Wiley Rein LLP

EXECUTIVE SUMMARY

Legal Developments Affecting Professional Liability Insurers | August 2016

Insurer Entitled to Rescind Policy Based on Insured's Failure to Disclose Claim Made After Application Submitted but Before Coverage Bound

Applying Iowa law, the United States Court of Appeals for the Eighth Circuit has held that an insurer can rescind an E&O policy because the insured failed to disclose the existence of a claim made after the submission of the application but before the insured agreed to purchase coverage. *Capson Physicians Ins. Co. v. MMIC Ins. Inc.*, 2016 WL 3902654 (8th Cir. July 19, 2016). The court also held that the insurer's failure to attach a copy of the application to the policy did not prevent the insurer from rescinding the policy.

A physician accepted a position at an Iowa hospital in 2012, and the insured hospital agreed to purchase insurance coverage for the physician. On October 29, 2012, the physician submitted an application stating that he was not aware of any potential claims or circumstances that might reasonably lead to a claim or lawsuit being brought against him. At that time, the hospital was unsure whether it wanted to purchase prior acts coverage for the physician, so it asked the insurer to bind coverage for the physician with no prior acts coverage, which the insurer did.

In November 2012, the physician was served with a complaint alleging medical negligence for the delivery of a stillborn child in 2011. The physician submitted the complaint to the hospital's CEO. After receipt of the complaint, the CEO requested that the insurer extend prior acts coverage to the physician dating back to 2007 but failed to disclose the lawsuit. The insurer endorsed the policy to provide prior acts coverage for the physician. The hospital's CEO sent the endorsement to the physician and suggested that they "meet to talk about the case current[ly] in process and how to go about reporting it." After the insureds tendered that lawsuit and an additional claim for acts performed by the physician in 2010, the insurer denied coverage and sought to rescind the policy based on material misrepresentations. The district court held that the insurer was entitled to equitable rescission of the policy.

The appellate court affirmed that the insurer was entitled to equitable rescission of the policy based on material misrepresentations. The court held that, under Iowa law, an insured has an ongoing obligation to disclose material information after submission of an application but before coverage is bound even if "the application did not instruct the applicant to update material information." It held that the failure to supplement the physician's application upon learning of the lawsuit was a false assertion rendering part of the application untrue, the information about the lawsuit was material, and the insurer would not have provided prior acts coverage if it was aware of the new lawsuit.

In addition, the court held that the insurer could rescind the policy even though it did not comply with an Iowa statute requiring an insurer to attach the application to the policy in order to rescind the policy based on misrepresentations in the application. The court held that the statute was inapplicable because the non-disclosure of facts occurred after the submission of the application. ■

ALSO IN THIS ISSUE

Rescission Proper Due to Failure to Disclose Known Losses in Application

Applying Connecticut law, a federal district court has held that an insurer properly rescinded multiple crime policies issued to an insured based on the insured's failure to disclose known losses in its applications for coverage. *Known Litigation Holdings, LLC v. Navigators Ins. Co.,* 2016 WL 3566653 (D. Conn June 24, 2016).

Beginning in 2007, the insurer issued successive, one-year armored car operator's insurance policies to an ATM company. For each of those policies, the ATM company completed an application, signed by its CEO, that included the question:

> In the last 6 years, have you or your predecessor company suffered a loss or losses, whether covered by insurance or not, and if insured, whether a claim was paid or not?

The insured responded each time: "No." The CEO, however, knew as of 2005 that the insured had in fact sustained significant losses due to its employees stealing money from one of its bank customers. When the bank ultimately discovered the theft in 2010, and demanded immediate reimbursement, the insured sought coverage from its insurer. The insurer, in turn, disclaimed coverage based on certain exclusions in the policies and issued notices of rescission based on the insured's material misrepresentations in its applications for the policies.

In the coverage litigation that followed, which was pursued by the bank as the assignee of the ATM company, the bank disputed that the insured had made any misrepresentations by its negative responses to the known loss question on the application. In this regard, the bank contended that the insured had not suffered any loss prior to 2010, because until the bank had made its demand for reimbursement, coverage was not triggered by the employee's theft of its money. The court rejected this argument, pointing out that the application question unambiguously called for the disclosure any losses, "whether covered by insurance or not."

The court also rejected the bank's reliance on the doctrine of promissory estoppel to negate the applicability of an exclusion in the policies that the insurer had raised as an alternative ground for a declination of coverage. That exclusion barred coverage for losses directly resulting from acts or omissions of an officer or director of the insured. According to the court, although the insurer had represented to the bank that the policies covered a theft of the bank's money by an employee of the ATM company, that statement had to be considered in conjunction with the express terms of the policies, and the bank could not use estoppel to expand insurance coverage beyond those terms. ■

No Double Recovery Under Policy for Amounts Paid by Contractual Indemnitor

The United States Court of Appeals for the Eleventh Circuit, applying Florida law, has held that an insurer did not breach its duty to defend or indemnify an insured where the insured's defense and settlement costs were paid by its contractual indemnitor. *MapleWood Partners, L.P. v. Indian Harbor Ins. Co.*, 2016 WL 3553212 (11th Cir. June 30, 2016).

The insured financial services firm had entered into an advisory services agreement with a company operating a chain of Mexican restaurants. The restaurant chain also agreed to defend and indemnify the insured in any lawsuits because of its association with the chain. When three such lawsuits were filed against the insured, the restaurant chain paid the vast majority of the insured's defense expenses and settlement costs pursuant to the parties' contractual indemnity provision. The insured later sued its professional liability insurer for breach of contract for failing to pay the insured's losses from the three suits. The district court granted summary judgment in favor of the insurer, concluding that allowing the insured to recover under the policy would give it an improper double recovery because the restaurant chain had already paid the insured's losses.

The Eleventh Circuit affirmed on appeal, holding that the contractual indemnification agreement between the insured and the restaurant chain gave the restaurant chain the "primary obligation" to pay the insured's losses in the three lawsuits. The court rejected the insured's

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No Double Recovery Under Policy for Amounts Paid by Contractual Indemnitor

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argument that the contractual indemnification provision was never intended to cover losses covered by an insurance policy, finding nothing in the provision's text to support that interpretation. The court observed that the insured was not "left alone as the losses were piling up," because the restaurant chain had paid the defense and settlement costs. ■

Business Enterprise Exclusion Bars Coverage for Trustee Sued in His Capacity as a Director or Officer of Businesses Affiliated with Trusts

The Supreme Court of Wisconsin has held that a professional liability policy issued to an insured for his conduct as a trustee of two trusts afforded no coverage for a series of claims arising out of the trustee's alleged conduct as a director or officer of businesses owned by the trusts. *Marks v. Houston Cas. Co.*, 2016 WL 3545848 (Wis. June 30, 2016).

The insured was a trustee of two trusts, which in turn owned a controlling interest in a holding company and various subsidiaries. The insured was sued in six underlying lawsuits, which contained allegations of wrongdoing in connection with the various companies. The insurer ultimately denied coverage under a business enterprise exclusion, which barred coverage for "liability arising out of the Insured's services and/or capacity as: an officer, director, partner, trustee, or employee of a business enterprise not named in the Declarations or a charitable organization or pension, welfare, profit sharing, mutual or investment fund or trust." Neither the holding company nor its subsidiaries were listed in the Declarations. After the disclaimer of coverage, the insured sued the insurer for breach of the duty to defend and bad faith. Both the trial and intermediate appellate courts ruled for the insurer.

On appeal, the Supreme Court of Wisconsin affirmed, holding that the business enterprise exclusion barred coverage in its entirety. The court determined that the underlying complaints alleged wrongdoing in connection with the insured's capacity as an officer or director of the holding company and its subsidiaries, but did not discuss the two trusts or the insured's position as a trustee at all. In other words, the insured was sued for activities pertaining to his performance as an officer or director of various businesses *affiliated* with the trusts, but the claims had nothing to do with the insured's services as trustee of the trusts. On this basis, the court ruled that the "plain terms of the business enterprise exclusion" barred coverage.

The court also addressed two additional arguments raised by the insured. First, the court rejected the insured's argument that the "trustee" prong of the business enterprise exclusion rendered coverage "illusory," noting that the insurer did not in any way rely upon the provision in the exclusion alleged to render coverage illusory. Second, the court rejected the insured's argument that an insurer that disclaims its duty to defend is estopped from relying on policy exclusions, concluding that such a rule "makes no sense" and was based on the insured's faulty reading of prior Wisconsin precedent.

The court also noted that the allegations involved the insured's activities for the holding company and its subsidiaries, whereas the policy was triggered only by a claim for the insured acting "solely in the performance of services as the [t]rustee of the" two trusts. The court expressed "significant doubts" that the policy would be triggered in the first instance, noting the limited coverage grant and the nature of coverage provided by professional liability policies in general. However, the court ultimately declined to determine whether the policy was triggered in the first instance because the operation of the business enterprise exclusion made that determination unnecessary. ■

Whistleblower Suit Alleging Violations of California False Claims Act Uninsurable Under California Law

The United States District Court for the Central District of California, applying California law, has held that liability under the California False Claims Act is uninsurable as a matter of law. *Office Depot Inc. v. AIG Specialty Ins. Co.*, No. 2:15-cv-02416 (C.D. Cal. July 21, 2016).

A whistleblower filed suit against the insured office supply company alleged violations of the California False Claims Act. The suit asserted that the office supply company knowingly presented false and fraudulent claims in order to obtain payment from California public entities by overcharging them under a supply contract for office and stationery supplies. The office supply company's insurer denied coverage, and the office supply company initiated coverage litigation seeking reimbursement of $30 million of the $68.5 million it paid to settle the whistleblower suit.

The court held that the insurer did not have a duty to indemnify the office supply company and was statutorily precluded from doing so pursuant to California Insurance Code § 533, which states that an "insurer is not liable for a loss caused by the willful act of the insured." The office supply company argued that the scienter required by the California False Claims Act includes not only the "willful" conduct precluded by § 533, but also reckless conduct that is insurable. The court found persuasive a line of cases holding that causes of action that include the intent to induce reliance are precluded from insurance coverage under § 533 as a matter of law, even if those causes of action do not require more than recklessness with respect to the truth or falsity of the statement made. The court concluded that the California False Claims Act creates such a cause of action because, by requiring that a false claim be submitted for payment and approval, it necessarily requires the intent to induce reliance.

Accordingly, the court granted the insurer's motion to dismiss with respect to its duty to indemnify. The court initially also granted the insurer's motion with respect to the duty to defend. However, on the office supply company's motion for reconsideration, the court limited the holding to the duty to indemnify because the insurer's motion papers had not specifically addressed the duty to defend. ■

Related Claims Provision Does Not Conflict with Prior and Pending Litigation Exclusion

A Florida federal court has held that a set of claims must be deemed first made at the time of the first such related claim in 2008, prior to the relevant policy period, notwithstanding the fact that a prior and pending litigation exclusion in the policies only excluded coverage for lawsuits brought prior to 2003. *RSUI Indem. Co. v. Attorney's Title Ins. Fund, Inc.*, No. 2:13-cv-00670-SPC-CM (M.D. Fla. June 6, 2016).

A title insurer sued a group of property sellers to recover money that it had to pay as the title insurer for fraudulently sold property. One of the sellers asserted a counterclaim for slander of title and other tort claims. The seller amended its counterclaim two times in the litigation. The seller moved to amend a third time to add a malicious prosecution claim arising out of the same facts, but the court denied the motion. The seller subsequently filed a separate malicious prosecution action, which was consolidated with the prior lawsuit.

The title insurer held a D&O policy, and tendered the amended counterclaim under a policy issued in 2011 and the malicious prosecution action under a policy issued in 2012. Pursuant to the "Related Claims" clause of the policies, the D&O insurer took the position that both claims were deemed first made at the time of originally-filed counterclaim in 2008. The insured argued that the suits were not deemed related and that coverage should be available under both policies.

In the ensuing coverage litigation, the court granted summary judgment to the D&O insurer, holding that coverage was not available under either policy because the claims were deemed first made in the 2008 policy period. The insured argued that the prior and pending litigation exclusion, which barred coverage for suits pending prior to 2003, somehow caused an "ambiguity as to why the parties would modify the Prior and Pending Litigation Exclusion

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Related Claims Provision Does Not Conflict with Prior and Pending Litigation Exclusion

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to include those same claims." The court held that there was no such ambiguity and that the claims were deemed made at the time of the first such related claim in 2008. First, the court stated that "adding a strict temporal limitation to an exclusion's applicability does not, and cannot, create coverage." Second, the court noted that the two provisions were fundamentally different as the "Related Claims" provision "confines coverage to those claims that are first made during the respective policy periods and unrelated to any previously made claim," while the prior/pending litigation exclusion "provides a strict deadline for when a claim related to preexisting litigation is automatically excluded from coverage." ■

Professional Services Exclusion Precludes Duty to Indemnify but Not Duty to Advance Defense Costs

Applying New York law, the United States District Court for the Southern District of New York has held that a D&O insurer was not obligated to indemnify the insured or the insured's E&O carrier because the D&O policy's professional services exclusion applied. *Beazley Ins. Co., Inc. v. ACE American Ins. Co.*, No. 15-cv-5119 (S.D.N.Y. Jul. 12, 2016). But the court nevertheless held that the D&O insurer had a duty to advance defense costs because a "legal uncertainty" about the application of the exclusion existed until the court issued its coverage decision.

Investors filed a class action against the insured stock exchange alleging that the exchange had mishandled an initial public offering. The investors asserted that technical issues on the day of the IPO caused trading delays and therefore artificially decreased the price of the stock. The exchange tendered the matter to both its E&O and D&O insurers. The E&O insurer accepted coverage subject to a reservation of rights; the D&O insurer disclaimed coverage based on a professional services exclusion. The exclusion barred coverage for "Loss on account of any claim . . . by or on behalf of a customer or client of the [insured], alleging, based upon, arising out of, or attributable to the rendering of or failure to render professional services."

Under an assignment of rights from the exchange, the E&O insurer sued the D&O insurer to recover defense and settlement amounts for the class action. The court held that the professional services exclusion applied, and therefore the D&O insurer had no duty to indemnify. Looking to case law, custom and usage in the insured's industry, and the allegations in the investors' complaint, the court held that retail investors in a company listed on a stock exchange are "customer[s] or client[s]" of the exchange. The court also rejected the E&O insurer's argument that the securities law claims in the underlying lawsuit fell outside the scope of the exclusion because misrepresentations are not professional services. The court reasoned that none of the underlying claims would exist "but for" the insured's allegedly botched rendering of professional services.

The court, however, denied summary judgment regarding the D&O insurer's duty to advance defense costs. The court opined that an insurer's duty to advance defense costs is broad, and a "legal uncertainty" regarding application of the exclusion existed until the court issued its opinion. The court concluded that the exchange and its E&O insurer therefore were entitled to pursue at trial any defense costs that remained unreimbursed and that exceeded the applicable retention on the D&O policy. ■

Statutory Request for Insurance Information Is Not a Claim

The United States District Court for the Middle District of Florida, applying Florida law, has held that a professional liability insurer was not obligated to contribute to defense costs where it received a letter during its policy period requesting insurance information pursuant to Florida statute, and a lawsuit regarding the incident discussed in the letter was filed after its policy period ended. *Lancet Indem. Risk Retention Group, Inc. v. Allied World Surplus Lines Ins. Co.*, 2016 WL 3906924 (M.D. Fla. July 19, 2016).

Two insurance companies issued professional liability policies to a diagnostics company for successive

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Statutory Request for Insurance Information Is Not a Claim *continued from page 5*

policy periods. During the first policy's term, the diagnostics company received a letter from an attorney that stated "[w]e are investigating a claim for damages" and demanded disclosure of all liability policies that could provide coverage for the incident being investigated. The diagnostics company forwarded the letter to the first insurer, but there was no further communication from the claimant before the end of the first policy period. After the first insurer's policy expired and the second policy incepted with a new insurer, the diagnostics company was sued in connection with the incident described in the letter. The second insurer defended the action, but the first insurer refused to contribute to defense costs. As subrogee of the insured, the second insurer sued the first insurer for breach of contract, a declaration that the attorney's letter satisfied the condition of "notice of a claim" against the insured, and equitable contribution.

The court determined that the letter did not constitute notice of a claim under the first insurer's policy. The policy defined "Claim" to mean "a written notice received by an Insured. . .demanding monetary damages or notifying the Insured of an intention to hold an Insured responsible for an Occurrence; or. . .the filing of a civil lawsuit or arbitration proceeding seeking money damages." The court reasoned that the letter was best understood not as a notice of the existence of a claim for damages but of an investigation to determine whether such a claim existed. The ultimate purpose of the letter was to request information regarding insurance coverage, not to express an intention to hold the company responsible for an incident. In reaching this conclusion, the court relied on policy language providing that notifying the insurer of an occurrence that may result in a claim "does not constitute a [notice of a] Claim." ■

Late Notice Bars Recovery of Claimant's Unsatisfied Default Judgment Under New York Statute

The Northern District of Alabama, applying New York law, has held that an injured party who fails to act "reasonably diligently" in identifying a defendant's insurer and then "expeditiously" notify the insurer of the claim, as provided in N.Y. Insurance Law § 3420(a), is not entitled to recover under an insured defendant's E&O policy for an unsatisfied judgment. *Nelson v. Northland Ins. Co.*, 2016 WL 3683196 (N.D. Ala. July 12, 2016).

The claimant, in a garnishment action against an insurer, sought recovery for a default judgment entered against an insured defendant under the insured's claims-made-and-reported policy pursuant to N.Y. Ins. Law § 3420(a)(2), which allows an injured party with an unsatisfied judgment to pursue an action against the defendant's insurer for satisfaction of the judgment. The insurer did not learn of the garnishment until it received a copy of the order and writ of garnishment more than 10 years after the entry of the default judgment. The insurer responded that it was not required to pay the claimant under the policy.

The court granted the insurer's motion for summary judgment, holding that in the instant case the claimant failed to act "reasonably diligently," as required under the applicable provision in N.Y. Insurance Law § 3420, in identifying and notifying the defendant's insurer of a default judgment entered in 2002, and therefore no coverage was available because of the lack of timely notice. In so holding, the court recognized that applicable New York law required that the injured party must show that it acted "reasonably diligently" in identifying the defendant's insurer and then "expeditiously" notified the insurer of the claim in order for the claimant to assert an action against the insurer. The court also noted that the claimant failed to present evidence of any correspondence to the insured defendant explicitly seeking the identity of the defendant's insurer and that publically available records in a related case against the insured for which the claimant was disclosed as a witness would have also provided information regarding the defendant's insurer. Furthermore, the court stated that purported evidence of a telephone call from the claimant's attorney to the insurer regarding the underlying case in 2004 was insufficient to serve as notice because the claimant failed to present evidence of *written* notice to the insurer. ■

New York Court Finds Insured v. Insured Exclusion Ambiguous

The New York Supreme Court, Appellate Division, applying New York law, has held that a duty to defend was not precluded by the terms of an Insured v. Insured exclusion because the exclusion did not state whether an employee, like the plaintiff in the underlying action, constituted an "insured" for purposes of applying the exclusion. *Boro Park Land Co., LLC v. Princeton Excess Surplus Lines Ins. Co.*, 32 N.Y.S.3d 651 (N.Y. App. Div. June 15, 2016). In so holding, the court concluded that the Insured v. Insured exclusion was ambiguous.

The owner of a building was an additional insured under a Senior Living Professional Liability, General Liability, and Employee Benefits Liability insurance policy issued by the insurer. An employee brought suit against the insured, alleging that she was injured on the premises. The insured tendered the claim to the insurer, and the insurer denied coverage based on the Insured v. Insured exclusion in the policy. The Insured v. Insured exclusion precluded coverage for "[a]ny 'claim' made by or for the benefit of, or in the name or right of, one current or former insured against another current or former insured." The building owner filed suit against the insurer, and the trial court held that the insurer was obligated to defend and indemnify the insured in the underlying action. The insurer appealed.

The appellate court affirmed, concluding that the insurer had a duty to defend and that coverage was not precluded by the Insured v. Insured exclusion. According to the court, it was not clear from the language of the Insured v. Insured exclusion whether the plaintiff in the underlying case, an employee of the named insured, constituted an "insured" for purposes of applying the exclusion. As such, the appellate court stated that the provisions of the Insured v. Insured exclusion "are ambiguous and subject to more than one interpretation." Accordingly, the court held that the insurer had a duty to defend. ■

No Coverage for Law Firm Employee's Misappropriation of Client Funds

Applying New Jersey law, a federal district court has held that a law firm's professional liability policy does not provide coverage for an employee's misappropriation of client funds. *Cadre v. ProAssurance Cas. Co.*, 2016 WL 3844208 (D.N.J. July 14, 2016).

A law firm discovered that an employee had embezzled funds from the firm's client trust account. The law firm sought coverage for the losses under its professional liability policy, which provides coverage for sums "the Insured shall become legally obligated to pay as damages because of any claim or claims . . . involving any act, error or omission in rendering or failing to render professional services." The policy defined "claim" as "a demand or suit for damages received by the Insured." It also defined "Damages" to mean "monetary judgments, award or settlements," but further provided that the term "does not include the return or restitution of legal fees, costs and expenses charged by the Insured, or any allegedly misappropriated client funds or interest thereon." The insurer denied coverage under the policy for the embezzlement losses.

In the subsequent coverage litigation, the court held that the policy does not afford coverage for the employee's embezzlement. As an initial matter, the court held that no "claim" had been made against the law firm because no demand or suit for damages had been asserted against the firm. In so holding, the court rejected the firm's argument that the discovery of facts that might lead to a potential suit also constitutes a claim.

Additionally, the court rejected the firm's argument that it reasonably expected its policy to cover losses from an employee's embezzlement of client funds. The insured argued that a New Jersey rule of court that requires limited liability companies such as the insured firm to purchase professional liability insurance binds not just law firms but also insurance companies, and therefore a compliant policy must cover all claims arising out of the performance of professional services. The court disagreed, finding that the rule governs attorneys only and says nothing of how the business of insurance is to be run. Moreover, the court held that, because the policy's definition of damages expressly excludes "misappropriated client funds," the insured reasonably should have concluded that the policy would not cover every claim arising out of the provision of legal services. ■

Seven-Month Delay Constitutes Late Notice as a Matter of Law

A Minnesota federal district court has held that an insurer was entitled to summary judgment in a breach of contract suit brought by its policyholder after the insurer denied coverage because the policyholder failed to provide notice of the suit "as soon as practicable" in accordance with the terms of the policy. *Food Market Merch., Inc. v. Scottsdale Indem. Co.*, 2016 WL 3976606 (D. Minn. July 22, 2016).

The insured, a food marketing and distribution company, was sued by a former employee on January 13, 2014 in Minnesota state court for breach of contract, unjust enrichment and violation of Minnesota labor laws. The court granted partial summary judgment and damages of nearly $500,000 to the former employee on June 27, 2014, and the insured then attempted to negotiate a settlement with the former employee. The insured notified its employment practices liability insurer of the suit on August 22, 2014. The insurer issued a tentative denial of coverage on September 30, 2014 and unequivocally denied coverage on June 17, 2015 based on both late notice and a determination that the policy did not cover the suit at issue.

In the coverage litigation that followed, the court held that the insurer was entitled to summary judgment based on the policyholder's failure to comply with the notice provisions of the policy, which stated that the insured "shall, as a condition precedent to their rights to payment . . . give Insurer written notice of any Claim as soon as practicable, but in no event later than sixty days after the end of the Policy Period." The court held that the notice language was unambiguous and dismissed as unreasonable the policyholder's contention that "sixty days after the end of the Policy Period" defined "as soon as practicable." While an insured's compliance with notice provisions is often a question of fact, here the court found that the insured did not identify any facts from which a factfinder could conclude that it provided notice as soon as practicable.

The policyholder also argued that the insurer must show prejudice to deny coverage based on late notice, but the court held that there is no such requirement under Minnesota law when the policy provides that notice is a condition precedent to coverage, as the policy did here. The court also rejected the insured's contentions that the insurer waived its right to notice as soon as practicable or should be estopped from asserting untimely notice as a defense to coverage. Finally, the court held that the insurer was entitled to summary judgment on the insured's claim for bad faith, because that claim rested on the same facts as its non-viable breach of contract claim. ■

Declaratory Judgment Complaint Not Subject to Insurer's Motion to Dismiss Based on Conversion of Funds Exclusion

A New Jersey federal district court has held that a declaratory judgment and breach of contract action against a professional liability insurer was not subject to dismissal for failure to state a claim based on the policy's conversion of funds exclusion as a matter of law because the court could not conclude whether conversion occurred, or whether the claim arose out of conversion, at such an early stage in the proceeding. *ABL Title Ins. Agency, LLC v. Maxum Indem. Co.*, 2016 WL 3610163 (D.N.J. June 30, 2016).

In connection with a real estate sale for which the insured title agency served as the closing agent, and after the insured had issued a check to the seller, the insured was forwarded fraudulent wiring instructions sent by a hacker using an email address resembling that of the seller's attorney. An employee of the insured, apparently failing to follow standard and prudent wire transfer procedures, initiated a wire transfer of $579,360.48 the following business day. After the transfer resulted in a shortfall in the insured's accounts, several other parties made demands on the insured for dishonored checks or escrowed items that the insured could not cover. The insured tendered the claim to its professional liability insurer, and, after the insurer did not confirm or deny coverage for a period of time, the insured filed an action for a declaratory judgment as to coverage and breach of contract.

The insurer sought dismissal of the complaint for failure to state a claim upon which relief could be granted based on a policy exclusion stating that the insurer had no duty to defend or indemnify any claim or suit "arising out of or resulting from . . . [a]ny damages arising out of the commingling, conversion, misappropriation or defalcation of funds or other property." The insurer asserted in its moving papers that the insured's employee committed

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conversion, and in its reply papers that the hacker committed conversion, and that, in either case, the exclusion applied. The insured argued that its claim arose not out of conversion, but instead out of its employee's negligence in initiating a wire transfer without following proper procedures. The insured further contended that its employee could not have converted the property because it was authorized to issue money to sellers at the direction of the buyer's attorneys, and that the hacker could not have converted the property because it was unclear who had the right to immediate possession of the property with which the hacker interfered.

The court held that dismissal would require the court to summarily determine that the claim for coverage arose out of a conversion, and that it was not in a position to do so at such an early stage of the proceedings. The court concluded that the applicability of the policy exclusion was a question of law dependent on underlying questions of fact (whether the tort of conversion occurred) and that it therefore could not determine from the factual allegations that the conversion exclusion barred coverage. Accordingly, it denied the carrier's motion to dismiss. ■

Negligent Misrepresentation Claim Alleges Wrongful Act Despite Contract-Based Damages

A Massachusetts intermediate appellate court has held that a claim for negligent misrepresentation alleged a Wrongful Act, even though the alleged damages were based on contractual services. *Winbrook Comm. Servs., Inc. v. U.S. Liability Ins. Co*., 2016 WL 3245059 (Mass. App. Ct. June 14, 2016). Additionally, the court held that the creation of an opportunity for an insured business can be an "advantage in fact" sufficient to trigger a personal profit exclusion.

An insurer issued a D&O policy to an insured company. The policy provided specified coverage for Wrongful Acts, defined as: "any actual or alleged act, error, omission, misstatement, misleading statement, neglect or breach of duties." The policy contained a personal profit exclusion, which stated that the insurer "shall not be liable to make payment for Loss in connection with any Claim made against any Insured arising out of, directly or indirectly resulting from or in consequence of, or in any way involving: . . . any of the Insureds gaining in fact any profit, benefit, remuneration or advantage to which such Insured was not legally entitled."

A claimant filed suit against the insured company alleging that the company had made negligent misrepresentations regarding its financial condition, which induced the claimant to continue to work on the development of a book series. The series never went to market, and the claimant sought compensation from the insured for the work performed on the series.

The company sought coverage for the claim under the D&O policy. The insurer denied coverage for the claim on the grounds that: (1) the claim was for failure to pay contractual debts and thus did not allege a Wrongful Act, and (2) the policy's personal profit exclusion barred coverage. The insured company failed to defend the claim, resulting in a default judgment against the company. The claimant then filed suit against the insurer for recovery of the judgment. In the coverage litigation, the trial court rejected the insurer's argument that the claim was based on contract and did not allege a Wrongful Act. The trial court did, however, grant summary judgment in favor of the insurer based on the application of the personal profit exclusion.

On appeal, the court again rejected the insurer's contention that the claim did not allege a Wrongful Act. According to the court, the underlying complaint had alleged liability based on negligent misrepresentation, not breach of contract. The court reasoned that, just because the damages sought for the negligence claim were the cost of the goods and the services performed, it does not mean the claim is one derived from contract and outside the coverage grant of the policy. Additionally, the court held that the insurer, which had failed to defend the insured, was bound by the default judgment entered against the insured company and could not relitigate the liability issues that pertained to coverage.

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Negligent Misrepresentation Claim Alleges Wrongful Act Despite Contract-Based Damages

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With regard to the personal profit exclusion, on appeal, the claimant argued that the insured did not actually receive a benefit because it received only the opportunity to gain a profit and no actual profit. The court rejected this argument, holding that an opportunity may constitute an "advantage in fact" under the exclusion because actions such as the extension of trade credit can create an advantage in the form of opportunity for a business to attract capital or customers. Nevertheless, the court held that the insurer had failed to demonstrate that such an opportunity was created, and that additional discovery was needed. Accordingly, the court reversed the grant of summary judgment to the insurer, and remanded the matter for further proceedings. ■

SPEECHES & EVENTS

Coverage and Conditions: The State of the Public D&O Market

Daniel J. Standish, Speaker

2016 Executive Risk Insights Conference

September 21, 2016 | New York, NY

How Could I Have Known? Prior Knowledge Coverage Issues in Lawyers Professional Liability Cases

Kimberly A. Ashmore, Speaker

American Bar Association's 2016 National Legal Malpractice Conference

September 22, 2016 | Chicago, IL

Private Equity and M&A Insurance: Not Your Mother's D&O Policy

Kimberly M. Melvin, Speaker

American Bar Association's 2016 Women in Insurance Networking and CL Workshop

October 20, 2016 | Washington, DC

Trying a Case and Strategies for Handling Legal Malpractice Cases

Richard A. Simpson, Speaker

American Conference Institute's Advanced Forum on LPL/Legal Malpractice

October 25, 2016 | New York, NY

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