INSURANCE UPDATE AND
COVERAGE FOR DEFECTIVE WORK

Presented at the
Arizona State Bar Convention
Phoenix, Arizona
June 11, 2010

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# Table of Contents

## I. INTERPRETING, MODIFYING AND REFORMING POLICY LANGUAGE .................................. 1
   A. Policy Interpretation ............................................................................................................ 1
   B. Modifying Policy Language ................................................................................................ 5
   C. Rewriting Policy Language To Correct A “Scrivener’s Error” ............................................. 5
   D. Reforming Policy Language Because Of Mutual Mistake .................................................... 6

## II. WHERE AND WHEN TO SUE AND WHAT LAW TO APPLY ............................................... 7
   A. Choice-Of-Law Provisions .................................................................................................. 7
   B. Forum-Selection Provisions ................................................................................................. 9
   C. Suit Limitation Provisions ................................................................................................. 10

## III. INSURED’S DUTIES............................................................................................................... 11
   A. Insured’s Duty To Be Truthful ........................................................................................... 11
   B. Insured’s Duty To Make Damaged Property Available For Inspection ............................... 12
   C. Insured’s Duty To Provide Timely Notice .......................................................................... 13
   D. Insured’s Duty To Timely Submit Proof Of Loss ............................................................... 15
   E. Insured’s Duty Not To Voluntarily Make Payments Without Insurer’s Consent ................. 16

## IV. COMMERCIAL GENERAL LIABILITY (CGL) COVERAGE ................................................ 17
   A. Duty to Defend .................................................................................................................. 17
      1. When is duty to defend determination ripe for consideration? ...................................... 17
      2. Is the duty to defend triggered only upon the filing of an action against the insured? .... 18
      3. Defense of affirmative defenses .................................................................................. 19
      4. Scope of the insurer’s duty to defend. .......................................................................... 20
      5. Resort to extrinsic evidence in evaluating defense obligation. ...................................... 20
      6. Reservation of rights letters ......................................................................................... 22
      7. Defense of additional insureds .................................................................................... 22
      8. Effect of another insurer’s defense on the duty to defend. ............................................ 25
      9. Consequences of breaching the duty to defend. ............................................................ 25
     10. Loan receipt agreements .............................................................................................. 27
   B. “Occurrence” Element ...................................................................................................... 28
   C. “Property Damage” Element .............................................................................................. 31
   D. “Bodily Injury” Element .................................................................................................... 34
   E. Timing of Injury ................................................................................................................ 34
      1. Latent injury of lasting duration ................................................................................... 35
      2. Proving injury occurred during policy period ............................................................... 36
      3. Allocating damages among “triggered” policies ........................................................... 37
      4. “Stacking” of limits of successive liability policies triggered by continuous loss ......... 38
F. Exclusions .......................................................................................................................... 40
   1. Pollution exclusion ........................................................................................................... 40
   2. Business risk exclusions j(5) and j(6) ........................................................................... 41
   3. “Your work” exclusion ................................................................................................ 42
   4. Breach of contract exclusion ....................................................................................... 43
   5. Contractual liability exclusion ..................................................................................... 43
   6. Professional services exclusion .................................................................................... 44
   7. Auto and watercraft exclusion .................................................................................... 45
   8. “Own property” exclusion ........................................................................................... 45
   9. Joint venture exclusion ................................................................................................ 46
  10. “Contractor-subcontractor” exclusion ........................................................................... 47
  11. Scope of work exclusions ........................................................................................... 47

G. Additional Insured Coverage .......................................................................................... 48
   1. Scope of additional insured coverage ......................................................................... 48
   2. Creation of additional insured status ......................................................................... 51
   3. Additional insured status under excess coverage ......................................................... 53

H. Other Insurance ................................................................................................................. 54

V. SUBROGATION ..................................................................................................................... 56
   A. Contractual Waivers of Subrogation ............................................................................ 57

VI. PROPERTY INSURANCE ..................................................................................................... 60
   A. Mixed Causes of Loss ................................................................................................... 60
   B. Deductibles ................................................................................................................... 61
   C. Limits of Coverage ....................................................................................................... 62
   D. Debris Removal ............................................................................................................. 63
   E. Testing and Commissioning Coverage ........................................................................ 64
   F. Business Interruption Coverage .................................................................................. 65
   G. Service Interruption Coverage ..................................................................................... 66
   H. Increased Cost of Construction Coverage ................................................................. 67
   I. Exclusions ....................................................................................................................... 70
      1. Faulty workmanship exclusion ................................................................................ 70
      2. Continuous seepage or leakage of water exclusion ................................................ 72
      3. Theft exclusion ......................................................................................................... 73
      4. Earth movement exclusion ..................................................................................... 73
      5. Shrinking and cracking exclusion ......................................................................... 74
      6. Wind exclusion ......................................................................................................... 76
   J. Collapse ......................................................................................................................... 77
K. Valuation .......................................................................................................................... 79
L. Appraisal .......................................................................................................................... 81

VII. EXCESS INSURANCE ............................................................................................................ 82
    A. “Follow Form” Excess Coverage .................................................................................. 83
    B. “Drop Down” Coverage .............................................................................................. 84

VIII. PROFESSIONAL LIABILITY INSURANCE ........................................................................ 86
    A. When is a Claim a “Claim” Under a Claims-Made Policy? ........................................... 86

IX. WRAP-UP INSURANCE ....................................................................................................... 87
I. INTERPRETING, MODIFYING AND REFORMING POLICY LANGUAGE

A. Policy Interpretation

Insurance policies are a species of contract and, as such, are interpreted pursuant to common contract interpretation principles. It is common for courts to begin their policy interpretation with the observation that insurance contracts are interpreted according to the general rules of contract interpretation. How rigorously they follow this approach varies, depending upon the nature of the dispute and the specific jurisdiction’s law on the subject. Not all policy language is treated the same, as most courts apply different rules for language that narrows policy coverage. Exclusions and restrictive endorsements are often strictly construed against the insurer. The Connecticut Supreme Court had occasion to discuss these concepts in the context of an intra-insurer dispute involving silicosis claims:

Under our law, the terms of an insurance policy are to be construed according to the general rules of contract construction. The determinative question is the intent of the parties, that is, what coverage the [insured] expected to receive and what the [insurer] was to provide, as disclosed by the provisions of the policy. If the terms of the policy are clear and unambiguous, then the language, from which the intention of the parties is to be deduced, must be accorded its natural and ordinary meaning. However, when the words of an insurance contract are, without violence, susceptible of two [equally reasonable] interpretations, which will sustain the claim and cover the loss must, in preference, be adopted. This rule of construction favorable to the insured extends to exclusion clauses.

Put differently, although policy exclusions are strictly construed in favor of the insured … the mere fact that the parties advance different interpretations of the language in question does not necessitate a conclusion that the language is ambiguous. The interpretation of an insurance policy is based on the intent of the parties, that is, the coverage that the insured expected to receive coupled with the coverage that the insurer expected to provide, as expressed by the language of the entire policy. The words of the policy are given their natural and ordinary meaning, and any ambiguity is resolved in favor of the insured. The Court must conclude that the language should be construed in

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1 The one exception to this rule is where the insurance policy is issued pursuant to a federal program, such as a standard flood insurance policy. Where the policy is issued pursuant to a federal program, it must be strictly construed and enforced. See Monistere v. State Farm Fire & Cas. Co., 559 F.3d 390, 394 (5th Cir. 2009). See also, Gowland v. Aetna, 143 F.3d 951,954 (5th Cir. 1998). Because insurance companies act as “fiscal agents” of the government under the National Flood Insurance Program, all policy awards deplete federally-allocated funds. In re Estate of Lee, 812 F.2d 253, 256 (5th Cir. 1987). “Therefore, ‘not even the temptations of a hard case’ will provide a basis for ordering recovery contrary to the terms of [a] regulation, for to do so would disregard ‘the duty of all courts to observe the conditions defined by Congress for charging the public treasury.’” Forman v. Fed. Emergency Mgmt. Agency, 138 F.3d 543,545 (quoting Office of Pers. Mgmt. v. Richmond, 496 U.S. 414, 420, 110 S. Ct. 2465, 110 L.Ed.2d 387 (1990) (emphasis in original)).

2 See Nova Cas. Co. v. Central Mut. Ins. Co., 59 A.D.3d 777, 872 N.Y.S.2d 603 (3d Dep’t 2009) (spray paint exclusion narrowly construed and did not apply to insured’s activities using sealants as these were not paints and therefore not covered by the exclusion).
favor of the insured unless it has a high degree of certainty that the policy language clearly and unambiguously excludes the claim.\(^3\)

The Connecticut court’s focus on the parties’ “intentions” is a bit unusual, given that insurance policies are standard form agreements which, in many cases, are not negotiated or, if they are, the negotiation is conducted through intermediaries such as brokers and agents. It is the unusual case that delves into extrinsic evidence pertaining to the parties’ negotiations over contract terms. The Connecticut court’s decision is typical. While the court looked outside the policy language, it did not delve into the parties’ negotiations. Rather it considered certain “scientific materials” submitted by the parties regarding the chemical makeup of silica, but did not discuss whether there were any negotiations over the policy language in question.\(^4\)

Other contract interpretation principles aid policy interpretation. For example, if construction of an insurance policy entirely neutralizes one provision, it should not be adopted if the contract is also susceptible of another construction which gives effect to all of its provisions and is consistent with the general intent.\(^5\)

Exclusionary language is also treated differently from other policy language from a “burden of proof” standpoint. In many jurisdictions, the insured bears the burden of demonstrating coverage under an insurance policy. This essentially boils down to establishing that the conditions set forth in the “insuring clause” are met. For example, under Coverage A of the commercial general liability (CGL) policy, the insured bears the burden of establishing the existence of an “occurrence” that resulted in “property damage” or “bodily injury” during the policy period. Once the insured meets its burden under the insuring clause, the burden shifts to the insurer to establish the applicability of any exclusions.\(^6\)

Policy interpretation was on display in two opinions exploring the meaning of certain policy endorsements. In *Auto-Owners Ins. Co. v. Ferwerda Enters., Inc.*,\(^7\) a family vacation was ruined when a cloud of chlorine and muriatic acid filled the swimming pool area of the Holiday Inn at which they were staying. The insurance dispute arose over the meaning of a “heating equipment exception” to the pollution exclusion contained in Holiday Inn’s policy. The lower court ruled that, as a matter of law, the heating equipment endorsement unequivocally provided coverage under the policy. While the policy contained an absolute pollution exclusion, this “heating equipment” endorsement made it a little bit less “absolute” because it excised the exclusion from the form policy when a person in the insured’s building suffers bodily injury “caused by smoke, fumes, vapor or soot from equipment used to heat a building at

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3. *Liberty Mut. Ins. Co. v. Lone Star Indus., Inc.*, 967 A.2d 1, 21-22 (Conn. 2009) (inner quotations and citations omitted) (asbestos hazard exclusion endorsement that contained the language “silica dust” barred coverage for silica-related claims).

4. The court also addressed whether the insured “accepted” the restrictive endorsements that eliminated coverage for silica claims. The insured claimed that it did not accept the endorsement as it did not sign the endorsement page containing the restrictive language. The court rejected the argument on the grounds that a representative of the insured signed the declarations page. Moreover, the endorsement specifically provided that it took effect upon the countersignature on the declarations page of a duly-authorized agent of the insurer. *Liberty Mut. Ins. Co. v. Lone Star Indus., Inc.*, 767 A.2d 1, 24-25 (Conn. 2009).


The question for decision was whether the heating equipment endorsement encompassed the pool’s heating, filtration, and treatment system.

The court led off its analysis with a discussion of the interpretation rules governing policy endorsements:

Endorsements often are issued to specifically grant certain coverage or remove the effect of particular exclusions. Thus, such an endorsement will supersede the terms of the exclusion in question. When a conflict arises between the terms of an endorsement and the form provisions of an insurance contract, the terms of the endorsement prevail. Endorsements by their very nature are designed to trump general policy provisions, and where a conflict exists between provisions in the main policy and the endorsement, the endorsement prevails.9

The appellate court determined that an ambiguity existed with respect to whether the building heating equipment endorsement encompassed the pool’s heating and filtration system. Instead of invoking the “construed against the drafter” rule, however, the court determined that a fact-finder should ascertain its meaning.10

Another decision that found an ambiguity requiring a factual determination as to its meaning is *Essex Ins. Co. v. Zota.11* Once again, the focus of attention was on a policy endorsement. The insured was in the business of building “spec” homes. A mural artist was injured in a fall while working in one of the insured’s homes. The insured’s policy contained a “Combination General Endorsement” which provided that, if the insured was a “contractor, builder or developer,” there was no coverage under the policy for injury caused by acts of independent contractors or subcontractors unless the insured obtained certificates of insurance naming it as an additional insured. Moreover, the endorsement eliminated coverage for injuries sustained by any independent contractor or subcontractor, unless an employee of the insured contractor, builder or developer was on site at the time of the time of the injury.12

The question boiled down to whether the insured was a “builder,” “contractor,” or “developer,” for purposes of the exclusion. The policy provided no definitions for these terms. As a consequence, the parties offered their own definitions culled from one or more dictionaries. The insured claimed that, because it did not supervise the construction, it was not a “builder.” It also claimed that it was not a

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9 *Auto-Owners Ins. Co. v. Ferwerda Enters., Inc.*, 771 N.W.2d 434, 440 (Mich. Ct. App. 2009). The court does not address whether these rules also apply to endorsements that restrict rather than enhance coverage.
10 The court does not offer any suggestions as to just how a fact-finder is to go about ascertaining the exclusion’s meaning. Because insurance contracts are on balance form contracts, many of the terms of which are not specifically negotiated, it can be a challenge to elicit factual evidence relevant to policy meaning. As a consequence, most courts simply resort to the rule that ambiguities are construed against the insurer. *See Dean Blanchard Seafood, Inc. v. Acadian Ins. Servs.*, 616 F. Supp. 2d 612 (E.D. La. 2008) (in a matter of first impression, where standard flood insurance policy’s circular definitions of covered “building” and covered “structure” created ambiguity, the policy was interpreted in the insured’s favor); *Royal Ins. Co. of Am. v. KSI Trading Corp.*, 563 F.3d 68 (3rd Cir. 2009) (ambiguity in policy as to whether coverage extended to domestically acquired merchandise required construction of policy in insured’s favor).
“contractor,” as it owned the property and was not responsible for the performance of the construction of the home in accordance with established specifications. Finally, it claimed that it was not a “developer,” as it failed to meet the statutory definition as it constructed less than ten units per year. While the court construed the policy against the insurer on the question of whether the insured was a “developer,” it founds disputed issues of material fact that could not be resolved at the summary judgment stage on the question of whether the insured was a “builder” or “contractor.”

An insured does not create an ambiguity merely by offering a different interpretation of policy language. The insured’s interpretation must be reasonable. In *Cain Petroleum, Inc. v. Zurich Am. Ins. Co.*, the insured’s interpretation of a pollution policy was unreasonable. In arriving at this conclusion, the court considered the insured’s argument that leaky storage tanks not scheduled in the declarations were nonetheless covered. The insured’s basis for its contention was that the policy’s “retroactive date” (the earliest date an event could occur and still be covered by the policy) preceded the installation dates of the scheduled tanks and, therefore, the policy must have been intended to cover older, unscheduled tanks. In ruling this interpretation unreasonable, the court noted:

“Ambiguity” is a term of art; in the context of construing an insurance policy, it refers to the existence of multiple, reasonable interpretations of the policy wording in the light of the context in which the disputed provisions are employed and in the context of the policy as a whole. To qualify as a “reasonable” construction, a proposed reading of the policy must, at the least, be consistent with the wording; conversely, if a proposed interpretation would require us to disregard any provision of the policy, it is not reasonable, as a matter of law. . . . The problem is that the plaintiff’s proposed construction is not plausible. It may, indeed, be the case that – at least with respect to the three tanks at the 833 Baseline location in Hillsboro – the uniform retroactive date that plaintiff itself selected becomes superfluous. The fact remains, however, that the interpretation of the policy that plaintiff proposes is directly contradicted by the express wording of the policy that “this policy is location-specific and storage tank system-specific: only ‘scheduled storage tank system(s)’ at ‘scheduled location(s)’ are covered.” As we have noted, a “reasonable” interpretation of an insurance policy, at a minimum, must not be contradicted by the terms of that policy. Plaintiff’s proposed interpretation does not satisfy that minimum requirement.

See also, *Progressive County Mut. Ins. Co. v. Kelley*, 24 S.W.3d 805 (Tex. 2009) (in a case where neither party claimed an ambiguity existed, court determined otherwise on question of whether insurance documents listing four vehicles on a two-page document and a fifth vehicle on a separate two-page document with different policy numbers but identical premium amounts was one or two policies).  


*Cain Petroleum, Inc. v. Zurich Am. Ins. Co.*, 197 P.3d 596, 600 (Or. Ct. App. 2008) (emphasis in original and certain inner quotations omitted). See also, *Bridgetown Condo. Homeowners Ass’n v. Ford Dev., Inc.*, 2009 WL 1743759 (June 18, 2009) (where developer’s policy contained a “designated work” exclusion that precluded work on “condominium” that contained five or more single-family units or any building in excess of three stories or forty feet in height; association’s claim that policy was ambiguous because the term “condominium” was unclear as it could either mean large individual buildings which contained five or more units or could mean an entire project which contained five or more units was unreasonable because the policy would not have needed to define the number of single-family units if the intent was only to exclude tall and complicated buildings).
B. Modifying Policy Language

Most policies contain a provision that expressly states how the policy can be amended or modified. In the usual case, policy language cannot be modified except by endorsement signed by an authorized representative of the company. For example, in *GuideOne Specialty Ins. Co. v. Admiral Ins. Co.*, the policy provided that its terms could not be amended or waived except by endorsement issued by the insurer and made a part of the policy. Admiral provided liability coverage to a contractor that agreed to build some housing for a school. The contract required the contractor to purchase liability coverage in the amount of $2 million. It also required the contractor to name the school as an additional insured under its policy. While the school was named an additional insured, the contractor’s policy was only in the amount of $1 million. The school also possessed a liability policy which provided secondary and excess coverage from GuideOne.

After a worker was seriously injured on the job, GuideOne sought assurance from Admiral that Admiral would provide a full defense and indemnification to the school. Admiral’s claims superintendent wrote GuideOne stating:

[Admiral] is providing [Torah Academy] with a full defense and indemnification in this matter, as it conforms with the contract between [WCH (contractor) & Torah Academy].

The injured worker’s suit was settled for $1,225,000. Admiral paid $1 million and GuideOne $225,000. GuideOne then sought recovery from Admiral, claiming that the policy had been modified to reflect the $2 million coverage required of the parties’ contract. The court denied GuideOne relief:

The letter signed by Admiral’s claims superintendent did not purport to be, and did not constitute, such an endorsement [sufficient to constitute a modification of the policy]. Moreover, inasmuch as the policy is unambiguous with respect to the limits of coverage afforded, resort to extrinsic evidence was not proper. Consequently, the documentary evidence submitted by Admiral in support of its motion conclusively established that its policy did not provide coverage beyond its stated limits.

C. Rewriting Policy Language To Correct A “Scrivener’s Error”

The existence of a “scrivener’s error” presents a narrow and demanding exception to the general rule that the court is not permitted to rewrite a document or add terms not included by the parties. The genesis of the exception arises from the belief that scrivener’s errors “are difficult to prevent, and . . . no useful social purpose is served by enforcing . . . mistaken term[s].” Nevertheless, most discussions

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20 *S.T.S. Transp., Inc. v. Volvo Light Truck Corp.*, 766 F.2d 1089, 1093 (7th Cir. 1985).
focus on the narrowness of the exception. In most cases, the error must be proven without resorting to parol evidence.\textsuperscript{21}

The exception was rejected in \textit{Tiger Fibers, LLC v. Aspen Specialty Ins. Co.},\textsuperscript{22} where an insurer claimed that such an error occurred in a property policy that was intended to provide coverage for business interruption and personal property, but not to the building itself. In rejecting the insurer’s contention, the court reasoned:

Aspen’s claim that the Aspen policy’s inclusion of building coverage is a scrivener’s error fails for several reasons. First, there is nothing on the face of the policy that would suggest that the coverages were intended to be different than what is listed. This is not a case where building coverage is listed in one part of the policy but disclaimed in another or where the building coverage listed in one part is inconsistent with some other provision of the policy. . . . Second, and similarly unavailing, is Aspen’s contention that in evaluating whether there is a scrivener’s error, this Court should look outside the Aspen policy and review other documents that were part of the application and underwriting process. Aspen asserts that the “X” in the box indicating building coverage is demonstrably contradicted by “all other documents,” including insurance application, the written quotation for property coverage, and the written binder of property coverage.

Under Virginia law, whether there is a scrivener’s error must be decided based on the policy itself and not any parol evidence, particularly where, as here, the policy disclaims any other agreements other than those set forth in the policy.\textsuperscript{23}

\textbf{D. Reforming Policy Language Because Of Mutual Mistake}

An insured’s contract, as with other types of agreements, may be reformed to reflect the parties’ original intentions at the time of entering into their bargain.\textsuperscript{24} Nevertheless, because the doctrine of mutual mistake results in modifying written contract language, it is cautiously applied. Some jurisdictions require a higher standard than mere preponderance of the evidence to establish mutual mistake.\textsuperscript{25}

Unlike a “scrivener’s error,” reformation by mutual mistake allows the court to entertain extrinsic evidence.\textsuperscript{26} The extrinsic evidence was insufficient to entitle an insurer to avoid providing property

\textsuperscript{25} \textit{See Morris Oil Corp. v. Maryland Cas. Co.}, 136 F. Supp. 63, 65 (W.D. Va. 1955) (“Nothing less than evidence that is plain and convincing beyond reasonable controversy will constitute such proof as will warrant a modification or reformation of a written agreement.”); \textit{Tiger Fibers, LLC v. Aspen Specialty Ins. Co.}, 594 F. Supp. 2d 630, 643-44 (E.D. Va. 2009) (mutual mistake must be proven by clear and convincing evidence). \textit{But see, Samuels v. State Farm Mut. Ins. Co.}, 939 So.2d 1235, 1240 (La. 2006) (noting that the party seeking reformation must prove by a preponderance of evidence that the reform did not substantially affect the risk assumed by the insurer).
\textsuperscript{26} \textit{Grand Acadian, Inc. v. Fluor Corp.}, 2009 WL 994990 at *4 (W.D. La. April 9, 2009) (“Parol evidence is admissible to show a mutual error warranting reformation, even absent an ambiguity in the contract.”).
coverage on a building destroyed by fire where the insured contended that it asked for such coverage from
the insurer’s agent:

Plaintiffs have submitted declarations that they specifically requested building coverage
from Mr. Potter of Franey [agent] and that Mr. Potter later confirmed that plaintiffs had
requested that coverage. This evidence has not been refuted. The testimony Aspen
[insurer] submitted from Franey and All Risks [an insurance broker Franey
communicated with] simply affirmed through persons other than Mr. Potter that they did
not think the insurance application or other communications with Aspen requested
building coverage. There is no evidence of any communications with the plaintiffs
themselves in which plaintiffs agreed to exclude building coverage. On the contrary, the
written communications with the plaintiffs include explicit warnings that the scope of
coverage under the Aspen Policy is determined by the policy itself, and that specifically
disclaim the insurance application is relevant for that purpose. Any mistake, therefore, is
a unilateral mistake on the part of Aspen and its statutory agents. Aspen has not
demonstrated by clear and convincing evidence that neither plaintiffs nor Aspen intended
the Aspen policy to provide building coverage. Thus, the record here falls short of the
high threshold required to establish a mutual mistake.27

II. WHERE AND WHEN TO SUIT AND WHAT LAW TO APPLY


The standard form general liability policy does not contain an express choice-of-law provision. While the policy may be standard, the law of the various jurisdictions is anything but uniform and, as a
consequence, it is not unusual for parties to dispute which law applies. In the absence of an express
choice-of-law provision, this situation usually requires the court to delve into a state’s conflict of laws
jurisprudence. Often there is no easy answer, as the Eleventh Circuit found in a case involving a Florida
loss. In U.S. Fid. & Guar. Co. v. Liberty Surplus Ins. Corp.,28 the insured contractor secured a liability
policy in Massachusetts which covered its operations in a variety of states, including Florida. Problems
arose on the Florida project, including claims of defective work, which eventually resulted in the owner
demanding arbitration. The insurer acknowledged the arbitration demand and reserved its rights under
the policy. Before the arbitration hearing, the insurer informed its insured that it would no longer
participate in its defense. The surety and the contractor settled with the owner. As the surety was
subrogated to the contractor’s rights under its policy, it sued the insurer. The district court applied
Massachusetts law and granted judgment in favor of the insurer.

On appeal, the surety argued that Florida law applied. As is often the case in these disputes, the
battle lines form over whether the law of the jurisdiction in which the contract was made governs or
whether the law of the jurisdiction in which the loss arose applies. The Eleventh Circuit determined that
Florida law was unsettled on this question and certified the question for review by the Florida Supreme
Court.

Acadian, Inc. v. Fluor Corp., 2009 WL 994990 (W.D. La. April 9, 2009) (additional insured able to seek
reformation of subcontract agreement incorrectly naming another party as an additional insured on grounds of
mutual mistake).

Choice of law provisions are more commonly found in such specialty policies as pollution liability and directors’ and officers’ liability coverage. Where there is an express choice-of-law provision, the issue shifts to whether the clause should be enforced. As with everything else involving “choice-of-law” analysis, the decisions scatter. Yet certain themes can be discerned.

Courts frequently look to see whether there is a substantial relationship or strong nexus with the chosen jurisdiction.29 A New York court explained that the enforcement of an express choice-of-law provision should only be considered after the court first determines, under choice-of-law principles, that the applicable substantive law is not the forum law, and whether New York’s nexus with the case is substantial enough to threaten a recognized public policy.30 On occasion a court will stray from the Restatement factors and look to such issues as the public policy of protecting parties’ freedom to contract as they desire. In Good v. Commerce & Indus. Ins. Co.,31 a pollution policy called for a New York law to apply. The policy was entered into in Florida, the accident (a petroleum spill) occurred in Florida, and the insured was a Florida resident. Notwithstanding the lack of a New York nexus, the court upheld the choice-of-law provision on the theory protecting the parties’ freedom of contract outweighed any policy interests in protecting Florida insureds.32

An opposite result was reached in Param Petroleum Corp. v. Commerce & Indus. Ins. Co.,33 where again a pollution policy contained a New York choice-of-law provision. In this case, the storage tank in question was located in New Jersey and the pollution event took place in the state. In declining to enforce the choice-of-law provision, the New Jersey court, like its Florida counterpart, also reached outside of the Restatement factors, but in this case looked to authority rejecting forum-selection provisions subject to local franchise law. This authority discussed the unfair superior bargaining power that franchisors have over their franchisees. Employing a similar “contract of adhesion” rationale the court declined to enforce the choice-of-law provision.34

30 See Weiss v. LaSuisse, 154 F. Supp. 2d 734 (S.D.N.Y. 2001). See also, Tens’ Cabaret, Inc. v. Am. Safety Ins. Servs., 2009 N.Y. Misc. LEXIS 2595 (Sup. Ct. N.Y. Co. 2009) (“Where parties have agreed on the law that will govern their contract, it is the policy of the courts of this state to enforce that choice-of-law, provided that (a) the law of the state selected has a “reasonable relation[ship]” to the agreement and (b) the law chosen does not violate a fundamental public policy of New York.”).
32 The cause of the fight was the fact that New York law does not recognize an independent tort action for bad faith, whereas Florida law does.
34 On occasion, a policy will contain a “service of suit” provision (e.g., parties submit to the jurisdiction of any court of competent jurisdiction) that also contains language that the parties agree that their dispute will be determined in accordance with the law of such court. While most courts do not construe such provisions as a “choice-of-law” designation, a few do. Compare, Chesapeake Utils. Corp. v. Am. Home Assurance Co., 704 F. Supp. 551 (D. Del. 1989) (mere fact that parties agree to the law and practice of a particular court is not the same as an explicit agreement that the law of a forum state will control); Revco D.S., Inc. v. Gov’t Employees Ins. Co., 791 F. Supp. 1254 (N.D. Ohio 1991) (same); W.R. Grace & Co. v. Hartford Accident & Indem. Co., 555 N.E.2d 214 (Mass. 1990) (same); Norfolk S. Corp. v. Cal. Union Ins. Co., 859 So.2d 167 (La. Ct. App. 2003) (same); Singer v. Lexington Ins. Co., 658 F. Supp. 341 (N.D. Tex. 1986) (while service of suit provision allows the parties to choose the forum of their choice, that forum must still determine the applicable substantive law to apply) with Lexington Ins. Co. v. UnionAmerica Ins. Co., 1987 11684 (S.D.N.Y. May 26, 1987) (because service of suit provision coupled
B. Forum-Selection Provisions

Forum-selection provisions designate an exclusive forum for hearing the dispute rather than expressly designate which jurisdiction’s law applies. Like choice-of-law provisions, the decision law is anything but uniform. Often a threshold issue is whether the clause clearly makes the identified forum the exclusive jurisdiction for the litigation. In Applied Waterproofing Tech., Inc. v. Am. Safety Indem. Co., the policy contained the following forum-selection clause:

By accepting this policy or by presenting a claim which an insured contends is or may be covered under this policy, the Named Insured and any other insured submits themselves to the jurisdiction of the Superior Court of Cobb County, Georgia and agrees that such court shall have jurisdiction and venue for purposes of determining all rights and obligations under this agreement.

Any insured expressly consents to jurisdiction and venue of the Superior Court of Cobb County, Georgia for any “suit” brought to interpret or enforce the provisions of this agreement. The insured brought suit in California, claiming that the forum-selection clause did not require suit to be filed in Georgia but only permitted the parties to do so if they so chose. In support of its argument, the insured cited a line of California authority to the effect that the term “shall” does not always connote exclusivity and, as a consequence, the policy’s provision only made Cobb County a permitted jurisdiction for any suit. The court determined otherwise:

Here, the first paragraph unambiguously states that the Superior Court of Cobb County, Georgia shall have jurisdiction and venue for purposes of determining all rights and obligations under this agreement. Furthermore, the second paragraph states that jurisdiction and venue will be proper in the Superior Court of Cobb County, Georgia for any suit brought to interpret or enforce the provisions of this agreement. These paragraphs specifically designate a particular court within the State of Georgia to serve as the exclusive appropriate form for the litigation of any and all rights and obligations arising under the agreement. Thus, the Court concludes the forum-selection clause is mandatory and prima facie enforceable.

Enforcement of forum-selection clauses often implicates policy considerations. These provisions are subject to attack where they deprive the insured of a remedy or contravene strong public policy of the forum state. Inconvenience is another basis offered by parties seeking to avoid these clauses. Of
course, inconvenience is a highly case-specific matter and, as a consequence, the decisions display a
range of outcomes from “mere inconvenience” foretelling the outcome to declining to enforce a provision
because a majority of witnesses were from outside the selected forum.\footnote{Compare Land O’ Sun Mgmt. Corp. v. Commerce & Indus. Ins. Co., 961 so.2d 1078 (Fla. Ct. App. 1st DCA 2007) (mere inconvenience or expense does not render provision unreasonable and insured must establish that being forced to litigate in an alternate forum would be so inconvenient as to deprive it of its day in court) with Keweenaw Konvenience, Inc. v. Commerce & Indus. Ins. Co., 2001 WL 34070116 (W.D. Mich. Jan. 11, 2001) (declining to enforce New York forum-selection provision as majority of witnesses were in Michigan); See also, In re AIU Ins. Co., 148 S.W.3d 109 (Tex. 2004) (clause designating New York court was enforced notwithstanding fact that loss occurred in Texas, insured was located in Texas, and the majority of witnesses were located in Texas); Seneca Ins. Co. v. Henrietta Oil Co., 2003 WL 255317 (S.D.N.Y. Feb. 4, 2003) (enforcement of New York forum-selection clause unjust, as all significant contacts were within Texas).

C. Suit Limitation Provisions

While not a staple of all policies by any means, on occasion one will encounter a policy
containing a provision requiring the insured to commence suit against the insurer within a specified
property policy required the insured to commence suit within two years after the date on which the loss or
damage occurred. The insured failed to do this, and the question became whether the suit limitation
provision was valid and, if so, whether the insurer waived or was estopped from asserting it. Pennsylvania law generally recognizes suit limitation clauses in insurance policies as valid.\footnote{See General State Auth. v. Planet Ins. Co., 346 A.2d 265 (Pa. 1975) (policy provision setting 12-month time limit on commencing suits to recover under insurance policy is valid and sustainable); World of Tires, Inc. v. Am. Ins. Co., 520 A.2d 1388 (1987), appeal denied, 532 A.2d 20 (Pa. 1987) (12-month time limit set forth in insurance policy is applicable, absent actions by insurer which led insured to believe that provision will not be enforced); Satchell v. Ins. Placement Facility of Penn., 361 A.2d 375 (Pa. Super. 1976) (insured not entitled to recovery where suit was brought after expiration of 12-month limitations period).} Unlike
notice provisions, which may require a finding of prejudice before the insurer is entitled to seek
enforcement of the provision, an insurer is not required to show prejudice when seeking enforcement of a

The insured was unable to make out a waiver or estoppel defense to the suit limitations provision. The mere declaration that the insurer was investigating the claim was insufficient to prove the insured was induced to forebear from commencing suit. Moreover, the insurer’s representative’s failure to mention
the suit limitations provision at his deposition was insufficient to prove grounds for estoppel. Nor did the
insurer’s letter denying coverage and specifying the reasons for the decision, which did not expressly
include the suit limitation provision but generally referenced the policy’s terms, exclusions and
limitations, did not amount to a waiver.\footnote{Prime Medica Assocs. v. Valley Forge Ins. Co., 970 A.2d 1149, 1158 (Pa. Super. 2009).}
III. INSURED'S DUTIES

A. Insured’s Duty To Be Truthful

The buying and selling of insurance often begins with the insured completing and submitting an insurance application. Incorrect information submitted as part of the application process can jeopardize coverage. The issue often boils down to whether the insurer can establish prejudice. This can depend on the materiality of the misrepresentation or omission. In Caribbean I Owners’ Ass’n, Inc. v. Great Am. Ins. Co. of New York, a condominium association along the Alabama Gulf Coast sought coverage from its property carrier for damage incurred from Hurricane Ivan. The insurer denied coverage on the ground that the insured failed to tell it about water intrusion problems when it first sought coverage, as well as when it renewed the policy. Alabama statutory law prohibits an insurer from denying coverage based upon misrepresentations or concealment unless they are either material to the acceptance of the risk or to the hazard assumed by the insurer; or the insurer can establish that in good faith it would not have issued the policy or contract if the true facts had been made known to it.

The court declined to rule, as a matter of law, in the insurer’s favor, concluding that the application could have been clearer about the type of information that was being requested from the insured:

First, it is far from clear that Caribbean I engaged in misrepresentations at all. In Great American’s words, the omissions in question are these: “Plaintiff never disclosed the ongoing water intrusion, construction defects or the damage or losses resulting from those defects to great American.” But no questions or instructions in Great American’s policy application documents specifically prompted Caribbean I to enumerate all known construction defects or maintenance problems in the Building, to set forth the Building’s history of water intrusion, to disclose whether Caribbean I was or had previously been involved in litigation with the Building’s contractors regarding alleged construction defects, or the like. In lieu of any such direct, targeted inquiries, Great American predicates its misrepresentation argument on the “Loss History” section of the application which requested that Caribbean I “enter all claims or losses (regardless of fault and whether or not insured) or occurrences that may give rise to claims for the prior five years.” Significantly, “claims or losses” is not defined in the application, and Great American does not suggest that this term was ever explained to the insured. Caribbean I answered the question by checking the box for “None.” It is not obvious, as a matter of law, that the terms “claims or losses” and “Loss History” would encompass matters such as construction defects; sporadic, minor water leaks for which no claims had been made or were contemplated; and disputes between the insured and its contractors regarding whether the Building comported with the promised quality standards. Given the ambiguities in the application form, the Court cannot find as a matter of law that Caribbean I’s failure to disclose the construction defects and maintenance issues as

46 Ala. Code §27-14-7(a)(2)-(3). It is immaterial whether the insured had any intent to deceive the carrier. See Alfa Life Ins. Corp. v. Lewis, 910 So.2d 757, 762 (Ala. 2005).
“claims or losses” amounted to a misrepresentation or omission supporting rescission [under Alabama law].

New York law requires the insurer to establish that the insured made the misrepresentation with the intent to defraud. Materiality is measured by the insurer’s likely conduct in the event it knew the truth. Only where the insurer would have refused to issue the policy, had it known the true facts, is the misrepresentation deemed material. Moreover, while materiality is ordinarily a jury question, it becomes a matter of law for the court’s determination when the evidence concerning materiality is clear and substantially uncontradicted. Applying these principles, a New York court determined that an insured’s misrepresentations to the effect that it performed interior painting work, when in reality he was a general contractor, were sufficient to permit the carrier to rescind the policy ab initio.

B. Insured’s Duty To Make Damaged Property Available For Inspection

It seems straightforward and not terribly burdensome for an insured to make available to its insurer property it claims is damaged for which it seeks recovery under the policy. Yet this is not always the case. In Coconut Key Homeowners Ass’n, Inc. v. Lexington Ins. Co., a condominium association attempted on several different occasions to secure entry into all the property’s units for inspection. Due to foreclosures, vacancies, or other reasons, a number of units were unavailable for inspection. The first issue for determination was whether the policy’s inspection clause was a “condition precedent” to coverage or merely a “cooperation clause.” As the court explained the difference:

A condition precedent is one to be performed before the contract becomes effective such that recovery is disallowed if the insured materially breaches the condition precedent at issue. Two commonly recognized conditions precedent in insurance policies are requirements that an insured (1) submit to an examination under oath and (2) submit a sworn proof of loss. Perhaps because of the severity of the effect of a condition precedent, it is a general rule that conditions precedent are not favored and courts will not construe provisions to be such, unless required to do so by plain, unambiguous language or by necessary implication.

Most insurance policies have “cooperation clauses” providing that the insured shall cooperate with the insurer, attend hearings and trials upon the insurer’s request, and shall assist in effecting settlements, in securing and giving evidence. Cooperation clauses are less onerous on insured parties because courts will reject defenses based on alleged material breaches of cooperation clauses if the insurer cannot demonstrate “substantial prejudice” from the breach. While an insurer need not show prejudice when the insured breaches a condition precedent to suit, the burden is on the

47 Caribbean I Owners’ Ass’n, Inc. v. Great Am. Ins. Co. of New York, 600 F. Supp. 2d 1228, 1241 (S.D. Ala. 2009) (the application form in question was the ACORD form).
The court determined that the inspection clause was a cooperation clause rather than a condition precedent. The insurer failed to present support for the proposition that inspection provisions are a condition precedent to coverage. Moreover, the general rule that policy provisions limiting coverage are to be construed in favor of the insured. The court did not believe that, as a matter of law, Lexington had established a material breach of the inspection clause as it was not clear that the insured had any control over the unavailable units. Nor was the court convinced that the insurer was able to establish substantial prejudice in light of its assertion that it had not found any additional damage to unit interiors during the re-inspection of units that were available.

C. Insured’s Duty To Provide Timely Notice

Obviously to the extent an insured seeks to recover under and insurance policy, it must contact the insurer. Insurers often seek to provide structure to these communications by inserting language in policies instructing insureds to communicate claims or other requested information within a certain time frame. This language may vary, although the phrase “as soon as practicable” is a common expression.52

Much of the law on this subject involves the question of prejudice. The jurisdictions handle the issue in three distinct ways:

As we recently observed . . ., American jurisdictions fall into three groups on the need to establish prejudice from late notice. Some hold that prejudice is irrelevant to enforcement of a late-notice defense. Others require an insurer asserting this defense to demonstrate actual prejudice, and a third group creates a rebuttable presumption of prejudice in favor of the insurer.53

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52 See Weitz Co., LLC v. Lloyd’s of London, 574 F.3d 885, 889 (8th Cir. 2009) (policy’s notice-of-loss provision required insured to give insurers notice of loss “as soon as practicable” after the loss or damage became known). Other variations include “as soon as possible.” See Dreaded, Inc. v. St. Paul Guardian Ins. Co., 904 N.E.2d 1267, 1271 (Ind. 2009). Some policies provide more structure, setting forth specific time periods for particular events. See World Health & Educ. Found. v. Carolina Cas. Ins. Co., 612 F. Supp. 2d 1089, 1094 (N.D. Cal. 2009) (insured shall give written notice of any claim; (1) in the event of a lawsuit, as soon as practicable, but in no event later than 15 days after such claim is first made; or (2) in the event of all other claims, as soon as practicable, but in no event later than 90 days after such claim is first made).

53 Tri-Etch, Inc. v. Cincinnati Ins. Co., 909 N.E.2d 997, 1004-05 (Ind. 2009) (concluding that Indiana falls into the third group). See also, Charles C. Marvel, Annotation, Modern Status of Rules Requiring Liability Insurer to Show Prejudice to Escape Liability Because of Insured’s Failure or Delay in Giving Notice of Accident or Claim, or in Forwarding Suit Papers, 32 A.L.R. 4th 141 (1984, Supp. 2008) (noting that a substantial number of jurisdictions fall into either the no-prejudice camp or the prejudice camp; whereas few adopt the presumption of prejudice approach); Erick Mills Holmes, 22 Holmes’ Appleman on Insurance 2d § 139.4, 316 (2003) (only in a decreasing minority of jurisdictions is the insurer not required to show that it was prejudiced by the insured’s lack of compliance with a policy notice requirement).
Where late notice is a defense to coverage, notwithstanding the lack of any prejudice to the insurer, timely notice becomes a condition precedent to coverage.\textsuperscript{54} The trend is away from holding timely notice a condition precedent to coverage.\textsuperscript{55}

In *Weitz Co., LLC v. Lloyd’s of London*,\textsuperscript{56} a builder’s risk policy’s notice provision required notice of claims “as soon as practicable after it became known to the insured’s risk management department.”\textsuperscript{57} Severe rains caused water damage to a Florida luxury retirement project. The rains occurred in June 2002, but the insurer was not notified of any claim until December 2002. While representatives of the insured were aware of the loss shortly after it occurred, the insured’s risk management department did not become aware of the loss until the same day notice was given to the insurer by the contractor that had repaired the damage and was seeking recovery under the policy. As a consequence, the court ruled there had been compliance with the policy’s notice-of-loss provision.

The proper interpretation of a notice provision within a claims-made policy was the subject of *World Health & Educ. Found. v. Carolina Cas. Ins. Co.*,\textsuperscript{58} where the policy required that, in the event of a lawsuit, the insured was required to give written notice to the insurer “as soon as practicable, but in no event later than 15 days after such claim is first made.”\textsuperscript{59} The insured missed the 15-day reporting requirement. The insured claimed that the policy was ambiguous as the “extended reporting period” entitled it to an additional sixty days to provide notice. The court rejected this contention, as the sixty-day extended reporting period only applied to claims that were made after the policy expired, which was not the case with the claim in question.

The most significant aspect of the case, however, pertains to the prejudice requirement. The insured argued that coverage was afforded under the policy as, in any event, the insurer could not establish it was prejudiced by the untimely notice. The court also rejected this argument, holding that California courts have held that the notice/prejudice rule does not apply to claims-made policies:

Plaintiff also invokes the notice-prejudice rule which provides that an insurer cannot assert lack of timely notice as a defense unless the insurer was actually prejudiced by such delay. However, California courts have repeatedly held that the notice-prejudice rule does not apply to claims-made policies, because to apply it as such would essentially convert these policies into occurrence-based policies.\textsuperscript{60}

The California courts, however, have confused two distinct concepts. While a claims-made policy is triggered by the making of a claim rather than when the injury occurs (the latter being the trigger for an occurrence-based policy). The trigger applies not when the claim is made or given to the insurer, but when the insured becomes aware of the claim. The insured’s obligation to provide timely notice of the claim is quite apart from when the policy is triggered by the making of the claim to the insured. While an insurer has a legitimate interest in learning about claims under a claims-made policy in a timely manner

\begin{footnotesize}
\textsuperscript{55} Erick Mills Holmes, 22 Holmes’ Applemoon on Insurance 2d § 139.4[C], 321 (overwhelming majority of states follow a prejudice rule in which the insurer must demonstrate actual prejudice from a failure of proper notice).
\textsuperscript{56} Weitz Co., LLC v. Lloyd’s of London, 574 F.3d 885 (8th Cir. 2009).
\textsuperscript{57} Weitz Co., LLC v. Lloyd’s of London, 574 F.3d 885, 890 (8th Cir. 2009).
\end{footnotesize}
(and this is the reason why these policies have notice provisions), the failure to provide timely notice does not turn the policy into occurrence-based coverage. Rather, late notice under a claims-made policy simply means the insurer may be faced with responding to a claim after more than a reasonable amount of time has passed for it to conduct an investigation or otherwise react to the claim. But this is no different for an issuer of an occurrence-based policy. Untimely notice does not turn the policy into occurrence coverage, as late notice is unrelated to a coverage trigger based upon when the injury arose, as opposed to when the claim was made.61

New York requires insurers to promptly disclaim coverage once they are put on notice of a claim.62 A failure to give prompt notice precludes an effective disclaimer or denial. However, an insurance carrier’s duty to timely disclaim is not triggered until an insured satisfies a notice-of-claim provision in an insurance contract. In J.T. Magen v. Hartford Fire Ins. Co.,63 the prompt disclaimer requirement was triggered when an insurance carrier received notice of claim, not from the insured but from another insurance carrier on behalf of a mutual insured, asking that the insured be provided a defense and indemnity.

D. Insured’s Duty To Timely Submit Proof Of Loss

Property policies generally require the insured to submit a proof of loss within a specified period of time. In Cox v. Tennessee Farmers Mut. Ins. Co.,64 the insureds’ property policy required them to provide the insurer a signed and sworn proof of loss within sixty days after the loss. The insureds failed to do this and, as a consequence, lost their ability to recover under the policy:

61 The Texas Court of Appeals, in Solvent Underwriters Subscribing to Energy Ins. Int’l, Inc. v. Furmanite Am., Inc., 282 S.W.3d 661 (Tex. Ct. App. 14th Dist. 2009), had occasion to discuss the differences between occurrence-based and claims-made policies:

Typically, an occurrence-based policy covers all claims based on an event occurring during the policy period, regardless of whether the claim or occurrence is brought to the attention to the insured or made known to the insured during the policy period. In contrast, a claims-made policy covers only claims made during the policy period for injuries or occurrences within a coverage period. While Furmanite is correct that many provisions in the Policy are occurrence-based, generally linking coverage to an occurrence or accident, these occurrence-based provisions would not provide coverage in the instant case. Coverage does not exist in this case except to the extent that the Operations or Pollution Buy Back Endorsements restore coverage. Reviewing first the Operations Buy Back endorsement, it is clearly a claims-made provision. Specifically, this particular endorsement states that there is coverage “of any claim . . . first made in writing against the assured during the policy period . . . .” Furmanite’s contention that the claim need not be made during the policy period contradicts the plain language of this Buy Back endorsement and therefore lacks merit.

62 N.Y. Ins. Law § 3420(d) (an insurer wishing to disclaim liability or deny coverage for death or bodily injury must give written notice as soon as is reasonably possible of such disclaimer of liability or denial of coverage).


The subject policy of insurance requires the insured to provide Tennessee Farmers a proof of loss within sixty days of the loss in the cooperation section of the policy. It is undisputed that plaintiffs did not provide a complete proof of loss for contents under Coverage C [personal property] until nine months after the fire and that coverage for loss of contents was denied due to plaintiffs’ tardiness. The only excuse for delay offered by plaintiffs is that Tennessee Farmers did not send a certified copy of the policy to plaintiffs until more than six months after the fire. The plaintiffs do not explain why a certified copy of the policy was necessary before they could proceed with preparing a proof of loss or why the copy of the policy Ms. Knight sent to plaintiffs in July 2000 did not suffice.\(^6\)

### E. Insured’s Duty Not To Voluntarily Make Payments Without Insurer’s Consent

A common feature of liability policies is a provision which prohibits the insured from voluntarily making a payment, incurring an expense, or assuming an obligation without first obtaining the insurer’s consent. In Danrik Constr., Inc. v. Am. Cas. Co. of Reading, Penn.,\(^6\) the insured installed underground conduits and communication cables. Without explaining the nature of the problem, the court notes that on four projects the insured’s negligent work caused several contractors and the owner to suffer damages. The insured reported these claims to its insurers and asked them to pay for the losses. The insurers began their adjustment process by retaining an engineer to provide them with advice on whether the claimed damages were reasonable and necessary. As a result of this investigation, the insurers made settlement offers to the injured contractors and owner. These offers were slightly lower than the original claims and were rejected. The insured, in order to continue to do business with the contractors and the owner, paid them the full amounts of their claims. The insured then sought to recover from its insurers. The court ruled that the insured violated the “voluntary payment” provision of its insurance policies and denied it recovery:

In sum Danrik [insured], without Insurers’ consent, paid BellSouth, Grady Crawford Construction, and SCI to settle the claims. The cases discussed above suggest that whether a court will excuse a breach of a consent-to-settle clause depends on the circumstances of the situation. Here, Insurers initially offered a settlement amount, and after the claimants refused it Danrik unilaterally settled the claims. There was no “time is of the essence” situation similar to that in Babst [488 So.2d 699] that might excuse Danrik’s action. Danrik’s suggestion that any attempt to obtain consent would have been useless or futile is unavailing, especially given that Insurers stipulate that they would have paid the amount their expert stated was reasonable and necessary and would not have objected to Danrik paying the difference. Thus, Danrik’s action discharged

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\(^6\) Cox v. Tennessee Farmers Mut. Ins. Co., 297 S.W.3d 237, 246 (Tenn. 2009). The court cites two Tennessee cases in support of its ruling. Central Nat’l Ins. Co. of Omaha v. Mfr’s Acceptance Co., 544 S.W.2d 362 (Tenn. 1976), suggests that the failure to timely provide a proof of loss is a material breach of the conditions of the policy. This case discusses the obligation to provide a proof of loss in terms of a condition for the insurer’s liability under the policy. As such, the concept of prejudice is irrelevant. The other case relied on by the court is Scot v. Exch. Mut. Ins. Co, 1986 WL 6276 (Tenn. Ct. App. June 4, 1986), aff’d 1987 WL 15298 (Tenn. Aug. 10, 1987), where the failure to timely file a proof of loss was deemed prejudicial to the insurer and resulted in the forfeiture of the plaintiff’s rights to recover under the policy. This case explains how the insurer was prejudiced by the late filing of the proof of loss as its adjuster was unable to make an appraisal of the loss.

Insurers’ responsibility under the insurance policy. . . . Under these facts, Danrik’s unilateral decision to settle the underlying claims precludes its ability to recovery from Insurers. 

IV. COMMERCIAL GENERAL LIABILITY (CGL) COVERAGE

A. Duty to Defend

The commercial general liability policy places upon the insurer two primary duties: (1) a duty to defend and (2) a duty to indemnify. The duty to defend is often characterized as a broader duty, as it is triggered when an allegation within a complaint against the insured arguably falls within coverage. The insurer must indemnify only when the loss results from a claim within coverage. In a typical loss scenario, a defense can be as important if not more critical to an insured as indemnity. It is not unusual for the costs of defense to exceed any indemnity payment made under the policy.

1. When is duty to defend determination ripe for consideration?

Many duty-to-defend disputes are handled by way of a complaint for declaratory relief. Insurers are often the plaintiff in these actions. They seek a ruling from the court that the allegations in the underlying complaint do not trigger a duty to defend under the policy. If there is no duty to defend, which is broader than the duty to indemnify, a ruling on the defense obligation will inevitably determine the indemnity obligation.

Declaratory judgments, by their very nature, can give rise to jurisdictional questions based upon whether the dispute is “ripe” for determination. Moreover, even if a dispute is “ripe” for adjudication the applicable declaratory judgment act may provide guidance as to when a court might decline to exercise jurisdiction. These issues were discussed in the context of federal court jurisdiction in Evanston Ins. Co. v. Layne Thomas Builders, Inc., where an insurer brought an action to determine whether it owed a duty to defend or indemnify a builder in connection with an underlying state court action involving severe injuries incurred by a worker on one of the insured’s construction projects. The insurer agreed to defend its insured under a reservation of rights. During the course of defending the action, the insurer brought a declaratory judgment action, seeking a determination that it owed neither a duty to defend nor indemnify in connection with the underlying state court action. The insured claimed that the insurer’s suit was not ripe for determination or that, in the alternative, the court should decline to exercise jurisdiction as part of its discretionary powers under the Federal Declaratory Judgment Act. The Declaratory Judgment Act provides in pertinent part:

In a case of actual controversy within its jurisdiction . . . any court of the United States, upon the filing of an appropriate pleading may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought.

As is customary in such cases, the court determined that the duty to defend determination was “ripe” for consideration and, furthermore, it would exercise jurisdiction over the matter:


The issue of ripeness is of particular concern in declaratory judgment actions between an insurer and an insured where, as here, an underlying tort action is simultaneously pending. Only when a court determines that an action is ripe for judicial review, will the action survive a motion to dismiss, as the issue of ripeness goes directly to the Court’s jurisdiction. In determining whether an action is ripe for adjudication, courts within the Third Circuit consider three factors: (1) the adversity of the parties’ interests; (2) the probable conclusiveness of a judgment; and (3) the practical utility of judgment to the parties.

In general, in the context of a declaratory judgment action, an insurer’s duty to defend an insured in an underlying action is ripe. Layne Thomas Builders [insured] makes no contrary argument here, and . . ., the Court concludes that Evanston Insurance’s request for declaratory judgment on its duty to defend is ripe for adjudication.

The Declaratory Judgment Act has been described as “an enabling Act,” which confers a discretion on the courts rather than an absolute right upon the litigant.” As such, a district court is authorized, in the sound exercise of its discretion, to stay or dismiss an action seeking a declaratory judgment. In determining whether to exercise their discretion, the courts of the Third Circuit consider several factors: (1) whether the state court is better able to settle the controversy; (2) whether the state court can adjudicate all the claims of the parties; (3) whether necessary parties have been joined and whether such parties are amenable to process in the state proceeding; (4) the likelihood that a federal court declaration will resolve the uncertainty of the obligation; (5) the convenience of the parties; (6) the public interest in settlement of the uncertainty of the obligation; and (7) the availability and relative convenience of other remedies.

Because the Court has before it all the documents necessary for adjudication of the duty to defend, the Court is unpersuaded that the potential for coordinated discovery through the consolidation of the underlying state action with this action, re-filed in Pennsylvania, is sufficient to warrant dismissal of this action. Accordingly, the Court cannot conclude that the Pennsylvania state court is the preferred forum for adjudication of this matter. . . . In sum, the Court is persuaded the most economical use of the resources of both parties and the courts involved in this litigation is to settle Evanston Insurance duty to defend in the first instance.70

2. Is the duty to defend triggered only upon the filing of an action against the insured?

Most insureds involved in the construction industry become aware of problems long before a lawsuit or arbitration (“suit”) is filed. Claims may be asserted long before any formal action is taken on

70 Evanston Ins. Co. v. Layne Thomas Builders, Inc., 635 F. Supp. 2d 348, 352-55 (D. Del. 2009) (citations and certain inner quotations omitted). The court also determined that the insurer’s request for a declaration on its duty to indemnify the insured was not ripe for determination. It therefore granted the insured’s motion to dismiss as to this matter. Nevertheless, because the duty to indemnify is more narrow than the duty to defend, the insured’s victory on this score is likely pyrrhic in the event the insurer prevails on its motion with respect to the duty to defend. Nevertheless, this ruling is not irrelevant, as the law is much more favorable to insureds with respect to the insurer’s obligations to defend. And, if there is a fight to be had, from the insured’s perspective, it is better to just to fight over the duty to defend rather than both defense and indemnity.
them. Not surprisingly, insureds often feel the need to retain counsel to represent their interests long before any suit is commenced. Does an insurer have an obligation to pay for counsel before the initiation of a suit?

The answer depends heavily upon the language of the insurance policy in question. Where the policy language defines the duty to defend in the context of a “suit” and defines the term to mean some form of civil proceeding, such as a court action, arbitration, or some other form of alternative dispute resolution proceeding, the insurer had no duty to defend in the absence of such a “suit.” Without a “suit,” there was nothing for the insured to tender:

The plaintiff seeks partial summary judgment for declaratory relief on its claim that defendant Golden Eagle owes a primary duty to defend Coury in relation to claims arising out of the water discharge incident. Yet, plaintiff has not established a vital element of its claim for declaratory relief regarding defendant’s duty to defend, i.e., plaintiff has not shown that any “suit” has been filed against Coury. Absent such “suit,” defendant has no duty to defend Coury under the terms of the Golden Eagle Policy, and plaintiff’s request for partial summary judgment on this claim must be denied. 71

3. **Defense of affirmative defenses.**

Does a litigant’s assertion of an affirmative defense, such as offset, in response to an insured’s complaint trigger an insurer’s duty to defend? Depending upon the relative size of the offset to the insured’s claim, the economic effects of an affirmative defense might well be equivalent to the assertion of a counterclaim. Divergence occurs, of course, where the defendant’s claim proves greater than that asserted by the plaintiff. Where the defendant’s claim takes the form of an affirmative defense, there is no positive recovery from the plaintiff flowing to the defendant. There would be a net recovery in favor of the defendant if it had asserted a counterclaim.

Even if pled as an affirmative defense, a claim of offset can mean real money out of an insured’s pocket. If the underlying claim giving rise to the defense of offset arguably falls within coverage of the insured’s general liability policy, does the insurer have an obligation to defend against the affirmative defense? A New York court ruled that no defense was required, as the policy’s requirement of a “suit” was not met:

The only remaining question is whether an affirmative defense based on offset in the collection action triggered the insurer’s duty to defend a “suit.” The motion court properly held that it did not.

Contrary to plaintiff’s arguments, an affirmative defense is substantively different from a counterclaim. A counterclaim is a cause of action asserted by a defendant against a plaintiff. By its very nature, a counterclaim seeks affirmative relief.

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Affirmative defenses, on the other hand, cannot seek such relief. Cauldwell could not obtain affirmative relief by asserting an offset defense. . . . Significantly, if plaintiff believed that Cauldwell’s defense was truly a counterclaim, the prudent action was to immediately move to strike the defense and force Cauldwell to replead the claim as a counterclaim. This would have triggered the insurer’s duty to defend. Had these steps been taken in the instant action, defendant would have been forced to defend plaintiff at the beginning of the case, rather than when the counterclaim was voluntarily asserted by Cauldwell several months later.72

4. Scope of the insurer’s duty to defend.

As the common expression goes: “The duty to defend is broader than the duty to indemnify.” An insurer has an obligation to defend its insured against all claims arguably within coverage. The insurer, however, only has to indemnify against those claims actually within coverage. The following is a common expression of an insurer’s duty to defend:

In determining whether a duty to defend exists a trial court must limit its examination to the four corners of the underlying complaint. An insurer’s duty to defend arises when the underlying complaint against the insured alleges any facts that might fall within the coverage of the policy. An insurance company has a duty to defend if the allegations in the complaint could impose liability under the policy. Alternatively, an insurance company has a duty to defend if the allegations in the complaint state a claim which is potentially or arguably within the policy coverage or if there is some doubt as to whether a theory of recovery within the policy coverage has been pleaded.73

5. Resort to extrinsic evidence in evaluating defense obligation.

It is common for courts to describe the analytical process in determining an insurer’s duty to defend as a comparison of two documents – the complaint against the policy. This is sometimes referred to as the “four corners” or “eight corners” test. Nor is it unusual for the court to claim that its examination is limited to these two documents.74

The courts split as to whether extrinsic evidence can be used to confirm or deny a duty to defend. The highest court of Montana has ruled that extrinsic evidence could support a duty to defend where the complaint, on its face, was insufficient. In Revelation Indus., Inc. v. St. Paul Fire & Marine Ins. Co.,75 a manufacturer of biodegradable bags for a field toilet sought a defense against a customer’s complaint that the product was defective. The insured farmed out the manufacture of the bag to another company. It was alleged the subcontractor left out cornstarch as a component in the polymer bag system. This


74 See Cyprus Amax Minerals Co. v. Lexington Ins. Co., 74 P.3d 294 (Colo. 2003) (in determining whether a duty to defend exists, the trial court must limit its examination to the four corners of the underlying complaint).

information was communicated to the insured’s carrier. The customer’s complaint, however, failed to make any mention of this subcontract arrangement and, as a consequence, the insurer denied a defense based upon a policy exclusion. The insured contested the denial on grounds that the “subcontractor exception” to the exclusion should apply and that the insurer had knowledge of extrinsic facts which triggered this exception. In the face of the insurer’s argument that its duty to defend is determined merely on the pleading alone, the court applied a “what’s good for the goose is good for the gander” rationale to rule for the insured:

Based on . . . our case’s holding that an insurer may deny coverage based on knowledge of facts obtained from outside the complaint, we conclude that the converse also holds: An insurer cannot ignore knowledge of facts that may give rise to coverage under the policy simply because the complaint – which is, after all, drafted by claimant over whose drafting the insured has no control – does not allege these facts of which the insurer has knowledge. Under such circumstances, the insurer must defend. It may commence a defense under a reservation of rights while conducting an investigation, and it may commence a declaratory action . . . . It may not, however, ignore information in its possession that may give rise to coverage simply because the complaint fails to recite it, and thereupon refuse to defend.\(^\text{76}\)

The Texas Supreme Court, however, reached the opposite conclusion based upon very similar facts in Pine Oak Builders, Inc. v. Great Am. Lloyd’s Co.,\(^\text{77}\) where a homebuilder sought a defense against suits brought by homeowners alleging various construction defects. The homebuilder utilized subcontractors to perform much of the work. The complaint, however, made no mention of subcontractors and, in ruling in favor of the insurer, the court reasoned:

In this coverage suit, Pine Oak submitted evidence that the defective work alleged in the glass case was performed by subcontractors. Based on this extrinsic evidence, Pine Oak contends Great American had a duty to defend Pine Oak in the glass case. Under the eight-corners rule, the duty to defend is determined by the claims alleged in the petition and the coverage provided in the policy. If a petition does not allege facts within the scope of the coverage, an insurer is not legally required to defend a suit against its insured . . . . The extrinsic fact Pine Oaks seeks to introduce in this coverage action contradicts the facts alleged in the glass suit. The petition in the glass suit alleges that Pine Oak agreed to construction the plaintiffs’ house, that Pine Oak alone constructed columns that provided inadequate support, failed to properly seal seams, negligently attempted to correct a problem with the balcony, failed to perform the work in a good and workmanlike manner, and failed to make the repairs described above. These claims of faulty workmanship by Pine Oak are excluded from coverage under the “your work” exclusion. Faulty workmanship by a subcontractor that might fall under the subcontractor exception to the “your work” exclusion is not mentioned in the petition. If the petition only alleges facts excluded by the policy, the insurer is not required to defend. . . . we will not read facts into the pleadings . . . nor will we look outside the pleadings, or imagine factual scenarios that might trigger coverage. Instead, an insurer is


\(^{77}\) Pine Oak Builders, Inc. v. Great Am. Lloyd’s Co., 279 S.W.3d 650 (Tex. 2009).
entitled to rely solely on the factual allegations contained in the petition in conjunction with the terms of the policy to determine whether it has a duty to defend.  

6. Reservation of rights letters

A customary communication early on in the claims process is the insurer’s reservation of rights letter. This letter is intended to set forth pertinent policy provisions that might well limit or eliminate the insurer’s duty to defend and/or indemnify its insured. Case law has developed as to whether, and to what extent, an insurer waives a coverage defense either because it failed to mention it in its reservation of rights letter or failed to timely send the letter. A number of jurisdictions regulate these communications. For example, New York requires the insurer to timely disclaim coverage. 

Florida has enacted a claims administration statute requiring insurers to send a reservation of rights letter within thirty days of when it knew or should have known of a coverage defense. In Sharp Gen. Contractors, Inc. v. Mt. Hawley Ins. Co., an insurer failed to provide a reservation of rights letter within the statutory time permitted. Instead, the insurer sent its first reservation of rights letter by fax fifty-one days after it was notified of the loss. The loss consisted of a fire which occurred at the project when an electrical panel, being worked on by an electrical subcontractor, arced and set fire to a pallet. The owner claimed its pharmaceuticals were damaged by the smoke and submitted a claim to its property insurer. The property insurer paid the claim and demanded reimbursement from the general contractor, who, in turn, sought coverage from its liability insurer. Its policy contained an endorsement referenced as a “Contractor’s Endorsement” which required the insured to obtain hold harmless agreements from subcontractors indemnifying it against all loss incurred by the insured as the result of the indemnitor’s activities. The policy further required that the insured secure additional insured status under all of the subcontractors’ general liability policies.

The insureds claimed that, by untimely reserving rights, the insurer waived its right to assert defenses based upon the failure to comply with the “Contractor’s Endorsement.” The insurer countered that the state’s claim statute was inapplicable, as it was not asserting a coverage defense, but rather a lack of coverage. In other words, the failure to comply with the “Contractor’s Endorsement” was a precondition to coverage and the failure to comply with this precondition meant that coverage never existed. The court agreed with the insurer, finding that the claim statute was inapplicable to the insurer’s defense, as it was not asserting a coverage defense but rather a lack of coverage.

7. Defense of additional insureds.

The construction industry, perhaps to an extent greater than any other industry, utilizes additional insured endorsements in its contracting. A common feature of most construction contracts require one party to procure additional insured coverage for the other party. Owners require this of their general contractors and general contractors, in turn, require the same from their subcontractors. Perhaps because of the lack of a commercial relationship between an insurer and its additional insureds, disputes over this

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79 See Bruner & O’Connor on Construction Law, § 11:57 (Thomson Reuters 2010).
80 N.Y. Ins. Law § 3420(d) (requiring insurer to provide written disclaimer “as soon as is reasonably possible”).
81 Fla. Stat. 627.426(2).
coverage arise with some regularity. These actions can take a number of different forms, including direct actions between the insurer and the additional insured, as well as contribution, subrogation, and/or indemnification actions among and between carriers. An example of the latter is *Royal Indem. Co. v. Am. Family Mut. Ins. Co.*, where a general contractor’s insurer unsuccessfully sought a defense from various subcontractor insurers for certain defective construction claims that arose after the subcontractors’ work was complete. The court determined that no duty to defend arose, as the general contractor’s purported status as an additional insured ended once the subcontractors’ operations were completed.

Another similar ruling is *Tri-Star Theme Builders, Inc./PCL Constr. Servs., Inc. v. Hawkeye-Sec. Ins. Co.*, in which an additional insured endorsement limited to “ongoing operations” was judged to be insufficient to trigger a duty to defend where the only allegation in the complaint that alleged damages before the work was completed failed to specifically reference the named insured’s work. The court reasoned:

> In order for Defendant’s duty to defend to properly attach, the complaint must contain allegations of damages that arose while GWM’s [named insured] work on the Resort was still in progress. Thus, the allegations must pertain to the time period before the Resort was open to the public.

The only allegation pertaining to the time frame before the resort was open to the public is contained in paragraph 30 of the underlying complaint. Paragraph 30 alleges that before the Resort was opened and thereafter, CRIT [owner] provided Tri-Star/PCL [additional insured] with punchlists of defects and other items requiring repair and correction by Tri-Star/PCL. It is not clear from the complaint what these defects pertain to, much less how they implicate the work of GWM. The punchlists of defects may or may not have been concerned with GWM’s work. However, the underlying complaint fails to adequately imply that the punchlists pertained to the work of GWM. Moreover, the underlying complaint does not allege what other damages, if any, resulted from the defects on the punchlists. As such, paragraph 30 of the underlying complaint fails to adequately invoke defendant’s duty to defend.

Another limited additional insured endorsement was at issue in *Pekin Ins. Co. v. Hallmark Homes, LLC*. In this case, the additional insured endorsement expressly stated that coverage was afforded only with respect to liability incurred solely as a result of some act or omission of the named insured and not for the additional insured’s own independent negligence or statutory violation. A construction worker was injured when he tripped over some debris. He sued the named insured’s

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85 *Tri-Star Theme Builders, Inc./PCL Constr. Servs., Inc. v. Hawkeye-Sec. Ins. Co.*, 653 F.Supp.2d 973, 983 (D. Ariz. 2009). The court also opined that, even if the named insured’s work was implicated by the complaint, more likely than not exclusions (j)(5) and (j)(6) would apply. It is not clear how the court arrived at this conclusion, given the cursory nature of the allegations involving the punchlist defects.
subcontractor and the additional insured’s general contractor under the theory of premises liability. He
also sued the general contractor under the retained control doctrine.87

The court ruled that the insurer had a duty to defend the general contractor. Noting that
allegations of the underlying complaint and the language of the insurance policy should be read liberally
when determining whether insurers owe a duty to defend, the court analyzed the complaint and found that
it could be read to impose vicarious liability on the general contractor. For example, the complaint
alleged that the contractor participated in coordinating the work being done and designated various work
methods as well as participated in the scheduling and inspection of the work. These allegations suggested
that the general contractor retained control over many of the operative details of the subcontractor’s work
and could subject it to vicarious liability.88

Another additional insured failed to secure a defense under an endorsement that expressly
excluded coverage for liability resulting from the sole negligence of the additional insured. In Nat’l Fire
Ins. of Hartford v. Walsh Constr. Co.,89 the additional insured was a general contractor on a renovation
project in downtown Chicago. The named insured was a roofing subcontractor. During the course of the
work, one of the employees of the roofer was injured. He sued the general contractor and owner alleging
that an employee of the general contractor moved a section of the roof’s support causing the roof deck on
which plaintiff was working to fall, causing him to sustain serious injury. He made similar allegations
against the owner.

The thrust of the court’s opinion, however, focused not on the relative culpability of the general
contractor and the owner, but rather whether the injured worker’s employer, the named insured, also bore
responsibility for the plaintiff’s injuries. The court rejected the general contractor’s argument that the
subcontractor must have breached its duty to provide a safe workplace because one of its employees was
injured. This is as it should be, but does not necessarily resolve the issue of whether a duty to defend
arises under the terms of the additional insured endorsement. The exception pertained to the “sole
negligence” of the additional insured. This is not equivalent to the named insured being free of fault. If
the general contractor shares liability with the owner for the plaintiff’s injuries, then the “sole negligence”
exception should not apply. Perhaps because the parties chose to frame the issue as one of the named
insured’s fault, the court held:

87 The retained control doctrine derives from the Restatement (Second) of Torts § 414, which provides: “One
who entrusts work to an independent contractor, but who retains the control of any part of the work, is subject to
liability for physical harm to others for whose safety the employer owes a duty to exercise reasonable care, which is
causally caused by his failure to exercise his control with reasonable care.” While the Restatement characterizes the doctrine
as one of direct or independent negligence, Illinois law allows it to be utilized in cases of vicarious negligence. See Cochran v. George Sollitt Constr. Co., 358 Ill. App. 3d 865, 295 Ill. Dec. 204, 832 N.E.2d 355 (2005) (doctrine
applicable where general contractor had actual or construction knowledge of the subcontractor’s hazardous
performance).

88 The court also rejected a line of cases holding common pleading language such as “the defendants, and each
of them” meant that the defendants were jointly liable and therefore the additional insured endorsement was not
triggered. The court reasoned that this was a bit of boilerplate commonly employed by plaintiffs and did not
necessarily mean that all liability was jointly shared. See also Aguirre v. Turner Constr. Co., 501 F.3d 825 (7th Cir.
2007) (section 414 of the Restatement permits claims beyond those of direct liability).

Ct. App. 1st Dist 2009).
Our review of the Brainerd complaint reveals no factual allegations on which the defendants might hang Adler’s [named insured] potential liability. . . . [T]he defendants here have pointed to no facts that support their claim that Adler potentially shares liability with the Walsh employee that, according to the construction negligence suit, moved a section of the roof’s support causing the roof deck to collapse and injure Brainerd. The facts alleged in Brainerd’s complaint do not give rise to a duty to defend on the part of National Fire.90

8. **Effect of another insurer’s defense on the duty to defend.**

A liability insurer owes its insured a complete defense, regardless of whether other insurers also have a defense obligation with respect to the same claims. In the additional insured context, this can give rise to a question of damages. If the additional insured is being provided a defense from its primary carrier, does the refusal of the additional insured carrier to provide a defense cause any harm? A Washington court concluded in the negative and, as a consequence, awarded no damages for bad faith, notwithstanding a determination that the additional insured carrier acted in bad faith in declining to accept an additional insured’s tender of defense:

The trial court found Ledcor [additional insured] ultimately received what the policy entitled it to, and therefore suffered no harm due to MOE’s failure to timely accept tender and defend. The evidence supports this finding. Ledcor was at all times, before and after its tender to MOE, represented by competent counsel who aggressively defended Ledcor’s interests and with whom Ledcor never expressed dissatisfaction. Ledcor’s claim that it wanted MOE to take over the defense is belied by the record, and there is no evidence the MOE’s involvement might have achieved a different end result. MOE stood ready to pay its share of defense costs, and MOE funded the eventual settlement with Zanetti. MOE’s bad faith failure to timely accept tender and promptly become engaged in Ledcor’s defense thus made no difference in the outcome as Ledcor ultimately suffered no harm resulting from MOE’s breach of its duties, the court did not err in awarding no damages for bad faith.91

9. **Consequences of breaching the duty to defend.**

The consequences of breaching one’s duty to defend vary greatly from jurisdiction to jurisdiction. One common consequence is that the insurer is responsible not only for the defense costs, but also to reimburse the insured its fees in bringing the insurer to account.92 However, a Massachusetts court has ruled that this exception to the “American rule” does not apply where, instead of the insured, it is another of the insured’s carriers that seeks recovery of defense costs. As the court explained:

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91 Ledcor Indus. (USA), Inc. v. Mut. of Enumclaw Ins. Co., 206 P.3d 1255, 1261 (Wash. Ct. App. Div. 1 2009). The court, however, affirmed the trial court’s ruling that the insurer was responsible for damages under a breach of contract theory. The trial court had determined, and the court of appeals agreed, that the insurer should be liable for 18.8% of the $541,877 that Ledcor incurred in overall defense costs, or $101,873, which was the ratio of Ledcor’s settlement with the siding subcontractor, the named insured, in relation to Ledcor’s overall settlement of $1,250,000.

Two insurers that have independently issued separate policies to the same insured have no contractual relationship with, and no special relationship to, each other, at least arising out of the fact that they share an insured. In bringing the declaratory judgment action, Zurich itself was thus not in a position to make a breach of contract claim, but was entitled to seek in effect contribution from Worcester in connection with the settlement of the underlying Lagoa action and the associated attorneys’ fees and expenses. But under our system, the costs associated with doing so – principally its attorneys’ fees – were Zurich’s responsibility, even though Zurich prevailed.

Zurich contends that the attorneys’ fees must be awarded here because Gamache establishes that Callahan, as the insured, is entitled to them. The undisputed fact, however, is that Callahan did not incur these fees; Zurich did. Gamache does not stand for the proposition that an insured should recover attorneys’ fees associated with establishing an insurer’s duty to defend even when the insured did not pay those fees. Zurich argues, however, that the policy underlying Gamache in effect requires the payment of the fees in this case because otherwise Worcester will be rewarded for its wrongful refusal to participate in Callahan’s defense, and Zurich – which acted responsibly in assuming fully that defense and in even going one step further to bring the declaratory judgment action – will be punished.

This argument fails. The policy underlying the Gamache exception to the American Rule is not to punish wrongdoers or to reward those who act responsibly. Rather, it is a policy designed to protect the insured’s right to receive the full benefit of its liability insurance contract. Through the successful declaratory judgment action, Callahan did receive that benefit at no cost to itself, thanks to Zurich. But Zurich also received a separate and very real benefit from the action: The requirement that Worcester reimburse Zurich for one-half the settlement amount and one-half the attorneys’ fees. Application of the American Rule to Zurich in this context deprives the insured, Callahan, of nothing, and comports with established practice. 93

The payment of some attorneys’ fees can be the least of an insurer’s problems if found to have breached its duty to defend. In Stryker Corp. v. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa., 94 an excess carrier, found to have wrongfully declined to defend its insured, was stripped of the right to insist that the insured bear the first $2 million of liability under the policy’s self-insured retention provision:

As XLIA breached its duty to defend, the Court must determine the issue preclusive effect of the Court’s analysis in the 2001 Stryker Case of Capitol Reproduction’s application to the self-insured retention. In a January 4, 2008, opinion in the 2001 Stryker Case the Court held that as a consequence of XLIA breaching the duty to defend with respect to the claims at issue in the 2001 Stryker Case, XLIA was not entitled to the benefit of the self-insured retention under Michigan law as Michigan law had been interpreted by the Sixth Circuit in Capitol Reproduction. As the Court has determined as a matter of summary judgment that XLIA breached the duty to defend with respect to the DUK claims underlying Pfizer v. Stryker, the Court is confronted with the same question about the self-insured retention as was presented in the 2001 Stryker Case. The question

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of the inapplicability of the self-insured retention was the subject of a summary judgment motion in the 2001 Stryker Case, so the question was actually litigated in that case. The status of the self-insured retention was a critical and necessary part of the 2001 Stryker Case as the motion for summary judgment determined that XLIA was obligated to indemnify Stryker for the $2 million that otherwise would have been excluded by the self-insured retention. In this lawsuit the self-insured retention is inapplicable because XLIA breached its duty to defend the DUK claims underlying Pfizer v. Stryker. As the self-insured retention is inapplicable, Stryker shows that it has exhausted the self-insured retention by showing that it has been subjected to liability without necessarily showing liability in excess of the self-insured retention. Stryker has shown as a matter of law that it is subject to liability in Pfizer v. Stryker. Thus, as a matter of summary judgment, Stryker satisfied the requirement that under the Asset Purchase Agreement it is obligated to pay an amount in excess of the self-insured retention.

10. Loan receipt agreements.

Treatment varies widely as to whether, and to what extent, insurers can seek recovery from their brethren for failing to participate in the defense of a mutually-shared insured. There are various theories upon which insurers seek to recover from their fellow insurers including equitable indemnity, contribution, and subrogation. The jurisdictions differ on whether they recognize all, some, or none of these liability theories. Minnesota, for example, requires an insurer providing a defense to enter into a “loan receipt agreement” with the insured before recovery can be sought from another co-primary carrier. A “loan receipt agreement” is essentially a device whereby the defending insurer makes a “loan” to the insured in the amount of its defense fees and expenses and agrees to look only to the insured’s right to recover from other insurers to “pay back” the loan. Minnesota courts arrive at the “loan receipt” requirement through a process of elimination:

[A]n insurer generally cannot pursue contribution for defense costs from another insurer with a parallel duty to defend because no privity of contract or joint liability exists between the insurers. Nor can reimbursement be based on principles of subrogation since each insurer has a “separate and distinct” obligation to defend that allows the insured to “call upon either or both carriers to fulfill their policy obligations.”

What if the insured refuses to enter into a loan receipt agreement? This can put the insurer at a significant disadvantage in a jurisdiction that requires these agreements in order for the insurer to seek reimbursement from other carriers also owing a duty to defend. It is not difficult to understand why an insured might wish to decline an insurer’s entreaties on this score. For example, a general contractor named as an additional insured normally prefers that its own carrier not participate in any defense or settlement if adequate protection is afforded through an additional insured policy endorsement. This issue

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95 Stryker Corp. v. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa., 2009 WL 56292 at *9 (W.D. Mich. Jan. 8, 2009). See also, Ledcor Indus., Inc. v. Mut. of Enumclaw Ins. Co., 206 P.3d 1255, 1261 (Wash. Ct. App. Div. 1 2009) (“When the insurer breaches the duty to defend in bad faith, the insurer should be held liable not only in contract for the cost of the defense, but also should be estopped from asserting the claim is outside the scope of the contract and, accordingly, that there is no coverage. The coverage by estoppel remedy creates a strong incentive for the insurer to act in good faith and protects the insured against the insurer’s bad faith conduct.”); Pine Oak Builders, Inc. v. Great Am. Lloyd’s Ins. Co., 279 S.W.3d 650 (Tex. 2009) (prompt payment of claims statute applies to insurer’s breach of its duty to defend under a liability policy).

was addressed in a non-construction case by the Minnesota Court of Appeals in *Cargill, Inc. v. ACE Am. Ins. Co.*  

Cargill brought a declaratory judgment action against fifty insurers seeking defense and indemnity from groundwater contamination claims. One of its insurers, Liberty Mutual, agreed to provide a defense, as long as Cargill entered into a loan receipt agreement. Cargill declined to do so out of concern that it could become responsible for additional deductible payments and retentions to the contributing insurers, and because contribution might be sought from Cargill’s “fronted policies” incorporated into its sophisticated insurance scheme. Cargill argued that, because Liberty Mutual had a separate and distinct duty to defend, it was under no obligation to enter into a loan receipt agreement with the insurer. The court disagreed:

> Although each insurer has a separate and distinct obligation to defend, in situations such as this, where multiple primary insurers have offered to tender a defense in exchange for a loan receipt agreement, we believe that principles of good faith and fair dealing impose an affirmative obligation on the insured to cooperate by entering into a neutral loan receipt agreement that equitably apportions liability between primary insurers. . . . Allowing Cargill to strategically select one insurer to bear the entire multi-million dollar burden defense when over 50 other insurers have insured Cargill against the same risks is incompatible with the underlying rationale of *Jostens* [prior Minnesota Supreme Court precedent]. As the *Jostens* court noted, “[W]ho should pay the insured’s defense costs should not depend on the whim or caprice of the insured, when, at the time the defense was needed, [numerous] insurers arguably had a duty to defend.”

Requiring Cargill to enter into a neutral loan receipt agreement also comports with the terms of the cooperation clause contained in the Liberty Mutual insurance policy. This clause requires Cargill to assist Liberty Mutual in “enforcing any right of contribution or indemnity against any person or organization who may be liable to [Cargill].” Therefore, Cargill has a contractual obligation to cooperate with Liberty Mutual as its insurer. By declining to execute a neutral loan receipt agreement customarily used in the insurance industry in order to impose upon one insurer the liability for the entire multi-million dollar defense costs, Cargill has acted in bad faith.  

B. “Occurrence” Element.

The insuring clause of the CGL policy’s coverage A sets forth three fundamental requirements: (1) an “occurrence” resulting in, (2) “property damage” or “bodily injury,” where such injury (3) occurs during the policy period. The policy defines “occurrence” as an “accident.” While the “occurrence” element is seldom a problem in “bodily injury” cases, the same cannot be said for “property damage” losses. State law is hopelessly divided over whether poor workmanship that results in some form of property damage constitutes an “occurrence.” While the trend appears to be moving slowly in the direction of holding that poor workmanship may well constitute an “occurrence,” the path is anything but smooth or uniform. Moreover, courts appear bedeviled by situations where the poor workmanship necessitates repair but does not injure work or property belonging to a third party. While there are exclusions that address a number of these situations, some courts still conclude that poor workmanship that simply results in property damage to the insured’s work requiring repair is not an “occurrence.” The Colorado Court of Appeals decision, in *Gen. Sec. Indem. Co. of Arizona v. Mountain States Mut. Cas.*

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98 *Cargill, Inc. v. ACE Am. Ins. Co.*, 766 N.W.2d 58, 65 (Minn. Ct. App. 2009) (imposing a constructive loan receipt obligation so as to protect the insurer’s interests).
Co.,99 is one such case. The facts, to the limited extent offered by the court, present a garden variety multi-housing defective work situation. A homeowners’ association sued the general contractor in contract, tort, and warranty, alleging a number of construction defects. In finding that no “occurrence” occurred, as required by the policy, the court reasoned:

Divisions of this court have previously defined “accident” in CGL policies as: “An unanticipated or unusual result flowing from a commonplace cause.” In addition, courts in Colorado and other jurisdictions have considered an accident to be a “fortuitous event.” . . . Whether defective workmanship can accomplish an occurrence for purposes for both tort and breach of warranty claims is an issue of first impression in Colorado. . . . We conclude the better rule is that a claim for damages arising from poor workmanship, standing alone, does not allege an accident that constitutes a covered occurrence, regardless of the underlying legal theory pled. . . . Next, we address whether general allegations of faulty workmanship constitute an occurrence under the policies at issue here. There is a split among other jurisdictions whether a defective workmanship claim, standing alone, is an “occurrence” under CGL policies. A majority of those jurisdictions has held that claims of poor workmanship, standing alone, are not occurrences that trigger coverage under CGL policies similar to those at issue here. . . . In contrast, a minority of jurisdictions has held that the damage resulting from faulty workmanship is an accident, and thus, a covered occurrence so long as the insured did not intend the resulting damage. We are persuaded by the majority rule because it . . . relies on the necessary element of fortuity inherent in the ordinary meaning of the term “accident.” Additionally, the Tenth Circuit and Colorado courts have found an “occurrence” only when additional, consequential property damages were alleged as a result of the faulty workmanship.100

100 Gen. Sec. Indem. Co. of Arizona v. Mountain States Mut. Cas. Co., 205 P.3d 529, 534-35 (Colo. Ct. App. Div. I 2009) (citations omitted). It is open to debate just where the majority of jurisdictions fall on this question. If anything, the trend appears to be moving away from the Colorado Court of Appeals reasoning. See BRUNER & O’CONNOR ON CONSTRUCTION LAW, Vol. 4 at § 11:76 (Thomson Reuters 2010). Moreover, the court provides so little information about the nature of the defective construction, or the injuries resulting from it, that it is very difficult to conclude what is meant by poor workmanship “standing alone” does not satisfy the “occurrence” element. Nor does the court explain why the fortuity requirement is any less satisfied by an insured unintended poor workmanship that results in only damage to itself as opposed to damage to other property. Why does poor workmanship performed by a roofer that results in water infiltration causing damage to the roof not an “occurrence”; whereas the same poor workmanship, if it results in a collapse or damage to interior contents, now suddenly is an “occurrence.” This reasoning has a conclusory feel about it. In addition, there are policy exclusions that address these situations and one has to wonder why insurers went to the trouble of inserting such exclusions when “poor workmanship” doesn’t even meet the “occurrence” element. See Auto-Owners Ins. Co. v. Newman, 684 S.E.2d 541 (S.C. 2009) (poor workmanship may constitute an “occurrence” and to hold otherwise renders “your work” exclusion meaningless). See also, Liparoto Constr., Inc. v. Gen. Shale Brick, Inc., 772 N.W.2d 801 (Mich. Ct. App. 2009) (discoloration of brick was not an “occurrence,” for purposes of company’s CGL policy); Greystone Constr., Inc. v. Nat’l Fire & Marine Ins. Co., 649 F.Supp.2d 1213 (D. Colo. 2009) (faulty workmanship to homes that was not caused by an occurrence since faulty workmanship caused damage only to the constructed homes themselves, without consequential damage to home owner’s personal property or property of third parties); Auto-Owners Mut. Ins. Co. v. Kendrick, 678 S.E.2d 196 (Ga. Ct. App. 2009) (contractor’s defective workmanship does not constitute an occurrence and the insurer is not a guarantor of contractor’s performance); Cincinnati Ins. Cos. v. Collier Land
The Supreme Court of Carolina, in revising a decision it issued in 2008, provides some traditional reasoning as to why poor workmanship, unless intended by the insured, meets the “occurrence” element. In *Auto Owners Ins. Co. v. Newman*, a homebuilder was sued for breach of contract, negligence, and breach of warranty as a result of allegedly defective installation of stucco siding. The homeowner and home builder arbitrated the dispute and the homeowner received an award of $55,898. The coverage action ensued and the trial court ruled in favor of the homebuilder. The South Carolina Supreme Court affirmed the ruling in March 2008. The insurer sought rehearing on the grounds that the court’s opinion in *L.J. v. Bituminous Fire & Marine Ins. Co.*, dictated a contrary result. After the rehearing, the court reaffirmed its core holding that poor workmanship may constitute an “occurrence”:

> Although the subcontractor’s negligent application of the stucco does not on its own constitute an “occurrence,” we find that the continuous moisture intrusion resulting from the subcontractor’s negligence is an “occurrence” as defined by the CGL policy. In our view, the continuous moisture intrusion into the home was “an unexpected happening or event” not intended by Trinity [insured homebuilder] – in other words, an “accident” – involving “continuous or repeated exposure to substantially the same harmful conditions.” Accordingly, we hold that the subcontractor’s negligence resulted in an “occurrence” falling within the CGL policy’s initial grant of coverage for the resulting “property damage” to the home’s framing and exterior sheeting.

We note that interpreting “occurrence” as we do in this case gives effect to the subcontractor exception to the “your work” exclusion in the standard CGL policy. On this matter, a brief history of CGL policies is instructive. A CGL policy in the home construction industry is designed to cover the risks faced by homebuilders when a homeowner asserts a post-construction claim against the builder for damages to the home caused by alleged construction defects. Several construction-specific exclusions in the standard CGL policy exclude from coverage certain types of property damage attributable to risks outside the scope of CGL recovery. The primary exclusion is the “your work” exclusion which provides that the policy will not cover “property damage” to “your work”. In 1986, the insurance industry amended the “your work” exclusion to provide that even if the property damage is to the builder’s own work, the “your work” exclusion does not apply “if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor.” In doing so, the insurance industry extended liability coverage for property damage to the contractor’s completed work arising out of work performed by the subcontractor.

The facts of this case establish exactly the type of property damage the CGL policy was intended to cover after the 1986 amendment to the “your work” exclusion. In construing the provision of an insurance policy, the Court must consider the policy as a whole and adopt a construction that gives effect to the whole instrument and to each of its various


parts and provisions. To interpret “occurrence” as narrowly as Auto-Owners suggests would mean that any time a subcontractor’s negligence led to the damage of any part of the contractor’s overall project, a CGL insurer could deny recovery on the basis that it is excluded from the policy’s initial grant of coverage. This interpretation would render both the “your work” exclusion and the subcontractor’s exception to the “your work” exclusion in the policy meaningless.\(^\text{104}\)

Where the insured’s behavior takes on a strong intentional flavor, even though the particular damages flowing from the behavior were not intended, courts have been known to eliminate coverage based on the failure of an “occurrence.” *M.L.P. Invs., LLC v. Quanta Specialty Lines*,\(^\text{105}\) is one such case. The insured was involved in the construction of a residential community. The development encroached on the utility’s natural gas pipeline easement. The utility informed the insured that it did not approve of the construction because a road would encroach upon its easement. The insured, nevertheless, continued building the road while the utility sought a temporary restraining order. Road construction was rushed in order to finish before any order could issue. During the course of the construction, a subcontractor damaged the utility’s pipeline. While the subcontractor did not intend to damage the pipeline, the court found that the activities to rush the construction and to encroach on the utility’s easement were intentional, and therefore the “occurrence” element had not been met.

C. “Property Damage” Element

Another requirement of the insuring clause is that the occurrence give rise to either “property damage” or “bodily injury.” “Property damage” is defined as physical injury to tangible property, including the loss of use of such property. Property damage may also take the form of “loss of use” damage without the physical injury component. An example of “loss of use” property damage was examined in *Essex Ins. Co. v. BloomSouth Flooring Corp.*,\(^\text{106}\) where a general contractor was hired to provide certain tenant improvements in a commercial building located in Massachusetts. The contractor hired a subcontractor to install carpet. After the renovation was complete, the owner experienced a foul odor in the space. The original carpet adhesive was removed and the floor re-carpeted, but the odor persisted and spread throughout the building. The owner demanded that the carpet be removed. The general contractor eventually paid the owner’s remediation costs after the carpet installer refused to address the problem. The general contractor sought recovery as an additional insured under the carpet installer’s liability policy. The insurer refused to defend or indemnify the general contractor. Both the general contractor and the subcontractor sought recovery from the insurer. The insurer claimed that the


\(^{106}\) *Essex Ins. Co. v. BloomSouth Flooring Corp.*, 562 F.3d 399 (1st Cir. 2009).
“property damage” element was not satisfied, as the complaint only alleged an offending odor which was not an injury to tangible property. Because the odor did not permeate the physical components of the property, there was no physical injury to tangible property. The court disagreed. In addition to the loss of use of the tenant space, the contractor’s remediation efforts involved bead-blasting the concrete floor to eradicate the odor. This suggested that the odor had permeated the physical structure and amounted to physical injury to tangible property. In the court’s words:

First, Essex reads too much into Suffolk’s [general contractor] complaint when it states that Suffolk alleged – and BFDS [owner] claimed – that odors only permeated the building’s “air.” Suffolk in fact alleged that an unwanted odor “permeated the building.” Such an allegation may be reasonably construed as claiming damage to property.

Second, Essex does not provide any authority in support of its contention that odor cannot constitute physical injury to property. Third and finally, although Essex may be correct that the odor can only constitute physical injury to property if it is permeating or pervasive, nothing in the complaint (the controlling document in the duty to defend inquiry) indicates that the odor was not pervasive or permeating. On the contrary, the underlying complaint explicitly asserts that the odor “permeated the building” and that Suffolk expended funds to “remediate the alleged odor.” . . .

Against this legal and factual backdrop, we are persuaded both that odor can constitute physical injury to property under Massachusetts law, and also that allegations that an unwanted odor permeated the building and resulted in a loss of use of the building are reasonably susceptible to interpretation that physical injury to property has been claimed. Further, since nothing in Essex’s policies suggests that odor cannot physical injury to property, Suffolk’s claim is colorable under the policies.  

While the insuring clause does not make any mention of whose property must be damaged in order to meet the “property damage” requirement, courts on occasion read into this requirement an “other property” gloss. The Indiana Court of Appeals decision in Sheehan Constr. Co. v. Continental Cas. Co., is an example of this reasoning. Sheehan was a homebuilder sued by homeowners alleging that subcontractors negligently constructed their homes. The case was resolved for $2,800,000. Damage included water leaks around windows; water stains below windows and on ceilings; discolored carpet, warped floors; roofing materials blowing off during storms; mold below windows, on floor, in crawl spaces and on siding; and decay of window frames and sheathing. In determining that the “property damage” element had not been met, and as a consequence the general contractor was not entitled to

107 Essex Ins. Co. v. BloomSouth Flooring Corp., 562 F.3d 399, 405-06 (1st Cir. 2009) (emphasis in original) (citations omitted). See also, Farmer’s Ins. Co. of Oregon v. Trutanich, 858 P.2d 1332 (Or. Ct. App. 1992) (odors from methamphetamine cooking were held to constitute “direct physical loss” to cover property under a homeowner’s property policy because the odor had infiltrated the house); Largent v. State Farm Fire & Cas. Co., 843 P.2d 445 (Or. Ct. App. 1992) (same); Matzner v. Seaco Ins. Co., 1998 WL 566658 (Mass. Super. 1998) (carbon monoxide levels sufficient to render buildings uninhabitable was direct loss under property). But see, Lyerla v. Amco Ins. Co., 536 F.3d 684 (7th Cir. 2008) (insured’s argument that coverage was afforded for the storage fees and liquidated damages sought by the owner because of “property damage” was rejected as liquidated damages were merely a contractual remedy for untimely construction and the storage fees were not covered because the policy required such damages to be incurred at the time of the “occurrence” that caused them, as this claim sought “loss of use” damages for which there was no physical injury to tangible property).

coverage, the court relied heavily on the business risk doctrine. The court interpreted this doctrine as holding that CGL policies are not intended to cover the business risk of poor workmanship to the insured’s work. Rather it is injury to persons and damage to other property that constitutes the type of risks intended to be covered under the CGL policy. As Indiana courts have a tendency to do, the court conflated the business risk doctrine that finds its expression in a number of policy exclusions, with the “property damage” requirement of the insuring clause. As a consequence, the court determined that there was no “property damage” because the only injury was to the homes themselves.

An insured successfully recovered the attorneys’ fees incurred by its surety in an arbitration involving a property owner’s claim for asbestos contamination. The policy provided coverage for “Loss as a result of Claims for . . . Property Damage.” The insurer claimed that the surety’s fees were too attenuated to be recoverable under the policy. The court disagreed, finding that the language “as a result of” was similar to the phrase “resulting from,” which had been the subject of scrutiny. Under Missouri law, the phrase “resulting from” was more narrow than “arising out of,” but not synonymous with proximate or immediate causation. Rather, “resulting from” required the causative link between a harm and a covered occurrence or event to be “reasonably apparent” such that the harm could be considered a “natural and reasonable incident or consequence of” the covered event or occurrence. The court, not surprisingly, found this test a bit unwieldy, but concluded that all ties and ambiguities break against the insurer:

At the end of the day, it is not clear in the present case what result must flow from application of Missouri’s “reasonably apparent” or “natural and reasonable incident or consequence of” test. Missouri, however, applies a general rule of construction requiring courts to interpret ambiguities in an insurance policy in favor of coverage and against the insurer. Given the state of the law in Missouri, and given the general rule that we must resolve ambiguities in favor of coverage, we believe it is necessary to view the present harm as “reasonably apparent” . . . such that there is coverage.

The insurer also argued that the surety’s attorneys’ fees were really nothing more than an unrecoverable economic loss. Once again the court declined to adopt the insurer’s position. Noting that there was no language in the policy excluding economic loss or economic harm from the definition of “Loss,” the court determined that the surety’s fees were “reasonably apparent” and a “natural and reasonable incident or consequence” of the underlying property damage claim.

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110 Sheehan Constr. Co. v. Continental Cas. Co., 908 N.E.2d 305, 307-08 (Ind. Ct. App. 2009) (“There was no claim of ‘bodily injury or damage to any property, other than the structural components of the homes themselves.’… Accordingly, in granting summary judgment, the court explicitly held ‘the Continental and Indiana insurance policies do not provide coverage for the class/Sheehan’s claims as there was no ‘occurrence’ and no ‘property damage.’ The trial court was correct.”).


D. “Bodily Injury” Element

As a general rule, the “bodily injury” requirement raises little controversy. Worker injuries satisfy the requirement. On occasion, however, a peculiar set of circumstances can cause a court to analyze whether the “bodily injury” requirement had been met. The decision in Admiral Ins. Co. v. Hosler, is one such case. A homeowner claimed that faulty soundproofing caused him to hear noises from his unit and to move his bed out of his bedroom and put it in the living room. Moreover, he alleged “loss of sleep” as a result of the faulty work. As a general rule, pure emotional distress does not meet the “bodily injury” requirement. An insured must establish physical manifestations as a result of the emotional distress. In declining to find “lack of sleep” as a sufficient physical manifestation of emotional harm to trigger the “bodily injury” requirement, the court reasoned:

First, causation is lacking. Mr. Hosler’s allegation is not that his emotional distress manifested itself in his loss of sleep, but that the “crinkle” and “click” noises from his earplugs he wore, the noise level at the Arlington generally, and the music from a neighbor kept him from sleeping. But even assuming Mr. Hosler could establish that his lost sleep was really a manifestation of his emotional distress, his allegations still would not be sufficient. This court is persuaded by precedent stating that loss of sleep cannot trigger insurance coverage for “bodily injury.” Specifically, this Court is persuaded by the Tenth Circuit’s interpretation of Kansas law, finding that although sleeplessness may affect the body, it is usually considered an aspect of mental suffering. It is not ordinarily considered a physical injury to the body or a sickness of the body. This Court is further persuaded by the New Jersey Supreme Court’s reasoning that sleeplessness is, at base, emotional in nature. To designate sleeplessness a physical injury would be tantamount to conceding that emotional and physical injuries are indistinguishable. In light of the stated precedent the Court finds that Mr. Hosler’s allegations of lost sleep do not render the term “bodily injury” ambiguous. Because Mr. Hosler makes no allegation of “bodily injury,” there can be no genuine issue of fact regarding whether coverage exists with respect to his claims in the Underlying Action.

E. Timing of Injury

The CGL policy’s insuring clause requires that the “bodily injury” or “property damage” occur during the policy period. In most bodily injury cases this is not much an issue, as worksite injuries are easy to date. Certain latent diseases, such as asbestosis, present more challenging timing issues. Property damage cases can be more difficult to pinpoint in time, particularly if the property damage arises from a latent defect and involves water infiltration – a common source of damage. Latent defective construction conditions which cause deterioration over long periods of time raise a host of timing and allocation issues. Cases which analyze these issues are sometimes referred to as “trigger of coverage” decisions.

A relatively straightforward timing of injury issue was evaluated in M.L.P. Invs., LLC v. Quanta Specialty Lines, where an insurer cancelled its CGL policy for non-payment of premium and a question arose as to whether the cancellation became effective before the damage giving rise to a claim against the insured occurred. The insurer claimed that its notice of cancellation occurred more than a month before

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the claim against its insured accrued. The insured argued that a valid policy existed at the time of the claim, because it had never received a cancellation notice. In addition, the insured argued that, even if the policy was validly cancelled, some of the claimant’s damages accrued before the policy’s cancellation. Because cancellation occurred upon the mailing of a written notice of cancellation rather than receipt, the policy was effectively cancelled upon sufficient documentation establishing the mailing of the notice. The inquiry then focused on whether damage occurred before cancellation. The claimant’s complaint alleged that the insured damaged its pipeline after the date the policy was cancelled. It also alleged that the insured’s construction activities threatened to or already blocked access to the pipeline. The complaint, however, was not specific as to when this blockage occurred. Nevertheless, the court concluded that even if the insured had started preparing the area by performing grading work while the policy was still in effect, that activity would not have resulted in blocking access or causing damage to the pipeline. Because the claim did not assert damages during the policy period, the insurer had no duty to defend or indemnify the insured.

1. Latent injury of lasting duration

Where injury occurs over a long period of time, such that it extends over several periods, an issue of allocation arises. This is often known as a “coverage trigger” or “trigger” issue. Courts have adopted several different “trigger” theories to determine which policies are “triggered” by virtue of the fact that injury is deemed to have occurred during the policy period. For some jurisdictions, depending upon the nature of the injury, the important factor is when the injury first manifests itself (the “manifestation” trigger). For these jurisdictions, the only policy in effect at the time the injury became known or manifested itself is triggered. Other jurisdictions look to when the harm first occurred, or when the first harmful exposure took place (the “exposure” trigger). Other jurisdictions consider all policies in effect at the time any injury was present are “triggered” (sometimes known as the “continuous” or “actual injury” or “injury-in-fact” trigger).

The Supreme Court of Texas addressed many of these “trigger” theories in Pine Oak Builders, Inc. v. Great Am. Lloyd’s Ins. Co., where a home suffered wood rot and other physical injury over a period of years. The Court of Appeals adopted the “exposure” rule for determining whether a property damage claim is covered under an occurrence-based CGL policy. The insurer urged the adoption of the “manifestation rule” for making this determination. The Texas Supreme Court rejected both theories, and instead applied an “actual injury” rule.

Minnesota courts apply the same “actual injury” rule, as was explained by the Minnesota Court of Appeals in a case involving water intrusion damage due to defective stucco:

Minnesota applies an “actual injury” rule to determine whether insurance coverage has been triggered by an occurrence. To trigger a policy, the insured must show that some damage occurred during the policy period. In this state, the actual-injury rule has evolved since it was first articulated in Singsaas v. Diederich, 307 Minn. 153, 156, 238 N.W.2d

878, 880 (1976). Singsaas held that the occurrence is not when the negligent work was done but when the complaining party was actually damaged.119

2. **Proving injury occurred during policy period**

The Missouri Court of Appeals decision in *D.R. Sherry Constr. v. Am. Family Mut. Ins. Co.*,120 discusses the level of proof necessary to establish injury occurred during the relevant policy period. The underlying dispute involved cracking to a home’s foundation due to poor soil conditions. The insured’s policy expired after the parties conducted their final inspection during which no foundation problems were discovered and before the homeowners notified the contractor that cracks had begun to appear in the home’s foundation. The court of appeals reversed the trial court, determining that the contractor failed to carry its burden that injury actually occurred to the home before the policy expired:

Thus, the fact that Sherry’s [insured] act of building the house on unanticipated poor soil conditions occurred before the policy ended on December 5, 2003, is irrelevant. To make a submissible case at trial, Sherry was required to present evidence that the unanticipated soil conditions caused property damage and the actual property damage occurred during the policy period. To the contrary, Sherry presented no evidence from which the jury could have concluded that the house’s property damage occurred during the policy period. Sherry, however, never presented any evidence that the completed home’s exposure to the unanticipated soil conditions actually caused physical property damage to the home before December 5, 2003. The jury, therefore, had no evidence from which it could conclude that the damage occurred before December 5, 2003. Instead, the jury could only theorize that the property damage occurred before December 5, 2003, and not between December 6, 2003 and April 2004. This is the definition of speculation. Of course, speculation cannot support a jury verdict.

At oral argument, Sherry’s attorney conceded that Sherry failed to present evidence at trial that the house’s actual physical property damage occurred between December 5, 2002, and December 5, 2003. He maintained, however, that the law required Sherry to prove only that the occurrence of building the house on poor soil conditions occurred during the policy period. In other words, Sherry’s attorney argues that Missouri recognizes damage to occur upon the exposure of the injury-producing condition. As we pointed about above, that is not the law of the State of Missouri.121

Proof issues are not unique to property damage trigger cases. Asbestos has been a scourge for those who have worked around it. The disastrous health effects occur many years after exposure. This has led to the ruin of many a company, as well as having been a painful lesson to insurers about the costs of long-latent work-related illnesses.

Robert A. Keasbey Co. was an insulation contractor that worked in and around New York in the latter half of the 20th century. It also distributed asbestos-containing insulation materials and finishing cements to utilities. Continental Insurance Company issued seventeen liability policies to Keasbey

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between 1970 and 1987. These policies did not contain an asbestos exclusion. Like so many companies in this business, Keasbey found itself the target of thousands of individual tort claims alleging asbestos-related injuries. The claims began in 1986 and continued to mount through the 1990s. Keasbey never saw the new century, as the mounting claims eventually were its undoing.

The mounting claims also threatened Continental. Much depended upon whether the claims were deemed to fall under the policies’ products/completed operations hazard or the premises/operations hazard. If the former, the claims were subject to combined aggregate limits of $8,700,000. If the latter, however, the claims were not subject to any aggregate limits but only separate “per occurrence” limits.

Deciding this question required one to delve into the timing of a claimant’s injury. The policies defined completed operations hazard as bodily injury that occurs after the insured’s operations have been completed. So did most claimants incur injury after Keasbey’s operations had exposed them to asbestos were completed? As with everything else involving asbestos-injury, proving what happened and when can be a Herculean task. The trial court placed the burden on Continental. The appellate division, however, disagreed finding that the burden was on the claimants to prove injury during operations and not on Continental to establish that injury occurred after the completion of operations. The appellate court made the claimant’s burden very difficult by rejecting the trial court’s inhalation trigger as inconsistent with New York’s injury-in-fact coverage trigger. Under this trigger, the claimants were required to prove that their exposure to asbestos fibers overwhelmed their bodies’ defenses before Keasbey completed work where each claimant was exposed. Not surprisingly, few claimants could successfully mount this challenge.\textsuperscript{122}

3. Allocating damages among “triggered” policies

Where a trigger is adopted that implicates more than one policy, then an allocation issue arises. Moreover, allocation questions can occur where an injury-in-fact trigger is adopted and there are periods where the insured possessed coverage and others where it did not. These allocation issues can be challenging.\textsuperscript{123} A number of thorny factual issues can be in play.\textsuperscript{124} For example, in a defective stucco case, the issue of when the injury occurred was not necessarily the date the defective work was performed.\textsuperscript{125} Another common complexity in water intrusion cases is due to the fact that, on occasion, there are multiple sources of water infiltration.\textsuperscript{126}

\textsuperscript{122}Continental Cas. Co. v. Employers Ins. Co. of Wausau, 871 N.Y.S.2d 48 (A.D. 2008). See also, In re Wallace & Gale Co., 385 F.3d 820, 825 (4th Cir. 2004) (“Any injuries that occurred after Wallace & Gale completed its installation work with asbestos were subject to aggregate limits of the policies under the completed operations hazard clauses in the policies.”); Nat’l Union Fire Ins. Co. v. Porter Hayden, 331 B.R. 652, 666 (D. Md. 2005) (“As a matter of law, any portion of bodily injury that occurs after completed operations will be subject to aggregate limits of any policies that were in effect after Porter Hayden’s operations were completed.”).

\textsuperscript{123}Donnelly Bros. Constr., Inc. v. State Auto Prop. & Cas. Ins. Co., 759 N.W.2d 651, 656 (Minn. Ct. App. 2009) (“Various decisions of Minnesota courts illustrate the difficult and complex task of determining insurer liability for damage arising from repeated incidents generally and particularly for damage to buildings resulting from moisture and water intrusion caused by contractors.”)

\textsuperscript{124}Westfield Ins. Co. v. Kroiss, 694 N.W.2d 102 (Minn. Ct. App. 2005) (holding that when property damage actually occurs during a policy period is a question of fact to be determined at trial).

\textsuperscript{125}Donnelly Bros. Constr., Inc. v. State Auto Prop. & Cas. Ins. Co., 759 N.W.2d 651, 657-58 (Minn. Ct. App. 2009) (“There is a difference between the misapplication of stucco and the actual failure of the misapplied stucco...
A number of different theories abound for allocating damages among triggered policies. For example, Minnesota has adopted an allocation scheme that apportions damages pro rata by time on the risk. But this pro rata allocation is tempered in cases where the damage arises from one clearly definable discrete event. Given this difference in treatment, it is not surprising that disputes arise over whether damages emanating from defective construction are best characterized as a “continuous process” and thus subject to a pro rata allocation based on time on the risk or more closely resembled a “discrete event” loss where damages are apportioned largely over the policy period encompassing the discrete loss event. In West Bend Mut. v. Valley Forge Ins. Co., water intrusion damages from defective stucco were considered more akin to a “continuous process” rather than a “discrete event,” and thus subject to an allocation by time on the risk:

The determinative question here is whether the water intrusion can be traced to a discrete and identifiable event, as in SCSC Corp. and In re Silicone, or if the water intrusion cannot be traced to a discrete and identifiable event as in NSP and Dontar. In other words, is the faulty construction of a home more closely analogous to a chemical spill or a surgical procedure than it is to environmental contamination resulting from years of seepage and multiple causes. The Court concludes that the construction of a home is not a discrete and identifiable event for purposes of triggering an actual injury analysis and damages are more appropriately apportioned pro rata by time on the risk.

4. “Stacking” of limits of successive liability policies triggered by continuous loss

The ability to a “stack” limits in continuous loss situations can be a significant benefit for an insured. For example, assume a continuous water intrusion loss occurring over two successive policy periods. Further assume that each policy contains an aggregate limit of $1 million. In a non-stacking jurisdiction, the amount of coverage available to the insured would be $1 million. In a jurisdiction that which allows damaging water intrusion. For our purposes, the date of the defective work cannot be substituted for the commencement of water intrusion or resulting damage.”).

126 Donnelly Bros. Constr., Inc. v. State Auto Prop. & Cas. Ins. Co., 759 N.W.2d 651, 658 (Minn. Ct. App. 2009) (“Our case has another complexity. Appellant is only responsible for defective stucco work, not other construction defects that may have first caused water intrusion. The expert testimony and inspection reports reveal numerous alleged construction defects, including: improper installation of windows, manufacturing and design defects of windows, lack of caulking, lack of flashing, architectural design defects, improper installation of roofing materials, and improper maintenance. All of these are causes that are apparently separate from the alleged defective stucco work. Any, all or some combination of these construction defects could have led to the water intrusion and this multi-cause dynamic may be different in each house. Respondent failed to establish that appellant’s defects were the initial or triggering cause of water intrusion which first led to damage in any of the six homes.”).

127 See Northern States Power Co. v. Fid. & Cas. Co. of New York, 523 N.W.2d 657 (Minn. 1994).

128 SCSC Corp. v. Allied Mut. Ins. Co., 536 N.W.2d 305 (Minn. 1995) (allocating costs pro rata by time on the risk was not appropriate where evidence demonstrated that the contamination was the result of one significant spill that occurred in one policy year).


permits stacking, the total amount of coverage available would be $2 million. Stacking is fairly common in the auto liability world.\textsuperscript{131} But anti-stacking language contained in auto policies will be enforced.\textsuperscript{132}

Stacking is less prevalent in general liability policies. A California Court of Appeals, however, has ruled where progressive property damage spans several policy periods, the “stacking” of limits of successive liability policies is permitted where the policies are triggered by a continuous loss. In \textit{State of California v. Continental Ins. Co.},\textsuperscript{133} an industrial waste disposal site was placed over fractured and permeable rock, resulting in contamination to an underground stream. In September 1998, a federal court found the State of California liable for negligence in choosing the site and failing to properly remedy the conditions. It determined that the state was liable for all past and future remediation costs. These costs were estimated to approach $700 million.

The state sought indemnity from its liability insurers and proceeded to trial against six excess liability insurers, each of whose policies covered a two-year or three-year period. The trial court determined that the excess carriers’ policies responded to the loss, but disallowed stacking of the limits.

The Court of Appeals disagreed with the no-stacking ruling. Before it addressed stacking, however, the court discussed a related issue sometimes referred to as the “all sums” rule. This rule is often best described by contrasting it with the alternative “pro rata.” Both apply in situations where more than one policy is triggered in a continuous loss situation. In “pro rata” jurisdictions, an insured is entitled to recover only in the amount an insurer is allocated based on a “time on risk” basis. In an “all sums” jurisdiction, the insured is entitled to recover all of its loss up to the policy limits from any of the triggered policies. The paying insurer then has a right of contribution from the non-paying carriers. It is a bit like the difference between a plaintiff’s collection rights in a state permitting only “several” liability in contrast to one that holds defendants “jointly and severally” liable for the plaintiff’s injuries. California had yet to rule definitively on whether it is an “all sums” or “pro rata” jurisdiction. The Court of Appeals came down on the “all sums” side of the issue.\textsuperscript{134}

With respect to stacking, the court determined that a no-stacking rule was difficult to reconcile with California’s adoption of “horizontal exhaustion” for purposes of determining when an excess policy responds to a loss. Essentially, “horizontal exhaustion” requires all applicable primary policies to be exhausted before the excess policy responds to the loss. This is in contrast to “vertical exhaustion” which

\begin{itemize}
  \item \textsuperscript{132} \textit{See Wagner v. State Farm Mut. Auto Ins. Co.}, 40 Cal.3d 460, 220 Cal. Rptr. 659, 709 P.2d 462 (Cal. 1985) (anti-stacking language in uninsured motorist policy enforced).
  \item \textsuperscript{133} \textit{State of California v. Continental Ins. Co.}, 169 Cal. App. 4\textsuperscript{th} 1114, 88 Cal. Rptr. 3d 288 (Cal. Ct. App. 2009).
  \item \textsuperscript{134} The court found support in a number of California Court of Appeals decisions, including \textit{California Union Ins. Co. v. Landmark Ins. Co.}, 145 Cal. App. 3d 462, 193 Cal. Rptr. 461 (Cal. Ct. App. 1982) (after \textit{Montrose}, it was settled rule that an insurer on the risk when continuous or progressively deteriorating damage or injury first manifests itself remains obligated to indemnify the insured for the entirety of the ensuing damage or injury); \textit{Armstrong World Indus. v. Aetna Cas. & Sur. Co.}, 45 Cal. App. 4\textsuperscript{th} 1, 52 Cal. Rptr. 2d 690 (Cal. Ct. App. 1996) (phrase “all sums” creates an independent obligation to respond in full to a claim). \textit{See also, Aerojet-Gen. Corp. v. Transp. Indem. Co.}, 17 Cal. 4\textsuperscript{th} 38, 70 Cal. Rptr. 2d 118, 948 P.2d 909 (Cal. 1997) (taking an “all sums” approach to allocation of defense costs and, \textit{in dicta}, suggesting the same approach should apply to the duty to indemnify).
\end{itemize}
permits the insured to look to excess coverage after just one primary policy is exhausted in a continuous loss situation. The court reasoned that, if excess carriers are permitted to in essence “stack” primary policies under the “horizontal exhaustion” doctrine, there is no reason to deny insureds the same benefit.\textsuperscript{135}

\textbf{F. Exclusions}

The CGL policy contains a number of standard exclusions. Some exclusions eliminate coverage because other traditional insurance policies cover these risks. The auto and employee exclusions are common examples of this type. Other exclusions are based on “business risk” principles. The work-related exclusions, such as the “your work” exclusion, all in this category. Other exclusions are based on what insurers believe are simply unacceptable risks from a severity standpoint. The nuclear exclusion is an example.

\textbf{1. Pollution exclusion}

The CGL’s pollution exclusion has had a convoluted history. When first introduced, it was subject to a “sudden and accidental” exception.\textsuperscript{136} This exception proved difficult to apply in many factual situations and eventually the industry moved to a “absolute” pollution exclusion. Nevertheless, a number of courts have had difficulty squaring intent with language. An historical review of the exclusion reveals that its primary purpose is to carve out traditional environmental liability from the CGL policy. Nevertheless, the exclusion’s language cuts a fairly wide swath. As a consequence, jurisdictions break into two camps: (1) those courts that enforce the exclusion broadly to capture any loss related to a pollutant; and (2) those courts that limit the exclusion to its historical roots of traditional environmental liability.

The conflict of these two competing approaches to the pollution exclusion on occasion arise within a single jurisdiction. Two federal courts applying Texas law have come to opposite conclusions with respect to the application of the pollution exclusion in a non-environmental liability context. In \textit{Nautilus Ins. Co. v. Country Oaks Apartments},\textsuperscript{137} the Fifth Circuit, applying Texas law, ruled that carbon monoxide release causing personal injuries to inhabitants of an apartment complex was captured by the pollution exclusion. The release occurred because workers accidentally blocked a furnace vent. In ruling that the insurance policy did not respond because of the pollution exclusion, the court held:

\begin{quote}
In sum, the emission of carbon monoxide from a furnace into an apartment unambiguously satisfies the pollution exclusion’s requirement of a “discharge, dispersal, seepage, migration, release, or escape.” It is irrelevant that a reasonable insured might
\end{quote}

\begin{footnotes}
\item [136] Even though the industry moved away from the “sudden and accidental” form of the pollution exclusion, cases still arise under the policy form. \textit{See State v. Allstate Ins. Co.}, 45 Cal. 4th 1008, 1027, 201 P.3d 1147, 1160, 90 Cal. Rptr. 3d 1, 17 (Cal. 2009) (“We conclude that to the extent the conditions in March 1978 threatened a “sudden and accidental” release of wastes from the Stringfellow site, a qualified pollution exclusion does not bar coverage for liability arising from the state’s intentional releases performed to prevent such a greater accidental release.”).
\item [137] \textit{Nautilus Ins. Co. v. Country Oaks Apartments}, 566 F.3d 452 (5th Cir. 2009).
\end{footnotes}
not expect this result, or that, given sufficient imagination, we can think of ways – not presented here – in which enforcement of this exclusion would lead to absurd results.\textsuperscript{138}

In Jones\textit{ v. Francis Drilling Fluids, Ltd.},\textsuperscript{139} an industrial cleaning subcontractor’s employee was allegedly injured when he was exposed to sodium hydrochloride liquid on an oil rig. He sued the drilling contractor and owner, who, in turn, sought coverage under his employer’s policy as additional insureds. In determining that the pollution exclusion did not apply, the court reasoned:

The evidence shows that the chemical-exposure incident in this case is more similar to the isolated, limited events found not to exclude coverage in\textit{ Gaylord, Smith} and\textit{ West} than the systematic, long-term environmental pollution that triggered the exclusions in\textit{ Grefer} and\textit{ Pro-Boll}. The release of the W.O. Break at issue was a one-time, discrete, sudden accident. Jones sustained the only injury. The release was in a limited and confined area. There is disputed evidence in the record that the W.O. Break was being used for its intended purpose – which ADTI’s Darrell Miller contends included cleaning oil-based drilling based fluid – even if it was poured into the wrong vessel. There is no evidence that the W.O. Break came into contact with water or land around RIG 46 and no environmental cleanup or reporting was required. This is not a case in which the surrounding land and water became contaminated after an extended period of release or dispersal. Applying the post-\textit{Doerr} case-law, the Total Pollution Exclusion does not apply.\textsuperscript{140}

2. Business risk exclusions j(5) and j(6)

These exclusions address certain property damage injuries that occur during the course of the insured’s work. The Fifth Circuit looked at both exclusions in connection with a dispute involving damages caused by water intrusion to a five-unit wood-framed residential structure. At the time of the damage, the model unit was complete and the remaining units were partially unfinished as they required painting, flooring, plumbing and electrical fixtures, which were intended to be installed once they were sold. It was at this stage of completion that the units were damaged by water due to an improper water-seal. The insurer raised exclusions j(5) and j(6) as the basis for denying an indemnity obligation. Exclusion j(5) excludes property damage to “that particular part of real property on which you or any contractors or subcontractors working directly or indirectly on your behalf are performing operations, if that property damage arises out of those operations. Exclusion j(6) excludes property damage to that particular part of any property that must be restored, repaired, or replaced because “your work” was incorrectly performed on it. The court determined that exclusion j(5) did not apply because the term “performing operations” meant the insured was actively involved in construction activity which, in this circumstance, was not the case as the project was in a prolonged suspension while the unfinished units were sold.

With respect to exclusion j(6), the court concluded that, by its terms, it did not apply to the interior finishes damaged as a result of the defective water seal on the exterior of the structure:

\begin{itemize}
  \item \textsuperscript{138} \textit{Nautilus Ins. Co. v. Country Oaks Apartments}, 566 F.3d 452, 458 (5\textsuperscript{th} Cir. 2009). \textit{See also, Continental Cas. Co. v. City of Jacksonville}, 654 F.Supp.2d 1338 (M.D. Fla. 2009) (claims that county school board was negligent by allowing an elementary school to be constructed over a dump site for incinerator ash without warning about the exposure to heavy metals was subject to the pollution exclusion).
  \item \textsuperscript{139} Jones\textit{ v. Francis Drilling Fluids, Ltd.}, 642 F.Supp.2d 643 (S.D. Tex. 2009).
  \item \textsuperscript{140} Jones\textit{ v. Francis Drilling Fluids, Ltd.}, 642 F.Supp.2d 643, 670 (S.D. Tex. 2009).
\end{itemize}
In this case, there is no allegation that JHP performed defective work on the interior portions of the condominiums that were damaged by the water intrusion, including interior drywall, stud framing, electrical wiring, and wood flooring. The damage to the interior portions of the condominiums were the result of JHP’s failure to properly water-seal the exterior finishes and retaining walls. The exterior finishes and retaining walls were distinct component parts that were each the subject of separate construction processes and are separable from the interior drywall, stud framing, electrical wiring, and wood flooring. The exterior finishes and resulting walls are “[t]hat particular part of any property that must be restored, repaired or replaced because [JHP’s] work was incorrectly performed on it.” Exclusion j(6) does not exclude coverage for the water damage to the interior portions of the condominiums.

3. “Your work” exclusion

This is another “business risk” exclusion. The exclusion states:

This insurance does not apply to:

“property damage” to “your work’ arising out of it or any part of it and included in the “products-completed operations hazard.”

Because the exclusion is related to the “products-completed operations hazard” it applies in instances where injury occurs after the insured’s work is completed. Moreover, the exclusion is subject to a “subcontractor” exception that reads:

This exclusion does not apply if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor.

The Fifth Circuit, applying Texas law, had an opportunity to address this exclusion in the context of a home that was completed in 1999 and experienced cracking in 2005. The insured was the foundation contractor and the cracks appeared in the home’s ceilings and walls. In concluding that the exclusion did not apply, the Fifth Circuit noted:

The complaint alleges that the faulty foundation caused damage to other part of the house that RJT [insured] did not work on including the walls and ceilings. The “your work” exclusion does not preclude coverage for damage to the parts of the house resulting from the allegedly faulty foundation. Because these damages present a covered claim, Wilshire must defend the entire suit.¹⁴²

¹⁴¹ Mid-Continent Cas. Co. v. JHP Dev., Inc., 557 F.3d 207, 217 (5th Cir. 2009). Compare, J. Lucarelli & Sons, Inc. v. Mountain Valley Indem. Co., 64 A.D.3d 856, 881 N.Y.S.2d 708 (3d Dep’t 2009) (exclusions applied to claims that builder constructed homes at an insufficient elevation in relation to season high ground water elevation which resulted in wet basements and other damages related to dampness) with Nova Cas. Co. v. Central Mut. Ins. Co., 59 A.D.3d 777, 872 N.Y.S.2d 603 (3d Dep’t 2009) (exclusion did not apply where fire to home was not the result of defendant’s poor workmanship on exterior siding but rather negligent storage of flammable rags).

¹⁴² Wilshire Ins. Co. v. RJT Constr., LLC, 581 F.3d 222, 227 (5th Cir. 2009). But see, Bresee Homes, Inc. v. Farmers Ins. Exch., 206 P.3d 1091 (Or. Ct. App. 2009) (exclusion applied to water intrusion damages due to exterior siding that allowed moisture buildup and the failure to properly install flashing); Westfield Ins. Co. v. Sheehan Constr. Co., 564 F.3d 817 (7th Cir. 2009) (exclusion applied to water damage to new homes).
4. Breach of contract exclusion

The insurance industry has, from time to time, espoused that CGL coverage is not intended to cover breach of contract damages. The courts, by and large, have rejected this theory as standard policy language does not break down along “tort” and “breach of contract” lines. Some insurers have addressed this situation by creating restrictive endorsements that specifically deal with breach of contract claims. In McNamara v. Augustino Bros., Inc., the policy contained the following breach of contract restrictive endorsement:

This insurance does not apply to claims for breach of contract, whether express or oral, nor claims for breach of an implied in law or implied in fact contract, whether “bodily injury,” “property damage,” “advertising injury,” “personal injury” or an “occurrence” or damages of any type is alleged; this exclusion also applies to any additional insureds under this policy.

The court determined that this exclusion applied not only to allegations of breach of contract, but also to the negligence allegations insofar as they were characterized as “negligent breaches of contract.”

5. Contractual liability exclusion

The standard CGL policy contains a “contractual liability” exclusion. This exclusion does not apply to liability that arises out of contract but rather targets liability that the insured contractually agrees to assume. The exclusion is subject to a number of exceptions, two of which are of importance to those in the construction business. One exception deals with “insured contracts,” which generally equate to indemnity obligations undertaken as part of contracting to do construction work. The other exception is liability that the insured would have, notwithstanding the agreement by which it assumed liability. The Illinois decision in Am. Family Mut. Ins. Co. v. Fisher Dev., Inc., found the exclusion applied in connection with alleged injuries caused to two retail employees at a Gap store. The Gap employees alleged that they were injured as a result of certain drywall work occurring at the store at which they worked. The owner sued the general contractor for the workers’ compensation benefits it was required to pay. The contractor tendered the defense of the suit to the drywall contractor’s insurer on grounds it was an additional insured under the policy. In concluding that the contractual liability exclusion applied, the court reasoned:

In the case at bar, FDI agreed to hold the Gap harmless in the indemnification clause of the Gap-FDI contract. The assumption of liability by FDI went beyond merely accepting its pro rata share of common liability. . . . FDI assumed additional liability based on the indemnification clause of the Gap-FDI contract, triggering the exclusion provision under the American Family CGL policy it issued to Shanahan. FDI is entitled to no greater coverage than the primary insured where FDI assumed additional liability through the

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143 See BRUNER & O’CONNOR ON CONSTRUCTION LAW at § 11:92 (West 2010).
144 McNamara v. Augustino Bros., Inc., 13 So.3d 736 (La. Ct. App. 4 Cir. 2009).
indemnification clause with the Gap, as property owner. We find nothing in Illinois law that renders that indemnification clause meaningless.\textsuperscript{147}

6. Professional services exclusion

A standard CGL policy does not contain a professional services exclusion, but it is often added by way of endorsement where insureds perform professional work. A common area of dispute is whether the losses arose out of a professional service or some non-professional activity that the insured was performing. Some courts find an activity performed by a professional might fall within the exclusion, whereas the same activity performed by a non-professional would not. For example, in \textit{Auto-Owners Ins. Co. v. State Farm Fire \& Cas. Co.},\textsuperscript{148} a construction manager that erroneously concluded a utility wire was not live was performing a professional service when sued in connection with injuries sustained by a backhoe operator who came in contact with the live wire. The policy’s exclusion indicated that supervisory services fell within the professional services exclusion. The construction manager’s activities were deemed to be supervisory, and therefore subject to the exclusion. The court distinguished another Georgia Court of Appeals decision that found the exclusion did not apply to a roofing contractor’s supervisory negligence that resulted in a fire. The difference between the two cases, from the court’s perspective, was that, while the construction manager was a professional, the roofer was engaged in a trade or occupation and hence its supervision was not professional in nature.\textsuperscript{149}

A California decision tests the nexus between professional services and the cause of loss. In \textit{Food Pro Int’l, Inc. v. Farmers Ins. Exch.},\textsuperscript{150} the insured was a consulting firm that provided service to the food industry. It provided engineering services from conducting feasibility studies to construction and equipment installation management. A food processor hired it to assist in the relocation of its operations into a new plant. During the course of the relocation effort, certain equipment was removed and a hole was created in the plant’s mezzanine level. The insured’s onsite supervisor brought this to the attention of the owner who directed its employees to cover the hole. The employees covered the hole with plastic and a wooden pallet. This proved insufficient, as the next day an electrical worker fell through the hole sustaining serious injuries. In ruling that the insured’s carrier owed a duty to defend notwithstanding a professional services exclusion, the court reasoned:

Here, the only link between Food Pro’s rendering of engineering services and Pettygrew’s [injured worker] injury is the allegedly wrongful actions occurred while Food Pro was on the site to provide professional services to Mariani [owner]. As Food Pro’s evidence shows, it did not design or direct the removal of the extruder, nor did it direct Pettygrew’s actions on March 5 as part of its professional services. In other words, Aamold’s [insured’s onsite representative] involvement in the Pettygrew incident arose

\textsuperscript{147} \textit{Am. Family Mut. Ins. Co. v. Fisher Dev., Inc.}, 391 Ill. App. 3d 521, 570 909 N.E.2d 274, 283, 330 Ill. Dec. 561 (Ill. Ct. App. 1\textsuperscript{st} Dist. 2009). While the court addressed the “liability in the absence of contract” exception by noting that it did not apply because the contract expanded the scope of insured’s common law duties, the court did not address the “insured contract” exception.


\textsuperscript{150} \textit{Food Pro Int’l, Inc. v. Farmers Ins. Exch.}, 169 Cal. App. 4\textsuperscript{th} 976, 89 Cal. Rptr. 3d 1 (Cal. Ct. App. 6\textsuperscript{th} Dist. 2009).
from his presence at the site, but the injury did not arise out of the rendering or failure to render any professional services.  

7. Auto and watercraft exclusion

Transportation risks are carved out of the CGL policy because they are subject to other standard policies, such as the automobile liability policy. Nevertheless, not all injuries involving a vehicle fall within the ambit of this exclusion. For example, in *Mid-Continent Cas. Co. v. Global Enercom Mgmt., Inc.*, the insured was hired to repair a cell phone tower. It rigged up a pulley system to convey workers to and from the tower. One end of the pulley system was attached to a pick-up truck that powered the pulley. Tragically, one of the ropes broke while three workers were being conveyed up to the tower and all three fell to their deaths. In ruling that the auto exclusion did not apply, the court held:

Here, the pick-up truck did not cause the deaths of the three workers, the defective rope did. Instead, the pick-up truck simply provided the power for the pulley system, which is not enough to constitute “use” under the CGL policy.

The auto exclusion also covers watercraft. In *First Specialty Ins. Corp. v. Am. Home Assurance Co.*, the issue was whether a barge was a “watercraft.” The court had little difficulty concluding that barges are, indeed, “watercraft.” It rejected the insured’s authority because it described situations where the barge was not being used as a watercraft when the injury arose. The land-based use of a barge might well not implicate the exclusion, but in this case the barge was being used as a watercraft. Moreover, the court rejected the insured’s argument that only vessels with motors or sails or other means of propulsion qualify as “watercraft.” The court noted case law where rowboats and other vessels were subject to the exclusion.

8. “Own property” exclusion

The CGL policy excludes property damage to property the insured owns, rents, or occupies. This exclusion usually does not play a major role in construction-related losses, except for certain homebuilders that build on speculation. Homebuilders that occupy or rent homes they build can run afoul of this exclusion. For example, in *Historical Home Designs, Inc. v. Central Mut. Ins. Co.*, an insured homebuilder constructed a home in Atlanta and conveyed the property to its owner and president, who resided in the home for one and one-half years. During that time, the insured rented a room in the home as an office for its president. Eventually, the president conveyed the home back to the insured, who, in turn, sold it. The sale was subject to an inspection which revealed problems with the slate roof that the insured repaired. In seeking repair costs from its liability carrier, the insured encountered the “own

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153 *Mid-Continent Cas. Co. v. Global Enercom Mgmt., Inc.*, 293 S.W.3d 322, 328 (Tex. Ct. App. 14 Dist. 2009). The court determine that, in order for the auto exclusion to apply, the automobile must not merely contribute to cause the condition which produces injury, but must itself produce the injury. *See Mid-Century Ins. Co. v. Lindsey*, 997 S.W.2d 153 (Tex. 1999). Because the pick-up did not actually produce the injury, the exclusion did not apply.


property” exclusion, which the court found applied, notwithstanding the transfer to the insured’s president:

Even if the relevant inquiry is whether Historical [insured] owned, rented, or occupied the property at the time the loss was discovered or the roof was replaced, the “own property” exclusion still would bar coverage for the loss. From approximately May or June 2002 until Ross [president] sold the home, Ross rented a home office from Historical. To the extent Historical maintained an office at the property through its president, Ross, Historical occupied the property and the Policy excludes coverage for property damage to “[p]roperty you . . . rent or occupy.” At all relevant times, therefore, Historical owned the property when the home was constructed, or it rented or occupied the home through Ross’s use of a home office. Under either circumstance, the “own property” exclusion of the policy precludes coverage for Historical’s loss.\footnote{156}

9. Joint venture exclusion

The CGL policy does not contain a standard “joint venture” exclusion, per se. Nevertheless, insureds that work as part of a joint venture without making sure their policy captures such activities can run into trouble. The problem arises because the CGL policy often defines who is an insured under the policy by reference to who is named in the policy Declarations. It is common for the policy to state that, if the insured is designated in the Declarations as a partnership or joint venture, then it will be covered when so engaged.\footnote{157} Policies may also contain a provision such as:

No person or organization is an insured with respect to the conduct of any current or past partnership, joint venture or limited liability company that is not shown as a Named Insured in the Declarations.

This was the policy language at issue in \emph{Clarendon Am. Ins. Co. v. B.G.K. Security Servs., Inc.}, \footnote{158} where the insured entered into a joint venture agreement to provide security services at a high-rise building in Chicago. When the building suffered a fire loss, the owner sued the insured, who in turn tendered the defense to its CGL carrier. The carrier unsuccessfully raised the “joint venture” exclusion, as the complaint did not make any mention of a joint venture:

Looking at the underlying complaints and Clarendon’s policy, it is clear that a potential for coverage exists. Clarendon’s “Named Insured,” B.G.K., was sued directly in the underlying lawsuits for its own alleged negligence during the fire. None of the underlying complaints name B.G.K. as a defendant in its capacity as a joint venture, it is only when extrinsic evidence is considered, as Clarendon advocates, that B.G.K.’s status as an insured is questioned. . . . However, we have already concluded that considering extrinsic evidence to determine whether B.G.K. was acting as part of a joint venture is


\footnote{157} Moreover, its members or partners are also considered insureds but only with respect to conduct of the insured’s business.

inappropriate at the duty to defend stage as that finding could expose B.G.K. to additional liability in the underlying litigation.\textsuperscript{159}

10. \textit{“Contractor-subcontractor” exclusion}

Insurers issue endorsements that can either broaden or narrow coverage. Restrictive endorsements, as the name implies, restrict coverage. One particularly restrictive endorsement was the subject of interpretation in \textit{Nautilus Ins. Co. v. 1452-4 N. Milwaukee Ave., LLC},\textsuperscript{160} where the policy contained what the court described as a “contractor-subcontractor” exclusion which eliminated from coverage all property damage arising out of operations performed for the insured by contractors or subcontractors, as well as the insured’s general supervision of their operations. The insured hired a contractor, project manager, and subcontractor to perform excavation work on its property. They botched the job and, as a result, an adjacent structure was so severely damaged it had to be demolished. In the ensuing lawsuits, the owner sought coverage under its CGL policy. It sought to avoid the “contractor-subcontractor” exclusion by claiming that, under Illinois Law, it had an independent duty to notify adjacent landowners of the excavation activities, which it was alleged to have breached. The court rejected this argument, finding that the cause of the injury was not the failure to warn but rather the excavation work:

1452 LLC was required to give adjacent property owners advance notice of the excavation; a failure to comply results in liability to adjacent property owners, their occupants, and tenants for any damage to the adjacent land or buildings “arising from such excavation.” While it is true that the statutory duty of the property owner is independent of the duties of contractors and subcontractors, there is no separate or independent compensable injury; a failure to comply gives rise to liability for any property damage “arising from” the excavation. Thus, the statutory claims in the underlying complaints seek recovery for the same loss as all the other claims – the property damage arising out of the faulty excavation performed by 1452 LLC’s contractors and subcontractor – and coverage for that property damage is excluded by the contractor-subcontractor exclusion.\textsuperscript{161}

11. \textit{Scope of work exclusions}

Insurance companies on occasion tailor their policies to cover only certain activities of an insured. One common approach is to carve out from coverage any work on multi-unit residential properties. In a reverse twist, a roofing company found itself without coverage due to such an exclusion for loss arising out of roofing work performed for a synagogue. The roofer’s policy only provided coverage for residential roofing work. The court had little difficulty concluding that a synagogue was not a residential structure.\textsuperscript{162}


\textsuperscript{160} \textit{Nautilus Ins. Co. v. 1452-4 N. Milwaukee Ave., LLC}, 562 F.3d 818 (7\textsuperscript{th} Cir. 2009).

\textsuperscript{161} \textit{Nautilus Ins. Co. v. 1452-4 N. Milwaukee Ave., LLC}, 562 F.3d 818, 822 (7\textsuperscript{th} Cir. 2009) (emphasis in the original). Obviously, this is a very troublesome exclusion for owners engaged in construction activities.

G. Additional Insured Coverage

Not too long ago, there were two additional insured endorsements commonly used in the construction industry – the short form and the long form. Today there is an embarrassing wealth of additional insured endorsements. Perhaps as a result, the number of additional insured coverage disputes involving construction participants is remarkable and growing.

1. Scope of additional insured coverage

An unremarkable, yet still important, concept to keep in mind is that scope of additional insured coverage is largely determined by the language of the additional insured endorsement. Before the issuance of the new forms, the primary scope dispute revolved around what it means for the additional insured to be covered, but only with respect to liability “arising out of” the named insured’s operations. Does this require a finding of negligence on the part of the named insured for which the additional insured is vicariously liable? Or does it connote more of a “but for” nexus? A New York court adopted the latter interpretation, in holding that a prime contractor’s insurer owed a construction manager additional insured coverage with respect to bodily injury claims suffered by a prime contractor’s employee, who slipped on a freshly painted floor:

Regal, the prime contractor at the Rikers Island project, had responsibilities that encompassed all of the demolition and construction work to be done. . . . LeClair [Regal’s project manager] even testified that it would have been Regal’s responsibility to paint the floor joists if instructed to do so by URS [additional insured]. Hence, there was a causal connection between LeClair’s injury and Regal’s work as a prime contractor, the risk for which coverage was provided. The dissent places unwarranted emphasis on the fact that the LeClair complaint does not set forth allegations of negligence on the part of Regal. Generally, the absence of negligence, by itself, is insufficient to establish that an accident did not “arise out of” an insured’s operations. The focus of a clause such as the additional insured clause here is not on the precise cause of the accident but the general nature of the operation in the course of which the injury was sustained.  

Another New York court, however, reached a different result. In Bovis Lend Lease LMB, Inc. v. Garito Contracting, Inc., a construction worker suffered injuries when he fell through an opening in the floor of a jobsite. The hole was created when a garbage chute was removed by the named insured. In the underlying personal injury action, the jury found that (1) Bovis, the additional insured, was negligent and that its negligence was a substantial factor in causing the worker to fall through the hole in the floor; and (2) the named insured was also negligent, but its negligence was not a substantial factor in causing the fall. The subcontractor’s insurer, which provided Bovis additional insured coverage, moved for summary judgment on grounds that it owed Bovis no coverage, as the named insured bore no responsibility for the injuries. The court agreed:

As Twin City argues, the jury's finding that Garito's negligence was not a substantial factor in causing Armentano to fall is as conclusive as the admission by Worth that Pacific’s activities were not a proximate cause of the underlying accident. That finding, after all, established that Bovis’ liability did not arise out of Garito's work for Bovis or out

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of acts or omissions of Bovis in connection with its general supervision of Garito’s work. To the contrary, the jury found that Bovis’ liability arose out of its own work. Just as the staircase created by Pacific was “merely the situs” of the accident, so, too, the hole created by Garito was “merely the situs” of the accident. Thus, as Worth makes clear, “liability arising out of” a named insured's work is absent where, as here, the named insured is absolved of liability. Accordingly, to require Twin City to indemnify Bovis is to confer a windfall on Bovis’ insurer, plaintiff National Union Fire Insurance Co.165

Still another New York court weighed in on this question where the operative language was “with respect to” rather than “arising out of.” This language does not necessarily require the named insured to be at fault, but only that its operations be implicated in the loss. As a New York court noted:

We also agree with plaintiffs that defendant is required to defend and indemnify Christa in the underlying action regardless of the dismissal of the third-party complaint against Spring Lake [named insured]. The language of defendant’s additional insured provision focuses not upon the precise cause of the accident, as defendant urges, but upon the general nature of the operation in the course of which the injury was sustained. The parties do not dispute that Rossa was employed by Spring Lake and injured while performing construction work got Spring Lake. Consequently, we conclude that Rossa was injured while acting “with respect to operations performed by or on behalf of” Spring Lake and that defendant is obligated to provide coverage to Christa as an additional insured pursuant to the policy. The fact that Rossa’s injuries may have been caused by Christa’s negligence is immaterial with respect to the issue of whether Christa is covered under defendant’s policy.166

In United Nat’l Ins. Co. v. St. Paul Fire & Marine Ins. Co.,167 an additional insured carrier argued that its coverage was secondary to that issued by the additional insured’s primary carrier. The court

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166 David Christa Constr., Inc. v. Am. Home Assurance Co., 59 A.D.3d 1136, 1139, 873 N.Y.S.2d 409, 412 (4th Dep’t 2009) (citations and certain inner quotations omitted). But “operations” doesn’t necessary mean that once an additional insured always an additional insured. For example, in Turk v. TIG Ins. Co., 616 F. Supp. 2d 1044 (D. Nev. 2009), the named insured performed a number of projects with the party seeking additional insured coverage under its CGL policy. While a certificate of insurance had issued, it did not apply to the particular project on which the loss occurred. In such a situation, there was no additional insured status conferred for the loss.

167 United Nat’l Ins. Co. v. St. Paul Fire & Marine Ins. Co., 214 P.3d 1260 (Mont. 2009). Three days before it issued the United Nat’l decision, the Supreme Court of Montana issued another decision on additional insured coverage. In Plum Creek Mkting, Inc. v. Am. Economy Ins. Co., 214 P.3d 1238 (Mont. 2009), an owner sought additional insured coverage under a contractor’s policy for claims arising out of injury to a worker caused while he was repairing a garage door on the business premises. The owner sought additional insured coverage, which the court rejected:

We agree with the District Court's interpretation of the Policy and Endorsement and conclude that they do not cover Plum Creek under the facts of this case. While the Policy by itself would have arguably provided coverage to Plum Creek in this case, the Endorsement modified and limited such coverage. Given the provisions of the Endorsement [coverage shall be limited to the extent of your [named insured’s] negligence or fault according to the applicable principles of comparative fault.], Garage Doors could not be held liable in this case because, as noted by American, Moser’s complaint alleged negligence against Plum Creek, not Garage Doors. Thus, it is unequivocally clear that American was not required to defend or indemnify Plum Creek.
disagreed, noting that the additional insured endorsement clearly identified the coverage afforded was primary and non-contributing.

A common form of additional insured endorsement limits the coverage afforded to loss arising out of the named insured’s “ongoing operations.” An Arizona court had occasion to examine what “ongoing operations” means in the context of a property damage dispute that arose in 2003, more than two years after construction was completed. The carrier issuing the additional insured endorsement claimed it owed no coverage as the additional insured’s liability could not have arisen out of the named insured’s “ongoing operations.” The court agreed:

Plaintiff [additional insured] argues that the phrase “ongoing operations” in the AI endorsement should be interpreted to mean that any damages “related to” the ongoing operations of GWM [named insured] must be covered by the policies, regardless of when the damages are discovered. The Court disagrees. Plaintiff’s proffered interpretation erases the distinction between ongoing operations coverage and completed operations coverage. Any claim for personal injury of property damage related to a subcontractor’s work will, necessarily relate back to the period of time when the subcontractor was working on the project. This is so because any action in the causation chain that a subcontractor sets in motion will inevitably relate back to the subcontractor’s negligent actions or faulty workmanship, which can only occur while the subcontractor is still performing on the project. Thus, the only meaningful distinction between the two types of coverage becomes one of when the damages manifest themselves: during the subcontractor’s ongoing operations or after the subcontractor’s work is completed? If the latter, then an AI endorsement containing ongoing operations language will not provide coverage.168

In MacArthur v. O’Connor Corp.,169 a general contractor on a utility project was sued by a worker injured when he tripped on temporary wooden stairs that had been constructed by the general contractor. The general contractor sought coverage under a subcontractor’s policy. The subcontractor’s policy contained an additional insured endorsement that provided coverage to the additional insured if it is found liable for the named insured’s acts or omissions. The court interpreted this language was limited to providing coverage for the vicarious liability of the additional insured due to the named insured’s acts or omissions. It rejected the additional insured’s interpretation that the “is liable” language could mean the additional insured and named insured were jointly and severally liable. The court concluded that this interpretation renders meaningless the “acts or omissions” language. Because the general contractor was sued for its own acts and negligence, additional insured coverage did not apply.170

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170 See also, A.F. Lusi Constr., Inc. v. Peerless Ins. Co., 847 A.2d 254, 264 (R.I. 2004) (additional insured endorsement only provided limited coverage and did not cover claims of direct negligence against general contractor).
2. Creation of additional insured status

Under Georgia law, an additional insured must “elect” coverage by forwarding a copy of the complaint to the insurer. Failure to timely elect can jeopardize coverage. Nevertheless, notifying the insurer approximately four months after suit was commenced was timely, particularly where the complaint initially failed to correctly name the additional insured.

Participants in the construction industry often use a “blanket” endorsement to create additional insured coverage. One common form confers additional insured status on anyone the named insured has agreed to provide such coverage to through a written agreement. If the agreement does not create the obligation, then there is no coverage. Disputes sometimes arise over whether the written agreement creates additional insured status. For example, in Aubris Resources, LP v. St. Paul Fire & Marine Ins. Co., an oil field explosion severely injured two workers. The workers sued the oil field owner who, in turn, sought additional insured coverage under their employer’s policy. The insurer argued that the written agreement did not provide additional insured coverage for the owner’s own negligence. The provision in question stated:

UNITED [owner] and its subsidiaries, affiliated companies, co-owners, partners and joint venturers (if any), directors, agents, and employees shall be named as additional insureds in each of the contractor’s policies, except Workers’ Compensation; however, such extension of coverage shall not apply with respect to any obligations for which UNITED has specifically agreed to indemnify contractor.

The parties’ agreement required the owner to indemnify the named insured for losses arising out of the owner’s negligence. In 2008, the Texas Supreme Court ruled that additional insured coverage was not limited by party’s indemnity obligations. The Fifth Circuit interpreted this precedent to mean that it could only consider the additional insured provision when determining coverage:

We take from Evanston Insurance that in determining whether there is coverage, a court looks only to the additional insured provision itself; that indemnity is a separate, and later arising, question from coverage. It is true that under the insurance policy in this case, unlike Evanston Insurance, additional insured coverage must be specifically required by the services agreement, and there is no question that the services agreement specifically states that UNITED be named an additional insured under J&R Valley’s policy. It is also true that, like Evanston Insurance, this agreement includes, in a separate section, a general indemnity provision. Yet, it is not material to the Evanston rule whether the additional insured provision is finally determined in the policy or with the aid of the

173 See West 64th St., LLC v. Axis U.S. Ins., 63 A.D.3d 471, 882 N.Y.S.2d 22 (1st Dep’t 2009).
parties’ service contract. The separate indemnity provision does not apply to limit the scope of coverage.  

Reviewing the additional insured provision standing alone, was the owner entitled to additional insured coverage? To this question, the Fifth Circuit answered in the affirmative, by reading the provision as requiring a separate independent decision to indemnify the named insured in a given loss situation:

[W]e acknowledge that section 10.2 itself stipulated that there will be no additional insured coverage for “any obligations for which UNITED has specifically agreed to indemnify [J&R Valley].” However, we do not think that this exclusionary language reasonably can be read to exclude from coverage all incidents for which United could possibly owe J&R Valley indemnity. We note that section 10.2 excludes obligations for which United has specifically, not generally, agreed to indemnify J&R Valley. The qualifier “specifically” reasonably can be read to indicate that United intended to forego additional insured coverage only in the event United makes a separately considered and extra-contractual decision, i.e., to specifically agree to indemnify J&R Valley.

Confusion can sometimes arise over whether additional insured status is created by the issuance of a Certificate of Insurance notwithstanding the lack of any indication in the underlying policy of such status. As a general rule, being listed as an additional insured in a Certificate of Insurance alone is insufficient to create coverage. Much can depend upon policy language. A scaffold accident that resulted in the deaths of several people involving the John Hancock Center in Chicago gave rise to an additional insured coverage dispute. The policy in question contained the following provision identifying who were insureds under the policy:

If you are required to add another person or organization as an insured under this policy by a written work contract or agreement which is in effect during the policy period and a certificate of insurance has been issued listing that person or organization as an Additional Insured, that person or organization is an insured. Such person or organization is referred to in this Coverage Part as an Additional Insured.

Because the policy expressly referenced the issuance of a Certificate of Insurance in connection with additional insured coverage, the question became whether this was a precondition to the creation of


178 Aubris Resources, LP v. St. Paul Fire & Marine Ins. Co., 566 F.3d 483, 49-90 (5th Cir. 2009) (emphasis in original). See also, W9/PHC Real Estate, LP v. Farm Family Cas. Ins. Co., 407 N.J. Super. 177, 193, 970 A.2d 382, 392 (2009) (“We do not see the relevance of this [indemnity] provision to the question of whether defendant had a duty to defend under its policy with Crabtree. Whether or not plaintiffs did or did not have a right to be indemnified for their own negligence has no bearing on whether they are entitled to a defense and indemnification for their negligent supervision as an additional insured under Crabtree’s policy with defendant. Indemnification agreements in insurance contracts cover separate matters.”).

179 West 64th St., LLC v. Axis U.S. Ins., 63 A.D.3d 471, 472, 882 N.Y.S.2d 22 (1st Dep’t 2009) (“The documentary evidence submitted by plaintiffs, including a Certificate of Insurance issued the same day as the accident giving rise to the underlying personal injury action, did not confer coverage, bring plaintiffs within the additional insured coverage afforded by the policy, or otherwise raise any factual issue which would warrant denial of the motion.”).

coverage and, if so, did the post-accident issuance meet the policy requirement. The court determined that the policy did not require the Certificates of Insurance to issue prior to the accident:

Here, defendants contracted in writing with Eckland, the insured, for additional insured coverage years before the scaffolding incident occurred. Additionally, certificates of insurance were issued to defendants under the 2002-2003 policy on March 15, 2002 and April 9, 2002. Those certificates expressly named defendants as additional insureds under the 2002-2003 policy and plainly restated the full effective period of that policy period. Further, the issued certificates were covered with comprehensive disclaimers, plainly stating that they were issued “as a matter of information only,” subject to all the terms, exclusions and conditions of the cited policy, conferring “no rights upon the certificate holder,” acknowledging that they did not “amend, extend or alter the coverage afforded” by the policy. . . . Plaintiff’s suggested interpretation of the endorsement effectively creates a different policy term each year, modifying the core policy term for each additional insured based on certificates that expressly disclaim all modification. As a result, similarly situated parties like the defendants would receive disparate and incomplete coverage. For example, HOA requested a certificate on March 11, 2002, but its certificate did not issue until April 9, 2002. Shorenstein also requested a certificate after the March 9, 2002 incident, yet its certificate issued much earlier – on March 15, 2002. Under plaintiff’s interpretation of the endorsement, HOA’s coverage would not start for several weeks after Shorenstein’s, even though the same written contract provided that both Shorenstein and HOA would receive additional insured coverage for the same project, under the same policy. Clearly, plaintiff’s reading of the endorsement is unreasonable and unduly limiting. The certificates of insurance did not have to issue prior to the March 9, 2002 incident for defendant’s additional insured status to attach.\(^{181}\)

3. Additional insured status under excess coverage

Excess policies often “follow the form” of their underlying scheduled primary policies. Therefore, if the primary policy provides additional insured coverage to a particular entity, then, to the extent the excess “follows the form” of primary coverage, it too will afford additional insured insurance to the same entity. What if excess coverage is not required by the named insured’s construction contract and the primary policy requires a written agreement to provide additional insured insurance as a precondition to coverage? That was the issue in \textit{Ins. Co. of Pa. v. Apac-S.E., Inc.},\(^{182}\) where the subcontract affording additional insured coverage did not require the named insured to procure general


liability coverage with limits in excess of $1 million. Nevertheless, the named insured procured an excess policy providing an additional $10 million of coverage. Its subcontract required “all policies,” except for workers’ compensation, shall name the general contractor as an additional insured. The issue boiled down to whether “all policies” referred to only the policies required by the subcontract or all policies purchased by the named insured subcontractor. The court concluded the latter:

ICSOP contends . . . the term “all policies” in Paragraph 5 of the Subcontract was limited to the specific types of policies that Costello [subcontractor/named insured] was required to procure under the subcontract. Consequently, ISCOP maintained that because Paragraph 5 did not require Costello to procure general liability insurance in excess of $1 million of coverage, the Excess Policy was not included within the meaning of “all policies” for which additional insured coverage had to be obtained.

We are unpersuaded. It is a cardinal rule of construction that a contract should be construed in a manner that gives effect to all the contractual terms. Following the “all policies” language, the parties go on to refer specifically to Paragraph 5 of the Subcontract to “required insurance” in setting forth other duties placed upon Costello relating to insurance procurement. Thus, if the parties wanted to limit additional insured coverage to policies specifically required under the Subcontract, they clearly knew how to do so. Put another way, the parties would not have used two different terms in short sequence within the same paragraph to mean the same exact thing. In order give effect to all the contractual terms, “all policies” thus must be construed as greater in scope than “required insurance” under the Subcontract.183

H. Other Insurance

General liability policies often contain a provision that discusses how coverage under the policy applies in the event there is other coverage available that responds to the loss. These “other insurance” clauses generally fall into three categories: pro rata, excess, and escape. As explained by a New Jersey court:

A pro rata provision generally provides that where the insured has other insurance against a loss covered by the policy, the insurer will not be liable for a greater proportion of such loss than the applicable limit of liability in the policy bears to the total applicable limit of liability of all insurance against such loss. An excess other-insurance clause seeks to make an otherwise primary policy excess insurance should another primary policy cover the loss in issue. Thus, where one policy has an excess other-insurance clause and another policy on the same risk does not, the former policy will not come into effect until the limits of the latter are exhausted. An escape clause seeks to hold the insurer not liable for a loss whenever there is other valid and collectible insurance covering the risk. There is also a hybrid excess-escape clause whereby the insurer is not liable where the limits of the other available coverage are equal to or exceeded by its own.184

It is important to distinguish between primary policies with “other insurance” provisions, even those that contain an excess-other insurance provision and true excess policies. Again, in the words of the New Jersey court:

Primary insurance attaches immediately upon the happening of the occurrence that gives rise to liability. An excess policy provides protection to an insured for liability for an amount above the maximum coverage provided by the primary policy. However, there is a distinction between a primary insurance policy containing an excess other-insurance clause and a true excess policy. A true excess policy is conditioned on the existence of a primary policy; on the other hand, a primary policy with an excess other-insurance clause is a device by which a primary insurer seeks to limit or eliminate its liability where another primary policy covers the risk, thus making it secondarily liable. 185

A primary policy with an excess-other insurance clause is not excess insurance. This becomes evident when one attempts to determine the coverage implications between various primary policies containing “other insurance” provisions. The situation most frequently arises in the construction context between an additional insured’s primary policy and the policy providing it additional insured coverage. Parties seek to limit the effect of “other insurance” provisions by contractually mandating that additional insured coverage is “primary and non-contributing.”186 Whether such contractual language trumps policy provisions is reminiscent of the debate over whether certificates of insurance alter policy language. Without such contract language, however, a court may have no alternative but to wade through “other insurance” provisions to figure out which policies share in the loss and to what extent. In New Jersey, where the question of allocating loss among insurers with competing “other insurance” clauses “appear substantially unresolved,” a court described the process:

Where two carriers have responsibility for a claim, the other-insurance clause of each policy must be examined to determine whether there exists language which may govern the contribution each party should make. In New Jersey, where the two policies in question each have an other-insurance clause stating that it is excess over any other policy, the provisions are “mutually repugnant,” and are disregarded. In such instance, the carriers stand on equal footing, with each sharing payment of liability equally until the limit of the smaller policy is exhausted. Where the other insurance clause of each policy contains a pro rata provision stipulating that each shall bear a proportion of the loss to the extent of the applicable insurance, then the policies are not mutually repugnant and each carrier must bear its respective proportionate share of the loss. The question that is raised in this instance is what is the outcome when the other insurance clauses of the two policies differ. . . . The issue of conflicting pro-rata and excess other-insurance clauses has been considered in other jurisdictions. Cases generally fall into two types. In the first type, the pro-rata clause in one policy and the excess clause in the other are not held mutually repugnant and the policy containing the pro-rata provision must be exhausted first up to the policy limits. This is the majority rule. In the second type, commonly referred to as the Lamb-Weston rule, . . . all other-insurance clauses, escape, excess or pro rata, are treated the same. Thus, any conflict between such clauses is

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186 See Ins. Co. of Pa. v. Apac-S.E., Inc., 677 S.E.2d 734, 735 (Ga. Ct. App. 2009) (contract language required “all policies, except for workers' compensation policies, shall name [Apac] as an additional insured with primary coverage (with any other third-party coverage provided for [Apac] to be deemed as excess only.").
considered to be mutually repugnant and the loss is apportioned according to the limits of each policy. This approach has been deemed the minority view. . . . We adopt the majority rule. This rule recognizes and considers the language in both policies. In the absence of controlling precedent, the specific language of the policies should be applied, and given its ordinary meaning. 187

V. SUBROGATION

When an insurer pays a loss on behalf of its insured, it “steps into its insured’s shoes” for purposes of pursuing recovery against third parties. As a general rule, subrogation is pursued more frequently by property insurers than those issuing liability policies. But this is not always the case. In *NYP Holdings, Inc. v. McCluer Corp.*, 188 a professional liability carrier paid more than $23 million to settle a suit against its insured, an architectural firm that provided design services in connection with a printing plant in the Bronx. The settlement agreement did not specify what amount of monies paid by the insurer were for design errors, for which its insured was responsible, and what sum was paid for construction defects for which various contractors were responsible. Having made the payment, the insurer sought subrogation from the contractors. The contractors claimed that the insurer was a “volunteer,” insofar as it paid monies for construction defects and, therefore, was not entitled to make a subrogation claim. 189 In rejecting the contractors’ contentions, the court reasoned:

Appellants urge that Lloyd’s was not under any compulsion to pay the non-covered claims, and argue that if it paid $23,150,000 for the covered professional negligence claims, then they are not liable to reimburse Lloyd’s because they performed no professional services.

The threshold issue, however, is not whether Lloyd’s was a volunteer, but, rather whether its insured, McClier, had a cognizable claim against appellants. We need not determine the merits of any such claim to ascertain whether McClier has standing to pursue the third-party claims. At this juncture of the litigation, there has not been any factual determination as to which of the parties were responsible for the losses suffered by NYP, nor any apportionment of responsibility. In the absence of the settlement funded by Lloyd’s, there would not even be an issue as to whether McClier could pursue its claims for, *inter alia*, contractual and common law indemnification, as well as contribution. Like any other party charged with wrongdoing, it would be perfectly within its rights to seek recovery against those whom it contends are actually responsible, in whole or in part, for the damages incurred by NYP.

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189 *See Barnan Assoc. v. 196 Owners Corp.*, 56 A.D.3d 309, 868 N.Y.S.2d 178 (2008) (the voluntary payment doctrine bars recovery of payments voluntarily made with full knowledge of the facts and in the absence of fraud or mistake of material fact or law).
That there was a settlement does not, in the circumstances, alter any of these basic principles. Regardless of whether Lloyd’s is the true party in interest, the claims belong to McClier, and they remain viable at this juncture.

Even of the focus were solely on whether Lloyd’s was a volunteer, it is evident, as the motion court concluded, that there are questions of fact as to whether it lost its right of subrogation. The existing record does not support determination that Lloyd’s settled a claim on behalf of its insured for which another party was wholly, or even partially, responsible. Further, the settlement itself was for a small fraction of the damages alleged by NYP, and was made to forestall the possibility of a larger recovery after trial of the first-party action. These damages could potentially have been assessed against any or all of the defendants. It would be inequitable, on this record, for the appellants to escape responsibility without an adjudication of liability by a fact-finder, merely because they chose not to join in the settlement.190

Blowout insurance provides coverage to owners of oil wells to cover the costs of well repair, and lost gas as a result of a blowout. In Bay Rock Operating Co. v. St. Paul Surplus Lines Ins. Co.191 a blowout insurer brought suit against a drilling engineer after a blowout and fire occurred at a well it insured. The engineer argued that, in order to establish its subrogation rights, the insurer had to establish that it paid a “covered loss” under the policy. In rejecting this contention, the court distinguished between equitable and contractual subrogation. While the former requires a party to show it involuntarily paid a debt primarily owed to another which in equity should have been paid by the other party; contractual subrogation, on the other hand, is created by an agreement or contract that grants the right to pursue reimbursement from a third party in exchange for payment of a loss.192 The blowout policy contained a provision expressly granting the carrier a subrogation right. As such, the insurer’s rights rested in contractual subrogation rather than the equitable form. Moreover, the provision stated that the subrogation right arose when the insurer paid “any” loss, not simply a “covered” loss.193

A. Contractual Waivers of Subrogation

Construction contracts frequently contain a clause in which the owner waives its right to pursue design professionals and contractors for any loss paid by property insurance. This provision has the effect of leaving the loss lie at the feet of the property carrier as it is unable to seek subrogation from those covered by the contractual waiver. These clauses have become a familiar feature in the landscape of construction contracting and are routinely upheld. The Third Circuit noted this fact when it rejected an argument that a waiver of subrogation provision contained in a standard American Institute of Architects (AIA) agreement was trumped by a non-standard clause stating that: “Nothing contained in the insurance

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192 See Fortis Benefits v. Cantu, 234 S.W.3d 642 (Tex. 2007) (there are three types of subrogation – contractual, statutory, and equitable); Mid-Continent Ins. Co. v. Liberty Mut. Ins. Co., 236 S.W.3d 765 (Tex. 2007) (discussing contractual or “conventional” subrogation in contrast to equitable subrogation).
requirements of this Article 13 is to be construed as limiting the extent of [Turner’s] responsibility for payment of damages resulting from its operations under this contract.”

We believe that the contract here waives subrogation, as it is not reasonable that people seeking to limit the waiver would have done so in the manner St. Paul contends the parties did. The contractual information that we find determinative is that the waiver has been a part of standard AIA contracts (hence, industry practice) for at least 20 years and courts have litigated related issues since at least the 1970s. Pennsylvania courts have repeatedly enforced the waiver in face of varied objections. We do not think a reasonable person would read the preservation-of-liability provision to nullify the waiver. The former does not refer specifically to the waiver and the drafters buried it at the end of a separate section. In light of Pennsylvania’s history of vigorous enforcement of the waiver, a reasonable person would assume that if the parties wished to nullify it, they would have amended the text of the waiver itself, not included at all, or included a statement of nullification that referenced to it specifically, appeared with it in the same section, or appeared in a stand-alone section.

Notwithstanding the common feature of these waivers, disputes can arise with respect to their scope. Another AIA standard form, this time the General Conditions document, was at issue in Copper Mountain, Inc. v. Indus. Sys., Inc., where the subrogation issue arose in connection with a fire loss to a ski lodge that was under renovation. The waiver of subrogation provision at issue stated:

The Owner and Contractor waive all rights against [] each other and any of their subcontractors . . . for damages caused by fire or other causes of loss to the extent covered by property insurance obtained pursuant to this Paragraph 11.4 or other property insurance applicable to the Work. . .

Because this was a renovation project, the fire caused significant damage to existing construction and its contents. The owner chose to comply with the contract’s insurance provisions by securing the appropriate endorsements to its existing property policy. As sometimes occurs in these type projects, a question arose as to whether the subrogation provision applied only to the construction work or to the entire structure and its contents. Because the clause uses the term “Work,” it is not uncommon for courts to conclude that the waiver is limited to only the loss associated with the new construction:

We conclude that neither Paragraph 11.4.7 nor Paragraph 11.4.5 bars Copper’s claims for damages to its non-Work property. Several aspects of the contract lead to our

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determination. Most significantly, the plain language of Paragraph 11.4.7 does not waive Copper’s rights for damages to non-work property. . . . Our interpretation harmonizing Paragraphs 11.4.7 and 11.4.5 effectuates the contract’s purpose. Like other AIA owner-contractor agreements, this contract represents a nuanced and intertwined set of agreements between commercial entities about how to allocate risks and responsibilities concerning the possibility of property damage. In this contract, the parties settled on a risk allocation scheme under which Amako [contractor] would procure liability insurance for and remedy damages to non-Work while Copper insured the Work. Amako’s and Industrial’s proposed interpretation of the contract would benefit owners who failed to insure their non-work property by allowing those owners to pursue claims for damages to non-work property, and would penalize owners who insure non-work property by disallowing many claims by such owners.199

In many of the AIA standard form agreements, the waiver of subrogation provision is contained in a general conditions document that is referenced in the agreement signed by the parties. Sometimes the parties mess this up and the waiver is not incorporated into their agreement:

There was no waiver of subrogation in the contract and rider at issue. The court correctly found the rider did not incorporate certain provisions in the AIA forms which provide for a waiver of subrogation. Specifically, the “contract documents” referred to in paragraph 3(d)(ii) of the rider are not the contract and rider. Rather that paragraph undoubtedly referred to contracts ZOne was to enter into with its subcontractors. Accordingly ZOne did not demonstrate that Lebowitz clearly and unequivocally waived any claim for subrogation.200

The temporal scope of the AIA’s waiver of subrogation provision was the focus of Hartford Underwriters Ins. Co. v. Phoebus,201 where final payment on a construction contract to build an Arby’s restaurant in Dunkirk, Maryland, occurred on January 30, 2004. More than a year later, on May 8, 2005, a fire broke out in the restaurant causing substantial damage. The owner’s property carrier paid more than $1 million as a result of the loss. It then sought recovery against the contractor. As is often the case, this question boiled down to what was meant in the AIA waiver by the term “Work.” Does “Work” include the completed restaurant? If so, the waiver of subrogation provision applied; if not, it had no effect when the fire loss was sustained. This was a matter of first impression in Maryland. The court concluded that the term “Work” was ambiguous in the context of temporal scope:

The ambiguity continues in (for our purposes) the critical language in the subrogation waivers clause: that the owner and contractor waive all rights against each other “for damages caused by fire . . . to the extent covered by . . . other property insurance applicable to the Work.” If that phrase was meant to have the broadest meaning, so as to

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200 Travelers Indem. Co. v. Zeff Design, 60 A.D.3d 453, 457, 875 N.Y.S.2d 456, 458 (1st Dep’t 2009). Unfortunately, the court does not explain in much detail just how the parties contracted in this case. It is a bit difficult to figure out what role the “rider” played in the parties’ agreement and just how the General Conditions document was left unincorporated.

include property insurance covering the completed Restaurant, with no time limitation, the word “Project” rather than the word “Work” would have been used. “Project” is clearly defined in the Contract to mean the Restaurant, with no time limitation. “[P]roperty insurance applicable to the Project” plainly would have meant such insurance on the Restaurant after completion. That word was not used, however, and “Work,” a word fraught with ambiguity, in fact was used.202

Faced with an ambiguity, the court was swayed by public policy arguments and the concepts that, because waiver is an intentional relinquishment of a known right, the ambiguity made it less likely that the owner knowingly waived its right to pursue the contractor for post-completion losses.203

VI. PROPERTY INSURANCE

Property insurance is first-party coverage. This means that the insurance is intended to provide direct benefits to the insured for losses to covered property. Property policies are less standard than commercial general liability policies. But in general terms, they contain schedules of covered property and an enumerated list of “covered causes of loss” (previous known as “named perils”). Where losses are sustained to covered property by virtue of a covered causes of loss, then the policy responds unless some condition or exclusion operates to limit or eliminate coverage.

A. Mixed Causes of Loss

Property destruction can be a messy affair. If two or more causes of loss combine, one of which is covered and the other excluded, some form of analysis must occur to determine whether the policy responds. Some policies contain language to the effect that mixed covered and excluded causes of loss result in no coverage.204 In the absence of such language, or in jurisdictions where such language is not enforceable, courts have adopted a number of analytical tools to assist in the inquiry. One of them is the “efficient proximate cause” test. This approach looks for the most predominant or important cause of loss as the basis for determining whether coverage is triggered. The California decision in Freedman v. State Farm Ins. Co.,205 where an insured’s home suffered water damage from a leaky pipe, examines when one applies the test. The insured’s property policy contained a section of “Losses Not Insured.” Among the losses not insured were latent defect or mechanical breakdown, corrosion, poor workmanship and design, and water damage, including continuous or repeated seepage or leakage of water or stream from a plumbing system. The court rejected the homeowner’s contention that the efficient proximate cause test provided coverage because the primary culprip was contractor negligence. Invoking the California


203 The public policy argument was really more of a lack of a public policy need to keep the waiver in place for post-construction damage. The court noted that the waivers made sense during construction because they eliminate the disruption to construction activities that would result if losses during that time were subject to litigation. This policy no longer applied once the project was complete. See Hartford Underwriters Ins. Co. v. Phoebus, 979 A.2d 299, 311 (Md. Ct. App. 2009).

204 Empire Indem. Ins. Co. v. Winsett, 325 Fed. Appx. 849, 2009 WL 1178516 (C.A. 11 (Fla.) May 4, 2009) (policy language which excluded coverage for mold “regardless of whether any other cause, event, material or product contributed concurrently or in any sequence to such injury or damage,” excluded application of Florida’s efficient proximate cause doctrine to mold claims suffered by insured); Arctic Slope Regional Corp. v. Affiliated FM Ins. Co., 564 F.3d 707 (5th Cir. 2009) (policy’s anti-concurrent cause clause was not ambiguous but provided that the hurricane storm surge, whether driven by wind or not, was not covered by the policy).

Supreme Court’s decision in Julian v. Hartford Underwriters Ins. Co.,\textsuperscript{206} the court declined to engage in an efficient proximate cause analysis:

\textit{Julian} applies straightforwardly here. The third-party negligence provisions of the Freedmans' policy exclude third parties' negligent conduct and defective workmanship whenever they interact with an excluded peril, just as the Julians' policy excluded weather conditions whenever they interacted with an excluded peril. Corrosion and continuous or repeated seepage or leakage of water are excluded perils under the Freedmans' policy, just as earth movement was excluded under the Julians' policy. Thus, the Freedmans' policy excludes contractor-negligence-induced corrosion and contractor-negligence-induced continuous or repeated seepage or leakage of water, just as the Julians' policy excluded a rain-induced landslide. The Freedmans have introduced no evidence that contractor negligence caused their loss in any way apart from the nail's role in triggering corrosion and a water leak, just as the Julians introduced no evidence that weather conditions caused their loss in any way apart from rain's role in triggering a landslide. Accordingly, the Freedmans' loss is not covered, just as the Julians' loss was not covered.\textsuperscript{207}

\textbf{B. Deductibles}

Property policies may have a number of different deductibles or self-insured retentions (SIRs) that apply to various types of loss or categories of property. Issues can arise as to how to calculate deductible amounts and how to apply any deductibles. For example, in Demers Bros. Trucking, Inc. v. Certain Underwriters as Lloyd’s,\textsuperscript{208} the insured suffered a fire loss to contents in a storage building it rented in Massachusetts. A number of different coverage issues arose, including how to apply the policy deductible. The insurer applied the deductible to the real and personal property sublimit and essentially lessened the amount of coverage available; whereas the insured applied it to the aggregate amount of its claims which exceeded the sublimit and therefore resulted in no reduction in recovery. The court agreed with the insured:

In their Motion, the Insured assert that the Insurer improperly reduced the Real and Personal Property sublimit by the $2,500 Policy deductible. The Policy states that the $2,500 deductible applies “per ‘Occurrence,’” and the Policy defines “Occurrence” as “any one ‘loss’, disaster, casualty or series of losses, disasters, or casualties, arising out of one event.” This means that the deductible applies to the top of the Insured's aggregate claims rather than the top of the Real and Personal Property sublimit. Given that the Insurer has not opposed this portion of the Insured's Motion and it is reasonably apparent that the Insured’s aggregate claims exceed $1,022,500 (the $1,020,000 Real and Personal Property sublimit plus the $2,500 deductible), the Insured are entitled to recover the $2,500 deductible.\textsuperscript{209}

C. Limits of Coverage

The CGL policy typically has a few specified limits of coverage – a per-occurrence and aggregate limit, as well as a limit for product/completed operations coverage. While there may be additional limits of coverage in any given CGL policy, as a general rule the number and types of limits and sublimits are quite finite. This is not necessary the case with property policies. In addition to an aggregate limit, these policies often have sublimits based on types of loss (e.g., flood), specific property (e.g., personal property), and specific coverages (e.g., time element coverages). The limits may not necessarily take the form of a dollar amount but, particularly in the case of time element coverages, they may be expressed in terms of time. As one might expect, the more complexity one incorporates into policy language with respect to limits of coverage, the greater the possibility that dispute may arise with respect to meaning and application.

Such was the case in Six Flags, Inc. v. Westchester Surplus Lines Ins. Co.,\(^{210}\) where an amusement park owner incurred substantial loss due to Hurricane Katrina. The severity of the loss implicated the insured’s primary and excess policies. The policies contained a flood sublimit. Most of the policies subsumed within the definition of “flood” loss or damage caused by flood including all covered loss or damage to covered property resulting directly or indirectly from flood. One of the excess policies, however, replaced the definition of flood in an endorsement which carved out from the flood sublimit loss resulting from, contributed to or aggravated by a “flood” caused by a peril not otherwise excluded under the policy.\(^{211}\)

The policies also lumped together all loss within a 72-hour window resulting from a single event into an occurrence – known as a Weather Cat Occurrence. The insured argued that, because Katrina was a named storm and therefore fell within the Weather Cat Occurrence provision, it was not subject to the flood sublimit. The Fifth Circuit disagreed with respect to all but one of the excess policies:

The relevant definition here is that of the Weather Cat Occurrence. A Weather Cat Occurrence is all loss occurring during a 72-hour period caused by or resulting from, \textit{inter alia}, flood, wind, hail, sleet, tornadoes, hurricane, or lightning, associated with or occurring in conjunction with a storm or weather disturbance named by the National Weather Service. Because “flood” is a weather phenomenon within the Weather Cat Occurrence, the flood sublimit applies one time per such occurrence to limit loss and damage as respects that flood. It is undisputed that the Six Flags New Orleans Theme Park is located in an area designated as Flood Zone A and that Hurricane Katrina was a Named Storm. Thus, the flood sublimit applies to limit the non-Commonwealth Excess Insurers’ liability at $2.5 million over the primary-layer insurer’s $25 million policy limit for loss or damage resulting from flooding caused by, associated with, or occurring in conjunction with Hurricane Katrina.\(^{212}\)

The analysis was different, however, for the Commonwealth excess policy that changed the definition of “flood”:

\(^{210}\) Six Flags, Inc. v. Westchester Surplus Lines Ins. Co., 565 F.3d 948 (5th Cir. 2009).
\(^{211}\) Six Flags, Inc. v. Westchester Surplus Lines Ins. Co., 565 F.3d 948, 952 (5th Cir. 2009).
\(^{212}\) Six Flags, Inc. v. Westchester Surplus Lines Ins. Co., 565 F.3d 948, 956 (5th Cir. 2009).
We conclude that the Commonwealth Flood definition endorsement creates an ambiguity in the Commonwealth policy. . . . One reasonable interpretation of the endorsement, when considered with the entire Commonwealth policy, is that loss resulting from a flood caused by a peril (such as a Named Storm) is not subject to the flood sublimit. The excess insurers do not dispute that Hurricane Katrina was a Named Storm and cannot (at least at this time) dispute that Hurricane Katrina caused the flooding at issue here. Thus, under this interpretation, the flood sublimit would not apply to the loss resulting from the flood at the Six Flags New Orleans Theme Park caused by Hurricane Katrina.\textsuperscript{215}

D. Debris Removal

When a building burns down or collapses, inevitably there is debris that needs to be removed from the site and disposed of in an appropriate manner. Depending upon the amount and nature of the debris, this can be quite expensive. Property policies often handle the cost of debris removal by making it an additional coverage subject to separate limits. This was the case in \textit{Whitt Mach., Inc. v. Essex Ins. Co.},\textsuperscript{214} where fire destroyed the insured’s building and, as a consequence, the insured incurred more than $200,000 to remove debris and cleanup and remove asbestos from the building. The insurer refused to cover the insured’s asbestos removal costs and declined to pay more than $10,000 for debris removal.

The policy provided for debris removal as an additional coverage. The amount afforded was limited to twenty-five percent of the amount the insurer paid for the direct physical loss of damage to covered property plus the deductible applicable to that loss or damage. In the policy’s “limits of insurance” provision, however, if the direct physical loss exceeds the limit of insurance or debris removal exceeds the twenty-five percent limitation under the Debris Removal Additional Coverage, the insurer will pay up to an additional $10,000 for each location in any one occurrence under the Debris Removal Additional Coverage.\textsuperscript{215}

The court agreed with the insurer that debris removal was limited by the policy’s total limits of coverage:

The Court also agrees with defendant that the policy’s limits of insurance provision applies to the debris removal additional coverage provision. Thus, while it is true the policy requires payment of 25\% of the amount paid for direct physical loss to covered property plus the deductible applicable to that loss or damage. In the policy’s “limits of insurance” provision, however, if the direct physical loss exceeds the limit of insurance or debris removal exceeds the twenty-five percent limitation under the Debris Removal Additional Coverage, the insurer will pay up to an additional $10,000 for each location in any one occurrence under the Debris Removal Additional Coverage.\textsuperscript{215} The plain and unambiguous language of the Policy limits plaintiff’s recovery to $600,000. The only exception is a provision for $10,000 in the event debris removal expenses exceed the Policy’s $600,000 limit. . . . The plain and unambiguous language of the Policy limits plaintiff’s recovery to $600,000. The only exception is a provision for $10,000 in the event debris removal expenses exceed the Policy’s $600,000 limit. It is uncontested that defendant paid the $600,000 policy limit and has attempted to pay $10,000 under the Debris Removal Additional Coverage provision. Plaintiff now seeks to recover over and above the obligations of the Policy.\textsuperscript{216}

\textsuperscript{213} \textit{Six Flags, Inc. v. Westchester Surplus Lines Ins. Co.}, 565 F.3d 948, 959 (5th Cir. 2009).


E. Testing and Commissioning Coverage

The testing and commissioning process can present unique risks to a property carrier, particularly where the project involves a great deal of process machinery. Some property policies specifically address the testing and commissioning process. In Slattery Skanska, Inc. v. Am. Home Assurance Co., the builder's risk policy covered the construction of a light rail transit system located at JFK International Airport in Queens, New York. The builder's risk policy provided testing and commissioning coverage. As part of this coverage, the policy contained the following language:

The Insured warrants that supervisory or safety systems shall not be deliberately circumvented during such [testing and commissioning]. But the Company shall not withhold coverage where it can be reasonably show[n] that the management or supervisory staff was not aware of such situations.

During the testing operations, the light rail system’s design/builder disabled the speed governors on two trains. During the second round of testing, one of the trains accelerated to approximately 58 miles per hour, entered a curved portion of the guideway with a speed limit of 25 miles per hour, and derailed. The train was severely damaged as well as 150 feet of parapet wall. More tragically, although not the subject of the builder's risk dispute, the train operator died in the crash.

The coverage question boiled down to whether recovery was conditioned upon the maintenance of safety procedures and, by deactivating the speed governors, had the insured breached the safety precaution warranty. The court held for the insurer:

[W]e find there is no question that Bombardier deliberately circumvented “safety systems” within the meaning of the policy. Not only is it undisputed that Bombardier deliberately disconnected a wire in the drive control panel in order to disengage the speed governor, but it is also undisputed Bombardier disregarded the procedure for waiving specific operating constraints.

Here, although the term “circumvent” is not specifically defined in the policy, the lack of a definition does not, in and of itself, mean that the word must be ambiguous. Bombardier argues that the term “circumvent” means “to get the better of or prevent from happening by craft of ingenuity.” That, of course, is not the only meaning of “circumvent.” Indeed, AHA cites another dictionary definition of “circumvent” that is, “to bypass.” Bombardier’s definition of “circumvent” is not only nonsensical when viewed within the parameters of the dispute but reduces the section to a nullity, giving it no comprehensible meaning at all. In context, there can be no question that the plain meaning of circumvent intended by the policy is to bypass or avoid.

Similarly, the phrase “safety system,” also undefined in the policy, is unambiguous. Construing the phrase according to common usage, a “safety system” implies a combination of parts forming a unitary whole that is designed to prevent danger, risk or injury. The record clearly reflects that Bombardier’s “safety system” consisted of various component parts including but not limited to: (1) the waiver of operating constraints and (2) a train operating in ATC mode without a driver on board or a train

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operating in manual mode with a properly trained driver on board with the speed governor engaged. In other words, these “parts” combined to form a unitary whole that was designed to prevent danger, risk or injury. Even Bombardier’s driving trainer testified that a speed governor was part of the train’s “overall safety system.” . . .

It is clear that an insurance company issues a policy pursuant to a calculated risk. Here, AHA entered the agreement with the bargained-for expectation that Bombardier would not “deliberately circumvent” any “supervisory or safety systems” during the testing and commissioning process.219

F. Business Interruption Coverage

Business interruption insurance is an additional coverage that can be added to a property policy. The coverage is intended to respond to an insured’s business losses resulting from a covered loss under the property policy. As such, business interruption coverage is often written so that direct physical damage to covered property by a covered cause of loss is a requirement to recover business losses. For example, in Yount v. Lafayette Ins. Co.,220 a medical office in New Orleans was damaged by Hurricane Katrina. The insurer cited the lack of “direct physical loss” from a “covered peril” in denying the business interruption claim. Flood was an excluded peril, and the insurer took the position that all the insured’s losses, including business losses, were related to the flood waters.

A jury trial was conducted on the matter and, after the close of evidence, the trial judge granted directed verdict in favor of the insured, finding that there was sufficient evidence to establish direct physical damage caused by wind, which resulted in mold, and that there was coverage under the policy for such. While the Court of Appeals disagreed with the trial court’s granting of a directed verdict, in considering the matter de novo, it also concluded that the insured had established entitlement to business interruption coverage:

We conclude that the suite did sustain direct physical loss and damage as a result of the wind and rain, and not due to direct contact with flood waters. Further, we find these losses and damages, alone, would have and did cause a suspension in operation of Dr. Yount’s medical practice.

Dr. Yount paid the premium for the additional coverage for “business interruption” for the term of the policy. The general purpose of such insurance is to protect the earnings which the insured would have enjoyed had no interruption or suspension occurred. Generally, a business interruption is a temporary cessation or impairment of the operations of an established business. Dr. Yount sustained her burden of proving by a preponderance of the evidence direct physical damage to her property in the leased suite sufficient to impair and suspend the operation of her medical practice. For these reasons, we find an award of insurance proceeds under the business interruption coverage of the policy to be appropriate under the facts.221

G. Service Interruption Coverage

Another additional coverage sometimes added to a property policy is service interruption coverage. This coverage is intended to protect against business losses due to disruptions in utility service. In order for coverage to attach, however, a number of conditions must be satisfied, such as the requirement that the interruption be caused by physical damage to specified electrical equipment and property located away from the insured’s property. At least that was the condition for coverage in *Wakefern Food Corp. v. Liberty Mutual Fire Ins. Co.* 222 where a grocer sustained damage in the nature of spoiled food and business interruption a four-day electrical blackout. On August 14, 2003, problems with the interconnected North American power system (the “electrical grid”) resulted in a four-day electrical blackout over much of the Northeastern United States and Eastern Canada. The insurer denied coverage on the ground that the utility interruption had not been caused by physical damage to off-premises electrical plant and equipment. It contended that, although the power grid was physically incapable of supplying power for four day, it suffered no “physical damage” and therefore there was no coverage. According to the insurer’s expert, a cascading outage or blackout occurs when an interconnection becomes unstable because of inadequate generation capacity, transition-line failure, or other abnormalities. Because of the instability and imbalance that results from such abnormal events in one part of the interconnection, “protection systems” operate to prevent physical damage to very expensive generators and transmission lines throughout the rest of interconnection. The insured’s expert disagreed, concluding that physical damage to generating and transmission equipment did occur. The court, for its part, determined that the undefined term “physical damage” was ambiguous, and that the trial court construed it too narrowly in favor of the insurer and inconsistent with the reasonable expectations of the insured. In the court’s view:

[T]he electrical grid was “physically damaged” because, due to a physical incident or series of incidents, the grid and its component generators and transmission lines were physically incapable of performing their essential function of providing electricity. There is also undisputed evidence that the grid is an interconnected system and that, at least in some areas, the power could not be turned back on until assorted individual pieces of damaged equipment were replaced. However, we do not rest our decision on that evidence. Rather, we look to the larger picture concerning the loss of function of the system as a whole.

We recognize that, to some extent, the blackout was caused by a combination of fortuitous events, together with the operation of safety features built into the system to insure that the essential elements of the grid could not be severely damaged. However, in concluding that the term “physical damage” is ambiguous, we consider the context, including the identity of the parties. These are not two electric utilities contracting about the technical aspects of the grid. Rather, the parties are an insurance company, in the business of covering risks, and a group of supermarkets that paid for what they believed was protection against a very serious risk – the loss of electric power to refrigerate their food. The average policy holder in plaintiffs’ position would not be expected to understand the arcane functioning of the power grid, or the narrowly-parsed definition of “physical damage” which the insurer urges us to adopt. In this context, we conclude that

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if Liberty intended that its policy would provide no coverage for an electrical blackout, it was obligated to define its policy exclusion more clearly.\footnote{Wakefern Food Corp. v. Liberty Mutual Fire Ins. Co., 968 A.2d 724, 734-35 (N.J. Super. 2009).}

\section*{H. Increased Cost of Construction Coverage}

Property policies often exclude losses in the form of additional costs an insured must spend to repair or replace damaged property due to the operation of a law or ordinance. The ordinance frequently involved is a building code. A structure that has existed for quite some time is quite likely out-of-date from the perspective of current building codes. If the damage is extensive enough, however, the insured must rebuild or replace according to current code and, as a consequence, the gap between what is recoverable under the policy and the cost associated with rebuilding can be substantial.\footnote{On occasion, but rather infrequently, courts will address this situation from the standpoint of equity and apply what has become known as the “constructive total loss doctrine.” This doctrine finds support in value policy cases involving local ordinances. \textit{See} Hart v. N. British & Mercantile Ins. Co., 162 So. 177 (La. 1935); Palatine Ins. Co. v. Nunn, 55 So. 44 (Miss. 1911). Courts have applied the doctrine and held that repair damages are inadequate when a local law prevents an insured from repairing a damaged structure. Under the “constructive total loss doctrine,” as a matter of equity, the insured is not required to absorb the compliance cost. \textit{See generally,} Scott Edwards, “The Wind and Waves: The Evolution of Florida Property Insurance Law in Response to Multiple-Causation Hurricane Damage,” 34 Fla. St. U. L. Rev. 541, 543-46 (2007). In \textit{Monistere v. State Farm Fire & Cas. Co.}, 559 F.3d 390 (5th Cir. 2009), the “constructive total loss doctrine” was rejected in the context of a standard flood insurance policy issued under federal law. The District Court had applied the doctrine to permit a homeowner to recover greater policy benefits due to a need to build at a higher elevation as a result of Hurricane Katrina. The Fifth Circuit reversed on grounds that the “constructive total loss doctrine” was limited to value policies and the flood policy in question was not a “value policy.” \textit{See} 44 C.F.R. pt. 61, App. A(1), art. II(B)(28).}

One way of addressing this is to purchase an endorsement that provides coverage for compliance with applicable laws and ordinances. Such coverage was at issue in the Tenth Circuit’s decision in \textit{Markwest Hydrocarbon, Inc. v. Liberty Mut. Ins. Co.},\footnote{MarkWest Hydrocarbon, Inc. v. Liberty Mut. Ins. Co., 558 F.3d 1184 (10th Cir. 2009).} where an explosion in a natural liquid gas pipeline caught the attention of the U.S. Office of Pipeline Safety (OPS). OPS ordered the insured to conduct a series of tests on its pipeline, and to repair “integrity threatening conditions” discovered in the course of those tests. The OPS issued a number of Corrective Action Orders (CAOs) requiring the insured to take a number of corrective actions to protect the public. These tests included hydrostatic pressure testing of the affected pipeline segment.

The insured made a claim under its property policy. The policy contained a Demolition and Cost of Construction Endorsement providing up to $5 million in coverage for specified losses resulting from enforcement of laws and ordinances regulating the “construction or repair” of damaged property.\footnote{The endorsement, in pertinent part, stated:

\begin{quote}
In the event of loss or damage by an insured peril under this policy that causes the enforcement or any law or ordinance regulating the construction repair [of] damaged facilities, underwriter shall be liable for: . . .

\textbf{C. Increased costs of repair or reconstruction of the damaged and undamaged facility on the same or another site and limited to the minimum requirements of such law or ordinance regulating the repair or reconstruction of the damaged property on the same site. However, the Company shall not be liable for any increased cost of construction loss unless the damaged facility is actually rebuilt or replaced.}
\end{quote} 

\textit{44 C.F.R. pt. 61, App. A(1), art. II(B)(28).}}
insured sought to recover the costs associated with complying with the COAs under the Demolition and Cost of Construction Endorsement.

The Tenth Circuit, affirming the trial court, concluded that coverage was not afforded under the endorsement. The endorsement only applied to increased costs of construction due to laws or ordinances regulating the repair or reconstruction of the damaged property. The CAOs did not meet this test:

For MarkWest’s losses to be covered by the endorsement, the OPS’s directives at issue still must “regulat[e] the construction or repair of damaged facilities.” They do not. Under Colorado law an insurance policy must be given effect according to the plain and ordinary meaning of its terms. We begin, then, by considering whether the CAO and amendments “regulat[e] the construction or repair of damaged facilities.” The plain meaning of the word “construction” denotes “forming” or “building.” But the CAO and its amendments did not require MarkWest to form, build, or “construct” anything. OPS required only that MarkWest test and take remedial actions to maintain the safety of a pipeline constructed over a half-century ago, in 1957.

Neither did the CAO or its amendments require the repair of damaged facilities. The endorsement specifies that the coverage only “[i]n the event of loss or damage by an insured peril . . . that causes the enforcement of any law or ordinance regulating the construction or repair [of] damaged facilities. . . . Moreover, in defining the extent of liabilities covered, the endorsement refers to the law or ordinances insured against as those “regulating the repair or reconstruction of the damaged property.” By the contract’s plain terms, then, only laws or ordinances regulating “property” or “facilities” that have been damaged by an insured peril are covered.

Even assuming that the Ivel accident was caused by an insured peril (a valve failure), by everyone’s admission the insured peril damaged, at most, only a small stretch of the pipeline (causing less than $250,000 in damage to that section). And the CAOs did not seek to tell MarkWest whether and how to repair this small stretch of pipeline. OPS was hardly concerned with telling MarkWest how to repair a broken valve stem, or how to repair the broken bits of the pipeline in Ivel. That was yesterday’s problem; OPS was concerned about preventing tomorrow’s. So the CAOs did not dictate a minor fix to a specific valve or pipeline segment in Ivel, but instead sought to insure the safe operation, going forward, of the entire 65-mile pipeline. . . . To read the policy as covering MarkWest’s costs of complying with safety regulations would be to convert the parties’ policy against unforeseen fortuities into a maintenance contract. The insurance companies would be responsible for MarkWest’s costs in testing the entire stretch of pipeline for any “integrity threatening” conditions – including normal wear and tear – and then repairing those conditions. A pipeline operator could run the least-safe, least-modern, and least well-run pipeline in the country, a pipeline in violation of every regulation in the books. Yet, under MarkWest’s reading of the contract, if an accident

D. Any increase [] in the Business Interruption and extra expense loss arising out of the additional time required to comply with state law or ordinance.

*MarkWest Hydrocarbon, Inc. v. Liberty Mut. Ins. Co.*, 558 F.3d 1184, 1188 (10th Cir. 2009).
exposed these problems to the OPS, the insurers would be on the hook for repairing and modernizing the entire pipeline.\(^{227}\)

An insured had more luck with this coverage in \textit{DEB Assocs. v. Greater New York Mut. Ins. Co.},\(^{228}\) where a windstorm sheared off most of the brick façade at the seventh floor of an eight-story office building in Cherry Hill, New Jersey. Local code officials discovered that the walls had been secured to the concrete flooring with mortar, but not steel fasteners known as “angle irons.” This condition was discovered to exist throughout the entire building. The building was ordered vacated and, as a condition of re-occupancy, angle irons were required to be installed so the building would comply with current construction code. These repairs cost more than a half-million dollars.

The property owner’s insurer agreed to pay for the repairs to the seventh floor, but refused to cover the cost of installing angle irons throughout the building. The dispute centered upon the increased cost of construction coverage which provided:

If a Covered Causes Of Loss occurs to the covered Building property, we will pay for the increased cost to:

(1) repair or reconstruct damaged portions of that Building property; and/or

(2) reconstruct or remodel undamaged portions of that Building property whether or not demolition is required

When the increased cost is a consequence of enforcement of building, zoning or land use ordinance or law.\(^{229}\)

The insurer contended that this section of the policy did not apply, as there was insufficient direct connection between the wind to the seventh floor and the code official’s direction that the plaintiff make repairs to the rest of the structure. The court did not buy this argument. Nor did it buy the insured’s claim that coverage under this section of the policy exists so long as a covered cause of loss (e.g., wind) occurs and the insured thereafter incurs increased costs of construction as a consequence of building code enforcement.\(^{230}\) While the proper interpretation of the policy language and application to the facts in this case fell somewhere between the parties’ contentions, it fell on the side of the line favoring coverage:


\(^{230}\) In the words of the court:

\textit{[W]e conclude that GNY’s [insurer] proposed construction of its policy language is unduly narrow and inconsistent with what a reasonable insured would expect. On the other hand, we reject plaintiff’s argument insofar as it would require coverage with no proximate connection between the damage and the required improvements to the undamaged portions of the structure.}

We agree with plaintiff that there is a clear causal connection between the collapse of the seventh floor wall and the code official’s mandate that plaintiff bring the remaining floors into compliance to prevent them from collapsing. Our courts have adopted the proximate cause test for determining:

Where a peril specifically insured against sets other causes in motion which, in an unbroken sequence and connection between the act and the final loss, produce the result for which recovery is sought, the insured peril is regarded as the proximate cause of the entire loss. . . . We need not decide here the precise outer reaches of coverage under the clause at issue. . . . [T]his was not a case in which the local inspector happened to be in the building because of the wall collapse and fortuitously discovered one or more unrelated code problems. This was a direct connection between the covered damage and the additional work required to the building. . . .

The language of the policy itself also supports our conclusion that there is coverage here. In this case, the policy explicitly precluded pre-existing code violations which the insured had failed to correct. However, the policy did not specifically exclude situations where, as here, a covered structure was grandfathered under the current code but lost its grandfathered status because of the occurrence of covered damage.231

I. Exclusions

Like liability policies, property policies also contain exclusions. In keeping with the less standard nature of property coverage, the exclusions exhibit a bit more variety than one usually encounters with liability policies. Nevertheless, there are certain common exclusions, one of which is of particular interest to those in the construction industry – the faulty design and construction exclusion. Other common exclusions include pollution, earth movement, and flood.

1. Faulty workmanship exclusion

As with CGL policies, property policies also typically exclude faulty design and workmanship from coverage. The wording and operation of this exclusion, however, differs from its liability cousin. One common version reads:

We will not pay for loss or damage caused by or resulting from any of the following: . . .

Negligent work;

Faulty, inadequate or defective:

(1) Planning, zoning, development, surveying, siting;

(2) Design, specifications, workmanship, repair, construction, renovation, remodeling, grading, compaction;

(3) Materials used in repair, construction, renovation or remodeling; or

(4) Maintenance;

At part or all of any property on or off the described premises.\textsuperscript{232}

This exclusion is frequently coupled with an “ensuing loss” exception, a common variant of which reads:

However, in the event an excluded cause of loss [such as the faulty workmanship exclusion] results in a Covered Causes Of Loss, the Company will be liable only for such resulting loss or damage.

Courts have struggled with applying the ensuing loss exception in the context of property coverage. For example, in \textit{Eckstein v. Cincinnati Ins. Co.},\textsuperscript{233} an insured’s home experienced water damage due to a variety of construction-related problems. The water damage ultimately resulted in the house becoming contaminated with toxic mold. The home became uninhabitable and the insureds were forced to live in temporary housing for nearly two years. The insureds’ expert determined that the mold damage was caused by massive amounts of water which entered the house and destroyed walls and related structures. The court determined that the water damage and the resulting mold were ensuing losses. It differentiated between the cost of repairing the water damage and resulting mold and the cost of repairing the faulty construction. Because the water and mold damage “ensued,” and was separate from the faulty construction, it was a separate and covered loss. Nevertheless, the cost of re-doing the faulty construction, \textit{i.e.}, repairing the roof, was excluded.

By contrast, the Minnesota decision in \textit{Bloom v. Western Nat’l Mut. Ins. Co.},\textsuperscript{234} presents a different conclusion based upon very similar facts. Once again, a home is damaged by water as a result of infiltration through its exterior envelope. The cause of the water was the failure to properly install windows and inadequate flashing. Water intrusion, like in the \textit{Eckstein} case, led to mold growth.

The policy contained a faulty workmanship exclusion.\textsuperscript{235} The policy also contained the following ensuing loss provision:

\begin{enumerate}
\item Errors, omissions, and defects – we do not pay for loss which results from one or more of the following:
  \begin{enumerate}
  \item An act, error, or omission (negligent or not) relating to . . .
    \begin{enumerate}
    \item the design, specification, construction, workmanship or installation of property; . . .
    \end{enumerate}
  \item A defect, a weakness, the inadequacy, the fault, or unsoundness of materials used in construction or repair, whether or not off the “insured premises”;
  \end{enumerate}
\end{enumerate}
We do not pay for loss if one or more of the following exclusions apply to the loss. However, we do pay for an ensuing loss that is otherwise covered by this policy.  

In concluding that the ensuing loss provision did not result in coverage, the court held:

Western argues that the ensuing-loss clause does not create or provide coverage for an otherwise excluded loss. It argues that the district court was wrong to find that the Blooms’ damages were covered under the ensuing-loss clause because the Blooms’ damages were not “otherwise covered” as required by the clause. Western argues that any ensuing loss was specifically excluded by both the defective construction and the rot-and-mold exclusions. Western also argues that because the rot and mold is inseparable from any resulting damage that is otherwise excluded under the policy, the rot and mold is not an ensuing loss and therefore not covered. We agree. . . . We conclude that the Blooms’ damage caused by mold and rot is not covered as an ensuing loss. Unlike Sentinel [563 N.W.2d 296], in which this court concluded that the release of the asbestos fibers in the building was a separable and distinct peril from regular wear and tear, the mold and rot here are not separable and distinct perils. The mold resulted from water that entered into the home through the faulty installation and workmanship of the contractor. In order for mold and rot to take hold and cause injury, water or moisture must be present. Without the faulty installation and workmanship, as indicated by the expert investigation, the water and moisture should not have entered the Blooms’ home to produce mold and rot. The mold and rot was caused by water that entered the home, a direct result of faulty installation and workmanship. It is not a surprise that mold and rot were found due to water intrusion. Unlike Sentinel, the water intrusion and resulting rot and mold are a “single phenomenon.” There is no intervening cause other than time. . . . Accordingly we answer the certified question in the affirmative as follows: When water enters a home because of defective design, faulty workmanship, or faulty materials furnished in connection with construction or remodeling and causes damages, we conclude that the damages are excluded from coverage under either the “Errors, Omissions and Defects” or “Wear and Tear” exclusions.

2. Continuous seepage or leakage of water exclusion

This exclusion operated to exclude coverage in Montclaire Condos. Ass’n, Inc. v. Cnty. Ass’n Underwriters of Am., Inc.  where a unit in a condominium was badly damaged as a result of wastewater intrusion. It was determined that the wastewater entered the unit when a PVC pipe under the kitchen sink failed due to stress induced from a misalignment of the pipe. The pipe was installed over twenty years before the homeowners observed the damage. The insurer’s expert opined that the crack in the pipe likely

Except as provided under the Incidental Property Coverage for Collapse.


Bloom v. Western Nat’l Mut. Ins. Co., 2006 WL 1806415 at *4-5 (Minn. Ct. App. Sept. 19, 2006). The reasoning here is a challenge to follow. It is not entirely clear how the court views the operation of the “ensuing loss” exception. While it is understandable how it might conclude that mold is not covered if it is otherwise excluded under the policy, the water damage was not discussed and yet was likely a covered cause of loss.

started slowly and worsened over a period of time. The insured’s expert, however, testified that the
fracture of the PVC plumbing fixture did not occur in a gradual manner, but would have been an abrupt
collapse brought about when the load of the wall exceeded the tensile strength of the fixture. While PVC
fixtures are quite strong, they are brittle and fracture in abrupt manner. The court concluded that
coverage was excluded for at least three reasons: (1) the policy excludes coverage for cracking, bulging,
expanding, mold, rot, and fungi; (2) the policy excludes coverage for faulty, inadequate, defective or
negligent workmanship in construction; and (3) the policy excludes coverage for continuous or repeated
seepage or leakage of water. Moreover, coverage was not reinstated through the “collapse” provisions of
the policy as there was no evidence that the PVC pipe abruptly fell down or caved in.

3. Theft exclusion

One coverage available under property policies is for acts of vandalism. Yet, the vandalism
coverage is sometimes subject to a theft exclusion. To make matters even more complex, some policy
forms provide an exception to the theft exclusion for the breaking in and exiting of burglars. The
interplay of these three coverage elements was at issue in the Fifth Circuit’s decision of Certain
Underwriters at Lloyd’s, London v. Law, where commercial air-conditioning units were damaged when
copper from within the units was stolen. Unlike most property policy “causes of loss,” vandalism has a
certain intentionality to it. While a flood is a flood and, except perhaps for speculation as to the intentions
of a higher being, it doesn’t matter why a flood occurs. Vandalism, on the other hand, is an act of man. It
is usually interpreted as wanton destruction of property for no apparent purpose other than to create the
destruction. The destruction of property for another purpose such as theft, however, is not straightforward
“vandalism” but the destruction of property for a particular purpose – that being the theft of other
property. So the court reasoned when concluding that the theft exclusion applied to the vandalism
coverage. With respect to the “ingress/egress” exception, the court found it did not apply:

We interpret the language of the burglary ingress/egress exception to the theft exclusion
to mean that the insurer will only pay for collateral damage caused by the burglars’
attempt to gain access to the interior of the building, as commonly understood. . . . The
definitions make clear that “breaking in or exiting” requires bodily intrusion into the
interior of the building. The thieves in this case sought no bodily passage into or out of
the building; they sought only the copper innards of free-standing exterior fixtures.
Although the thieves might have damaged a part of the building during the commission
of their crime, they did not do so while in the act of breaking into or exiting the building
itself. Indeed, the thieves never sought or gained access to the interior of the building
itself, i.e., they never became “burglars” vis-à-vis the building qua building.

4. Earth movement exclusion

The earth movement exclusion is a common feature of property policies. A common version
reads:

We will not insure loss from . . .

239 Certain Underwriters at Lloyd’s, London v. Law, 570 F.3d 574 (5th Cir. 2009).
240 Certain Underwriters at Lloyd’s, London v. Law, 570 F.3d 574, 581 (5th Cir. 2009).
Earth movement, meaning the sinking, rising, shifting, expanding or contracting of earth all whether combined with water or not. Earth movement includes but is not limited to earthquake, landslide, erosion and subsidence but does not include sinkhole collapse.

But if accidental direct physical loss by fire, explosion other than explosion of a volcano, theft or building glass breakage results, we will pay for that resulting loss.\textsuperscript{241}

The highest court of New York determined that this exclusion was ambiguous as it applied to loss in the form of cracks and separations in a building that resulted from excavation on an adjacent lot. As the court reasoned:

This case is a close one, but we cannot say that the event that caused plaintiffs loss was unambiguously excluded from the coverage of this policy. . . . The earth movement applies, defendant says, because the loss was caused by the movement of earth, and specifically by its “sinking” and “shifting” beneath plaintiff’s building. . . . Plaintiff argues, however, that a literal reading of the words does not give the meaning that an ordinary reader would assign to these exclusionary clauses. As to the earth movement exclusion, plaintiff stresses the examples of earth movement given in the policy – earthquake, landslide, erosion and subsidence. Plaintiff argues that an excavation – the intentional removal of earth by humans – is a different kind of event from an earthquake and the other examples given; plaintiff suggests that, when specific examples are mentioned, those not mentioned should be understood to be things of the same kind. Indeed, if the drafter of the policy intended to bring excavation – an obvious and common way of moving earth – within the exclusion, why was it not listed as an example while less common events were listed?\textsuperscript{242}

5. Shrinking and cracking exclusion

The shrinking and cracking exclusion is another common feature of property policies. A common version of which reads:

We do not insure loss from the following:

Settling, shrinking or expansion, including resultant cracking, of pavements, patios, foundations, walls, floors, roofs or ceilings.\textsuperscript{243}


\textsuperscript{242}Pioneer Towers Owners Ass’n v. State Farm Fire & Cas. Co., 12 N.Y.3d 302, 307-08, 908 N.E.2d 875, 877, 880 N.Y.S.2d 885, 887 (N.Y. 2009). The court also determined that the settling or cracking exclusion was also ambiguous. In the insurer’s view, this exclusion applied because the loss consisted of cracking that was directly or immediately caused by the settling of the building. The plaintiff argued, however, that the settling or cracking exclusion would not be thought, by the ordinary reader, to apply to settling or cracking that is the immediate and obvious result of some other event, such as the intentional removal of earth in the vicinity of the building. Read literally, the exclusion would apply, for example, where a refrigerator fell over and cracked a wall, but that can hardly been the intent of the policy’s drafters.

This exclusion operated to eliminate coverage for damage to a driveway as the result of expansion and contraction. The insured attempted to avoid the operation of the exclusion by arguing that the cause of the damage was the shrinking and expanding of the pavement or concrete slabs in the municipal street adjoining the insured’s property. The court was unconvinced:

The Policy explicitly excludes from coverage loss caused by “[s]ettling, shrinking, bulging or expansion, including resulting cracking, of pavements, patios, foundations, walls, floors, roofs or ceilings.” The exclusions contained in the Policy excludes coverage in this matter. The Policy excludes coverage for shrinking or expansion of pavement, which is the cause of the plaintiffs’ damage, as alleged by the plaintiffs. Whether the damage was caused by the failure of the plaintiffs’ driveway to expand into the street or the encroachment of the street into the plaintiffs’ property makes no apparent different under the terms of the insurance contract.\(^{244}\)

By contrast, the New York Court of Appeals concluded that the shrinking and cracking exclusion was ambiguous when applied to such damages caused by excavation activities on an adjacent lot. In *Pioneer Towers Owners Ass’n v. State Farm Fire & Cas. Co.*,\(^{245}\) the court found the exclusion ambiguous and construed it against the insurer:

\[T\]he shrinking or cracking exclusion applies, in defendant’s view, because the loss consisted of cracking that was directly and immediately caused by the settling of the building (which was in turn caused by the excavation). Indeed, plaintiffs own engineer’s report says “that the left wing of the building . . . had settled . . . as evidenced by the cracking and lateral displacement of the structure.”

[\[P\]]laintiff argues that the settling or cracking exclusion would not be thought, by an ordinary reader, to apply to settling or cracking that is the immediate and obvious result of some other event, such as the intentional removal of earth in the vicinity of the building. Read literally, the exclusion would apply, for example, where a refrigerator fell over and cracked a wall, but that can hardly have been the intent of the policy’s drafters.

\[^{244}\] *Wurtele v. Cincinnati Ins. Co.*, 2009 WL 205057 at *4 (D. Neb. Jan. 27, 2009). The court also determined that the loss was excluded under the faulty workmanship exclusion. This exclusion expressly contemplated poor workmanship of property off of the insured premises, and, as such, the court determined it directly undermined the insureds’ argument that the exclusion didn’t apply because the cause of the damage was the adjoining street.

We conclude that both plaintiff's and defendant's readings of the clauses are reasonable. Our precedents require us to adopt the readings that narrow the exclusions and result in coverage.\textsuperscript{246}

6. Wind exclusion

Most property policies cover wind damage. But insureds in certain areas of the country, particularly those prone to hurricanes, can find wind coverage a challenge to secure. For example, in \textit{Great Am. Ins. Co. of N.Y. v. Lowry Dev., LLC},\textsuperscript{247} the insured was developing a condominium project in Gulfport, Mississippi. In 2004, it secured a builder's risk policy for the project. The policy contained no wind coverage. Instead, wind protection was purchased from the Mississippi Wind Pool.\textsuperscript{248}

The first phase of the project was completed without a hitch. Phase Two, however, was under construction when Hurricane Katrina struck. By that time, the Mississippi Wind Pool coverage had expired. The builder's risk policy, however, issued in connection with Phase Two, did not contain a wind exclusion. The insurer attributed this to a clerical mistake. The insurer caught its mistake in April 2004 – more than a year before the hurricane struck. It send a wind exclusion endorsement through its managing agent to the insured's agent. There was no change in premium and the insurance agent did not respond to the endorsement. When the policy was scheduled to expire in January 2005, the insured sought a renewal. The extension was granted, which took coverage into the time when Hurricane Katrina damaged the property.

The insurer denied coverage on grounds that the renewal policy included a wind exclusion endorsement. The court agreed:

Groves [insured's agent] received the April 2004 wind exclusion endorsement, which clearly stated that a wind exclusion was being added to the policy and asked Groves to read “and advise if there are any changes or corrections to be made.” Groves sent that April 2004 change to Lowry [insured]. We have already discussed that a notification given to an agent is notice to the principal, if the agent is so authorized. Groves was.

Therefore, even though the wind exclusion in the January 2005 renewal policy was not highlighted the change was the subject of the April 2004 letter. That put Groves and Lowry on notice at that time and at least required them to be aware that the renewal policy likely did not contain wind coverage. What this means is that even though the April 2004 wind exclusion endorsement may not have been adequate to modify the terms of the original policy because of the absence of consideration, it was sufficient to notify Lowry that, upon renewal, wind coverage would not be included.\textsuperscript{249}


\textsuperscript{247} \textit{Great Am. Ins. Co. of N.Y. v. Lowry Dev., LLC}, 576 F.3d 251 (5th Cir. 2009).

\textsuperscript{248} The Mississippi Wind Pool is a name commonly given to the Mississippi Wind Storm Underwriting Association. This entity was established by the Mississippi legislature in 1987 to provide a mandatory program to assure an adequate market for wind storm and hail insurance in the coastal area of Mississippi. \textit{See} Miss. Code Ann. §83-34-1.

\textsuperscript{249} \textit{Great Am. Ins. Co. of N.Y. v. Lowry Dev., LLC}, 576 F.3d 251, 258 (5th Cir. 2009).
J. Collapse

Property policies have treated the condition of collapse in many different and often conflicting ways. Some have treated it as a covered cause of loss, although it is much different than wind or fire as it is the end result of some infirmity rather than the cause of it. Others policies exclude collapse. While still others provide some coverage but with qualification. Moreover, there is little uniformity in how “collapse” is defined. Some jurisdictions require the complete “falling down” of the structure, while others find that the imminent threat of “collapse” is sufficient. The Second Circuit’s description of New York law on the question of “collapse” is illuminating:

New York law is unsettled as to the meaning of “collapse.” Citing a ruling of the New York Supreme Court, Appellate Division, 2d Department, Graffeo, 2 A.D.2d 643, 246 N.Y.S.2d 258, the District Court ruled that the term “collapse” in an insurance policy means “total or near total destruction” and is not satisfied by a condition of “substantial impairment of the structural integrity of a building.” The District Court recognized that a ruling of the Appellate Division, 3d Department, adopted a contrary view that “substantial impairment of the structural integrity” was sufficient to constitute collapse, and that total or near-total destruction was not required. See Royal Indem. Co. v. Grunberg, 155 A.D.2d 187, 553 N.Y.S.2d 527 (App. Div. 3d Dep’t 1990). The District Court, however, concluded that New York’s highest court had tacitly accepted the Graffeo court’s narrow definition of “collapse” by declining to grant a motion for leave to appeal from the 2d Department’s ruling in Graffeo.

This was a misunderstanding of the significance of the denial of a motion for leave to appeal an Appellate Division ruling. The District Court construed it as the equivalent of an affirmation of the lower court’s ruling. Refusal to review the lower court’s ruling has no such significance. The Court of Appeals recently reiterated that denial of a motion for leave to appeal is not equivalent to an affirmation and has no precedential value.

The state of law in New York with respect to the meaning of the term “collapse” in such a policy is a conflict of Appellate Division rulings as to whether “substantial impairment of the structural integrity” suffices to come within the term, as held by the 3d Department in Grunberg or whether “total or near-total destruction” is required as held by the 2d Department in Graffeo.250

Perhaps because of the conflict in jurisdictions and the tendency of courts to find the term “collapse” ambiguous, many property policies exclude collapse from coverage and require an endorsement, often referred to as a Collapse Additional Coverage Endorsement, to provide this protection. A common form of the endorsement provides a detailed definition of what collapse means (an abrupt falling down or caving in of a building or any part of a building) and what it does not mean (a building in danger of falling down is not considered to be in a state of collapse). Such was the policy in Malbco Holdings, LLC v. Amco Ins. Co.,251 where a hotel underwent significant repairs due to the failure of a floor truss system that threatened a collapse and caused authorities to consider “red tagging” or shutting down the hotel until repairs were completed. Notwithstanding the fact that the policy defined the


term “collapse,” the parties disputed its meaning. More importantly, the court found the language “abrupt falling down or caving in” ambiguous and construed it against the insurer:

The Policy is not written in terms of how far a building must fall down or to what degree a building must cave in to constitute a collapse. Clearly one cannot occupy a building if it has completely fallen down or caved in. However, the same may be true for a building which has partially fallen down or caved in. It is far from clear that the Policy requires total destruction in order for a collapse to occur. Instead, the occupancy restriction stands as a proxy for a substantial impairment of integrity by adding a life and/or safety element to the definition. If parts of a building abruptly fall or cave in to any degree such that they cannot be occupied for their intended purposes under subsection (a) [defining collapse as an “abrupt falling down or caving in of a building or any part of a building, with the result that the building or part of a building cannot be occupied for its intended purpose”], then a collapse has occurred.

Viewing subsection (a) in the context of the other three subsections does not change this analysis. Since Malbco claims that the Hotel collapsed when the trusses broke and portions of the building fell a few inches, it was not “in danger of falling down or caving in” as excluded under subsection (b). Instead, it collapsed. Furthermore, both subsections (c) and (d) exclude certain conditions from a state of “collapse” when a building is still “standing.” This implies that a building may still be “standing” yet still be “in a state of collapse.” And if “standing” is deemed to be the opposite of “collapse,” then it rests entirely on the definition of “collapse” as defined in subsection (a), rendering it ambiguous. 252

On the same day as the Oregon federal district court issued its opinion in Malbco, an Oregon Court of Appeals issued a decision interpreting “collapse” in Hennessy v. Mut. Of Enumclaw Ins. Co. 253 where a portion of a stucco wall had visibly separated from the building’s underlying wall. The policy provided collapse as an additional coverage. The policy language did not define the term “collapse” but conditioned the coverage on the collapse being caused by certain specified condition, such as “hidden decay.” As one might expect, the insured and insurer disputed whether the stucco condition constituted a “collapse.” Given that the policy did not define “collapse” but only stated what it did not mean (i.e., settling, cracking, shrinking, bulging, or expansion), the court did what courts so often do in these situations – it turned to a dictionary. This was not particularly helpful, as two of the definitions for the term supported the insurer and one supported the insured. Eventually the court struck a middle ground, finding the cost to repair the stucco that was actually separated from the underlying wall was covered, but the cost associated with repairing the remaining stucco was not covered. 254


K. Valuation

Property policies contain provisions that address how a property loss is to be valued and adjusted. Two common valuation approaches are: (1) actual cash value (ACV) method, and (2) replacement cost value (RCV) method. As a general rule, policies do not define these terms. Moreover, in order to recover replacement cost value (which is, in most cases, higher than actual value), most policies require the insured to make the repairs without advance funding from the insurer. Many insureds are unable to undertake repairs without insurance proceeds. This process can create hard feelings and result in disputes. The Indiana Court of Appeals decision in *Rockford Mut. Ins. Co. v. Pirtle*,255 is instructive. The insured owned a historic building that was damaged by fire. The insured purchased the building by obtaining a mortgage for $140,250. He rented the building out while restoring it. By early 1999, the historic building was valued at $165,000. After the fire, the insured made a claim under his policy and the independent adjuster hired by the insurer estimated the damage at $79,907.49. The insurer’s claim supervisor gave the adjuster authority to settle the claim for $80,000. The insured rejected the amount because it was not enough to satisfy the mortgage nor repair the building. The insured hired a contractor who estimated the damage at $232,915.

The insurer assigned a second claims supervisor to the matter who obtained authority to settle the claim for $193,000. The insurer offered $193,000 as reimbursement, but only if the insured first repaired the building. The insured hired a lawyer and received an offer from the insurer of $69,874.62, representing what the carrier considered to be the “actual cash value” of the building. The insured filed suit alleging, among other things, bad faith. The bad faith claim was dismissed when the insurer paid $86,146.66 for the building’s actual cash value, which the insured accepted while reserving the right to contest the actual cash value methodology used. At trial, the insurer was found to have breached its contract. The jury awarded $124,149.55 under the insurance policy and $406,136.58 in consequential damages for an aggregate award of $524,286.13. The case tumbled up to the Court of Appeals on the question of whether the insured was limited to actual cash value and, if so, what was that amount. The insurer contended that the policy required the insured to actually replace the structure in order to recover the actual replacement cost. If it did not, it was entitled to receive only actual cash value. The court was not terribly impressed with the argument, nor with the insurer’s behavior:

Here, Pirtle indicated to Rockford that he wanted his replacement costs paid. Rockford offered Pirtle $80,000 in January 2001, that was to “cash out” the insurance policy, meaning that would be all the money Pirtle would receive, even though the policy limit under Coverage A was $193,000. Pirtle refused this offer as there was no contractor who could repair the building for that amount. Nearly six months later in May 2001, only after the mortgage foreclosure process had started, and the property had been condemned by the city, did Rockford offer $69,874 with the balance of the $193,000 to be paid when the property was repaired. This was the first time Rockford made an actual cash value offer to Pirtle under 5(c)(4) [provision in policy addressing loss settlement process], and it came six months after the fire, at which time the property was already in jeopardy. At this point, Pirtle was in a very bad position to start any repairs. . . . It thus appears that Pirtle proceeded under provision 5(c)(4) of the insurance policy, which requires completion of repairs or replacement, but because of Rockford’s actions in handling Pirtle’s claim, specifically its actions in regards to the actual cash value payment, the jury excused the requirement, . . .

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We acknowledge that other courts, including our own Seventh Circuit, have held that the contract must be strictly construed to require the completion of the repair or replacement before liability under the replacement cost endorsement attaches. However, we are convinced that equitable principles win the day in this situation; otherwise, the repair or replacement endorsement paid for by Pirtle would be rendered illusory. Rockford had the ability to advance sums of money under that endorsement to assist in commencement of the rebuilding and could have joined Pirtle in agreements entered into for repairs.\footnote{Rockford Mut. Ins. Co. v. Pirtle, 911 N.E.2d 60, 66-67 (Ind. Ct. App. 2009) (citations omitted, emphasis in original). The court also affirmed the jury’s award of consequential damages against the insurer, finding that they flowed naturally and probably from the carrier’s breach of the policy. \textit{But see Gellman v. Cincinnati Ins. Co.}, 602 F. Supp. 2d 705, 708 (W.D.N.C. 2009) (requiring insured to repair property to obtain replacement cost and noting “in ‘actual cash value’ policies, an insurer is obligated to pay to a policy holder who suffers a covered loss the depreciated value of the insured item – its actual cash value at the time of the loss. In this scenario, an insured is made less than whole because he cannot avoid suffering the economic loss of depreciation of the asset. Insurance companies began to essentially insure against the depreciation loss by writing replacement value policies which obligate the company to pay for the repair or replacement of the damaged property to its pre-loss condition. This obviously leads to the policy holder receiving a better asset than he had before the loss. For example, a depreciated carpet in a fire-damaged building will be replaced with new carpet. However, replacement cost coverage does not take effect until the lost or damaged property is actually repaired or replaced.”)}

Actual cash value disputes have blossomed into class actions in New Orleans in the aftermath of Hurricane Katrina. In \textit{Press v. Louisiana Citizens Fair Plan Prop. Ins. Corp.},\footnote{Press v. Louisiana Citizens Fair Plan Prop. Ins. Corp., 12 So.3d 292 (La. Ct. App. 4 Cir. 2009).} dissatisfaction over how an insurer calculated actual cash value led to the filing of a class action. Plaintiffs claimed that the insurer failed to pay general contractor overhead and profit (GCOP) as part of actual cash value. Historically, the insurer paid for anticipated coordination and supervision of the various sub-trades at a flat rate of twenty percent of the total claim. It deviated from this policy when adjusting Hurricane Katrina claims. The Louisiana Court of Appeals determined that the proposed class satisfied the requirements for certification.

In \textit{Carey v. Am. Family Brokerage, Inc.},\footnote{Carey v. Am. Family Brokerage, Inc., 391 Ill. App. 3d 273, 909 N.E.2d 255, 330 Ill. Dec. 542 (Ill. Ct. App. 1st Dist. 2009).} the insured’s building was substantially damaged by fire in 2001. The insurer denied the claim based on its investigation that led it to believe the fire was the result of arson in which the plaintiffs participated. The matter proceeded to trial, where the insured prevailed, and the issue on appeal became a question of damages. The insurer’s appraiser prepared an estimate of damage using a software program and arrived at a replacement cost of $398,725.61. The appraiser testified that to arrive at actual cash value she would determine the replacement cost first and then subtract depreciation. Her report, however, did not consider the depreciation of the items that were damaged in the fire. At closing argument, the insurer claimed that the insured failed to sustain its burden of proving damages because the only evidence admitted was based on replacement cost value rather than actual cash value, as called for under the policy. The trial court awarded the insured the replacement cost value testified to by the insurer’s appraiser.

The appellate court agreed with the insurer:

There is no evidence in the record before us regarding depreciation of the subject building. Spoerlein [insurer’s appraiser] testified that she did not consider depreciation in arriving at her estimate. Spoerlein arrived only to a replacement cost estimate, which

\footnote{257}
could only operate as a starting point to arrive at an actual cash value of the damage to
the subject building once a deduction for depreciation was made. Accordingly, plaintiffs
failed to prove the actual damages in the case at bar, and the trial court’s award was
against the manifest weight of the evidence. . . . Although plaintiffs failed to provide an
adequate basis on which the trial court could calculate damages with reasonable certainty,
the record is of course sufficient to establish that plaintiffs suffered damages as a result of
the February 6, 2001 fire. Accordingly, it would be unjust to reverse the award for
damage to the subject building outright, and we, therefore, reverse and remand for a new
trial solely on the question of the actual cash value of the damage to the building, where
depreciation must be determined and subtracted from replacement cost. 259

I. Appraisal

Property policies often contain an appraisal provision. This provision requires the parties to
engage in an appraisal process if they have a dispute over valuation. A typical format is for the insured
and insurer to select separate appraisers with the appraisers selecting an umpire. It is not necessary to
seek court intervention to initiate the appraisal process, but, if the parties have been involved in a
coverage dispute, it is not uncommon for the court to order appraisal in the event valuation is also
contested. In Am. Storage Ctrs. v. Safeco Ins. Co. of Am., 260 a federal court issued detailed instructions
for the conduct of the appraisal process. Moreover, the court determined that it would address the issues
depreciation of plaintiff’s claim after the loss determination was filed in accordance with the court’s
instruction. The court’s instructions included:

1. Visual Inspection: The two appraisers and umpire were required to make a visual
inspection of the 15 buildings at issue on a building-by-building basis. The appraisers were
to make a determination of loss separately for each building.

2. Reasonably Comparable Appearance: Any conflict between Ohio law’s requirement
regarding “reasonable comparable appearance” and the policy’s provision about “wear and
tear” was to be resolved in favor of the application of the plaintiff the “reasonably comparable appearance” standard. As a consequence, the two appraisers and umpire were
required to make a judgment call following a visual inspection as to the extent to which
replacement was required to result in a reasonably comparable appearance. In that context,
the fact that the building also suffered from wear and tear would not negate the necessity
for replacement where replacement was necessary for a “reasonably comparable appearance.”

3. Loss Determination: In the event the appraisers’ loss calculations do not agree, the umpire
may recommend a different loss amount than either of the appraisers. If the appraisers
agree on a building-by-building basis as to a loss determination, their decision is binding.
Upon completion of the process, an agreement between any two of the three regarding the
loss, the two appraisers and umpire shall file with the court the loss determination upon


which two of them agreed and indicate the amount of loss on a building-by-building analysis. 261

The appraisal process outlined by the court was not followed. The insurer’s appraiser failed to inspect the roofs of any of the fifteen buildings. Moreover, the umpire failed to perform a complete visual inspection, as he viewed only eleven of the fifteen buildings. Nor did the appraisers and umpire conduct their visual inspection together, as required by the court. The insurer’s appraiser also failed to follow the court’s instruction with respect to the “reasonably comparable appearance” analysis. Nor did the insurer’s appraiser and umpire, who agreed on an amount, file their determination with the court. The court only learned about their decision when the insured filed a motion to strike the appraisal process.

Not surprisingly, the court was less than pleased with how the appraisal was conducted. The insurer claimed that the court was limited to overturning the appraisal determination only upon a finding of fraud, mistake or corruption. The court granted the insured’s motion to strike the appraisal determination on two grounds: (1) that, because its instructions were not followed, no appraisal award was actually achieved, and (2) even if an appraisal award was achieved, it was the result of mistake:

The Court finds that an appraisal award was not achieved by the appraisal process in this case because the process was not conducted in accordance with the Court’s instructions…. These instructions were material in determining the loss. The loss determinations arrived at by the participants are not valid because they were not arrived at in accordance with the Court’s instructions. As a consequence, those loss determinations, which were arrived at contrary to the Court’s instructions, cannot form the basis of an appraisal award.

Even assuming for the sake of argument that the agreement between Barton [umpire] and Keenan [insurer’s appraiser] resulted in an appraisal award, the Court finds that it would be set aside. Under Ohio law, fraud and mistake are a proper legal basis for setting aside an appraisal award. The mistake must be of such a character that appraiser would have corrected it had it been called to his attention.

The Court assumes without deciding for the purpose of this analysis that the participants in the appraisal process intended to comply with the Court’s orders, and that their failure to do so was not a deliberate contempt of the Court’s orders. Had the participants in the appraisal process been consciously aware that their conduct of the appraisal process was contrary to the Court’s orders, they most certainly have corrected their actions. Accordingly, the Court finds that even if the agreement between Barton and Keenan resulted in an “appraisal award,” the award was based on a mistake by the participants because the loss determinations were not arrived at in accordance with the Court’s instructions, and is therefore properly set aside. 262

VII. EXCESS INSURANCE

Large losses can exhaust primary coverage and implicate excess layers. Moreover, insolvency of primary carriers can raise issues as to whether the excess insurers must “drop down” to provide primary


policy benefits to insureds. Other coverage issues can arise where the terms of the excess coverage do not match those of the primary policy.

A. “Follow Form” Excess Coverage

It is common to contractually specify that excess coverage shall “follow form” of the underlying primary policy. Many excess policies state that they “follow form” of the scheduled primary policy. Just how closely the excess policy “follows form” depends upon policy language. It is not uncommon for “follow form” excess policies to deviate in material respects from the underlying primary coverage. This was the case in *Insituform Tech., Inc. v. Am. Home Assurance Co.*,\(^{263}\) where the insured entered into a subcontract to rehabilitate roughly 5,400 feet of an East Boston sewer. The project did not go well, and eventually the insured spent $7 million in an attempt to repair or replace sewer pipe. It filed a claim with both its primary carrier, Liberty Mutual, and its excess insurer, American Home. The Liberty Mutual policy contained an endorsement “Contractor Rework Coverage Amendment.” The effect of this endorsement was to override many of the policy’s business risk exclusions and provide coverage for the insured’s losses. As a consequence, Liberty Mutual paid its policy limits.

American Home, however, denied coverage. While the policy was written on a “follow form” basis, it did not contain the rework endorsement. The court had occasion to opine about what “follow form” means:

The phrase “follow form” refers to the practice common in excess policies, of having the second layer coverage follow substantively the primary layer provided by the main insurer, and it would be easy to write a short excess policy that adopted all of the terms of the primary (except that coverage cuts in after the primary layer is exhausted and cuts off at the excess policy limit). But “follow form” is a loose term, and the American Home policy does not by any means “follow [the] form” of the Liberty Mutual policy in all respects.\(^{264}\)

The District Court found that a provision in the excess policy created an ambiguity as to whether the rework endorsement flowed into the excess policy. The excess policy contained a sentence in one coverage section that stated that if insurance for bodily injury or property damage is provided by a policy listed in the schedule of underlying insurance, then “this exclusion” shall not apply. The Appellate Court agreed with the District Court that this language was arguably ambiguous and, as a consequence, none of the exclusions contained in this coverage section applied. Nevertheless, the excess policy elsewhere contained a number of standard business risk work-related exclusions that, if operative, would exclude coverage. The Appellate Court disagreed with the District Court that the ambiguity in the one coverage section had the effect of eliminating all exclusions in the excess policy. The District Court’s reasoning had the effect of creating mirror coverage between primary and excess policies as the excess carrier could only rely on the exclusions contained in the primary policy which were overridden by the rework endorsement. The First Circuit was willing only to buy half a loaf. While policy language was ambiguous and affected the exclusions within the section of the policy containing the ambiguity, this did not affect other sections of the policy including the “excluded hazards” section that contained the standard work-related business risk exclusions.

\(^{263}\) *Insituform Tech., Inc. v. Am. Home Assurance Co.*, 566 F.3d 274 (1st Cir. 2009).

\(^{264}\) *Insituform Tech., Inc. v. Am. Home Assurance Co.*, 566 F.3d 274, 278 (1st Cir. 2009).
B. “Drop Down” Coverage

A substantial body of case law has developed over whether, and under what circumstances, excess insurers are required to “drop down” and pick up a primary carrier’s obligations. In most cases, these cases arise because of the primary carrier’s insolvency. Such was the case in Donald B. MacNeal, Inc. v. Interstate Fire & Cas. Co.,265 where an excess insurer, whose umbrella policy provided that it would pay bodily injury liability claims in excess of “amount recoverable under underlying insurance,” assumed the risk that underlying insurer might become insolvent and therefore was obliged to pay the entire $1 million bodily injury claim rather than merely the excess over the $300,000 limit of the underlying policy.

Much depends upon policy language. As the Supreme Court of Louisiana noted:

With these settled principles of [insurance policy] construction in mind, we turn to the contractual terms of Interstate’s excess policy alleged to support drop down coverage. In reviewing them, we first observed the conspicuous absence in the policy of any provision addressing the problem created by the primary insurer’s [Champion’s] insolvency. We next observe that the policy repeatedly refers to the fact that Interstate is an excess insurer. . . .

The sole source of potential ambiguity in Interstate’s policy, and thus the sole grounds on which LIGA, supported by the appellate court’s conclusion, relies in support of drop down coverage is the fourth sentence of the limits of liability provision “[WE shall then be liable to pay only such additional amounts necessary to provide YOU with a total coverage under the PRIMARY INSURER’S and thus policy combined.”] LIGA argues that the insured’s reasonable expectations, the ambiguity created by the fourth sentence and public policy considerations are all reasons that support affirming the appellate court’s construction of the fourth sentence. Alternatively, LIGA suggests that we construe the fourth sentence as a clear, unconditional contractual guarantee by Interstate to pay the combined policy limits.

On the other hand, Interstate argues that the appellate court erred in focusing all of its attention on that one sentence of the policy in isolation and in relying on that sentence to the exclusion of the balance of the policy. . . .

[We]e translate this sentence as providing that after the triggering event defined in the third sentence, the next event is the activation of Interstate’s obligation to pay, and that obligation will be for no more than such supplemental amounts necessary to provide the total combined coverage. This sentence thus clarifies that the excess insurer’s [Interstate’s] limits are in addition to the primary insurer’s [Champion’s] limits. This sentence also sets forth a formula for calculating the supplemental amount that Interstate is obligated to pay after its coverage is activated. Under this formula, the amount Interstate must pay is determined by totaling the sum of the underlying primary limits and the excess limits and subtracting from that sum the full amount of the primary limits, which the third sentence [“WE are not obligated to pay under this policy until the PRIMARY INSURER has paid or has been held liable to pay the full amount of the

PRIMARY INSURANCE.”] mandates that the primary insurer have either paid or been held liable to pay. Stated differently, the formula defines Interstate’s obligation to pay as the remainder resulting after subtracting the full amount of the underlying primary limits from the “total coverage.” It necessarily follows that Interstate’s liability is limited to the amount over and above the underlying primary insurance, regardless of its collectability. We thus discern no indication from this sentence that the parties intended Interstate coverage to “drop down” in the event of Champion’s insolvency.266

“Drop down” disputes do not always arise due to primary carrier insolvency. For example, in *N. Am. Capacity Ins. Co. v. Claremont Liability Ins. Co.*,267 a CGL carrier sought contribution from, among others, an umbrella insurer after participating in a settlement of a construction defect action. The primary carrier’s policy contained an endorsement providing that coverage would not apply to operations performed by independent contractors unless the insured has received a written agreement from each and every independent contractor holding the insured harmless from all liabilities incurred by the independent contractor and furthermore has obtained certificates of insurance from all independent contractors indicating they will maintain similar coverage as provided under the primary policy. The conditions of this warranty endorsement were not satisfied and, as a result, the primary carrier claimed its policy did not respond to the loss.

In response, the carrier seeking contribution argued that, if the primary carrier did not respond then the excess insurer was required to “drop down” and pick up the primary insurer’s obligations. The court disagreed:

In the present case, Coverage A [of the excess policy] states Claremont will pay an amount “in excess of the amount payable under the terms of any ‘underlying insurance’” provided that “the ‘underlying insurance’ [i.e., the Claremont primary policy] also applies, or would apply but for the exhaustion of its applicable limits of insurance.” We have held ante that, by reason of the contractors’ warranty endorsement, the Claremont primary policy does not apply to covered claims for defects arising from the conduct of all but two contractors of JDG. The underlying insurance therefore did not “also appl[y]” to such uncovered claims, and the amount Claremont contributed toward settlement of the claim did not exhaust the limits of its primary policy. Coverage under the excess insurance provisions under Coverage A thus was not triggered by settlement of the underlying action.268


268 *N. Am. Capacity Ins. Co. v. Claremont Liability Ins. Co.*, 177 Cal. App. 4th 272, 293, 99 Cal. Rptr. 3d 225, 242-43 (Cal. Ct. App. 2d Dist. 2009). The excess policy had another coverage known as “Coverage B” which provided coverage for the amount the general contractor became legally obligated to pay as damages because of “injury” to which this insurance applies. This was essentially “umbrella coverage.” Coverage B, however, clearly excluded from its application injury that was “the subject of” the underlying primary policy. While the failure to comply with the warranty endorsement rendered the primary policy unavailable, the underlying defect claims were nevertheless the “subject of” the underlying primary policy.
VIII. PROFESSIONAL LIABILITY INSURANCE

Professional liability policies are written on a “claims-made” form. These forms have a number of substantial differences from policies, such as the CGL policy, written on an “occurrence-based” form. One of the primary differences is the “trigger” of coverage. Under the CGL “occurrence-based” form, the coverage trigger is when bodily injury or property damage occurs. In contrast, the coverage trigger for a professional liability policy written on a claims-made form is the date the insured becomes aware, or should have been aware of the existence of a claim. Just what constitutes a claim can be the subject of dispute.

A. When is a Claim a “Claim” Under a Claims-Made Policy?

In Matkin-Hoover Eng’g, Inc. v. Everest Nat’l Ins. Co., an engineer and contractor were sued when a shopping center parking lot did not drain properly. The engineer’s insurer declined to defend. Two policies arguably covered the engineer. One policy covered the time period from April 15, 2005 to April 15, 2006 (the “2005 Policy”). The second policy covered the time period from April 15, 2006 to April 15, 2007 (the “2006 Policy”). To trigger coverage under the policies, “the claim arising out of the wrongful act is first made against any insured during the policy period” and “the claim is reported in writing to [Everest] no later than 60 days after the end of the policy period. . . .”

The insurer claimed that a letter received by the engineer from the owner constituted a “claim” and, because the engineer did not timely give notice of the claim, coverage was not afforded. The insurer characterized the letter as a “demand letter.” On the other hand, the engineer characterized the letter as simply a request for additional engineering services to fix construction defects in the parking lot.

To ferret out a resolution to the dispute, the magistrate had to examine the letter in light of the definition of “claim” under the policy:

The policy defined “claim” as a demand for money or professional services received by the insured for damages, including but not limited to, the service of a lawsuit or the institution of arbitration proceedings or other alternative dispute resolution proceedings, alleging a wrongful act arising out of the performance of professional services.

Without providing a copy of the letter or discussing its language in any detail, the magistrate proceeded by recounting the parties’ varying characterizations of the letter. The insurer contended the letter constituted a “claim” because it (1) demanded “professional services” to repair the drainage problems and (2) alleged that the engineer committed a wrongful act. The magistrate disagreed, finding the characterization “over-stated.” As the court noted:

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269 This is the coverage trigger for Coverage A, which is the primary coverage of interest to those in the construction industry.


272 Matkin-Hoover Eng’g, Inc. v. Everest Nat’l Ins. Co., 2009 WL 1457669 at *2 (W.D. Tex. May 26, 2009) (emphasis in original). The magistrate rejected the insured’s argument that the definition of “claim” was ambiguous. The insured argued that there is ambiguity as to the nature of the communications as the language suggested only “formal” communications rise to the level of a claim. The magistrate disagreed, finding that the definition anticipates communications other than such formal items as the service of a lawsuit.
The GEWAC letter responded to Matkin-Hoover’s [engineer] February 13, 2006 letter. The letter reported that the general contractor for Marbock Square had a drilling test performed on the pavement on March 16, 2006, and assessed the pavement as structurally sound and showing no indication of distress or excessive settlement. The letter continued to state the Matkin-Hoover’s design provided a .0525% slope instead of at least two (2) percent slope as recommended by the geotechnical report. That is the reason the parking lot is not draining. The letter concluded with “you need to develop a plan to correct the drainage problem. Your plan has to include an engineering design and provision for adequate funds to finance the construction. Please provide such a plan to us by the close of business on April 10, 2006.” Although Everest maintains the letter clearly indicated that GEWAC expected Matkin-Hoover to pay for the repair of the parking lot, neither the letter’s language nor the communications that followed make it clear that GEWAC held Matkin-Hoover responsible for the problem or expected Matkin-Hoover to pay to fix the problem.

As a consequence, the magistrate issued her report and recommendation denying both parties summary judgment on grounds that a reasonable person could either interpret the letter in question as a request for additional services to fix a drainage problem for which it would be paid, or as a demand for professional services for damages, and as such there existed a question of fact for the jury to decide.

IX. WRAP-UP INSURANCE

Large construction projects implicate numerous policies covering the many participants in the design and construction process. The sheer number of players makes it difficult to coordinate coverage so as to avoid duplicate coverage, secure adequate limits and eliminate coverage gaps. Moreover, the tendency for construction participants to require additional insured coverage creates certain inefficiencies when accidents occur. As a consequence, owners and general contractors on large construction projects sometimes find that it is more efficient to structure an integrated insurance program rather than have all the players bring their own practice policies to the table. These insurance programs come in a number of forms and are known by a number of different names, including: “wrap-up coverage,” “owner-controlled insurance programs” (OCIPs), and “contractor-controlled insurance programs” (CCIPs).

While aggregating coverages can solve a number of problems, it also raises new challenges. One challenge is determining who is covered and who is not. In Alpha Constr. & Eng’g Corp. v. Ins. Co. of State of Pa.,274 inspection consultants on a transit project brought suit against an owner’s OCIP seeking a declaration that they were covered under the policy. The policy contained a broad “named insured” definition, as is typical for these products. It included all contractors, all tiers of subcontractors, each separate contractor of the owner and others with whom the owner contracts to furnish insurance under the insurance program. The inspection consultants claimed they were either contractors or separate contractors. While the court noted that the definition of “named insured” was quite broad, the consultants were explicitly excluded under a policy endorsement. Essentially the endorsement limited CGL coverage to those who were enrolled under the workers’ compensation program. Because the insureds were not so-enrolled, they were not afforded coverage under the CGL program.

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A similar issue arose under another OCIP program, but with respect to workers' compensation coverage, in *Workers' Compensation Fund v. Wadman Corp.*, 275 where a workers' compensation fund sought coverage under the workers' compensation policy of an OCIP program for an employee of a subcontractor injured on the project. Unfortunately, neither the injured worker's employer or the injured worker completed an enrollment form. Pursuant to the OCIP manual, the failure to enroll was fatal to coverage:

The notion that an implied contract existed between Argonaut [insurer] and other participants in the OCIP team that required Argonaut to provide insurance to all subcontractors is not supported by the terms found in the OCIP manual. The OCIP manual supplemented the individual insurance policies issued to contractors and subcontractors and set forth the terms of the OCIP. The manual states that it “identifies, defines, and assigns responsibilities related to the administration of the [OCIP]. . . .” The manual specifies that the owner’s responsibility consists of providing general support for the worksite. The OCIP manual specifically contemplates the possibility that a contractor may not choose to enroll with the OCIP insurance provider. The manual specifies that “[non-enrolled] contractors should notify their own insurance company” instead of the OCIP insurance of injuries. The OCIP manual also repeatedly states that although all subcontractors should enroll OCIP, coverage is only valid for properly enrolled subcontractors, stating that the OCIP will be only for the benefit of . . . contractor/subcontractor(s) of all tiers who have been properly enrolled in the OCIP program. In order to be properly enrolled, the manual specifies that all contractors/subcontractors are required to submit enrollment forms and complete certain requirements. Each subcontractor also received a separate contract of insurance. The necessity of each subcontractor obtaining a separate contract of insurance and enrolling separately in the OCIP indicates no general contract of insurance existed between Argonaut and all subcontractors.276

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276 *Workers' Compensation Fund v. Wadman Corp.*, 210 P.3d 277, 283-84 (Utah 2009) (emphasis in original). Another “insured-status” dispute under a wrap-up program arose in McGinnis v. Union Pacific R.R. Co., 612 F. Supp. 2d 776, 795 (S.D. Tex. 2009), where a railroad sought coverage for a suit brought by an injured worker. The wrap-up policy provided that the general contractor and all of its subcontractors of any tier were insureds under the policy. Because the railroad was not a subcontractor, it was not an insured.