Ohio High Court Rules That Allocation Is Unnecessary If the Injuries Occur at a Discernable Time

The Ohio Supreme Court ruled, in a product defect case, that it is unnecessary to allocate liability across multiple insurers and policy periods if the injury occurred at a discernable time. Only the insurers who provided coverage for that time period are liable for the claim.

The Case

Petitioner, Lubrizol Advanced Materials, Inc. (“Lubrizol”), manufactured and sold allegedly defective resin to IPEX, Inc., between 2001 and 2008. IPEX used the resin to make pipes for its Kitec plumbing systems that were sold to consumers in the United States and Canada. These pipes failed, resulting in numerous claims against IPEX for selling defective pipes. IPEX settled the claims, but it sued Lubrizol alleging negligence, breach of contract, and breach of warranty on the basis that Lubrizol knew or should have known the resin it sold to IPEX was not fit or suitable for the resin’s intended purpose of being used in pipes. IPEX sought complete indemnification from Lubrizol. IPEX and Lubrizol settled their claims.

Lubrizol then sued National Union Fire Insurance Company of Pittsburgh, PA. (“National Union”), which insured Lubrizol pursuant to an umbrella policy effective February 28, 2001 to February 28, 2002. Lubrizol argued that under Ohio law, all of its triggered insurance policies should be treated as establishing joint and several liability, such that Lubrizol could recover under

the policy of its choice. Accordingly, Lubrizol claimed it was entitled to recover all amounts it paid to defend and settle IPEX's claims, less the underlying policy limits and retention amount.

While attempting to mediate their claims, National Union and Lubrizol notified the federal court that they disagreed about the appropriate allocation method to be used and that an answer to that question would allow them to make significant progress toward a settlement. The district court certified the following question to the Ohio Supreme Court:

> Whether an insured is permitted to seek full and complete indemnity, under a single policy providing coverage for "those sums" the insured becomes legally obligated to pay because of property damage that takes place during the policy period, when the property damage occurred over multiple policy periods.

The Decision

The Ohio Supreme Court held that because the time of damage was known or knowable, there was no reason to allocate liability across multiple insurers and policy periods. The court noted that it should be ascertainable how much resin was produced on a given date, how much resin was sold to IPEX, which lots of Kitec plumbing were produced on certain dates, when the Kitec plumbing was sold and installed, and when it failed. In these circumstances, the court ruled that the operative policy language was not the reference to policy coverage for "those sums" but rather to injury "that takes place during the Policy Period."

The court concluded that "there is no reason to allocate liability across multiple insurers and policy periods if the injury or damage for which liability coverage is sought occurred at a discernible time. In that circumstance, the insurer who provided coverage for that time period should be liable, to the extent of its coverage, for the claim."

In so holding, the court distinguished other “all sums” decisions where there was an injurious process that began with an initial exposure, ended with manifestation of disease, and injury continued to develop at all the points in between.

The case is *Lubrizol Advanced Materials, Inc. v. Nat’l Union Fire Ins. Co., et al.*, No. 2018-1815 (Ohio Apr. 23, 2020).

Texas Supreme Court Adopts Narrow Exception to Eight Corners Rule for Collusive Fraud

After reaffirming the eight corners rule just six weeks earlier, the Texas Supreme Court carved out a narrow exception to that rule, permitting the consideration of extrinsic evidence where the insured and a third-party suing the insured colluded to make false representations of fact for the purpose of securing a defense and coverage where they would not otherwise exist.

The Case

Karla Flores Guevara was the named insured under an automobile policy. Her husband, Rodolfo Flores, was explicitly excluded from the policy's coverage. While moving Guevara's car, Flores collided with another car carrying Osbaldo Hurtado Avalos and Antonio Hurtado. The Hurtados, Guevara, and Flores agreed to tell both the responding police officer and the insurer that Guevara was driving the car rather than Flores.

The Hurtados sued Guevara claiming damages resulting from Guevara's negligent operation of her vehicle. Guevara was defended by her auto insurer. During discovery, Guevara disclosed the lie to her attorney and identified Flores as the driver. In response, the insurer canceled Guevara's scheduled deposition and denied coverage. The trial court granted the

Hurtados' motion for summary judgment and rendered judgment against Guevara for $450,343.34.

Guevara assigned her rights against the insurer to the Hurtados, who then sued the insurer for breach of contract and bad faith. The insurer asserted counterclaims for fraud and sought a declaratory judgment that it owed no coverage on the basis that Flores, an excluded driver, was driving at the time of the accident. The insurer deposed Guevara, who recanted her initial statement that she, rather than Flores, was driving. The insurer then moved for summary judgment on the ground that it owed no duty to defend or indemnify, and it attached excerpts of Guevara's depositions as evidence.

The trial court ruled in favor of the insurer, but the court of appeals reversed, holding that "as logically contrary as it may seem," the insurer had a duty to defend under the eight-corners rule.

The Texas Supreme Court's Decision

The court began by summarizing the eight corners rule. "Generally, only the four corners of the policy and the four corners of the petition against the insured are relevant in deciding whether the duty applies. Under this eight-corners rule, a 'court should not consider extrinsic evidence from either the insurer or the insured that contradicts the allegations of the underlying petition.'"

The court noted that twice before it signaled that collusive fraud may provide an exception to the eight corners rule, but each time reserved judgment on the issue. But here, there was no question as to whether there was falsity or collusion.

As to falsity, it was undisputed that Guevara was not driving the car at the time of the accident, her husband was.

As to collusion, there was also no dispute that Hurtados agreed with Guevara and her husband to make false statements about who was driving in order to trigger Guevara's insurance coverage.

The court concluded that the eight corners rule did not bar courts from considering extrinsic evidence regarding collusive fraud by the insured in determining the insurer's duty to defend. The court explained that while an insurer may have a duty to defend fraudulent allegations against the insured asserted *by third parties*, the insurer has no duty to defend the insured against fraudulent allegations brought about *by the insured itself*. Thus, the court stated, “an insurer owes no duty to defend when there is conclusive evidence that groundless, false, or fraudulent claims against the insured have been manipulated by the insured's own hands in order to secure a defense and coverage where they would not otherwise exist.”

The court next provided practical guidance. It instructed that an insurer faced with undisputed evidence of collusive fraud should not be required to pursue a declaratory judgment action before withdrawing its defense. It gave two reasons supporting its conclusion.

First, requiring a declaratory judgment action regardless of need would subject the parties to unnecessary time and expense, waste judicial resources, and undermine an insurer's ability to make prompt determinations of its coverage and defense obligations—an important benefit of the eight-corners rule.

Second, an insurer that breaches its duty to defend by withdrawing can be held liable for substantial damages and attorneys' fees, which will help ensure that an insurer withdraws its defense without first securing a declaratory judgment only in clear-cut cases.

These consequences, the court added, are adequate to ensure that insurers will seek a favorable declaratory judgment before withdrawing a defense in most cases where there is a real controversy regarding the duty to defend. The court encouraged insurers to take that course.

The case is *Loya Ins. Co. v. Avalos*, No. 18-0837 (Tex. May 1, 2020).

Supreme Court of Pennsylvania Finds Insurer Has Duty to Defend Claim Involving a Man Injured During a Premeditated Murder-Suicide

The Supreme Court of Pennsylvania found that an insurer had a duty to defend the estate of a man who, after intentionally killing his ex-wife, shot another person who interfered before the man was able to complete his plan of turning the gun on himself.

The Case

The underlying complaint alleged as follows: On the evening of September 26, 2013, Harold McCutcheon broke into the home of his ex-wife, Terry McCutcheon, in order to shoot and kill her, and then kill himself. He communicated these intentions in a note he left for his adult children. McCutcheon succeeded in executing this plan, first shooting and killing Terry and, eventually, shooting and killing himself. However, after McCutcheon killed Terry but before he killed himself, Terry's boyfriend, Richard Carly, arrived on the scene. Carly was pulled into the home by McCutcheon and a fight ensued between the two men. McCutcheon held a gun in his hand and fired shots "carelessly, negligently and recklessly." One shot struck Carly in the face.

Carly was severely injured and sued McCutcheon's estate. The estate sought coverage of the lawsuit under two insurance policies issued by Erie to McCutcheon: the Erie Insurance Home Protector Policy (homeowner's policy) and the Erie Insurance Personal Catastrophe Liability Policy (personal catastrophe policy). The policies provided coverage for amounts an insured becomes

legally obligated to pay due to personal injury resulting from an "occurrence." They defined a covered "occurrence" as "an accident, including continuous or repeated exposure to conditions, which results in personal injury or property damage which is neither expected nor intended." Both policies excluded from coverage "bodily injury, property damage or personal injury expected or intended by anyone we protect." The homeowner's policy further provided that expected or intended injury is excluded even if "the degree, kind or quality of the injury or damage is different than what was expected or intended," or "a different person, entity, real or personal property sustained the injury or damage than was expected or intended."

Based on these provisions, Erie concluded it owed no coverage to the estate because Carly's injuries were not caused by an accidental "occurrence," but rather were "expected or intended" by McCutcheon. Erie filed a declaratory judgment action.

The parties, including Carly, cross-moved for summary judgment. In support of its no "occurrence" position, Erie pointed to the facts in the complaint that "describe a shooting during the commission of multiple felonies." Erie insisted that a gunshot injury sustained at the hands of a perpetrator of a premeditated murder-suicide was not the sort of event that has the requisite degree of fortuity necessary to constitute an "occurrence." Erie also argued that simply because McCutcheon never made an affirmative statement of his intention to harm Carly did not rule out a determination that he acted intentionally. Erie urged the court to view the totality of facts from McCutcheon's perspective.

Carly responded that the factual allegations of the complaint indicated that the insured accidentally shot him. Carly also argued that presuming the accidental discharge of the gun was criminal would mean that the policy excludes all risks associated with gunfire. Carly argued that

Erie could have written its policy as such, but it did not. Carly also argued that a holding that there was a duty to defend served the important public policy of providing compensation to tort victims.

The trial court agreed with Erie and granted summary judgment in its favor, holding Erie had no duty to defend the estate against Carly's complaint. The Superior Court reversed the trial court. The Superior Court ruled that the shooting constituted an "occurrence" under the policy. Erie appealed.

The Pennsylvania Supreme Court's Decision

The Pennsylvania Supreme Court held that the "four corners of the complaint" alleged an accidental shooting. The court reasoned that the allegations in the complaint was not mere "artful pleading" designed to present intentional acts as accidental for purposes of insurance coverage. The allegations in the complaint did not preclude the possibility that McCutcheon accidentally shot Carly, or indicate that he "expected or intended" to cause the injuries. McCutcheon intentionally pulled Carly into the house. But the court noted that McCutcheon's surprise encounter with Carly was not part of the insured's other intentional conduct for purposes of insurance coverage.

The court also noted that Carly did not seek damages for a fistfight or shoving match, but for being shot by the insured. The court noted that the policy did not expressly exclude coverage for any incidents involving firearms, but for injuries "expected or intended" by the insured.

The court also concluded that denying a duty to defend in this case would not serve as a crime deterrent and would unnecessarily withhold compensation to tort victims.

The case is *Erie Ins. Exch. v. Moore*, No. 20 WAP 2018 (Pa. Apr. 11, 2018).

Pennsylvania Appellate Court Upholds Application of Criminal Acts and Personal Profit Exclusions to Claim Involving Money Laundering Scheme by Hotel Employees

The Pennsylvania Superior Court held that two individuals who engaged in unlawful behavior were employees, and thus, "Insureds" under an insurance policy issued to a management services company so as to trigger the application of the criminal acts and personal profit exclusions.

The Case

Meyer Jabara is a management company that provides management services to the Sheraton University City Hotel. Kenneth Kapikian was the hotel's general manager and Dennis Gagliardi was the hotel's chief engineer.

Kapikian and Gagliardi created a phony company that they used to submit invoices for payment to the Sheraton Hotel. They also instructed various vendors to inflate service invoices by as much as 20% as part of a kickback scheme.

The U.S. Attorney for the Eastern District of Pennsylvania filed criminal complaints against Kapikian and Gagliardi charging them with wire fraud and conspiracy to commit money laundering. They ultimately pleaded guilty, served jail time, and were required to pay restitution to the hotel owner.

The hotel owner demanded more than $5.4 million from Meyer Jabara for losses arising from the criminal scheme perpetrated by several entities and individuals working at the Sheraton Hotel. Meyer Jabara tendered the claim to its professional liability insurer, Gemini.

Gemini defended under a reservation of rights and later advanced $975,000 toward a settlement between Meyer Jabara and the hotel owner, subject to the right of reimbursement should Gemini prevail on its coverage defenses.

Gemini then sought a declaration of no coverage against Meyer Jabara and subrogation against those involved in the fraudulent scheme.

Gemini contended that two exclusions applied: the criminal acts and the personal profit exclusions. Meyer Jabara countered by arguing that Kapikian and Gagliardi were employees of MJ Employment, a subsidiary of Meyer Jabara, and thus, were not "rendering professional services on behalf of the Named Insured" (Meyer Jabara) when they committed their crimes for which the hotel owner sought restitution from Meyer Jabara. Therefore, according to Meyer Jabara, Kapikian and Gagliardi were not “Insureds” under the policy and neither exclusion applied.

Gemini and Meyer Jabara both moved for summary judgment.

The Trial Court’s Decision

The trial court granted Gemini’s motion and denied Meyer Jabara’s motion.

The insurance policy defined "Insured" as "[t]he Named Insured listed on the Declarations including any partner, director, officer or full time, part time, temporary and leased employee of the Named Insured while rendering Professional Services on behalf of the Named Insured." There was no dispute the Meyer Jabara was the Named Insured.

The policy did not define the term "employee." Meyer Jabara argued that a person is an "employee" of the Named Insured only when he or she is paid by, supplied workplace benefits by, and receives a federal W-2 form from the Named Insured. Alternatively, Meyer Jabara argued that the term "employee" is ambiguous and should be construed against Gemini.

The trial court found that the term "employee" is not ambiguous. In defining the term, the trial court looked to Black's Law Dictionary and concluded that an "employee" is a person “who works in the service of another person (the employer) under an express or implied contract of hire, under which the employer has the right to control the details of work performance." The trial

court noted that this definition is consistent with Pennsylvania case law, as "control over the work to be completed and means of performance" is often used in determining whether an employer/employee relationship exists. Thus, the trial court held that the term "employee," as used in Gemini's policy, was not restricted solely to those people who received a salary, workplace benefits, or a federal W-2 form from Meyer Jabara.

Once past this threshold issue, the trial court next considered the meaning of the term "Professional Services" as used in the insurance contract. "Professional Services" meant "only those professional services listed on the Declarations Page as performed by or on behalf of the Named Insured for others for fee or other form of compensation." According to the Declarations Page, "Professional Services" included:

> Hotel Professional Management Services meaning those services you perform for others pursuant to a signed and valid management contract, including financial management and accounting services, human resources management services, food and beverage management services, marketing services, operation management services, communications, information and technology management services.

Meyer Jabara argued that Kapikian and Gagliardi were not rendering Professional Services on behalf of the Named Insured when they stole from the hotel. The criminal conduct was not done on behalf of Meyer Jabara; it was not in furtherance of Meyer Jabara's business of providing hotel management services and actually harmed Meyer Jabara.

The trial court rejected this argument, finding that Meyer Jabara's interpretation would render the criminal acts exclusion meaningless.

The Appellate Court's Decision

The Pennsylvania Superior Court affirmed.

First, it found no error in the trial court's conclusion that Kapikian and Gagliardi were "employees" of Meyer Jabara. It agreed that the term "employee" was not ambiguous and found that the trial court was correct in giving the term "employee" the common and approved meaning of the word as described in Black's Law Dictionary. The court emphasized that merely because Meyer Jabara and Gemini did not agree on the definition of the term did not render the insurance policy ambiguous.

Second, the court also agreed with the trial court's application of the criminal acts and personal profit exclusions. The court noted that there was no dispute that Kapikian and Gagliardi committed their wrongful conduct while performing their management responsibilities, such as hiring vendors and approving payments at the Sheraton Hotel. The court reasoned that Meyer Jabara's argument – that criminal conduct committed by the employees during the performance of the employees' management responsibilities can never be deemed a "professional service" – would forgo the need for the criminal acts exclusion, since all criminal conduct could be deemed out of the realm of "professional services." The court determined that Meyer Jabara's interpretation was unreasonable, and when the insurance policy is taken as a whole, this was not the parties' intent.

The court agreed that Kapikian and Gagliardi were "Insureds" under the insurance policy so as to trigger the application of the criminal acts and personal profit exclusions.

The case is *Gemini Ins. Co. v. Meyer Jabara Hotels LLC*, No. 2312 EDA 2019 (Pa. Super. Ct. Apr. 3, 2020).

Pennsylvania Appellate Court Rules that Insurer's Reservation of Rights Failed to Adequately Preserve Potential Coverage Defense That Was Evident from the Outset

A Pennsylvania appellate court ruled that an insurer was estopped from asserting a coverage defense (a snow and ice removal exclusion) because its reservation of rights letter failed to identify the issue even though the exclusion was evident on the face of the policy.

The Case

MAK Services was exclusively in the business of snow and ice removal. MAK Services worked with a broker, Henry Dunn, Inc., which obtained liability insurance for its operations. To that end, Selective Way (the "insurer") issued a Policy to MAK Services, effective from July 11, 2011, to July 11, 2012. The Policy excluded various types of coverage. Among these exclusions was one titled "Exclusion — Snow and Ice Removal."

On or about October 30, 2011, Oscar Gordon slipped and fell on ice while walking through a parking lot on the premises of the Valley Forge Marketplace in Norristown, Pennsylvania, which was a client of MAK Services. Mr. Gordon and his wife sued MAK Services and others. The Gordons asserted that MAK Services had been negligent in removing snow and ice from the parking lot. The insurer appointed defense counsel to represent MAK Services regarding the Gordons' claims.

On May 1, 2013, the insurer sent a reservation of rights letter to MAK Services. The letter did not acknowledge or discuss the snow and ice removal exclusion contained in the Policy. That same day, defense counsel retained by the insurer entered an appearance on behalf of MAK Services. For the next eighteen months, the insurer represented MAK Services in all aspects as to its defense against the Gordons' civil claims.

On November 13, 2014, the insurer filed a declaratory judgment action seeking a ruling that it had no duty to defend or indemnify MAK Services for the claims in the Gordons' civil action. MAK Services filed an answer and counterclaim alleging that the insurer was estopped from ceasing its representation and indemnification of MAK Services because the reservation of rights letter failed to properly preserve the potential coverage defense of the snow and ice removal exclusion.

The trial court entered an order in favor of the insurer.

The Appellate Court's Decision

The appellate court reversed.

The court instructed that a reservation of rights must fairly inform the policyholder of the insurer's position to preserve an insurer's assertion of a policy exclusion once a defense of the insured has been mounted. The court acknowledged that although an insurer is not required to list every potential defense, some level of specificity is necessary. The court noted that the insurer's reservation of rights letter failed to specifically identify any emergent coverage issues. The court also noted the snow and ice removal exclusion was evident on the face of the policy and the insurer admitted to having actual knowledge of the exclusion from the outset.

The court further reasoned that, given the inherently speculative nature of determining how the case may have unfolded differently had the insurer acted with appropriate diligence, prejudice to MAK Services should be presumed. Alternatively, the court noted that MAK Services proved prejudice because, had MAK Services been fully and fairly informed, it could have declined the insurer's "empty 'offer to defend'" and retained representation to protect its own interest.

A dissenting judge would have found that MAK Services failed to prove prejudice sufficient to estop the insurer from asserting the snow and ice removal exclusion. The dissent noted that

MAK Services had not claimed lost evidence or witnesses, or that it would have handled its defense differently. Rather, the dissent noted, “all the record indicates is that [the insurer] provided free legal representation to MAK Services for 18 months.”

The majority disagreed, reasoning that the dissent’s view would incentivize insurers to send anticipatory reservation of rights letters in response to all of its claims. Consent of the policyholder is necessary, the court noted, if the insurer is to retain control of the defense and at the same time reserve the right to disclaim liability under the policy. Under those specific facts, the court found that it was unclear how a party that receives incomplete and misleading information could be said to have “consented to anything.”

Accordingly, the court reversed the trial court’s order granting summary judgment to the insurer and remanded the case for further proceeding.

The case is *Selective Way Ins. Co. v. MAK Servs.,* No. 1289 EDA 2019 (Pa. Super. Ct. Apr. 24, 2020).

No Duty to Defend or Indemnify Class Action Complaint Alleging Wrongful Repossession of Motor Vehicles, Missouri Federal Court Rules

The Eastern District of Missouri rejected a credit union’s bid to have its insurer pay its defense in a class action suit over improperly noticed vehicle repossessions, on that basis that any loss of use alleged was not caused by an “occurrence” and any claim for false or derogatory credit reporting was barred by the professional services exclusion.

The Case

Anheuser Busch Employee Credit Union ("ABECU") filed a petition in Missouri state court seeking to recover a deficiency judgment against an individual following its repossession and sale

of the individual's vehicle. The individual filed a counterclaim on behalf of himself, a nationwide class, and a Missouri subclass of similarly situated borrowers whose vehicles were repossessed and disposed of by ABECU.

The counterclaimants "sought relief to redress an unlawful and deceptive pattern of wrongdoing followed by [ABECU] regarding collection . . ., enforcement, repossession, and disposition of collateral." Among other things, the counterclaimants alleged that ABECU failed to issue UCC-compliant notices before accelerating the maturity of the counterclaimants' unpaid balances, before repossessing the counterclaimants' vehicles, before disposing of the repossessed vehicles, and after the sale of the vehicles. The counterclaimants further alleged that ABECU reported false or derogatory credit information related to the repossessions to local and national credit bureaus.

ABECU tendered the counterclaim to its insurer, contending that it was owed a defense under both Coverage A, for the alleged "property damages" stemming from the counterclaimants' loss of use of their vehicles, and under Coverage B, for the alleged "personal injury" damages stemming from ABECU's issuance of defective notices and false or derogatory credit reporting.

The insurer ultimately refused to defend. ABECU settled the class action suit and renewed its request for coverage. After the insurer maintained its denial, ABECU then sued the insurer, alleging breach of contract and vexatious refusal. The insurer moved for summary judgment on both of ABECU’s claims.

The Decision

The court first addressed the “Property Damage” coverage under Coverage A of the policy. “Property Damage” was defined to include damages resulting from the "loss of use of tangible property . . . that is not physically damaged." To trigger coverage under Coverage A, the

damage must be caused by an "occurrence," which was defined as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions."

The insurer argued that it had no obligation to cover any potential "loss of use" damages under Coverage A because ABECU intentionally repossessed the counterclaimants' vehicles.

ABECU countered by arguing that "the act of repossession was not the basis of the counterclaim," instead characterizing the "majority" of the underlying claims as stemming from ABECU's negligence in the pre- and post-sale notice drafting process. ABECU thus argued that the "loss of use" damages were not attributable to the actual vehicle repossessions, but rather, to the counterclaimants' inability to redeem their vehicles post-repossession because of the defective or missing notices. According to ABECU, the issuance of defective notices constituted an accidental "occurrence" because it was unforeseeable that the at-issue notices could have subjected them to statutory liability.

The court rejected ABECU’s arguments. Instead, it found that there was no potential for coverage for any claimed "loss of use" damages under Coverage A because the damages were unavoidably attributable to ABECU's deliberate vehicle repossessions, and therefore, could not be attributed to any accidental "occurrence." The court further noted that the fundamental premise of ABECU's argument—that the asserted "loss of use" damages are conceptually and legally severable from the act of repossession which causes the loss of use—had been addressed and squarely rejected by courts in factually similar wrongful repossession cases involving nearly identical insuring provisions.

The court explained that any "loss of use" damages flowed from the repossessions. Because repossessing a vehicle is an intentional act, the resulting damages are necessarily considered intentional as well, and cannot be considered the result of an accidental "occurrence."

This remains true, the court added, even if the "loss of use" damages were attributed to any pre- or post-repossession administrative errors committed by ABECU because such errors do not constitute accidental "occurrences" within the meaning of the policies.

The court further noted that the intentional injury exclusion would bar coverage because ABECU intended both the act that caused the loss of use and the claimed "loss of use" damages.

The court next addressed ABECU's claims under Coverage B, and specifically, the "Personal Injury" provisions. The court assumed that the asserted damages stemming from ABECU's allegedly false or derogatory credit reporting fell within the "personal injury" definition. The issue was whether the "professional credit union financial services" exclusion applied.

The professional services exclusion stated that: "[t]his insurance does not apply to 'personal injury' . . . arising out of providing or failing to provide professional 'credit union financial services' by any insured to others." "Credit union financial services" was defined, in relevant part, as:

> (c) Evaluating, analyzing, administering, managing, advising on or servicing, or providing opinions or instructions in connection with, any of the following operations or activities:
>
> (1) Lending, leasing, or extension of credit; or
>
> (2) Credit card or debit card;
>
> (d) Checking or reporting of credit;
>
> (e) Maintaining or providing information concerning any financial account, record or balance. . . .

ABECU conceded that the alleged "personal injury" damages arose out of ABECU's provision or failure to provide "credit union financial services." But ABECU argued that the scope of the professional services exclusion was so broad that it effectively revoked all coverage that

Coverage B purported to provide, and therefore, was ambiguous. ABECU further argued that the professional services exclusion was ambiguous because the word "professional" was not defined in the insuring agreements.

The court rejected these arguments too. It held that the professional services exclusion was not ambiguous and plainly barred coverage for all "personal injury" damages alleged in the counterclaim. It determined that the exclusion is a standard limitation of liability for ABECU's controllable business risks, and reasoned that it is not rendered ambiguous merely because the word "professional," which has a plain and ordinary meaning under Missouri law, was left undefined in the policies.

As the counterclaims presented no potential for coverage, the insurer had no duty to defend or indemnify ABECU, and it was awarded summary judgment.

The case is *Anheuser Busch Employee Credit Union v. Travelers Prop. Cas. Co. of Am.,* Case No. 4:18 CV 1208 CDP (E.D. Mo. Apr. 6, 2020).

Iowa Federal Court Backs Insurer's Denial of Suspicious Fire Claim

A federal court in Iowa granted summary judgment to an insurer in a suit for breach of contract and bad faith because the homeowners failed to raise a genuine issue of material fact as to whether the fire was accidental.

The Case

Two weeks after purchasing a homeowner's policy, the insureds submitted a claim for fire damage to their home. The fire emanated from a toaster in their kitchen. After extinguishing the fire and entering the home's kitchen, a volunteer firefighter observed a fluffy and flaky "block,

almost square . . . three to four inches thick" on top of the toaster. He thought it was some sort of paper product. He also observed that "[o]ne knob of the toaster was stuck down." The firefighter then asked the fire Chief to observe the "strange-looking ash pattern on top of the toaster." The Chief saw something "kind of light and fluffy, more like tissue paper or something laying across the top of the toaster." He thought the inch and a half thick layer of ash was very strange.

In his official report, completed day of the fire, the Chief recorded that the cause of the fire was "undetermined" and the source of ignition "unintentional."

Nine days after the fire, a fire inspector examined the damage in the home and concluded that the fire originated along the wall behind the toaster on the countertop. He believed that the fire was caused by an electrical malfunction with the toaster's cord because "plug blades for the power cord on the toaster were arced off inside the electrical outlet." He did not observe any identifiable remains of paper products inside of or on top of the toaster. But the unusual material on top of the toaster was inadvertently destroyed before the investigation when firefighters performed some demolition in the home.

Eleven days after the fire, a former co-worker of one of the homeowners contacted the insurer to bring to its attention some odd behavior by the homeowner, including an unusually upbeat demeanor, the purchasing of unseasonal clothing, and statements made about how one could start a fire by sticking tissues in a toaster.

Based on this tip, the insurer decided to further investigate the fire. It hired an electrical engineer to determine whether the fire had been caused by an electrical malfunction within the toaster. The electrical engineer ultimately concluded that the toaster had not malfunctioned. He stated that the arcing identified by the fire inspector was a result of the fire, not an internal defect of the toaster. The fire inspector later agreed with this finding and concluded that it was possible

the fire was caused by paper products being put in and on top of the toaster. However, based on standards set by the National Fire Protection Association (NFPA), the inspector concluded that the cause of the fire must be classified as undetermined.

The insurer concluded that the homeowners intentionally started the fire and denied the insurance claim on three grounds: (1) "the fundamental insuring agreement had not been met" because the fire was not accidental, (2) the homeowners violated the policy's intentional acts exclusion by intentionally starting the fire and (3) the contract was void due to the homeowners' concealment and fraud regarding the fire.

The homeowners sued for breach of contract and bad faith.

The insurer moved for summary judgment on the breach of contract claim because the fire that caused the homeowners' damages was not accidental and, therefore, was either not covered under the policy or subject to a policy exclusion. The insurer also argued that regardless of whether there is a genuine issue of fact as to the breach of contract claim, it was entitled to summary judgment on the homeowners' bad faith claim because it had a reasonable basis for denying the claim.

The Decision

The insurer first argued that the policy's insuring clause covers only "accidental direct physical loss to property." Because the homeowners failed to establish that the fire was accidental, the insurer argued, there was no coverage for their loss.

Second, the policy excluded coverage for intentional acts by the insured:

> If you or any person insured under this policy cause or procures a loss to property covered under this policy for the purpose of obtaining insurance benefits, then this policy is void and we will not pay you or any other insured for this loss.

Third, the policy also contained a fraudulent concealment provision, which stated:

> This entire policy shall be void if, whether before or after a loss, an insured has willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of an insured therein, or in case of any fraud or false swearing by an insured relating thereto.

The insurer argued that both exclusions applied because the homeowners intentionally set the fire and fraudulently concealed their involvement.

In response, the homeowners argued that genuine issues of material fact as to whether the fire was accidental precluded summary judgment being awarded to the insurer.

The court observed that under Iowa law there is no single definition for the term "accident" or "accidental" in insurance policies. Buy the Iowa Supreme Court has generally interpreted it to mean an event that was unplanned, unintentional, and unexpected by the person to whom the event occurs. The court therefore framed the issue as whether a reasonable jury could find that the fire was unplanned, unintentional, and unexpected by the homeowners.

Reviewing all the evidence, the court concluded that there was undisputed evidence that the fire started at the toaster, that a paper-like material was observed on top of the toaster after the fire and that the toaster was in the "on" position. There was also unrebutted expert opinion evidence that a defect in the toaster, or in the home's electrical system, could not have caused the fire and that the fire could have been started by putting paper products in and on the toaster. On this record, the court concluded, no reasonable jury could find that the fire was accidental. As such, and as a matter of law, the insurer did not breach the insurance contract by denying coverage for the loss that resulted from the fire.

The record further demonstrated that the intentional acts exclusion applies. Electrical engineering tests, combined with the firefighters' testimony regarding the paper-like substance on

the toaster and the toaster being in the on position, all indicate that the toaster was used as an instrument to intentionally start the fire. Even the fire Chief, whose testimony the homeowners relied upon, concluded that someone "must have acted on the toaster."

The court further determined that the homeowners, in contrast, provided no evidence, aside from their own denials, from which a reasonable jury could find that the intentional acts exclusion did not apply. They offered no explanation for the paper-like substance discovered on top of the toaster — neither what it was nor how it arrived there. Nor did they provide expert opinion evidence to rebut the insurer's evidence and show that the fire could have started accidentally. And they presented no evidence from which the jury could find that someone else started the fire. Thus, as a matter of law, the court held that the intentional acts exclusion applied.

It granted summary judgment to the insurer and dismissed the breach of contract and bad faith claims.

The case is *Jones v. State Farm Fire and Cas. Co.*, No. C18-4084-LTS (N.D. Iowa Apr. 6, 2020).

Colorado Federal Court Finds No Coverage for Claim Involving Illegal Telemarketing Practices

A federal district court in Colorado ruled that an insurer had no obligation to defend or indemnify an insured for a claim involving illegal telemarketing practices.

The Case

From 2003 to 2009, Plaintiff National Union Fire Insurance Company of Pittsburgh issued seven Commercial Umbrella Policies to Defendant DISH Network, L.L.C.

In 2009, the U.S. Government and the States of California, Illinois, North Carolina, and Ohio sued DISH, alleging that the company had repeatedly engaged in illegal telemarketing practices. The complaint alleged violations under the Federal Telemarketing Sales Rule, the federal Telephone Consumer Protection Act ("TCPA"), and similar state statutes and regulations. In particular, the complaint alleged that DISH violated these statutes by causing calls to be placed to residential phone lines using artificial or prerecorded voices to deliver a message without the prior express consent of the called party.

At issue was whether National Union's duties to defend and indemnify DISH under its Commercial Umbrella Policies had been triggered by the suit.

After the Underlying Lawsuit was filed, DISH submitted a claim for defense and indemnity to National Union under the policies. DISH's claim was rejected, and National Union eventually brought a declaratory judgment action. DISH asserted counterclaims alleging that National Union had breached its policies by denying DISH's claim for coverage.

The parties cross-moved for summary judgment.

The Decision

The court granted National Union's motion for summary judgment and ruled that it had no obligation to defend or indemnify DISH in the underlying lawsuit.

Applying Colorado law, the court ruled that the National Union Policies, which limited coverage to "damages," did not include any cost to comply with the injunctive relief requested in the underlying complaint. The court reasoned that the request to enjoin DISH from violating the telemarketing statutes was prospective in nature.

The court also concluded that the statutory damages sought in the underlying complaint were not insurable under Colorado law. Colorado public policy prohibits the insurability of such

penalties and barred coverage. The court determined that the request for statutory damages were brought by governmental entities and were not tied to any specific injuries or damages incurred by call recipients.

The court further concluded that coverage was unavailable because the allegations in the underlying complaint did not implicate the policies' coverage for Bodily Injury, Property Damage, Personal Injury, or Advertising Injury. The court noted that the underlying complaint did not describe any bodily injury suffered, nor did it describe any destruction of physical property or loss of use of such property. The court also concluded that even if the allegations in the underlying complaint implicated the policies' Advertising Injury coverage, several exclusions applied.

The case is *Nat'l Union Fire Ins. Co. v. Dish Network*, 2020 U.S. Dist. LEXIS 71993 (D. Colo. Apr. 17, 2020).

A Montana Federal Court Applies Pollution Exclusion to Chemical Exposure Claim

A federal court in Montana, siding with an insurer, ruled that a pollution exclusion barred coverage for a claim by workers who alleged injury from exposure to chemicals in an epoxy coating.

The Case

Swank Enterprises, Inc., the general contractor for the 2015 construction of the Butte-Silverbow Metro Wastewater Treatment Plant in Butte, Montana, hired T&L Painting, Inc. as a subcontractor. In June 2018, two T&L employees sued Swank and Tnemec Company, Inc., an epoxy manufacturer, alleging injury through exposure to chemicals contained in the coatings they applied at the project.

At the time, T&L was insured by Defendant United Fire and Casualty Company. Swank tendered the underlying cases to United Fire for defense and indemnity, insisting that it was an additional insured under T&L's policy. United Fire rejected the tender and a lawsuit followed.

United Fire moved for judgment on the pleadings.

The Decision

The court granted United Fire's motion on the basis that, even assuming Swank was an additional insured, the policy's pollution exclusion bars coverage.

The policy did not apply to "'[b]odily injury' or 'property damage' which would not have occurred in whole or part but for the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of 'pollutants' at any time." "Pollutants' was defined as "any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste."

The court found that this language unambiguously included the epoxies used at the project site. In assessing ambiguity, the court said, "[c]ourts should not . . . seize upon certain and definite covenants expressed in plain English with violent hands, and distort them so as to include a risk clearly excluded by the insurance contract."

The court granted United Fire's motion.

The case is *Swank Enters. v. United Fire & Cas. Co.,* CV 19-179-M-DWM (D. Mont. Apr. 7, 2020).

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