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Iowa Supreme: Residential Contractor Acting As Unlicensed Public Adjuster May Not Enforce Post-Loss Contractual Assignment of Insurance Benefits Against Homeowners' Insurer

The Iowa Supreme Court, in a trio of cases, has ruled that a residential contractor acting as an unlicensed public adjuster may not enforce the post-loss contractual assignment of insurance benefits it received from homeowners against their insurer.

The Primary Case

After a hailstorm struck Bettendorf, Iowa, and damaged the roof and siding of a home owned by Brant and Sarah Clausen, an employee of 33 Carpenters Construction, Inc., approached the Clausens and asked if he could inspect their roof for hail damage. The Clausens agreed and the employee said that he found hail damage to the roof and siding.

The Clausens then signed two contracts that provided that 33 Carpenters would repair the storm damage in exchange for the Clausens' insurance proceeds and that authorized 33 Carpenters to act on the Clausens' behalf regarding the submission, adjustment, and payment of an insurance claim for the hail damage.

33 Carpenters later sued the Clausens' insurer, alleging that it was the assignee of the Clausens' rights and that the insurer had breached the insurance policy by failing to pay 33 Carpenters "all benefits due and owing under the policy."

The insurer moved for summary judgment. It asserted that the assignment of insurance benefits to 33 Carpenters was unenforceable because 33 Carpenters was not a licensed public adjuster. Under Iowa law, contracts entered into by residential contractors that performed public adjuster services without being licensed were "void."

In response, 33 Carpenters argued that its conduct had not violated Iowa's public adjuster licensing law and that, in any event, only Iowa's insurance commissioner – and not the Clausens' insurer – could use that law to invalidate the Clausens' assignment of benefits.

The trial court granted the insurer's motion for summary judgment, ruling that the Clausens' assignment of their claim to 33 Carpenters was invalid under Iowa law because 33 Carpenters had acted as an unlicensed public adjuster within the meaning of Iowa law.

The dispute reached the Supreme Court of Iowa.

The Iowa Supreme Court's Decision

The court affirmed.

In its decision, the court rejected 33 Carpenters' contention that only the state's insurance commissioner, and not a trial court, could enforce the licensing requirements for public adjusters.

The court also decided that the "undisputed facts" established that 33 Carpenters, a residential contractor, was acting as an unlicensed public adjuster representing the Clausens on their hail damage claim against their homeowners' insurer. 33 Carpenters had advised the Clausens about their "first-party claims for damage" to their home, the court noted.

The court concluded that contracts entered into by a residential contractor acting as an unlicensed public adjuster were "void" and, therefore, that the Clausens' assignment to 33 Carpenters was void and unenforceable.

The cases are *33 Carpenters Construction, Inc. v. State Farm Life and Casualty Co.*, No. 18-1354 (Iowa Feb. 14, 2020); *33 Carpenters Construction, Inc. v. IMT Ins. Co.*, No. 19-0678 (Iowa Feb. 14, 2020); *33 Carpenters Construction, Inc. v. Cincinnati Ins. Co.*, No. 17-1979 (Iowa Feb. 14, 2020).

Rivkin Comment

Iowa is one of 45 states with statutes requiring licensure of public adjusters. As the Supreme Court of Iowa observed, these laws seek to "protect homeowners and insurers against exploitation by unlicensed contractors after hailstorms, tornadoes, and other natural disasters."

The court's decisions in the *33 Carpenters* cases may influence courts in other states with those laws to reject claims by contractors against insurers where the contractors are acting as public adjusters but are not licensed as such, even where they are asserting claims under post-loss assignments.

It also is worth noting that a number of states, including Iowa, have recently enacted legislation regulating insureds' post-loss assignments to residential contractors. This legislation, too, will protect homeowners and insurers against exploitation by unlicensed contractors.

Wisconsin Supreme: Insurer Did Not Breach Duty to Defend Where It Sought Coverage Ruling

The Supreme Court of Wisconsin, deciding an insurance coverage duty-to-defend issue of first impression, has ruled that an insurer does not breach its duty to defend when it denies a tendered claim and then files a motion to intervene and stay the underlying lawsuit pending a coverage determination – even if the trial court denies the motion, causing the insured to defend the liability suit and, simultaneously, to litigate coverage at its own expense.

The Case

Six retired employees of a Wisconsin school district, as representatives in a class action, sued the district after it discontinued group long-term care ("LTC") insurance for its current employees, which the retired employees asserted caused them to lose their LTC insurance benefit. The district tendered the defense of the suit to its insurer.

The insurer denied the tender, explaining that the policies covered the district for negligent acts, not deliberate acts, and that because it determined that the employees' lawsuit did not allege negligence, there was no coverage under the insurance policies.

The insurer then moved to intervene in the employees' action, requesting that the trial court bifurcate the liability and coverage issues and stay the liability portion of the lawsuit until coverage could be resolved.

The trial court denied the insurer's motion to stay the liability proceedings and the insurer decided to provide a full defense for the district until coverage could be resolved. The trial court explained that it could not decide as a matter of law whether the individuals who made the decision to terminate LTC insurance for current employees had acted negligently or intentionally with respect to the impact that the decision would have on retired employees. As a result, this issue was presented to a jury at the coverage trial.

The jury found that the district decisionmakers had acted negligently. Based on that finding, the trial court concluded that the insurer had a duty to defend the district.

The case proceeded to trial on liability and the jury returned a verdict in favor of the district. Thereafter, the trial court ruled that because the insurer had followed one of four judicially preferred approaches to the coverage dispute (that is, defend under a reservation of rights; defend under a reservation of rights but seek a declaratory judgment on coverage; enter into a nonwaiver agreement under which the insurer defends the insured but the insured acknowledges that the insurer has the right to contest coverage; and file a motion with the trial court requesting a bifurcated trial on coverage and liability and a stay of the proceedings on liability until coverage is determined), it had not breached its duty to defend.

An appellate court affirmed, and the dispute reached the Supreme Court of Wisconsin.

The Wisconsin Supreme Court's Decision

The Supreme Court of Wisconsin affirmed, holding that the insurer's initial denial of coverage did not breach its duty to defend because the insurer promptly followed a judicially-approved method to resolve the coverage dispute: filing a motion with the trial court requesting a bifurcated trial on coverage and liability and a stay of the proceedings on liability until coverage was determined.

The court noted that the insurer, when presented with the district's tender, responded by letter explaining why the insurer concluded that the complaint did not allege any covered claims and that it then filed a motion asking to intervene in the liability lawsuit, to bifurcate the liability and coverage issues, and to stay the liability case so that coverage could be decided promptly. These actions, the court found, "precisely followed one of the judicially preferred approaches this court has said will protect an insurer from breaching its duty to defend."

The court added that when the trial court's rulings forced the district to simultaneously defend itself on both liability and coverage, the insurer stepped in to defend the district on liability and agreed to pay for all reasonable liability attorneys' fees the district had incurred retroactive to the date of tender.

Accordingly, the court ruled, because the insurer acted to prevent the district from paying for both liability and coverage, but the trial court's actions thwarted its efforts, the insurer satisfied its obligations under the policy.

The court concluded by encouraging trial courts to decide bifurcation and stay motions expeditiously and to grant the requested stay whenever possible and appropriate.

The case is *Choinsky v. Employers Ins. Co.*, No. 2018AP116 (Wisc. Feb. 13, 2020).

Arkansas Supreme: Intentional Act Exclusion Applies to Innocent Co-Insured

The Supreme Court of Arkansas has ruled that a trial court erred in determining that language in an insurance policy excluding coverage for an intentional act, as applied to an innocent co-insured, was void against public policy.

The Case

A fire destroyed Edna Lyle Lovelace's home and its contents. Lovelace's estranged husband, Frank T. Williams, Jr., died by suicide inside the home. Before the fire started, Williams left a suicide note, $19,000 in cash, wedding photos, wedding bands, and his truck keys in the mailbox.

Lovelace made a claim for the loss under the homeowners' insurance policy that she and Williams had purchased. The insurer investigated and determined that Williams had intentionally caused the fire, without any involvement by Lovelace.

The insurer paid the loss payee for the balance due on the mortgage but denied coverage to Lovelace, citing the policy's intentional act exclusion.

Lovelace sued, arguing that the policy language allowing the insurer to deny a claim by an innocent insured because of actions taken by another insured was void as against public policy.

The trial court agreed with Lovelace and entered judgment against the insurer.

The dispute reached the Supreme Court of Arkansas.

The Arkansas Supreme Court's Decision

The Arkansas Supreme Court reversed.

In its decision, the court explained that the policy terms were "clear and unambiguous" and that they "explicitly" excluded coverage for losses caused by an intentional act by "any insured."

The court reasoned that Williams was "any insured" and that he allegedly engaged in an intentional act when he set fire to the home. Therefore, the court found, under the "clear terms of the policy," and under its precedent, Lovelace could not recover under the policy.

The court was not persuaded by Lovelace's contention that the intentional act exclusion contravened public policy. vAccording to the court, criminal conduct by one co-insured precluded recovery by an innocent co-insured if the insurance policy so allowed, as it did in this case.

The case is *Shelter Mutual Ins. Co. v. Lovelace*, No. CV-19-578 (Ark. Feb. 27, 2020).

Vermont Supreme Court Concludes that Phrase "Date of Loss" in Homeowners Policy's Suit-Limitation Provision Unambiguously Meant the Date of the Occurrence

The Vermont Supreme Court, siding with an insurer, held that the phrase "date of loss" in a homeowners policy's one-year suit-limitation provision unambiguously meant the date of the occurrence giving rise to coverage, not the date coverage was denied.

The Case

The insured was covered by a homeowner's policy issued by New England Guaranty Insurance Company. The policy included the following language: "Suit Against Us. No action can be brought unless the policy provisions have been complied with and the action is started within one year after the date of loss." "Date of loss" was not defined in the policy.

The insured alleged that, on January 18, 2010, her property was damaged by water. She reported the incident and the insurer began investigating the loss. The parties disagreed about the value of the claim and the insurer's obligations and communicated about the claim over the course of several years. Following its adjuster's "Fifth and Final Supplement Report," the insurer made its final payment on February 16, 2017. After the insurer did not act on the insured's subsequent request for an appraisal, the insured sued the insurer on February 12, 2018, alleging breach of contract and bad faith.

The insurer moved for summary judgment, arguing that the insured failed to sue within the one-year limitation period provided in the contract, which the insurer construed as running from the date of

the occurrence giving rise to coverage. The insured cross-moved for partial summary judgment on the issue of whether her suit was timely filed, arguing that the term "date of loss" in the policy was ambiguous, and therefore, should be construed against the insurer to mean the date insurer breached its agreement under the policy. The homeowner also asserted that by continuing to engage in negotiations with the insured, the insurer had waived any defense that the contractual period for filing suit had expired.

The trial court sided with the insured and concluded that the policy provision requiring an action to be brought "within one year after the date of loss" was ambiguous and must be interpreted against the insurer to mean that the one-year period began to run when insurer breached its obligations, *i.e.*, at the time the homeowner received final, allegedly insufficient, payment from the insurer.

The Vermont Supreme Court's Decision

The Supreme Court of Vermont reversed. The court ruled that the suit-limitation provision was unambiguous in requiring suit to be brought within one year of the date of the occurrence giving rise to coverage.

The court reasoned that, under Black's Law Dictionary, the term "loss" referred to the covered loss for which the insurer was liable to the homeowner. The court also noted that other policy provisions using the term "loss" (such as the homeowners' duty to notify the insurer after the "loss") made clear that the term "loss" meant the event causing damage for which the homeowner seeks coverage. The court noted that the policy never used the term "loss" to refer to the date coverage is denied or final payment is made. The court also noted that its interpretation was consistent with a majority of jurisdictions to consider the same issue.

However, the court remanded to the trial court to decide in the first instance whether the insurer had waived the time-suit limitation by continuing to engage in negotiations with the insured.

The case is *Brillman v. New England Guar. Ins. Co.*, 2020 VT 16 (Feb. 21, 2020).

Lawsuits Asserting That Insured Supplied Non-Compliant Lumber Did Not Allege "Occurrence," Seventh Circuit Holds

The U.S. Court of Appeals for the Seventh Circuit, affirming a district court's decision, has ruled that an insurer did not have to defend its insured in three underlying lawsuits alleging that it supplied non-compliant lumber because the complaints did not allege an "occurrence" as required to trigger the insurer's duty to defend.

The Case

Chicago Flameproof & Wood Specialties Corporation, an Illinois-based distributor of commercial building materials, was sued in three lawsuits alleging that it failed to deliver specific certified lumber to the plaintiffs for their use in various projects as Chicago Flameproof had contractually agreed to do. The complaints charged Chicago Flameproof with negligent misrepresentation, fraudulent misrepresentation, deceptive business practices, false advertising, consumer fraud, breach of warranties, and breach of contract.

Chicago Flameproof's insurer asked the U.S. District Court for the Northern District of Illinois to declare that it did not have to defend Chicago Flameproof for the conduct alleged in the underlying complaints.

The district court entered summary judgment for the insurer, holding that if Chicago Flameproof knowingly supplied non-compliant lumber and concealed that it did so, as the underlying complaints alleged, then the property damage that allegedly resulted "from tearing out that non-compliant lumber" could not be said to have been caused by an accident but, rather, was the "natural and ordinary consequence of knowingly supplying a non-compliant product" and did "not potentially fall within the [] policy's coverage." (For our previous discussion of the district court's decision, *see* "Allegedly Supplying Non-Compliant Lumber Was Not an 'Occurrence,' Illinois District Court Rules," *available here).*

Chicago Flameproof appealed to the Seventh Circuit. It argued that its insurer had to provide a defense because its shipment of lumber and the tearing out of that lumber were occurrences that caused property damage.

The Seventh Circuit's Decision

The Seventh Circuit affirmed, agreeing with the district court that the complaints against Chicago Flameproof did not trigger the insurer's duty to defend because they did not allege an "occurrence." In its decision, the circuit court explained that the underlying complaints alleged that Chicago Flameproof deliberately shipped uncertified lumber, concealed that fact, and was aware or should have been aware of the consequences of those actions – namely, that the uncertified lumber would need to be ripped and torn from the projects.

According to the circuit court, the underlying complaints against Chicago Flameproof alleged no "unforeseen," "undesigned," or "unexpected" event. V The underlying complaints, the circuit court added, alleged that Chicago Flameproof "deliberately shipped uncertified lumber despite knowing the consequences of doing so."

The Seventh Circuit acknowledged that a count in one of the underlying complaints used the label "negligent," but it concluded that the alleged injury stemmed from Chicago Flameproof's allegedly "unilateral decision" to supply the uncertified lumber and its alleged concealment of having done so – not from any negligent conduct.

The case is *Lexington Ins. Co. v. Chicago Flameproof & Wood Specialties Corp.*, No. 19-1062 (7th Cir. Feb. 27, 2020).

Commercial Auto Insurer Did Not Have to Defend or Indemnify Suit Stemming from Flash Fire at Fracking Site, Tenth Circuit Decides

The U.S. Court of Appeals for the Tenth Circuit has ruled that a commercial auto insurer did not have to defend or indemnify defendants in a lawsuit stemming from a flash fire at a fracking site.

The Case

David Garza alleged that he was injured by a flash fire at a fracking site that occurred after Jason Metz, a driver for RW Trucking, LLC, flicked his cigarette lighter and fumes ignited.

Garza sued RW Trucking, which had contracted to haul water at the site, and Metz. Garza alleged that Metz owed him a duty to exercise ordinary care, which Metz breached. He further alleged that RW Trucking had negligently hired, trained, supervised, and retained its agents and had not trained, controlled, directed, or supervised its employees as a reasonable employer would have done. Garza also asserted a claim for vicarious liability against RW Trucking.

Garza settled his claim. The commercial general liability ("CGL") insurer for RW Trucking paid $415,000 on behalf of RW Trucking and Metz. RW Trucking's commercial automobile insurer paid $375,000 on behalf of RW Trucking.

Thereafter, the auto insurer asked the U.S. District Court for the District of Wyoming to declare that the CGL insurer owed RW Trucking and Metz a duty to defend and a duty to indemnify and that it did not.

The dispute reached the Tenth Circuit.

The Tenth Circuit's Decision

The Tenth Circuit ruled that the auto insurer did not have any duty to defend or indemnify RW Trucking or Metz.

In its decision, the circuit court explained that the primary issue under the auto policy was whether Garza's injuries "result[ed] from the ownership, maintenance or use of" an RW Trucking auto.

The Tenth Circuit observed that Garza mentioned an auto (Metz's tractor-trailer) when referring to RW Trucking's business and Metz's presence at the fracking site, and said that this allowed the

inference that Metz had somehow used an auto on the day of the accident. The circuit court found, however, that this did "not connect the auto to the accident." In the circuit court's view, Garza did not point to a causal connection between Metz's inferred use of an auto and the fire that resulted when he flicked his lighter and fumes ignited.

Accordingly, the Tenth Circuit ruled, Garza's claims could "not rationally or potentially" fall within the auto policy coverage, the auto insurer had no duty to defend RW Trucking or Metz in Garza's personal injury lawsuit, and the auto insurer did not owe the CGL insurer any share of the defense costs.

Finally, the Tenth Circuit ruled that the CGL insurer had a duty to indemnify RW Trucking and Metz. It observed that the CGL policy covered bodily injury and property damage caused by an "occurrence." It concluded that the policy's auto exclusion did not apply, reasoning that the fire arose from the cigarette lighter, not from any use of an auto.

The case is *Carolina Casualty Ins. Co. v. Burlington Ins. Co.*, No. 18-8071 and No. 18-8077 (10th Cir. Feb. 27, 2020).

Virginia District Court Denies Coverage for Loss Stemming from Email Scam

A federal district court in Virginia has ruled that an insurer did not have to cover a loss suffered by its insured when an employee of the insured wired funds after receiving an email she believed was from the insured's president but that actually came from hackers.

The Case

An employee of Midlothian Enterprises, Inc., received an email that she believed came from the Midlothian president, which asked her to wire thousands of dollars from Midlothian's bank account

to a bank account in Alabama. After she wired the funds, Midlothian discovered that hackers, not the president, had sent the email and had stolen the money.

Midlothian submitted a claim to its insurer, seeking coverage for its loss. The insurer denied coverage and Midlothian sued, arguing that the insurer had to cover the loss under the policy's "money and securities" and "forgery or alteration" endorsements.

The parties moved for summary judgment.

The District Court's Decision

The court granted summary judgment in favor of the insurer, holding that neither endorsement covered the loss.

The court explained that the "voluntary parting" exclusion in the money and securities endorsement excluded coverage for a "[l]oss resulting from [Midlothian's], or anyone acting on [Midlothian's] express or implied authority, being induced by any dishonest act to voluntarily part with title to or possession of any property."

The court then ruled that the "plain language" of this exclusion "unambiguously" included Midlothian's loss. The court reasoned that the Midlothian employee, acting on the president's behalf, wired money from Midlothian's bank account to the hackers' bank account. The court ruled that although the president did not make the request, that did "not change the voluntariness of the transfer itself."

The court said that there was only "one reasonable interpretation" of the voluntary parting exclusion: that the money and securities endorsement did not cover a loss caused by an employee voluntarily wiring money to another account due to a fraudulent email. The fact that another individual pretended to authorize the transaction did not negate the voluntariness of the transfer or the authority the Midlothian employee had to make these types of transfers, the court found.

The court then turned to the policy's forgery or alteration endorsement and the parties' dispute about whether the email directing the Midlothian employee to wire the funds constituted a "covered instrument, defined as "[c]hecks, drafts, promissory notes, or similar written promises, orders[,] or directions to pay a sum certain in 'money.'"

In the court's view, "orders or directions to pay" had to be similar to a check, draft, or promissory note for the forgery or alteration endorsement to apply. The fraudulent email was not similar to those types of items, the court ruled. Therefore, the fraudulent email did not constitute a "covered instrument" under the terms of the endorsement and the forgery or alteration endorsement did not cover Midlothian's loss as a matter of law, the court concluded.

The case is *Midlothian Enterprises, Inc. v. Owners Ins. Co.*, No. 3:19-cv-51 (E.D. Va. Feb. 20, 2020).

Insurer Had No Obligation to Cover Judgment Without Evidence That Property Damage Occurred During Its Policy Periods, New Jersey District Court Rules

A federal district court in New Jersey has ruled that, in the absence of any proof of property damage while the insured's commercial general liability insurance policies were in effect, there was no occurrence that triggered coverage under those policies.

The Case

Grand Slam Partners, LLC, and Randolph Enterprises, LLC (together, "Grand Slam") sued Rigid Building Systems, Ltd., among other contractors, for water leaks that allegedly occurred at the Grand Slam tennis center between 2009 and 2012, as well as a partial roof collapse following a snow storm in February 2014.

The trial court prohibited Grand Slam from presenting evidence of any damage from events in 2009 to 2011. At trial, a central theory of liability put forth by Grand Slam was that Rigid only had

designed the tennis center to a "ground snow load" of 30 pounds-per-square-foot ("PSF"), when the local building code required 35 PSF. Grand Slam also presented evidence that, upon inspection following the partial collapse, Rigid's pre-engineered metal structure was missing bolts, the rod bracing was not tight, and the frame was "deflected" and "deformed."

The jury found for Grand Slam and the trial court entered judgment for $1,633,036.65 against Rigid.

Rigid's insurer asked the U.S. District Court for the District of New Jersey to declare that the damages awarded to Grand Slam were not covered by its policies and that it had no obligation to defend or indemnify Rigid for the claims in Grand Slam's action.

The insurer moved for summary judgment, arguing that no property damage had "occurred" for purposes of either of the two consecutive occurrence-based commercial general liability insurance policies it had issued to Rigid.

The District Court's Decision

The district court granted the insurer's motion.

In its decision, the district court found that Grand Slam had not been "actually damaged" until after the insurer's policies had expired. The district court noted that Grand Slam was barred from presenting any evidence of damages from 2009 to 2011, and that the $1.6 million verdict against Rigid was based exclusively on the costs to repair structural damage to the tennis center from the partial roof collapse in February 2014 and the business losses that flowed from that collapse.

As such, the district court found, the "occurrence" that led to "property damage" occurred "well after the expiration" of the insurer's policies in March 2011. It then held that because Grand Slam could not point to any proof of damage during the policy periods, it could not demonstrate an "occurrence" triggering coverage under those policies.

Finally, the district court ruled that Rigid was not entitled to coverage under a continuous trigger theory. The district court reasoned that all of the damages attributed to Rigid in Grand Slam's lawsuit related to the 2014 partial roof collapse. It stated that even if it accepted that leaks from 2009 to 2011 were an occurrence that started the continuous trigger, the "wholesale lack of any damages" from the policy periods defeated any arguments for coverage. Put differently, the district court concluded that the fact that no damages could even be allocated to the policy periods demonstrated that there was "no basis for coverage."

The case is *Travelers Lloyds Ins. Co. v. Rigid Global Buildings, LLC*, No. 18-5814 (D.N.J. Feb. 13, 2020).

Owned Vehicle Exclusion Precluded Coverage of Suit Alleging Injuries Caused by Insured's Negligent Operation of Golf Cart, New Jersey Appellate Court Says

An appellate court in New Jersey, reversing a trial court's decision, has ruled that an auto policy's owned vehicle exclusion precluded coverage of a lawsuit against the insured seeking damages for his alleged negligent operation of a golf cart.

The Case

Joseph Tolotti was sued in a personal injury lawsuit that alleged that his negligent operation of the golf cart he owned caused the plaintiff to be thrown from the golf cart and injured. Tolotti sought coverage under the insurance policy covering his pick-up truck, although the policy did not identify the golf cart as a covered vehicle.

The insurer denied coverage and Tolotti asked a New Jersey court to declare that his policy provided coverage.

The trial court found coverage under the policy, and the insurer appealed.

The Appellate Court's Decision

The appellate court reversed.

In its decision, the appellate court explained that the policy included golf carts in the definition of "miscellaneous vehicle" and that it excluded coverage for any vehicle or miscellaneous vehicle owned by Tolotti other than a covered auto (that is, Tolotti's pick-up truck) identified on the policy's declarations page.

Accordingly, the appellate court ruled, because the golf cart was a miscellaneous vehicle owned by Tolotti that was not listed as a covered auto on the policy's declarations page, the policy did not cover the golf cart, and it reversed the trial court's decision.

The case is *Tolotti v. United Services Automobile Association*, No. A-4102-18T4 (N.J. App. Div. Feb. 21, 2020).