sexual molestation, arson, premeditated murder, etc. – would be deemed an “accident” simply because the victim did not expect or foresee the event.

The Court further held that even if Reid (the insured) had an unreasonable, subjective belief in the need for self-defense, that did not convert his act of hitting and kicking Delgado (the claimant) into an “accident.” According to the Court, “an injury-producing act is not an ‘accident’ ... when all of the acts, the manner in which they were done, and the objective accomplished occurred as intended by the actor.” Because Reid’s acts of hitting and kicking Delgado were done “with the intent to cause injury,” there was no “accident” and hence no potential for coverage.

The Court explained that while some prior appellate cases do contain language suggesting

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that an insured's acts of self-defense might be covered, those cases all dealt with *exclusionary* clauses for "intentional injuries", not *coverage* clauses requiring an "accident." Moreover, it was irrelevant that Delgado may have *provoked* Reid into attacking Delgado, since "[t]he term 'accident' in a policy's coverage clause refers to the injury producing acts of the insured, not those of those of the injured party."

In short, since Delgado's claims against Reid in the underlying action were not potentially covered under the ACSC homeowners policy, ACSC had no duty to defend Reid in the underlying action. Therefore, Delgado (as Reid's assignee) could not recover against ACSC in the bad faith action.

Comment

The *Delgado* case clears up confusion generated by prior California cases involving whether a liability insurer has a duty to defend an insured who is sued for assault and battery. In several of those prior cases, courts had suggested that an insured's unreasonable belief in the need for self-defense could result in a finding of coverage. However, *Delgado* now makes it clear that an insured's unreasonable belief in the need for self-defense does *not* turn the insured's deliberate act of assault and battery into an "accident" within a policy's coverage clause.

The *Delgado* case represents a significant victory for insurers, who have long resisted the notion that a standard liability policy might cover an insured's alleged act of assault and battery. At least under standard policies covering injuries caused by "accident," such conduct should not be covered – even if the insured claims he was acting in "self-defense."

Insurer That Denies Defense to Insured May Not Later Intervene In Third-Party Suit

The California Court of Appeal has held that an insurer that refuses to defend its insured in a

third-party lawsuit cannot later file a complaint in intervention in that litigation, because the insurer, having denied coverage, does not have a direct interest in the outcome of the lawsuit. (*Hinton v. Beck* (2009) 176 Cal.App.4th 1378)

Facts

Jonni Hinton sued Eldon Beck for personal injuries he sustained in a farming accident. Beck tendered his defense to his liability insurer, Grange Insurance Group, which refused to defend or indemnify him.

Hinton and Beck then entered into an agreement whereby Hinton would not execute any judgment against Beck in exchange for an assignment of Beck's rights against Grange. Hinton served a statement of damages in excess of \$6 million on Beck and then filed a request for entry of default. At that point, Grange sought permissive intervention pursuant to Code of Civil Procedure section 387(a). Although the trial court initially allowed Grange's complaint in intervention, it later reconsidered the matter and granted Hinton's motion to strike Grange's complaint. Grange appealed the order.

Holding

The Court of Appeal affirmed, finding that the trial court did not abuse its discretion in striking Grange's complaint in intervention. The Court of Appeal noted that trial courts have discretion to allow intervention under section 387(a) when (1) the intervenor has a direct and immediate interest in the litigation, (2) the intervention will not enlarge the issues in the case, and (3) the reasons for intervention outweigh opposition by the existing parties. Focusing entirely on the first factor, the court concluded that Grange did not have a direct and immediate interest in the litigation because it had already denied coverage and refused to defend Beck.

To support this conclusion, the court compiled various California cases which held that an insurer that disclaims liability on its policy has no interest justifying intervention. When an insurer refuses to defend, the insured is relieved of his

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obligation to allow the insurer to manage the litigation, and the insurer loses its right to control the litigation; the insurer in essence rejects its opportunity to contest the liability of its insured. The insurer cannot later inject itself into the litigation, because it lost its right to control the litigation when it refused to defend or indemnify.

The court rejected Grange's argument that it had a direct and immediate interest in the lawsuit because it might ultimately be required to pay the judgment against Beck pursuant to Insurance Code section 11580. Nearly all of the cases cited by Grange to support this theory involved situations where the insurer had not in fact denied coverage. Also, in the one case in which the insurer *did* deny coverage (*Noya v. A.W. Coulter Trucking* (2006) 143 Cal.App.4th 838), the court stated in *dicta* that the insurer had a direct interest, but the court still denied the insurer's motion to intervene.

The *Hinton* court noted Grange's arguments based on the second and third factors — namely, that intervention would not enlarge the issues in the case and that the reasons for intervention outweigh opposition by the existing parties. However, the court concluded that Grange's lack of a direct interest in the litigation was "dispositive," and thus did not reach the two remaining factors.

Comment

It is unclear what remains of the three-factor test for allowing intervention under section 387(a). Although the *Hinton* court claimed to apply the three-factor test, it totally disregarded the second and third factors. Thus, at least under *Hinton*, the "direct and immediate interest" factor is a threshold inquiry, and courts will not even look to the second or third factors unless a direct interest exists.

***"Contractors Warranty Endorsement"
Limits Insurer's Duty to Indemnify
General Contractor Who Fails to
Obtain Indemnity Agreements and***

Certificates of Insurance from Subcontractors

The California Court of Appeal has held that a general liability policy's "contractors warranty endorsement" relieved the insurer of any duty to indemnify a general contractor who had failed to obtain indemnity agreements and certificates of insurance from its subcontractors. (*North American Capacity Insurance Company v. Claremont Liability Insurance Company* (2009) 177 Cal.App.4th 272)

Facts

A property owner hired JDG Group, Inc. (JDG) to act as general contractor for construction of a large home in Los Angeles. JDG in turn hired numerous subcontractors, some of whom did not provide indemnity agreements in favor of JDG and/or evidence of insurance to JDG.

In 1998 construction began, and in April 2001, the City issued a certificate of occupancy for the home. In May 2001, the owner moved into the home, but as of September 2001, construction of the home was still underway. Because the home was not completed in a timely manner, JDG paid the owner liquidated damages from May 2001 through the end of September 2001. At the end of September 2001, the owner's representative filed a notice of completion.

The owner later sued JDG, alleging that the home suffered from various construction defects causing water intrusion. JDG sought defense and indemnity from both Claremont Liability Insurance Company (Claremont), which provided general liability coverage to JDG from January 2001 to January 2002, and North American Capacity Insurance Company (NAC), which provided general liability coverage to JDG from January 2002 to January 2003. Both Claremont and NAC agreed to defend JDG under a reservation of rights.

The owner eventually settled his claims against JDG for a total of \$1.1 million. Of the \$1.1 million

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settlement amount, NAC contributed \$800,000 and Claremont contributed the remaining \$300,000. NAC then filed an equitable contribution action against Claremont, claiming that Claremont owed a larger share of the settlement.

The trial court found that of the \$1.1 million settlement amount paid on behalf of JDG, \$909,574 was attributable to subcontractors who had failed to provide indemnity agreements in favor of JDG and/or evidence of insurance to JDG. The trial court ruled that this \$909,574 amount was *not* covered under the Claremont policy. That was because the Claremont policy contained a “contractors warranty endorsement” which barred coverage for work done by JDG’s subcontractors *unless* JDG obtained both (1) an indemnity agreement from the subcontractor and (2) a certificate of insurance showing that the subcontractor was insured. The trial court thus ruled that the \$909,574 amount was *not* covered under the Claremont policy, but *was* covered under the NAC policy.

The trial court found that the remaining \$190,426 of the overall settlement amount was covered under both the NAC policy and the Claremont policy, and that per the insurers’ agreement that amount should be allocated based on “time on the risk.” The trial court determined that the “time on risk” should be calculated from the date the construction project was completed (end of September 2001) through expiration of the NAC policy (January 2003). As such, Claremont’s “time on risk” (beginning with project completion in September 2001 and ending with policy expiration in January 2002) was 21%, and NAC’s “time on risk” (beginning with policy inception in January 2002 and ending with policy expiration in January 2003) was 79%. Thus, of the remaining \$190,426 of the settlement amount, Claremont was responsible for 21%, or \$40,028, and NAC was responsible for 79%, or \$150,398.

The net effect of the trial court’s ruling was that NAC (which had contributed \$800,000 to the settlement) was not entitled to recover anything from Claremont (which had contributed \$300,000 to the settlement). NAC appealed.

Holding

The Court of Appeal affirmed.

The appellate court agreed that, with regard to the \$909,574 portion of the settlement which was attributable to subcontractors who had failed to provide indemnity agreements in favor of JDG and/or evidence of insurance to JDG, there was no coverage under the Claremont policy. The Claremont policy’s “contractors warranty endorsement” clearly informed JDG that obtaining indemnity agreements and certificates of insurance from subcontractors was a *condition precedent* to coverage under the Claremont policy. It did not matter that JDG might have hired the subcontractors *before* JDG obtained the policy through Claremont. The Claremont policy simply did not cover any liability JDG might have arising from work done by contractors from whom JDG had failed to secure both an indemnity agreement and a certificate of insurance.

The appellate further agreed that, with regard to the remaining \$190,426 portion of the settlement covered under both policies, the trial court had properly allocated 21% (\$40,028) to Claremont and 79% (\$150,398) to NAC. The insurers had agreed that the trial court could use the “time on the risk” method in allocating damages that were covered under both policies. Further, the insurers apparently agreed that Claremont would not be liable for any property damage occurring prior to “completion” of the home, and the trial court could properly find that the home was “completed” in September 2001 (when the notice of completion was filed) rather than May 2001 (when the owner moved in). Thus, the trial court correctly determined that the \$190,426 portion of settlement which was covered under both policies should be allocated \$40,028 to Claremont and \$150,398 to NAC.

Comment

This case is consistent with an earlier case, *Scottsdale Ins. Co. v. Essex Ins. Co.* (2002) 98 Cal.App.4th 86, in which the appellate court upheld a similar “contractors warranty

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endorsement.” This type of endorsement acts as a condition precedent to coverage, i.e., the general contractor does *not* have coverage for damage caused by a subcontractor *unless* the general contractor has obtained an indemnity agreement and a certificate of insurance from the subcontractor. In essence, this removes the risk of the subcontractor’s defective performance from the general contractor’s insurer, and places that risk on the subcontractor and its insurer.

“First Publication” Exclusion Relieves Insurer of Duty to Defend Insured In Trademark Infringement Action

The California Court of Appeal has held that a general liability policy’s “first publication” exclusion relieved an insurer of any duty to defend an insured in a suit for trademark infringement. (*Kim Seng Company v. Great American Insurance Company of New York* (2009) 179 Cal.App.4th 186)

Facts

Derek and Constance Lee Corporation dba Great River Food (Great River), an Asian food wholesaler, filed a trademark infringement lawsuit against Kim Seng Company (Kim Seng), another Asian food wholesaler. Great River alleged that Kim Seng had infringed on Great River’s “Que Huong” trademark.

Kim Seng had previously registered the trademark “Old Man Que Huong Brand,” stating in its trademark application that it had used that mark since *March 1988*. Kim Seng had also previously registered the trademark “Que Huong,” stating in its application that it had used that mark since *January 1993*.

Kim Seng tendered defense of the trademark lawsuit to Great American Insurance Company of New York (Great American) under a commercial general liability policy which had become effective on *October 6, 1997*. The Great American policy covered various “advertising injury” offenses, including “misappropriation of

advertising ideas or style of doing business.” However, the policy also excluded coverage for advertising injury “arising out of oral or written publication of material whose first publication took place before the beginning of the policy period.” Based on the “first publication” exclusion, Great American refused to defend Kim Seng in the trademark infringement lawsuit brought by Great River.

Thereafter, Kim Seng filed a declaratory relief action against Great American, seeking a ruling that Great American was obligated to defend Kim Seng in the underlying trademark infringement lawsuit. The trial court ruled in favor of Great American, finding that the Great American policy’s first publication exclusion clearly excluded coverage. Kim Seng appealed.

Holding

The Court of Appeal affirmed the judgment in favor of Great American.

Kim Seng argued that the first publication exclusion only applies to advertising injury offenses involving defamation and invasion of privacy, and not to advertising injury offenses involving infringement. The appellate court disagreed, holding that the first publication exclusion applies to *all* advertising injury offenses – including advertising injury offenses involving infringement.

Kim Seng also argued that it had begun using new “Que Huong” marks with additional words or logos during the Great American policy period. Kim Seng argued that the “Que Huong” marks adopted during the policy period were different from the “Que Huong” marks used before the policy period, and that the first publication exclusion therefore did not relieve Great American of the duty to defend. The appellate court disagreed, finding that all of the underlying trademark infringement claims against Kim Seng’s were based on Kim Seng’s use of the words “Que Huong.” Kim Seng’s use of the term “Que Huong” during the policy period was substantially similar – and indeed identical – to

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its use of the term “Que Huong” before the policy period. Thus, the first publication exclusion relieved Great American of any duty to defend Kim Seng in the underlying trademark infringement lawsuit.

Comment

The *Kim Seng* case is consistent with the Ninth Circuit Court of Appeals’ recent decision in *United National Insurance Co. v. Spectrum Worldwide, Inc.* (9th Cir. 2009) 555 F.3d 772. In both cases the courts held that under California law a “first publication” exclusion can relieve a general liability insurer of any duty to defend an insured against claims of trademark infringement where the alleged infringement began prior to the policy period.

BAD FAITH

Delays in Handling Fire Claim Support Award for Emotional Distress, Attorney’s Fees and Punitive Damages

The California Court of Appeal has held that evidence of delays in handling a fire claim was sufficient to support a substantial award for emotional distress, attorney’s fees and punitive damages. (*Major v. Western Home Ins. Co.* (2009) 169 Cal.App.4th 1197)

Facts

Patrick and Elsa Major owned a residence and personal property, which they insured through Western Home Insurance Company. After a wildfire destroyed their property, the Majors submitted a claim to Western Home.

At the time of the fire, the policy provided stated limits of \$193,000 for the dwelling, \$19,300 for other structures, \$135,100 for personal property and \$38,600 for living expenses. However, the policy also included extended replacement cost coverage up to 25 percent over the stated policy

limits, meaning the policy, as written, actually provided coverage up to \$241,250 for the dwelling, up to \$24,125 for other structures, up to \$168,875 for personal property, and up to \$48,250 for additional living expense.

As a condition to recovering extended replacement cost coverage, Western Home required that, at the inception of the policy, the dwelling coverage limits be equal to the cost to replace the house. To ensure the limits were adequate, the policy required an inspection of the dwelling and a report specifying the dwelling’s replacement cost. However, Western Home did not send an inspector until after the policy was issued and the coverage limits set. The inspection report identified the replacement cost as \$235,578 (i.e., substantially more than the stated \$193,000 dwelling coverage limit). Based on this valuation, the extended replacement cost coverage for coverage A *should* have been \$305,216 for the dwelling, \$30,522 for other structures, \$213,651 for personal property, and \$61,043 for additional living expense.

Western Home used an independent adjusting to firm to handle the Majors’ fire claim. The evidence established that Western Home had retained the independent adjusting firm to handle a significant aspect of Western Home’s business. The evidence also established there was no day-to-day oversight of the adjusting firm’s claims supervisor and that the supervisor exercised substantial discretionary authority to pay or not pay claims. In addition, the supervisor managed 35 employees in an office that handled claims across the country.

The independent adjusting firm assigned the claim to an adjuster, and later re-assigned the claim to a second adjuster. At the time of the re-assignment, the second adjuster had not received the training required by California’s Fair Claims Settlement Practices Regulations, and was handling over 200 other claims (which his own manager admitted was “way too many”). Several months after the file was re-assigned to the second adjuster, he told the Majors he had not reviewed their file and told them their claim

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was "third in his stack." He also told the Majors on at least three occasions their claim was not his top priority. The adjuster also failed for months to review the Majors' 77-page personal property claim, which at that time was the most significant unpaid portion of their claim. Eventually, the independent adjusting firm's supervisor assumed direct handling of the file.

About one year after the fire, the Majors became "exhausted" by their own efforts to resolve the claim and, therefore, they retained an attorney. After the Majors retained counsel, Western Home's vice president of claims reviewed the underwriting inspection report for the Majors' dwelling and noted that it showed a replacement cost (\$235,578) for the Majors' house that was significantly higher than the \$193,000 stated limit for the dwelling. He thereafter authorized what Western Home characterized as a "courtesy" increase in the policy limits to correspond to the replacement cost set forth in the inspection report. With this adjustment, the extended replacement cost amount for personal property increased from \$168,875 to \$213,651.

Later, the Majors submitted receipts apparently totaling \$31,359.55 for personal property they had replaced. Because the extended replacement cost limit had been increased to \$213,651, there were sufficient policy limits remaining to pay the supplemental personal property claim of \$31,359.55. However, the independent adjusting firm's supervisor did not authorize payment of this supplemental amount, claiming that the receipts had been transmitted via facsimile and were illegible, and also asserting that the receipts were not marked so that they could be cross-referenced to the original personal property inventory.

The Majors ultimately sued Western Home. At trial the supervisor admitted that the personal property replacement receipts that allegedly had been faxed and allegedly were illegible actually had been mailed and were legible. The supervisor also admitted that the policy did not specifically require that the replacement receipts be marked so that they could be cross-

referenced to the original personal property inventory.

The jury awarded the Majors \$1,316,831.08 (\$31,359.55 for the personal property the Majors had replaced, \$450,000.00 for emotional distress, \$189,000.00 for *Brandt* attorney fees, and \$646,471.53 for punitive damages).

On appeal, Western Home contended that the \$31,359.55 the jury awarded for personal property was improper. More specifically, Western Home contended that, prior to the trial, Western Home already had paid \$168,875 for personal property (the original extended replacement cost limit for personal property). Western Home argued that its "courtesy" decision to adjust the extended replacement cost personal property policy limits from \$168,875 to \$213,651 was not a binding modification of the policy because it was not supported by consideration. As such, Western Home argued, it was not obligated to pay the \$31,359.55 for the personal property replacement cost claim.

Holding

The Court of Appeal rejected Western Home's argument that the adjustment of the policy limits was a "courtesy" decision instead of a legally binding modification of the policy. The Court noted that the extended replacement cost coverage was available to the Majors only if they allowed Western Home to adjust the Coverage A limit of liability and premium in accordance with property valuations that Western Home itself established. Thus, the Court concluded that the trial court and jury reasonably could have concluded the policy had been modified by Western Home to comply with the original terms of the policy, and thus no new consideration was necessary to support the modification.

The Court of Appeal also found that the evidence was sufficient to support the \$450,000.00 award for emotional distress, the \$189,000.00 award in *Brandt* attorney fees and the \$646,471.53 in punitive damages. In particular, the Court of Appeal ruled the evidence was sufficient to

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support a finding that the independent adjusting firm's supervisor was a "managing agent" such that Western Home was liable for punitive damages stemming from the supervisor's action in handling the claim.

Comment

Because the Majors were the prevailing parties in the trial court, the Court of Appeal disregarded the evidence favorable to Western Home and instead focused on the evidence favorable to the Majors. Based on the evidence, the jury apparently found that the independent adjusting firm was simply too overwhelmed with other claims to properly handle the Majors' claim. The Court of Appeal also found that the independent adjuster's supervisor qualified as a "managing agent" and that Western Home therefore was liable for punitive damages based on the supervisor's conduct.

Bad Faith and Punitive Damages Award Upheld Where Insurer Conducted Biased Investigation, Judge Excluded Evidence of Insured's Prior Violent and Dishonest Acts, and Judge Excluded Recorded Statements as Hearsay

The California Court of Appeal has held that a bad faith and punitive damages award was proper where an insurer conducted a biased investigation of a car theft claim, where the trial judge excluded evidence of the insured's prior dishonest and violent acts, and where the judge excluded tape-recorded statements as hearsay. (*McCoy v. Progressive West Insurance Company* (2009) 171 Cal.App.4th 785)

Facts

Cedric McCoy submitted a claim to Progressive West Insurance Company for theft of and damage to McCoy's vehicle. After conducting an extensive investigation, Progressive denied the

claim on the grounds that McCoy had staged the theft and had intentionally damaged the car. McCoy sued Progressive and, after a jury trial, McCoy obtained an award for breach of contract and bad faith, as well as punitive damages.

McCoy claimed his car had been stolen from the parking lot of a Las Vegas casino. Authorities ultimately recovered the car, which had been set on fire and was a total loss. Progressive thought the claim was suspicious for many reasons. For example, videotape of the casino's parking lot did not show any evidence that McCoy's car had been in the parking lot prior to the alleged theft. In addition, there was no evidence that anyone had tampered with the ignition, suggesting that the last person who had driven the car had used a key. Further, McCoy and a female friend had driven from California to Las Vegas in separate cars, which Progressive believed suggested that McCoy had never expected to drive his car back to California.

When Progressive's investigator interviewed McCoy's ex-wife and McCoy's brother, both stated that McCoy had been suggesting for some time that he wanted to dispose of the car and buy a nicer one. McCoy himself denied that he had ever made these statements, and his ex-wife ultimately recanted her statement. A Progressive claim supervisor ultimately wrote a claim log note which stated: "We can't just rely on having two witnesses like this And if we don't come up with something else, we are going to have to pay the claim."

Although there certainly was some evidence suggesting the claim was fraudulent, there also was evidence suggesting the claim was not fraudulent. For example, the value of the car prior to the alleged theft was less than the amount that McCoy owed to the lender, which indicated that McCoy would not obtain a financial benefit from the destruction of the car. In addition, McCoy was steadily employed, and was current on all payments including the car payments. Further, Progressive could not rule out the possibility that the car had been stolen by means of a tow truck or duplicate key.

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Although the evidence on the issue of fraud was conflicting, Progressive ultimately denied the claim. During trial, the judge refused Progressive's request to admit the entire claim file (including the recorded statements of McCoy's ex-wife and brother) into evidence at once, and instead ruled that Progressive needed to introduce evidence contained within the claim file on a "piece by piece" basis.

During the trial, Progressive sought to introduce evidence that McCoy had physically abused his ex-wife (which Progressive believed explained why McCoy's ex-wife had recanted her statement that McCoy said he wanted to dispose of his car and buy a new one). Progressive also sought to introduce evidence that McCoy had submitted a prior claim against Zurich which, even though Zurich had paid, was actually fraudulent. The trial judge refused to allow Progressive to introduce evidence of the physical abuse and the prior claim against Zurich, ruling that this evidence was more prejudicial than probative, and was likely to confuse and mislead the jury.

McCoy's evidence established that Progressive had conducted a one-sided investigation that was designed to uncover evidence that the claim was fraudulent. McCoy's evidence also established that Progressive had violated various provisions of the Fair Claims Settlement Practices Regulations. The jury found that Progressive had breached the policy, and had acted in bad faith. The jury also assessed punitive damages of \$100,000 against Progressive.

Holding

The Court of Appeal upheld the jury's finding that Progressive had breached the policy and had acted in bad faith. The Court also upheld the jury's award of punitive damages.

The Court of Appeal held that the trial judge properly refused to admit the entire claim file into evidence as one exhibit, and that Progressive was required to establish a foundation for

individual pieces of evidence in the claim file (such as witness statements) on a "piece by piece" basis. The Court of Appeal also noted that the recorded statements were hearsay, and that Progressive's alleged "reliance of its investigative or claim agents on these recorded statements in resolving the coverage issue does not satisfy the requisite foundation showing."

Comment

In this case, Progressive certainly had some evidence that McCoy's claim was fraudulent. However, there also was contrary evidence, which Progressive ultimately disregarded. This supported a finding that Progressive's investigation was one-sided and biased.

It is important to remember that trial judges have wide discretion to admit or refuse certain types of evidence. An appellate court will not overturn a trial judge's discretionary ruling unless the appellate court concludes that the trial court abused its discretion and acted in an "arbitrary, capricious or patently absurd manner that resulted in a manifest miscarriage of justice." Here, the trial judge exercised his discretion to exclude evidence that would have cast McCoy as a dishonest and violent man. If the court had exercised its discretion to admit some or all of this evidence, the jury's verdict might well have been different.

This case also highlights the fact that recorded statements are hearsay, and that the party offering the statement into evidence at trial must establish that the statement falls within one of the recognized exceptions to the rule against hearsay evidence. Here, Progressive probably could have avoided this problem if, after McCoy had filed suit, Progressive had obtained pre-trial deposition testimony from the witnesses who previously had given the recorded statements.

UNINSURED / UNDERINSURED MOTORIST INSURANCE

Uninsured Motorist Coverage Does

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Not Apply to Listed "Driver" Who is Injured as Pedestrian

The California Court of Appeal has held that uninsured motorist coverage did not apply to a listed "driver" who, while crossing the street as a pedestrian, was struck by an uninsured motorist. (*Mercury Ins. Co. v. Pearson* (2008) 169 Cal.App.4th 1064)

Facts

Susan Hyung and her live-in fiancé, Douglass Pearson, were pedestrians in a crosswalk when they were struck by a speeding car driven by an uninsured motorist. Hyung died from her injuries and Pearson was seriously injured.

Prior to the accident, Mercury Casualty Company had issued an automobile insurance policy which listed Hyung as the "named insured," and which listed both Hyung and Pearson as "drivers." The policy's uninsured motorist section provided coverage to (1) named insureds, their spouses and resident relatives while occupying a motor vehicle or otherwise, and (2) *any other person "while in or upon or entering into or alighting from an insured motor vehicle."* The policy also contained a "Designated Persons Endorsement" which was signed by both Hyung and Pearson, and which stated among other things that the UM coverage did *not* apply to bodily injury "sustained by a resident of the same household as the Named Insured, who is not a relative, unless such person(s) is occupying a motor vehicle listed in the policy declarations."

Hyung's heirs made a claim under the UM coverage of the policy. In response, Mercury paid Hyung's heirs the UM coverage's per-person limit of \$100,000. Pearson also made a claim under the UM coverage of the policy. However, Mercury denied Pearson's UM claim on the grounds that Pearson did not qualify as (1) a named insured, spouse or resident relative, or (2) any other person "while in or upon or entering into or alighting from an insured motor vehicle."

Mercury sued Pearson for declaratory relief, and Pearson cross-complained against Mercury for declaratory relief, breach of contract and bad faith. The trial court ruled in favor of Mercury and Pearson appealed.

Holding

The Court of Appeal affirmed. Although the Mercury policy's UM section covered a named insured, spouse or resident relative either while occupying a motor vehicle or as a pedestrian, Pearson was not a named insured, spouse or resident relative. Further, although Mercury's UM section covered any other person "while in or upon or entering into or alighting from an insured motor vehicle," Pearson was injured not while occupying an insured motor vehicle, but rather, while crossing the street on foot. Accordingly, the Mercury policy did not provide UM coverage for Pearson.

Comment

In California, UM coverage is governed by Insurance Code section 11580.2. The statute requires insurers to provide UM coverage for bodily injury to named insureds, spouses and resident relatives, whether or not they are occupying a motor vehicle at the time of the accident. However, the statute only requires insurers to provide UM coverage for other persons "while in or upon or entering into or alighting from an insured motor vehicle." In this case, the language of Mercury's UM coverage mirrored the language set forth in the statute, and thus there was no basis for arguing that the policy language was ambiguous.

AGENTS & BROKERS

Agent/Broker Who Claims to Have Special Knowledge of Insured's Business Assumes Special Duty to Obtain Proper Coverage

The California Court of Appeal has held that where an insurance agent or broker claims to have special knowledge of an insured's business

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risks and exposures, the agent/broker assumes a special duty to obtain proper coverage, and can be liable to the insured for breach of that duty. (*Williams v. Hilb, Rogal & Hobbs Insurance Services of California, Inc.* (2009) 98 Cal.Rptr.3d 910)

Facts

Rhino Linings USA, Inc. (Rhino USA) is a national franchisor. John Daniel Williams and Steven Stuart Simon formed a partnership and purchased from Rhino USA a franchised dealership known as Rhino Linings of Santa Fe Springs (Rhino SFS). The franchise was engaged in the business of installing spray-on linings onto the beds of pickup trucks. Williams provided most of the financing and Simon was responsible for sales and managing the business, including obtaining insurance.

Even though Williams was not the partner responsible for obtaining insurance, Rhino USA (the national franchisor) referred Williams to Robyn Thaw, who was then employed by the Robert F. Driver Company, an insurance agency/brokerage. At the time, Thaw had already procured coverage for between 50 and 100 other Rhino franchisees. Thaw represented that she knew the operations of Rhino Linings dealerships very well, that she had a custom-made insurance package specifically designed for Rhino Linings dealerships, and that she “was the go-to person to take care of the insurance needs for Rhino Linings dealerships.”

Williams called Thaw and asked to meet with her to review insurance needs for Rhino SFS, but Thaw told Williams a meeting would not be necessary, because she was already very familiar with Rhino Linings dealerships and programs. Williams did not request any specific type of insurance, and instead simply asked Thaw to obtain whatever insurance was needed to operate the business.

Thaw sent Williams a blank application form by fax, which indicated that the program was “designed specifically for Rhino Liners dealers.” Williams filled in basic information,

leaving blank all portions relating to insurance coverages. He signed the application, and returned it to Thaw, who selected the insurance coverages. Thaw submitted the application to Travelers Insurance Company.

Thaw attended informational seminars for new dealers given by Rhino USA, and spoke at the seminars about the insurance needs of Rhino Linings dealerships. The package of insurance coverages Thaw participated in designing for Rhino Linings dealerships was not available through all Travelers’ agents; brochures with Thaw’s name on them were distributed at the Rhino USA seminars at which she spoke. Thaw represented and marketed the insurance package as having been specifically designed for Rhino Linings dealers.

After Thaw submitted Williams’ application to Travelers, she sent Williams an insurance proposal for Rhino SFS, which Williams accepted “as is.” The proposal included commercial general liability coverage, and Williams “scanned it briefly” and thought it was “complete and in order.” Although Williams believed he had “all the appropriate insurance coverages” needed to operate the business, the policy did not include workers compensation coverage.

By the time the Travelers policy expired, Thaw had changed her employment and had begun working for Hilb, Rogal & Hobbs Insurance Services of California, Inc. (HRH). Thaw continued to act as insurance agent for Rhino SFS after she began working for HRH. By this point, Travelers was no longer offering the Rhino Linings insurance package, so Thaw, while employed by HRH, created a new insurance package, underwritten by Hartford Casualty Insurance Company. Again, the package she created for Rhino SFS from Hartford did not contain workers compensation insurance.

A fire at the Rhino SFS premises caused severe burn injuries to Kendall Mann, one of Rhino SFS’ employees. When Williams called Thaw to report the fire, he learned for the first time that Rhino

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SFS did not have the necessary workers compensation coverage.

Mann brought a civil action against Rhino USA, Rhino SFS, Williams and Simon. Hartford provided Williams and Simon with a defense through Hartford-appointed defense counsel. The jury rendered a verdict against Rhino USA and Rhino SFS (the latter including Williams and Simon, jointly and severally) for approximately \$11.3 million, finding Rhino USA and Rhino SFS each 50 percent at fault. Hartford paid \$1 million in partial satisfaction of Mann's judgment against Williams and Simon, leaving approximately \$5.8 million outstanding on the judgment.

Williams and Simon filed a negligence action against HRH, seeking compensatory damages in the amount outstanding on the Mann judgment. A trial judge, sitting without a jury, rendered a verdict in favor of Williams and Simon against HRH for the full amount of the \$5.8 judgment. HRH appealed, arguing that the evidence was not sufficient to support the judgment and arguing that the suit was time-barred by a two-year statute of limitations.

Holding

First, the Court of Appeal held that the evidence was more than ample to support the court's finding that Thaw, when employed by HRH, failed to use the skill and care a reasonably careful insurance professional would have used in similar circumstances. Among other things, the Court relied on the fact that Thaw specifically held herself out as understanding the specific insurance needs of Rhino Linings franchisees, and that Thaw (and, therefore, HRH) therefore assumed a duty of care that was greater than might ordinarily have been owed.

Second, the Court held that the action was not barred by the applicable two-year statute of limitations (Code Civil Procedure Section 339, subd. 1.) The Court held that the statute did not begin to run on the date the employee was injured in the fire, but instead began to run when the jury rendered a verdict in excess of the \$1

million Hartford policy. As such, the suit against Thaw and HRH was timely.

Comment

An insurance producer (whether an agent or a broker) does not have a duty to volunteer to an insured that the latter should procure additional or different insurance coverage. Thus, ordinarily producer only has a duty to use reasonable care, diligence, and judgment in procuring the insurance requested by an insured. The rule changes, however, when any one of the following three things occurs: (a) the producer misrepresents the nature, extent or scope of the coverage being offered or provided; (b) the insured requests (or at least inquires) about a particular type or the extent of coverage; or (c) the producer assumes an additional duty by either express agreement or by representing that he or she has expertise in a given field of insurance being sought by the insured.

STATUTES

New California Law Further Defines "Agents" and "Brokers"

Generally, an insurance "agent" is a person who transacts insurance *on behalf of* an admitted insurer. In contrast, an insurance "broker" is a person who transacts insurance *with, but not on behalf of*, an admitted insurer. (Insurance Code Section 1621.) The distinction is important, because an insurer generally is not responsible for errors and omissions of a broker, but can be responsible for errors and omissions of an agent.

Pursuant to legislation effective January 1, 2009, there is now a rebuttable presumption that a licensee is a broker if the licensee (1) is licensed as a broker, (2) maintains a bond in a specified amount, and (3) discloses, in a written agreement signed by the consumer, all of the following:

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(a) That the licensee is transacting insurance on behalf of the consumer;

(b) The general nature of the services the licensee will perform as a broker;

(c) The fees being charged by the licensee;

(d) Whether the insurer will compensate the licensee in connection with the transaction.

The presumption that a licensee is a broker is rebutted in case of *any* of the following: (1) the insurer has filed with the California Department of Insurance a notice appointing the licensee as an agent; (2) the insurer and the licensee have entered into a written agreement that authorizes the licensee to bind coverage; (3) the insurer and the licensee have entered into a written agreement that authorizes the licensee to appoint other licensees as agents; or (4) the insurer and the licensee have entered into a written agreement that authorizes the licensee to pay claims on behalf of the insurer.

In all other cases, the presumption that a licensee is a broker is rebutted if the "totality of the circumstances" indicates that the licensee is acting on behalf of the insurer. (Insurance Code Section 1623.) However, a broker who merely collects and transmits premiums and delivers policies is not deemed to be the insurer's agent. (Insurance Code Section 1732.)