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Insured's Failure to Give Notice of Suit Barred Coverage, Even If It Gave Notice of Claim, Fourth Circuit Rules

The U.S. Court of Appeals for the Fourth Circuit, affirming a district court's decision, has ruled that an insurer had no duty to indemnify its insured where the insured had not timely notified the insurer of a lawsuit that led to a default judgment against the insured, even if the insured had notified the insurer of the underlying claim.

The Case

On September 29, 2012, a bar patron assaulted another customer, leaving him in a permanent, quasi-vegetative state. The bar did not notify its commercial general liability insurer of the customer's injuries when they occurred.

The bar did, however, send its agent a notice of representation letter that the customer's attorney sent it on November 21, 2012. The agent forwarded the letter to the insurance wholesaler from which she had acquired the bar's insurance.

The customer sued the bar on December 19, 2012. The bar did not forward the legal papers to its insurer or the wholesaler.

The state court entered a default judgment against the bar and scheduled a hearing on damages.

In May 2013, the bar's insurer received the summons and complaint. The insurer subsequently filed an action seeking a declaration that it did not have to cover the claim against the bar.

The U.S. District Court for the District of South Carolina granted summary judgment in favor of the insurer, finding that the bar had failed to provide its insurer with timely notice of the customer's lawsuit.

The customer appealed to the Fourth Circuit.

The Fourth Circuit's Decision

The Fourth Circuit affirmed.

In its decision, the circuit court explained that the bar's insurance policy required that it provide the insurer with notice "as soon as practicable" if a claim was made or lawsuit was brought against the bar. Moreover, the circuit court added, its policy required that the bar "immediately send [the

insurer] copies of any demands, notices, summons or legal papers received in connection with the claim or 'suit.'"

Here, the Fourth Circuit continued, the insurer did not receive notice of the lawsuit or copies of the legal papers until after the state court had entered default in favor of the customer. Indeed, the circuit court added that there was no evidence indicating that the insurer had ever received notice that the customer had filed a lawsuit before the trial court entered the default judgment.

According to the circuit court, even if the insurer had actual knowledge of a potential claim or occurrence triggering coverage under the policy, the bar was not relieved of its contractual obligation to provide the legal papers to the insurer.

The Fourth Circuit then ruled that the insurer had been substantially prejudiced by the bar's failure to provide notice because the insurer did not have the opportunity to properly investigate the case, to raise defenses to the lawsuit, or to negotiate a settlement without the handicap of the default position. Summary judgment in favor of the insurer, the circuit court concluded, was appropriate.

Interestingly, the circuit court also ruled that the customer was not entitled to recover medical payments under the bar's insurance because the customer refused to provide medical bills to the insurer even after the insurer specifically requested them. The circuit court rejected the customer's contention that his failure to provide proof that he incurred medical expenses did not matter because the insurer was not prejudiced by his failure to provide the medical bills, concluding that the insurer had to show prejudice only where the rights of an innocent third party was jeopardized by the insured and here the customer was not an innocent third party whose rights were jeopardized by the bar.

The case is *Founders Ins. Co. v. Richard Ruth's Bar & Grill LLC*, No. 17-1282 (4th Cir. Feb. 21, 2019).

Late Notice of Leak Prejudiced Insurer and Doomed Homeowner's Bid for First-Party Coverage

A federal district court in Michigan has ruled that a homeowner was not entitled to coverage for damage suffered after a water leak where the homeowner did not notify her insurer about the alleged loss for two months – during which time she nearly completed repairing all of the alleged damage.

The Case

Sometime between January 28 and February 2, 2014, a pipe allegedly froze or burst at a home in Belleville, Michigan. The homeowner filed a claim with her insurer on April 4, 2014.

Between the date of the alleged loss and the date on which the homeowner alerted her insurer, the homeowner, in her own words, "gutted the house," fully completed remediation of the damage, and nearly completed all repairs, employing family, friends, and some outside contractors, and paying them almost exclusively in cash.

The homeowner ultimately submitted a claim to her insurer for approximately $132,000, with no invoices, receipts, or documented proof of payment to support the scope of the loss, the necessity of the extensive repairs that she undertook, or the amounts that she claimed to have paid.

The insurer denied the claim and the homeowner sued.

The insurer moved for summary judgment. It argued that the insured's notice two months after the alleged loss violated the policy's "immediate notice" provision. Because the homeowner did not provide immediate notice, the insurer was unable to determine the actual date of occurrence, the actual extent of the damage, or the nature of the repairs that had been undertaken.

The District Court's Decision

The district court granted the insurer's motion.

In its decision, the district court decided that the insured's notice to her insurer on April 4, 2014 did not comply with the policy's notice provision and was untimely.

The district court also ruled that, as a result of the untimely notice, the insurer was "materially prejudiced" by its inability to "investigate liability and damage so as to protect its interests," and by its inability to evaluate the damage in its original state, to determine the necessary repairs, to negotiate with contractors for the repairs it might have deemed necessary, and to contest its liability to the homeowner.

The district court concluded that, on these facts, reasonable minds could not differ in finding that the delay in this case, and more specifically the work completed during that delay by the homeowner before giving notice to her insurer, prejudiced the insurer's ability to investigate the facts and circumstances of the alleged loss. It also prejudiced the insurer's ability to determine the scope of the loss and the extent of its liability.

The homeowner's failure to comply with the condition precedent to coverage under her policy entitled the insurer to summary judgment, the district court concluded.

The case is *Keathley v. Grange Ins. Co.*, No. 15-cv-11888 (E.D. Mich. Feb. 4, 2019).

State Notice-Prejudice Rule Did Not Apply to ERISA Case, First Circuit Affirms

The U.S. Court of Appeals for the First Circuit, affirming a district court's decision, has ruled that New Hampshire's notice-prejudice rule did not apply to a case brought against an insurer of a long-term disability benefits plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA").

The Case

A disability insurer notified a participant in a long-term disability benefits plan governed by the ERISA that the long-term disability ("LTD") benefits it had provided her under the plan would expire because she had not shown that she was eligible for a continuation of those benefits.

The notice informed the participant that she had to file any appeal within 180 days of receipt of the notice. She did not do so, instead filing her appeal about two months after the deadline. The insurer denied the appeal as untimely.

The participant sued the insurer, arguing that her untimely appeal was excusable. Among other things, she argued that New Hampshire's common law notice-prejudice rule (under which an insurer must show prejudice to deny certain limited types of untimely insurance claims) applied to her situation.

The U.S. District Court for the District of New Hampshire rejected her contentions, found that she had not exhausted her administrative remedies, and ruled in favor of the insurer.

The participant appealed to the First Circuit.

The First Circuit's Decision

The First Circuit affirmed, ruling that New Hampshire's notice-prejudice rule did not apply in the ERISA context.

In its decision, the First Circuit explained that Congress' apparent intent in mandating internal claims procedures in ERISA cases was to minimize the number of frivolous ERISA lawsuits, promote the consistent treatment of benefit claims, provide a non-adversarial dispute resolution process, and decrease the cost and time of claims settlement. In the First Circuit's opinion, applying New Hampshire's notice prejudice rule "would reduce consistency in determinations and national consistency" and jeopardize those goals.

The First Circuit added that permitting appeals well after the time for them had passed would "increase the cost and time of the settlement process" and would undercut ERISA's exhaustion requirement.

Accordingly, the First Circuit decided, New Hampshire's notice-prejudice rule did not apply to ERISA appeals.

The case is *Fortier v. Hartford Life & Accident Ins. Co.*, No. 18-1752 (1st Cir. Feb. 20, 2019).

Insects and Vermin Exclusion Barred Coverage for Claim That Brown Recluse Spiders Infested Insureds' Home

A federal district court in Alabama has ruled that an insects and vermin exclusion in a homeowners' insurance policy precluded coverage of a claim that brown recluse spiders infested the insureds' home.

The Case

The owners of a home in Gadsden, Alabama, asserted that it was infested with "a large colony of highly venomous brown recluse spiders." They alleged that "brown recluse spiders have been found in every area and room" of their home, "including inside their children's clothes, shoes, in their bathrooms and showers, under their beds, in the kitchen sink, and in light fixtures."

The homeowners asserted that even after a pest control company treated their home on three occasions in an effort to eradicate the spider infestation, the spiders continue to "permeate" their home.

The homeowners filed an insurance claim with their insurer, which denied the claim based on the policy's insects/vermin exclusion.

The homeowners sued for breach of contract, and the insurer moved to dismiss.

The District Court's Decision

The district court granted the insurer's motion.

In its decision, the district court explained that the homeowners' insurance excluded coverage for loss "[c]aused by . . . birds, vermin, rodents, or insects." Thus, the district court continued, if spiders were "insects" or "vermin," then the exclusion applied. If spiders were not "insects" or "vermin," then the exclusion did not apply.

After noting that the policy did not define "insects" or "vermin," the district court turned to dictionaries to determine whether an ordinary person would have understood them to include spiders. The court determined that the majority of definitions included spiders within the definition of "insect."

The homeowners argued that scientifically, spiders and insects are classified differently depending on body shape and the number of legs. Therefore, it contended that the average person understands that spiders are arachnids, not insects.

But the court rejected the homeowners' argument and ruled that the term "insect," in its "plain and ordinary sense," included spiders. To hold otherwise, the court stated, would require it to ignore the rules of contract interpretation. When applying the ordinary, rather than technical or scientific meaning, the term "insect" includes spiders.

The district court also found that the exclusion applied because "a person of ordinary intelligence" would understand that spiders were small harmful, objectionable, noxious, or disgusting animals that sometimes occurred in great numbers and that could be difficult to control – that is, that they were "vermin."

The district court concluded that the terms "insect" and "vermin" were not ambiguous and, applying their ordinary meanings, reiterated that the terms included spiders. Accordingly, the insects and vermin exclusion precluded coverage of their claim.

The case is *Robinson v. Liberty Mutual Ins. Co.*, No.: 4:18-cv-1509-ACA (N.D. Ala. Feb. 11, 2019)

Pollution Exclusion Applied to Welder's Lung Claim, 11th Circuit Decides

The U.S. Court of Appeals for the Eleventh Circuit has affirmed a district court's decision that a pollution exclusion in a commercial general liability insurance policy precluded coverage of a lawsuit against the insured brought by an employee who claimed that he developed an occupational disease known as welder's lung.

The Case

Sandersville Railroad Company, the operator of a short line railroad in Georgia, was sued by an employee who alleged that he developed a lung disease called siderosis, or welder's lung.

After Sandersville notified its commercial general liability insurer of the lawsuit, the insurer declined coverage based on its policy's pollution exclusion.

Sandersville settled the claim without contribution from the insurer. The insurer meanwhile sought a declaration that the pollution exclusion clause in its policy excluded coverage of the welder's lung claim.

The U.S. District Court for the Middle District of Georgia granted summary judgment to the insurer, holding that the pollution exclusion barred coverage. Sandersville appealed to the Eleventh Circuit.

The Eleventh Circuit's Decision

The circuit court affirmed.

In its decision, the circuit court explained that the employee who sued Sandersville alleged that his injury arose from inhaling welding fumes containing iron particles. The Eleventh Circuit ruled that, under the policy's pollution exclusion, welding fumes "unambiguously" qualified as an "irritant or contaminant, including . . . fumes."

Lung disease caused by the inhalation of fumes released by welding, the circuit court concluded, fell "within the terms of the pollution exclusion."

The case is *Evanston Ins. Co. v. Sandersville Railroad Co.*, No. 17-14487 (11th Cir. Feb. 8, 2019).

Intentional Acts Exclusion Precluded Coverage of Estate's Suit Against Insured, 8th Circuit Rules

The U.S. Court of Appeals for the Eighth Circuit, affirming a district court's decision, has ruled that an insurer that issued a commercial excess liability insurance policy had no duty to defend the insured against a lawsuit brought by the estate of an employee who died at work.

The Case

After a Strata Corporation employee fell to his death at a Montana mine, his estate sued Strata, alleging that its intentional failure to maintain a safe workplace triggered an exception to the exclusive remedy of Montana's workers' compensation law and gave it a cause of action against Strata.

Strata eventually settled the estate's lawsuit, with the insurer that previously issued Strata a workers' compensation and employers' liability insurance policy contributing a portion of the settlement in exchange for a release from Strata.

The insurer that had issued a commercial excess liability insurance policy to Strata declined to contribute to the settlement and sought a declaratory judgment that it had no duty to defend or indemnify Strata and that it had not breached its duty of good faith.

The U.S. District Court for the District of North Dakota granted summary judgment in favor of the insurer, and Strata appealed to the Eighth Circuit.

The Eighth Circuit's Decision

The Eighth Circuit affirmed.

In its decision, the circuit court explained that the excess policy stated that it was subject to exclusions in the underlying coverage, and that an endorsement to the workers' compensation and employers' liability insurance policy excluded coverage for bodily injury caused by any intentional, malicious, or deliberate "act" by Strata.

The circuit court found that the exclusion was not ambiguous. It then pointed out that, to evade the exclusivity provision of Montana's workers' compensation law, the estate alleged that Strata's deliberate and intentional acts had caused his death. Those allegations, the circuit court ruled, brought the estate's lawsuit within the exclusion.

The Eighth Circuit concluded that because the excess policy did not provide coverage for the estate's claims, the excess insurer also had not breached its duty of good faith.

The case is *Houston Casualty Co. v. Strata Corp.*, Nos. 17-3404, 17-3405 (8th Cir. Feb. 6, 2019).

Insurer Failed to Reserve Rights Before Undertaking Insureds' Defense

A federal district court in Georgia has ruled that an insurer was estopped from denying coverage to two officers of an insured limited liability company where the insurer undertook the officers' defense before sending them reservation of rights letters.

The Case

In May 2015, a construction worker allegedly was injured while working at a construction site. A subcontractor that was a limited liability company did not notify its commercial general liability insurer about the construction worker's claim until it was served with a complaint filed by the construction worker on April 5, 2017.

On April 18, 2017, the subcontractor's insurer mailed a reservation of rights letter to the subcontractor that was delivered on April 20, 2017. The insurer retained counsel to defend the subcontractor, and counsel filed an answer on the subcontractor's behalf on April 24, 2017.

On April 28, 2017, the construction worker amended his complaint to add claims against two officers of the subcontractor. On May 23, 2017, counsel filed an answer on behalf of the subcontractor and the two officers.

Thereafter, the insurer issued two more reservation of rights letters. These were mailed a day apart to separate officers of the subcontractor. Both letters were delivered on August 10, 2017.

The insurer asked the U.S. District Court for the Northern District of Georgia to declare that it had no duty to defend or indemnify the subcontractor or its officers against the construction worker's complaint.

The parties moved for summary judgment.

Among other things, the two officers disputed the efficacy of the second and third reservation of rights letters sent by the insurer, arguing that the insurer was estopped from denying coverage to them because it failed to reserve its rights before providing them with a defense.

The District Court's Decision

The district court granted summary judgment in favor of the two officers.

In its decision, the district court ruled that the insurer was estopped from denying coverage to the two officers "due to its failure to reserve rights before providing [them] with a defense."

The district court pointed out that the policy treated each insured – the subcontractor, and the two officers – "separately for purposes of coverage" by way of the policy's "separation of insureds" provision.

Therefore, the district court reasoned, the first reservation of rights letter, which the insurer sent to the subcontractor before its officers were sued by the construction worker, "was insufficient for the insurer to reserve its rights as to [the officers]."

Significantly, the district court pointed out, the insurer defended the officers in the construction worker's action for nearly three months, between May 23, 2017, when counsel filed an answer on their behalf in the underlying action, through August 2017, when the second and third letters were delivered. The district court also pointed out that the insurer pursued its action for declaratory relief as to the subcontractor but not as to the two officers from May 31 to August 18, 2017.

Under these circumstances, the district court concluded, the insurer was estopped from denying coverage to the two officers.

The case is *Auto-Owners Ins. Co. v. Cribb*, No. 2:17-CV-106-RWS (N.D. Ga. Feb. 5, 2019).

With Broad Reading of Causal Connection Requirement, Wisconsin Supreme Court Finds Advertising Injury Coverage

The Supreme Court of Wisconsin has ruled in favor of a company seeking advertising injury coverage under its commercial general liability insurance policy, broadly interpreting the causal connection requirement and rejecting arguments that coverage was precluded by two exclusions.

The Case

Abbott Laboratories sued Ixthus Medical Supply, Inc., and more than 100 other defendants, asserting trademark infringement and unfair competition claims for relief based on its belief that the defendants were importing, advertising and distributing boxes of Abbott's international test strips in the United States.

A Wisconsin trial court ruled that the insurer that issued a commercial general liability insurance policy to Ixthus did not have to defend Ixthus. An appellate court reversed, concluding that the insurer did have a duty to defend Ixthus. The case reached the Wisconsin Supreme Court.

The Wisconsin Supreme Court's Decision

The court affirmed.

In its decision, the court decided that the allegations in Abbott's complaint fell within the initial grant of coverage under the "personal and advertising injury liability" provision of Ixthus' insurance policy.

The insurer argued that the complaint did not allege any advertising that caused injury to Abbott. Instead, the allegations in the complaint focused on importation and distribution, not advertising.

In considering whether the claim potentially fell within the coverage grant, the court said the test is whether the allegations sufficiently assert that advertising did in fact contribute materially to the

injury. The court pointed to allegations in the complaint that applied to all defendants that suggested unauthorized importation, advertisement, and subsequent distribution caused consumer confusion. The insurer conceded that the general reference to "defendants" included the insured, Ixthus, but contended that Ixthus was not an advertising defendant, only a distributing defendant. It did not advertise or sell products directly to end users. The insurer thus argued that the "causation" paragraphs were insufficient to connect Ixthus's activity to the enumerated offenses in the advertising injury coverage.

The court rejected this argument, stating that the insurer's spin on these causation paragraphs did not eliminate coverage at the duty to defend stage. The court pointed to a Wisconsin appellate court decision that found a manufacturer had engaged in covered advertising activity because its packaging constituted a published advertisement. Just like the manufacturer in that case, the court noted that Ixthus need not be the "'first, last or only, entity' alleged to advertise in order to be engaged in covered advertising activity." The court further reasoned that the advertising need not be the sole cause of the harm; it must merely contribute materially to the harm.

The court acknowledged that "[f]leshing out the factual allegations at trial may affect indemnification," but at the duty to defend stage, it must liberally construe all allegations in the complaint and make all reasonable inferences from those allegations. In the court's view, given the allegations in the complaint, it was "reasonable to infer" that Ixthus' alleged advertising activity contributed materially to Abbott's alleged injuries.

The court then found that neither the policy's knowing violation exclusion nor its criminal acts exclusion precluded coverage.

First, the court ruled, the knowing violation exclusion did not apply because it precluded coverage at the duty-to-defend stage only when every claim alleged in the complaint required the plaintiff to prove the insured had acted with knowledge that its actions "would violate the rights of another and would inflict 'personal and advertising injury.'" The court pointed out that neither Abbott's claim for trademark dilution under the Lanham Act nor its separate claim for trademark dilution under New York law required proof that Ixthus had acted knowingly or intentionally.

The court concluded that the criminal acts exclusion also did not preclude coverage, reasoning that Abbott's complaint alleged some claims – such as Lanham Act violations – that were not dependent on a showing of criminal conduct.

The case is *West Bend Mutual Ins. Co. v. Ixthus Medical Supply, Inc.*, No. 2017AP909 (Wis. Feb. 28, 2019).

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