

2<sup>ND</sup> QUARTER '07

**IN THIS ISSUE**

**NEW ALLOCATION METHODOLOGY:**

Minimizing Losses in Insurance Coverage ..... 1

**ANALYZING THE NUMBER OF OCCURANCES**

From the Policyholder's Perspective (Part 2) ..... 2

**DOES YOUR INSURER KNOW EVERYTHING IT NEEDS TO KNOW?** ..... 3

**ALSO FEATURED**

**INSURANCE COVERAGE CASE HIGHLIGHTS** ..... 4

**HOWREY INSURANCE IN THE NEWS** ..... 10

**CONTACT US** ..... 12

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**New Allocation Methodology for Minimizing Losses Potentially Created by Gaps in Insurance Coverage**

by Helen K. Michael



Although it has yet to be considered in any reported appellate decision, a number of trial court decisions in California have approved an allocation methodology that enables policyholders confronting mass tort and other long-tail liabilities to avoid having to absorb gaps in coverage created by insolvencies or less-than-limits settlements as a precondition for accessing the overlying excess coverage. See *International Paper Co., et al. v. Affiliated FM Ins. Co., et al.*, No. 974350, Ruling re Issue H Allocation of Insolvent and Less Than Policy Limit Settlements (“*International Paper*”), at 1 (Cal. Super. Ct., San Francisco, Mar. 17, 2005); *Kaiser Aluminum & Chemical Corp. v. Certain Underwriters at Lloyd*, No. 312415, Decision on Group IIA Trial Issues (“*Kaiser I*”), at 9 (Cal. Super. Ct., San Francisco, June 13, 2003); see *Kaiser Aluminum & Chemical Corp. v. Certain Underwriters at Lloyd*, No. 312415, Decision on Group IIB Trial Issues at 5 (“*Kaiser II*”) (Cal. Super. Ct., San Francisco, Feb. 20, 2004). This methodology, which has been described as “hopscotching” around the coverage chart (*International Paper* at 1; *Kaiser I* at 5), permits a policyholder in specified circumstances to move outside a vertical line of underlying insurance in one policy year and to tap into a horizontally located policy in a different policy period in order to fill gaps in coverage.

The methodology depends upon two essential building blocks: (1) standard-form insuring agreement provisions that grant coverage for “all sums” that the policyholder becomes obligated to pay; and (2) standard-form attachment point provisions typically found in CGL (and other) policies that obligate the carrier to provide coverage once a specified amount of underlying liability has been incurred. A third building block for this methodology is that at least some of the policies in the coverage

[continued on page 6]

# How Many Times Must An Occurrence Repeat Before Coverage is Fully Realized (part 2)

By: Curtis Porterfield and Douglas Gastélum

This issue of Risk includes part 2 of a two-part article. For a copy of part 1 of this article, please contact Kim Coffee (coffeek@howrey.com) for the 1<sup>st</sup> Quarter '07 issue of *Risk*.



## I. Factors courts consider to determine the number of occurrences

Virtually all courts agree that the number of Occurrences is determined by referring to the cause of the policyholder's potential liability rather than to the number of individual claims or injuries.

Given this general rule that the cause or causes of liability determines the number of occurrences, the factors implicit

in that rule include at least the language of the policy, the cause of the liability and whether any intervening business decisions contributed to the injuries alleged.

### A. Policy Language

Obviously one of the most important clauses in an insurance policy is the definition of Occurrence. Most CGL policies define Occurrence to mean

something like “an accident, including continuous or repeated exposure to substantially the same general harmful conditions.”

Other parts of a policy that might be useful to determine the number of Occurrences include:

- the declarations page or retention endorsement that describes how a retention applies;
- the limits of liability section that may provide that the insurer will not be liable for more than the Occurrence limit, irrespective the number of claims made per occurrence;
- the policyholder's duties in the event of an Occurrence, Claim or Suit section may differentiate between duties in the event of an Occurrence and duties in the event of a Claim, indicating that they are not the same; and
- if a policy has a provision for notice of a potential claim, that may provide insight as to the meaning of Occurrence (or Claim).

### B. Cause of liability, not number or cause of injuries

A subtly more precise statement of the general rule is that the business purpose sought to be achieved by the parties should inform the court's reasoning on this issue, so courts look to the underlying conduct or cause of



<sup>1</sup> See, ISO Form CG 00011188.

[continued on page 8]

# Does Your Insurer Know Everything It Needs To Know?

by: Sanaz Asgharzadeh



When seeking policy coverage, have you informed your insurer of certain details about your business? Do you wonder if this information is even relevant to whether or not the insurer will issue or reissue the policy? It may very well be that the insurer is already aware of these facts, or that they don't deem the information necessary to issue the policy. Nevertheless, later on when you are seeking coverage, the insurance company may try to back track and claim you failed to disclose, or concealed, these facts at the time it was underwriting the policy. The insurance company will try to claim it needed this information in determining whether to issue the policy in the first place, and had it known these facts, it would not have issued the policy. By using the defense of concealment, the insurer is attempting to rescind its policy.

Concealment is commonly defined as the “[n]eglect to communicate that which a party knows and ought to communicate.” Cal. Ins. Code § 330 (2007). When seeking a policy, if you believe certain information is relevant to the policy, you should disclose it at that point. An insurer is relying on an insured's answers in its application to determine

whether to issue the policy or whether to reinsure the policy, at what rate to set the premiums for the policy, and whether to include any exclusion in the policy. The information communicated to the insurer should be that which the insured knows of and in good faith believes to be “material” to the policy. Cal. Ins. Code § 332 (2007). You don't have to disclose every fact per se but do need to inform them of facts material to the policy. Simply because a fact is not included in the policy does

§ 334 (2007). Whether or not the information is material to issuing the policy, is determined at the time the policy is negotiated. Materiality should not be determined by an insurance company's opinion given with the aid of hindsight. “Postmortem” assertions that an insurance company would not have issued the policy had it known of the undisclosed facts are suspect and may be disbelieved. *Thompson v. Occidental Life Ins. Co.*, 9 Cal.3d 904, 915-916 (1973); *see also McAuliffe v. John Hancock Mut.*

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The information communicated to the insurer should be that which the insured knows of and in good faith believes to be “material” to the policy.

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not mean that the insurer can later claim concealment.

The relevant question is whether the insured misled the carrier “into accepting a risk, fixing a premium of insurance, estimating the disadvantages of the proposed contract, or making [its] inquiries.” *Merced County Mut. Fire Ins. Co. v. State*, 233 Cal.App.3d 765, 772 (1991). Materiality is based only on “the probable and reasonable influence of the facts” on the insurer in forming its opinion of the proposed contract or in making further inquiries. Cal. Ins. Code

*Life Ins. Co.*, 245 Cal.App.2d 855, 858 (1966).

Additionally, it is the insurer's burden to prove that had it known of this fact it would not have issued the policy or would have issued it in a different form. The omitted fact must be something material to the policy. If this is a fact that the insured knew about and failed to communicate that the insurer was aware of at that time, the insurer has no right to rescind the policy. California Insurance Code section 333 provides that neither party is bound to communicate information

[continued on page 9]

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## Case Highlights

By Scott Malzahn

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*These summaries are not intended to be an exhaustive analysis of legal developments in the insurance field. Rather, they are an overview of recent "highlights" of developments in selected states. Should the need arise, Howrey is able to assist its clients in a more detailed analysis of recent legal developments pertaining to insurance coverage in any state.*



### CALIFORNIA

#### Coverage Where Construction Activities Are Taking Place on Otherwise Vacant Property

*TRB Investments, Inc. v. Fireman's Fund Ins. Co.*, 40 Cal. 4th 19 (2006)

California Supreme Court reversed grant of summary judgment and remanded the matter to the superior court for further proceedings to determine whether an insured's water damage claim fell within an exception to an exclusion in a property insurance policy.

TRB Investments, Inc. ("TRB") owned a commercial building that sustained substantial water damage when a water heater or waterline ruptured. The building had no tenants at the time of the accident. However, an architectural firm and a general contractor hired by TRB were working on transforming the building into a "leasable shell" by removing interior non-supporting walls so that space could be used more efficiently to suit a particular tenant's needs.

TRB properly tendered its water claim damage to Fireman's Fund Insurance Company ("Fireman's") under its property insurance policy. The policy included a "vacancy exclusion," which provided that Fireman's would not cover water damage that occurs "to a building that has been vacant for more than 60 consecutive days prior to" the damage. The exclusion also stated that "[b]uildings under construction are not considered vacant." The word "construction" was not defined in the policy. Fireman's denied coverage for the claim based on the vacancy exclusion and TRB sued.

The superior court ruled on summary judgment that the vacancy exclusion applied because the building had been vacant for more than 60 consecutive days prior to the damage and the building was not under

construction. The Court of Appeal affirmed that ruling and distinguished mere renovations to an existing structure from construction of a new structure. The Court of Appeal specifically held that the word "construction" in the policy "envisions the building of a new structure," which had not occurred here.

The California Supreme Court disagreed with the lower courts, reasoning that the purpose of the vacancy exclusion is to exclude from coverage unoccupied properties that face an increased risk of property damage, whether from crimes such as vandalism and theft or from neglect of the building. The exception in the vacancy exclusion for buildings "under construction" reflected the recognition that a continuous and substantial presence of workers on a property reduces the risks otherwise associated with unoccupied properties. Moreover, the Court stated that the plain meaning of the words "under construction" in the vacancy exclusion would not seem to exclude all work performed on an existing structure. Accordingly, the Court reversed the lower court decisions and remanded the matter to the superior court for further proceedings to determine whether there were "substantial continuing activities" by persons associated with the building project at the premises around the time of the water damage.

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### WASHINGTON

#### "Occurrence" Coverage for the Intentional Act of Turning on the Water

*Nationwide Mut. Ins. Co. v. Hayles, Inc.*, 136 Wn. App. 531 (2007)

Court of Appeal affirmed grant of summary judgment in favor of insured ruling that water damage to an onion crop after the insured operated its irrigation system incorrectly was covered as an "occurrence" within the meaning of a farm liability policy.

Hayles, Inc. ("Hayles") subleased a field to a family to grow onions. Under the terms of the sublease, Hayles maintained and controlled the field's irrigation system and the family directed Hayles when to turn the water

on and off. After Hayles turned on the water after the family told the company to keep the water off, the onions rotted. In a subsequent dispute over the damage to the onion crop, Hayles agreed to a stipulated judgment of more than \$400,000 and the family agreed to execute on the judgment against Hayles' insurer, Nationwide Mutual Insurance Company ("Nationwide").

Nationwide, however, denied any responsibility under the farm liability policy that it had issued to Hayles for the damage to the onion crop. The policy at issue covered property damage caused by an "occurrence," which it defined as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." Nationwide argued that Hayles' intentional act of turning on the water was not an accident.

The court rejected Nationwide's argument, and held that an "accident" means an unintended and unexpected event. Moreover, an intentional act may constitute an "accident" where the insured committed that act without awareness of the implications or consequences of his act. In this case, there was no evidence that Hayles knew or should have known that turning on the irrigation system would damage the onion crop. Accordingly, the court ruled as a matter of law that the policy provided coverage for the damage. Additionally, the court summarily rejected various defenses to coverage raised by Nationwide based on policy exclusions.

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## NEW YORK

### **Insured Has Right to Trial As to Whether Particulate Damage From September 11, 2001 is Excluded By Contamination Exclusion**

*Parks Real Estate Purchasing Group v. St. Paul Fire and Marine Ins. Co.*, 472 F.3d 33 (2d Cir. 2006)

Second Circuit vacated the district court's grant of summary judgment in favor of an insurance carrier in an action to recover on a first party property damage claim arising out of the events of September 11, 2001. The matter was remanded to the district court for further proceedings.

Parks Real Estate Purchasing Group ("Parks")—the insured plaintiff—owned a building located in downtown New York City. On September 11, 2001, the collapse of the World Trade Center Twin Towers

caused a cloud of particulate matter and dust to spread throughout downtown New York City area. The particulate matter and dust entered the interior and exterior of Park's building, resulting in more than \$16 million in property damage to building systems, components, and equipment as well as more than \$1 million in business interruption losses.

St. Paul Fire & Marine Insurance Company ("St. Paul")—the defendant insurance carrier—had issued Parks an all-risk property insurance policy providing that St. Paul would "[p]rotect covered property against risks of direct loss or damage . . ." However, the policy included a contamination exclusion, which stated that St. Paul would not "cover loss or damage caused by or made worse by any kind of contamination of . . . products or property covered by this insuring agreement." The policy did not define the word "contamination."

St. Paul argued that the damage to Park's building was "contamination" excluded from coverage under the all-risk policy by the contamination exclusion. The district court agreed and granted summary judgment in favor of St. Paul. The district court reasoned that the word "contamination" was unambiguous, and, borrowing definitions used by other courts, determined that "contamination" meant the "introduction of a foreign substance that injures the usefulness of the object" or "a condition of impurity resulting from the mixture or contact with a foreign substance." Applying those definitions, the district court concluded that the damage to Park's building was the result of contamination.

On appeal, the Second Circuit disagreed with the district court and ruled that the word "contamination" was ambiguous in the context of the all-risk policy. The Second Circuit reasoned that virtually any unintended damage to a building could be considered contamination as defined by St. Paul and the district court. Applying a common-sense approach to policy interpretation, the Second Circuit wondered whether the parties intended damage caused by the settling of particulate matter and dust from the attacks on the World Trade Center Twin Towers to be excluded from coverage under a contamination exclusion. Because the word "contamination" was ambiguous, the Second Circuit vacated the district court's summary judgment ruling and instructed the district court to admit extrinsic evidence at trial of what the parties intended by use of this ambiguous word.

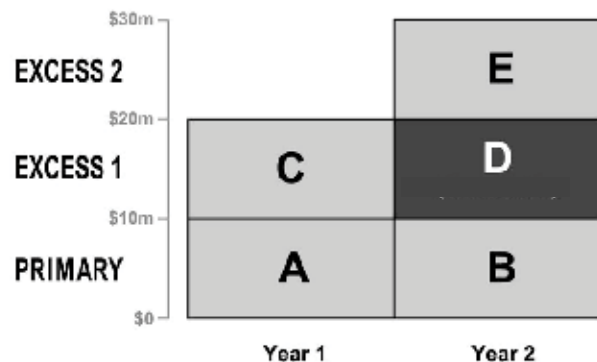
block may be exhausted vertically, rather than being accessible only after the policyholder's liability is sufficient to exhaust all of the policies in the underlying layer of coverage.

With respect to the standard-form insuring agreement provisions, this methodology follows the majority view that policies providing “all sums” coverage permit the policyholder to choose which of multiple policies triggered by a continuing injury claim will provide coverage on the ground that each triggered policy in successive policy periods has a separate and independent obligation to provide full indemnification up to policy limits. *See, e.g., Dart Indus., Inc. v. Commercial Union Ins. Co.*, 28 Cal.4th 1059, 1080 (2003); *Aerojet-General Corp. v. Transport Indem. Co.*, 17 Cal.4th 38, 57 n.10 (1997); *Montrose Chem. Corp. v. Admiral Ins. Co.*, 10 Cal.4th 645, 686 (1995).

With respect to the standard form attachment point provisions, this methodology follows the precedent establishing that a policy must pay so long as the policyholder's liability has exceeded a specified amount and regardless of whether payment of the underlying policy limit actually has been made. *See, e.g., Rummell v. Lexington Ins. Co.*, 945 P.2d 970, 981 (N.M. 1997) (“the excess insurer has no rational interest in whether the [underlying] policies are collected in full, as long as it is only required to pay the loss for which it would otherwise have been liable under the terms of its contract”); *Denny's, Inc. v. Chicago Ins. Co.*, 234 Cal.App.3d 1786, 1794 (1991) (“the insured's liability [must] exceed the underlying insurance limits before any liability attaches to the excess insurer, whether or not the underlying insurer has actually paid out the policy limit.”); *Span, Inc. v. Associated Int'l Ins. Co.*, 227 Cal.App.3d 463, 476-80 (1991) (excess policy must respond once the insured's liability reaches stated attachment point); *Gasquet v. Commercial Union Ins. Co.*, 391 So.2d 466, 471 (La. 1980) (settlement with underlying insurance company for less than policy limits does not relieve excess insurance company from its obligations).<sup>1</sup>

The methodology prescribes that, when applied together, these policy provisions render a triggered policy “responsible for its appropriate level of 'all sums' liability even when [the policy] is filling an insolvency [or settlement] gap from a different position in the coverage chart,” and that the excess policy overlying the gap in coverage must provide indemnification once the policyholder has paid the specified amount of underlying liability. *Kaiser I* at 10. As stated above, it is irrelevant under this methodology whether the underlying policy actually pays its specified limit of liability. Once the policyholder itself has paid an amount exceeding the specified attachment point of overlying excess policy, that policy may be chosen to provide coverage because the amount of liability incurred by the policyholder and not whether the underlying insurer actually has provided indemnification for that liability, controls the point at which each excess policy must assume its coverage obligations.

A simple hypothetical will illustrate how this allocation methodology works in practice. Assume that a policyholder purchases two \$10 million “all sums” policies in Year One and three \$10 million “all sums” policies in Year Two:



Assume also that the hypothetical policyholder has paid four \$10 million claims for continuing property damage for a total of \$40 million, and that these four claims trigger both of the policy periods. Assume next that the policyholder exhausts its primary coverage

<sup>1</sup> Typical attachment point provisions include ones providing “that liability shall attach to the Company only after the underlying Umbrella Insurers have paid or have been held liable to pay the full amount of their respective” underlying liability, or that “[l]iability of the Company under this policy shall not attach unless and until the Insured or the Insured's Underlying Insurance has paid or has been held liable to pay the total applicable underlying limits.”



by allocating a \$10 million claim to Policy A and a \$10 million claim to Policy B. If all three of the excess policies were available to provide coverage, then the policyholder would have a choice under the “all sums” and attachment point provisions of the contracts: it could choose to allocate \$10 million to Policy C and \$10 million to Policy D; or it could choose to allocate a \$10 million claim to Policy D and the remaining \$10 million claim to policy E (which would be obligated to respond because its specified attachment point of \$20 million has been reached). Either choice would be permissible because all five policies cover “all sums” involving property damage that occurs during the policy period and because the attachment points of the three excess policies would be satisfied.

Assume instead, however, that Policy D is not available to provide coverage owing to an insolvency or settlement for less than policy limits. After allocating two claims equaling \$20 million that the policyholder previously had paid to exhaust Primary Policies A and B, suppose that the policyholder chooses to allocate a \$10 million claim that it previously had paid to Policy C. Under the “all sums” and attachment point provisions of Policy E, the policyholder is not required to absorb the gap in coverage created by Policy D before accessing the coverage granted by Policy E. The policyholder instead may “hopscotch” from Policy C to Policy E by using the claims that it has allocated to Policy C to fill “the gap” in coverage created by Policy D, and by then allocating a previously paid claim to Policy E. The

policyholder is entitled to do so because the previously paid claim allocated to Policy C also triggered Year Two, and because the total \$20 million in claims paid by the policyholder that have been allocated to Year One reach the attachment point of Policy E. The policyholder, therefore, may allocate to Policy E the final \$10 million claim that it previously paid. Policy E is liable for “all sums” because the policyholder has paid \$20 million satisfying the attachment point of Policy E. If, instead of being completely unavailable to provide coverage, Policy D had settled for \$5 million, the allocation would work in substantially the same way. The only difference would be that after allocating \$10 million to Policy C, the policyholder would allocate \$5 million to Policy D, before allocating any loss to Policy E. In the example above, only \$5 million would be allocated to Policy E.

It is important to note that Policy E is no worse off than it would have been had Policy D been available to provide coverage. If Policy D were available to pay its specified \$10 million in underlying liability, the policyholder still could have chosen Policy E to pay the last \$10 million.

While this methodology may appear novel at first blush, it is founded upon the settled principles of policy interpretation requiring policy terms to be construed broadly in favor of coverage and restrictions on coverage to be clearly expressed. It is consistent with the terms of standard-form “all sums” provisions to permit a policyholder to move outside a single policy period for the purpose of allocating claims that would trigger an unavailable policy to a triggered policy that is available to pay the claims. It also is consistent with the terms of standard-form “all sums” and attachment point provisions to permit the policyholder to select the excess policy overlying an unavailable policy to provide coverage, so long as the policyholder has incurred sufficient liability to reach the attachment point of the overlying excess policy, and only allocates to that excess policy claims that trigger the selected excess policy.

To limit the coverage afforded by the standard-form “all sums” and attachment point provisions, settled principles of policy interpretation require

[continued on page 11]

the liability that was insured.

Many cases where the adoption of policies or standard practices was at issue have resulted in single Occurrence conclusions. For example, in *Mead Reinsurance v. Granite State Ins. Co.*, 873 F.2d 1185 (9<sup>th</sup> Cir. 1989), the court held that the policyholder City's potential liability arising from injuries alleged in eleven lawsuits claiming that the City had adopted a policy condoning police brutality constituted a single occurrence. Similarly, in *Appalachian Ins. Co. v. Liberty Mut. Ins. Co.*, 676 F.2d 56, (3d Cir. 1982) the court held that

implemented, if the liability arises *Eureka Fed. Sav. & Loan Ass'n*, from the implementation rather than the policy. In *Eureka Fed. Sav. & Loan Ass'n v. American Cas. Co. of Reading*, 873 F.2d 229 (9<sup>th</sup> Circuit 1989), the court held that although the losses alleged in the underlying complaints all arose from a single aggressive lending strategy adopted by the board of directors, each of the 200 or more failing loans were separate occurrences because "numerous *intervening business decisions* that took place after the [business] policy was initiated . . . required the exercise

to be aligned with you?

What created the potential for liability? Were subsequent, independent, decisions and acts required to complete the liability-causing transactions?

**B. Review the policy language carefully**

Do relevant policies have adequate limits? Do they have applicable aggregate limits? Can the claims fit within categories with no aggregates? Do ancillary provisions indicate how either limits or retentions apply?

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**Virtually all courts agree that the number of Occurrences is determined by referring to the cause of the policyholder's potential liability rather than to the number of individual claims or injuries.**

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injuries alleged in a class action suit alleging a discriminatory employment policy were a single occurrence for the purposes of the policy deductible. The court found that the only Occurrence that caused liability at issue was a single adoption of employment policies that limited employment opportunities for women in Liberty Mutual's claim organization.

**C. Intervening Business decisions**

Other courts have found that single business policies can lead to multiple occurrences when

of independent judgment." 873 F. 2d at 235 (emphasis in original).

**II. Preparing for a Dispute over the Number of Occurrences**

**A. Consider the factors discussed above**

Is the total amount of potential liability within the primary policy limits? Total available limits? Are there applicable retentions? On what basis do they apply? Could they outstrip the coverage if improperly applied?

Are carriers on any level likely

**C. Determine how the carrier has acted up to this point**

How have prior claims on the same or similar policies been treated?

**D. Conduct a Choice of Law analysis**

Frequently, insurance coverage disputes turn on which state's law is being used to support particular positions. Accordingly, we cannot overemphasize that the policyholder really has to make two separate analyses when reviewing the carrier's declination of coverage or a carrier's position regarding the number of occurrences that

[continued on page 11]

of matters “which the other knows” or “which in the exercise of ordinary care, the other ought to know, and of which the party has no reason to suppose him ignorant.” Cal. Ins. Code § 333 (2007). The insurance company chose to issue the policy in its current form with knowledge of the allegedly material fact and cannot later claim that it would have done anything differently.

Equity allows an insured to rescind the policy if: (1) it would not have issued the policy in the first place; (2) or it would have charged different premiums; or (3) it would have included particular exclusions in the policy. However, equity does not step in when the insurance company, with full knowledge of the facts it claims are significant to the policy, issued the policy without taking into account the later claimed material fact. Reissuing the same policy in subsequent years with knowledge of the material facts is a further indicator that the fact was not material. See *Atmel Corp. v. St. Paul Fire & Marine Ins. Co.*, 416 F.Supp.2d 802, 811 (N.D. Cal. 2006) (supposed materiality of circumstances that resulted in lawsuit tendered under the policy called in question by fact that “after [insured] had tendered [the lawsuit] to St. Paul, St. Paul renewed [insured’s] insurance policies” without additional inquiry).

Most jurisdictions place a heavy burden on the insurer to ask questions in the application process about matters that it considers material. Should the insurer specifically ask direct



questions during the underwriting process, the insured must respond truthfully and accurately. But, it is the insurer's responsibility to ask about facts it deems material to issuing and reissuing the policy and it must do so in a clear and unambiguous manner. The insured, in turn, is not obligated to decipher what the insurer finds material. Likewise, in evaluating whether answers to questions on insurance applications are misstatements, questions posed by the insurer must be so plain and intelligible that any applicant can readily comprehend them; any ambiguities in that regard are to be construed in favor of the insured. See *Nadel v. Manhattan Life Ins. Co.*, 621 N.Y.S. 2d 180 (1995).

Insureds cannot reasonably be expected to anticipate every question an insurer may have and where the insurer does not ask a question or ask for further information, the insured cannot be held accountable for a purported failure to disclose.

If a statement is so doubtful and obscure upon its face that a prudent underwriter would have inquired further, by failing to inquire, the insurer will be deemed to have waived its rights concerning the ambiguity or incompleteness of the representation. See *L. Black Co. v. London Guar. & Accid. Co.*, 144 N.Y.S. 424 (1913) rev'd on other grounds, 216 N.Y. 560 (1921)

In assessing whether or not a fact is material, a key indicator is whether the insurer thought the information was significant enough to ask specific questions regarding it at the time of underwriting. See *Maryland Cas. Co. v. Nat'l American Ins. Co. of Cal.*, 48 Cal.App.4th 1822, 1932 (1996); see also *Farmers Auto. Inter-Ins. Exch. v. Calkins*, 39 Cal.App.2d 390, 396 (1940) (“the failure to inquire into [a] subject indicates an entire lack of interest in it”); *Reserve Ins. Co. v. Apps*, 85 Cal.App.3d 228, 231 (1978) (insurer assumes risk of loss where no specific question is

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# HOWREY<sup>LLP</sup> INSURANCE IN THE NEWS

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## Speaking Engagements

**Mary Craig Calkins** (Los Angeles) will present at the Mealey's Global Warming Litigation conference in Chicago, IL, May 10 – 11, 2007.

**Ty Childress** (Los Angeles) will be speaking at the Risk & Insurance Management Society (RIMS) Annual Meeting in New Orleans on May 2, 2007 on the subject "Additional Insureds, Indemnitors and Insurers: Who Owes Whom What?"

Register to attend the annual meeting at: <http://www.rims.org>

**Jill B. Berkeley** (Chicago) will be a panelist at the ABA Section of Dispute Resolution's Annual Spring Conference in Washington, DC in April, 2007 on the topic of "Mentoring Mediators" from the standpoint of litigation counsel.

Event information at: <http://www.abanet.org>

**Mary Craig Calkins** (Los Angeles) gave the presentation, "Policy Ownership and Coverage for Corporations in Bankruptcy," at the American Conference Institute's 13th Annual D&O Liability Insurance in San Antonio, TX, April 11 – 14.

**Ms. Calkins** also presented on "The Limits of Permissible Guidelines," at the Mealey's

Litigation Management Guidelines in New York, NY, April 18 – 19, 2007.

**Robert Shulman** (Washington DC) spoke at the March Mealey's conference on e-discovery in insurance cases.

On February 15, 2007, **Helen Michael** (Washington DC) gave the presentation, *Issues Arising from the Tripartite Relationship*, the American Bar Association, and Tort Trial & Insurance Practice Section, Insurance Coverage Litigation Committee, at University of Arizona, Tucson.

**Helen Michael** (Washington DC) gave the presentation, *Best Claims-Handling Practices and Emerging Limitations on Punitive Damages Awards*, at the Mealey's 5th Annual Advanced Insurance Coverage Conference: Top 10 Issues, in Philadelphia, PA, January 23, 2007.

Also at the American Bar Association, Tort Trial & Insurance Practice Section, Insurance Coverage Litigation Committee, 15th Annual Coverage Litigation Committee Midyear Program on February 16, 2007 in Tucson, AZ, Helen Michael (Washington DC) presented "Insurer Liability to cover Stipulated Judgments."

## Awards and Honors

*Howrey's* insurance recovery co-chair, **Robert Shulman** (Washington DC), was named one of Washington, D.C.'s Leading Insurance Recovery lawyers. "His imagination and intellectual curiosity and ability to fashion aggressive legal theories makes him able to provide convincing arguments to both courts and adversaries," says John Hartje, former chief counsel of corporate litigation at International Paper. "He has an encyclopedic understanding of insurance law. But he's always trying to move it to the next level."

## Published Articles

### "Keep a Record," *Resort & Recreation*

Legal analysts say that in light of disastrous hurricane activity that has taken place over the last few years, it is important to keep proper records. In particular, business costs should be carefully tracked. "Have your accountant set up separate accounts to track these expenses," advises **Patrick McDonough** (Los Angeles) who specializes in insurance recovery." In this article, Mr. McDonough lists the five main areas to document.



## NEW ALLOCATION METHODOLOGY

[continued from page 1]

the insurer selling the policy to include clear and specific coverage-limiting terms. See, e.g., *Haynes v. Farmers' Ins. Exch.* 32 Cal.4th 1198, 1204 (2004) (any provisions that purport to take away or limit coverage must be “conspicuous, plain and clear.”); *Smith Kandal Real Estate v. Continental Cas. Co.* 67 Cal. App.4th 406, 414-15 (1998) (if an exclusion or limitation on coverage is at all ambiguous, “the ambiguity will be resolved against the insurer and in favor of coverage.”). Absent such clear and specific coverage limitations, standard-form “all sums” and attachment point provisions should be construed to permit policyholders to access the coverage overlying an unavailable policy without absorbing the gap in coverage created by the unavailable policy based on the allocation methodology discussed herein. As one court concluded in approving the methodology, “[t]his result” obligates insurers “to pay out exactly what” they “bargained to be responsible for” as long as: “(a) that insurer is liable on an ‘all sums’ basis for the same losses as was the insolvent [or otherwise unavailable policy]; and b) the amounts of underlying liability specified in that insurer’s policy have been satisfied.” See *Kaiser I* at 10; see also *Kaiser II* at 4-5; *International Paper*, at 5 (“Absent specific restrictive language to the contrary, nothing precludes” policyholders “from filling. . . coverage gaps with other eligible policies issued by different carrier[s] in different policy years.”).

## ANALYZING NUMBER OF OCCURRENCES (PART 2)

[continued from page 8]

may create a disadvantage for the policyholder.

First, the policyholder must analyze the carrier’s position in accordance with the law of the state the carrier relies upon for that position. If the carrier’s position is in any way debatable under the law of that state, the policyholder should object to it immediately. Even if the law of the state cited by the carrier for its position supports the carrier’s position, the policyholder must determine whether the state cited by the carrier is the correct state for law governing the insurance coverage dispute at issue. If the carrier has a solid position in the state that it cites, but a debatable position in another potentially applicable state, then the policyholder should consider arguing that the other state’s law applies and that its coverage position is based on that other state’s law.

The factors affecting insurance coverage dispute jurisdiction frequently include:

- Choice of law provisions in policies;
- The state in which the policyholder is domiciled;
- The state in which the underlying action or claim is made;
- The state in which the insurance contract was made;
- The state in which the insurer is domiciled.

In any event, review an insurer’s stated rationale with care to make certain that your rights under the policy are fully considered.

## DOES YOUR INSURER KNOW...

[continued from page 9]

asked). Insurers reveal their lack of interest by not asking for particular information, and are often stopped from doubling back after a claim has been made to argue for the first time that the information never asked for would have been material to their underwriting decisions. See *Reserve Ins. Co. v. Apps*, 85 Cal.App.3d at 231; *Ashley v. American Mut. Liab. Ins. Co.*, 167 F.Supp. 124, 130 (N.D. Cal. 1958) (“A failure to inquire into a subject, with specificity, is held to indicate an entire lack of interest in it.”); *E.A. Boyd Co. v. U.S. Fidelity and Guaranty Co.*, 35 Cal.App.2d 171, 181-182 (1939) (“If no questions are asked and the insurer possesses facts that should place a reasonably prudent person on inquiry, failure of the insured to voluntarily inform the insurer of those facts is not fraud or concealment that will warrant the rescission or cancellation of the policy.”)

Not every omission in an insurance application warrants rescission by the carrier or even a defense to coverage. The insured should be mindful to provide all material facts in response to questions that are asked of it when seeking insurance and of any other material facts that might affect the underwriting of its policy. While the right to rescind is an equitable remedy, the insurance company is precluded from later asserting the fact would have been material when the evidence indicates that it would have issued the same policy in the same form.

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