2014 ANNUAL REVIEW OF CALIFORNIA INSURANCE LAW

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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 from December 2013 through November 2014 that will impact your California claims next year.

Best wishes for the coming year.

SMITH SMITH & FEELEY LLP

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PENDING BEFORE THE CALIFORNIA SUPREME COURT

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

Fluor Corp. v. Superior Court (Case No. S205889) - Are the limitations on assignment of third party liability insurance policy benefits recognized in Henkel Corp. v. Hartford Accident & Indemnity Co. (2003) 29 Cal.4th 934 inconsistent with the provisions of Insurance Code section 520?

Hartford Casualty Ins. Co. v. J.R. Marketing, L.L.C. (Case No. S211645) - After an insured has secured a judgment requiring an insurer to provide independent counsel to the insured, can the insurer seek reimbursement of defense fees and costs it considers unreasonable and unnecessary by pursuing a reimbursement action against independent counsel or can the insurer seek reimbursement only from its insured?

Nickerson v. Stonebridge Life Ins. Co. (Case No. S213873) - Is an award of attorney fees under *Brandt v. Superior Court* (1985) 37 Cal.3d 813 properly included as compensatory damages where the fees are awarded by the jury, but excluded from compensatory damages when they are awarded by the trial court after the jury has rendered its verdict?

MISCELLANEOUS

PROPERTY INSURANCE

Subrogation Action Fails Where Insurer Failed to Give Timely Notice to Residential Home Builder Under "Right to Repair" Statute

Where a residential home builder's sales contract included a right-to-repair addendum based on a "Right to Repair" statute, an insurer who arranged for repairs of water damage to an insured's property before notifying the builder was barred from pursuing a subrogation action against the builder. (*KB Home Greater Los Angeles, Inc. v. Superior Court* (2014) 223 Cal.App.4th 1471)

Facts

Dipak Roy purchased a new home from KB Home Greater Los Angeles, Inc., a builder. The purchase agreement Roy signed included a right-to-repair addendum that was based on the "Right to Repair Act" set forth in Civil Code section 895 et seq. The addendum outlined the pre-litigation procedures of the Right to Repair Act and listed KB Home's corporate address, where notices of defect claims were to be sent. The limited warranty agreement allowed for telephone notice in cases of emergency, to be followed by a reasonably-timely written warranty claim.

A property manager discovered a water leak in Roy's house, which was vacant at the time. The property manager shut off the water and called Roy, who in turn called his insurer, Allstate Insurance Company. A mitigation company removed excess water, as well as some water-damaged dry wall and carpet. Allstate inspected the property and paid for repairs of the home within the next few months. About one month after repairs were completed, Allstate sent KB Home a notice that Allstate intended to pursue subrogation to recover the payments made to the insured, Roy. KB Home did not respond.

Eventually, Allstate filed a complaint in subrogation against KB Home. After a lengthy battle regarding the sufficiency of the pleadings, Allstate filed an amended complaint that advanced a single cause of action for property damage based upon defective construction, as defined in the Right to Repair Act.

Eventually, KB Home filed a motion for summary judgment based on Allstate's failure to give KB Home timely notice (under the Right to Repair Act) to allow KB Home to repair the defect. However, Allstate filed its own motion for summary judgment, asserting that KB Home had violated building standards set forth in the Right to Repair Act and was statutorily liable for damages, and further arguing that, in the event of actual resulting damage (such as the water damage that had occurred), the Right to Repair Act did not require notice to the builder before repairs began. The trial court granted Allstate's motion for summary judgment. KB Home sought review by the Court of Appeal.

Holding

The Court of Appeal reversed. It held that at least where an owner (or an owner's insurer in a subrogation action) files suit against a builder based *solely* on the theory that, when constructing an improvement, the builder violated standards set forth in the Right to Repair Act, the owner (or insurer) must allege and prove timely notice to the builder. Here, the appellate court concluded that Allstate's admitted failure to contact KB Home until *after* repairs were completed was fatal to Allstate's cause of action under the Right to Repair Act, and that KB Home was therefore entitled to summary judgment. The appellate court further held that even "catastrophic" damage cannot be an excuse to deprive a builder of its statutory right to receive timely notice of a defect, to inspect the property, to offer to repair the defect and to compensate the homeowner.

Comment

The Right to Repair Act applies to the original construction of individual homes sold after January 1, 2003. It provides definitions; describes actionable construction defects by setting forth standards for residential construction; requires the builder to provide an express limited warranty covering the fit and finish of specified building components; addresses the builder's obligations if the builder offers greater protection to the homeowner through an enhanced protection agreement; sets forth a pre-litigation procedure designed to give a builder the opportunity, before litigation commences, to repair defects brought to its attention by a homeowner's claim; and sets forth standards for litigation, such as the deadline for filing a lawsuit, the burden of proof, damages that may be recovered, and defenses the builder may assert.

The Right to Repair Act further requires an owner to provide a written notice of a violation of any of the building standards, and sets forth a detailed set of procedures that is to follow the written notice. Among other things, the Right to Repair Act gives the builder an opportunity to inspect and test, and provides for mediation, a repair offer or a cash offer. The owner can be released from this pre-litigation procedure and may file a lawsuit if the builder does not acknowledge receipt of the owner's notice; elects not to go through the procedure; fails to request an inspection; fails to make an offer to repair; makes a cash offer that the homeowner rejects; does not complete the repair in time; or does not comply with other statutory timeframes.

Here Allstate's case against KB Home was based on KB Home's failure to construct the house in accordance with the requirements of the Right to Repair Act. Thus, when Allstate sought recovery for the defect, KB Home successfully argued that Allstate's repair of the defect and the resulting damage *before* giving notice to KB Home precluded Allstate from recovering damages through subrogation. This case appears to leave open the possibility that an owner (or insurer) that is seeking to recover under *other* theories (e.g., common law negligence or strict liability) might not be bound to the notice requirements set forth in the Right to Repair Act.

Loss Payee Who Owns First and Second Loans and Forecloses on Second by Making "Full Credit Bid" Cannot Recover from Insurer for Property Damage

A loss payee who owns both a first loan and a second loan, and who forecloses on the second loan by making a "full credit bid," cannot recover from an insurer for property damage that occurred before the foreclosure sale. (*Najah v. Scottsdale Ins. Co.* (2014) 230 Cal.App.4th 125)

Facts

Orange Crest Realty Corporation (Orange Crest) purchased commercial land that was improved with a building. Orange Crest financed part of the purchase price with a first loan from the Lantzman Family Trust (Lantzman Trust), and financed the remainder with a second loan from Jamshid Najah and Mark Akhavain, the sellers. The first loan was secured by a first trust deed, and the second loan was secured by a second trust deed. (Under California law, a "trust deed" arrangement is essentially the same as a "mortgage" arrangement.)

Orange Crest ultimately defaulted on the first loan, and the Lantzman Trust commenced foreclosure proceedings. In order to protect their interest, Najah and Akhavain purchased the first loan for $1.749 million (the full amount Orange Crest owed to the Lantzman Trust) and obtained an assignment of the first trust deed held by the Lantzman Trust. As a result, Najah and Akhavain owned both the first and second loans.

Later, Najah and Akhavain discovered that Ronald Shade (Orange Crest's principal) had caused

extensive damage to the building, and had stolen various building components. After discovering the damage and theft, Najah and Akhavain instituted foreclosure proceedings on the second trust deed. At the foreclosure sale, Najah and Akhavain re-acquired the property by bidding $2.878 million, which was the full amount of the unpaid debt on the second promissory note, including interest, fees, and the costs of foreclosure. (As will be explained, this is known as a "full credit bid.")

Najah and Akhavain then submitted a claim to Scottsdale Insurance Company (Scottsdale), which had issued a policy on which Orange Crest was named as the insured and on which Najah and Akhavain were named as loss payees pursuant to a "standard" lender's loss payable endorsement. Scottsdale denied coverage for numerous reasons, and Najah and Akhavain filed suit for breach of contract and bad faith.

At trial, the court found in favor of Scottsdale. Among other things, the court ruled that because Najah and Akhavain had made a "full credit bid" when Najah and Akhavain foreclosed on the second loan, this eliminated their right to recover on the policy. Najah and Akhavain appealed.

Holding

On appeal, Najah and Akhavain did not dispute that their full credit bid at the foreclosure sale on the second trust deed extinguished *that* debt. However, they contended they should still be able to recover from Scottsdale because, before the foreclosure sale, they held *two* trust deeds that secured *two* separate debts, and after the foreclosure sale, they still held the first loan. More specifically, they contended that, even though they had made a full credit bid, a recovery from Scottsdale would not provide them with an unfair windfall, as they had invested a total of $4.627 million to acquire the property – the $1.749 million they paid to the Lantzman Trust for the first loan and the $2.878 million they bid at the foreclosure sale when they foreclosed on the second loan. Thus, Najah and Akhavain argued that all liens held by a single loss payee should be aggregated to determine whether a full credit bid extinguished a loss payee's right to recover from an insurer.

The Court of Appeal rejected all of these arguments, and held that when Najah and Akhavain made a full credit bid at the foreclosure sale regarding the second loan, that bid established that, at the time of the foreclosure sale, the property was equivalent to the value of the *total* debt they held. Therefore, their full credit bid barred any claim against Scottsdale for damage that occurred before the foreclosure sale.

Comment

Generally, when a lender forces a foreclosure sale, anyone – including the lender – can bid at the sale. At the foreclosure sale, the lender has "credit" that is equal to the sum of the unpaid principal, accrued interest, late charges and costs of sale. Because it would be a pointless exercise for a lender to tender cash or a check to itself to satisfy the unpaid debt, the courts recognize that the lender can use some or all of this "credit" to bid at the foreclosure sale.

If the property sustains damage before the sale and the lender then acquires title at the sale, the lender often will make a claim against any property insurance policy on which the lender was named as a loss payee. However, in many instances, the "credit bid" rules will limit or even altogether eliminate the lender's recovery against the policy. (*Track Mortgage Group, Inc. v. Crusader Insurance Company* (2002) 98 Cal.App.4th 857)

A loss payee's recovery for damage that occurred before the sale is limited to the difference between the amount of the debt and the amount of the lender's credit bid at the foreclosure sale. Two examples illustrate application of the credit bid rules.

Suppose the full amount of the debt is $100,000 and the lender acquires title at the foreclosure sale by making a credit bid of $50,000. (This generally is known as a "partial credit bid," because the lender used only part of its "credit" to acquire title.)

However, after acquiring title, the lender discovers that, prior to the foreclosure sale, the property sustained damage of $75,000 caused by a peril covered by the policy on which the lender is named as the loss payee. Although the property has damage of $75,000, the carrier is obligated to pay the lender only $50,000 (i.e., the difference between the debt of $100,000 and the lender's partial credit bid of $50,000).

Alternatively, suppose the full amount of the debt is $100,000 and the lender acquires title at the foreclosure sale by making a credit bid of $100,000. (This generally is known as a "full credit bid," because the lender used the full amount of its "credit" to acquire title.) However, after acquiring title, the lender discovers that, prior to the foreclosure sale, the property sustained damage of $75,000 caused by a peril covered by the policy on which the lender is named as the loss payee. Although the property has damage of $75,000, the carrier is obligated to pay the lender nothing (i.e., the difference between the debt of $100,000 and the lender's full credit bid of $100,000).

In order to determine the possible effect of California's credit bid rules, it is first necessary to determine whether the damage occurred before or after the foreclosure sale. Importantly, the credit bid rules apply only to damage that occurred *before* the sale.

LIABILITY INSURANCE

Statutes Do Not Require, and Automobile Policies Do Not Provide, Underinsured Motorist Coverage for Named Insured's Non-Resident Daughter Killed While Pedestrian

California statutes did not require, and various automobile policies themselves did not provide, underinsured motorist coverage for the named insured's adult, non-resident daughter who was killed while she was a pedestrian. (*Berendes v. Farmers Insurance Exchange* (2013) 221 Cal.App.4th 571)

Facts

Kristina Berendes was married to and lived with Todd Berendes. While Mrs. Berendes was a pedestrian, she was struck and killed by a car driven by David Duril. Mr. Duril's liability insurer paid its $50,000 limit to Mrs. Berendes' surviving spouse, Mr. Berendes. Mr. Berendes also received $200,000 pursuant to the underinsured motorist (UIM) section of his own automobile policy which covered Mrs. Berendes as his spouse.

Mr. Berendes then submitted a UIM claim to Farmers Insurance Exchange under policies which Farmers had issued to Mrs. Berendes' father, William Felix. The Farmers policies included (1) an auto policy for a Chrysler PT Cruiser which listed Mrs. Berendes as rated driver, and (2) an auto policy for a Mercedes-Benz ML350 which did not list any rated drivers. Farmers denied the claim on the ground that Mr. Felix's non-resident daughter, Mrs. Berendes, was not an "insured person" under the Farmers policies with respect to UIM coverage.

Mr. Berendes subsequently sued Farmers for breach of contract and bad faith. Farmers moved for summary judgment, arguing that the Farmers policies did not include UIM coverage for Mrs. Berendes either by statutory mandate or contract interpretation. The trial court agreed with Farmers and granted the summary judgment motion. Mr. Berendes appealed.

Holding

The Court of Appeal affirmed the summary judgment in favor of Farmers. In reaching its decision, the Court rejected three separate arguments advanced by Mr. Berendes.

First, Mr. Berendes argued that California Insurance Code Section 11580.2 required Farmers to afford UIM coverage to Mrs. Berendes. The

appellate court disagreed. That statute requires insurers to include a provision in automobile insurance policies covering the "insured" for the liability of an uninsured motorist. The statute then defines the "insured" so as to include "[1] the named insured [i.e., Mr. Felix], [2] the spouse of the named insured, [3] while residents of the same household, relatives of either while occupants of a motor vehicle or otherwise, [and] [4] heirs and any other person while in or upon or entering into or alighting from an insured motor vehicle…." Here, at the time of her death, Mrs. Berendes did not fit within any of these statutory categories. She was not the named insured. Nor was she the spouse of the named insured. Further, although she was the daughter of the named insured, she did not live in the named insured's household. Last, because she was a pedestrian at the time of the accident, she was not engaged in an activity related to one of the covered vehicles. Since Mrs. Berendes was not an "insured," Farmers was under no statutory obligation to provide her with coverage for the liability of an underinsured motorist.

Next, Mr. Berendes argued that the Farmers policies were ambiguous because the liability coverage (Part I) and UIM coverage (Part II) in the policies included different definitions of the term "insured person." The appellate court rejected this argument as well. The court noted that auto liability and UIM coverages are distinct and serve different purposes, and thus the different definitions of "insured person" in those sections did not create an ambiguity. Further, while the Farmers policy for the PT Cruiser did include an endorsement which stated that any "rated" driver such as Mrs. Berendes was an "insured," that endorsement by its own terms only applied to *liability* coverage, not *UIM* coverage.

Last, Mr. Berendes argued that the circumstances caused both the named insured, Mr. Felix, and the decedent, Mrs. Berendes, to "reasonably expect" that the Farmers policies included UIM coverage for Mrs. Berendes as a pedestrian. The appellate court disagreed. According to the court, because the policy language was clear and unambiguous, the policy language governs the coverage dispute. Thus, neither Mr. Felix, as named insured, nor Mrs. Berendes, the decedent, could have had any reasonable expectation of coverage.

Comment

Insurance Code section 11580.2 does not statutorily mandate UIM coverage for all individuals who may qualify as an insured under the separate auto liability portion of an automobile policy. Thus, the fact that Mrs. Berendes may have qualified as an insured under the liability section of the Farmers policies did not mean that she also qualified as an insured under the UIM section of those policies.

Food Truck Is "Mobile Equipment" and Thus Is Not Subject to "Auto" Exclusion in General Liability Policy

A food truck owned by the insured qualified as "mobile equipment," and therefore was not subject to a standard "auto" exclusion contained within the insured's commercial general liability policy. (*American States Ins. Co. v. Travelers Property Casualty Ins. Co. of America* (2014) 223 Cal.App.4th 495)

Facts

Royal Catering Company leased a food truck to Esmeragdo Gomez and his wife Irais Gomez. The food truck had two seats and two seatbelts. It was equipped with a specially-designed deep fryer, grill, steam table, oven, refrigerator and coffee maker. The Gomezes would drive the leased food truck from site to site, where the Gomezes would prepare and sell food to customers.

One day Mr. Gomez was driving the food truck while Mrs. Gomez was standing in the back of the truck. At an intersection, Mr. Gomez swerved to avoid an approaching vehicle, and in the process of swerving, hot oil from the food truck's deep fryer splashed on Mrs. Gomez and burned her.

The Gomezes sued Royal and others for injuries sustained in the accident. Mrs. Gomez asserted a cause of action against Royal for products liability, based on allegations that Royal had supplied the food truck with a deep fryer that did not have a properly working lid. Mr. Gomez asserted a cause of action against Royal for loss of consortium based on the injury to Mrs. Gomez.

At the time of the accident, Royal was the named insured on a commercial automobile policy issued by American States Insurance Company as well as a commercial general liability policy issued by Travelers Property Casualty Company of America. Pursuant to the American States auto policy, American States agreed to defend Royal against the Gomezes' lawsuit. Travelers, on the other hand, declined to defend Royal based on the "auto" exclusion in the Travelers general liability policy.

American States eventually paid $500,000 in settlement of any claims the Gomezes might have against Royal that would be covered by the American States auto policy. Under the terms of the settlement, the Gomezes were allowed to continue pursuing their products liability-based claims against Royal, but only to the extent such claims were covered by the Travelers general liability policy.

The Gomezes and Royal then submitted Mrs. Gomez' product liability claim and Mr. Gomez's loss of consortium claim to binding arbitration. The arbitrator ruled in favor of the Gomezes and against Royal, and awarded the Gomezes damages of over $2.4 million against Royal.

American States filed a complaint for declaratory relief against Travelers, and Travelers filed a cross-complaint for declaratory relief back against American States, Royal and the Gomezes. The trial court later ruled that the Gomezes' claims against Royal in the underlying action were barred from coverage by the "auto" exclusion in Travelers' general liability policy. American States, Royal and the Gomezes appealed.

Holding

The Court of Appeal reversed. The appellate court acknowledged that the Travelers general liability policy excluded coverage for bodily injury arising out of the ownership, maintenance or use of any "auto" owned by Royal. However, the policy's "auto" exclusion contained an exception for "mobile equipment," and the policy defined "mobile equipment" so as to include vehicles "maintained primarily for purposes other than the transportation of persons or cargo…."

Here, according to the appellate court, "the primary purpose" of the food truck was to "serve as a mobile kitchen and not to transport persons or cargo." Under such circumstances, the food truck qualified as "mobile equipment," and thus it was not subject to the "auto" exclusion in the Travelers general liability policy. Therefore, Travelers had been obligated under its general liability policy to defend and indemnify Royal against Mrs. Gomez' product liability claim and Mr. Gomez's loss of consortium claim.

Comment

If a vehicle is maintained primarily for purposes other than the transportation of persons or cargo, that vehicle will be considered "mobile equipment" and thus will not be subject to the "auto" exclusion contained in the current version of a commercial general liability policy. The state appellate court's decision that the food truck was "mobile equipment" is consistent with an earlier case decided by a federal appellate court. (See *Employers Mutual Casualty Company v. Bonilla* (5th Cir. 2010) 613 F.3d 512, 518 ["The 'inherent purpose' of a mobile catering truck certainly could be seen as including the use and maintenance of its kitchen facilities . . ."].)

Commercial Auto Policy's "Employee" Exclusion Does Not Relieve Insurer of Duty to Defend Insured When There Is Factual Dispute As to Whether Claimant Was "Employee" or "Independent Contractor" of Insured

A commercial auto policy's "employee" exclusion did not relieve an insurer of a duty to defend its insured when there was factual dispute as to whether the injured claimant was an "employee" or an "independent contractor" of the insured. (*Global Hawk Ins. Co. v. Le* (2014) 225 Cal.App.4th 593)

Facts

V&H Transport (V&H) operated a commercial trucking business. V&H hired Jerry Le and another individual, Quyen Cao, to haul goods on a single cross-country trip. V&H representatives allegedly told Le that V&H would pay Le a lump sum of $1,100 for the trip; that V&H would not withhold any taxes or social security from the amount it would pay Le; and that V&H would provide Le with "a 1099" at the end of the year.

During the cross-country trip, while Cao was driving the truck and Le was sleeping in the sleeper berth, the truck was involved in a single-vehicle accident. Le was ejected from the cab and suffered serious injuries.

After the accident, V&H representatives allegedly told Le that because he had not finished the trip, V&H would not pay him the $1,100. In addition, V&H representatives allegedly told Le that he was "*not* an employee" and would "*not* be entitled to worker's compensation."

Le subsequently filed a personal injury action against various defendants, including V&H. V&H tendered the defense of the personal injury action to V&H's commercial auto insurer, Global Hawk Insurance Company (Global Hawk). Apparently, the Global Hawk policy did not contain the federally-mandated MCS-90 endorsement. Global Hawk denied V&H's tender, asserting that Le *was* an "employee" of V&H, and that Le's claim against V&H therefore fell within the "employee" exclusion in the Global Hawk commercial auto policy.

Later, Global Hawk filed a declaratory relief action against its named insured, V&H, and the injured party, Le. Global Hawk moved for summary judgment, asserting that the Federal Motor Carrier Safety Administration Act defines an "employee" as *"*a driver of a commercial motor vehicle *(including an independent contractor while personally operating a commercial vehicle*)*."* Global Hawk thus argued that irrespective of whether Le was an "employee" or an "independent contractor" of V&H, Le's claim against V&H was barred from coverage by the "employee" exclusion in the Global Hawk policy. The trial court agreed with Global Hawk and entered summary judgment in favor of Global Hawk. Le appealed.

Holding

The Court of Appeal reversed, concluding that there was a triable issue of fact as to whether Le was an "employee" or an "independent contractor" of V&H, and hence an issue as to whether the "employee" exclusion in the Global Hawk policy applied.

According to the appellate court, the issue of whether Le was an "employee" or an "independent contractor" should be governed by *California common law and insurance principles*, not *federal laws governing the trucking industry*. This is especially true because the federal laws *broadly defined* an "employee" to *include* an "independent contractor" in order to *protect the public* from trucking companies who try to avoid liability for accidents by claiming that their drivers are not "employees" but rather are "independent contractors."

The appellate court then observed that under California law, "employee" and "independent contractor" are mutually exclusive categories, and that whether a person is an employee or independent contractor will often present a factual question. In determining whether a worker was an "employee" or an "independent contractor," California courts consider numerous factors, including the method of payment and whether or not the parties believed they were creating the relationship of employer-employee.

Here, there was evidence that Le was to be paid a lump sum; that he was to be paid without any withholding for taxes; and that at the end of the year he would receive a 1099 tax form that is for independent contractors. Further, V&H representatives allegedly had told Le that he was "not an employee" and would "not be entitled to worker's compensation." According to the appellate court, this evidence indicated that Le was an "independent contractor," not an "employee." Thus, there was a triable issue of fact as to whether Global Hawk's "employee" exclusion barred coverage for V&H's alleged liability to Le in the underlying action.

Comment

Because the appellate court found that there was a factual dispute as to whether Le was an "employee" or an "independent contractor" of V&H, it presumably means that Global Hawk breached its duty to defend V&H in the underlying personal injury suit brought by Le. This is because if coverage depends on an unresolved *factual dispute,* the very existence of that factual dispute establishes a "possibility" of coverage and hence a duty to defend.

Reasonable Expectations of Named Insured May Differ From Those of Additional Insured

In evaluating allegedly ambiguous language in liability policy, the reasonable expectations of the named insured may differ from the reasonable expectations of an additional insured. (*Transport Insurance Co. v. Superior Court* (2014) 222 Cal.App.4th 1216)

Facts

Vulcan Materials Company (Vulcan) manufactured perchloroethylene (PCE), a solvent used by dry cleaners. One of Vulcan's distributors was R.R. Street & Co., Inc. (Street). Various parties sued Vulcan and Street alleging that Vulcan and Street had manufactured, distributed and/or sold PCE, resulting in soil and groundwater contamination in Modesto, California.

Vulcan was the named insured, and Street was an additional insured, on a commercial umbrella liability insurance policy issued by Transport Insurance Company (Transport). The Transport umbrella policy provided among other things that Transport would defend an insured against claims covered by the Transport umbrella policy but not covered by "underlying insurance." The Transport umbrella policy's schedule of underlying insurance identified nine primary policies issued to Vulcan as named insured (although Vulcan also had other policies). Street was listed as an additional insured on the Transport umbrella policy, but was not listed as an additional insured on any of the nine underlying primary policies listed in the Transport umbrella policy.

Transport filed an initial declaratory relief action to determine the scope of its obligations to its *named insured, Vulcan*. In that action, Transport argued that it had no duty to defend Vulcan under the Transport umbrella policy, because the Transport policy was excess to "underlying insurance," and "underlying insurance" meant all primary policies available to Vulcan during the period of a continuous loss, not just the primary policies listed in the schedule of the Transport umbrella policy. The appellate court disagreed. It held that the term "underlying insurance" was ambiguous; that the ambiguity had to be resolved in favor of the "reasonable expectations of the insured [i.e., Vulcan]"; and that Vulcan could reasonably expect

that "underlying insurance" only referred to the primary policies listed in the schedule of the Transport excess policy. (See *Legacy Vulcan Corp. v. Superior Court* (2010) 185 Cal.App.4th 677.)

Transport then filed a second declaratory action to determine the scope of its obligations to its *additional insured, Street*. Transport argued that its duty to defend Street had not been triggered, because all of the primary policies available to Vulcan had not been exhausted. In response, Street pointed to Transport's earlier litigation with Vulcan and asserted that Transport was "collaterally estopped" from arguing that the term "underlying insurance" referred to something other than the policies listed on the schedule of the Transport umbrella policy. The trial agreed with Street, and granted summary adjudication in favor of Street. Transport sought appellate review.

Holding

The Court of Appeal reversed the summary adjudication in favor of Street. The appellate court held that "collateral estoppel" did not apply because the earlier litigation had focused on the reasonable expectations of *Vulcan*, the named insured, not on the reasonable expectations of *Street*, the additional insured. According to the appellate court, *"[w]hen the party claiming coverage is an additional insured, it is the additional insured's objectively reasonable expectations of coverage that are relevant, and not the objectively reasonable expectations of the named insured*." Thus, the trial court had erred in relying on *Vulcan's* objectively reasonable expectations of coverage instead of relying on *Street's* objectively reasonable expectations of coverage. Accordingly, the appellate court remanded the case to the trial court for further proceedings to determine the reasonable expectations of the additional insured, Street.

Comment

Ambiguities in insurance policies are generally construed in favor of the insured's reasonable expectations. However, when faced with allegedly ambiguous policy language, a court must consider the reasonable expectation of the *particular insured* who is seeking coverage. As this case makes clear, the reasonable expectations of the named insured may be different from the reasonable expectations of the additional insured.

Insured "Hires" or "Borrows" Vehicle Only If Insured Exercises Exclusive "Dominion and Control" Over Vehicle

For purposes of commercial automobile coverage, an insured is deemed to "hire" or "borrow" a vehicle only if the insured exercises exclusive "dominion and control" over the vehicle. (*Travelers Prop. Cas. Co. of Am. v. LK Transp., Inc.* (E.D. Cal. 2014) 3 F.Supp.3d 799

Facts

Descor, Inc. hired LK Transportation, Inc. to drive to Yuba City, pick up a trailer owned by Descor, and move the trailer to Sacramento for a fee. While LK's employee was driving an LK tractor to Yuba City to pick up Descor's trailer and transport it to Sacramento, LK's employee was involved in a two-vehicle accident. The driver of the other vehicle, Martha Shower, was killed. At the time of the accident, LK's employee had not yet arrived at Descor's work site and had not yet begun to haul Descor's trailer. However, LK's employee was on the road only because he was on his way to pick up Descor's trailer.

On the date of the loss, LK was the named insured and its tractor was a covered auto on a $1 million commercial auto policy issued by Northland Insurance Company. Descor, on the other hand, was the named insured and its trailer was a covered auto on a $1 million commercial auto

policy issued by Travelers Property Casualty Company of America.

Shower's heirs filed a wrongful death lawsuit LK, which tendered defense of the action to Northland. Northland paid its $1 million policy limit in partial settlement of LK's liability to Shower's heirs. As part of the settlement, Shower's heirs were allowed to continue pursuing LK, but only to the extent that LK was entitled to coverage under the Travelers policy.

Travelers filed a declaratory judgment action against LK and Shower's heirs, seeking a judicial determination that the Travelers policy did not cover any liability LK might have to Shower's heirs in the underlying action. Thereafter, Travelers moved for summary judgment.

Holding

The United States District Court, applying California law, granted Travelers' motion and held that the Travelers commercial auto policy did not cover LK's alleged liability to Shower's heirs.

Shower's heirs argued that Descor had "hired" or "borrowed" LK's tractor (making the tractor a covered auto under the Travelers policy), and that Descor had then allowed LK to use the tractor (making LK an insured under the Travelers policy). The district court rejected this argument. Under California insurance law, an insured "hires" or "borrows" a vehicle only if the insured exercises exclusive "dominion and control" over the vehicle. Here, Descor did not exercise any "dominion and control" over LK's tractor. Rather, LK merely used the tractor in furtherance of LK's own business interests, and never relinquished control of the tractor to Descor. Accordingly, LK's use of the tractor could not provide a basis for coverage under Descor's policy through Travelers.

Show's heirs also argued that LK's liability "resulted from the use" of Descor's trailer (which admittedly was a covered auto under the Travelers policy). Again, however, the district court disagreed. Under California's "predominating cause / substantial factor" test, in order for an auto policy to apply, the vehicle's "operation, movement, maintenance, loading, or unloading must be a substantial factor or predominating cause of the claimant's injury." Here, although LK had the intention of eventually moving Descor's trailer, it was undisputed that the trailer had not been moved at the time of the accident. Thus, because the accident did not "result from the use" of Descor's trailer, the Travelers policy did not apply.

Comment

With regard to the issue of "hiring" or "borrowing," the mere fact that a vehicle is being used for the insured's business purposes, without more, is insufficient to establish that the vehicle has been "hired" or "borrowed." Rather, the insured must have use of the vehicle for the insured's own purposes, *to the exclusion of the vehicle's owner.*

"Personal and Advertising Injury" Coverage for "Disparagement" Is Not Triggered Where Insured's Advertisements Do Not Specifically Refer To and Clearly Derogate Claimant's Products

A commercial general liability policy's "personal and advertising" coverage for "disparagement" was not triggered where the insured's advertisements did not specifically refer to and clearly derogate the claimant's products. (*Hartford Cas. Ins. Co. v. Swift Distribution, Inc.* (2014) 59 Cal.4th 277)

Facts

Gary-Michael Dahl (Dahl) manufactures and sells a collapsible cart called the "Multi-Cart," which is used to move music, sound and video equipment. Dahl owns a patent for the collapsible cart design, as well as a trademark for the "Multi-Cart" name.

Swift Distribution, Inc. dba Ultimate Support Systems (Swift) manufactures and sells a competing product known as the "Ulti-Cart."

Dahl filed a federal court lawsuit against Swift, alleging that Swift was impermissibly manufacturing, marketing and selling the "Ulti-Cart," thus infringing patents and trademarks for Dahl's "Multi-Cart." Dahl's complaint attached copies of Swift's advertisements, which mentioned Swift's Ulti-Cart but did not mention Dahl's Multi-Cart. In addition, Swift's catalog stated that Swift "designs and builds innovative, superior products" and that Swift provides "unique support solutions that are crafted with unparalleled innovation and quality and accompanied by superior customer service."

Swift tendered the defense of the lawsuit to its general liability insurer, Hartford Casualty Insurance Company (Hartford). The Hartford policy covered Swift for various "personal and advertising" offenses, including "oral, written or electronic publication of material that slanders or libels a person or organization *or disparages a person's or organization's goods, products or services*." Hartford declined to defend Swift against Dahl's lawsuit.

Hartford later filed a declaratory judgment action seeking a determination that it had no duty to defend or indemnify Swift against Dahl's claims. The trial court and the Court of Appeal both ruled in favor of Hartford, finding that Dahl's claims against Swift did not potentially trigger coverage under the "disparagement" provision contained in the "personal and advertising injury" section of the Hartford policy. At Swift's request, the California Supreme Court agreed to review the case.

Holding

The California Supreme Court affirmed the declaratory judgment in favor of Hartford. The Supreme Court concluded that in the underlying lawsuit Dahl did not potentially seek damages from Swift because of "disparagement," and thus Swift was not entitled to a defense under the "personal and advertising injury" provisions of the Hartford policy. According to the Supreme Court, a claim of "disparagement" requires a plaintiff to show "a false or misleading statement that *(1) specifically refers to the plaintiff's product or business and (2) clearly derogates that product or business. Each requirement must be satisfied by express mention or by clear implication."*

Here, even if Swift's advertisement referring to its Ulti-Cart could reasonably imply a reference to Dahl's Multi-Cart, Swift's advertisement did not "disparage" Dahl or its product. Consumer confusion resulting from similarity may support a claim of patent infringement, trademark infringement or unfair competition, but does not by itself support a claim of "disparagement." While Swift may have designed and named its Ulti-Cart to mimic Dahl's Multi-Cart, that fact did not derogate or malign Dahl's Multi-Cart.

Nor did it matter that Swift's catalog used words like "unique," "superior" and "unparalleled" to describe Swift's company. According to the Supreme Court, Swift's generalized claim of superiority was mere "puffing" and was not specific enough to "disparage" Dahl's products. Otherwise, "almost any advertisement extolling the superior quality of a company or its products would be fodder for litigation."

Comment

The Supreme Court's holding in *Swift* clarifies and limits the scope of an insurer's duty to defend an insured against a possible claim of "disparagement," as that term is used in a commercial general liability policy. The Supreme Court noted that an insurer and its insured may contract for any broader coverage to which they mutually agree. Here, however, because the facts and pleadings were not sufficient to support a possible claim of disparagement, there was no duty to defend under the Hartford policy.

In the course of its opinion, the Supreme Court specifically disapproved the case of *Travelers Property Casualty Co. of America v. Charlotte Russe, Inc.* (2012) 207 Cal.App.4th 969. In *Charlotte Russe*, a California appellate court held that the personal injury offense of "disparagement" required an insurer to defend an insured against a suit alleging that the insured had improperly advertised the claimant's products at severely discounted prices, thus potentially "disparaging" the claimant's products. The Supreme Court disagreed with the theory of "disparagement" recognized in *Charlotte Russe*, i.e., that a price reduction could result in a disparagement of the claimant's products. According to the Supreme Court, a mere reduction of price "may suggest any number of business motivations" and "does not clearly indicate that the seller believes the product is of poor quality."

Liability Insurer Has No Duty to Defend Insured Steel Subcontractor Against Suit Arising From Installation of Allegedly Inadequate Seismic Tie Hooks in Building

A commercial general liability insurer was not obligated to defend its insured, a steel subcontractor, against a suit arising from the insured's installation of allegedly inadequate seismic tie hooks in an apartment building. (*Regional Steel Corp. v. Liberty Surplus Ins. Corp.* (2014) 226 Cal.App.4th 137)

Facts

JSM Construction, Inc. (JSM) was the general contractor for construction of a 14-story apartment building that included several floors of garage parking. In June 2004, JSM hired a subcontractor, Regional Steel Corporation (Regional), to provide the reinforcing steel for the columns, walls and floors at the project. Regional prepared shop drawings that called for both 90 degree and 135 degree seismic tie hooks in concrete shear walls.

In October 2004, Regional began construction on the project, using both the 90 degree and 135 degree tie hooks as approved in the shop drawings. Thereafter, JSM had another subcontractor pour concrete that encased the rebar and tie hooks.

In January 2005, a city building inspector issued a correction notice requiring the exclusive use of 135 degree tie hooks. In April 2005, JSM informed Regional that it could only use 135 degree tie hooks, and Regional immediately began fabricating 135 degree tie hooks. Further, in June 2005, city officials notified JSM that the 90 degree tie hooks that had previously been installed in the garage levels were inadequate and would have to be replaced.

Subsequently, on August 5, 2005, Liberty Surplus Insurance Corporation (Liberty) issued a "wrap" commercial general liability policy which listed the general contractor, JSM, as the named insured, and the rebar subcontractor, Regional, as an additional named insured. The policy provided that Liberty would indemnify and defend an insured against suits seeking damages because of "property damage" caused by an "occurrence" taking place on or after the policy's "retroactive date" of August 5, 2005. The policy defined "property damage" as "physical injury to tangible property" and "loss of use of tangible property that is not physically injured," and defined an "occurrence" as an "accident." The policy included a "wrap endorsement" which provided among other things that "[t]his insurance applies only to ... 'property damage' ... that occurs at a project site."

In August 2007, Regional sued JSM for amounts JSM allegedly owed to Regional under the subcontract. JSM responded by filing a cross-complaint against Regional for breach of contract, breach of warranties and negligence. JSM alleged that Regional failed to comply with the subcontract and building code by installing 90 degree tie hooks in the garage levels. JSM alleged that as a result of

Regional's failures, JSM had to open up numerous locations in the concrete walls, weld reinforcements to the steel placed by Regional, and otherwise strengthen Regional's inadequate installation.

After JSM filed its cross-complaint against Regional, Regional tendered defense of the cross-complaint to Liberty. However, Liberty rejected Regional's tender, asserting that the Liberty policy did not potentially cover Regional's alleged liability to JSM.

Regional later filed a breach of contract / bad faith action arising from Liberty's refusal to defend Regional against JSM's cross-complaint in the underlying lawsuit. However, the trial court ruled that JSM's claims against Regional were not potentially covered under the Liberty policy, and that Regional was therefore not entitled to a defense from Liberty. Regional appealed.

Holding

The Court of Appeal affirmed the judgment in favor of Liberty, for several reasons.

First, city officials had discovered the alleged tie hook problem in *January 2005*, and Regional had become aware of the problem by *April 2005*. The Liberty policy, however, only applied to property damage resulting from an occurrence on or after the policy's retroactive date of *August 5, 2005*. Thus, any occurrence and property damage happened *before* the policy's retroactive date. The appellate court rejected Regional's argument that the policy's "wrap endorsement" replaced the requirement that property damage result from an occurrence "on or after the retroactive date" with a requirement that the property damage merely occur "at a project site." Although the wrap endorsement made certain changes to the policy, that endorsement did not modify the requirement that coverage only applied to property damage resulting from an occurrence on or after the policy's retroactive date.

Second, JSM did not make any claim against Regional in the underlying lawsuit that would fall within the "physical injury to tangible property" prong of the definition "property damage." In the underlying lawsuit, JSM only alleged that Regional failed to install proper tie hooks, and that Regional's omission required demolition and repair of the affected areas. The appellate court held that, at least in the context of allegedly defective construction, "the incorporation of a defective component or product into a larger structure does not constitute property damage unless and until the defective component causes physical injury to tangible property in at least some other part of the system."

Third, even if JSM made a claim against Regional for "loss of use of tangible property that is not physically injured" under the second prong of the definition of "property damage," any such claim was excluded from coverage under the Liberty policy. In particular, policy exclusion m. barred coverage for property damage to "property that has not been physically injured, arising out of … a defect, deficiency, inadequacy or dangerous condition in 'your product' or 'your work.'" According to the appellate court, "[u]nder that exclusion, there is no coverage for property damage to 'property that has not been physically injured' arising out of Regional's negligent failure to perform its contractual obligations based on installation of defective tie hooks."

In short, because JSM's claims against Regional were not potentially covered under the Liberty policy, Regional was not entitled to a defense from Liberty.

Comment

Where an insured supplies an inherently hazardous product which is incorporated into other property, courts have generally found "physical injury" to the other property at the moment the incorporation occurs. (See, e.g., *Armstrong World Industries, Inc. v. Aetna Casualty & Surety Co.* (1996) 45 Cal.App.4th 1 [coverage found where insured supplied asbestos-containing materials

that were incorporated into buildings]; *Shade Foods, Inc. v. Innovative Products Sales & Marketing, Inc.* (2000) 78 Cal.App.4th 847 [coverage found where insured supplied contaminated almonds that were incorporated into nut clusters used in cereal].) These courts have basically reasoned that when the inherently hazardous product is incorporated into the larger whole, the hazardous product immediately "contaminates" and thus "physically injures" the larger whole.

On the other hand, where the insured merely supplies a defective component which is incorporated into a construction project, courts have been more inclined to hold that there is no property damage "unless and until the defective component causes physical injury to tangible property in at least some other part of the system." (See, e.g., *F&H Construction v. ITT Hartford Ins. Co*. (2004) 118 Cal.App.4th 364 [no coverage where insured contractor supplied defective steel pile caps that were welded onto pilings].) This approach is consistent with the idea that general liability policies are not "performance bonds" and are not designed to cover contractors against claims that their work is inferior or defective.

Insurer Has No Duty to Defend Insureds Against Suit Alleging Conspiracy to Aid In Abduction of Child

A homeowners insurer had no duty to defend its insureds against a lawsuit alleging that the insureds conspired to aid in the abduction of a child. (*Upasani v. State Farm General Insurance Company* (2014) 227 Cal.App.4th 509)

Facts

Avinash Kulkarni sued Meera and Mohan Upasani, alleging that the Upasanis conspired with Kulkarni's wife to abduct the Kulkarnis' infant son to India. Kulkarni's complaint against the Upasanis contained causes of action for violation of Civil Code section 49(a), negligence per se, intentional infliction of emotional distress and negligent infliction of emotional distress. The Upasanis denied that they had ever been part of any conspiracy to abduct Kulkarni's son.

The Upasanis tendered defense of the lawsuit to their homeowners insurer, State Farm General Insurance Company. However, State Farm declined to defend the Upasanis, primarily on the ground that the Upasanis' alleged liability to Kulkarni was not based on an "occurrence," or "accident."

The jury in Kulkarni's lawsuit against the Upasanis ultimately returned a defense verdict in favor of the Upasanis. The jury specifically found that the Upasanis had not committed any acts in relation to the abduction of Kulkarni's son.

The Upasanis later sued State Farm for breach of contract and bad faith arising from State Farm's refusal to defend the Upasanis against Kulkarni's lawsuit. However, the trial court ruled that State Farm did not have a duty to defend the Upasanis, and the trial court thus entered summary judgment in favor of State Farm. The Upasanis appealed.

Holding

The Court of Appeal affirmed the judgment in favor of State Farm. The appellate court primarily focused on the fact that the State Farm policy only covered bodily injury caused by an "occurrence," or "accident." According to the appellate court, the allegations that the Upasanis had conspired to aid in the abduction of Kulkarni's son were allegations of "non-accidental, intentional, and purposeful" conduct. In order for a "conspiracy" to exist, the alleged conspirators must have knowledge of an objective and must intend to achieve that objective. That cannot happen by "accident."

Further, it was immaterial that the underlying complaint against the Upasanis had included causes of action labeled "negligence." Irrespective of the *labels* that were affixed to the complaint, the

factual allegations in the complaint showed that the Upasanis' alleged conduct was intentional.

Nor did it matter that in the underlying case the Upasanis had steadfastly denied that they ever conspired to aid in abduction of Kulkarni's son. The mere fact that Upasanis denied liability did not create a potential that their alleged conduct was an "accident."

In short, because Kulkarni's claims against the Upasanis in the underlying action did not arise from an "occurrence," or "accident," State Farm had no duty to defend the Upasanis.

Comment

The appellate court correctly held that the mere fact that Upasanis denied any involvement in the alleged conspiracy was not sufficient to create a potential for coverage. That is because in determining whether there is a duty to defend, the test is whether the claimant might recover damages against the insured that would be covered under the policy. (*Montrose Chemical Corp. v. Superior Court* (1993) 6 Cal.4th 287, 295.) Here, the Upasanis either participated in a conspiracy or they did not. In the *former scenario*, Kulkarni would obtain an award of *uncovered damages*, and in the *latter scenario*, the Upasanis would obtain a *defense verdict*. However, in neither scenario would State Farm have a duty to *indemnify* the Upasanis. Because there was *no possibility of indemnification*, there was *no duty to defend*.

Unloading Injured Passenger from Motor Vehicle Constitutes "Use" of Motor Vehicle

Under California law, a defendant's act of unloading an injured passenger from a motor vehicle constituted a "use" of that motor vehicle. (*Encompass Ins. Co. v. Coast National Ins. Co.* (9th Cir. 2014) 764 F.3d 981)

Facts

Anthony Watson was driving a car in which Alexandra Van Horn was a passenger. Watson lost control of the car, causing the car to strike a light pole.

Lisa Torti was in a second car which stopped at the scene of the accident to render aid. Torti saw Van Horn trapped inside Watson's wrecked car and allegedly feared that the wrecked car might catch fire. Torti thus grabbed Van Horn and physically removed her from Watson's car. In the process, Torti allegedly caused Van Horn to suffer a severe spinal injury and become a paraplegic.

Van Horn later sued Torti in California state court. Van Horn alleged that Torti's act of removing Van Horn from Watson's car resulted in injuries to Van Horn.

At the time of the accident, Torti was insured under a "Package Policy" (which included auto, homeowners and personal excess liability coverage) issued by Encompass Insurance Company. Torti tendered her defense to Encompass, and Encompass accepted Torti's defense.

Torti also tendered defense of the action to her auto insurer, Mid-Century Insurance Company. The Mid-Century policy covered Torti in connection with her own car (which was not involved in the accident), and also covered Torti for "use" of "any other private passenger car" provided such "use" was "with the permission of the owner." Thus, if Torti "used" Watson's car with Watson's permission when she removed Van Horn from Watson's car, the Mid-Century policy covered Torti.

In addition, Torti tendered defense of the action to Watson's auto insurer, Coast National Insurance Company. The Coast National policy covered not only Watson, but also "any person using '[Watson's] covered auto' with [Watson's] permission." Thus, if Torti "used" Watson's car with Watson's permission when she removed Van Horn

from Watson's car, the Coast National policy also covered Torti.

Both Mid-Century and Coast National denied coverage to Torti. Encompass thus bore sole responsibility for Torti's defense, and ultimately paid $4 million in settlement of Torti's alleged liability to Van Horn.

Encompass then sued Mid-Century and Coast National in federal district court, seeking contribution for the costs Encompass had incurred in defending and indemnifying Torti. Encompass alleged that Torti's act of removing Van Horn from Watson's car constituted permissive "use" of Watson's car, and that Mid-Century and Coast National thus had a duty to contribute toward the costs of defending and indemnifying Torti. The district court ruled in favor of Mid-Century and Coast National, reasoning that Torti did not "use" Watson's car when she removed Van Horn from Watson's car. Encompass appealed.

Holding

The Ninth Circuit Court of Appeals, applying California law, reversed. The appellate court noted that California Insurance Code section 11580.06(g) specifically defines "use" of a motor vehicle so as to include "unloading" of a motor vehicle. Thus, section 11580.06(g) "unambiguously equates the 'unloading' of a motor vehicle with the 'use' of a motor vehicle." Here, Torti allegedly injured Van Horn while Torti was "unloading" Van Horn from Watson's vehicle. Because Torti's alleged liability arose from a "use" of Watson's vehicle, Mid-Century and Coast National covered Torti, provided Torti had Watson's "permission" to use Watson's vehicle.

The appellate court rejected Mid-Century's and Coast National's argument that "unloading" a motor vehicle only constitutes "use" of that motor vehicle if the person doing the unloading "gains a benefit" from the vehicle as a means of transportation. According to the appellate court, prior case law does not does not support that conclusion.

The appellate court remanded the case to the district court for further proceedings, which will presumably focus on whether Torti had Watson's "permission" to use Watson's motor vehicle.

Comment

One judge dissented, arguing that the unloading of a vehicle constitutes use of the vehicle only when the unloading is part of the user's act of availing himself or herself of the vehicle. Thus, according to the dissent, while loading or unloading a vehicle *may* constitute a use of the vehicle, it must be a component of some broader employment of the vehicle. Here, the dissenting judge argued, Torti's act of unloading Van Horn from Watson's vehicle was not part of some broader act of using Watson's vehicle.

Policy Which Describes Tractor Portion of Tractor/Trailer Rig Is "Primary" to Policy Which Does Not Describe Any Portion of Rig

Pursuant to California Insurance Code section 11580.9, a policy which specifically described the tractor portion of a tractor/trailer rig was "primary" to another policy which did not describe any portion of the rig. (*Scottsdale Indemnity Co. v. National Continental Insurance Co.* (2014) 229 Cal.App.4th 1166)

Facts

Manuel Lainez was a commercial trucker who owned a 1999 Freightliner tractor (i.e., power unit). Lainez purchased a trucker's liability policy from Scottsdale Indemnity Company (Scottsdale) with a $1 million liability limit. The Scottsdale policy specifically described and rated the 1999 Freightliner, and covered any attached trailer.

Western Transportation Services, LLC (Western Transportation) was a company which did not own tractors or trailers, but which contracted with

owner/operators and arranged for them to pick up and deliver loads to various customers. Western Transportation entered into a motor carrier agreement with Lainez pursuant to which Lainez agreed to haul goods for Western Transportation. Western Transportation obtained a commercial assigned risk policy from National Continental Insurance Company (NCI). The NCI policy described Western Transportation's business as "trucker for hire-excess" and named Lainez as a driver. However, the NCI policy did not list, describe, or rate any vehicle.

Lainez was hauling goods for Western Transportation in his 1999 Freightliner tractor with an attached 1984 Hyundai box trailer when he was involved in a fatal collision with Constancio Barcenas. Barcenas' heirs later filed various wrongful death actions against Lainez and Western Transportation.

NCI tendered Lainez's and Western Transportation's defense to Scottsdale. Initially Scottsdale agreed that Scottsdale was the "primary" insurer, and that Scottsdale would defend Lainez and Western Transportation and indemnify them up to the limits of the Scottsdale policy. However, two years later Scottsdale reversed course, asserted that NCI was a "co-primary" insurer, and demanded that NCI reimburse Scottsdale for a pro rata share of the defense costs. NCI rejected Scottsdale's demand.

At a subsequent mediation, Barcenas' heirs settled their wrongful death claims against Lainez and Western Transportation for a total of $675,000, with Scottsdale contributing $475,000 and NCI contributing $200,000. As part of the settlement, Scottsdale and NCI each reserved rights against the other.

Scottsdale then filed a contribution action against NCI. On cross-motions for summary judgment, the trial court ruled in favor of NCI and against Scottsdale. Scottsdale appealed.

Holding

The Court of Appeal affirmed. Pursuant to California Insurance Code section 11580.9(d), when two or more policies apply to the same motor vehicle or motor vehicles involved in an accident, the policy which describes or rates the vehicle is "primary" and any other policy is "excess." Here, only Scottsdale's policy described or rated any vehicle, namely, Lainez's 1999 Freightliner tractor. Because Scottsdale's policy specifically described the 1999 Freightliner tractor, which was part of the tractor/trailer "rig," section 11580.9(d) applied. Thus, Scottsdale's policy was primary and NCI's policy was excess.

Scottsdale argued that the priority of coverage should be governed not by section 11580.9(d), but rather by section 11580.9(h). Subdivision (h) provides that when two or more policies apply to a tractor and an attached trailer, and one policy affords coverage to an insured who is a trucker and who is operating the tractor, that policy shall be primary for both the tractor and trailer, and any other policy shall be excess. Scottsdale argued that because both the Scottsdale policy and the NCI policy covered the tractor and the trailer, and because Lainez and Western Transportation were both truckers, the Scottsdale policy and the NCI policy were "co-primary" under subdivision (h). The appellate court disagreed, reasoning that subdivision (h) was only intended to apply when one policy covers a tractor and another policy covers the trailer. Subdivision (h) did not apply in a situation such as this, where *both* policies covered the entire tractor/trailer rig.

Comment

According to the appellate court, the conclusive presumption set forth in subdivision (h) was intended to resolve coverage disputes between insurers of *tractors* and insurers of *trailers*. There was nothing in the statute or the legislative history to suggest that subdivision (h) applies when two policies provide coverage to the entire rig. The appellate court thus concluded that subdivision (d) was the more specific subdivision that applied,

thereby rendering the Scottsdale policy "primary" and the NCI policy "excess."

Employment-Related Practices Exclusion Relieves General Liability Insurer of Duty to Defend Insured Employer Against Suit Arising from Alleged Strip Search of Employees

An "employment-related practices" exclusion relieved a commercial general liability insurer of any duty to defend an insured employer against a suit arising from an alleged "strip search" of its employees. (*Jon Davler, Inc. v. Arch Insurance Co.* (2014) 229 Cal.App.4th 1025)

Facts

Jon Davler, Inc. is a cosmetics company. One of Jon Davler's managers, Christina Yang, became very upset when she found a used sanitary napkin by the toilet in the women's bathroom. Yang thus confronted several of the company's female employees and demanded to know who was on their menstrual period so that Yang could determine who had left the used sanitary napkin by the toilet. When the female employees denied being on their menstrual cycle, Yang required the employees to go into the restroom and pull down their pants and underwear so that Yang could determine who was menstruating. Yang told the female employees that if they did not comply, they would be fired. The female employees complied.

Three of the female employees later sued Jon Davler and Yang for sexual harassment, failure to prevent sexual harassment, invasion of privacy, intentional infliction of emotional distress and false imprisonment. In their cause of action for false imprisonment, the employees alleged that they "were wrongfully detained and confined by [Jon Davler and Yang] in the bathroom for the purpose of conducting a humiliating and wrongful inspection of their vaginal area to determine if they were on their menstrual period."

Jon Davler and Yang sought coverage under Jon Davler's commercial general liability policy issued by Arch Insurance Company. The Arch policy covered damages because of various "personal and advertising injury" offenses, including "false arrest, detention or imprisonment...." However, the policy also contained an "employment-related practices exclusion," which stated that there was no coverage for personal injury "arising out of" any refusal to employ a person, termination of a person's employment, or "employment-related practices, policies, acts or omissions, such as coercion, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination or malicious prosecution directed at that person...." Citing the policy's employment-related practices exclusion, Arch refused to defend or indemnify Jon Davler and Yang against the employees' lawsuit.

Jon Davler subsequently sued Arch for breach of contract and bad faith. However, the trial court ruled that all of the claims asserted against Jon Davler in the underlying action fell within the employment-related practices exclusion in the Arch policy, and that Arch thus had no duty to defend Jon Davler in the underlying action. Jon Davler appealed.

Holding

The Court of Appeal affirmed, holding that the policy's employment-related practices exclusion relieved Arch of any duty to defend Jon Davler against the employees' lawsuit.

The appellate court rejected Jon Davler's argument that the exclusion's use of the term "such as" required that any excluded acts be similar to "coercion, demotion, evaluation," etc., and that "false imprisonment" was not similar to such acts. According to the appellate court, "such as" is not a term of limitation but rather contemplates additional matters not specifically enumerated. Further, "false

imprisonment" was sufficiently similar to several of the listed acts, including "coercion," "discipline" and "harassment."

The appellate court also rejected Jon Davler's argument that the exclusion's "arising out of" language rendered the exclusion ambiguous. According to the court, the term "arising out of" only requires a "minimal causal connection" between the injury and the excluded activity. Here, the "arising out of" requirement was easily met. Indeed, the only reason the employees were forced into the bathroom for inspection was that they were employed by Jon Davler; were following a directive from a supervisor at their place of employment; and would lose their jobs if they did not comply with the inspection demand.

Last, the appellate court rejected Jon Davler's argument that an ambiguity was created by the presence of "false imprisonment" in the coverage provision and its absence in the exclusion. According to the appellate court, the employment-related practices exclusion provides a non-exhaustive list of examples of employment-related practices, policies, acts or omissions, so that other practices, policies, acts or omissions (e.g., false imprisonment) may qualify as employment-related. In reaching that conclusion, the appellate court disagreed with the federal district court's contrary decision in *Zurich Ins. Co. v. Smart & Final, Inc.* (C.D. Cal. 1998) 996 F. Supp. 979, and stated that the federal district court had "missed the mark."

Comment

A general liability policy's employment-related practices exclusion will generally bar coverage for claims arising in the employment setting. Thus, courts have generally held that the exclusion will bar coverage for an insured's alleged liability arising from unlawful strip search of an employee at the workplace. (See, e.g., *LDF Food Group, Inc. v. Liberty Mutual Fire Ins. Co.* (Kan. 2006) 146 P.3d 1088, 1095 and *Cornett Management Co., LLC v. Fireman's Fund Ins. Co.* (4th Cir. 2009) 332 Fed.Appx. 146, 147.)

Auto Insurer Cannot Exclude Coverage for Insured's Liability to Non-Relative Resident of Household

An auto insurer could not validly exclude coverage for an insured's liability for bodily injury suffered by a non-relative resident of the insured's household. (*Mercury Casualty Co. v. Chu* (2014) 229 Cal.App.4th 1432)

Facts

Mercury Casualty Company issued an auto policy to Hung Chu, who had a roommate named Tu Pham. While Chu was driving his car with Pham riding as a passenger, Chu caused an accident in which Pham was injured.

Pham subsequently filed a personal injury action against Chu, who sought defense and indemnity from Mercury. The Mercury auto policy excluded coverage for bodily injury suffered by an "insured," and defined an "insured" so as to include Chu as named insured *as well as any "resident … who inhabits the same dwelling as the named insured*." Mercury agreed to defend Chu against Pham's lawsuit. However, Mercury reserved its right to assert that it had no duty to indemnify Chu on the ground that Pham was a "resident" of the same dwelling as Chu, and hence Pham was an "insured" under Chu's policy. Eventually, Pham obtained a $330,000 judgment against Chu in the personal injury action.

Mercury filed a declaratory relief action seeking a determination that it had no duty to indemnify Chu for any liability to Pham in the underlying personal injury action. The trial court ruled that the Mercury policy excluded coverage for Chu's liability to Pham and entered judgment for Mercury. Pham appealed.

Holding

The California Court of Appeal reversed, and held that in these circumstances the exclusion in Mercury's auto policy was not enforceable.

The appellate court acknowledged that California Insurance Code section 11580.1(c)(5) allows an auto insurer to exclude coverage for bodily injury to an "insured." However, the appellate court held that for purposes of the statutorily-authorized exclusion, there are limits as to how an insurer can define the term "insured." The appellate court observed that historically, the exclusion was intended to bar coverage when an insured is sued by a *relative* residing in the same household. That is because in that situation there is a high potential for collusion between family members. Here, by contrast, Mercury's exclusion purported to bar coverage when the insured was sued by a *non-relative* residing in the same household. According to the appellate court, in this latter situation there is not the same potential for collusion, and thus the exclusion should not apply.

In short, the court held that Mercury's non-relative resident exclusion was "an overbroad expansion" of the statutorily-allowed exclusion and "contrary to public policy." As such, the exclusion did not bar coverage for Chu's liability to Pham.

Comment

In *Farmers Insurance Exchange v. Cocking* (1981) 29 Cal.3d 383, the California Supreme Court upheld a traditional "resident *relative*" exclusion, explaining that the public policy behind the exclusion was to prevent the insurer from being subjected to "suspect inter-family legal actions which may not be truly adversary and over which the insurer has little or no control."

However, in this case, the appellate court concluded that the broader "resident" exclusion which was at issue did not further the goal of avoiding collusive lawsuits. Indeed, the appellate court noted that cohabitation in the same residence is often temporary and can involve complete strangers. Thus, there was no basis to assume that in this situation insurers face the same risk of fraudulent lawsuits.

General Liability Insurer Has No Duty to Defend Massage Company's Employee Against Suit Alleging Employee's Sexual Assault of Client

A commercial general liability insurer had no duty to defend a massage company's employee against a suit alleging that the employee sexually assaulted a client during a massage. (*Baek v. Continental Casualty Co.* (2014) 230 Cal.App.4th 356)

Facts

Jamie Weinberg filed a lawsuit against Luis Baek and Baek's employer, Heaven Massage and Wellness Center (HMWC). In her complaint, Weinberg alleged that Baek was an HMWC massage therapist, and that during a massage Baek sexually assaulted Weinberg by touching, rubbing and fondling Weinberg's breasts, buttocks and genitals. Weinberg asserted causes of action against Baek and HMWC for sexual harassment, sexual battery, assault, battery, false imprisonment, intentional infliction of emotional distress, and negligence.

Baek claimed that he was either an employee of or partner in HMWC, and that he therefore qualified as an insured under HMWC's general liability policy issued by Continental Casualty Company. However, Continental declined to defend Baek, asserting that Baek's alleged tortious conduct was not within the scope of Baek's employment.

Baek subsequently filed an action for breach of contract and bad faith against Continental, alleging that Continental had wrongfully failed to defend Baek in the underlying tort action filed by

Weinberg. The trial court ruled in favor of Continental. Baek appealed.

Holding

The California Court of Appeal affirmed, holding that Continental had no duty to defend Baek against Weinberg's lawsuit.

The appellate court noted that the Continental policy covered HMWC's employees "for acts within the scope of their employment" and "while performing duties related to the conduct of [HMWC's] business." However, according to the appellate court, Baek's alleged sexual assault of Weinberg could not have been an "act within the scope of [Baek's] employment" and could not have occurred "while performing duties related to the conduct of [HMWC's] business." Although Baek's alleged sexual assault occurred at the workplace and during the work day, it was unrelated to Baek's duties for HMWC. Thus, even if Baek was an employee of HMWC, Baek could not qualify as an additional insured under these provisions of HMWC's policy though Continental.

The appellate court also noted that the Continental policy covered HMWC's partners "with respect to the conduct of [HMWC's] business." However, the appellate court concluded that Baek's alleged sexual assault of Weinberg was not an act undertaken "with respect to the conduct of HMWC's business." Baek's conduct was not done at HMWC's request or for its benefit, but rather was simply the product of Baek's lust. Thus, even assuming Baek was a partner in HMWC, Baek was not an insured in these circumstances.

In short, because Baek's alleged acts of sexual battery could not properly be characterized as relating to the conduct of HMWC's business or within the scope of Baek's employment, Baek was not an additional insured under the Continental policy. Thus, Continental has no duty to defend Baek in the underlying action.

Comment

The appellate court found that while Baek's employment with HMWC may have provided Baek with the opportunity to be alone with Weinberg, Baek's alleged sexual assault on Weinberg was a purely personal act and was committed for reasons unrelated to work. Therefore, Baek was not an insured under HMWC's policy through Continental.

BAD FAITH

Insured Can Maintain Bad Faith Action Against Insurer Who Allegedly Forces Insured to Arbitrate Uninsured Motorist Claim Without Investigating, Evaluating and Attempting to Resolve Claim

An insured could maintain a bad faith lawsuit against an insurer who allegedly forced the insured to arbitrate his uninsured motorist claim without ever fairly investigating, evaluating and attempting to resolve the insured's claim. (*Maslo v. Ameriprise Auto & Home Insurance* (2014) 227 Cal.App.4th 626)

Facts

In September 2008, a vehicle driven by an uninsured motorist rear-ended a vehicle driven by Ted Maslo, resulting in injuries to Maslo. The police investigated and determined that the uninsured motorist was solely at fault. Maslo subsequently underwent two surgeries for his injuries.

At the time of the accident, Maslo was the insured on an automobile insurance policy issued by Ameriprise Auto and Home Insurance. The policy included uninsured motorist (UM) coverage with bodily injury limits of $250,000. In August 2009, Maslo provided all his medical records and bills to

Ameriprise and demanded that Ameriprise pay the UM policy limit of $250,000 in settlement. In response, Ameriprise allegedly refused to investigate, evaluate or attempt settlement of Maslo's UM claim. Rather, in February 2010, Ameriprise allegedly demanded that Maslo arbitrate his UM claim against Ameriprise.

Between February 2010 and November 2011, the parties engaged in discovery for the arbitration proceeding. During that time frame, Maslo allegedly provided Ameriprise with all documents that Ameriprise needed to fully and fairly evaluate the case, but Ameriprise made no offer to Maslo. In addition, Ameriprise allegedly never took the depositions of Maslo's doctors, and never had Maslo examined by a defense doctor.

In November 2011, the UM claim was arbitrated. At the conclusion of the arbitration, the arbitrator awarded Maslo medical expenses of $64,120 and general damages of $100,000 for a total award of $164,120. Ameriprise paid the arbitration award to Maslo.

Subsequently, Maslo filed a bad faith action against Ameriprise. In his complaint, Maslo alleged that Ameriprise had breached duties to Maslo by forcing him to arbitrate his UM claim without ever fairly investigating, evaluating and attempting to resolve the claim. The trial court sustained Ameriprise's demurrer and dismissed Maslo's complaint. Maslo appealed.

Holding

The Court of Appeal reversed, and held that Maslo had adequately stated a claim for bad faith against Ameriprise. The appellate court noted that when an insurer unreasonably withholds payment from an insured, the insurer is subject to liability in tort. Here, Maslo alleged that although he had presented Ameriprise with evidence of a valid UM claim, Ameriprise failed to investigate, evaluate and attempt settlement of the claim, and instead insisted that Maslo proceed to arbitration. That was sufficient to state a claim for bad faith.

The appellate court rejected Ameriprise's argument that the "genuine dispute" rule necessarily relieved Ameriprise of any bad faith liability to Maslo. According to the appellate court, the "genuine dispute" rule does not apply when the insurer has failed to fairly investigate, process and evaluate an insured's claim. Thus, the genuine dispute rule did not prevent Maslo from stating a claim for bad faith against Ameriprise in this case.

The appellate court also rejected Ameriprise's argument that Ameriprise could not be held liable for bad faith because the amount the arbitrator awarded (i.e., $164,120) was less than Maslo's initial policy limits demand (i.e., $250,000). The appellate court stated that "[e]ven where the amount of damages is lower than the policy limits, an insurer may act unreasonably by failing to pay damages that are certain and demanding arbitration on those damages."

Last, the appellate court rejected Ameriprise's argument that because Maslo did not allege he would have accepted less than his initial demand, he had not alleged Ameriprise's conduct "caused" harm to him. According to the court, the problem was not Maslo's initial demand, but rather Ameriprise's alleged refusal to investigate and process Maslo's claim. Thus, Maslo adequately alleged that Ameriprise's conduct caused Maslo harm.

Comment

In the UM context, when the insurer and insured disagree whether the insured is entitled to recover damages or the amount of such damages, the insurer has a statutory right to demand arbitration of those issues. (Ins. Code § 11580(f).) However, the insurer's right to demand arbitration does not abrogate the insurer's duty to fairly investigate, process and evaluate an insured's claim. As this case suggests, where there is no real issue to be resolved by arbitration, the insurer's insistence on arbitration can violate the insurer's duties and give rise to tort liability.

Third-Party Claimant's Failure to Make Effective "Policy Limits Demand" Against Correct Insured Insulates Insurer From Liability for Failure to Settle

A third-party claimant's failure to make an effective "policy limits demand" against the correct insured insulated the insurer from liability for alleged bad faith failure to settle. (*Graciano v. Mercury General Corp.* (2014) 231 Cal.App.4th 414)

Facts

Sonia Graciano (Graciano) was severely injured when she was struck by a car driven by Saul Ayala (Saul). At the time of the accident, Saul was the named insured on a California Automobile Insurance Company (CAIC) auto policy with bodily injury liability limits of $50,000. Previously, Saul's father, Jose Saul Ayala (Jose), had been the named insured on a CAIC auto policy with bodily injury liability limits of $15,000; however, Jose's policy had been cancelled six months before the accident.

A few days after the accident, Saul reported the matter to CAIC. CAIC opened a claim file, assigned a claim number, and began investigating the matter. However, at least initially, neither Saul nor CAIC knew the identity of the injured party, Graciano.

Three days later, Graciano's lawyer separately reported a claim to CAIC. However, Graciano's lawyer incorrectly identified the responsible driver as "*Saulay Ala*," and mistakenly identified the relevant policy as the one issued to *Jose*. As a result, CAIC opened another claim file under a separate claim number and began investigating. Shortly thereafter, a CAIC claim representative informed Graciano's lawyer that CAIC was investigating a "coverage problem" for *Jose* because it appeared that *Jose's* policy had been cancelled before the accident.

A few days later, Graciano's lawyer sent CAIC a letter which mistakenly identified the insured as *Jose* and mistakenly identified the policy as *Jose's policy*. In that letter, Graciano's lawyer gave CAIC ten days to pay its policy limits in settlement of any liability *"your above-referenced insured [i.e., Jose]"* might have to Graciano. Prior to expiration of Graciano's settlement demand against Jose, CAIC informed Graciano's lawyer that Jose's policy through CAIC had been cancelled before the accident.

The following day, CAIC claim representatives realized that although CAIC had two open claim files with separate claim numbers, there had only been *one accident*, the responsible driver was *Saul*, and Saul had a policy with a *$50,000 liability limit*. CAIC thus immediately sent Graciano's lawyer a letter offering to pay CAIC's $50,000 policy limit in settlement of any liability Saul might have to Graciano, Graciano's spouse and any lien claimant.

Graciano did not accept CAIC's offer to pay its $50,000 policy limit in settlement of any liability Saul might have. Instead, Graciano obtained a judgment against Saul for over $2 million and then obtained an assignment of Saul's rights against CAIC.

Graciano then sued CAIC for insurance bad faith based on CAIC's alleged unreasonable refusal to settle Saul's liability to Graciano. The jury in the bad faith case returned a verdict in Graciano's favor. CAIC appealed.

Holding

The Court of Appeal reversed, holding that as a matter of law CAIC had not acted in bad faith.

The appellate court reasoned that an insured's claim for "wrongful refusal to settle" cannot be based on the insurer's failure to initiate settlement discussions with the injured third party. Rather, there must be proof that the third party made a reasonable offer to settle the claim against the

insured for an amount within the policy limits. Here, however, Graciano never offered to settle her claim against *Saul* for an amount within *Saul's* policy limits; rather, Graciano had only made a settlement demand against *Jose* for an amount within *Jose's* policy limits. Because Graciano had never offered to settle her claims against Saul for an amount within Saul's policy limit, CAIC did not breach any duties to Saul. Thus, Saul's assignee, Graciano, had no viable claim against CAIC for failure to settle.

Nor was there any evidence that CAIC's eventual "full policy limits offer" on behalf of Saul was unreasonable. The appellate court reasoned that a liability insurer cannot offer to pay its policy limits on behalf of an insured without attempting to get a complete release of any liability the insured might have to all third-party claimants. Thus, CAIC was fully justified in tendering its $50,000 policy limit in settlement of any liability that Saul might have to Graciano, *Graciano's spouse and any lien claimant.*

Comment

A claim for bad faith based on an alleged wrongful refusal to settle requires proof that the insurer unreasonably failed to accept an otherwise reasonable offer within the time specified by the third party for acceptance. However, when a liability insurer timely tenders its "full policy limits" in an attempt to effectuate a reasonable settlement of its insured's liability, the insurer has acted in good faith as a matter of law because, by offering the policy limits in exchange for a release, the insurer has done everything within its power to effect a settlement.

BROKERS

Broker Has No Duty to Procure Insurance Beyond What Insured Requests

An insurance broker has no legal duty to procure insurance coverage for an insured beyond what the insured requests. (*San Diego Assemblers, Inc. v. Work Comp for Less Insurance Services, Inc.* (2013) 220 Cal.App.4th 1363)

Facts

San Diego Assemblers, Inc. (Assemblers) was a remodeling contractor. Work Comp for Less Insurance Services, Inc. (Broker) is an insurance broker. In 2000, Assemblers contacted Broker seeking a "basic" liability policy. Assemblers told Broker the policy limits it required, but never described the types of coverage it wanted, and only stated that it wanted the "least expensive" coverage. Broker procured liability policies and provided them to Assemblers' personnel, who read them. Assemblers' personnel never had any questions for Broker after reading the policies and Assemblers never asked Broker for different coverage.

In April 2004 Assemblers performed work for a restaurant. In July 2008 an explosion and resulting fire occurred at the restaurant, causing substantial property damage. The restaurant's property insurer, Golden Eagle Insurance (Golden Eagle) paid for the damage under the restaurant's insurance policy and subsequently pursued a subrogation claim against Assemblers. Assemblers tendered Golden Eagle's subrogation claim to Preferred Contractors Insurance Company (Preferred), which provided liability insurance to Assemblers at the time of the explosion in 2008. Preferred refused to indemnify or defend Assemblers on the ground that the Preferred policy contained a "prior completed work" exclusion which barred coverage for property damage arising from an insured's work competed before the policy period.

Golden Eagle sued Assemblers and obtained a default judgment. Assemblers assigned to Golden Eagle any claims Assemblers had against Broker. Assemblers then filed a petition for bankruptcy.

Subsequently, Golden Eagle brought an action against Broker in Assemblers' name alleging that Broker had negligently failed to procure for Assemblers a liability policy with full "completed operations" coverage. Broker moved for summary judgment, arguing it had no legal duty to provide Assemblers with different or additional coverage than Assemblers had requested. The trial court granted summary judgment in favor of Broker. Assemblers appealed.

Holding

The appellate court affirmed, finding that Broker did not owe a duty to Assemblers to procure liability insurance with full completed operations coverage. The appellate court reasoned that an insurance broker generally owes an insured a limited duty, which is only to use reasonable care, diligence and judgment in procuring the insurance requested by the insured. An insurance broker does not breach its duty to an insured to procure the requested insurance policy unless: (a) the broker misrepresents the nature, extent or scope of the coverage being offered or provided; (b) there is a request or inquiry by the insured for a particular type or extent of coverage; or (c) the broker assumes an additional duty by either express agreement or by "holding itself out" as having expertise in a given field of insurance being sought by the insured. Here, Golden Eagle standing in the shoes of Assemblers did not assert, and did not produce any evidence, that Broker had breached its limited duty to Assemblers in any of these respects. Thus, Golden Eagle as assignee of Assemblers did not have a legally cognizable claim against Broker.

Comment

This case reaffirms that a broker generally has a limited duty to use reasonable care, diligence and judgment in procuring the insurance requested by an insured. While there may be some situations where the broker's duty can be expanded, the facts of this case did not warrant any such expansion. As such, neither the insured nor anyone claiming through the insured could prevail on a negligence claim against the broker.

Whether Producer Was "Broker" or "Agent" Was Question of Fact Where Insurer Sought to Rescind Due to Misrepresentations on Application

Whether a producer was a "broker" (acting on behalf of the insured) or an "agent" (acting on behalf of the insurer) was a question of fact where the insurer sought to rescind due to misrepresentations on the application. (*Douglas v. Fidelity National Insurance Co.* (2014) 229 Cal.App.4th 392)

Facts

Jerry and Betty Douglas owned a residence and sought to insure it. Thus, Mr. Douglas contacted InsZone Insurance Services, Inc., an insurance "producer." (A "producer" is a generic term for someone who, depending on the facts, is a "broker" or an "agent.")

Fidelity National Insurance Company is an insurer that utilizes an internet-based underwriting and rating system. The system is designed so that a producer can submit an application consisting of 43 questions, and receive an instantaneous notification from Fidelity that the application has been accepted or rejected. If Fidelity accepts the application, the producer is supposed to print a copy and obtain the applicant's signature.

Using this internet-based application process, InsZone transmitted to Fidelity an application that contained factually-inaccurate information about several issues. If the application had contained accurate information, Fidelity's system immediately would have rejected the application. Instead, however, based on the inaccurate information, Fidelity's system immediately accepted Mr. and Mrs. Douglas' application.

After Fidelity issued the policy, a fire caused substantial damage to Mr. and Mrs. Douglas' residence and various items of their personal property. While investigating the claim, Fidelity discovered that the application InsZone had submitted on behalf of Mr. and Mrs. Douglas contained several factually-inaccurate answers. Thus, Fidelity notified Mr. and Mrs. Douglas that Fidelity was rescinding the policy, and Fidelity sent Mr. and Mrs. Douglas a check to refund the premium payment they had made.

After Fidelity purported to rescind the policy, Mr. and Mrs. Douglas filed suit against both Fidelity and InsZone. Mr. Douglas asserted that, during the application process, he had signed a blank application at the behest of an InsZone employee. Mr. Douglas also asserted that InsZone's employee had only asked Mr. Douglas three questions (not 43 questions).

The case proceeded to a jury trial, during which a central issue was whether InsZone was Fidelity's "agent" or Mr. and Mrs. Douglas' "broker." The jury awarded a substantial verdict (including contractual damages, bad faith damages and punitive damages) against Fidelity. Although the judge later struck the award of punitive damages, the remainder of the award exceeded $800,000. Fidelity appealed, as did Mr. and Mrs. Douglas.

Holding

The Court of Appeal reversed, finding that the trial judge had erroneously instructed the jury on the issue of whether InsZone was a "broker" (who was acting on behalf of Mr. and Mrs. Douglas) or an "agent" (who was acting on behalf of Fidelity).

The appellate court noted that an insured is responsible for the contents of an application submitted by a broker. Thus, the jury should have been allowed to determine whether InsZone was acting as Mr. and Mrs. Douglas' "broker" or Fidelity's "agent." If InsZone was Mr. and Mrs. Douglas' "broker" at the time of the application, then Fidelity would not be legally responsible for any errors Mr. and Mrs. Douglas claimed InsZone had made (e.g., having Mr. Douglas sign blank forms, failing to ask all questions on the application, etc.).

The appellate court observed that whether a producer is a "broker" or an "agent" is often a question of fact. Generally, a producer is deemed to be an "agent" if (1) the insurer has filed with the California Department of Insurance a notice appointing the producer as an agent; or (2) the insurer and the producer have entered into a written agreement that authorizes the producer to bind coverage. Here, there was no evidence that Fidelity had filed with the California Department of Insurance a notice appointing InsZone as an agent. Further, the Court of Appeal noted that InsZone apparently did not have authority to bind coverage and that, instead, it was Fidelity itself (through its internet-based application system) that had approved the application.

Because the issue of whether InsZone was a "broker" or "agent" was a material question of fact, the jury should have been presented with properly-crafted jury instructions and allowed to decide this factual issue. Thus, the Court of Appeal reversed the judgment and ordered a new trial.

Comment

Under California law, it is well established that material misrepresentations or concealments in an application for insurance entitle an insurer to rescind, even if the misrepresentations are not intentionally made. In addition, it is well established that an insurer has no responsibility for a misrepresentation that is attributable to a broker, but that an insurer may have responsibility where the misrepresentation is attributable to an agent.

If the insurer has filed a notice of appointment with the Department of Insurance, the producer will be deemed an agent as a matter of law. In addition, if the insurer has granted the producer authorization to bind coverage, the producer will be deemed to be an agent as a matter of law. In most other

cases, the issue of whether the producer is an "agent" or a "broker" will present a question of fact.

Insurance Broker Owes No Duty To Client To Investigate Financial Condition Of Insurer Before Placing Client's Insurance With Insurer

An insurance broker owed no duty to its client to investigate the financial condition of an insurer before placing the client's insurance with the insurer. (*Mark Tanner Construction, Inc. v. HUB International Insurance Services, Inc.* (2014) 224 Cal.App.4th 574)

Facts

Compensation Risk Managers of California, LLC (CRM) administered the Contractors Access Program of California (CAP), a self-insured workers compensation program for contractors. CRM contracted with Diversified Risk Insurance Brokers (Diversified) to market CAP. Thereafter, Diversified served as insurance broker for Mark Tanner Construction, Inc. (Tanner) and Mt. Lincoln Construction, Inc. (Mt. Lincoln), who enrolled in and became members of CAP from 2006 to 2009.

Sometime later, state regulators declared CAP insolvent and CAP defaulted on payment of benefits for its workers' compensation liabilities. As a result, Tanner and Mt. Lincoln were left exposed to significant liability for unpaid workers' compensation claims.

Tanner and Mt. Lincoln subsequently sued Diversified's successor, HUB International Insurance Services, Inc. (HUB), for professional negligence and constructive fraud. Tanner and Mt. Lincoln essentially alleged that Diversified had breached a duty to investigate, discover and inform Tanner and Mt. Lincoln of all information that might affect Tanner's and Mt. Lincoln's decision to enroll in CAP, including information about CAP's financial condition. The trial court entered summary judgment in favor of HUB, finding that neither the professional negligence nor the constructive fraud cause of action had any merit. Tanner and Mt. Lincoln appealed.

Holding

The Court of Appeal affirmed.

With respect to the professional negligence claim, the appellate court held that insurance brokers generally owe a limited duty to their clients to use reasonable care, diligence and judgment in procuring the insurance requested by a client. Thus, an insurance broker owes no duty to a client to investigate the financial condition of an insurer before placing the client's insurance with the insurer.

With respect to the constructive fraud claim, the appellate court held that constructive fraud is applicable only to a fiduciary or confidential relationship. While a broker does act as a fiduciary when receiving and holding premiums, there is no authority for extending a duty owed by an insurance broker beyond the recognized duty to use reasonable care and diligence in the procuring of insurance at the insured's request. The appellate court reiterated that an insurance broker has no duty to ascertain the financial soundness of the insurer, or to advise an insured of adverse changes in the insurer's financial capability.

Therefore, the Court of Appeal held the trial court had properly granted summary judgment in favor of HUB and against Tanner and Mt. Lincoln.

Comment

The Insurance Code prescribes the financial requirements for an insurer, and the Department of Insurance has a continuing duty to oversee an insurer's financial condition. Similarly, the Department of Industrial Relations regulates self-funded workers compensation programs. Under the circumstances, the appellate court held that it

would be "superfluous" and "would create a conflict with the regulatory scheme" to impose on a broker "a similar duty to ascertain the financial soundness of an insurer."

MISCELLANEOUS

Insured Can Sue Insurance Adjuster for Negligent Misrepresentation and Intentional Infliction of Emotional Distress

A California appellate court has allowed an insured to proceed with a lawsuit against an insurance adjuster for negligent misrepresentation and intentional infliction of emotional distress arising out of the insurance adjuster's alleged misconduct in handling the insured's property claim. (*Bock v. Hansen* (2014) 225 Cal.App.4th 215)

Facts

A 41-foot long, 7,300 pound tree limb fell onto the home of Michael and Lorie Bock. The Bocks promptly reported the incident to their homeowners' insurer, Travelers Property and Casualty Insurance Company. Travelers, in turn, assigned one of its employees, Craig Hansen, to adjust the loss.

On Hansen's first visit to the Bocks' house, Hansen allegedly performed only a cursory inspection, altered the scene before taking photos of the damage, and spoke rudely and derogatorily to the Bocks. In addition, Hansen allegedly misrepresented that the policy did not cover debris removal, causing the Bocks to perform the clean-up themselves, in the course of which Mrs. Bock suffered an injury. The Bocks allegedly requested that Travelers replace Hansen as the adjuster, but Travelers refused. Subsequently, Hansen allegedly revised an estimate to include false information, conspired with an unlicensed contractor to create a false report, and engaged in various other acts of misconduct.

The Bocks sued both Travelers and Hansen. The Bocks' complaint included claims against Hansen for "negligent misrepresentation" and "intentional infliction of emotional distress." The trial court dismissed the Bocks' claims against Hansen, concluding that the Bocks had not stated, and could not state, claims against Hansen. The Bocks appealed.

Holding

The California Court of Appeal reversed.

The appellate court held that an insured *can* assert a claim for "negligent misrepresentation" against an insurance adjuster, and that the Bocks had adequately pled such a claim against Hansen in this case. The appellate court distinguished prior cases holding that agents and employees of insurance companies do not owe a duty to the insured as long as the agency relationship was disclosed and the conduct took place within the course and scope of such agency. The appellate court noted that the prior cases involved claims of "negligence" against the insurer and its agent, and that negligence is different from "negligent misrepresentation," which is a form of deceit. In finding that the Bocks had stated a claim against Hansen for negligent misrepresentation, the appellate court noted that an "agent or employee is always liable for his or her own torts, whether the principal is liable or not, and in spite of the fact that the agent acts in accordance with the principal's directions."

The appellate court further held that while the Bocks had not alleged facts sufficient to state a claim for "intentional infliction of emotional distress" against Hansen, the trial court should have given the Bocks leave to amend to attempt to assert such a claim. According to the court, the Bocks might have been able to allege the type of extreme and outrageous conduct which is required for that cause of action.

Comment

California courts have consistently recognized that because agents and employees of insurance companies are not parties to the insurance contract, they cannot be liable for breach of contract or bad faith. However, as the above case illustrates, agents and employees of insurance companies can be liable on other theories, such as misrepresentation, invasion of privacy, intentional infliction of emotional distress, etc. In such event, they can be held personally liable for their tortious conduct, even though they are not parties to the insurance contract.

Having said this, keep in mind that the above *Bock* decision is a pleading case in which the appellate court assumed the truth of the insureds' allegations. Whether the insureds can actually prove their claims against the insurance adjuster is another matter.