

2010 ANNUAL REVIEW OF CALIFORNIA INSURANCE LAW



SMITH SMITH & FEELEY LLP *INSURANCE LAWYERS*

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2010 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 2009 through November 2010 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:

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?

Century National Ins. v. Garcia (case S179252) - May an insurer enforce an exclusion clause in a fire insurance policy that denies coverage to innocent insureds for damages from a fire intentionally caused by a coinsured, or does such a clause impermissibly reduce coverage that is statutorily mandated?

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PROPERTY INSURANCE

Party Who Bought Fire-Damaged Property at Sheriff's Sale Was Not Entitled to Insurance Proceeds, and Insurer Was Entitled to Refund from Lender to Extent Lender Received Payoff from Sheriff's Sale

A third party who bought a fire-damaged property at a sheriff's sale was not entitled to insurance proceeds issued for the property, and an insurer was entitled to a refund from the lender to the extent the loan was satisfied with proceeds from the sheriff's sale. (*Washington Mut. Bank v. Jacoby* (2010) 180 Cal.App.4th 639)

Facts

Rubin Pittman owned a residence that was encumbered by a first deed of trust held by Washington Mutual. State Farm issued a homeowner's insurance policy that included a standard lender's loss payable endorsement.

A third party obtained a judgment against Pittman, and the sheriff recorded a writ of execution against the property as part of the third party's collection efforts.

Ultimately, a fire damaged the property, and Pittman submitted a claim against his homeowner's insurance policy. State Farm suspected Pittman was involved in setting the fire, and State Farm eventually denied Pittman's claim because he failed to comply with various policy conditions. Pittman later died. Neither Pittman nor his successors in interest challenged State Farm's denial of coverage. However, the lender's loss payable endorsement in favor of Washington Mutual remained in effect.

Later, Scott Jacoby bought the property at a sheriff's sale for \$480,100.00. On the date of the purchase, \$113,854.61 remained owing on the note and trust deed Washington Mutual held. After the sale, the sheriff issued payment of \$113,854.61 to Washington Mutual. Thereafter, Washington

Mutual informed State Farm that the amount required to pay off the note was actually \$118,169.98. In response, State Farm sent Washington Mutual a check for \$118,169.98 in accordance with the lender's loss payable endorsement.

The combined amount Washington Mutual received (i.e., the proceeds from the sheriff's sale and the payment from State Farm) exceeded the amount owing on the note. Washington Mutual applied all of the sheriff's sale proceeds to the loan, and further applied \$4,942.27 from the State Farm proceeds to complete the loan payoff.

Washington Mutual filed a complaint in interpleader against State Farm, Pittman's successors and Jacoby to resolve a dispute over the remaining funds, which totaled \$113,227.51. Pittman's successors did not respond to the interpleader complaint, and the court entered a default against Pittman's successors.

Jacoby and State Farm subsequently filed cross-motions for summary judgment, each claiming an entitlement to the excess funds. The trial court granted State Farm's motion and Jacoby appealed.

Holding

The Court of Appeal affirmed the ruling in favor of State Farm. The Court ruled that Jacoby's status as current owner of the property did not make him a party to the insurance contract that State Farm had issued to Pittman, and that Jacoby had no entitlement to the insurance proceeds. The Court relied on California Insurance Code section 305, which states in part that "[t]he mere transfer of subject matter insured does not transfer the insurance" In short, the Court reiterated the well-established rule that an insurance policy does not "run with the land."

The Court also held that State Farm's obligation under the lender's loss payable endorsement was to pay only the extent of Washington Mutual's interest, which was the amount outstanding on the promissory note. Once the debt was discharged,

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Washington Mutual had no further claim on any insurance proceeds.

Comment

The main concept utilized in this case frequently has been applied in connection with foreclosure sales and a lender's "full credit bid." When a trustee or mortgagee forecloses on an encumbered property and makes a successful full credit bid—a bid that is equal to the unpaid principal and interest of the mortgage debt, along with all costs and foreclosure expenses—the debt is extinguished and the trustee/mortgagee is not entitled to insurance proceeds payable for pre-purchase damage to the property.

Appraiser's Service as Expert in Unrelated Case is Not Basis for Disqualification from Appraisal Panel

Where a policyholder's appraiser was serving as an expert for the policyholder's attorney in an unrelated case, there was no "impression of possible bias" and no basis to disqualify the appraiser from the appraisal panel. (*Mahnke v. Superior Court* (2009) 180 Cal.App.4th 565)

Facts

After Peter and Patricia Mahnke's residence was severely damaged by a wildfire, they made a claim to their insurer, California Fair Plan Association (CFPA). The Mahnkes did not agree with CFPA's assessment of their damages, and therefore elected to proceed under the appraisal provision of their policy.

CFPA designated Bruce Reid as its appraiser, and the Mahnkes designated Robert McConihay as their appraiser. Each appraiser made a written disclosure in an effort to demonstrate that he was not only "competent" but also "disinterested." Reid disclosed that he was serving, in a separate appraisal proceeding, as CFPA's party-appointed appraiser. McConihay disclosed that he was serving, in an unrelated case, as a construction

expert for the law firm that was representing the Mahnkes.

McConihay's resume, which was attached to his written disclosure, listed the law firm representing the Mahnkes as one of 14 law firm references. His resume further listed 30 other cases – none of which involved the Mahnkes' counsel – in which he had participated as a lead expert or consultant.

CFPA demanded the Mahnkes withdraw McConihay as their appraiser based on McConihay's concurrent association with another party represented by the Mahnkes' counsel. When the Mahnkes refused, CFPA filed a petition in the superior court in an effort to disqualify McConihay from acting as the Mahnkes' designated appraiser. The superior court granted the petition, largely on the grounds McConihay's professional relationship with another client of the law firm representing the Mahnkes created "an impression of possible bias" that warranted his disqualification. The Mahnkes then sought relief from the Court of Appeal.

Holding

In California, appraisals must be conducted pursuant to the provisions of the California Arbitration Act, which is set forth in Code of Civil Procedure section 1280 et seq. (the "Arbitration Act"). Section 1281.9 of the Arbitration Act requires a proposed *neutral* arbitrator – such as the umpire in an appraisal proceeding – to disclose in writing to opposing parties the existence of any potential grounds for disqualification. If a party objects to the proposed umpire, section 1281.91 requires the objecting party to serve a notice of disqualification within 15 days of receipt of the proposed umpire's disclosure statement.

The statutory disclosure requirements set forth in the Arbitration Act apply only to the *neutral* arbitrator, and do not apply to party-appointed arbitrators. Although the Arbitration Act, as written, does not require a party-appointed arbitrator to make any disclosure, Insurance Code section 2071 nonetheless contains a statutory requirement that party-appointed appraisers be not only "competent" but "disinterested." This requirement, incorporated

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into every fire insurance policy issued in California, in effect constitutes a contractual agreement between the parties to select unbiased appraisers.

Although a party-appointed appraiser does not have a statutory obligation to make a disclosure, a party-appointed appraiser nonetheless has a judicially-created obligation to disclose any facts that might cause a reasonable person to have an “impression of possible bias.”

Based on the fact that McConihay was only serving as an expert for the Mahnkes' attorney on one unrelated case, the Court found that a reasonable person would *not* have on “impression of possible bias” by McConihay. Thus, the Court of Appeal directed the trial court to reinstate McConihay as the Mahnkes' party-appointed appraiser.

Comment

Most property insurance policies provide that, when the insurer and its insured fail to agree on the amount of a loss, either party can demand appraisal. Under California law, appraisal is a limited form of arbitration in which the appraisal panel determines only the “amount of loss.” In the event one party demands appraisal, Insurance Code 2071 requires each party to select a “competent and disinterested appraiser.” The two party-appointed appraisers, in turn, are required to agree on a “competent and disinterested umpire” (or request appointment of one by the court) to form a three-member panel to determine the amount of loss.

Although the Insurance Code requires that appraisal proceedings be “informal,” the proceedings must also conform to the procedural requirements of the Arbitration Act. Therefore, it is imperative that the members of the appraisal panel (the two party-appointed appraisers and the neutral umpire) understand and adhere to the procedural requirements of the Arbitration Act. Otherwise, the parties risk having a court set aside the award.

Failure to Answer Questions at EUO and to Submit Complete Proof of Loss Defeats Insured's Suit

An insured's failure to answer questions at an examination under oath (even on advice of counsel), combined with failure to submit a complete and supported proof of loss form, defeated the insured's suit for breach of contract and bad faith. (*Abdelhamid v. Fire Ins. Exchange* (2010) 182 Cal.App.4th 990)

Facts

Zary Abdelhamid purchased a house. Thereafter, she purchased a homeowner's insurance policy from Fire Insurance Exchange (FIE). A fire damaged Abdelhamid's house, and a subsequent investigation revealed the fire was intentionally set. In addition, investigation revealed a number of circumstances that suggested Abdelhamid herself might have been responsible for starting the fire.

In particular, FIE uncovered information that Abdelhamid: (1) believed the seller had defrauded Abdelhamid into paying too much for the residence; (2) had been forced to carry three mortgages, amounting to sizeable monthly payments, for the five or six months prior to the fire; (3) had paid a large sum of money upfront to contractors for a remodel job that the building department ultimately halted because of failure to obtain permits; and (4) had been unable to get the contractors to complete the remodel or return her money.

FIE also learned Abdelhamid had filed bankruptcy a few years before the fire. At the time she filed the bankruptcy, she had sizeable debt and minimal income. In addition, Abdelhamid's sole source of claimed income at the time of the fire was a restaurant she recently had opened.

FIE requested Abdelhamid to submit a completed proof of loss form, produce various categories of documentation and appear for an examination under oath (EUO). Abdelhamid, working with a public adjuster, submitted a proof of loss to FIE.

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The proof of loss claimed a building loss in the amount of \$459,000 and listed losses for contents, separate structures and additional living expenses in amounts “to be determined.” The proof of loss failed to state where Abdelhamid was residing at the time of the claimed loss, and the proof of loss did not include much of the necessary supporting documentation.

Abdelhamid appeared at her EUO with her public adjuster, but not an attorney. During her EUO, Abdelhamid repeatedly refused to answer any questions about her business or personal finances. She asserted her refusals to answer were based on legal advice that the questions were not reasonably related to her claims. FIE’s counsel specifically cautioned Abdelhamid that her refusals to answer could constitute a basis for FIE to deny the claim.

Ultimately, FIE denied Abdelhamid’s claim because of her: (1) failure to produce requested documentation; (2) failure to answer material questions when examined under oath; (3) failure to submit a completed proof of loss with necessary documentation; and (4) general failure to cooperate in the processing of her claim. Although FIE denied the claim, FIE offered to consider any additional information or documentation Abdelhamid might submit in the future.

After FIE denied the claim, Abdelhamid submitted a proof of loss form and some (but not all) of the documents FIE previously had requested. Upon receipt of this new information, FIE sought to conduct a second EUO, but Abdelhamid did not respond to this request and, instead, filed suit for breach of contract and bad faith.

The trial court granted summary judgment in favor of FIE on the grounds that Abdelhamid had not complied with the conditions of the policy. Abdelhamid appealed.

Holding

The Court of Appeal affirmed the summary judgment, holding that Abdelhamid’s purported reliance on advice of counsel in refusing to answer

FIE’s questions and failing to supply requested documentation did not excuse her failure to comply with the policy conditions. In addition, the Court held that the proof of loss forms that Abdelhamid submitted were incomplete and lacked all necessary supporting documentation.

The Court concluded that FIE was substantially prejudiced by Abdelhamid’s failure to produce documentation, failure to answer material questions at the examination under oath, failure to submit a complete proof of loss with supporting documentation, and general refusal to cooperate. These material breaches of the policy conditions precluded coverage for Abdelhamid’s contract claim which, in turn, defeated her bad faith claim.

Comment

This case is another in a growing body of cases in which California appellate courts have firmly held that a first-party insurer can deny coverage to an insured that does not reasonably cooperate in the investigation of the claim. The Court provided a detailed explanation of the circumstantial evidence that suggested the insured was responsible for the arson. Based on this circumstantial evidence, the Court concluded that the insurer was entitled to conduct a detailed investigation into the insured’s background, including her finances.

An insurer that intends to require the insured to submit a proof of loss form should bear in mind several points. First, the Fair Claims Settlement Practices Regulations require that an insurer provide necessary claim forms within fifteen days after receiving notice of the claim. Second, Insurance Code section 554 provides that, if an insured fails to submit a proof loss within the time required, the insurer must object “promptly and specifically” or will waive the defense.

Even If Insured Business Was Operating at Net Loss Greater than Operating Costs at Time of Loss, Business Interruption Benefits for Continuing Normal Operating

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Expenses Are Not Reduced by Net Loss

Interpreting a policy that provided business interruption coverage for net income “and” continuing normal operating expenses, the California Court of Appeal has held that even if the insured was operating at a net loss, the insured is still entitled to its operating expenses, which are not offset by the net loss. (*Amerigraphics, Inc. v. Mercury Cas. Co.* (2010) 182 Cal.App.4th 1538)

Facts

Amerigraphics, Inc. (“Amerigraphics”) is a printing and graphics design company. Although it was financially successful until September 11, 2001, its business fell off sharply in 2002. In 2003, its premises were completely flooded, causing damage to all its equipment and forcing Amerigraphics to temporarily relocate.

Amerigraphics submitted a claim to its business personal property insurer, Mercury Casualty Company (“Mercury”). Amerigraphics’ policy with Mercury included business interruption coverage, whereby Mercury agreed to pay for Amerigraphics’ lost “business income” during the “period of restoration.” The policy defined “business income” as “(i) Net Income (Net Profit or Loss before income taxes) that would have been earned or incurred if no physical loss or damage had occurred ...; and (ii) Continuing normal operating expenses incurred, including payroll.” Mercury denied Amerigraphics’ business interruption claim on the grounds that Amerigraphics’ projected expenses exceeded its projected income, resulting in a projected net loss.

Amerigraphics sued Mercury for breach of contract and bad faith and sought a judicial interpretation of the policy’s business interruption provision. The trial court held that Amerigraphics was entitled to recover both its net income and its continuing operating expenses, without having to offset one against the other. Mercury appealed.

Holding

The Court of Appeal affirmed. It first noted that the word “and” used between subparts (i) and (ii) of the policy’s definition of “business income” indicates that Mercury must pay its insured for lost income *in addition to* continuing normal business expenses. Thus, to the extent there is no lost income (i.e., when there is a net loss), the amount paid under subpart (i) would be zero, but the insured would still be entitled to its operating expenses under subpart (ii).

Mercury argued that the word “and” is the equivalent of the mathematical operator “plus.” Under Mercury’s interpretation, if the insured was operating at net loss (i.e., a negative number) greater than its operating expenses, the insured would be paid nothing. The Court of Appeal rejected this interpretation because the policy does not use the words “plus,” “offset,” “subtract,” “minus,” or the like. According to the Court, the plain language of the policy does not support subtracting the net loss from the operating expenses. Instead, the insured is entitled to its operating expenses (a positive number), in addition to its net income (which would be zero if the insured was operating at a loss).

Mercury contended that this interpretation would read the “Net ... Loss” language out of the policy’s definition of “business income.” The Court rejected this argument, noting that in the event of a net loss, the insured’s entitlement to benefits of “net income” is zero, thus taking into account the phrase “Net ... Loss.”

The Court further noted that even if Mercury’s interpretation were reasonable, an ambiguity would exist, and that ambiguity would have to be resolved in the sense the insurer believed the insured understood the policy when the contract was made. Given the language of the provision, it would be objectively reasonable for the insured to believe the policy covered both its lost income stream and the costs of ongoing expenses, since those problems are to be expected following a loss and are mentioned in the policy language. Thus, any ambiguity would be resolved in favor of the insured.

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Finally, the Court noted that a business should not have to be concerned that poor performance for one or two years prior to a covered loss will eliminate coverage under a business interruption provision. Such would make it pointless for the business to purchase the additional coverage.

Comment

Considering that this case involved an issue of first impression in California, that it dealt with policy language common to most business interruption policies, and that a number of insured businesses are likely operating at net losses as a result of the economic recession, this decision could have significant pro-insured consequences for business interruption claims made in California over the months and years to come.

No Coverage for Claimed Property Damage and Loss of Income Where Insured Failed to Show "Accidental Direct Physical Loss"

There was no coverage for claimed property damage and loss of income where the insured failed to meet its initial burden of showing that business equipment had sustained "direct physical loss" or that the claimed damage was "accidental." (*MRI Healthcare Center of Glendale, Inc. v. State Farm General Insurance Company* (2010) 187 Cal.App.4th 766)

Facts

MRI Healthcare Center of Glendale, Inc. (MHC) provided magnetic resonance imaging (MRI) scanning services from a leased location. Years before the loss that was the subject of this claim, MHC had renovated and customized the leased building so that MHC could install and operate the MRI machine. Among other things, MHC had cut a hole in the roof of the building in order to bring the MRI machine into the building. MHC also had modified the roof by installing a skylight and copper barrier to keep electrical or radio wave interference out of the MRI room.

State Farm General Insurance Company (State Farm) issued to MHC a business policy that included coverage for business personal property and loss of income.

As a result of some storms, MHC's landlord was required to repair the roof over the room housing MHC's MRI machine. Initially, the landlord believed it would be possible to simply install another layer of roofing on top of the existing roofing. Eventually, however, the landlord discovered some rot due to long-term water intrusion, and determined that it would be necessary to remove and replace substantially all the existing roof.

The necessary roof replacement could not be undertaken unless the MRI machine was demagnetized, or "ramped down." MHC was aware that, if the machine was ramped down, there was a possibility it could not be "ramped up" without extensive and time-consuming repairs.

Once the machine was ramped down, it did in fact fail to ramp back up. MHC contended this failure constituted "damage" to the MRI machine and caused MHC to suffer a loss of business income. Because the chain of events was set in motion by the storms, MHC asserted that the storms were the predominant ("efficient proximate") cause of the loss; and, because storm damage was covered under the business policy issued to MHC by State Farm, MHC claimed it was entitled to recover both the amount it expended to return the MRI machine to working condition and the income loss sustained while the machine was inoperable.

The policy State Farm issued to MHC provided coverage for "*accidental direct physical loss to business personal property ... caused by an insured loss.*" The policy also provided coverage for loss of income caused when business operations were suspended due to "*accidental direct physical loss to property ... caused by an insured loss*"

The exclusions provided, in part, as follows: "We do not insure under any coverage for any loss caused by one or more of the items below: a. conduct, acts or decisions, including the failure to

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act or decide, of any person, group, organization or governmental body whether intentional, wrongful, negligent or without fault; b. faulty, inadequate, unsound or defective: (1) planning, zoning, development, surveying, siting; (2) design, specifications, workmanship, repair, construction, renovation, remodeling, grading, compaction; (3) materials used in repair, construction, renovation or remodeling; or (4) maintenance; of part or all of any property (including land, structures or improvements of any kind) on or off the described premises; c. weather conditions. But if *accidental direct physical loss* results from items 3.a., 3.b. or 3.c., we will pay for that resulting loss unless the resulting loss is itself one of the losses not insured in this Section.

State Farm denied MHC's claim, and MHC sued. The Court granted State Farm's motion for summary judgment, and MHC appealed.

Holding

The Court of Appeal held that State Farm's denial of coverage was correct.

First, the Court held that MHC had not met its burden, as the insured, of demonstrating "direct physical loss" to the MRI machine. The fact that the machine failed to ramp up did not, by itself, demonstrate a physical alteration of the MRI machine.

Second, the Court held that the loss was not "accidental." The Court concluded that the ramping down of the MRI machine was intentional, and the machine's subsequent failure to ramp back up was an expected, although unwelcome, result of the ramp down.

Third, the Court rejected MHC's contention that the storms (a covered risk) were the predominant (or "efficient proximate") cause of the loss. The Court held that even if the storms could be deemed to be the "trigger" (i.e., the cause that set the loss in motion), the storms were not the predominant cause of the loss. Instead, it ultimately was the ramping down itself that was the sole, and predominating, cause of MHC's loss. The Court

also noted that the evidence established that the roof needed to be replaced not because of the storms, but because of long-term, pre-existing rot damage, which the policy excluded.

Comment

Almost every modern all-risk property policy contains an insuring agreement that requires the existence of "direct physical loss" (or "accidental direct physical loss"). It is the insured's burden to demonstrate the existence of physical damage, after which the burden shifts to the insurer to show the cause of the damage and that the policy excludes the cause of the damage.

In this particular case, the insured showed that the MRI machine stopped working after it was ramped down, but failed to show that the machine actual had undergone some kind of physical change. Moreover, since the insured was aware, before the machine was ramped down, that it later might not ramp up, any physical damage that might have occurred would not be deemed to be "accidental," i.e., unexpected.

LIABILITY INSURANCE

"Land Subsidence" Exclusion Relieves Insurer of Duty to Defend Insured Against Suits Arising From Landslide

A general liability insurer had no duty to indemnify its insured for third-party property damage claims resulting from a landslide where the policy unambiguously barred coverage for all property damages arising out of land subsidence "for any reason whatsoever." (*City of Carlsbad v. Insurance Company of the State of Pennsylvania* (2009)180 Cal.App.4th 176)

Facts

Various homeowners sued the City of Carlsbad, alleging that the City had negligently maintained and repaired a water line, resulting in a landslide. The homeowners alleged that as a result of the

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landslide, they suffered both property damage and bodily injury.

The City sought defense and indemnity under its general liability policy with Insurance Company of the State of Pennsylvania (ISOP). ISOP agreed to defend the City under a reservation of rights and ultimately indemnified the City for the bodily injury claims. However, ISOP denied coverage for the property damage claims based on a policy exclusion which barred coverage for “any property damage arising out of land subsidence *for any reason whatsoever*.” The policy defined “land subsidence” as “movement of land or earth,” specifically including “landslide” as an example.

Following ISOP’s denial of coverage for the property damage claims, the City sued ISOP for breach of contract and breach of the implied covenant of good faith and fair dealing. The trial court ruled that the ISOP policy’s “land subsidence” exclusion barred coverage for any liability the City had on the property damage claims, and thus entered judgment in favor of ISOP.

Holding

The Court of Appeal affirmed. The Court ruled that an exclusion barring coverage for “any property damage arising out of land subsidence for any reason whatsoever” unambiguously barred coverage for any liability the City had for property damage arising out of the landslide – regardless of the cause of the landslide.

The Court rejected the City’s argument that the City was entitled to indemnification under the “efficient proximate cause” doctrine. Specifically, the City claimed that the “efficient proximate cause” of the property damage was not the landslide, but rather, the City’s earlier negligence in maintaining its water line. The Court disagreed, holding that the “efficient proximate cause” doctrine is limited to first party property insurance cases, and is not applicable in third party liability insurance cases.

The Court noted that the “concurrent proximate cause” doctrine might apply where the insured is seeking coverage for liability to a third party. However, in this case, the “concurrent proximate cause” doctrine was inapplicable because there were not two separate and independent causes that combined to cause the homeowners’ damages. Any negligence by the City in maintaining its water line only became actionable because of the subsequent landslide, which was clearly excluded from coverage.

Comment

In reaching its conclusion, the Court reiterated a seemingly obvious proposition, i.e., that the “efficient proximate cause” doctrine applies in first party property insurance cases and the “concurrent proximate cause” doctrine applies in third party liability insurance cases.

Note that the result in this case is consistent with an earlier case, *Blackhawk Corp. v. Gotham Ins. Co.* (1997) 54 Cal.App.4th 1090, in which another California Court of Appeal upheld a similar exclusion for “movement of land or earth.”

“Products-Completed Operations Hazard” Exclusion Bars Coverage for Insured’s Operations, Regardless of Whether Operations are Related to Insured’s Products

A commercial general liability policy’s “products-completed operations hazard” exclusion precludes coverage for bodily injuries arising out of the insured’s completed services, even if those services are not related to the insured’s products. (*Baker v. Nat’l Interstate Ins. Co.* (2010) 180 Cal. App.4th 1319)

Facts

Four Winds Day Camp (“Four Winds”) sold one of its used school buses to La Shaun Clemmons. Two months later, Four Winds agreed to perform certain inspections on the bus that were mandated by law, in exchange for payment that was separate

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and apart from the bus sale price. As part of its inspection, Four Winds performed related maintenance work, including repairs to the bolts holding down the seats. Several months later, Clemmons was driving the bus when she was involved in a collision. The driver's seat of the bus broke loose from the floor, and Clemmons was ejected through the windshield, causing her to sustain fatal injuries.

Clemmons' husband, Antonio Baker, along with their sons (collectively "the Bakers") filed a wrongful death lawsuit against Four Winds. Four Winds tendered defense of the lawsuit to its commercial general liability carrier, American National Fire Insurance Company ("American"). American's policy excluded coverage for claims falling within the "products-completed operations hazard," which the policy defined as including all "bodily injury" and "property damage" occurring away from premises you own or rent and arising out of "your product" or "your work." Maintaining that the lawsuit fell within the "products-completed operations hazard," American declined to defend Four Winds.

Four Winds assigned its rights under the policy to the Bakers, who filed suit against American. The trial court ruled in favor of the Bakers, finding that under the California Supreme Court's holding in *Insurance Co. of North America v. Electronic Purification Co.* (1967) 67 Cal.2d 679, such exclusions only apply to the insured's operations if they were performed on its products. The trial court thus held that the exclusion did not apply because Four Wind's inspection services were independent of the sale of its product, the bus. American appealed.

Holding

The Court of Appeal reversed. First, it distinguished *Electronic Purification* on the grounds that the exclusion there was written in such a way that products and operations were meant to be interrelated, with the result that the exclusion only barred coverage for operations if they were related to the insured's product. The Court of Appeal then noted that the American policy's definition of the "products-completed operations hazard," which

was markedly different from the exclusion in *Electronic Purification*, clearly excluded bodily injury arising out of "your product" or "your work." Focusing on the use of the disjunctive conjunction "or," the court concluded that the exclusion applied to the insured's "work," regardless of whether the work was related to the insured's "products."

Applying that reading to the underlying action, the Court of Appeal concluded that Four Winds' inspection of the bus in return for payment clearly fell within the exclusion. The Court reasoned that "the common understanding of 'work' includes a person's services performed in return for payment of money." Since Four Winds performed inspection services for a customer for payment, any bodily injury arising out of those completed services was necessarily excluded from coverage.

Comment

Rejecting the argument that its holding would undo decades of insurance jurisprudence based on *Electronic Purification*, the Court of Appeal noted that it was "not decree[ing] as a matter of law that 'products' and 'completed operations' shall no longer be considered 'related' elements under a CGL policy," and that the interpretation of the exclusion will depend on the exact policy language at issue. However, as a practical matter, since the American policy contained a standardized definition of "products-completed operations" that appears in many commercial general liability today, the *Baker* decision will likely supplant *Electronic Purification* as the preeminent case on "products-completed operations" exclusions in commercial general liability policies.

Insured's Mistaken Construction of House Over Property Line Does Not Constitute "Occurrence," or "Accident"

An insured's good faith but mistaken construction of a house on neighboring property does not constitute an "occurrence," or "accident," within the meaning of a homeowners policy. (*Fire Ins. Exch. v. Superior Court* (2010) 181 Cal.App.4th 388)

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Facts

Kenneth and Dorothy Bourguignon owned property in the City of Big Bear adjacent to property owned by Louise Leach. In 1984, Leach granted the Bourguignons an access easement over a five-and-a-half-foot wide portion of her property that bordered the Bourguignons' property. Later, in 1988, Leach conveyed a one-third interest in her property to her two sons.

Subsequently, the Bourguignons' house suffered earthquake damage. In order to renovate and rebuild their house, the Bourguignons obtained Leach's signature on an application for a "lot-line adjustment" for the five-and-a-half-foot easement. The City approved the application and a certificate of compliance was recorded. The Bourguignons then proceeded to construct a house which was partially located on the five-and-a-half-foot wide section of property.

Years later, Robert and Marie Parsons negotiated to purchase Leach's property and discovered that the "lot-line adjustment" was a cloud on title. The Parsons obtained an assignment of any rights possessed by Leach and her two sons to contest the validity of the lot-line adjustment, and the Parsons then purchased Leach's property. Thereafter, the Parsons disputed the validity of the lot-line adjustment on the ground that Leach had previously conveyed a one-third interest in the property to her sons, who did sign the application for the lot-line adjustment.

The Bourguignons sued the Parsons for quiet title and adverse possession of the easement. The Parsons cross-complained against the Bourguignons for quiet title, declaratory relief and fraud.

The Bourguignons tendered defense of the cross-complaint to their homeowners insurer, Fire Insurance Exchange ("Fire Insurance"). Fire Insurance refused to defend the Bourguignons asserting, among other things, that the Bourguignons' alleged liability to the Parsons did not arise from an "occurrence," or "accident," as required by the policy.

Thereafter, the Bourguignons sued Fire Insurance for breach of contract and bad faith. Fire Insurance moved for summary judgment, claiming that the Bourguignons' intentional act of building over the lot line was not the result of an "accident." The trial court denied Fire Insurance's motion, and Fire Insurance filed a petition for writ of mandate in the Court of Appeal.

Holding

The Court of Appeal granted the petition for writ of mandate and ordered the trial court to enter summary judgment in favor of Fire Insurance. The Court held that the undisputed facts showed the Bourguignons intended to build their house where they did. Even if the Bourguignons believed that they owned the five-and-a-half-foot strip of land and believed that they had the legal right to build on it, their act of construction "was intentional and was not an accident even though they acted under a mistaken belief that they had the right to do so." According to the Court, the Bourguignons' "mistaken belief in their legal right to build does not transform their intentional act of construction into an accident."

Comment

Following prior California decisions, the Court of Appeal held that where an insured commits an act based on a mistaken belief that his conduct is legal, such act does not constitute an "accident." Here, the Bourguignons constructed the house based on a mistaken belief that they owned the five-and-a-foot strip of property and had the right to build there. That was not an "accident."

One justice dissented, arguing that the Bourguignons' alleged liability should be deemed to arise from an "accident." According to the dissenting justice, while the Bourguignons may have intended to build a house, they did not necessarily intend to build the house on their neighbors' property. Under such circumstances, the Bourguignons' alleged liability could have arisen from an "accident."

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"Personal and Advertising Injury" Coverage Does Not Apply to Alleged Damages Caused by Insured's False Advertising of Its Own Products

A general liability insurer had no duty to defend a suit alleging damages caused by the insured's false advertising of its own products, because the suit fell outside the scope of "personal and advertising injury" coverage and because a "nonconformity exclusion" in the policy applied. (*Total Call International, Inc. v. Peerless Insurance Company* (2010) 181 Cal.App.4th 161)

Facts

Total Call International ("Total Call") provides telecommunications products and services including pre-paid phone cards. Peerless Insurance Company ("Peerless") issued a general liability policy to Total Call that provided coverage for damages because of "personal and advertising injury," which the policy defined as including "[o]ral or written publication, in any manner, or material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services." The policy also contained a "nonconformity exclusion" that eliminated coverage for personal and advertising injury "arising out of the failure of goods, products or services to conform with any statement of quality or performance made in [Total Call's] advertisement."

Two competitors filed a federal court lawsuit against Total Call alleging claims for false and deceptive advertising under the Lanham Act and violation of California's unfair competition law. The competitors alleged that Total Call sold pre-paid phone cards that provided significantly less minutes than the actual minutes advertised by Total Call. The competitors alleged that Total Call's false advertising damaged the reputation of the competitors and the phone card industry as a whole. The competitors further alleged that they lost market share because consumers were misled to ignore the competitors' phone cards and to buy Total Call's falsely advertised phone cards.

Total Call tendered defense of the federal court lawsuit to Peerless. However, Peerless denied a defense to Total Call on the ground that the competitors' claims against Total Call fell outside the policy's coverage for "personal and advertising injury" and were barred by the policy's "nonconformity exclusion."

Total Call then filed suit against Peerless alleging causes of action for breach of contract and bad faith. However, the trial court dismissed Total Call's lawsuit against Peerless, finding that underlying federal court lawsuit against Total Call was not potentially covered under the Peerless policy.

Holding

The Court of Appeal affirmed the trial court ruling, for two reasons.

First, the Court held that the false advertising claims against Total Call did not fall within the scope of the policy's "personal and advertising injury" coverage. The Court noted that the policy's insuring clause covered defamation, trade libel and product disparagement, all of which required an injurious false statement that specifically referred to the derogated person or product. The Court then examined the competitors' complaint and found it did not allege that any of Total Call's false advertising specifically referred to the competitors or their products. The Court rejected Total Call's argument that references in the complaint to damaged reputation were sufficient to trigger a duty to defend, stating that "[t]he fact that the third party complaint mentions an element of a covered claim does not trigger the duty to defend when the facts known to the insurer, viewed as a whole, establish that no such claim is potentially asserted."

Second, the Court held the "nonconformity exclusion" eliminated coverage because the false advertising concerned the price or quality of Total Call's own phone cards. The Court rejected Total Call's argument that the "nonconformity exclusion" was ambiguous, and could be reasonably construed as barring coverage only for claims by consumers, and not claims by competitors. The

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Court held that the language of the exclusion contained no suggestion it was limited to consumer claims. The Court also relied on cases from outside California that had construed nonconformity exclusions to preclude competitor claims.

Comment

Total Call International confirms that “personal and advertising injury” coverage is triggered by the offense committed rather than the damages that are alleged. In evaluating the duty to defend, insurers should carefully review the complaint and extrinsic evidence to determine if any of the enumerated “personal and advertising injury” offenses are alleged. If none of the “personal and advertising injury” offenses are alleged, the insurer has no duty to defend.

Total Call International also establishes the “nonconformity exclusion” as a defense under California law to claims brought by consumers or competitors that arise out of puffing in the insured’s advertising about the quality, price or performance of its goods.

Fax Blasting is Not Covered Under CGL Policy’s “Advertising Injury” or “Property Damage” Coverages

Fax blasting is not covered under a commercial general liability policy’s “advertising injury” or “property damage” coverages, because fax blasting does not involve the publication of “material that violates a person’s right of privacy,” nor is it the result of an “accident.” (*State Farm Gen. Ins. Co. v. JT’s Frames, Inc.* (2010) 181 Cal.App.4th 429)

Facts

Acting on behalf of itself and a class of similarly situated entities, JT’s Frames, Inc. (“JT’s”) filed a class action lawsuit in Illinois against the Friedman Group, a company which had transmitted over 74,000 unsolicited faxes to class members. JT’s alleged that the Friedman Group violated the

Telephone Consumer Protection Act, which makes it illegal to use fax machines to send unsolicited advertisements, and which allows for statutory damages of \$500 per violation.

The Friedman Group sought a defense under several commercial general liability policies it had obtained through State Farm General Insurance Company (“State Farm”), but State Farm denied coverage. JT’s subsequently entered into a settlement agreement with the Friedman Group in the amount of \$19,520,000, subject to a covenant not to execute and an assignment of its rights under the State Farm policies.

State Farm then filed a declaratory relief action against JT’s in California state court, seeking a declaration that the claims were not covered under its policies. The trial court ruled in favor of State Farm, and JT’s appealed.

Holding

The Court of Appeal affirmed, finding that JT’s claims were not covered under the State Farm policies’ “advertising injury” coverage or “property damage” coverage.

The Court first held that fax blasting does not fall within State Farm’s definition of “advertising injury,” which the policies define as the “oral or written publication of material that violates a person’s right of privacy.” The Court observed that “right of privacy” can refer to either the right to seclusion (the right to be free from unwanted intrusions), or the right to secrecy (the right to keep one’s personal information confidential), but that blast faxing, by its very nature, only violates the right to seclusion, not the right to secrecy.

The Court then noted that under the “last antecedent rule,” which provides that qualifying language is applied only to immediately preceding words and not more remote words, the phrase “that violates a person’s right to privacy” must modify the word “material.” Thus, reasoned the Court, the policy should be read to require that the “material” at issue “violate a person’s right to privacy,” which would only be the case if the

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material contained confidential information and violated the victim's right to secrecy. Since the policy language only embodied violations of the privacy right of secrecy and not the privacy right of seclusion, fax blasting did not fall within the policy language.

The Court further noted that the context of the phrase "oral or written publication of material that violates a person's right of privacy" in the policies as a whole also supports the conclusion that "advertising injury" coverage applies only to content-based claims. Specifically, the other three types of torts listed in State Farm's definition of "advertising injury" – slander/libel, misappropriation of advertising ideas, and infringement of copyright, title or slogan – all relate to injury caused by the information contained in the advertisement, not merely sending and receiving information. Thus, the phrase "oral or written publication of material that violates a person's right of privacy," viewed in context, must refer to material whose *content* violates a person's right of privacy. Since fax blasting is not a content-based offense, the Court concluded it does not fall within the definition of "advertising injury."

Finally, with respect to coverage for "property damage caused by an occurrence," the Court held that although a fax blaster's unauthorized use of the victim's fax machine, paper, and toner could constitute "property damage," the fax blasting itself was not accidental, and thus is not an "occurrence." The Court noted that an "accident" requires unintentional acts or conduct, and even if the Friedman Group did not intend to violate the Telephone Consumer Protection Act, it did certainly intend to send the faxes. Thus, fax blasting did not qualify for "property damage" coverage under the State Farm policies.

Comment

As the *State Farm* Court itself noted, courts throughout the United States are split on whether fax blasting is a covered "advertising injury." California and the Seventh Circuit have found that it is not, but Ohio, Massachusetts, Texas, and Florida have found that it is. This split may result in forum shopping. Granted, the choice of law for

interpretation of an insurance policy typically turns on where the policy was issued, but it appears that Courts may be lenient in deciding which law governs. By way of example, in this case, JT's, the Friedman Group, and State Farm are *all* based in Illinois, yet the Court still applied California law in interpreting the policy.

Insurer Seeking Equitable Contribution Can Only Recover Fees and Costs Exceeding Its "Fair Share"

An insurer seeking equitable contribution has the burden of proving that it paid more than its "fair share" of defense and indemnity costs for a common insured, and cannot recover from another insurer any amount that would result in the first insurer paying less than its "fair share." (*Scottsdale Insurance Company v. Century Surety Company* (2010) 182 Cal.App.4th 1023)

Facts

Scottsdale Insurance Company (Scottsdale) and Century Surety Company (Century) had many common insureds, most of whom were construction subcontractors. When a lawsuit was filed against one insured, the claim would be tendered to all of the insured's insurers. Century, relying on various policy provisions, would frequently decline to participate in the defense and indemnification of the insured.

While Century declined to participate in the defense and indemnity of the common insureds, Scottsdale and other insurers did participate. In allocating defense and indemnity costs amongst themselves, Scottsdale and the other participating insurers generally selected "equal shares" for defense costs and "time on risk" for indemnification costs.

Scottsdale alone filed an equitable contribution against Century to recover a share of the defense and indemnity costs incurred in the underlying actions. The trial court ruled that Century *did* have a duty to defend and indemnify the insureds in many of the underlying actions, and that Scottsdale

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was thus entitled to recover equitable contribution from Century.

With regard to the *amount* that Scottsdale was entitled to recover from Century, Scottsdale argued that Scottsdale was entitled to contribution in the amount of *one-half* of the amounts Scottsdale had paid, regardless of whether any other insurers shared in the defense or indemnity of any of the common insureds. Century, on the other hand, argued that the *total* costs of defense and indemnity could be recalculated, according to the methods Scottsdale and the other insurers had agreed to use, with Century in the mix. The trial court ruled in favor of Scottsdale, concluding that Scottsdale could recover *one-half* of the amounts it paid on the underlying claims. Ultimately, judgment was entered in favor of Scottsdale. Century appealed the court's ruling as to the amount Century owed.

Holding

As to the *amounts* owed to Scottsdale, the Court of Appeal reversed and remanded for further proceedings. The Court held that an insurer seeking equitable contribution has the burden of proving that it paid more than its "fair share" of defense and indemnity costs for a common insured, and cannot recover from another insurer any amount that would result in the first insurer paying less than its "fair share." By allowing Scottsdale to recover *one-half* of everything it had paid from Century, the trial court ignored this principal.

The Court held that Scottsdale's evidence of damages, which primarily consisted of evidence that Scottsdale paid defense and indemnity costs and that Century did not, was insufficient to meet Scottsdale's burden to establish that it paid more than its fair share. However, Century's evidence as to the number of other insurers involved in the defense and indemnification of the insureds and the allocation agreements between the participating insurers did establish that Scottsdale had paid more than its fair share.

The Court then held that the trial court's allocation method was not supported by the evidence because Scottsdale and the participating insurers had agreed on allocation methods, i.e., the participating insurers generally selected "equal shares" for defense costs and "time on risk" for indemnification costs. The Court held that these allocation methods were patently reasonable and that Scottsdale should be bound by its choices. Thus, Scottsdale could only recover from Century based on evidence that it paid more than its fair share under the allocation agreements it made with the other insurers. The Court of Appeal thus remanded the case to the trial court for a redetermination of Scottsdale's equitable contribution damages.

Comment

This case stands for the proposition that where multiple insurers have defended and indemnified a mutual insured, an insurer seeking contribution from a recalcitrant insurer is only entitled to the amounts it paid over and above its "fair share." Where applicable, an insurer's "fair share" will be determined based on the same allocation methods agreed upon by the participating insurers.

A hypothetical example assists in explaining the problem with Scottsdale's approach in this case. Suppose that, with respect to a particular underlying claim, Scottsdale equally shared the defense costs with three other insurers. In such a scenario, each insurer would have paid 25% of the total defense costs. Nevertheless, Scottsdale sought to recover *half* of what it had paid in defense costs from Century. In other words, under Scottsdale's theory of relief, Century and Scottsdale would equally split the 25% paid by Scottsdale (12.5% each), while the other three insurers would still have paid 25% each.

Subhaulers Are Not "Insureds" Under Trucker's Commercial Auto Policy Providing "Hired Auto" Coverage

Two sub-haulers were not "insureds" under a trucker's commercial auto policy which covered persons from whom the trucker had "hired" or

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“borrowed” a covered auto. (*American International Underwriters Insurance Company, Inc. v. American Guarantee & Liability Insurance Company* (2010) 181 Cal.App.4th 616)

Facts

American Guarantee & Liability Insurance Company (“American”) issued a Commercial Auto Policy with a Truckers Coverage Form to Denbeste Transportation (“Denbeste”). The policy defined an “insured” so as to include “the owner or anyone else from whom you [Denbeste] hire or borrow a covered ‘auto’ that is a ‘trailer’”

Denbeste entered into a contract with Double D Transportation Company (“Double D”) whereby Double D agreed to haul soil from a construction site. Double D had a separate subhaul agreement with James Camara. Both Double D and Camara were acting as independent contractors. Camara drove his own tractor connected to a Double D trailer from the construction site and ran over Christopher Torgerson, severely injuring him. Torgerson sued Camara, Double D, Denbeste and others for negligence.

Double D’s insurer, American International Underwriters Insurance Company (“AIU”), and Denbeste’s insurer, American, each contributed \$1.45 million toward settlement of Torgerson’s suit, and then sought indemnification from each other. American argued that it had no duty to contribute because Double D and Camara did not qualify as “insureds” on American’s policy. AIU argued that Double D and Camara were “insureds” under the American policy, and that AIU’s policy was excess to American’s policy.

On cross-motions for summary judgment, the trial court granted AIU’s motion and denied American’s motion. The court found Double D and Camara were persons from whom Denbeste had “hired” a covered auto as a trailer; that Double D and Camara were thus “insureds” under Denbeste’s policy through American; and that AIU’s policy was excess to American’s. Judgment was entered in favor of AIU. American appealed.

Holding

The Court of Appeal reversed. It held that Camara and Double D were not persons from whom Denbeste had “hired” or “borrowed” the vehicles involved in the accident. Therefore, neither Camara and Double D were “insureds” under Denbeste’s policy through American.

The Court cited Civil Code § 1925, which defines “hiring” as synonymous with renting. The chief characteristic of a renting or leasing is the giving up of possession to the hirer so that the hirer and not the owner uses and controls the rented property. The Court held that the agreement between Denbeste and Double D provided for the hauling of property and not the renting of trucks and trailers. Denbeste engaged the transportation services of Double D as an independent contractor, without assuming possession or control over Double D’s trailer or Camara’s tractor. Denbeste therefore did not “hire” the tractor and trailer involved in the accident.

The Court also found that Denbeste did not “borrow” the trailer or tractor, as it held that the term “borrow” also connoted the right to exercise dominion and control.

The Court concluded that Camara and Double D were not persons “from whom [Denbeste] hired a covered auto that was a trailer,” and thus Camara and Double D were not “insureds” on the American policy. The Court also held that its decision was dispositive as to American’s cross-motion for summary judgment. Hence, it reversed the trial court ruling with directions to deny the AIU’s motion and to grant the American motion.

Comment

This case suggests that absent specific policy language to the contrary, courts will interpret the terms “hire” and “borrow” in commercial auto or truckers policies to require possession or control. This could reduce the number of parties beyond the named insured that are entitled to coverage under such policies.

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This case also highlights the need to review the insured's sub-haul agreement to fully evaluate coverage. The Court's ruling here turned on its evaluation of the subhaul agreement, which evidenced Denbeste's lack of control over the sub-haulers' vehicles.

Liability Policy's Self-Insured Retention Can Only Be Satisfied By Named Insured, Not Additional Insured

A general liability policy unambiguously provided that the policy's self-insured retention could only be satisfied by the named insured, and not by someone else such as an additional insured. (*Forecast Homes, Inc. v. Steadfast Ins. Co* (2010) 181 Cal.App.4th 1466)

Facts

Forecast Homes, Inc. (Forecast) is a residential home developer which typically hires subcontractors to build the homes. The subcontracts give Forecast express indemnity rights against the subcontractors and require that Forecast be listed as an additional insured on the subcontractors' policies.

Between 2001 and 2003, Forecast was served with five different construction defect lawsuits. Forecast was the only named defendant in the lawsuits; the subcontractors were not named.

After being served with the lawsuits, Forecast tendered its defense to various subcontractors' insurers which had issued additional insured endorsements in favor of Forecast. Over a dozen of the subcontractors had policies through Steadfast Insurance Company (Steadfast), and each Steadfast policy had self-insured retention (SIR). Some of the Steadfast policies provided that "you [i.e., the named insured subcontractor] shall be responsible for payment of all damages and defense costs for each occurrence or offense, until you have paid self-insured retention amounts and defense costs equal to the per occurrence amount shown in the Schedule." Other Steadfast policies contained similar language and further stated that

"[p]ayments by others, including but not limited to additional insureds or insurers, do not serve to satisfy the self-insured retention."

Steadfast denied Forecast's tenders on the ground that the only the named insured subcontractor could satisfy the SIR requirement, and none of the subcontractors had satisfied the SIRs.

Forecast sued Steadfast for breach of contract and bad faith. The trial court ruled that only the named insured subcontractors (not an additional insured such as Forecast) could satisfy the SIR requirement. The trial court thus ruled that Steadfast's duty to defend Forecast had not been triggered. Forecast appealed.

Holding

The Court of Appeal affirmed. The appellate court held that under both versions of the Steadfast policies, only the named insured subcontractor could pay the SIR and thereby trigger the duty to defend. The appellate court further held that this was not counter to public policy, noting that Forecast could have (1) required its subcontractors to list Forecast as a named insured on the policies or (2) insisted on policy language permitting an additional insured to satisfy the SIR. Because the named insured subcontractors had not satisfied the SIRs, Forecast was not entitled to a defense from Steadfast.

Comment

In this case, the appellate court confirmed that payment of an SIR is a condition precedent to triggering coverage under a policy. Further, if the SIR language clearly provides, only the named insured – not an additional insured – can satisfy this condition precedent.

The court specifically distinguished some prior cases in which courts had held that someone other than a named insured might be able to satisfy an SIR. According to the appellate court, those prior cases involved different, arguably ambiguous, policy language.

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Party Liable Under "Peculiar Risk" Doctrine For Independent Contractor's Use Of Vehicle Is "Legally Responsible" For Independent Contractor's Conduct And Hence An "Insured" Under Independent Contractor's Auto Policy

A party who was potentially vicariously liable under the "peculiar risk" doctrine for an independent contractor's use of a vehicle was potentially "legally responsible" for the independent contractor's conduct and thus qualified as an "insured" under the independent contractor's auto policy. (*American States Ins. Co. Progressive Casualty Ins. Co.* (2009) 180 Cal.App.4th 18)

Facts

TRII LLC (TRII), a developer, hired Garden Communities (Garden) to act as general contractor for a construction project. Garden in turn retained Vinci Pacific Corporation (Vinci) to act as grading subcontractor. Vinci in turn hired Western Trucking LLC (Western) to haul dirt from the site. Western assigned a portion of the work to Victor Meza (Meza), a self-employed trucker.

There was only one entrance to the construction site. It required truckers entering the site to make a U-turn (while driving westbound in eastbound lanes), encroach on at least two pedestrian crosswalks, jump a curb, and drive across a sidewalk.

Meza was driving a truck that he owned and pulling a trailer that Western owned. As Meza tried to enter the construction site, the rear portion of the trailer ran over and severely injured a pedestrian, Yevdokia Bristman (Bristman). Bristman later filed a personal injury lawsuit against TRII, Garden, Vinci, Western and Meza. Bristman alleged among other things that TRII, Garden and Vinci (collectively the Vinci Parties) employed Western and Meza, and that the Vinci Parties failed to take necessary safety precautions at the construction site's entrance.

The Vinci Parties were insured under a commercial auto policy issued by American States Insurance Company (American States). Western, owner of the trailer, was insured under a commercial auto policy issued by Wilshire Insurance Company (Wilshire). Meza, driver of the truck that was pulling the trailer, had a commercial auto policy through Progressive Casualty Insurance Company (Progressive).

American States agreed to defend the Vinci Parties against Bristman's lawsuit and then tendered the defense of the Vinci Parties to both Western's insurer, Wilshire, and Meza's insurer, Progressive. However, Wilshire and Progressive declined to defend the Vinci Parties on the ground that the Vinci Parties did not qualify as "insureds" on the Wilshire and Progressive auto policies. Both the Wilshire auto policy and the Progressive auto policy defined an "insured" so as to include parties who were "legally responsible" for the named insured's or a permissive user's operation of a covered vehicle.

American States later filed a coverage action against Wilshire and Progressive, seeking to recover from Wilshire and Progressive all or some portion of the costs of defending the Vinci Parties in the underlying personal injury action. The trial court ruled in favor of Wilshire and Progressive, finding that the Vinci Parties were not "insureds" on the Wilshire and Progressive policies. American States appealed.

Holding

The Court of Appeal reversed. The court observed that as a general rule, one who hires an independent contractor is *not* vicariously liable for the torts of the independent contractor. However, the general rule is subject to various exceptions, including the "peculiar risk" exception. Under the peculiar risk exception, one who hires an independent contractor to perform work involving a peculiar risk of harm *is* vicariously liable for injuries arising from the independent contractor's performance of that work. Here, the facts suggested that under the peculiar risk exception, one or more of the Vinci Parties might be vicariously liable for Western's and Meza's

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operation of the tractor-trailer rig at the entrance to the construction site.

Further, Western's auto policy through Wilshire and Meza's auto policy through Progressive both defined an "insured" so as to include those who were "legally responsible" – i.e., vicariously liable – for the named insured's or a permissive user's operation of a covered vehicle. Since one of more of the Vinci Parties might be vicariously liable for Western's and Meza's operation of the tractor-trailer rig, and since Western's policy through Wilshire and Meza's policy through Progressive defined an "insured" so as to include parties who were vicariously liable for the operation of covered vehicles, the Vinci Parties were "insureds" on the Wilshire and Progressive policies.

Therefore, American States was entitled to recover from Wilshire and Progressive some portion of the costs of defending the Vinci Parties in the underlying action. The appellate court remanded the matter to the trial court for a determination as to how much American States was entitled to recover from Wilshire and Progressive.

Comment

The typical situation in which the "legally responsible" language is implicated is an employer-employee relationship, where the employer is alleged to be vicariously liable for the negligent driving of its employee. In that scenario, the allegedly vicariously liable employer is "legally responsible" for the employee's negligence, and hence the employer qualifies as an "insured" under the employee's auto policy.

The twist in this case is that it involved a hirer-independent contractor relationship. Although a hirer is generally not vicariously liable for the independent contractor's negligence, that rule is subject to various exceptions, including the "peculiar risk" exception. Since under the peculiar risk exception the hirer was potentially vicariously liable for the independent contractor's conduct in this case, the hirer was potentially "legally responsible" for the independent contractor's negligence, and hence the hirer did qualify as an

"insured" under the independent contractor's auto policy.

In Light of "Severability" Clause, Exclusion for Intentional Act of "An" Insured Only Applies to Particular Insured Who Commits Such Act

The California Supreme Court has held that based on a policy's "severability" clause, an exclusion for the intentional act of "an" insured only applied to *the particular insured* who committed the intentional act, and did *not* apply to another insured who was merely negligent in failing to prevent the intentional act. (*Minkler v. Safeco Ins. Co. of America* (2010) 49 Cal.4th 315)

Facts

Scott Minkler (Minkler) filed a lawsuit against David Schwartz (David) and David's mother, Betty Schwartz (Betty). In his complaint, Minkler alleged that beginning in 1987 and continuing for several years thereafter, he had been sexually molested by David in Betty's home. Minkler further alleged that Betty had negligently failed to prevent David's acts.

During the time of the alleged molestations, Betty was the named insured on a series of homeowners policies issued by Safeco Insurance Company of America (Safeco). Betty's son David also qualified as an insured on the policies. The policies specifically excluded coverage for bodily injury "which is expected or intended by *an* insured or which is the foreseeable result of an act or omission intended by *an* insured." However, the policies' "Conditions" section contained a "severability" clause which stated that "[t]his insurance applies separately to each insured. This condition will not increase our limit of liability for any one occurrence."

David and Betty tendered Minkler's lawsuit to Safeco for defense and indemnity. Relying on the policies' exclusion for intentional acts of "an" insured, Safeco refused to defend either David or Betty against Minkler's lawsuit.

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Thereafter, Minkler obtained a default judgment against Betty for over \$5 million. Betty assigned her claims against Safeco to Minkler, and Minkler agreed not to enforce the judgment against Betty's personal assets.

Minkler (as Betty's assignee) then filed a bad faith lawsuit against Safeco in state court. Minkler alleged that the Safeco policies were ambiguous because the policies' "severability" clause stated that "this insurance *applies separately to each insured,*" while at the same time the policies' "intentional act" exclusion purported to bar coverage for all claims arising from intentional acts of "an insured." Minkler thus alleged that the Safeco policies did not bar coverage for Betty's alleged negligence in failing to prevent David's intentional acts of molestation. Safeco removed the lawsuit to federal district court.

The federal district court ruled in favor of Safeco. The district court found that despite the policies' "severability" clause, the policies' exclusion for intentional acts of "an" insured precluded coverage for both an insured who commits an intentional act *and* any other insured who might only be negligently liable for such act. In other words, the intentional act of any one insured (such as David) barred coverage for all other insureds (such as Betty).

Minkler appealed to the Ninth Circuit Court of Appeals. During the pendency of the appeal, the Ninth Circuit requested the California Supreme Court to address the interplay between the policies' "severability" clause and the policies' exclusion for the intentional acts of "an" insured. The Supreme Court agreed to address that issue.

Holding

The California Supreme Court held that the Safeco policies' exclusion for intentional acts of "an" insured, read in conjunction with the policies' "severability" clause, created an ambiguity which had to be construed in favor of coverage. According to the Supreme Court, while an exclusion for the intentional acts of "an" insured would normally mean that the intentional act of one

insured bars coverage for all insureds, a severability clause stating that "[t]his insurance applies *separately to each insured*" reasonably implies a contrary result. Given that ambiguity, Betty would "reasonably have expected Safeco's policies ... to cover her *separately* for her *independent* acts or omissions causing such injury or damage, so long as *her* conduct did not fall within the policies' intentional acts exclusion, even if the acts of *another* insured contributing to the same injury or damage *were* intentional."

In short, given the policies' "severability" clause, the exclusion for intentional acts of "an" insured did *not* bar coverage for Betty's alleged negligence in failing to prevent David's molestation of Minkler.

Comment

Minkler is an extremely important case. In several prior decisions, the California Courts of Appeal had interpreted an exclusion for intentional acts of "an" insured (as opposed to "the" insured) to mean that the intentional act of any one insured would bar coverage for all other insureds under the same policy. However, the prior cases did not specifically deal with what effect a "severability" clause might have on such an exclusion. In *Minkler*, the Supreme Court held that if the policy does contain a "severability" clause which states that the policy applies "separately to each insured," the severability clause renders ambiguous an exclusion for intentional acts of "an" insured. As *Minkler* indicates, that ambiguity will be resolved in favor of the insured. In reaching that conclusion, the *Minkler* court rejected the rule followed by a majority of jurisdictions and instead adopted the rule followed in a minority of jurisdictions.

The *Minkler* court noted that an insurer can avoid the problem simply by changing the language of the severability clause from "[t]his insurance applies separately to each insured" to "[t]he *limits of liability* of this policy apply separately to each insured." According to the Court, such language would make it clear that the severability clause's purpose is merely "to extend the full individual *indemnity limits* to each person among several insureds under the same policy," and "not to make

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exclusions from coverage *individual rather than collective.*”

The *Minkler* court was also careful to stress that its reasoning and conclusion were aimed at the “specific circumstances of this case, which involves the interplay between a severability clause and an exclusion for the *intentional acts* of ‘an’ insured....” The Court emphasized that its conclusion in this case “does not mean a severability clause necessarily affects *all* exclusions framed in terms of ‘an’ or ‘any’ insured.” Rather, “each exclusion applicable to ‘an’ or ‘any’ insured must be examined individually, and in context, to determine the effect a severability clause like the one at issue here might have on its operation.”

In any event, after *Minkler*, it is clear that a standard “severability” clause will limit an insurer’s ability to rely on an exclusion for intentional acts of “an” insured to deny coverage for an “innocent insured.”

Automobile Policy "Step-Down" Provisions Limiting Coverage for Permissive Users Are Valid if They Are Conspicuous, Plain and Clear

The California Court of Appeal has held that an automobile liability policy’s “step-down” provision, which reduced liability limits for permissive users, was “conspicuous, plain and clear” and thus limited the coverage that was available to a permissive user. (*Dominguez v. Financial Indem. Co.* (2010) 183 Cal.App.4th 388)

Facts

Lucia Dominguez (Dominguez) was allegedly injured in an automobile accident caused by Ningju Qui (Qui). The vehicle Qui was driving was owned by, and used with the permission of, Michael Welch (Welch). Welch was the named insured on an auto policy issued by Financial Indemnity Company (FIC), and Qui as a permissive user also qualified as an insured on the FIC policy.

The FIC policy’s declaration page stated that the bodily injury liability limits were \$100,000 each person and \$300,000 each accident. However, the policy’s face sheet, table of contents and liability section all referred to a “Reduction in Coverage” on page 7 of the policy. On page 7, under a heading labeled “REDUCTION IN COVERAGE,” the policy limited coverage for permissive users to the minimum limits required by the applicable financial responsibility laws. In addition, the policy’s insuring agreement stated that “[t]he limits shown on the Declarations page are subject to reduction to the state mandatory minimum of \$15,000 each person, \$30,00 each accident ... where there is a permissive user of the ‘insured vehicle.’”

Dominguez filed an action against Qui and Welch for her injuries arising out of the accident. While that action was pending, Dominguez also filed an action for declaratory relief action against FIC to obtain a determination as to what limits were available to the permissive user, Qui. FIC prevailed in the declaratory relief action, with the trial court concluding that the “step-down” permissive user limitation was sufficiently “conspicuous, plain and clear.” Dominguez appealed.

Holding

The Court of Appeal affirmed. Insurance Code §11580.1 (b)(4) provides that an automobile policy must provide the same coverage to a permissive user as is afforded the named insured, but only up to the limits of the Financial Responsibility Law. However, a policy which includes such a limitation on coverage and will be subjected to “close scrutiny.” The Court of Appeal noted that it is the insurer’s burden to make its coverage exclusions and limitations “conspicuous, plain and clear.” The court also observed that in interpreting an automobile policy’s permissive user limitations, the court must examine the reasonable expectations of the insured car owner, *not* the reasonable expectations of the permissive user.

The Court proceeded to hold that the permissive user limitation in the FIC policy was “conspicuous” and distinguished the limitation from that in *Haynes v. Farmers Ins. Exch.* (2004) 32 Cal.4th 1198 because of the location of the limitation in the FIC

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policy. According to the Court, the FIC policy notified the insured “early and often” that a permissive user had lower limits than the named insured.

The Court also found the limitation “plain and clear” because the policy did more than simply state that a permissive user was only covered to the extent of the “Financial Responsibility Law.” On the first page of the FIC policy, the insuring agreement provided that the limits in the Declarations are subject to a reduction “to the state mandatory minimum of \$15,000 each person, \$30,000 each accident, and \$5,000 for property damage when there is a permissive user of the insured vehicle.” According to the Court, that was “plain and clear.”

Comment

Provisions which limit the amount of coverage available to permissive users are subject to close judicial scrutiny. However, as this case makes clear, if an insurer uses language which is “conspicuous, plain and clear,” the insurer can in fact limit a permissive user to the statutory minimum limits.

Court of Appeal Enforces Exclusion in Legal Malpractice Policy for Claims Made by Entities That Are Owned or Managed by the Insured

The California Court of Appeal has held that a legal malpractice policy’s exclusion for claims made by business entities that are owned or managed by the insured applies so long as the insured owned or managed the entity at the time the insured first gave notice of the claim to the insurer. (*Car. Cas. Ins. Co. v. L.M. Ross Law Group, LLP* (2010) 184 Cal.App.4th 196)

Facts

L.M. Ross Law Group, LLP (“Ross Law Group”) is a two-person law firm whose sole equity partner is Leonard M. Ross. Mr. Ross is both the settlor and trustee of the Leonard M. Ross Revocable Trust, which owns a majority interest in an entertainment

company called Diversified Entertainment (“DEC”). As of 2005, Mr. Ross also served as DEC’s manager.

In June 2005, DEC was sued for damages arising out of a distribution agreement it had entered into under the legal advice of Mr. Ross’ law firm, Ross Law Group. DEC in turn made a legal malpractice claim against Ross Law Group, claiming over \$800,000 in damages.

Ross Law Group tendered the claim to its legal malpractice insurer, Carolina Casualty Insurance Company (“Carolina Casualty”), in September 2005. Significantly, Carolina Casualty’s “claims made” policy contained an exclusion for claims made by any business enterprise (other than the insured) in which the insured owned more than a 10% interest, or in which the insured was an owner, partner, or employee, or which was directly or indirectly controlled, operated, or managed by the insured.

DEC filed a legal malpractice lawsuit against Ross Law Group in December 2007. By that point, Mr. Ross was allegedly no longer the manager of DEC. Carolina Casualty agreed to defend Ross Law Group under a reservation of rights. The lawsuit ultimately settled for \$250,000, with Ross Law Group contributing \$175,000 and Carolina Casualty contributing \$75,000 toward the settlement, and with each side reserving its right to recover the amount paid from the other party.

Carolina Casualty then filed the subject action against Ross Law Group. Finding that coverage was barred by the insured-controlled enterprises exclusion, the trial court granted Carolina Casualty’s motion for summary judgment. Ross Law Group appealed.

Holding

The Court of Appeal affirmed the judgment in favor of Carolina Casualty. To begin with, the Court held that the insured-controlled enterprises exclusion was triggered because Ross was DEC’s manager at the time the potential claim was reported in 2005. The Court rejected Ross Law Group’s argument

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that since Ross was no longer managing DEC when the actual lawsuit was filed in 2007, the exclusion did not apply. Instead, the Court found that conditions should be measured when the insured first gives notice of the potential claim to the insurer — i.e., in 2005 — because the policy expressly provides that claims “shall be deemed to have been made when notice was first given” to Carolina Casualty. The Court also noted that the mere fact that the exclusion was not drafted to expressly cover this specific fact pattern — i.e., where an insured lawyer managed the client when his firm notified the insurer of a potential claim but not when the actual action was filed — does not render the exclusion ambiguous.

The Court further found that the exclusion was also triggered because Mr. Ross, through his trust, had a majority interest in DEC. The Court explained that under California law, property held in a revocable inter vivos trust is deemed the property of the settlor. Since the Leonard M. Ross Revocable Trust was the majority owner of DEC, Mr. Ross himself was in effect the majority owner, thus triggering the exclusion.

Notably, the Court emphasized that its holding was consistent with the exclusion’s anti-collusion purpose. In essence, Ross was the real party on both sides of the claim: he asserted the legal malpractice claim on behalf of DEC, *and* he guided Ross Law Group’s response to that claim. As the Court noted, the potential for collusion under such circumstances is readily apparent.

Comment

The insured-controlled enterprises exclusion is not frequently litigated. This is the first reported California decision to elaborate on the relationship between the notice provisions of a “claims made” policy and the timing component of the exclusion.

Insured's Alleged Negligent Supervision Of Employee Is Not An "Occurrence"

An insured’s alleged negligence in supervising an employee does not constitute an “occurrence,” or “accident,” within the meaning of a general liability policy. (*L.A. Checker Cab Cooperative, Inc. v. First Specialty Ins. Co.* (2010) 1886 Cal.App.4th 767)

Facts

L.A. Checker Cab Cooperative, Inc. (Checker), a taxi cab company, employed Alexander Terminassian (Terminassian) as a cab driver. Terminassian was operating his taxi one evening when he got into a dispute with a would-be passenger, Marco Cifuentes (Cifuentes). In the course of the dispute, Terminassian, allegedly acting in “self-defense,” shot Cifuentes.

Cifuentes later filed a personal injury action against Checker, alleging that Checker had negligently supervised Terminassian. Checker tendered defense of the action to its liability insurer, First Specialty Insurance Company. First Specialty declined to defend Checker.

Checker later sued First Specialty for breach of contract and bad faith, alleging that First Specialty had wrongfully refused to defend Checker in the underlying personal injury lawsuit filed by Cifuentes. The trial court entered summary judgment in favor of First Specialty. Checker appealed.

Holding

The Court of Appeal affirmed, holding that First Specialty had no duty to defend Checker in the underlying personal injury lawsuit filed by Cifuentes. According to the appellate court, Checker’s alleged negligent supervision of its employee, Terminassian, did not constitute an “occurrence,” or “accident,” within the meaning of the First Specialty policy. The court reasoned that the term “occurrence,” or “accident,” refers to “the event causing damage, not the earlier event

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creating the potential for future injury....” Thus, “Checker’s alleged negligence in not adequately supervising Terminassian was not the direct cause of Cifuentes’s injury but, if anything, only a remote antecedent cause which does not qualify as an ‘occurrence’ under the policy.” Since Checker’s alleged liability did not arise from an “occurrence,” First Specialty had no duty to defend Checker.

Comment

Courts applying California law have split on the issue of whether an insured’s negligent supervision of another constitutes an “occurrence” within the meaning of a liability policy. The state appellate court in this case, along with the federal district courts in *American Empire Surplus Lines Ins. Co. v. Bay Area Cab Lease* (N.D. Cal. 1991) 756 F.Supp. 1287 and *Farmer v. Allstate Ins. Co.* (C.D. Cal. 2004) 311 F.Supp. 884, have held that negligent supervision is *not* an occurrence. In contrast, the federal district courts in *Keating v. National Union Fire Ins. Co.* (C.D. Cal. 1990) 754 F.Supp. 1431, *Westfield Ins. Co. v. TWT, Inc.* (N.D. Cal. 1994) 723 F.Supp. 492 and *Fireman’s Fund Ins. Co. v. National Bank for Cooperatives* (N.D. Cal. 1994) 849 F.Supp. 1347 all held that negligent supervision *can* be regarded as an occurrence. (Oddly, the state appellate court in the present case did not mention any of the prior cases dealing with the issue.)

In any event, given the existing split in case authority, one can expect further litigation on the issue of whether negligent supervision is an occurrence within the meaning of a liability policy.

Duty to Defend "Suit" Includes Duty to Defend Proceedings Under Calderon Act

A provision in a commercial general liability insurance policy requiring the insurer to “defend the insured against any ‘suit’ seeking ... damages” to which the insurance applies includes the duty to defend the insured in proceedings under the Calderon Act. (*Clarendon Nat’l Ins. Co. v. StarNet Ins. Co.* (2010) 186 Cal.App.4th 1397)

Facts

Centex Homes (Centex) was the developer of a residential development known as Westwood Ranch. Centex hired WSM Transportation doing business as Sam Hill & Sons, Inc. (Sam Hill) to act as a subcontractor during construction. Pursuant to the subcontract, Centex was listed as an additional insured on Sam Hill’s general liability policies issued by StarNet Insurance Company (StarNet).

California Civil Code section 1375 et seq. – typically referred as the “Calderon Act” – establishes procedural rules and practices that a common interest development association must follow prior to filing a construction defect lawsuit against a developer, builder or contractor. The Calderon Act’s stated purpose is to encourage settlement of construction defect disputes and to discourage unnecessary litigation.

In 2006, the Westwood Ranch Homeowners Association, Inc. (HOA) served a notice of commencement of legal proceedings against Centex pursuant to the Calderon Act. The notice set forth a list of alleged construction defects at the Westwood Ranch development. Centex subsequently incurred legal fees in defending against the Calderon process initiated by the HOA.

Centex later sued Clarendon National Insurance Company (Clarendon), asserting that Clarendon had a duty to pay defense costs incurred by Centex in connection with the Calderon process initiated by the HOA. Clarendon filed a cross-complaint against StarNet, asserting that StarNet also had a duty to contribute toward defense costs incurred by Centex during the Calderon process. StarNet denied liability under its policies, claiming that the Calderon process did not qualify as a “suit” within the meaning of the StarNet policies.

The trial court entered judgment in favor of Clarendon, finding that the Calderon process against Centex was a “suit” within the meaning of the StarNet policies, and that StarNet thus had a duty to defend Centex during the Calderon process. StarNet appealed.

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Holding

The Court of Appeal affirmed. The appellate court noted that under the StarNet policies, StarNet agreed to indemnify an insured against damages because of covered bodily injury or property damage, and to defend an insured against any "suit" seeking such damages. The StarNet policies then defined a "suit" so as to include "a *civil proceeding* in which damages because of 'bodily injury' [or] 'property damage' ... to which this insurance applies are alleged."

According to the appellate court, the Calderon process qualified as a "civil proceeding" within the meaning of the StarNet policies' definition of "suit". The court emphasized that the Calderon Act requires a common interest development association to satisfy certain dispute resolution requirements with respect to the builder, developer, or general contractor before the association may file a complaint in court for construction or design defects. The court reasoned that although the Calderon Process occurs before a complaint is filed and itself does not result in a judgment or court-ordered payment of money, the Calderon process is nevertheless an "integral part of construction defect litigation initiated by a common interest development association." The Calderon process was thus a "suit." As such, StarNet was obligated to contribute toward the defense costs Centex had incurred in defending against the Calderon process initiated by the HOA.

Comment

In *Foster-Gardner, Inc. v. National Union Fire Insurance Company* (1998) 18 Cal.4th 857, the California Supreme Court held that where a policy does not define the term "suit," the term "suit" will be construed to mean "a court proceeding initiated by the filing of a complaint." However, in the present case, the policy defined the term "suit" so as to include "a civil proceeding" in which covered damages are asserted. Thus, according to the Court of Appeal, under the subject policy, the term "suit" meant something more than a proceeding initiated by the filing of a complaint. Applying the "literal meaning" approach to policy interpretation used by the Supreme Court in *Foster-Gardner*, the

Court of Appeal held the Calderon process is a "civil proceeding" within the meaning of the current standard-form CGL policy.

"Per Claim" Self-Insured Retention Endorsement Applies Only Once to Construction Defect Action Involving Multiple Homes

In the context of a general liability policy as a whole, a \$25,000 "per claim" self-insured retention endorsement applied only once to a construction defect action involving multiple homes. (*Clarendon America Ins. Co. v. North American Capacity Ins. Co.* (2010) 186 Cal.App.4th 556)

Facts

Tanamera Homes and Resort Communities, LLC (Tanamera) was the developer of a 450-home residential development in Victorville, California. Clarendon American Insurance Company (Clarendon) and North American Capacity Insurance Company (NAC) insured Tanamera under separate and consecutive CGL policies. The NAC policy included a self-insured retention (SIR) endorsement that required Tanamera to pay a \$25,000 SIR with respect "to each and every claim made against any insured...regardless of how many claims arise from a single 'occurrence' or are combined in a single 'suit'."

Owners of 43 homes within the project sued Tanamera for alleged construction defects at their homes (the underlying action). Tanamera tendered the defense of the underlying action to both Clarendon and NAC. Clarendon agreed to defend Tanamera under a reservation of rights. However, NAC declined to defend Tanamera unless and until Tanamera satisfied the NAC policy's \$25,000 "per claim" SIR with respect to *each of eight homes* at the project to which the NAC policy potentially applied (i.e., NAC asserted that Tanamera had to pay \$200,000 before the NAC policy would be triggered).

Clarendon filed a contribution action against NAC seeking to recover some portion of the defense

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costs that Clarendon had paid in defending Tanamera. Clarendon argued that Tanamera had spent \$25,000 of its own funds in defense of the underlying action, thus satisfying the NAC policy's per claim SIR. NAC, on the other hand, argued that the \$25,000 SIR applied to each of the eight homes in the underlying action to which the NAC policy applied, and that Tanamera's \$25,000 payment thus did not satisfy the NAC policy's SIR endorsement.

The trial court entered summary judgment in favor of NAC. Clarendon appealed.

Holding

The Court of Appeal reversed and remanded. The Court noted that NAC had the burden of demonstrating that the terms of NAC's SIR endorsement were never met and that therefore NAC never had a duty to defend.

The Court first looked to whether the parties' intent could be inferred from the written provisions of the contract. Both NAC and Clarendon asserted that the policy used the term "claim" in its "ordinary and popular sense," but advanced different meanings of the term. In evaluating whether the NAC policy's "per claim" SIR applied to each of the homes involved in the underlying action or only to the one single action, the Court surveyed the use of the terms "claim" and "suit" within the NAC policy to determine whether the term "claim" was synonymous with "suit." Given the mixed use of the word "claim" in the context of the policy as a whole, the Court concluded that, as used in the SIR endorsement, the term "claim" had no ordinary and popular meaning as applied to the underlying action.

Next, the Court reasoned that an ambiguity may be construed against the insurer only if the insured had an objectively reasonable expectation there would be coverage under the policy consistent with the ambiguity. Thus, NAC had the burden of showing that Tanamera could not have had an objectively reasonable expectation that the SIR would apply only one time to a single construction defect lawsuit involving numerous homeowners

and homes. According to the Court, NAC failed to meet its burden because it did not proffer any extrinsic evidence as to Tanamera's objectively reasonable expectations. The Court concluded that NAC had not shown Tanamera did have had an objectively reasonable expectation that the \$25,000 per claim SIR would apply only one time to a single construction defect lawsuit involving numerous homes. Because NAC failed to meet its burden, the appellate court reversed the trial court's order granting NAC summary judgment.

Comment

While other California courts have observed that the words "suit" and "claim" are not synonymous, the appellate court in this case noted the importance of evaluating the terms in the context of the policy as a whole and the circumstances at issue. The court observed that NAC had charged a premium of over \$400,000 for the policy. The policy potentially covered as many as 450 homes with limits up to \$2 million. Assuming the policy covered 450 homes, if the SIR applied on a "per claim" basis for each home, that would mean Tanamera paid \$400,000 in premiums but would potentially have to pay an additional \$11.25 million (450 times \$25,000) in defense or settlement expenses before it could access the \$2 million in limits the NAC policy afforded, even for purposes of the duty to defend.

"Personal Injury" and "Advertising Injury" Coverage Do Not Apply To Claims That Insured Misappropriated Competitor's Customer List and Project Information

A general liability insurer had no duty to defend a suit alleging that the insured misappropriated a competitor's confidential customer list and project information, because the suit did not allege an "advertising injury" or "personal injury" offense and because the "intellectual property exclusion" in the policy applied. (*S.B.C.C., Inc. v. St. Paul Fire & Marine Insurance Co.* (2010) 186 Cal.App.4th 383)

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Facts

S.B.B.C., Inc dba South Bay Construction Company (South Bay) hired a project manager named Richard Foust (Foust) away from a competitor, San Jose Construction, Inc. (SJC). Foust allegedly took with him confidential information about SJC's customers and ongoing projects, and then used that information to solicit those customers for South Bay. SJC filed a suit against South Bay for misappropriation of trade secrets, interference with contract and prospective economic advantage, unfair competition and related claims.

South Bay tendered the suit to its commercial general liability insurer, St. Paul Fire & Marine Insurance Company (St. Paul). St. Paul refused to defend South Bay for several reasons, including that SJC's suit did not allege "advertising injury" or "personal injury" as defined in the St. Paul policy. St. Paul also asserted its "Intellectual Property" exclusion, which stated that "we [St. Paul] won't cover injury or damage ... that result[s] from any actual or alleged infringement or violation of ... Trade secret ... [or] Other intellectual property rights or laws ... nor will we cover any other injury or damage that's alleged in any claim or suit which also alleges any such infringement or violation."

Following St. Paul's disclaimer, South Bay sued St. Paul for breach of contract, bad faith and declaratory relief. The parties filed cross-motions for summary judgment regarding St. Paul's duty to defend the SJC suit under the "advertising injury" and "personal injury" coverage of the policy.

The trial court granted summary judgment to St. Paul, finding that St. Paul had no duty to defend South Bay against SJC's lawsuit. South Bay appealed.

Holding

The Court of Appeal affirmed the summary judgment in favor of St. Paul for three reasons.

First, the Court held that SJC's suit against South Bay did not allege "advertising injury," which the St.

Paul policy defined as including the "unauthorized use of any 'advertising idea' or 'advertising material'... of others in your advertising." The policy specifically defined "advertising idea" so as *not* to include a customer list. Further, SJC's complaint did not allege the use of "advertising material," which the policy defined as being both subject to copyright law and used by others to attract attention in their advertising. The Court rejected South Bay's argument that the definition of "advertising" was broad enough to include Foust's personal solicitations of SJC customers. As defined in the policy, "advertising" involved "attracting the attention of others." Since SJC's customers already knew Foust before he solicited them, Foust did not use the customer list or project information to attract any customer's attention.

Second, the Court found no duty to defend under the "personal injury" offense for violation of a "person's" right of privacy. The Court reasoned that the word "person" as used in the policy referred to natural person and did not include organizations such as SJC.

Finally, the Court held that the "intellectual property" exclusion was clear and explicit and applied to any suit that alleged a violation of trade secret, even if the suit also alleged other claims. Since SJC's suit unquestionably alleged "infringement or violation of...trade secret," the exclusion eliminated any potential coverage and provided a separate ground to affirm summary judgment for St. Paul.

Comment

In this case, the Court interpreted a unique policy form that specially defined almost all the key terms of "advertising injury" coverage. The Court reached a proper result that is consistent with prior California "advertising injury" cases, which have denied coverage under different policy language for similar lawsuits between business competitors.

Pursuant to "Going and Coming" Rule's "Required Vehicle" Exception, Employee Is "Insured" For Accident

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While Driving to Work, and Employer's Liability Thus Falls Within "Auto" Exclusion of CGL Policy

In light of the "going and coming" rule's "required vehicle" exception, an employee was an "insured" for an auto accident while driving to work, with the result that his employer's liability was barred from coverage by an "auto" exclusion in a CGL policy. (*Sprinkles v. Associated Indemnity Corp.* (2010) 188 Cal.App.4th 69)

Facts

Sinco Co., Inc. (Sinco) was a property management company which required its employee, Juan Babinz (Babinz), to use his own vehicle to transport himself to various job sites each day. While Babinz was driving to work in the vehicle which he used to visit job sites, he caused an automobile accident which resulted in the death of Michael Sprinkles (Sprinkles).

Sprinkles' heirs filed a wrongful death action against Sinco and Babinz, alleging that Sinco was vicariously liable for the acts of its employee Babinz, and that Sinco had negligently hired Babinz. Sinco and Babinz sought defense and indemnity under various policies issued to Sinco, including a \$1 million commercial general liability policy issued by Fireman's Fund Insurance Company (Fireman's Fund). However, Fireman's Fund declined to participate in defending or indemnifying Sinco and Babinz under the CGL policy, citing that policy's exclusion for injuries "arising out of the ownership, maintenance, use or entrustment to others of any ... auto ... owned or operated by or rented or loaned to any *insured*." The policy defined an "insured" so as to include "your [Sinco's] employees, but only with respect to *acts within the scope of their employment by you while performing duties related to the conduct of your business.*"

Sprinkles' heirs entered into a settlement with Sinco and Babinz. Among other things the settlement agreement provided that Sprinkles' heirs would receive \$2 million under two other policies issued to Sinco; that Sprinkles' heirs would

submit their claims against Sinco and Babinz to arbitration; and that Sinco and Babinz would give Sprinkles' heirs an assignment of any rights against Fireman's Fund in exchange for Sprinkles' heirs' agreement not to enforce any judgment against Sinco's and Babinz's personal assets.

Thereafter, an arbitrator issued an award of over \$27 million in favor of Sprinkles' heirs and against Sinco and Babinz. The award included a finding that at the time of the accident, Babinz was acting within the course and scope of his employment with Sinco pursuant to the "required vehicle" exception to the "going and coming" rule. The superior court confirmed the award as a judgment.

Sprinkles' heirs, as assignees of Sinco and Babinz, then filed a bad faith action against Fireman's Fund. In the bad faith action, Sprinkles' heirs argued that the Fireman's Fund CGL policy's "auto" exclusion only applied to the use of an auto by an "insured," and that at the time of the accident Babinz was *not* an "insured." Specifically, Sprinkles' heirs argued that under the particular wording of the Fireman's Fund policy, an employee was an "insured" only if the employee was both acting "within the scope of [his or her] employment" by [Sinco] *and* "performing duties related to the conduct of [Sinco's] business." According to Sprinkles' heirs, at the time of Babinz's accident while driving to work, Babinz may have been acting "within the scope of [his] employment by [Sinco]," but he was *not* "performing duties related to the conduct of [Sinco's] business." Sprinkles' heirs thus asserted that since Babinz was not an "insured," the CGL policy's "auto" exclusion did not bar coverage for Sinco's liability arising out of Babinz's use of his car.

The trial court concluded that Babinz was an "insured" under the Fireman's Fund CGL policy, and that the policy's "auto" exclusion thus barred coverage for any liability Sinco had in the underlying wrongful death action. The trial court thus entered judgment in favor of Fireman's Fund. Sprinkles' heirs appealed.

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Holding

The Court of Appeal affirmed the judgment in favor of Fireman's Fund. The appellate court noted that under the so-called "going and coming rule," an employee is not deemed to be acting within the scope of his employment while going or coming from his place of work. However, the "going and coming" rule is subject to the "required vehicle" exception, which applies when an employer requires an employee to use his or her own vehicle for transportation on the job.

Here, pursuant to the "going and coming" rule's "required vehicle" exception, Babinz's act of driving to work was deemed to be an "act within the scope [his] employment by [Sinco]." Further, because the accident occurred while Babinz was on the way to work, Babinz was "performing duties related to the conduct of [Sinco's] business." Under such circumstances, Babinz was an "insured" under the Fireman's Fund CGL policy, and that policy's "auto" exclusion thus barred coverage for any liability Sinco had to Sprinkles' heirs in the underlying wrongful death action.

Comment

A standard CGL policy defines an "insured" so as to include the named insured's employees "for acts within the scope of their employment by you *or* while performing duties related to the conduct of your business." In contrast, the Fireman's Fund CGL policy's definition of "insured" dropped the disjunctive word "or," so that an "insured" included the named insured's employees "for acts within the scope of their employment by you while performing duties related to the conduct of your business." However, according to the appellate court, this slight difference in wording did not affect coverage under the Fireman's Fund CGL policy. According to the court, it is difficult to conceive of "acts within the scope of employment" that would not also constitute "duties related to the conduct of the business."

In Contribution Action, Once Participating Insurer Proves Potential Coverage Under Non-Participating

Insurer's Policy, Non-Participating Insurer Must Prove Absence of Actual Coverage

In an equitable contribution action between liability insurers, once a participating insurer proves a potential for coverage under a non-participating insurer's policy, the burden shifts to the non-participating insurer to prove the absence of actual coverage under its policy. (*Arrowood Indem. Co. v. Travelers Indem. Co. of Connecticut* (2010)188 Cal.App.4th 1452)

Facts

Ruth and George Dunmore (the Dunmores) owned an apartment complex. In *August 2000*, the Dunmores hired a general contractor, Krata, Inc. dba Five Star Services (Five Star), to perform dry rot remediation work at the property.

A few years later, in *November 2002*, the Dunmores hired Five Star to perform some additional dry rot remediation work at the property. Shortly after the November 2002 work, the Dunmores sold the property to Ron and Maureen Ashley (the Ashleys). Thereafter, the Ashleys allegedly discovered that the property had dry rot damage that Five Star either had not found or had found and concealed.

The Ashleys sued the Dunmores, and the Dunmores cross-complained against Five Star. Both the Ashleys' complaint and the Dunmores' cross-complaint contained allegations that, in *November 2002*, Five Star negligently failed to detect and repair dry rot conditions on the property. Neither the Ashleys' complaint nor the Dunmores' cross-complaint mentioned that, in *August 2000*, Five Star had also performed dry rot remediation work at the property.

Five Star had general liability coverage through Travelers Indemnity Company of Connecticut (Travelers) from July 1, 2000 to July 1, 2001 and Arrowood Indemnity Company (Arrowood) from July 1, 2002, to July 1, 2003. Both policies covered property damage occurring "during the policy

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period.” Because the pleadings in the tort case indicated that Five Star performed dry rot work at the property in *November 2002* (during Arrowood’s policy period), Arrowood agreed to defend Five Star under a reservation of rights. When it was subsequently shown through discovery that Five Star had also done dry rot work at the property in *August 2000* (during Travelers’ policy period), Travelers agreed to participate in Five Star’s defense, also subject to a reservation of rights.

In the course of the litigation, Five Star incurred defense costs of \$253,819. Most of that was paid by Arrowood, with the balance paid by Travelers. Following a jury trial, the court entered a judgment against Five Star for \$619,105 (consisting of compensatory damages, contractual attorney’s fees, costs and prejudgment interest). Arrowood paid most of the judgment, with Travelers contributing a small amount toward the contractual attorney’s fees part of the judgment.

Arrowood then filed a contribution action against Travelers, seeking a ruling that Travelers was responsible for more than what Travelers had contributed toward the costs of defending and indemnifying Five Star in the underlying action. Travelers cross-complained against Arrowood, asserting that Travelers never had a duty to defend or indemnify Five Star in the underlying action, and that Travelers was entitled to reimbursement of the amounts Travelers had contributed toward the defense and indemnification of Five Star.

The trial court concluded that all of the claims asserted against Five Star in the underlying litigation were based on Five Star’s alleged performance of dry rot remediation work in *November 2002*, which was *after* Travelers’ policy period. The trial court thus ruled that Travelers never had any duty to defend Five Star in the underlying action, and that Travelers was entitled to reimbursement of the amounts Traveler had contributed toward the defense and indemnification of Five Star. Arrowood appealed.

Holding

The Court of Appeal reversed. The appellate court agreed that the *pleadings* in the underlying case alleged tortious conduct by Five Star in *November 2002*, which was *after* Travelers’ policy period. However, the *extrinsic evidence* raised the possibility of tortious conduct by Five Star in *August 2000*, which was *during* Travelers’ policy period. Since it was possible that Five Star had engaged in tortious conduct during Travelers’ policy period that caused dry rot damage during Travelers’ policy period, Travelers had a duty to participate in *defending* Five Star.

With respect to whether Travelers had a duty to participate in *indemnifying* Five Star, the appellate court noted that during trial of the underlying case, there was evidence that Five Star negligently did dry rot repairs in both *November 2002 and August 2000*. Further, neither the jury instructions nor the special verdict form eliminated the possibility that some portion of the damages was based on Five Star’s work in *August 2000*. Thus, it was possible that a portion of the judgment against Five Star was based on work that Five Star performed – and hence property damage that occurred – during Travelers’ policy period.

The appellate court went on to hold that, once Arrowood satisfied its burden of proving a *potential for coverage* under the Travelers policy, the burden shifted to Travelers to prove the *absence of actual coverage* under the Travelers policy. That is, once Arrowood proved that Travelers had a *duty to defend*, Travelers had to prove that it had *no duty to indemnify*. Since Travelers had not established that it had no duty to indemnify, the appellate court remanded the matter to the trial court to determine how defense and indemnity costs should be allocated between Arrowood and Travelers.

Comment

The decision in this case is consistent with an earlier case, namely, *Safeco Ins. Co. of America v. Superior Court* (2006) 140 Cal.App.4th 874. These cases make it easier for a participating insurer to recover contribution from a non-participating

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insurer, irrespective of whether the underlying case is resolved by way of settlement or judgment. Once the participating insurer shows that there was a potential for coverage (i.e., a duty to defend), the non-participating insurer must show that there was no actual coverage (i.e., no duty to indemnify). In many cases, the non-participating insurer will have difficulty meeting that burden. If the non-participating insurer cannot prove the absence of actual coverage, then the question simply becomes how the trial court will, in its discretion, allocate the loss between the insurers.

Policy's "Anti-Montrose" Endorsements Do Not Eliminate Insurer's Duty to Defend Insured in "Continuous and Progressively-Deteriorating" Property Damage Case

A general liability policy's "anti-Montrose" endorsements did not eliminate an insurer's duty to defend an insured subcontractor in a construction defect case involving "continuous and progressively-deteriorating" property damage. (*Pennsylvania General Ins. Co. v. American Safety Indemnity Co.* (2010) 185 Cal.App.4th 1515)

Facts

D.A. Whitacre Construction, Inc. (Whitacre) was a framing subcontractor. Whitacre purchased general liability policies through Pennsylvania General Insurance Company (Pennsylvania General) for the period of October 1998 through December 2001. During the time the Pennsylvania General policies were in force, Whitacre both started and completed framing work on a residential construction project. After the last Pennsylvania General policy expired, and after Whitacre completed its framing work on the project, Whitacre purchased a general liability policy through American Safety Indemnity Company (ASIC) for the period of December 2001 through December 2002.

In subsequent construction defect litigation involving Whitacre, various parties alleged that Whitacre's framing work on the project was

deficient and had caused continuous property damage to the project. However, it was unclear when that property damage had first started.

Whitacre tendered its defense to both Pennsylvania General and ASIC. Pennsylvania General agreed to defend Whitacre under a reservation of rights and ultimately paid all the defense and settlement costs on behalf of Whitacre. ASIC declined Whitacre's tender on the ground that the ASIC policy contained "anti-Montrose" endorsements under which coverage was triggered only if both the "occurrence" (i.e., the causal act) and the "property damage" (i.e., the result) happened "during the policy period." ASIC asserted that since the "occurrence" (i.e., Whitacre's negligent work) took place before inception of the ASIC policy, the ASIC policy was not potentially triggered.

After the underlying construction defect litigation was settled, Pennsylvania General filed a lawsuit against ASIC seeking equitable contribution from ASIC for a portion of the defense and indemnity costs that Pennsylvania General had paid on behalf of Whitacre. The trial court entered summary judgment in favor of ASIC, concluding that ASIC's policy excluded coverage for the claims asserted against Whitacre in the construction defect litigation because Whitacre's work was completed before the inception of ASIC's policy. Pennsylvania General appealed.

Holding

The Court of Appeal reversed, holding that ASIC's policy did potentially cover Whitacre's alleged liability in the underlying construction defect litigation, and that ASIC therefore was obligated to pay a portion of the costs of defending and indemnifying Whitacre in the construction defect litigation.

The appellate court acknowledged that the ASIC policy contained two endorsements that were apparently intended to circumvent the "continuous injury" trigger of coverage set forth in *Montrose Chemical Corp v. Admiral Ins Co.* (1995) 10 Cal.4th 645. The first endorsement amended the

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ASIC policy's definition of "occurrence" by adding the following italicized language: "Occurrence' means an accident, including continuous or repeated exposure to substantially the same general harmful conditions *that happens during the term of this insurance. 'Property damage' ... which commenced prior to the effective date of this insurance will be deemed to have happened prior to, and not during, the term of this insurance.*" (Italics added.) The second endorsement, entitled "Pre-Existing Injury or Damage Exclusion," stated: "This insurance does not apply to: ... any 'occurrence', incident or 'suit' ... (a) which first occurred prior to the inception date of this policy ...; or (b) which is, or is alleged to be, in the process of occurring as of the inception date of this policy ... even if the 'occurrence' continues during this policy period."

ASIC argued that in light of these endorsements, coverage under the ASIC policy was triggered only if both the "occurrence" (i.e., the causal act) and the "property damage" (i.e., the result) happened "during the policy period." The appellate court disagreed, stating that the ASIC policy's endorsements do "not clearly and unambiguously limit coverage" to claims in which both the causal act and the property damage occur during the policy period. According to the appellate court, the ASIC policy limited coverage to property damage that first occurred during the policy period, but there was a factual dispute as to when the property damage in the underlying construction defect litigation first occurred. As such, ASIC had a duty to participate with Pennsylvania General in defending Whitacre in the underlying construction defect litigation.

Comment

The ASIC policy endorsements were obviously designed to circumvent the "continuous injury" trigger rule set forth in the *Montrose decision*. However, as the appellate court correctly noted, under the ASIC endorsements, "the appropriate focus is on *when the damages caused by the negligent causal acts of the insured first commenced, ... not on when the insured completed its work.*" Because it was unclear when property damage first began, the trial court erred in

granting summary judgment in ASIC's favor. The claims against Whitacre in the underlying construction defect litigation were potentially covered under both the Pennsylvania General and ASIC policies.

Insurer Has Duty to Defend Insured Against Lawsuit That Potentially Alleges Claim for Slogan Infringement

A general liability insurer had a duty to defend its insured against an underlying lawsuit that potentially alleged a claim for "infringement of slogan." (*Hudson Ins. Co. v. Colony Ins. Co.* (9th Cir. 2010) 624 F.3d 1264)

Facts

Hudson Insurance Company (Hudson) and Colony Insurance Company (Colony) both issued liability policies to a sports memorabilia company, All-Authentic Corporation (All-Authentic). The National Football League (NFL) later filed a trademark infringement suit against All-Authentic, alleging that All-Authentic had sold counterfeit NFL jerseys on All-Authentic's website, including a "Steel Curtain Custom Limited Edition Steelers Jersey." The NFL alleged that the counterfeit jerseys had the words "Steel Curtain" on the back, strongly resembled the actual jerseys worn by the NFL's Pittsburgh Steelers, and infringed the trademarked phrase "Steel Curtain".

Hudson agreed to defend All-Authentic, while Colony refused to defend. After Hudson settled the NFL lawsuit, Hudson sought equitable contribution from Colony for 50% of the defense fees and costs Hudson incurred in that lawsuit.

The federal district court granted Hudson's motion for partial summary judgment against Colony, ruling that Colony had a duty to participate in defending All-Authentic in the underlying lawsuit brought by the NFL. The court held that the NFL's complaint *potentially* alleged a claim against All-Authentic for "infringement of slogan" covered by the "personal and advertising injury" section of the Colony policy. That was true even though the

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NFL's complaint did not refer to "Steel Curtain" as a slogan or explicitly allege a claim entitled "infringement of slogan." Colony appealed.

Holding

The Ninth Circuit Court of Appeals, applying California law, affirmed the district court's ruling in favor of Hudson. The Ninth Circuit held that a "slogan" is a brief attention-getting phrase used in advertising and promotion, and that a fair reading of the NFL's complaint revealed that the phrase "Steel Curtain" was used to promote fan loyalty to the Pittsburgh Steelers in general and a subset of those fans in particular. The phrase "Steel Curtain" therefore qualified as a slogan and All-Authentic's alleged unauthorized use of the phrase "Steel Curtain" in connection with the sale of its jerseys potentially supported a claim for "infringement of slogan."

Since facts supporting a legal theory of slogan infringement were alleged in the NFL complaint, the Ninth Circuit rejected Colony's argument that Hudson "was speculating about unpled claims to manufacture a potential for coverage."

The Ninth Circuit also rejected as irrelevant Colony's theory that the NFL consciously chose not to assert a claim for slogan infringement against All-Authentic. The court emphasized that the complaint as alleged created a "potential" for a covered slogan infringement claim.

Finally, the Ninth Circuit acknowledged ambiguity in the complaint as to the NFL's ownership of the "Steel Curtain" slogan or its standing to sue for slogan infringement. However, the court held that any ambiguity in the complaint or doubt regarding the duty to defend must be resolved in favor of coverage.

Comment

Insureds frequently seek to obtain "advertising injury" or "personal and advertising injury" coverage for trademark infringement suits by arguing that the infringed mark is a "slogan." Generally a trademarked word or business name

like "IBM," "Apple" or "Boss" is not a slogan. (See, *Palmer v. Truck Insurance Exchange* (1999) 21 Cal.4th1109 [the name "Valencia" not a slogan].) However, if the trademark is a phrase with descriptive words used in advertising, a Court may find potential coverage. Other examples of slogans in case law include the phrase "Wearable Light" to advertise a flashlight and the phrase "Touch of Class" to advertise jewelry.

BAD FAITH

Defending Under One Policy Does Not Insulate Insurer from Liability for Alleged Breach of Duty to Defend / Settle Under Second Policy

When an insured has two policies through the same insurer, providing a defense under one policy does not insulate the insurer from liability for its alleged breach of the duty to defend and settle under a second policy. (*Risely v. Interinsurance Exchange of the Automobile Club* (2010) 183 Cal.App.4th 196)

Facts

Sean Turner gave Lisa Risely a ride in his car and then allegedly began to drive erratically and negligently. Risely allegedly asked Turner to stop and to immediately take her home, but Turner refused. An accident occurred in which Risely suffered severe injuries. Risely sued Turner for motor vehicle negligence, negligence per se and false imprisonment.

At the time of the incident, Turner was insured under an automobile policy and a homeowners policy, both issued by the Interinsurance Exchange of the Automobile Club (Exchange). The automobile policy had limits of \$50,000 but did *not* provide coverage for personal injury arising from false imprisonment. The homeowners policy had limits of \$300,000 and *did* provide coverage for personal injury arising from false imprisonment.

The Exchange defended Turner under the automobile policy but did not defend him under the

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homeowners policy. The Exchange rejected an offer to settle the claim for \$300,000 on the ground that it was in excess of the policy limits of the automobile policy and that there was no other applicable coverage.

Risely and Turner then stipulated to a judgment of \$434,000 on Risely's false imprisonment claim against Turner. As part of this arrangement, Risely received an assignment of all claims Turner might have against the Exchange. Risely then sued the Exchange for alleged bad faith arising from the Exchange's refusal under the homeowners policy to defend and indemnify Turner against Risely's false imprisonment claim.

The trial court granted summary judgment in favor of the Exchange and held that the Exchange could not be bound by Turner's and Risely's agreement to settle. The trial court reasoned that because the Exchange provided Turner with a complete defense to Risely's lawsuit under the automobile policy, it fulfilled its contractual obligation to provide a defense and the failure to defend under the homeowners policy was of "no consequence" to the insured, Turner. The trial court further held that when an insurer provides a complete defense to an insured, a settlement of an action by the insured without the consent of the insurer is insufficient to impose liability on the insurer in a later action against the insurer. Risely appealed.

Holding

The Court of Appeal reversed the summary judgment. According to the appellate court, "the mere fact that the insurer provided its insured with a defense under one policy does not necessarily insulate the insurer from liability for its alleged breach of the duty to defend and settle under a second policy." The court reasoned that the Exchange's refusal to defend Turner under the homeowners policy "... potentially increased the insured's [Turner's] exposure to personal liability." Therefore, the Exchange had not established as a matter of law that Risely could not show damages.

Comment

Under *Wint v. Fidelity & Casualty Co.* (1973) 9 Cal. 3d 257, where a non-defending insurer's failure to provide a defense potentially increases the insured's exposure to personal liability, the insured can demonstrate damages from an alleged breach of the duty to defend, notwithstanding that another insurer assumed the costs of providing a defense. In the present case, the appellate court acknowledged that there is no reported decision dealing with a single insurer's breach of its duty to defend under one of two policies. However, despite the fact that *Wint* dealt with two different insurers, the court in this case found no reason why the law should differ depending on whether the policies are issued by one insurer or multiple insurers.

Note that in this case, there has not yet been any determination regarding whether the homeowners policy actually covered Turner's alleged liability to Risely. If the homeowners policy did not in fact cover Turner's alleged liability to Risely, then presumably the Exchange would face no liability for failing to defend and settle under the homeowners policy.

Insurer Acts in Bad Faith in Failing to Defend and Indemnify Insured Bishop In Suit Arising From Priest's Sexual Molestation of Parishioner

An insurer was found to have acted in bad faith in failing to defend and indemnify its insured, a catholic bishop, in a case arising from a priest's sexual molestation of a young parishioner. (*Howard v. American National Fire Insurance Company* (2010) 187 Cal.App.4th 498)

Facts

The Roman Catholic Bishop of Stockton (Bishop) employed a priest, Father Oliver O'Grady (O'Grady), who sexually molested a young parishioner, James Howard (James). After O'Grady was criminally convicted, James filed a civil suit against O'Grady, alleging that O'Grady repeatedly molested James "beginning in

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approximately 1979” and continuing through 1988. James also named the Bishop as a defendant, alleging that the Bishop had negligently supervised and retained O’Grady.

The Bishop tendered the defense of the action to various insurers, including American National Fire Insurance Company (American), which had issued a \$500,000 general liability policy to the Bishop for the period of November 1, 1978 through November 1, 1979. Although James alleged in his complaint that the molestations began “in approximately 1979” (*during* American’s policy period), American relied on one part of James’ deposition testimony to conclude that the molestations actually began in 1984 (*after* American’s policy period). American thus declined to participate in the Bishop’s defense, asserting that James had not suffered any bodily injury “during the [American] policy period.” Other insurers defended the Bishop under a reservation of rights.

Before trial, James offered to settle his claims against the Bishop for \$1.85 million, which was more than American’s policy limit of \$500,000 but less than all of the insurers’ combined limits of \$4.3 million. American did not offer to contribute toward settlement, and the case proceeded to trial.

A jury found the Bishop liable and the trial court entered a judgment against the Bishop for \$5.5 million (\$2.5 million in compensatory damages and \$3 million in punitive damages). The Bishop had difficulty providing collateral for an appeal bond and, fearing the loss of diocese assets, the Bishop negotiated a settlement with James. The settlement involved a partial payment of the judgment by the Bishop and some of his insurers. In addition, the Bishop agreed to prosecute litigation against American and pay any proceeds to James. The participating insurers also assigned their contribution rights to James.

Thereafter, James filed a judgment creditor action against American in an attempt to collect on his judgment. In addition, the Bishop filed a breach of contract / bad faith action against American for failing to defend and indemnify him against James’ lawsuit. The actions were consolidated in the trial court. The trial court found that American had a

duty to defend and indemnify the Bishop against James’ lawsuit, and that American had acted in bad faith in failing to defend and indemnify the Bishop. The court awarded James (as judgment creditor) the policy limit of \$500,000, and the Bishop (as insured) additional bad faith damages of approximately \$2.5 million. American appealed.

Holding

In a wide-ranging opinion, the Court of Appeal affirmed the judgment in all material respects.

With respect to the duty to defend, the appellate court agreed that American had a duty to defend the Bishop in the underlying action filed by James. In his complaint in the underlying action, James had alleged that the molestations began “in approximately 1979,” and in his deposition in the underlying action, James had testified that he had “vague memories ... that [molestations] started during the late ‘70s.” That was sufficient to raise the *possibility* that James had suffered bodily injury during the American policy period (i.e., November 1978 to November 1979). American’s sole ground for refusing to defend the Bishop in the underlying action was an isolated part of James’ deposition in which he testified that the “first detailed incident” he could recall occurred in 1984 (after American’s policy period). However, according to the appellate court, that was merely the first “detailed” incident James could recall, and did not preclude the possibility that James had been molested during American’s policy period. As such, American had a duty to defend the Bishop against James’ lawsuit.

With respect to the duty to indemnify, the appellate court likewise agreed that American had a duty to indemnify the Bishop for the underlying judgment entered in favor of James. It was true that at the trial in the *underlying action* James did not present any evidence that he had been molested during the American policy period. However, that did *not* prevent James from introducing evidence in the *coverage action* that he had in fact been molested during the policy period. According to the appellate court, the evidence in the underlying action simply focused on *whether* the Bishop had negligently allowed O’Grady to molest James, and did not focus on *when* the molestations had occurred. In

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the coverage action, James presented both testimonial and documentary evidence that he had been molested during American's policy period, and that was sufficient to support the trial court's conclusion that American was obligated to indemnify the Bishop for the underlying judgment entered in favor of James.

The appellate court also concluded that American had breached its implied duty to settle the underlying action on behalf of the Bishop. The court rejected American's assertion that because James had never made a settlement demand within American's \$500,000 policy limit, American alone could not have settled the underlying action. The court acknowledged held that in actions involving a single insurer, a settlement offer within policy limits generally is necessary to support a finding of bad faith. However, the court concluded that where multiple insurers are on the risk, an insurer can be held liable for failure to settle if the settlement offer is less than the total limits of all policies insuring the risk. Here, although American's policy limit was \$500,000, there was a settlement demand for \$1.85 million that was well within the various primary insurers' aggregate policy limits totaling \$4.3 million. The appellate court reasoned that if American and the other insurers had responded to this offer, the underlying case could have been settled.

In addition, the appellate court rejected American's argument that its refusal to settle was prompted by a "genuine dispute" concerning coverage and that this precluded a finding of bad faith. According to the court, an insurer in a third-party case may not rely on a genuine dispute over coverage to refuse a reasonable settlement demand. Moreover, even if the genuine dispute doctrine did apply, American's "no-coverage" position was founded on an unfair and selective reading of James' deposition testimony that distorted James' account of specific episodes of molestation into an admission that no molestation occurred during the policy period. Thus, even if the genuine dispute doctrine could apply in a third party case involving a coverage dispute, the doctrine would not apply here, since American's coverage position was not maintained reasonably and in good faith.

The appellate court held that American was liable for various items of damage, including but not limited to (1) the \$500,000 policy limit owed to James as judgment creditor, (2) approximately \$1.5 million the Bishop had contributed to the settlement with James, (3) attorney's fees ("*Brandt* fees") of approximately \$662,000 and (4) prejudgment interest of approximately \$1.4 million.

Comment

At least in hindsight, it seems clear that American did have a duty to defend the Bishop in the underlying lawsuit filed by James. At a minimum, there was a factual dispute about when James was molested, and that factual dispute by itself was sufficient to create a potential for coverage and, hence, a duty to defend. Having found a duty to defend, the trial court the appellate court were both willing to impose significant damages on American, despite the fact that (1) other insurers had defended the Bishop, (2) there was never any settlement demand within American's policy limits and (3) the compensatory damages awarded against the Bishop did not exceed the total of all insurers' policy limits.

AGENTS & BROKERS

"Evidence of Insurance" Was Binder and, Despite Terms of Written Producer's Agreement, Producer Issuing Binder Was Insurer's Agent

An "Evidence of Insurance" form was a binder and, despite the express terms of a written agreement between a producer and an insurer, the producer who issued the binder was the insurer's agent. (*Chicago Title Insurance Company v. AMZ Insurance Services, Inc.* (2010) 188 Cal.App.4th 401)

Facts

Thomas Mustain and Cheryl Mustain (the Mustains) sought to refinance an existing home loan. They hired a loan broker who, in turn,

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contacted New Century Mortgage (New Century), the proposed lender. New Century instructed Chicago Title Insurance Company (Chicago Title) to open an escrow for the transaction.

New Century would not fund the loan without evidence the Mustains had purchased an insurance policy for the property. As such, the loan broker contacted an insurance producer, AMZ Insurance Services, Inc. (AMZ), and requested that AMZ obtain insurance and provide Chicago Title with evidence of insurance. The initial premium was supposed to be paid through escrow.

AMZ transacted business with Pacific Specialty Insurance Company (PSIC) on a regular basis, but PSIC had never filed a notice of agency appointment filed with the Department of Insurance (an action which clearly would have made AMZ an agent of PSIC). Although PSIC never appointed AMZ as an agent, PSIC did have a written producer's agreement with AMZ. The producer's agreement stated that AMZ was not PSIC's agent, and that AMZ did not have authority to bind coverage until AMZ had first transmitted a signed application and collected at least a partial premium payment, and until PSIC had receiving written approval to bind from PSIC.

Despite the express terms of the producer's agreement, PSIC knew that, on at least 30 prior occasions, AMZ had issued a form entitled "Evidence of Insurance" (EOI) without first obtaining a written application or collecting at least a partial premium payment. In other words, PSIC and AMZ engaged in a course of conduct over time that was inconsistent with the terms of the written producer's agreement.

AMZ provided Chicago Title with an EOI form that stated on its face that "[t]his is evidence that insurance as identified below has been issued, is in force, and conveys all the rights and privileges afforded under the policy." The EOI identified the insurer as PSIC, the insureds as the Mustains, the address of the Mustains' property, the nature and limits of coverage, the amount of the deductible, the amount of the annual premium, and the effective date of coverage.

After AMZ issued the EOI, New Century funded the loan and escrow closed. However, although the premium was supposed to be paid from the escrow account, Chicago Title failed to remit the premium. Shortly after the close of escrow, a fire destroyed the house and killed Mr. Mustain.

PSIC refused to pay Ms. Mustain's property insurance claim, asserting that the EOI was not a binder, that no one had paid the premium payment, and that AMZ was not PSIC's agent. Chicago Title paid Ms. Mustain \$270,200 (the full amount she would have been entitled to recover if PSIC had issued the policy described on the EOI), and she assigned to Chicago Title all of her rights against PSIC, AMZ and others.

A jury found PSIC liable to Chicago Title for breach of contract and bad faith. The court entered judgment in favor of Chicago Title for \$270,200 as contract damages and approximately \$210,000 in bad faith damages for the attorney fees that Chicago Title incurred. Thereafter, PSIC appealed.

Holding

The Court of Appeal affirmed. The EOI form that AMZ issued qualified as a binder, which is a contract that temporarily obligates the insurer to provide insurance coverage pending issuance of the insurance policy for which the applicant has applied. Per Insurance Code section 382.5, a binder is a writing that includes, among other things, the name and address of the insured (and any additional named insureds, mortgagees, or lienholders), a description of the property insured, a description of the nature and amount of coverage, any special exclusions not contained in a standard policy, the identity of the insurer and the agent executing the binder, the effective date of coverage.

Although AMZ did not adhere to the terms of the written producer's agreement, the evidence established that, through a pattern of dealing in prior escrow transactions, PSIC had authorized AMZ to bind coverage by issuing an EOI before receiving a signed application and collecting any premium.

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Although PSIC had not filed a notice appointing AMZ as an agent, and despite the terms of the written producer's agreement, there was substantial evidence to support the jury's determination that AMZ had actual authority to bind PSIC by issuing EOI forms for escrow transactions.

Comment

In this instance, it appears that PSIC put form over substance on several different occasions. For example, PSIC insisted that the EOI form was not a binder, even though the EOI form contained all of the statutory elements of a binder. In addition, PSIC steadfastly maintained that AMZ was not PSIC's agent, even though the evidence established that, through a course of conduct, PSIC had allowed AMZ to deviate from the terms of the written producer's agreement and that PSIC effectively had made AMZ an agent for the purpose of binding coverage in connection with escrow transactions.

In retrospect, it might have been more cost-effective for PSIC to pay the insurance claim under a reservation of rights and to then seek to recoup the money from Chicago Title and/or AMZ. Instead, PSIC denied coverage outright, and exposed itself not only to a contract claim but to a bad faith claim. Because Ms. Mustain assigned her contractual and extra-contractual claims to Chicago Title, PSIC ultimately had to pay the contract claim and Chicago Title's attorney fees (per the *Brandt* case).

RESCISSION

Where Insured Contends Insurer Fraudulently Induced Settlement Agreement, Insured Cannot Affirm Agreement and Sue for Damages, But Instead Must Seek Rescission

Where an insured contends an insurer fraudulently induced the insured into entering into a settlement agreement, the insured cannot affirm the agreement, keep the money and sue for damages but, instead, must seek to rescind the settlement agreement in accordance with California's

rescission statutes. (*Village Northridge Homeowners Association v. State Farm Fire and Casualty Company* (2010) 50 Cal.4th 913)

Facts

An earthquake caused damage to property that Village Northridge Homeowners Association (Village Northridge) owned. Village Northridge made a claim to its insurer, State Farm Fire and Casualty Company (State Farm).

State Farm represented that the policy limit for earthquake damage was \$4,979,900, with a 10 percent deductible. State Farm made several payments, totaling about \$2,068,000, to Village Northridge for the earthquake loss.

Later, Village Northridge located documents indicating the limits were different than State Farm had represented. In addition, Village Northridge discovered additional allegedly caused by the earthquake. State Farm re-inspected the property and concluded that some of the additional damage was earthquake-related, while other damage was not. State Farm paid Village Northridge about \$7,466 for the additional damage.

Still later, although they continued to dispute the policy limits and the amount of money owed, Village Northridge and State Farm negotiated a written settlement agreement by which State Farm paid an additional \$1.5 million. Pursuant to the settlement, Village Northridge released State Farm from all known or unknown claims related in any way to Village Northridge's earthquake claim. More specifically, Village Northridge specifically agreed to "refrain and forbear from commencing, instituting, or prosecuting any lawsuit, action, or any other proceeding against [State Farm] based on, arising out of, or in connection with any claims, actions, causes of action, charges, demands, contracts, covenants, liabilities, obligations, expenses . . . and damages that are released and discharged."

After entering into the settlement agreement and accepting the \$1.5 million settlement payment, Village Northridge sued State Farm. In its

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complaint, Village Northridge alleged that State Farm had misrepresented that the policy limit for earthquake damage was only \$4,979,900, and that the actual limit was much higher. Village Northridge also alleged that the \$1.5 million additional settlement State Farm paid was grossly deficient and represented only a partial payment for the actual damage. In addition, Village Northridge alleged that it had signed the settlement agreement "under compulsion" in order "secure partial benefits owed."

Significantly, Village Northridge insisted throughout the litigation that it did *not* seek to rescind the settlement agreement and that it did *not* intend to refund the \$1.5 million that State Farm had paid. Instead, Village Northridge asserted that it wanted affirm the release and to sue for additional damages.

The trial court ruled in favor of State Farm, and concluded that Village Northridge "could not affirm the settlement agreement and simultaneously assert claims that were explicitly released in it." The case went to the Court of Appeal and, eventually, to the California Supreme Court.

Holding

The Supreme Court ruled in favor of State Farm, and concluded that Village Northridge could not affirm the settlement agreement and simultaneously assert claims that were explicitly released in the settlement agreement. The Court noted that California statutes and California case law specify the rules under which a party can seek to set aside a settlement agreement.

Village Northridge alleged State Farm committed fraud in the inducement in the settlement process by misrepresenting policy limits. Generally, when one party contends he entered into a contract because he was induced to do so by fraud, that party must rescind the agreement.

Civil Code section 1691 requires the party seeking rescission to give notice to the other party "as to whom he rescinds," and to restore all consideration or "everything of value which he has received"

under the contract. A related statute, Civil Code section 1693, provides that a party who files an action for rescission "shall not be denied relief because of a delay in restoring or in tendering restoration of such benefits before judgment unless such delay has been substantially prejudicial to the other party; but the court may make a tender of restoration a condition of its judgment."

Although California has rejected the "affirm and sue" principle adopted by several states, Civil Code section 1693 permits a plaintiff who is unable to restore the consideration received through a settlement agreement to delay the restoration of consideration until final judgment consistent with equitable principles, including that the defendant not be substantially prejudiced by the delay. Had Village Northridge sued for rescission of its release under the statutory scheme governing rescission, it might have had the opportunity to delay restoration of the consideration it received in settling the property damage matter. Again, however, Village Park never attempted to rescind the settlement agreement.

Comment

To allow an insured to settle with an insurer and sign a release, keep the money, and then sue the insurer for alleged fraud without rescinding the release under California's statutory scheme would violate the terms of the bargain and frustrate its purpose. It would also likely inhibit insurance companies' practice of using a release to settle disputed claims. The Legislature has created a fair and equitable remedy to address the alleged fraud problem: rescission of the release, followed by suit. When restoration is impossible because the settlement monies have been spent, the financially constrained parties can turn to Civil Code section 1693 to delay restoration until judgment, unless the defendants can show substantial prejudice.

Insurer's Failure to Follow Own Underwriting Guidelines' Investigation Requirements Does Not Prevent Insurer from Later Raising Insured's

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Material Misrepresentation on Application as Defense to Coverage

An insurer who fails to follow its own underwriting guidelines' investigation requirements, and who as a result does not discover an applicant's material misrepresentations, may still raise the applicant's misrepresentations as a defense to coverage. (*Colony Ins. Co. v. Crusader Ins. Co.* (2010) 188 Cal.App.4th 743)

Facts

Positive Investments, Inc. ("PII") owned a residential apartment building. On three different occasions 2002, PII was cited by the Los Angeles Housing Department for habitability violations.

The following year, PII submitted an application for a general liability policy to Crusader Insurance Company ("Crusader"). Among other things, the application asked whether any governmental department had ever notified PII of any deficiencies or code violations regarding PII's building. PII answered "No."

Crusader's internal guidelines required its underwriters to attempt to verify the existence of any citations against a building through public records. Although the underwriter of the PII policy attempted to check the building's history through an unofficial website, the website was not current, and the underwriter did not discover the 2002 citations.

In reliance on the representations in the application, Crusader issued a liability policy to PII that covered tenants' claims of substandard living conditions. Crusader did not know about the 2002 citations at the time it issued the policy; if it had, it would not have issued the policy.

PII was later sued by several tenants. Crusader initially agreed to defend the action under a reservation of rights. However, when Crusader learned of the 2002 citations during the course of the litigation, it denied coverage and withdrew from the defense, citing PII's material

misrepresentations on the application as the basis for denial.

Colony Insurance Company ("Colony"), which insured PII after Crusader, defended PII against the tenants' lawsuit. Colony then sued Crusader for equitable contribution of defense costs and declaratory relief regarding the materiality of PII's misrepresentations. Following a bench trial, the trial court found in favor of Crusader.

Holding

The Court of Appeal affirmed, finding that despite Crusader's failure to follow its own underwriting guidelines, Crusader was not barred by either estoppel or waiver from asserting the misrepresentation defense.

First, the Court held that Crusader was not equitably estopped from raising PII's material misrepresentation as a defense to coverage because the first element of estoppel — knowledge of the facts — was not met. Crusader did not actually learn of the 2002 citations until midway through the underlying litigation. Further, it was of no consequence that an investigation in compliance with its own guidelines might have uncovered the citations, because Crusader was not legally obligated to follow its internal guidelines. To the contrary, there was no evidence that PII had detrimentally relied on the guidelines, and Crusader's policy expressly provided that it "embodie[d] all agreements between the insured and the company," thus reflecting the lack of any enforceable right resulting from the guidelines.

Second, the Court held that Crusader's failure to follow its guidelines did not result in a waiver of its misrepresentation defense. Waiver requires the intentional relinquishment of a known right, and there was no evidence that Crusader, which did not discover the citations until midway through the litigation, intentionally relinquished any such right. Moreover, the guidelines themselves could not result in a waiver because California's statutes expressly permit an insurer to rely on an insured's representations.

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Last, the Court rejected Colony's argument that Crusader had engaged in improper "post-claims underwriting." Although post-claims underwriting is prohibited in the context of health insurance and in third-party claims against auto insurers, those rules are founded in fact-specific public policy considerations and are not applicable to other types of insurance claims.

Comment

Although not specifically addressed by the Court, this case assumes that an insured's material misrepresentation on an application submitted to one insurer can give that insurer a complete defense to an equitable contribution claim by another insurer. That, in any event, was the net effect of the Court's ruling.