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Alabama Supreme Court Finds No Coverage for Claim Alleging Faulty Work

The Supreme Court of Alabama has reversed a trial court's decision and ruled that a construction company was not entitled to coverage for a claim alleging faulty workmanship.

The Case

Saurin and Valerie Shah purchased a newly built house from The David Group, Inc. ("TDG"), a construction company specializing in custom-built houses, remodeling, and construction services. But soon they began experiencing problems with their new house.

The Shahs sued TDG, alleging that the house had "severe structural issues" and that they had discovered "numerous and substantial construction defects in the residence including, but not limited to, serious defects resulting in health and safety issues, building code violations, poor workmanship, misuse of construction materials, and disregard of proper installation methods."

TDG's commercial general liability ("CGL") insurance carrier determined that it was not obligated to defend or to indemnify TDG because the alleged damage did not constitute an occurrence.

TDG asked an Alabama court to declare that its insurer was required to defend and indemnify TDG. That declaratory judgment action was stayed while the Shahs and TDG went to arbitration. The arbitrator awarded the Shahs $12,725.

The trial court in TDG's declaratory judgment action granted partial summary judgment in favor of TDG on the issue of coverage. The trial court held that the Shahs' complaint alleged, and the arbitration award indicated, that there was damage to the Shahs' house that resulted from or, was caused by, TDG's faulty work. The trial court concluded that TDG was entitled to both defense costs and indemnification under the CGL policy.

The insurer appealed to the Alabama Supreme Court. It argued that the defects alleged by the Shahs and identified by the arbitrator referred to nothing more than faulty work performed by TDG, and therefore, were not occurrences that triggered coverage under the CGL policy.

The Alabama Supreme Court's Decision

The court reversed.

In its decision, the court explained that it had repeatedly held that "faulty workmanship itself" was not an occurrence under a CGL policy. However, the court held that faulty work could lead to an

occurrence and trigger coverage under a CGL policy "if it subjects personal property or other parts of the [damaged] structure to 'continuous or repeated exposure' to some other 'general harmful condition' . . . and, as a result of that exposure, personal property or other parts of the structure are damaged."

This concept, the court added, was consistent with the idea that a CGL policy was intended to protect an insured contractor from tort liability, and not to insulate it from its own faulty work.

The court noted that the Shahs' complaint alleged that there were "numerous and substantial construction defects" throughout their house. The court noted that although the Shahs did not specifically describe those defects in their complaint, they alleged that they included, but were not limited to, "structural issues," "serious defects resulting in health and safety issues, building code violations, poor workmanship, misuse of construction materials, and disregard of proper installation methods."

The court disagreed with the trial court's conclusion that, although the arbitrator's award was not "expressly clear" as to the basis for awarding damages, the Shahs' complaint "sufficiently allege[d] claims other than faulty workmanship and pray[ed] for damages on [those] claims" and that the arbitrator "had the opportunity to find [that] the Shahs suffered damages due to occurrences caused by faulty workmanship."

Rather, the court ruled, the Shahs' complaint "clearly allege[d] faulty workmanship," and at no point did the Shahs allege additional or resulting damage to their house or to their personal property as a result of that faulty workmanship. The court concluded that there was no property damage or personal injury resulting from an occurrence that triggered coverage under the CGL policy.

The case is *Nationwide Mut. Fire Ins. Co. v. The David Group, Inc.*, No. 1170588 (Ala. May 24, 2019).

Iowa Supreme Court Rejects Bad Faith Action Against Third-Party Claims Administrator for Workers' Compensation Insurer

The Supreme Court of Iowa, in response to a question certified to it by the U.S. District Court for the Northern District of Iowa, has ruled that there is no common law cause of action in Iowa for bad faith failure to pay workers' compensation benefits against a third-party claims administrator.

The Case

The claimaint, Samuel De Dios, alleged that he was injured at work and sought workers' compensation benefits.

After his claim was denied, De Dios filed a bad faith action against his employer's workers' compensation insurer and the third-party administrator to which he alleged the insurer had delegated its authority to investigate, handle, manage, administer, and pay benefits under Iowa's workers' compensation law.

The district court asked the Supreme Court of Iowa to answer the following question of Iowa law:

> In what circumstances, if any, can an injured employee hold a third-party claims administrator liable for the tort of bad faith for failure to pay workers' compensation benefits?

The Iowa Supreme Court's Decision

The court ruled that there is no common law cause of action in Iowa for bad faith failure to pay workers' compensation benefits against a third-party claims administrator.

In its decision, the court explained that, in Iowa, a cause of action for bad faith arises from: (1) the special contractual relationship between insurer and insured; (2) the specific statutory and administrative duties imposed on insurers; or (3) some combination of the two.

The court then found that a third-party administrator did not possess the attributes that have led to the imposition of bad faith liability. For one thing, the court noted, a third-party administrator was not in an insurer-insured relationship with anyone. The court added that a third-party administrator was not required to meet "rigorous financial requirements" and was not under the ongoing supervision of the workers' compensation commissioner.

In addition, the court observed that although Iowa's workers' compensation law imposed affirmative obligations on insurers with respect to their handling of workers' compensation claims, it did not impose any such obligations on third-party administrators.

In the court's view, this showed that a third-party administrator was not an insurer or the substantial equivalent of an insurer. Therefore, the court concluded, the statutes and regulations directed at the duty of good faith and fair dealing owed by insurance carriers to injured workers did "not apply to third-party administrators."

The case is *De Dios v. Indemnity Ins. Co. of North America*, No. 18-1227 (Iowa May 10, 2019).

Delaware Trial Court Dismisses Bad Faith Claim Against Insurers Over Dole Food-Related Lawsuits

A Delaware trial court has rejected a bad faith claim against numerous insurance companies stemming from litigation relating to Dole Food Company, Inc. on the basis that the insurers had reasonable justification to deny coverage.

The Case

Shareholders of Dole Food Company, Inc., sued David Murdock, who owned 40 percent of Dole stock and was its chief executive officer, challenging the fairness of Dole's merger with DFC Holdings, LLC.

Dole asked its insurers to fund a settlement. In response, the insurers cited various potential exclusions and requested more information from Dole.

After Dole and Murdock signed a formal settlement agreement of the shareholder suit, Dole and Murdock were sued in a separate action by a pension plan. They also settled the pension plan action.

The insurers filed a declaratory judgment action. Dole and Murdock asserted a number of counterclaims, including that the insurers had breached the implied covenant of good faith and fair dealing by denying coverage for the two settlements.

The bad faith counterclaim alleged that the insurers had acted in bad faith by, among other things, artificially and narrowly interpreting the insurance policies, asserting grounds to avoid coverage that the insurers knew were contrary to law and policy, and failing to inquire into bases that would support indemnification.

The insurers moved for summary judgment on the bad faith claim.

The Court's Decision

The court granted the insurers' motion.

In its decision, the court explained that, under Delaware law, claimants had the burden of proof for a bad faith claim and had to show that their insurers lacked "reasonable justification" to deny coverage.

The court found that the insurers had provided "a number of well-reasoned arguments" for denying coverage, including their policies' fraud exclusion and the defendants' alleged failure to comply with their policies' written consent and cooperation clauses.

The court rejected the defendants' argument that the insurers had acted in bad faith because they had applied California law as a default without conducting a more thorough choice of law analysis. According to the court, applying California law as a default, while incorrect, was reasonable. The court noted that the policies were delivered to Dole at its California headquarters, were negotiated by California brokers, and included California amendatory endorsements. Moreover, the court said, it was aware of only one other written decision by a court on the issue of the law that applied to directors and officers liability insurance policies.

The court also pointed out that the insurers "quickly moved" to have a determination as to indemnification by filing their declaratory judgment action.

Because the insurers had reasonable grounds for denying coverage, the court concluded that the insurers were entitled to summary judgement on the bad faith counterclaim.

The case is *Arch Ins. Co. v. Murdock*, No. N16C-01-104 EMD CCLD (Del. Super. Ct. May 1, 2019).

Court Adopts *Pro Rata* Allocation in Lead Paint Exposure Case, Leaving Issue of Start Date Open

A federal court in Maryland has adopted *pro rata* allocation in a case involving allegations of lead paint exposure, but found a material issue of fact as to the start date for calculating the amount of the insurer's obligation.

The Case

Ky'Won Pitts filed a lawsuit alleging that he had been exposed to lead paint at his Baltimore residence.

An insurer issued a personal umbrella liability insurance policy to one of the defendants that was effective on June 13, 1988. It asked the U.S. District Court for the District of Maryland to declare that the *pro rata* method of damages allocation applied and resulted in the insurer being liable for 24.01 percent of the total damages payable by its insured, with its insured responsible for the balance.

The insurer claimed that its liability corresponded to its time on the risk divided by the period of time between Pitts' date of birth and June 13, 1999. In particular, for the numerator, the insurer claimed the policy covered only the 213-day period from November 12, 1998 (Pitts' date of birth) to June 13, 1999 (the date the policy was modified to exclude lead coverage). For the denominator, the insurer asserted that the entire period during which exposure had occurred was the 887-day period between November 12, 1998 (Pitts' date of birth) and April 17, 2001 (the last possible date he resided at the property). Therefore, the insurer asserted it could be held liable for 24.01 percent (213/887) of the damages awarded to Pitts.

Pitts disagreed. He argued that it was inappropriate to use the *pro rata* method in this case. Pitts also asserted that if the *pro rata* method applied, the proper start dates for calculating both the numerator and denominator were earlier than the insurer asserted because his exposure to the lead paint had begun before he was born. According to Pitts, that altered the *pro rata* calculation to a numerator of 361 days and a denominator of 1,035 days and resulted in the insurer being liable for 34.88 percent (361/1,035) of any damages award.

The parties moved for summary judgment.

The Court's Decision

The court first ruled that the *pro rata* method applied because the policy stated that coverage applied to an occurrence that occurred "while the insurance is in force."

The court then addressed how to calculate the percentages payable by the insurer and its insured. The court noted that Pitts had provided a physician's affidavit that said that it was his opinion within a reasonable degree of medical certainty that Pitts had been exposed to lead-based paint while in utero, from the date on which his mother had moved to the Baltimore residence until his birth.

As a result, the court found that there was a genuine dispute of material fact as to the proper start date of the exposure period and it denied without prejudice the insurer's motion as to the correct starting date of the exposure period.

The case is *Allstate Ins. Co. v. Pitts*, No. 1:18-cv-01795-JMC (D. Md. May 3, 2019).

Invasion of Privacy Exclusion Precluded Coverage of $60 Million Settlement in TCPA Suit

A federal district court in Florida has ruled that an insurer had no obligation to cover a $60 million settlement of a lawsuit alleging that its insured had violated the federal Telephone Consumer Protection Act ("TCPA") by sending unsolicited text messages.

The Case

Class action plaintiffs sued iCan Benefit Group, LLC, for allegedly violating the TCPA.

iCan's insurer denied coverage.

The plaintiffs and iCan settled the TCPA suit, agreeing to a judgment of $60,413,112 that the plaintiffs could seek to collect from iCan's insurer.

The plaintiffs then sued iCan's insurer, and the parties moved for summary judgment.

The insurer argued that the entire lawsuit arose out of an invasion of privacy and that the policy's invasion of privacy exclusion applied.

The plaintiffs contended that the invasion of privacy exclusion was inapplicable because there were other allegations, in addition to invasion of privacy, in the complaint against iCan.

The District Court's Decision

The court granted the insurer's motion.

In its decision, the court explained that if the complaint against iCan or its causes of action, "expressly or by incorporation, originated from, grew out of, flowed from, or merely *had a connection with* any actual or alleged invasion of privacy," there was no coverage under the insurance policy.

The court then found that, based on the allegations in the complaint against iCan, all of the plaintiffs' claims arose out of alleged TCPA violations that invaded the class action plaintiffs' privacy, and the policy therefore did not cover the settlement or iCan's defense costs.

The case is *Horn v. Liberty Ins. Underwriters, Inc.*, No. 9:18-CV-80762 (S.D. Fla. May 30, 2019).

'Fraudulent Transfer Request' Exclusion Barred Coverage for Payments to Impostor's Bank Account

A federal district court in Washington has ruled that an insurer was not required to cover losses an insured suffered after it made payments to an impostor's bank account instead of to its contractor's account following its receipt of a spoofed email.

The Case

On November 16, 2017, an accounts payable clerk at Tidewater Holdings, Inc., received a computer generated external email from an impostor instructing the clerk to alter the payment details Tidewater held on file for JH Kelly, a general contractor for Tidewater.

In response to the email, Tidewater's clerk changed the payment details for JH Kelly in Tidewater's computer system. This resulted in Tidewater making four payments totaling $568,448.92 to the imposter's bank account instead of to JH Kelly's actual account.

Tidewater engaged KPMG to assist in an investigation. Tidewater, which was invoiced $27,879.48 for the cost of KPMG's investigation, was able to recover $288,388.91 of the fraudulently diverted funds. Overall, it lost $280,060.01 and incurred the costs of its investigation.

Tidewater's insurer offered to provide $25,000 of coverage to Tidewater under its policy's supplemental funds transfer coverage provision, minus the applicable deductible, for the costs of KPMG's investigation.

Tidewater asserted that this effectively resulted in a denial of coverage under the computer fraud coverage provision of its insurance policy, and it sued the insurer.

The insurer moved to dismiss.

The District Court's Decision

The court granted the insurer's motion.

In its decision, the court assumed for purposes of deciding the insurer's motion that Tidewater's loss was a covered loss. It then found the following exclusion to be dispositive:

> b) With respect to all Insuring Clauses other than the Supplemental Funds Transfer Insuring Clause, the Insurer shall not be liable for any loss resulting from any Fraudulent Transfer Request.

The court ruled that the fraudulent transfer request exclusion was unambiguous and that it applied to "every clause" in the policy that provided coverage.

Therefore, the court concluded, the insurer had met its burden to establish that the fraudulent transfer request exclusion limited coverage for Tidewater's loss to the $25,000 coverage provided in the supplemental funds transfer endorsement, less the deductible.

The case is *Tidewater Holdings, Inc. v. Westchester Fire Ins. Co.*, No. C18-6006 BHS (W.D. Wash. May 31, 2019).

Missouri Federal District Court: "Sudden And Accidental" Pollution Exclusion Bars Coverage for Asbestos Claim

A Missouri federal court, enforcing a "sudden and accidental" pollution exclusion, has ruled that an insurer wasn't obligated to contribute to the settlement or defense costs paid by another insurer for an asbestos claim.

The Case

A brewery was sued in a wrongful death action by the estate of the wife of a former employee of the brewery. The suit alleged that the wife contracted mesothelioma as a result of her husband's exposure to asbestos during his employment as a mechanic with the brewery. The suit involved "take-home" exposure. The decedent's husband allegedly carried asbestos dust on his clothes, which the decedent "inhaled and ingested" when she came into contact with his person and while laundering his work clothes.

One of the brewery's insurers, Zurich American Insurance Company (ZAIC), agreed to provide the brewery with a defense subject to a reservation of rights to seek contribution from other insurers that issued policies to the brewery during the relevant time period. The parties settled during a 2014 mediation for $1.5 million. ZAIC then sued Insurance Company of North America (INA) for equitable contribution, subrogation, and unjust enrichment.

The insurers each moved for summary judgment. INA contended that it was not liable to ZAIC because the pollution exclusion in its policies barred coverage for the underlying claim. ZAIC responded that INA failed to adequately plead the pollution exclusion as an affirmative defense and that the exclusion did not apply asbestos in any event. And even if the pollution exclusion did apply to asbestos, ZAIC argued that it didn't apply to the case at hand because the releases took place inside a building and the pollution exclusion required a release into "the atmosphere."

The Decision

The court sided with INA.

The court first ruled that INA properly pleaded the pollution exclusion as an affirmative defense. INA's affirmative defense stated that "[t]he Plaintiff is not entitled to contribution, subrogation, indemnity, unjust enrichment or any other form of relief on the grounds that the Underlying Claim does not come within the coverage afforded by the Defendant's policy and/or the Underlying Claim is within an exclusion from coverage, including but not limited to asbestos exclusions." The court held that this language was sufficient to plead the asbestos exclusion notwithstanding that the pollution exclusion relied upon by INA was separate from the "asbestos exclusion" referenced in its affirmative defense.

The court then ruled that asbestos unambiguously fell within the exclusion's definition of "contaminants," "irritants," and/or "pollutants." The underlying complaint alleged that asbestos and asbestos dust were ultra-hazardous and dispersed or released in the air by the brewery. The court concluded that asbestos dust and fibers were unambiguously contaminants under the ordinary meaning of the word because they "corrupted" the air "by contact" and made it "unfit for use." The court ruled that the policy was not rendered ambiguous as a matter of law simply because asbestos was not explicitly listed in the exclusion.

Lastly, the court addressed ZAIC's argument that the pollution exclusion didn't apply because it requires the discharge to take place in "the atmosphere," which ZAIC interpreted to exclude discharges that take place inside buildings.

The court acknowledged that Webster's dictionary defines "atmosphere" as "a gaseous mass enveloping a heavenly body," "the whole mass of air surrounding the earth," or "the air of a given place or locality." But, the court made clear that it didn't need to adopt ZAIC's interpretation of the policy in order to reach a decision on this issue. In this regard, the court noted that the exposure in the underlying case occurred not to a brewery employee inside the brewery but instead to his wife outside the brewery. Under these circumstances, the court held that the asbestos couldn't travel from inside the brewery and come into contact with the decedent without also being released into the "atmosphere." Therefore, the court held that, even if it adopted ZAIC's view of the policy, there was no ambiguity that the underlying claim involved an asbestos release "into the atmosphere" under the pollution exclusion.

Accordingly, the court held that INA's pollution exclusion unambiguously excluded coverage for the underlying claims, and therefore, INA had no obligation to contribute to the settlement or defense costs paid by ZAIC.

The case is *Zurich Am. Ins. Co. v. Insurance Co. of North America, et al*., 14-CV-1112 (E.D. Mo. May 21, 2019).

Louisiana Federal District Court: Insured Fails to Satisfy Timely-Reporting Provisions of Buyback Exception to a Pollution Exclusion

A federal district in Louisiana, granting an insurer's motion to dismiss for failure to state a claim, has held that the insured failed to satisfy the timely-reporting provisions to a buyback exception to a pollution exclusion.

The Case

The dispute arose out of an oil spill caused by backup of a water container and pump at one of the insured's wells. The insured performed the required clean up and remediation. The insured then noticed a claim to its insurer, 153 days after the oil spill. The insurer denied coverage. The insurer argued that a total pollution exclusion applied. The insurer also argued that the insured failed to satisfy a buyback exception to the exclusion because it failed to satisfy a 90-day reporting requirement in the exception.

The insured sued, arguing that the pollution exclusion was inapplicable because oil is not a pollutant. It also argued that the insurer was not prejudiced by its failure to timely report the claim, as the cleanup and remediation was timely performed.

The insurer moved to dismiss for failure to state a claim.

The Decision

The court granted the insurer's motion and dismissed the suit. The court found that the pollution exclusion applied.

The court noted, that under Louisiana law, three factors (the *Doerr* factors) determined the applicability of a pollution exclusion: (1) whether the insured is a "polluter" within the meaning of the exclusion; (2) whether the injury-causing substance is a "pollutant" within the meaning of the exclusion; and (3) whether there was a "discharge, dispersal, seepage, migration, release or escape" of a pollutant by the insured within the meaning of the policy.

Applying this test, the court first found that the insured was a "polluter." The court noted that the insured was in the business of operating oil wells "which clearly presented the risk of pollution." Next, the court found that oil is a "pollutant." The court stated that oil is, at the very least, a "liquid . . . contaminant" such as a "chemical." The court then found that the discharge constituted a "discharge . . . release or escape" of the pollutant. The court said it was immaterial that the insured did not intend the damage that arose out of the discharge or release.

The court also found that the insured failed to satisfy the buyback exception to the pollution exclusion. It observed that the buyback exclusion required the insured to satisfy certain conditions, including providing notice of a claim within 90 days after the insured first learns of the occurrence. Those requirements were conditions precedent to coverage, which the insured failed to satisfy. The court also noted that the policy shouldn't be construed against the insurer because nothing in the complaint suggested that the insured was a consumer rather than a "sophisticated user."

Accordingly, the court concluded that the total pollution exclusion barred coverage.

The case is *Apollo Energy, LLC v. Certain Underwriters at Lloyd's London*, 17-CV-1741 (M.D. La. May 1, 2019).

Second Circuit: Five-Month Delay in Giving Notice Precludes Coverage for MGP Claim

The Second Circuit, affirming a district court's grant of summary judgment to two insurers, has found that an insured's five-month delay in providing notice was untimely as a matter of law.

The Case

The insured sought coverage for its investigation and remediation costs as 22 former manufactured gas plant (MGP) sites. The insured had known about obligations associated with its MGP sites for many years. For example, in 1981, the insured signed a consent order with the New York State Department of Environmental Conservation to remediate hazardous waste at one of the MGP plants. In 1982, the insured notified EPA that its MGP sites contained potentially hazardous waste. In 1986, the insured reported contamination at every site for which investigation had advanced enough to reach a conclusion. In 1987, the DEC informed the insured that MGP sites were categorically "a significant contamination problem." By July 1991, the insured's investigation had either confirmed or indicated contamination at 21 of the 22 sites at issue in the case.

In November 1991, the insured provided notice of its claim. The insurer denied coverage based on late notice.

A lawsuit ensued. The district court granted summary judgment to the insurers.

The Decision

The Second Circuit affirmed.

The relevant policies required the insured to provide notice "as soon as practicable" or once the insured reasonably should have known that liability was likely to implicate the policy. Under either standard, the Second Circuit held, the insured failed to provide timely notice of occurrence to the insurers.

The court found that the insured should have known of occurrences likely to implicate the policies at all of its MGP sites by July 1991, at the latest. Therefore, its November 1991 notice to the insurers was untimely as a matter of law.

The court also rejected the insured's argument that one of the insurers waived its right to disclaim on late-notice grounds. The insurer's claims handler drafted a disclaimer letter that denied coverage for all sites, including on late notice grounds. But when the claims handler realized that the insured had not asked the insurer to take action on the site, he stopped work and never sent the letter.

To show waiver, the court explained, the insured must "put forward evidence of a clear manifestation of intent to waive by the other party." The court noted that insurer reserved its rights, including on late notice. Thus, an unreviewed, unsent letter could not have lulled the insured into sleeping on its rights.

The Second Circuit also rejected the insured's excuse for its late notice. The insured argued that it could not have reasonably known that the policies would be implicated because, under New York's *pro rata* rule of allocation, the policies would not have been triggered until allocated damages for a site exceeded $20,000 per year, which for one representative site required $1,960,000 in

damages. The court rejected this argument, reasoning that the New York Court of Appeals didn't establish *pro rata* allocation until 2002.

Accordingly, the court affirmed the district court's summary judgment ruling in favor of the insurer.

The case is *New York State Elec. & Gas Corp. v. Century Indem. Co.,* No. 18-CV-1012 (2d Cir. Apr. 25, 2019).

North Carolina Federal District Court: Insurer Relieved of Liability Based on Insured's Failure to Provide Notice of Claim

A federal district court in North Carolina, granting a default judgment to an insurer, has found that the insurer was relieved of liability based on an insured's failure to provide notice of a claim.

The Case

The insureds were sued in construction defect civil actions. The insureds never notified their insurer of the underlying litigation or sent their insurer copies of the summonses and complaints in those actions. Rather, the insurer received notice for the first time when it received a letter from counsel for the plaintiffs in the underlying action, which stated that the insureds were in danger of defaulting.

The insurer commenced a declaratory judgment action against the insureds, seeking to avoid coverage on the basis of late notice. The insureds failed to answer the complaint or otherwise appear in the declaratory judgment action. The insurer then moved for a default judgment.

The Decision

The court granted the insurer's motion for a default judgment.

The court laid out the three-part test in North Carolina to determine whether an insurer is relieved of liability based upon the insured's failure to comply with the notice requirements in an insurance policy. Under this test, the court first decides whether the notice was given as soon as practicable. If not, the court decides whether the insured has shown that it acted in good faith. If it didn't act in good faith, the insurer is relieved of its obligations to defend and indemnify the insured, even if the insurer was not prejudiced by the delay. But, if the good faith test is met, the burden then shifts to the insurer to show that its ability to investigate and defend was materially prejudiced by the delay.

Applying this test, the court found that the insurer had no liability.

First, the insureds made no attempt to abide by the notice and cooperation conditions of coverage of the relevant policies. There wasn't merely a delay in providing notice; the insureds didn't give notice at all.

Second, the insureds' lack of good faith was admitted by virtue of their default in the coverage action. But, the court noted that, even if the lack of good faith hadn't been admitted, it would still find lack of good faith on the basis that the insureds were served with summonses and complaints in the underlying litigation. In other words, the insureds were aware of their possible liability, yet they still purposefully and knowingly failed to notify their insurer about the litigation.

Third, even if the insureds had acted in good faith, the insurer was still relieved of liability because it was prejudiced by the insured's lack of notice and cooperation. The court reasoned that the insurer was deprived of an opportunity to investigate the claims, engage in discovery in the underlying litigation, or otherwise defend the claim.

The case is *Pennsylvania Nat'l Mut. Cas. Ins. Co. v. JJA Constr., Inc.*, 18-CV-00266 (M.D.N.C. May 23, 2019).