

NO. 68478-7

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION I

QUELLOS GROUP, LLC,

Appellant/Cross-Respondent,

v.

FEDERAL INSURANCE COMPANY and INDIAN HARBOR
INSURANCE COMPANY,

Respondents/Cross-Appellants.

On Appeal from the King County Superior Court
Case No. 10-2-41637-4 SEA
Hon. Dean S. Lum, Judge Presiding

**REPLY BRIEF OF CROSS-APPELLANT
FEDERAL INSURANCE COMPANY**

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TABLE OF CONTENTS

	Page
I. SUMMARY OF ARGUMENT	1
II. ARGUMENT	3
A. Greenstein’s and Wilk’s Pre-Inception Knowledge of Point’s Fraudulent Nature Bars Coverage.	3
1. The Prior Knowledge Exclusion Applies on the Basis of its Plain Terms, not Any Misrepresentation by Quellos.	3
2. Under its Plain Terms, the Prior Knowledge Exclusion Clearly Bars Coverage.	7
3. The Continuity Date Exclusion Similarly Bars Coverage for All of the POINT Claims.....	12
B. The Admitted Fraudulent Conspiracy Underlying Point Compels Summary Judgment in the Insurers’ Favor.	14
1. Proper Application of the Fraud Exclusion Does Not Entail Any Allocation Beyond That Already Done by Quellos.	14
2. The Knowing Wrongful Act Exclusion Similarly Bars Coverage.	23
III. CONCLUSION.....	25

TABLE OF AUTHORITIES

Page(s)

FEDERAL CASES

<i>American Guarantee & Liability Insurance Co. v. Fojanini</i> , 90 F. Supp. 2d 615 (E.D. Pa. 2000)	5
<i>American Home Assurance Co. v. Cohen</i> , 815 F. Supp. 365 (W.D. Wash. 1993).....	24, 25
<i>American Home Assurance Co. v. Pope</i> , 591 F.3d 992 (8th Cir. 2010)	24
<i>Caterpillar, Inc. v. Great American Insurance Co.</i> , 62 F.3d 955 (7th Cir. 1995)	16
<i>Culver v. Continental Insurance Co.</i> , 11 F. App'x 42 (4th Cir. 1999)	6, 9
<i>In re Feature Realty Litigation</i> , 634 F. Supp. 2d 1163 (E.D. Wash. 2007).....	22
<i>In re Feature Realty Litigation</i> , 468 F. Supp. 2d 1287 (E.D. Wash. 2006).....	22
<i>Gluck v. Executive Risk Indemnity, Inc.</i> , 680 F. Supp. 2d 406 (E.D.N.Y. 2010)	6
<i>International Insurance Co. v. Peabody International Corp.</i> , 747 F. Supp. 477 (N.D. Ill. 1990)	9
<i>Maynard v. Westport Inc. Corp.</i> , 208 F. Supp. 2d 568 (D. Md. 2002), <i>aff'd</i> , 55 F. App'x 667 (4th Cir. 2003).....	5
<i>Medical Mutual Insurance Co. v. Indian Harbor Insurance Co.</i> , 583 F.3d 57 (1st Cir. 2009).....	20, 21
<i>MGIC Indemnity Corp. v. Home State Savings Association</i> , 797 F.2d 285 (6th Cir. 1986)	20
<i>National Union Fire Insurance v. Seafirst Corp.</i> , 662 F. Supp. 36 (W.D. Wash. 1986).....	7

TABLE OF AUTHORITIES
(continued)

	Page(s)
<i>Nordstrom, Inc. v. Chubb & Son, Inc.</i> , 54 F.3d 1424 (9th Cir. 1995)	15, 16
<i>Owens Corning v. National Union Fire Insurance Co.</i> , 257 F.3d 484 (6th Cir. 2001)	16
<i>PLM, Inc. v. National Union Fire Insurance Co.</i> , No. C-85-7126, 1986 WL 74358 (N.D. Cal. Dec. 2, 1986), <i>aff'd</i> , 848 F.2d 1243, 1988 WL 58031 (9th Cir. 1988).....	18
<i>Piper Jaffray Cos. v. National Union Fire Insurance Co.</i> , 38 F. Supp. 2d 771 (D. Minn. 1999).....	16
<i>Platte River Insurance Co. v. Baptist Health</i> , No. 07cv0036, 2009 WL 2015102 (E.D. Ark. Apr. 17, 2009) ..	6, 9
<i>Professional Managers, Inc. v. Fawer, Brian, Hardy & Zatzkis</i> , 799 F.2d 218 (5th Cir. 1986)	5
<i>Richardson Electronics, Ltd. v. Federal Insurance Co.</i> , 120 F. Supp. 2d 698 (N.D. Ill. 2000)	18, 20
<i>Ross v. Continental Casualty Co.</i> , 420 B.R. 43 (D.D.C. 2009)	5
<i>Safeway Stores, Inc. v. National Union Fire Insurance Co.</i> , 64 F.3d 1282 (9th Cir. 1995)	16
<i>St. Paul Fire & Marine Insurance Co. v. Sledjeski & Tierney, PLLC</i> , No. 08-cv-5184, 2009 WL 2151425 (E.D.N.Y. July 17, 2009).....	5
<i>XL Specialty Insurance. Co. v. Level Global Investors, L.P.</i> , -- F. Supp. 2d --, 2012 WL 2138044 (S.D.N.Y. June 13, 2012)....	6

STATE CASES

<i>American Continental Insurance Co. v. American Casualty Co.</i> , 103 Cal. Rptr. 2d 632 (Ct. App. 2001)	18
<i>American Special Risk Management Corp. v. Cahow</i> , 192 P.3d 614 (Kan. 2008).....	6

TABLE OF AUTHORITIES
(continued)

	Page(s)
<i>James F. O'Connell & Associates v. Transamerica Indemnity Co.</i> , 61 Wn. App. 103 (1991)	9
<i>Public Utility District No. 1 v. International Insurance Co.</i> , 124 Wn.2d 789 (1994)	21
<i>Queen City Farms, Inc. v. Central National Insurance Co.</i> , 126 Wn.2d 50 (1995)	7
<i>Ratcliffe v. International Surplus Lines Insurance Co.</i> , 550 N.E.2d 1052 (Ill. App. Ct. 1990)	9
<i>Safeco Title Insurance Co. v. Gannon</i> , 54 Wn. App. 330 (1989)	17
<i>Stouffer & Knight v. Continental Casualty Co.</i> , 96 Wn. App. 741 (1999)	21

STATE STATUTES

RCW 48.18.090	4, 6, 7
RCW 64.40	22

I. SUMMARY OF ARGUMENT

Quellos seeks insurance coverage for sums it expended as a consequence of an admitted criminal conspiracy to defraud the IRS.¹ Confronted with the stark clarity of this record, Quellos concedes that \$17.4 million it paid to defend its CEO and another principal against the government charges of crimes is not covered under the policies. However, Quellos argues that the remaining \$45.15 million it paid (consisting of \$34.75 million spent to settle two Client Claims and \$10.4 million incurred in defense of those claims and in responding to governmental investigations arising from the POINT strategy) might nonetheless be recoverable from the Insurers. The Court should reject Quellos's attempts to evade the plain language of the policies excluding coverage for the POINT Claims in their entirety.

First, Quellos tries to avoid exclusions triggered by its pre-inception knowledge of circumstances that might give rise to claims. Quellos attempts to divert the Court's attention away from the Prior Knowledge Exclusion's clear terms to a statute that governs rescission of insurance contracts. But Federal seeks to enforce the contract, not rescind it. These are distinct remedies, and the Court should reject Quellos's

¹ Capitalized terms have the same meanings as those set forth in Federal Insurance Company's opening brief and/or the Primary Policy.

efforts to conflate them. Because Greenstein and Wilk indisputably had “any knowledge of any fact or circumstance which might give rise to a claim” in relation to POINT before the relevant policy period, and alternatively “knew of such Wrongful Act or could have reasonably foreseen that such Wrongful Act could lead to a claim,” no coverage is available to any Insured for any POINT Claim.

Second, policy exclusions applicable to deliberate fraudulent conduct and the knowing commission of Wrongful Acts also bar coverage for the POINT Claims in their entirety. Quellos urges the Court to undertake an intricate allocation exercise to determine which portions of the \$45.15 million at issue could be covered. However, no allocation is necessary or permissible because, with the exception of less than \$1.3 million of defense expenses, none of the amounts Quellos seeks to recover were incurred in defense or settlement of claims “made against” Individual Insureds to whom the relevant exclusions might not apply. Quellos claims the ability to indemnify directors and officers for amounts they incur, but the Primary Policy applies to amounts paid as indemnification only to the extent claims are “made against” Individual Insureds. As the POINT Claims were directed to and made against Quellos alone, the consequences of Quellos’s foray into the tax shelter business are for Quellos to bear alone.

II. ARGUMENT

A. GREENSTEIN'S AND WILK'S PRE-INCEPTION KNOWLEDGE OF POINT'S FRAUDULENT NATURE BARS COVERAGE.

1. **The Prior Knowledge Exclusion Applies on the Basis of its Plain Terms, not Any Misrepresentation by Quellos.**

The Prior Knowledge Exclusion contained in Section VI of the 2000 Application incorporated into the Primary Policy unequivocally bars coverage for “*any* claim arising from” “*any* knowledge of *any* fact or circumstance which might give rise to a claim under the proposed policy” possessed as of September 20, 2000 by Quellos “*or any* of its partners, directors, officers, employees or trustees.” CP 1122 (Ex. E) (emphasis added). Greenstein and Wilk clearly understood from POINT’s inception that the POINT tax shelter had been built upon a “synthetic” stock portfolio, the nature of which had not been disclosed to Quellos’s clients or the attorneys drafting the legal opinions attesting to POINT’s economic substance. They knew that the information given to clients and their counsel regarding POINT’s critical characteristics was false. And they knew that the warrants to be issued by the special purpose vehicles formed to implement POINT—the feature designed to allow POINT to pass muster with the IRS as a transaction with economic substance—would never be and were not intended to be exercised. The potential for claims based on such non-disclosures in the event of IRS audit was evident and

the topic of conversation in 2000. Fed. Br. at 10-15. Under any standard, Greenstein and Wilk knew that claims might be made. As Quellos concedes, no non-imputation clause applies to the Prior Knowledge Exclusion, and under black letter Washington law, Greenstein's and Wilk's knowledge precludes coverage for all Insureds.

Quellos tries to sidestep the Prior Knowledge Exclusion's plain language by positing that Federal needs to satisfy additional requirements under Washington's statute governing rescission of insurance policies. *See* RCW 48.18.090(1); Quellos Br. at 38-39. The statute does not apply. The statute provides that a "written *misrepresentation or warranty* made in the negotiation of an insurance contract" shall not "be deemed material or *defeat or avoid the contract or prevent it attaching* unless the misrepresentation or warranty is made with the intent to deceive." *Id.* (emphasis added). The Prior Knowledge Exclusion is a self-executing exclusion. It bars coverage for claims arising from facts or circumstances of which any Insured has knowledge as of the application date regardless of the truthfulness of Quellos's answer to the question. CP 1122 (Ex. E). The Prior Knowledge Exclusion bars coverage, not because Quellos failed to disclose its knowledge of relevant facts or circumstances, but because "such knowledge exists" regardless of its disclosure. As such, Federal is not relying on any "misrepresentation or warranty" by Quellos, nor is

Federal attempting to “defeat or avoid” the Federal Policy or “prevent it from attaching.” Federal seeks to enforce an exclusionary term of the insurance contract, not to invalidate the contract.

As the case law demonstrates, professional liability insurance policies commonly include provisions similar to the Prior Knowledge Exclusion. Fed. Br. at 39-40 & 42 n.6. Numerous courts have rejected the position advanced by *Quellos* that enforcement of a prior knowledge limitation on coverage obligates an insurer to satisfy the statutory or common law requirements for rescission. “Exclusion of prior acts from coverage under a contractual provision . . . is a ground for denying coverage distinct from rescission on the basis of material misrepresentation.” *Maynard v. Westport Inc. Corp.*, 208 F. Supp. 2d 568, 575 (D. Md. 2002), *aff’d*, 55 F. App’x 667 (4th Cir. 2003).²

Contrary to *Quellos*’s suggestion, the fact that the Prior Knowledge Exclusion appears in the 2000 Application incorporated into the Primary Policy, rather than in the exclusions section of the policy form, does not undermine this clear distinction between exclusionary and rescissory remedies. The Prior Knowledge Exclusion plainly spells out the

² See also *Ross v. Continental Cas. Co.*, 420 B.R. 43, 48 (D.D.C. 2009); *St. Paul Fire & Marine Ins. Co. v. Sledjeski & Tierney, PLLC*, No. 08-cv-5184, 2009 WL 2151425, at *10 (E.D.N.Y. July 17, 2009); *American Guar. & Liab. Ins. Co. v. Fojanini*, 90 F. Supp. 2d 615, 619 n.7 (E.D. Pa. 2000) ; *Professional Managers, Inc. v. Fawer, Brian, Hardy & Zatzkis*, 799 F.2d 218, 224-25 (5th Cir. 1986).

consequences for claims arising from misconduct of which any Insured has pre-inception knowledge: “It is agreed that if such knowledge exists any claim arising from such fact or circumstances will not be covered by the policy.” CP 1122. The statutory “language should not be read to extend a materiality requirement to contractual exclusions, because excluded claims are, by prior agreement, not part of the insurance contract.” *Gluck v. Executive Risk Indem., Inc.*, 680 F. Supp. 2d 406, 417 (E.D.N.Y. 2010). Confronted with similar self-contained exclusions in applications incorporated into professional liability policies, courts have repeatedly enforced the exclusions according to their express terms, rejecting insureds’ attempts to engraft extraneous statutory or common law requirements applicable to rescission or avoidance of the policy.³

Quellos attempts to distinguish some of these authorities on the ground that “they merely confirm . . . the narrow scope of the common-law remedy of rescission due to application fraud.” *Quellos Br.* at 39. These courts, though, considered—and rejected—application of both common law rescission standards and statutes similar to RCW 48.18.090. In doing so, they cogently explained why standards governing avoidance of

³ *American Special Risk Mgmt. Corp. v. Cahow*, 192 P.3d 614, 622-23 (Kan. 2008); *XL Specialty Ins. Co. v. Level Global Investors, L.P.*, --- F. Supp. 2d ---, 2012 WL 2138044, at *14 (S.D.N.Y. June 13, 2012); *Platte River Ins. Co. v. Baptist Health*, No. 07cv0036, 2009 WL 2015102, at *7-8, *18 (E.D. Ark. Apr. 17, 2009); *Culver v. Continental Ins. Co.*, 11 F. App’x 42, 44-45 (4th Cir. 1999).

a contract do not apply where an insurer seeks instead to enforce the contract's terms. *Quellos* offers no rationale as to why the appearance of the relevant contract term in an application alters that analysis in any way.

None of the authorities *Quellos* cites supports a different conclusion under Washington law. As *Quellos* concedes, the "broad statutory prohibition" effected by RCW 48.18.090 applies solely when "an insurer attempts to deny coverage based on alleged fraud in the application." *Quellos* Br. at 39; *see id* at 46 (referring to "insurer's application fraud defense"). Enforcement of the Prior Knowledge Exclusion does not entail a finding of "fraud in the application." Thus, the authorities upon which *Quellos* relies have no application here. *See National Union Fire Ins. Co. v. Seafirst Corp.*, 662 F. Supp. 36, 39-40 (W.D. Wash. 1986) (determining that RCW 48.18.090(1) precluded insurer from "offset[ing]" liability on basis of "intentional or negligent misrepresentations"); *Queen City Farms, Inc. v. Central Nat'l Ins. Co.*, 126 Wn.2d 50, 96-97 (1995) (addressing insurers' defense that insured "made material misrepresentations in obtaining insurance coverage").

2. Under Its Plain Terms, the Prior Knowledge Exclusion Clearly Bars Coverage.

Once one leaves the rescission framework that *Quellos* clumsily tries to erect around the Prior Knowledge Exclusion, the rest of its

arguments fall away as well. First, Quellos's myopic focus on Ms. Bender's state of mind when she signed the 2000 Application is beside the point: the Prior Knowledge Exclusion explicitly excludes coverage for claims arising from knowledge possessed by "*any* of [Quellos's] partners, directors, officers, employees or trustees," which Greenstein and Wilk indisputably were as of 2000. CP 1122, (Ex. E) (*italics added*), 1163-64. The AISLIC application contains no language limiting the relevant knowledge to that of the signatory or otherwise qualifying the facts or circumstances subject to inquiry and to which the exclusion applies. In addition, as Quellos tacitly concedes, no severability or non-imputation clause applies to the Prior Knowledge Exclusion. Quellos Br. at 37-38 n.11. Under Washington law, Greenstein's and Wilk's knowledge therefore bars coverage for all Insureds. *See* Fed. Br. at 32 & n.5.

Second, Quellos's contention that a purely subjective inquiry applies—one that governs not only what the Insureds knew but whether they subjectively expected claims—runs afoul of Washington law. Courts have mandated an objective inquiry in connection with similar prior knowledge provisions in professional liability policies. Fed. Br. at 39-40. The question posed by the Prior Knowledge Exclusion—whether any insured has knowledge of facts or circumstances "which might give rise to a claim"—requires an objective inquiry no less than similar provisions that

also include the word “reasonably.” The United States Court of Appeals for the Fourth Circuit, for example, analyzed a similar prior knowledge exclusion applicable to any insured attorneys’ knowledge of circumstances “that could result in a claim or suit.” *Culver*, 11 F. App’x. at 44. The court concluded that “[t]he plain language of the application excludes coverage for *any* claim, meritorious or otherwise, that an applicant could have reasonably foreseen at the time the policy issued” and “invokes an objective standard of foreseeability.” *Id.* at 45-46.⁴

While *Quellos* suggests that *James F. O’Connell & Associates v. Transamerica Indemnity Co.*, 61 Wn. App. 103 (1991), “is instructive,” *Quellos* Br. at 40, *O’Connell* did not involve the “which might give rise to a claim” language at issue here. *O’Connell* turned instead on whether the court could conclude that the insured had knowledge of particular facts there that “would give rise to a reasonable expectation of a claim.” 61 Wn. App. at 110. By contrast, the Prior Knowledge Exclusion does not call for any expression of the applicant’s subjective belief; it simply asks whether any applicant has knowledge of facts that “might give rise to a claim,” which requires examination of the facts known to each of the Insureds from an objective perspective.

⁴ See also *Platte River*, 2009 WL 2015102 at *7, *12-14; *International Ins. Co. v. Peabody Int’l Corp.*, 747 F. Supp. 477, 482-84 (N.D. Ill. 1990); *Ratcliffe v. International Surplus Lines Ins. Co.*, 550 N.E.2d 1052, 1057 (Ill. App. Ct. 1990).

Of course, when properly applied from the perspective of Greenstein's and Wilk's knowledge, the question whether an objective versus subjective inquiry applies is moot. Under any standard, their knowledge as of September 2000 of POINT's hollow underpinnings, of their deliberate failure to disclose POINT's fraudulent nature to clients and their counsel, and of actual discussions with Euram concerning the likelihood of claims being asserted if clients did not understand the very facts that Quellos failed to disclose, demonstrates that they should have and did know of "of any fact or circumstance which might give rise to a claim under the proposed policy." CP 1122 (Ex. E); *see* Fed. Br. at 40-42.

Quellos's only defense to the clear import of the record is to point to Greenstein's testimony before a U.S. Senate committee in 2006. Quellos Br. at 45. Whatever Greenstein's state of mind when he appeared before the Senate, his and Wilk's criminal admissions demonstrate that at the time POINT was designed and executed in 2000, both men knew that POINT rested on "fictitious losses"; that they provided clients "information and documentation for POINT that they knew were false"; and that they "knew these [legal] opinions relied on false information and documentation." CP 946-47, 958-59. They also had discussed the risk of claims resulting from audits stemming from the non-disclosure of POINT's "synthetic" nature. CP 607-08, 815, 818. Greenstein has also

admitted that the SPVs' issuance of warrants was designed "to create the impression that there was a legitimate business reason for the contributions to the partnership," but he "knew that the warrants would never be exercised" and that clients were therefore misled as to POINT's lack of economic substance. CP 590-91. Given all this, Greenstein was clearly aware of facts and circumstances that were subjectively and objectively likely to give rise to claims as of September 2000, no matter what rationalizations—which Greenstein explicitly abjured in his plea agreement—he might have offered the Senate in 2006.

Finally, Quellos suggests that its disclosure in the application for the 2004-2005 policies that it provided tax minimization strategies to clients somehow negated Quellos's failure to disclose Greenstein's and Wilk's extensive knowledge of POINT's specific myriad problems. Quellos Br. at 46-47. However, advising the Insurers in 2004 as to a generic risk that the IRS could disallow certain tax benefits, *see* CP 1158, is quite different from advising the Insurers in 2000 that Quellos's CEO and tax planning principal knowingly designed a tax strategy around a fictitious paper portfolio of stocks and that the legal opinions upon which its clients were relying to claim tax benefits were worthless because Greenstein and Wilk had knowingly withheld that critical information from the legal opinion writers. And again, the Prior Knowledge Exclusion

applies to “any claim arising from” the relevant pre-inception knowledge “if such knowledge exists,” regardless of what Quellos might have disclosed. CP 1122 (Ex. E).

All of the POINT Claims “aris[e] from such fact or circumstances” known to Greenstein and Wilk as of September 2000. Quellos does not seriously dispute this. The theoretical allocation questions Quellos attempts to pose with respect to the Fraud Exclusion do not apply with respect to the Prior Knowledge Exclusion given the inapplicability of any non-imputation clause. As such, the trial court erred in failing to award summary judgment in the Insurers’ favor.

3. The Continuity Date Exclusion Similarly Bars Coverage for All of the POINT Claims.

In addition to the Prior Knowledge Exclusion incorporated through the application, the Primary Policy also addresses prior knowledge of conduct that could give rise to claim through the Continuity Date Exclusion. Under that provision, the “policy does not apply . . . to any actual or alleged Wrongful Act occurring prior to the Continuity Date specified in Item 6 of the Declarations, if on or before such Continuity Date any Insured knew of such Wrongful Act or could have reasonably foreseen that such Wrongful Act could lead to a claim.” CP 54-55. The trial court concluded that the exclusion applied to the POINT Claims but

failed to apply it to preclude coverage entirely for all of the POINT Claims, implicitly on the basis of the non-imputation clause. RP 98:1-3. The non-imputation clause, though, does not apply to the Continuity Date Exclusion. Because Greenstein's and Wilk's admitted fraud establishes their knowledge dating to 1999 of Wrongful Acts that they foresaw could lead to claims, the Insurers were entitled to summary judgment.

The sole ground offered by Quellos in support of the trial court's limitation on the Continuity Date Exclusion is to dispute the relevant Continuity Date. The date specified in the declarations of the Primary Policy is September 20, 2000. CP 47. By endorsement, the date applicable to the Insured seeking coverage here, Quellos Group, LLC, was amended to August 25, 2000. CP 78. Quellos argues, though, that Quellos Group, LLC brought this action on behalf of its affiliates and the Continuity Dates for the affiliates involved in POINT's implementation pre-date POINT's design in 1999. Quellos Br. at 48-49.

The Continuity Date Exclusion, however, broadly bars coverage when "any Insured" had the requisite knowledge before "such Continuity Date." CP 54-55. Washington law dictates that such an exclusion be applied based on the knowledge of "any Insured," not merely the knowledge attributable to specific Quellos affiliates. Federal Br. at 32-33 & n.5. Regardless whether plaintiff Quellos Group, LLC makes

allegations in its complaint here “on behalf of itself and its affiliated companies,” CP 146, or itself alone, Quellos Group—to which the knowledge of its CEO, Greenstein, is imputed—constitutes “an[] Insured” from whose vantage point the Continuity Date Exclusion must be assessed.

Quellos cannot evade the ramifications of the knowledge possessed by its CEO and the Named Insured under the policies by the simple expedient of alleging in its complaint that Quellos virtually represents the interests of unnamed affiliates. Even if it could, the knowledge possessed by Quellos Group as the Named Insured and named plaintiff governs the application of an exclusion triggered by the knowledge of “any Insured.” Accordingly, the August 25, 2000 Continuity Date applies. Because the POINT Claims result from Wrongful Acts occurring before that date, the Continuity Date Exclusion bars coverage for them.

**B. THE ADMITTED FRAUDULENT CONSPIRACY
UNDERLYING POINT COMPELS SUMMARY
JUDGMENT IN THE INSURERS’ FAVOR.**

1. Proper Application of the Fraud Exclusion Does Not Entail Any Allocation Beyond That Already Done by Quellos.

Quellos posits that the \$45.15 million for which it seeks coverage should be broken down and allocated between the Quellos entities (which are subject to the Fraud Exclusion) and Individual Insureds other than

Greenstein and Wilk (to whom the Fraud Exclusion does not apply by virtue of the non-imputation clause). Quellos constructs a two-step allocation process, averring that the Court must ascertain what portion of the disputed amounts may be allocated to Quellos entities and then which portion of that may be allocated to claims barred by the Fraud Exclusion. The record, however, amply demonstrates that the allocation methodology urged by Quellos has no application here and the answer to both of the questions Quellos asks the Court to pose is clearly “all.”

Initially, the specific allocation principles advocated by Quellos—the so called “larger settlement rule” and “reasonably related test”—do not apply here. As the case law upon which Quellos relies makes clear, those authorities addressed a very specific question: “the issue of how a court should allocate settlement payments and defense costs between directors and officers and the corporate entity when they are joined as co-defendants.” *Nordstrom, Inc. v. Chubb & Son, Inc.*, 54 F.3d 1424, 1431-32 (9th Cir. 1995) (predicting Washington law). The question arose because the policies before these courts applied to losses incurred directly by individual directors and officers or for which the corporate entity indemnified them but not losses incurred by the corporate entity for its

own direct liability. *Id.* at 1429.⁵ The Primary Policy here, though, affords coverage to Quellos entities for their direct liability. The Primary Policy extends coverage to covered losses resulting from claims against “the Insured,” which includes Quellos Group, LLC as the Named Insured and other affiliated entities. CP 50-51, 78, 91. Thus, whatever validity these specific allocation principles have under Washington law, they address a completely different situation.

More fundamentally, Quellos glosses over the essential predicate for any allocation analysis—the expenditure of amounts in connection with claims “made against” both covered and non-covered parties. CP 50-51. Here, the record confirms that the Client Claims were “made against” Quellos alone, and with respect to the remaining governmental investigations, Quellos itself has already identified the amounts attributable to defense of Individual Insureds to whom the non-imputation clause applies.

The Primary Policy covers “all sums for which *the Insured* shall

⁵ See also *Safeway Stores, Inc. v. National Union Fire Ins. Co.*, 64 F.3d 1282, 1283-84 (9th Cir. 1995) (addressing allocation of settlement and defense cost payments with respect to lawsuit naming both directors and officers and entity under policy applicable to individuals and amounts paid by entity for indemnification of individuals but not to the entity itself for direct liability); *Owens Corning v. National Union Fire Ins. Co.*, 257 F.3d 484, 489-90 (6th Cir. 2001) (same); *Caterpillar, Inc. v. Great Am. Ins. Co.*, 62 F.3d 955, 956-57 (7th Cir. 1995) (same); *Piper Jaffray Cos. v. National Union Fire Ins. Co.*, 38 F. Supp. 2d 771, 774 (D. Minn. 1999) (same).

become legally obligated to pay as damages resulting from any claims first *made against the Insured.*” CP 50-51, 94 (italics added). Although the Primary Policy does not expressly define the term “claim,” this Court has held that in the context of a liability insurance policy, “[c]laim’ ordinarily means a demand *on the insured* for damages resulting from the insured’s alleged negligent acts or omission.” *Safeco Title Ins. Co. v. Gannon*, 54 Wn. App. 330, 334-35 (1989) (emphasis added). Accordingly, the Client Claims, which were limited to demands settled prior to litigation, were “made against” the Individual Insureds only to the extent that the demands were “on the insured” for compensation that any such individual became “legally obligated to pay.”

Neither Client Claim was “made against” an Individual Insured. Quellos’s interrogatory answers establish that the Saban and Schein pre-suit demands were asserted to Quellos entities and plainly state that the demands involved legal action under consideration by the client “against Quellos.” CP 1279-81. Ms. Bender’s declaration below similarly notes that Quellos entities “contracted with clients” to engage in POINT and that the two clients “asserted claims . . . against Quellos.” CP 1106-07, 1109. Although Quellos tries to undermine these admissions, Quellos Br. at 27, they are perfectly clear. “Quellos settled” the Client Claims, and it was “Quellos [that] negotiated and executed” those settlements. CP 1110.

Quellos concedes that none of the Individual Insureds were parties to either of the settlements, *Quellos Br.* at 28, and as such none of the Individual Insureds became “legally obligated to pay” any damages as required under the Insuring Agreements.⁶ Moreover, because the only demands for compensation were made on *Quellos* entities and paid for by *Quellos* entities, neither of the Client Claims were “made against” any Individual Insured outside the scope of the Fraud Exclusion. As the Primary Policy affords coverage directly to *Quellos*, and the Fraud Exclusion precludes coverage for such direct liabilities, there is nothing to allocate. *See Richardson Elecs., Ltd. v. Federal Ins. Co.*, 120 F. Supp. 2d 698, 704 (N.D. Ill. 2000) (holding that “the [larger settlement] rule does not apply” where company “is directly liable to pay” and “[t]he officers and directors are not liable at all”).

Given that the Fraud Exclusion bars coverage for the \$34.75 million expended by *Quellos* in settlement of the Client Claims, the question of coverage for the remaining \$10.4 million in defense expenses

⁶ *See, e.g., PLM, Inc. v. National Union Fire Ins. Co.*, No. C-85-7126, 1986 WL 74358, at *4 (N.D. Cal. Dec. 2, 1986) (holding that directors and officers released under settlement agreement were not “legally obligated to pay” any amounts where corporation paid settlement and individuals were never called upon to perform under personal guarantees), *aff’d*, 848 F.2d 1243, 1988 WL 58031, at *2 (9th Cir. 1988); *American Cont’l Ins. Co. v. American Cas. Co.*, 103 Cal. Rptr. 2d 632, 638-39 (Ct. App. 2001) (holding that employee released pursuant to settlement agreement for which employer paid never became “legally obligated to pay” any amounts under settlement).

Quellos seeks to recoup is moot since such amount is less than the combined \$2.5 million retention and \$10 million Primary Policy limit (even assuming that payments by Quellos can fill the \$5 million gap left by its settlement with AISLIC). But the bulk of these costs are subject to the Fraud Exclusion as well. Indeed, Quellos has identified less than \$1.3 million incurred on behalf of Individual Insureds. CP 1282; *see also* CP 1109 (noting that “Quellos incurred costs in responding to this formal investigation on behalf of the company and eleven directors, officers and employees”). That amount does not even satisfy the retention.

Quellos attempts to create the appearance of factual issues by asserting that because it ostensibly indemnified its directors and officers in connection with some of the POINT Claims, some amounts should be apportioned to “innocent” Individual Insureds. Quellos Br. at 28. Even if true, Quellos’s indemnification of directors and officers cannot create coverage. The Insuring Agreements apply to amounts that Quellos “is permitted or required to pay as indemnification for *such liability of the Individual Insured.*” CP 50-51, 94 (italics added). “[S]uch liability” refers to the liability of “the” Individual Insured to pay damages “resulting from a claim or claims first made against the Insured.” *Id.* Where there is no claim “made against” an Individual Insured, no covered liability of “the Insured” exists for Quellos to indemnify. Assuming that the Client Claims

identified misconduct on the part of Individual Insureds, the assertion that an Individual Insured committed a Wrongful Act does not equate with the making of a claim against such Insured. Saban and Schein “not only would have to allege wrongful acts on the part of the directors or officers, but also would have to bring a claim against them. These are complementary requirements, and allegations of wrongful conduct, without more, do not satisfy them both.” *Medical Mut. Ins. Co. v. Indian Harbor Ins. Co.*, 583 F.3d 57, 63 (1st Cir. 2009); *see also MGIC Indem. Corp. v. Home State Savs. Ass’n*, 797 F.2d 285, 287-88 (6th Cir. 1986). Thus, even if Quellos can as a matter of corporate law “indemnify” its directors and officers in the absence of claims made against them, the Primary Policy affords no coverage for such payments.

Finally, Quellos points to the inclusion of its directors and officers in the releases given to resolve the Client Claims as a basis for finding coverage. Quellos Br. at 28. “However, [Quellos] does not explain how a release of potential liability against its executives translates into an actual claim against them that generates losses for which they were liable.” *Richardson*, 120 F. Supp. 2d at 704. While the releases forestalled potential claims that could have been asserted against the Individual Insureds, “a mere potential for such claims is not enough to meet the condition imposed by the policy.” *MGIC*, 797 F.2d at 288. “It would

make no sense to allow an insured to manufacture coverage by the simple expedient of insisting, as a condition of settlement, that a plaintiff frame a release more broadly than the plaintiff had framed the claim actually made.” *Medical Mut.*, 583 F.3d at 64.

The second half of Quellos’s proposed allocation two-step fares no better. Not only are the vast bulk of the amounts at issue the direct responsibility of Quellos (to which the non-imputation clause does not apply), but all of those amounts are subject to the Fraud Exclusion. As the Court of Appeals recognized in *Stouffer & Knight v. Continental Casualty Co.*, 96 Wn. App. 741 (1999), where a claim grows directly out of excluded fraudulent conduct, a professional liability policy affords no coverage for losses also arising out of the insured’s asserted negligence. *Id.* at 750 n.11, 751. The legal theory asserted is immaterial where the claim flows from and has its origins in excluded conduct.

The authorities relied upon by Quellos do not compel a different result here. In *Public Utility District No. 1 v. International Insurance Co.*, 124 Wn.2d 789 (1994), the court briefly noted that an insured was not required to have a jury allocate damages between covered negligence counts and non-covered counts based on intentional conduct because the claims “consist of the same factual core.” *Id.* at 810. The *P.U.D.* decision did not recite the exclusionary language at issue there and did not address

the scope of “arising out of” or similar language. Nor did *P.U.D.* consider the implications of requirements such as the “in fact” trigger applicable to the Fraud Exclusion. Regardless whether the legal theories asserted as part of the Client Claims “consist of the same factual core,” the claims are premised on the same excluded conduct that Greenstein and Wilk have admitted occurred. Where the excluded conduct “in fact” occurred—as Quellos tacitly concedes it did with respect to the POINT Claims—the claim necessarily arises out of the excluded conduct whether a claimant asserts theories of intentional misconduct or negligence.

Similarly, the complaint against the insured in *In re Feature Realty Litigation*, 468 F. Supp. 2d 1287 (E.D. Wash. 2006), pled counts for violation of RCW 64.40 and for the common law tort of interference with business expectancy. *Id.* at 1290. The court concluded that an exclusion for claims “arising from the willful violation of statute” did not apply to the common law claim because it was “a distinct claim based upon similar facts.” *Id.* at 1303-04. In a later phase of the case, the court determined that no allocation was necessary because “it is undisputed that both counts were based upon the same *covered acts* and the same harm arising from those acts.” *In re Feature Realty Litig.*, 634 F. Supp. 2d 1163, 1173 (E.D. Wash. 2007) (emphasis added). Here, however, the Fraud Exclusion by its plain terms applies to the POINT Claims regardless of the source of the

legal obligations allegedly breached by the Insureds, be it statute or common law. The Fraud Exclusion precludes coverage for claims based on conduct that “in fact” occurred. In light of the admitted fraudulent conduct upon which the POINT Claims are based, any claim for negligence or breach of fiduciary duty falls within the exclusion’s sweep.

As the trial court concluded, once the Fraud Exclusion was triggered, its preclusive effect went “all the way back.” RP 98:10. Although the settlements of the Client Claims pre-dated Greenstein’s and Wilk’s guilty pleas, those claims nonetheless arose out of Greenstein’s and Wilk’s “deliberate fraudulent act[s]” committed “in fact.” With the arguable exception of some defense expenses incurred in connection with the federal grand jury investigation, all of the sums expended in connection with the POINT Claims were incurred for claims made against Quellos alone. Accordingly, the Fraud Exclusion bars coverage here.

2. The Knowing Wrongful Act Exclusion Similarly Bars Coverage.

Quellos challenges application of the Knowing Wrongful Act Exclusion on many of the same bases as the Fraud Exclusion. And its challenge fails for the same reasons that it fails with respect to the Fraud Exclusion. No allocation is required, and no factual issues exist, given the absence of claims “made against” Individual Insureds to whom the non-

imputation clause applies, and the POINT Claims result from “actual” “Wrongful Acts committed with knowledge”—imputed to Quellos—“that [they were] Wrongful Act[s].” CP 54. Regardless whether the exclusion also employs “arising out of” language, it encompasses all of the POINT Claims because they assert Wrongful Acts that Greenstein and Wilk have explicitly admitted were wrongful at the time they were committed.

Quellos further contends that the Knowing Wrongful Act Exclusion is ambiguous and therefore must be interpreted to require evidence of specific intent to harm the various clients. *Quellos Br.* at 36. The exclusion does not admit of such a construction. It applies where a Wrongful Act is “committed with knowledge that it was a Wrongful Act.” CP 54. The plain language of the exclusion focuses on the Insured’s knowledge of the wrongfulness of the conduct, not on an intent to inflict any specific harm. The lone decision cited by Quellos that actually construes a similar exclusion provides no guidance here because there the insurer argued for application of the exclusion to negligent acts even though the definition of Wrongful Acts was limited to negligent acts. *American Home Assurance Co. v. Pope*, 591 F.3d 992, 999-1000 (8th Cir. 2010).⁷ Here, application of the Knowing Wrongful Act Exclusion does

⁷ *American Home Assurance Co. v. Cohen*, 815 F. Supp. 365 (W.D. Wash. 1993), also cited by Quellos, *see* *Quellos Br.* at 36, is likewise inapposite. The *Cohen* court held

not implicate the same concerns expressed by *Pope* because Federal seeks application of the exclusion to clearly intentional conduct, and such application preserves coverage for negligent conduct (not otherwise excluded under the Policy).

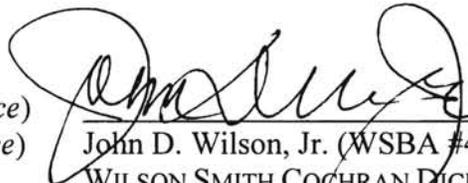
III. CONCLUSION

For the foregoing reasons and those set forth in Federal's opening brief, Federal respectfully requests the Court reverse the trial court's order granting partial summary judgment in favor of the Insurers with respect to the policy exclusions and instead enter judgment in full in favor of the Insurers on all of Quellos's claims.

Dated: October 10, 2012

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that an exclusion for knowing wrongful acts could not be applied to bar coverage for all sexual misconduct where the policy provided sub-limited coverage for defined sexual misconduct. *Id.* at 368-69. By contrast, the Primary Policy affords no coverage for the intentional design of a fraudulent tax shelter and the deliberate failure to inform clients of the shelter's known lack of economic substance.

CERTIFICATE OF SERVICE

The undersigned certifies that on this 10th day of October, 2012, I caused the foregoing to be served on:

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Connie Enns Jory

NO. 68478-7

IN THE COURT OF APPEALS OF THE STATE OF WASHINGTON
DIVISION I

QUELLOS GROUP, LLC,

Appellant/Cross-Respondent,

v.

FEDERAL INSURANCE COMPANY and INDIAN HARBOR
INSURANCE COMPANY,

Respondents/Cross-Appellants,

On Appeal from the King County Superior Court
Case No. 10-2-41637-4 SEA
Hon. Dean S. Lum, Judge Presiding

**APPENDIX TO REPLY BRIEF OF CROSS-APPELLANT
FEDERAL INSURANCE COMPANY**

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ORIGINAL

--- F.Supp.2d ---, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

C

Only the Westlaw citation is currently available.

United States District Court,
S.D. New York.
XL SPECIALTY INSURANCE CO., Plaintiff,
v.
LEVEL GLOBAL INVESTORS, L.P. et al., Defen-
dants.

No. 12 Civ. 1598(PAE).
June 13, 2012.

Background: In insurer's declaratory judgment ac-
tion, insureds moved for a preliminary injunction
requiring insurer to resume advancing, pursuant to a
professional-liability insurance policy, their costs of
defending themselves against, inter alia, a federal
criminal investigation.

Holdings: The District Court, Paul A. Engelmayer,
J., held that:

- (1) failure to receive defense costs under a profes-
sional liability policy at the time they were incurred
constituted an immediate and direct injury sufficient
to satisfy the irreparable harm requirement for pre-
liminary injunction;
- (2) balance of hardships tipped lopsidedly in favor of
the insureds;
- (3) insureds demonstrated that there were sufficiently
serious claims going to the merits on the question of
whether prior knowledge exclusion was ambiguous;
and
- (4) insurer did not have a duty to advance costs while
the applicability of an exclusion in professional li-
ability insurance policy was litigated.

Motion granted.

West Headnotes

[1] Injunction 212 ↪1114

212 Injunction
212II Preliminary, Temporary, and Interlocutory
Injunctions in General
212II(B) Factors Considered in General

212k1110 Availability and Adequacy of
Other Remedies
212k1114 k. Recovery of Damages.
Most Cited Cases

Where there is an adequate remedy at law, such
as an award of money damages, preliminary injunc-
tions are unavailable except in extraordinary circum-
stances.

[2] Injunction 212 ↪1080

212 Injunction
212II Preliminary, Temporary, and Interlocutory
Injunctions in General
212II(A) Nature, Form, and Scope of Remedy
212k1080 k. Mandatory Preliminary In-
junctions. Most Cited Cases

A mandatory preliminary injunction may issue
only upon a clear showing that the moving party is
entitled to the relief requested, or where extreme or
very serious damage will result from a denial of pre-
liminary relief.

[3] Injunction 212 ↪1097

212 Injunction
212II Preliminary, Temporary, and Interlocutory
Injunctions in General
212II(B) Factors Considered in General
212k1094 Entitlement to Relief
212k1097 k. Serious or Substantial
Question on Merits. Most Cited Cases

Injunction 212 ↪1109

212 Injunction
212II Preliminary, Temporary, and Interlocutory
Injunctions in General
212II(B) Factors Considered in General
212k1101 Injury, Hardship, Harm, or Ef-
fect
212k1109 k. Balancing or Weighing
Hardship or Injury. Most Cited Cases

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

A prohibitory injunction may be granted on a showing of irreparable harm and either (1) likelihood of success on the merits or (2) sufficiently serious questions going to the merits to make them a fair ground for litigation and a balance of hardships tipping decidedly toward the party requesting the preliminary relief; overall burden on a movant to show sufficiently serious questions going to the merits and that the balance of hardships tips decidedly in its favor is no lighter than the one it bears under the likelihood of success standard.

[4] Injunction 212 ↻1377

212 Injunction

212IV Particular Subjects of Relief

212IV(L) Trade or Business

212k1377 k. Insurance. Most Cited Cases

For purposes of determining whether injunction sought, which would require insurer to resume advancing, pursuant to a professional-liability insurance policy, insureds' costs of defending themselves against a federal criminal investigation was prohibitory or mandatory, status quo would be measured as date immediately before insurer told the insureds that it would no longer advance defense costs, and based on such determination, injunction sought was prohibitory.

[5] Injunction 212 ↻1377

212 Injunction

212IV Particular Subjects of Relief

212IV(L) Trade or Business

212k1377 k. Insurance. Most Cited Cases

Failure to receive defense costs under a professional liability policy at the time they were incurred constituted an immediate and direct injury sufficient to satisfy the irreparable harm requirement for preliminary injunction; insurer's termination of payment of costs of defense in a federal criminal investigation presented an obvious risk that one or more insureds, as a result of a sudden inability to pay legal fees, would lose his existing counsel in the middle of sensitive matters, and thereby harm the ability of replacement counsel to coordinate his client's defense with other subjects of the investigation.

[6] Injunction 212 ↻1377

212 Injunction

212IV Particular Subjects of Relief

212IV(L) Trade or Business

212k1377 k. Insurance. Most Cited Cases

Balance of hardships tipped lopsidedly in favor of the insureds for purposes of their request for preliminary injunction requiring insurer to resume advancing, pursuant to a professional-liability insurance policy, their costs of defending themselves against a federal criminal investigation; absent an injunction, insureds would face an increased risk of having to defend against a criminal investigation or prosecution, without their present counsel, and very likely without the funds to mount a fully effective defense against these complex charges, and they also faced a parallel Securities and Exchange Commission (SEC) investigation that could result in serious civil charges.

[7] Insurance 217 ↻1813

217 Insurance

217XIII Contracts and Policies

217XIII(G) Rules of Construction

217k1811 Intention

217k1813 k. Language of Policies.

Most Cited Cases

Under New York law, an insurance contract is interpreted to give effect to the intent of the parties as expressed in the clear language of the contract.

[8] Insurance 217 ↻1808

217 Insurance

217XIII Contracts and Policies

217XIII(G) Rules of Construction

217k1808 k. Ambiguity in General. Most

Cited Cases

Insurance 217 ↻1810

217 Insurance

217XIII Contracts and Policies

217XIII(G) Rules of Construction

217k1810 k. Construction as a Whole.

Most Cited Cases

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

In resolving question as to whether terms of insurance contract are ambiguous, a New York court may not view the particular terms at issue in a vacuum; rather, it must view these terms from the perspective of one who has examined the context of the entire integrated agreement.

[9] Insurance 217 ↪1808

217 Insurance
217XIII Contracts and Policies
217XIII(G) Rules of Construction
217k1808 k. Ambiguity in General. Most Cited Cases

Under New York law, an insurance contract is unambiguous if the language it uses has a definite and precise meaning, unattended by danger of misconception in the purport of the agreement itself, and concerning which there is no reasonable basis for a difference of opinion.

[10] Insurance 217 ↪1832(1)

217 Insurance
217XIII Contracts and Policies
217XIII(G) Rules of Construction
217k1830 Favoring Insureds or Beneficiaries; Disfavoring Insurers
217k1832 Ambiguity, Uncertainty or Conflict
217k1832(1) k. In General. Most Cited Cases

Insurance 217 ↪1840

217 Insurance
217XIII Contracts and Policies
217XIII(G) Rules of Construction
217k1838 Materials Related or Attached to Policies
217k1840 k. Applications. Most Cited Cases

Under New York law, if the terms of an insurance policy are ambiguous, any ambiguity must be construed in favor of the insured and against the insurer; similarly, any ambiguity in the terms of an insurance policy application is also to be construed in favor of the insured.

[11] Insurance 217 ↪1832(2)

217 Insurance
217XIII Contracts and Policies
217XIII(G) Rules of Construction
217k1830 Favoring Insureds or Beneficiaries; Disfavoring Insurers
217k1832 Ambiguity, Uncertainty or Conflict
217k1832(2) k. Necessity of Ambiguity. Most Cited Cases

Under New York law, only if the extrinsic evidence fails to cure the ambiguity must the ambiguity be resolved against the insurer which drafted the contract.

[12] Insurance 217 ↪2117

217 Insurance
217XV Coverage—in General
217k2114 Evidence
217k2117 k. Burden of Proof. Most Cited Cases

Where an insurer claims that an exclusion in the policy applies to an otherwise covered loss, the insurer bears the burden of proof under New York law to demonstrate that the exclusion applies.

[13] Insurance 217 ↪2270(1)

217 Insurance
217XVII Coverage—Liability Insurance
217XVII(A) In General
217k2267 Insurer's Duty to Indemnify in General
217k2270 Defense Costs, Supplementary Payments and Related Expenses
217k2270(1) k. In General. Most Cited Cases

Insurance 217 ↪2271

217 Insurance
217XVII Coverage—Liability Insurance
217XVII(A) In General
217k2267 Insurer's Duty to Indemnify in General

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

217k2271 k. Accrual; Conditions
Precedent. Most Cited Cases

Insurance 217  **3506(2)**

217 Insurance

217XXX Recovery of Payments by Insurer

217k3501 Reimbursement of Payments

217k3506 Liability Insurance

217k3506(2) k. Defense Costs. Most Cited Cases

Under New York law, an insurer's duty to pay arises at the time the insured becomes legally obligated to pay; once that duty attaches, under a directors and officers liability policy calling for the reimbursement of defense expenses, insurers are required to make contemporaneous interim advances of defense expenses, while reserving the right to seek recoupment if the facts ultimately show that no coverage was afforded.

[14] Insurance 217  **1816**

217 Insurance

217XIII Contracts and Policies

217XIII(G) Rules of Construction

217k1815 Reasonableness

217k1816 k. In General. Most Cited Cases

Insurance 217  **1822**

217 Insurance

217XIII Contracts and Policies

217XIII(G) Rules of Construction

217k1822 k. Plain, Ordinary or Popular Sense of Language. Most Cited Cases

Under New York law, unless otherwise indicated, words in an insurance contract should be given the meanings ordinarily ascribed to them and absurd results should be avoided.

[15] Injunction 212  **1377**

212 Injunction

212IV Particular Subjects of Relief

212IV(L) Trade or Business

212k1377 k. Insurance. Most Cited Cases

For purposes of insureds' motion for a preliminary injunction requiring insurer to resume advancing, pursuant to a professional-liability insurance policy, their costs of defending themselves against a federal criminal investigation, insureds demonstrated that there were sufficiently serious claims going to the merits on the question of whether prior knowledge exclusion was ambiguous under New York law as to whether knowledge of all proposed insureds, even if concealed from the corporate signatory, was required to be disclosed.

[16] Insurance 217  **2270(1)**

217 Insurance

217XVII Coverage—Liability Insurance

217XVII(A) In General

217k2267 Insurer's Duty to Indemnify in General

217k2270 Defense Costs, Supplementary Payments and Related Expenses

217k2270(1) k. In General. Most Cited Cases

Insurer did not have a duty under New York law to advance costs while the applicability of an exclusion in professional liability insurance policy was litigated.

[17] Insurance 217  **3110(2)**

217 Insurance

217XXVI Estoppel and Waiver of Insurer's Defenses

217k3105 Claims Process and Settlement

217k3110 Denial or Disclaimer of Liability on Policy

217k3110(2) k. Failure, Delay, or Inadequacy. Most Cited Cases

In the context in which an insurer provides a defense to the insured, under New York law, the insurer may be estopped from disclaiming coverage where it has unreasonably delayed in doing so, and where that delay has prejudiced the insured.

OPINION & ORDER

PAUL A. ENGELMAYER, District Judge.

*1 Defendants Level Global Investors, L.P.

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

(“Level Global”), Michael Alessi, Gregory Brenner, Anthony Chiasson, Joseph Chiasson, and David Ganek (collectively, with Level Global, the “Insureds”) move for a preliminary injunction requiring plaintiff XL Specialty Insurance Company (“XL”) to resume advancing, pursuant to a professional-liability insurance policy, their costs of defending themselves against, *inter alia*, a federal criminal investigation. For the following reasons, defendants' motion is granted.

I. Background^{FN1}

A. November 2010 through March 2012: XL Advances Funds to Cover the Insureds' Defense Costs

Level Global is an investment advisor which manages hedge funds. As of 2010, it had approximately \$4 billion in assets under management. SEC Compl. ¶ 25. Both Chiassons, Alessi, Brenner, and Ganek were or are Level Global directors, officers, or employees.

On November 22, 2010, the Federal Bureau of Investigation executed a search warrant on Level Global's New York offices. Compl. ¶ 18. The same day, the United States Attorney's Office for the Southern District of New York (the “USAO”) issued a grand jury subpoena duces tecum to Level Global. *Id.*

As publicly reported, these steps were part of a broad criminal investigation—which drew nationwide publicity—into alleged insider trading within the securities industry. As described in news reports, the government was investigating allegations that hedge funds, mutual funds, and other financial firms had obtained material non-public information regarding public issuers, including from so-called “expert networks” or third-party consultants, and traded on this information, in violation of the federal securities laws.^{FN2}

Soon thereafter, the Securities and Exchange Commission (“SEC”) subpoenaed Level Global for records in connection with a parallel investigation. Compl. ¶ 18.

Level Global promptly notified XL of these

claims. It sought coverage from XL under an Investment Fund Management and Professional Liability Coverage Policy (the “Policy”) which Level Global had entered into with XL in April 2010, covering claims made between April 21, 2010 and April 21, 2011. Level Global sought coverage for the fees and costs incurred by the Insureds in defending against the USAO and SEC investigations.

XL acknowledged receipt of Level Global's notice. It began advancing the Insureds' defense costs in connection with the two investigations. *Id.* ¶¶ 18–19.

On January 17, 2012, Anthony Chiasson, Level Global's co-founder, was indicted (along with others not party to this litigation) in this District (the “Criminal Action”). The Indictment charges Chiasson with four counts of securities fraud and one count of conspiracy to commit securities fraud. Ind't ¶¶ 11, 31–32. It alleges that Chiasson received material non-public information regarding technology companies, including from a co-worker at Level Global regarding Dell, Inc. *Id.* ¶¶ 8, 11, 19. It alleges that Chiasson learned of Dell's quarterly earnings before they were publicly announced on May 29, 2008, and traded on that information, resulting in a \$4 million trading gain. *Id.* ¶ 19. The Indictment alleges that Chiasson again received material non-public information in advance of Dell's August 28, 2008 earnings announcement, based on which Level Global shorted 700,000 shares of Dell stock, resulting in an approximately \$53 million trading gain. *Id.* ¶ 22.

*2 The following day, January 18, 2012, the SEC sued Anthony Chiasson and Level Global for securities fraud (the “SEC Action”). Compl. ¶ 26. The allegations in the SEC Action are similar to those in the Criminal Action.

The Court henceforth uses the term the “Government Actions” to refer, collectively, to (1) the Criminal Action, as against Anthony Chiasson, (2) the SEC Action, as against Anthony Chiasson and Level Global, and (3) the continuing criminal and SEC investigations of all the Insureds.

B. March 5, 2012: XL Ceases Advancing the Insureds' Defense Costs

On January 18, 2012, the USAO unsealed an Information against a former Level Global mid-level research analyst, Spyridon Adondakis. *Id.* ¶ 26.

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

Adondakis had worked at Level Global between 2006 and May 2010. Unbeknownst to XL or the Insureds, the Information had been filed, and Adondakis had pled guilty to it, in a sealed proceeding, nine months earlier, on April 25, 2011. *Id.* ¶¶ 20, 24 & Ex. B. The Information charged Adondakis with securities fraud and conspiracy to commit securities fraud. Inf'n ¶¶ 2, 16.

In his guilty plea colloquy, also unsealed on January 18, 2012, Adondakis allocuted to these charges as follows:

From 2007 to 2010 I agreed, with others, to commit securities fraud. Namely, I agreed to obtain, directly and indirectly, material non-public information from employees of public companies. I knew that the inside information I received was disclosed by the company employees in violation of duties of trust and confidence. I agreed to share that information with the other individuals at other companies as well as with others at the hedge fund where I worked. When I gave the inside information to the others at the hedge fund where I worked, I knew the information would be used to execute trades. Moreover, I did in fact obtain such information and provide it to others. For example, on August 27, 2008, I spoke with others at the hedge fund where I worked and discussed with them inside information that I obtained indirectly from an employee at [Dell].

Compl. Ex. D at pp. 17–18.^{FN3}

By letter sent on March 5, 2012, XL notified the Insureds that—based on Adondakis's guilty plea allocution—it would no longer advance defense costs relating to the Government Actions. Naunton Decl. Ex. B. Up to that point, XL had advanced nearly three-quarters of the Policy's \$10 million aggregate coverage limit. This included \$4,721,677.68 advanced to Level Global, \$1,800,408.54 to Ganek, \$573,672.26 to Anthony Chiasson, \$286,812.72 to Brenner, \$48,223.05 to Joseph Chiasson, and \$21,022.50 to Alessi. *Id.* at p. 7. Since March 5, 2012, XL has not reimbursed any such defense costs. These include fees and costs the Insureds had incurred before January 18, 2012, and between January 18, 2012 and March 5, 2012.

XL's basis for denying a duty to cover the Insur-

eds—as explained in its letter—is a provision in the application that Level Global had submitted to XL in seeking the Policy (the “Application”). The Application was completed and signed by Jeremy Bohrer, Level Global's General Counsel and Chief Operating Officer, on April 16, 2010. Naunton Decl. Ex. C at p. 4. Question 8.b on the Application asks:

***3** Is any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which might afford valid grounds for any claim such as would fall within the scope of the proposed insurance? (If “Yes,” please explain by attachment to this Application.)

Id. at p. 2. Bohrer checked the box corresponding to “No.” *Id.* Immediately following this question is the following statement:

Without prejudice to any other rights and remedies of the Insurer, any Claim arising from any claims, facts, circumstances or situations required to be disclosed in response to 8.a) or 8.b) above is excluded from the proposed insurance.

Id. (the “Prior Knowledge Exclusion” or “Exclusion”) (boldface in original).

In its letter to the Insureds, XL took the position that the Exclusion applies to the Government Actions. It explained that, based on his plea allocution, Adondakis—a person “proposed for this insurance”—necessarily knew, as of the April 2010 date of the Application, of facts which could give rise to a claim, *i.e.*, an investigation, prosecution, or lawsuit, based on his insider trading scheme while at Level Global. Naunton Decl. Ex. B at p. 6. XL demanded that the Insureds repay the funds it had previously advanced. *Id.* at p. 7.

C. XL Files This Lawsuit

On March 5, 2012, the same day it terminated coverage, XL commenced this lawsuit. XL seeks (1) a declaration that, under the Prior Knowledge Exclusion, XL has no duty to cover any Insured in connection with the Government Actions, as a result of Adondakis's admitted crimes while at Level Global between 2007 and 2010; and (2) restitution of all defense costs (more than \$7.3 million) that it has advanced to the Insureds.

--- F.Supp.2d ---, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

D. The Insureds' Motion for a Preliminary Injunction

On March 28, 2012, the Insureds moved for a preliminary injunction. Dkt. 4. They argue that, in the absence of an injunction compelling XL to resume advances for defense expenses, their ability to defend against the Government Actions will otherwise be irreparably harmed. Insureds' Br. 13–15. The Insureds argue that they are likely to succeed in demonstrating an entitlement to coverage under the Policy, because, when the Prior Knowledge Exclusion is read in tandem with other provisions in the Application, it is at best ambiguous whether it permits XL to terminate coverage for all Insureds, and, under New York law, ambiguities in an insurance contract are construed to favor the insured. Insureds' Br. 16–17.

The Insureds point, first, to a provision at the end of the Application. It appears immediately before Bohrer's signature. It states:

FOR THE PURPOSE OF THIS APPLICATION, THE UNDERSIGNED AUTHORIZED AGENT OF THE PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSURANCE DECLARES THAT TO THE BEST OF THEIR KNOWLEDGE AND BELIEF AFTER REASONABLE INQUIRY, THE STATEMENTS HEREIN ARE TRUE AND COMPLETE. THE INSURER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. SIGNING THIS APPLICATION DOES NOT BIND THE INSURER TO COMPLETE THE INSURANCE.

*4 Naunton Decl. Ex. C at p. 3 (the “Reasonable Inquiry Provision” or “Provision”) (boldface and capitals in original). The Insureds argue that the Provision qualifies the Prior Knowledge Exclusion, such that when Bohrer answered “no” to Question 8.b, did not—and was not required to—attest omnisciently that no proposed Insured was aware of a basis for a claim. Rather, he was attesting—and was required to attest—only that he, on behalf of Level Global, was unaware, after a reasonable inquiry, that any proposed insured was aware of a basis for a claim. Accordingly, the Insureds argue, Adondakis' crimes—concealed from Bohrer—did not trigger the Exclusion. Insureds' Br. 18.

The Insureds also point to Condition K (a “War-

ranty” clause) in the Application, which provides:

No knowledge or information possessed by any Insured will be imputed to any other Insured. In the event that any of the particulars or statements in all material respects in the Application are untrue, this Policy will be void with respect to any Insured who had actual knowledge of the untruth in any material respect [*sic*] knew of such untruth.

Naunton Decl. Ex. A at p. 26; Insureds' Br. 19–20. The Insureds argue that, in excluding them from coverage, XL is, effectively, imputing Adondakis's criminal knowledge to the Insureds in violation of Condition K.

The Insureds separately argue that, regardless of whether they ultimately prevail on the underlying issue of whether the Prior Knowledge Exclusion bars coverage, they are entitled to advancement of defense costs until a court resolves that issue. Insureds' Br. 20–24; *see also id.* at 23 (“insurers are required to make contemporaneous interim advances of defense expenses where coverage is disputed, subject to recoupment in the event it is ultimately determined no coverage is afforded.”) (internal quotation marks and citations omitted). They argue that XL does not have the unilateral right to cease advancement in mid-stream. *Id.*

On April 16, 2012, XL filed its opposition. Dkt. 19. XL argues that neither the Reasonable Inquiry Provision nor Condition K modifies the Prior Knowledge Exclusion, and that the Insureds thus fail to establish a likelihood of success on the merits. XL's Br. 9–11. XL also denies that it must await a judicial determination that the Exclusion applies before terminating coverage. It distinguishes the cases on which the Insureds rely as arising in the different context of insurer attempts to rescind a policy altogether. *Id.* at 19–22. XL also asks that, if an injunction is granted, the Insureds be required to post a bond. *Id.* at 22–24.

On April 26, 2012, the Insureds filed a reply brief. Dkt. 23.

On May 10, 2012, the Court held a nearly three-hour hearing on the motion. At the end of that hearing, the Court informed the parties that it intended to grant the Insureds' motion for a preliminary injunc-

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

tion, and that an appropriate opinion and order would follow.

II. Discussion

A. Applicable Legal Standards

*5 A preliminary injunction

is an extraordinary remedy never awarded as of right. In each case, courts must balance the competing claims of injury and must consider the effect on each party of the granting or withholding of the requested relief. In exercising their sound discretion, courts of equity should pay particular regard for the public consequences in employing the extraordinary remedy of injunction.

Salinger v. Colting, 607 F.3d 68, 79 (2d Cir.2010) (quoting Winter v. Natural Res. Def. Council, 555 U.S. 7, 24, 129 S.Ct. 365, 172 L.Ed.2d 249 (2008)). Thus, a plaintiff seeking a preliminary injunction must normally “establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest.” Litwin v. OceanFreight, Inc., No. 11-cv-7218, 2011 U.S. Dist. LEXIS 127362, at *13-14, 2011 WL 5223022 (S.D.N.Y. Nov. 2, 2011) (quoting Psyhoyos v. John Wiley & Sons, Inc., No. 11-cv-1416, 2011 U.S. Dist. LEXIS 115835, at *3, 2011 WL 4634172 (S.D.N.Y. Oct. 4, 2011) (citing Winter, 555 U.S. at 20 (2008))); see also Reckitt Benckiser Inc. v. Motomco Ltd., 760 F.Supp.2d 446, 451-52 (S.D.N.Y.2011).

[1] The Second Circuit has repeatedly emphasized that “[a] showing of irreparable harm is ‘the single most important prerequisite for the issuance of a preliminary injunction.’” Faiveley Transp. Malmo AB v. Wabtec Corp., 559 F.3d 110, 118 (2d Cir.2009) (quoting Rodriguez v. DeBuono, 175 F.3d 227, 234 (2d Cir.1999)); see also Singas Famous Pizza Brands Corp. v. New York Adver. LLC, No. 11-1038, 2012 U.S.App. LEXIS 6753, at *3, 2012 WL 899231 (2d Cir. Mar. 19, 2012) (slip op.) (summ.order); Bisnews AFE (Thail.) Ltd. v. Aspen Research Group Ltd., 437 F. App'x 57, 58 (2d Cir.2011) (summ.order); Borey v. Nat'l Union Fire Insur. Co., 934 F.2d 30, 34 (2d Cir.1991). “To satisfy the irreparable harm requirement, [movants] must demonstrate that absent a pre-

liminary injunction they will suffer an injury that is neither remote nor speculative, but actual and imminent, and one that cannot be remedied if a court waits until the end of trial to resolve the harm.” Faiveley Transp., 559 F.3d at 118 (quoting Grand River Enter. Six Nations, Ltd. v. Pryor, 481 F.3d 60, 66 (2d Cir.2007)). Thus, “[w]here there is an adequate remedy at law, such as an award of money damages, injunctions are unavailable except in extraordinary circumstances.” Faiveley Transp., 559 F.3d at 118 (quoting Moore v. Consol. Edison Co. of N.Y., 409 F.3d 506, 510 (2d Cir.2005)).

“The decision to grant or to deny a preliminary injunction depends in part on a flexible interplay” between the likelihood of success and irreparable harm. Packard Instrument Co. v. ANS, Inc., 416 F.2d 943, 945 (2d Cir.1969) (citing Unicon Mgmt. Corp. v. Koppers Mgmt. Co., 366 F.2d 199 (2d Cir.1966)). Thus, those two factors should not be considered in isolation. See Dopp v. Franklin Nat'l Bank, 461 F.2d 873, 886 (2d Cir.1972) (“The likelihood of success on the merits that a movant for injunctive relief must demonstrate varies with the quality and quantum of harm that it will suffer from the denial of an injunction.”); IBM Corp. v. Johnson, 629 F.Supp.2d 321, 329 (S.D.N.Y.2009); Suthers v. Amgen Inc., 372 F.Supp.2d 416, 429 (S.D.N.Y.2005).

*6 [2][3] The Second Circuit has, further, differentiated between injunctions that propose to alter the status quo (mandatory injunctions) and those that merely seek to maintain it (prohibitory injunctions). A mandatory injunction may “issue only upon a clear showing that the moving party is entitled to the relief requested, or where extreme or very serious damage will result from a denial of preliminary relief.” Cacchillo v. Insmad, Inc., 638 F.3d 401, 406 (2d Cir.2011) (citing Citigroup Global Mkts., Inc. v. VCG Special Opportunities Master Fund Ltd., 598 F.3d 30, 35 n. 4 (2d Cir.2010)); see also LSSi Data Corp. v. Time Warner Cable, Inc., No. 11-cv-7780, 2012 U.S. Dist. LEXIS 72122, at *27, 2012 WL 1893650 (S.D.N.Y. May 23, 2012). By contrast, a prohibitory injunction may be granted on a showing of “(a) irreparable harm and (b) either (1) likelihood of success on the merits or (2) sufficiently serious questions going to the merits to make them a fair ground for litigation and a balance of hardships tipping decidedly toward the party requesting the preliminary relief.” Citigroup Global Mkts., Inc., 598 F.3d at 35

--- F.Supp.2d ---, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

(citing *Jackson Dairy, Inc. v. H.P. Hood & Sons, Inc.*, 596 F.2d 70, 72 (2d Cir.1979)) (additional citations omitted). Under the prohibitory injunction standard, the overall burden on a movant to show “sufficiently serious questions going to the merits” and that “the balance of hardships tips ‘decidedly in its favor’” is “no lighter than the one it bears under the ‘likelihood of success’ standard.” *Citigroup Global Mkts., Inc.*, 598 F.3d at 35 (internal citation omitted).

The parties differ as to whether the injunction sought here is mandatory or prohibitory. XL argues that, because it ceased to advance defense costs on March 5, 2012, and the Insureds did not move for resumption of advancement until 23 days later, the injunction would alter the status quo and thus is mandatory. See XL's Br. 4–5 (citing *Brewer v. W. Irondequoit Cent. Sch. Dist.*, 212 F.3d 738, 744 (2d Cir.2000)). The Insureds counter that XL should not be allowed to effectively heighten the Insureds' burden on this motion, by unilaterally ceasing advancement without warning.^{EN4} They argue that the relevant date for classifying the requested injunction is March 5, 2012, the date XL terminated advancement and filed this lawsuit. Thus, the Insureds argue, they seek a prohibitory injunction. Insureds' Reply 2–3 & n. 1.

[4] To be sure, “ ‘the distinction between mandatory and prohibitory injunctions is not without ambiguities or critics’ “ and often leads to “ ‘distinctions that are more semantic[] than substantive .’ “ *Mastrovincenzo v. City of New York*, 435 F.3d 78, 90 (2d Cir.2006) (quoting *Tom Doherty Assocs., Inc. v. Saban Entm't, Inc.*, 60 F.3d 27, 34 (2d Cir.1995)) (alteration in original). However, on the facts at hand, the Insureds have far the better of this argument. But for XL's unilateral decision to terminate advancement and file suit, it would have been XL, not the Insureds, that would have been seeking an injunction (and to alter the status quo). And it is long settled that the “ ‘[s]tatus quo’ to be preserved by a preliminary injunction is the last actual, peaceable uncontested status which preceded the pending controversy.” *LaRouche v. Kezer*, 20 F.3d 68, 74 n. 7 (2d Cir.1994) (quoting Black's Law Dictionary 1410 (6th ed.1990)); see also *O Centro Espirita Beneficente Uniao Do Vegetal v. Ashcroft*, 389 F.3d 973, 1013 (10th Cir.2004) (“ ‘Status quo’ does not mean the situation existing at the moment the law suit is filed, but the last peaceable uncontested status existing between

the parties before the dispute developed. Thus, courts of equity have long issued preliminary injunctions requiring parties to restore the status quo ante”) (McConnell, J., concurring) (internal quotation omitted), *aff'd and remanded*, 546 U.S. 418, 126 S.Ct. 1211, 163 L.Ed.2d 1017 (2006); *United Steelworkers of Am., AFL-CIO v. Textron, Inc.*, 836 F.2d 6, 10 (1st Cir.1987) (construing an injunction requiring payment of insurance premiums “not as mandatory, but as prohibitory” where, immediately before controversy erupted, premiums were being paid) (Breyer, J.); *Davis v. Shah*, No. 12–cv–6134, 2012 U.S. Dist. LEXIS 62295, at *13–15, 2012 WL 1574944 (W.D.N.Y. May 2, 2012); *Blom ASA v. Pictometry Int'l Corp.*, 757 F.Supp.2d 238, 243 (W.D.N.Y.2010); *Stockstill v. Quinnipiac Univ.*, No. 10–cv–265, 2010 U.S. Dist. LEXIS 49481, at *21, 2010 WL 2011152 (D.Conn. May 19, 2010).

*7 Applied here, that principle requires that the status quo be measured as of March 4, 2012, immediately before XL told the Insureds that it would no longer advance defense costs. The Court, therefore, holds that the injunction sought is prohibitory, not mandatory.

B. Irreparable Harm

[5] The failure to receive defense costs under a professional liability policy at the time they are incurred “constitutes ‘an immediate and direct injury’ “ sufficient to satisfy the irreparable harm requirement. See *In re Worldcom, Inc., Sec. Litig.*, 354 F.Supp. 455, 469 (S.D.N.Y.2005) (quoting *Wedtech Corp. v. Fed. Ins. Co.*, 740 F.Supp. 214, 221 (S.D.N.Y.1990)); see also *In re Adelpia Commc'ns Corp.*, No. 02–41729, 2004 U.S. Dist. LEXIS 19478, at *21–22, 2004 WL 2186582 (S.D.N.Y. Sept. 27, 2004) (upholding, despite asset freeze during bankruptcy proceeding, release of funds to pay for defense of serious criminal charges, because failure to do so would likely result in irreparable harm); *In re CyberMedica, Inc.*, 280 B.R. 12, 18–19 (Bankr.Ct.D.Mass.2002) (granting relief from automatic stay in bankruptcy because directors and officers would suffer irreparable harm if prevented from exercising rights to legal defense payments under D & O policy); cf. *Flood v. ClearOne Commc'ns, Inc.*, No. 08–cv–631, 2009 U.S. Dist. LEXIS 2145, at *15–16, 2009 WL 87006 (D.Utah Jan. 12, 2009), *injunction vacated on other grounds* at 618 F.3d 1110 (10th Cir.2010) (finding irreparable harm and granting injunctive relief where

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

insured “face[d] a criminal trial in less than three weeks” and “[i]n the absence of continued payment of fees and costs by ClearOne, Ms. Flood’s counsel ha[d] represented to the Court that they cannot continue representation”); Great Am. Ins. Co. v. Gross, No. 05-cv-159, 2005 U.S. Dist. LEXIS 8003, at *13-14, 2005 WL 1048752 (E.D.Va. May 3, 2005) (granting preliminary injunction compelling insurer to resume advancement of defense costs, because insured faced prospect of “massive civil liability due to ... complex, fact intensive actions” and “[t]he practical effect of Plaintiff’s failure to advance costs of defense to Moving Defendants would be to cause [insureds’ counsel] to withdraw”); Emons Indus., Inc. v. Liberty Mutual Ins. Co., 749 F.Supp. 1289, 1293 (S.D.N.Y.1990) (finding irreparable harm where insurer sought to force insured whose policy covered defense costs to replace his attorney of a decade); Nu-Way Envtl., Inc. v. Planet Ins. Co., No. 95-cv-573, 1997 U.S. Dist. LEXIS 11884, at *7 (S.D.N.Y. Aug. 5, 1997).

Presumably as a result of this body of authority, XL concedes that, absent an injunction, the Insureds will suffer irreparable harm.^{FN5} But this spare concession is quite inadequate to capture the full extent of the harm and risk to these Insureds presented by XL’s decision to abruptly stop paying their defense costs. For three independent reasons, the Court finds that, if XL is not directed to resume paying those costs, the Insureds are likely to suffer “extreme or very serious damage,” the highest of the standards the Second Circuit uses to measure irreparable harm. Cacchillo, 638 F.3d at 406.

*8 First, in the underlying legal actions, the Insureds are confronted by criminal charges, either actual or threatened, and XL’s termination of payment came at a critical juncture for the defense. As of the time that XL ceased paying their legal fees, the Insureds were each either the subject of a broad and ongoing criminal investigation^{FN6} or, in the case of Anthony Chiasson, an indicted defendant awaiting trial. To date, the Department of Justice’s investigation into insider trading on Wall Street has resulted in the indictments of nearly 60 people.^{FN7} The Government Actions thus present a real risk to the Insureds not only of monetary liability, but of prosecution and a loss of liberty. The SEC Action and its investigation present the added risk of serious regulatory sanctions, including a potential bar from the securities

industry.

XL’s termination of payment of defense costs presents an obvious risk that one or more Insureds, as a result of a sudden inability to pay legal fees, would lose his existing counsel in the middle of (and quite possibly at a key moment in) these sensitive matters. The potential injury to a criminal defendant or an investigative subject of losing counsel in midstream cannot be minimized. *Cf. Flood*, 2009 U.S. Dist. LEXIS 2145, at *16, 2009 WL 87006. An Insured’s new counsel, starting from scratch in a highly complex matter, will not have, and may not be able to quickly acquire, predecessor counsel’s familiarity with the evidence, legal principles, strategy, and witnesses. Nor may such counsel be able to quickly replicate prior counsel’s working relationships with the prosecutors, counsel for co-defendants or fellow investigative subjects, or with his or her new client. A defendant without substantial assets to pay for counsel also has no assurance that the new counsel will have the talent and experience of the predecessor, with price now potentially a decisive factor in choosing counsel. *See United States v. Stein*, 435 F.Supp.2d 330, 362, 371 (S.D.N.Y.2006) (finding that if accounting firm were to cease paying legal fees of former partners who were charged in a complex tax fraud prosecution, these defendants would be inhibited in presenting their defense, and relying on appointed or lower-cost counsel to marshal a comparable defense was “unrealistic”); *cf. United States v. Eisenberg*, No. 01-cr-210, 2002 U.S. Dist. LEXIS 5354, at *7-10, 38-39 (S.D.N.Y. Mar. 8, 2002); United States v. Rosen, 487 F.Supp.2d 721, 734-35 (E.D.Va.2007).

The potential damage from interrupting and destabilizing ongoing defense efforts is multiplied here. That is because XL’s decision extends to all Insureds. It therefore jeopardizes at once every existing representation of persons affiliated with Level Global, and of Level Global itself.^{FN8} It is well known that, where investigative subjects have a common interest—including having worked in the business unit that is the focus of a criminal or regulatory investigation—the subjects’ defense counsel often collaborate and/or pool resources in a “joint defense” or “common interest” group. The work of coordinated defense groups is well known, *see, e.g., United States v. Weissman*, No. 94-cr-760, 1996 U.S. Dist. LEXIS 19066, at *16-18 (S.D.N.Y. Dec. 26, 1996), and, as

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

practitioners appreciate, can sometimes be vital to the successful defense of a government investigation. *See also United States v. McPartlin*, 595 F.2d 1321, 1336 (7th Cir.1979) (communication among co-defendants' counsel "can be necessary to a fair opportunity to defend" in a multi-defendant case); *cf. In re Grand Jury Subpoena Duces Tecum Dated Nov. 16, 1974*, 406 F.Supp. 381, 390 (S.D.N.Y.1975) (noting defense group collaboration in defending against SEC enforcement action). This is particularly true where an investigation probes complex areas of alleged corporate misconduct. As a result of this coordinated work, a criminal defendant or investigative subject may have a real interest in the continuity of fellow subjects' legal representations. Not surprisingly, collaboration among counsel for the Insureds appears to be underway in this investigation. *See* Hg. Tr. 18 (statement of counsel for Mr. Brenner).

*9 XL's global termination could, therefore, act as a ten-strike aimed at the entire Level Global defense group. It would create the risk at this key juncture that multiple defense counsel—or, conceivably, counsel for all Insureds—would step aside, because their fees in this costly matter could no longer realistically be paid. Were this to happen, the productive collaborative efforts and the existing body of joint-defense intellectual capital could be substantially impaired, to the detriment of all Insureds. *See United States v. Stepney*, 246 F.Supp.2d 1069, 1084 (N.D.Cal.2003) (noting harm to joint defense group presented by one attorney's disqualification).

Second, the government's charges or potential charges in the complex underlying matters are by their nature unusually costly to defend against. The prosecution of Anthony Chiasson illustrates the point well. Based on counsel's representations at the hearing, Chiasson's trial is presently scheduled for October 2012, and is projected to last between six to eight weeks. Hg. Tr. 7. The prosecution has produced between one and two terabytes of electronic discovery to Chiasson's counsel—equating to between 100 million and 1 billion pages. *Id.* In addition, although the Indictment charges Chiasson with insider trading in two securities across eight trading days, the prosecution has stated that it may supersede to add charges relating to up to 33 other securities. *Id.* at 8–9.

As to any instance of alleged insider trading, a diligent defense counsel can be expected to investi-

gate numerous potential defenses. These, presumably, include whether information about the security was communicated to his client in advance of the particular trade; whether that information was material; whether it was non-public, as opposed to known or fairly ascertainable through legitimate means; whether it had been obtained by the expert network or other third-party intermediaries in breach of a duty; and whether counsel's client knew the answers to those questions at the time of the trade. Hg. Tr. 8. It is likely that defense counsel will wish to retain expert assistance in connection with these inquiries. Further, because the government alleges that material non-public information was furnished to Level Global and Chiasson not directly by a company insider, but indirectly, including by means of one or more intermediary experts and/or consultants, counsel can also be expected to vigorously investigate these intermediaries. *See* SEC Compl. ¶¶ 2–7 (alleging that information from "Dell Insider" traveled through two intermediaries before reaching Adondakis). All this defense work will be costly. Without professional liability coverage, these costs are likely beyond the financial reach of some Insureds, if not all.^{FN9}

Third, at stake here is not only whether the Insureds can access the \$2.7 million left to be paid out on Level Global's \$10 million policy with XL. Also in jeopardy is the Insureds' ability to access additional layers of excess insurance to which the Insureds are entitled after the XL policy has been exhausted. At argument, Level Global's counsel explained that it had purchased \$15 million in additional layers of excess coverage, atop XL's Policy, from other carriers. But, counsel explained, the carrier responsible for the next layer of coverage has taken the position that its duty to pay is not triggered until XL, the primary insurer, has paid out the full \$10 million on its Policy. *See* Hg. Tr. 11–12 (next-layer carrier has rejected Insureds' position that its duty has been triggered by fact that Insureds have incurred more than \$10 million in defense costs). Although the duty of the next insurer to advance costs under these circumstances could certainly be litigated if necessary, as a practical matter, XL's decision to cease payment of the Insureds' defense fees is blocking the Insureds from accessing not just the remaining \$2.7 million under XL's policy, but an additional \$15 million in excess coverage as well.^{FN10}

--- F.Supp.2d ---, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

*10 In *In re Worldcom*, the district court succinctly summarized why the insurer's refusal to advance fund's—with civil lawsuits underway and a trial date approaching—confronted the insureds with irreparable harm:

Every party ... requires effective representation. It is impossible to predict or quantify the impact on a litigant of a failure to have adequate representation at this critical stage of litigation. The ability to mount a successful defense requires competent and diligent representation. The impact of an adverse judgment will have ramifications beyond the money that will necessarily be involved. There is the damage to reputation, the stress of litigation, and the risk of financial ruin—each of which is an intangible but very real burden.

Worldcom, 354 F.Supp.2d at 469. Those considerations apply here, and, for the reasons stated, with special force. The Court, accordingly, finds that the Insureds' need to access additional legal defense costs from XL under the Policy is immediate and concrete, and that in the absence of the requested injunction, the Insureds would suffer irreparable harm and sustain "extreme or very serious damage." *Cacchillo*, 638 F.3d at 406 (citing *Citigroup Global Mkts.*, 598 F.3d at 35 n. 4).

C. The Balance of Hardships

[6] For many of the same reasons, the balance of hardships tips, not only decisively but lopsidedly, in favor of the Insureds.

Absent an injunction, the Insureds would face an increased risk of having to defend against a criminal investigation or prosecution, without their present counsel, and very likely without the funds to mount a fully effective defense against these complex charges. They also face a parallel SEC investigation that may result in serious civil charges. Insured Anthony Chiasson would face the pending criminal Indictment against him (to which may be added expanded insider trading charges) with a risk of losing his existing counsel months before trial, and without the funds to pay for the investigation and preparation such charges merit. All Insureds face the risk that, because of XL's refusal to complete payout under its Policy, they will be inhibited from accessing the additional layers of coverage—totaling \$15 million—for which

Level Global contracted. The Insureds thus stand to lose, from a strictly monetary perspective, access to approximately \$17.7 million. From a human perspective, they stand to lose much that is far more consequential, including their liberty.

XL, by contrast, faces at most the loss of an additional \$2.7 million, and then only if a court were to determine that it had no duty to advance or pay out those funds, and in such circumstances, XL could seek to recoup those funds from the Insureds. At argument, XL's counsel acknowledged that \$2.7 million "is not going to tank XL" and that XL "will continue as a viable insurer." Hg. Tr. 71. XL has not identified any non-monetary adverse consequences to it from granting the injunction. The balance of equities thus, decisively, favors the Insureds.

D. Likelihood of Success on the Merits

1. Authorities Relied on by the Parties

*11 As both parties recognize, this is not the first case to address the application of a prior knowledge exclusion or an attempt by an insurer to cease advancement of defense costs based on undisclosed claims or misconduct.

For its part, XL relies on three cases enforcing prior knowledge exclusions, which, it claims, defeat the Insureds' claim of a likelihood of success on the merits.

At issue in *Gluck v. Executive Risk Indemnity, Inc.*, 680 F.Supp.2d 406 (E.D.N.Y.2010), was a prior knowledge exclusion worded quite similarly to the one here. The insured had sought a declaratory judgment of coverage for defense costs; the insurer moved for summary judgment, based on the fact that the insured had not disclosed a dispute and settlement agreement with the Federal government. *Id.* at 407, 411–12. The district court held that because the insured entity had been required to disclose the settlement, had not done so, and the claims for which coverage was sought arose from that settlement, the exclusion barred coverage for the underlying claims for all insureds. *Id.* at 413–14, 424.

In *MDL Capital Management, Inc. v. Federal Insurance Company*, No. 05–cv–1396, 2008 U.S. Dist.

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

LEXIS 57089 (W.D.Pa.2008), the insurance application asked the corporate applicant: “Does the applicant or any of its partners, directors, officers, employees or trustees have any knowledge of any fact or circumstances which might give rise to a claim under the proposed policy?” *Id.* at *18–19. The application provided: “It is agreed that if such knowledge exists any claim arising from such fact or circumstances will not be covered by the policy.” *Id.* at *36. One such insured (Lay, the company’s CEO) was later found guilty of mail and wire fraud. The district court held that that conviction “establishes that [he] knew or should have known of the likelihood of a claim related to his fraudulent conduct.” *Id.* at *44–45. The court rejected the other insureds’ claim that their “lack of privity” to Lay precluded application of the exclusion to them. It noted that the application question “inquired about the knowledge of ‘any’ director, officer or employee, and the [Exclusion] provide[d] that any such knowledge eliminate[d] coverage for ‘any claim arising from such fact or circumstances.’” *Id.* at *46 (emphasis in original). Thus, Lay’s subjective knowledge defeated coverage for all claimants. *Id.* at *47–48.

Finally, in *Shapiro v. American Home Assurance Company*, 584 F.Supp. 1245 (D.Mass.1984), the application asked the applicant, Giant Stores: “Does any Director or Officer have knowledge or information of any act, error or omission which might give rise to a claim under the proposed policy?” *Id.* at 1247. It further provided: “It is agreed that if such knowledge or information exists any claim or action arising therefrom is excluded from this proposed coverage.” *Id.* Shapiro, Giant’s president, completing the application for the company, answered “no”; he was later convicted of securities fraud based on conduct predating the application. *Id.* On the claim by other officers and directors that they had been unaware of Shapiro’s crimes, the district court held, as a matter of contract interpretation, that the insurer, American Home, was entitled to rescind the agreement, and that the “clear language” of the exclusion also justified denying coverage even to innocent corporate officials, based on Shapiro’s knowledge at the time of the application of a potential claim. *Id.* at 1252–53.

*12 The Insureds, for their part, rely principally on three different cases, in which courts have refused to permit insurers to cease advancement of defense

costs.

In *In re Worldcom*, a former director sought a preliminary injunction compelling Worldcom’s D & O insurer to advance defense costs in connection with litigation related to the company’s accounting irregularities. 354 F.Supp.2d at 462. The insurer argued that misrepresentations made in Worldcom’s insurance policy application had made that policy void *ab initio*; it sought to rescind the policy. *Id.* at 462–63. The district court (Cote, J.) held that, on a motion for a preliminary injunction, the insured need establish a likelihood of success only as to the issue of a duty to advance defense costs while the claim of rescission was *sub judice*, not a likelihood of success in defeating the rescission claim. *Id.* at 466–67. The court found such a likelihood, and issued an injunction compelling the insurer to advance defense costs until the underlying claims had been adjudicated. *Id.* at 471. It explained: “Until the issue of rescission is adjudicated, a contract of insurance remains in effect and the duty to pay defense costs is enforceable.” *Id.* at 465.

In *In re HealthSouth Corporation Insurance Litigation*, 308 F.Supp.2d 1253 (N.D.Ala.2004), former directors and officers of HealthSouth sought partial summary judgment against a complaint brought by 10 insurers, seeking, as in *Worldcom*, to void D & O policies *ab initio* as having been procured by materially false financial information. *Id.* at 1256–57. The district court granted (in part) the insureds’ motions, on the ground that, under the insurance contract, the knowledge of wrong-doers within the company could not be imputed to innocent fellow employees seeking coverage under the policy. *Id.* at 1283–85. In so concluding, the court stated, in a passage quoted by the Insureds here:

If the companies can rescind coverage because of misstatements or misleading statements in HealthSouth SEC filings, without showing that the individual insured knew of the misstatement, then coverage under the D & O policies would be totally illusory. Under the interpretation urged by the excess carriers, officers and directors who have no specific control over or intimate knowledge about statements contained in SEC filings and other financial reports would not have insurance protection in cases of misstatements by the corporation or other insureds.

--- F.Supp.2d ---, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

Id. at 1285; Insureds' Br. 20.

Finally, in *Associated Electric & Gas Incorporated v. Rigas*, 382 F.Supp.2d 685 (E.D.Pa.2004), a number of former officers and directors of Adelphia Communications sought summary judgment against the complaint of their D & O insurer, which sought to disclaim coverage for defense costs based on, *inter alia*, both rescission and a prior knowledge exclusion. The insurers claimed that they could unilaterally invoke the exclusion, without any judicial determination that it applied, as a basis to cease advancing legal costs. *Id.* at 685, 690. The district court granted the insureds' motion. *Id.* at 702–03. It noted that a bankruptcy stay prevented it “from making any determination at [that] time about whether the Prior Knowledge Exclusion applie [d,]” or whether other language in the application (including a warranty clause not dissimilar from Condition K here), made “only the signatory to the policy application or all of the directors and officers subject to the Prior Knowledge Exclusion.” *Id.* at 700.

*13 However, the *Rigas* court held that, pending a judicial determination of the exclusion's applicability, the insurer was required to continue to advance defense costs. The court noted that the policy's prior knowledge exclusion “does not ... contain any language to suggest that it operates at the discretion of the insurer,” “does not say that the exclusion precludes the payment of defense costs when the insurer believes the insured had prior knowledge, and it does not say that the insurer can itself determine whether such knowledge was likely to give rise to claims.” *Id.* at 699. The court therefore held that it was ambiguous whether the contract empowered the insurer to unilaterally invoke a policy exclusion, and to cut off the forwarding of defense costs, without a judicial determination that the exclusion applied. *Id.* at 699–700. Drawing on Pennsylvania law, the *Rigas* court noted that an insurer becomes “legally obligated” to advance defense costs as those costs are incurred by the insureds, at least in the absence of contravening language in the relevant policy. *Id.* at 700. Because the policy was ambiguous whether the insurer had contracted around that background norm, the court construed the ambiguity in favor of the insured, and compelled the insurer to advance defense costs pending a judicial resolution of the exclusion's applicability. *Id.*

In the Court's view, although all of these cases are instructive, none is dispositive here. XL's cases—*Gluck*, *MDL Capital*, and *Shapiro*—all demonstrate that, under an unambiguously drafted insurance contract containing a prior knowledge exclusion, coverage of all insureds can be excluded based on the knowledge of a single insured, as of the application date. The Insureds' counsel conceded this point at argument. Hg. Tr. 43–44. *Gluck* particularly assists XL, because the exclusion there is similar to the one here. See XL's Br. 9–11.

However, none of those cases involved the claim here that specific policy language outside the four corners of the prior knowledge exclusion informs its proper construction. That is the Insureds' primary argument. As discussed *supra*, they have made a substantial argument that the Reasonable Inquiry Provision narrows the “claims, facts, circumstances or situations” that are “required to be disclosed”—the decisive term in XL's Prior Knowledge Exclusion—so as not to require disclosure of information, like Adondakis's crimes, unknown to signatory Bohrer after his due diligence inquiry. Notably, had such a provision existed, it would not have changed the outcomes in *Gluck*, *MDL Capital*, or *Shapiro*. That is because, in each case, the signatory to the insurance application had personally been aware—based on firsthand involvement—of the undisclosed circumstances giving rise to the claim forming the basis for the exclusion. In *Gluck*, the signatory, CEO Klein, had signed the undisclosed settlement agreement, see 680 F.Supp.2d at 411–12, and in *MDL Capital Management and Shapiro*, the respective signatories, CEO Lay and President Shapiro, were each later convicted of federal crimes based on their pre-application conduct. See 2008 U.S. Dist. LEXIS 57089, at * 4, 18–19, 26, 584 F.Supp. at 1247. Thus, in each case, the excluding circumstance would have been “required to be disclosed” because the signatory personally knew it. At argument, XL's counsel agreed that whether the interplay between XL's Prior Knowledge Provision and its Reasonable Inquiry Provision gives rise to contractual ambiguity presents a question of first impression. See Hg. Tr. 69.

*14 The Insureds' cases, too, are distinguishable. *Worldcom* and *HealthSouth* are rescission cases. In each, the insurers sought a declaration that the insurance contract had been void *ab initio*. This, however,

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

is an exclusion case. XL concedes that a binding Policy exists with Level Global; it seeks a declaration that the Government Actions are excluded under the Policy's Prior Knowledge Exclusion. XL's Br. 17. The Insureds note that the impact on them of termination of advancement is the same, whether the legal issue is cast as rescission or exclusion; and that, inasmuch as Level Global did not make any other claims for coverage during the policy period, exclusion of the Covered Claims in substance works a rescission of the agreement (save for the non-return of the insured's premium). See Insureds' Br. 22; Hg. Tr. 74. However, under the case law, the contractual defenses of rescission and exclusion are distinct. They must be analyzed pursuant to separate principles. See, e.g., *Gluck*, 680 F.Supp.2d at 416–17 & n. 8; *Home Ins. Co. of Ill. v. Spectrum Info. Techs., Inc.*, 930 F.Supp. 825, 835–41, 848–49 (E.D.N.Y.1996) (analyzing rescission and exclusion separately); *Barkan v. New York Schools Ins. Reciprocal*, 65 A.D.3d 1061, 1063–64, 886 N.Y.S.2d 414 (2d Dep't 2009) (same). Of the Insureds' cases, *Rigas* is most closely on point, because it involved a prior knowledge exclusion, not a claim for rescission. But it, too, is distinguishable, for a variety of reasons, discussed *infra* at 40–41.

Accordingly, although the Court is guided by the valuable analyses in these cases, to resolve the pending motion, the Court must independently analyze, under principles of New York insurance law, the specific Policy provisions at issue here.

2. Principles of New York Law

[7] Under New York law, “an insurance contract is interpreted to give effect to the intent of the parties as expressed in the clear language of the contract.” *Parks Real Estate Purchasing Grp. v. St. Paul Fire & Marine Ins. Co.*, 472 F.3d 33, 42 (2d Cir.2006); see also *Vill. of Sylvan Beach v. Travelers Indem. Co.*, 55 F.3d 114, 115 (2d Cir.1995); *St. Paul Fire & Marine Ins. Co. v. Novus Int'l, Inc.*, No. 09-cv-1108, 2011 U.S. Dist. LEXIS 150317, at *23, 2011 WL 6937593 (S.D.N.Y. Dec. 28, 2011). “When the provisions are unambiguous and understandable, courts are to enforce them as written.” *Parks Real Estate Purchasing Grp.*, 472 F.3d at 42 (citing *Goldberger v. Paul Revere Life Ins. Co.*, 165 F.3d 180, 182 (2d Cir.1999)); see also *Essex Ins. Co. v. Laruccia Constr., Inc.*, 71 A.D.3d 818, 819, 898 N.Y.S.2d 558 (2d Dep't 2010) (under New York law, courts must give “unambiguous provisions of an insurance con-

tract ... their plain and ordinary meaning”).

[8] “The initial interpretation of a contract ‘is a matter of law for the court to decide.’ “ *10 Ellicott Square Court Corp. v. Mt. Valley Indem. Co.*, 634 F.3d 112, 119 n. 8 (2d Cir.2010) (quoting *Morgan Stanley Grp. Inc. v. New England Ins. Co.*, 225 F.3d 270, 275 (2d Cir.2000)); see also *White v. Cont'l Cas. Co.*, 9 N.Y.3d 264, 267, 848 N.Y.S.2d 603, 878 N.E.2d 1019 (2007). “Part of this threshold interpretation is the question of whether the terms of the insurance contract are ambiguous.” *Parks Real Estate Purchasing Grp.*, 472 F.3d at 42 (citing *Alexander & Alexander Servs., Inc. v. These Certain Underwriters at Lloyd's*, 136 F.3d 82, 86 (2d Cir.1998)). In resolving that question, a court may not view the particular terms at issue in a vacuum. Rather, it must view these terms from the perspective of one “who has examined the context of the entire integrated agreement.” *Bank of N.Y. v. First Millennium, Inc.*, 607 F.3d 905, 914 (2d Cir.2010); see also *Int'l Multifoods Corp. v. Commercial Union Ins. Co.*, 309 F.3d 76, 83 (2d Cir.2002).

*15 [9] “It is well settled that [a] contract is unambiguous if the language it uses has a definite and precise meaning, unattended by danger of misconception in the purport of the [agreement] itself, and concerning which there is no reasonable basis for a difference of opinion.” *White*, 9 N.Y.3d at 267 (quoting *Greenfield v. Philles Records*, 98 N.Y.2d 562, 569, 750 N.Y.S.2d 565, 780 N.E.2d 166 (2002)) (brackets in original, additional citation and internal quotation marks omitted). Conversely, “[a]n ambiguity exists where the terms of an insurance contract could suggest ‘more than one meaning when viewed objectively by a reasonably intelligent person who has examined the context of the entire integrated agreement and who is cognizant of the customs, practices, usages and terminology as generally understood in the particular trade or business.’ “ *Parks Real Estate Purchasing Grp.*, 472 F.3d at 42 (quoting *Lightfoot v. Union Carbide Corp.*, 110 F.3d 898, 906 (2d Cir.1997)) (citation and internal quotation marks omitted); see also *U.S. Licensing Assocs. v. Rob Nelson Co.*, No. 11-cv-4517, 2012 U.S. Dist. LEXIS 58712, at *8, 2012 WL 1447165 (S.D.N.Y. Apr. 26, 2012).

[10][11] “If the terms of a policy are ambiguous, however, any ambiguity must be construed in favor

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

of the insured and against the insurer.” *White*, 9 N.Y.3d at 267 (citing *United States Fid. & Guar. Co. v. Annunziata*, 67 N.Y.2d 229, 232, 501 N.Y.S.2d 790, 492 N.E.2d 1206 (1986)); see also *Woodhams v. Allstate Fire & Cas. Co.*, 748 F.Supp.2d 211, 218 (S.D.N.Y.2010); *Hunt v. Ciminelli-Cowper Co., Inc.*, 93 A.D.3d 1152, 1154, 939 N.Y.S.2d 781 (4th Dep’t 2012); *Appleby v. Chicago Title Ins. Co.*, 80 A.D.3d 546, 549, 914 N.Y.S.2d 257 (2d Dep’t 2011); *Tower Ins. Co. of N.Y. v. Diaz*, 58 A.D.3d 495, 496, 871 N.Y.S.2d 123 (1st Dep’t 2009).^{EN11} Similarly, any ambiguity in the terms of an insurance policy application is also to be construed in favor of the insured. *Home Ins. Co. v. Spectrum Info. Techs.*, 930 F.Supp. 825, 837 (E.D.N.Y.1996) (citing *Vella v. Equitable Life Assurance Soc’y*, 887 F.2d 388, 392 (2d Cir.1989)); see also *Sec. Mut. Ins. Co. v. Perkins*, 86 A.D.3d 702, 703, 927 N.Y.S.2d 189 (3d Dep’t 2011); *Fanger v. Manhattan Life Ins. Co.*, 273 A.D.2d 438, 439, 709 N.Y.S.2d 622 (2d Dep’t 2000); *Nadel v. Manhattan Life Ins. Co.*, 211 A.D.2d 900, 901, 621 N.Y.S.2d 180 (3d Dep’t 1995). This principle derives from the common law doctrine of *contra proferentem*, which holds that, in the case of insurance contracts, “drawn as they ordinarily are by the insurer,” *Miller v. Continental Ins. Co.*, 40 N.Y.2d 675, 678, 389 N.Y.S.2d 565, 358 N.E.2d 258 (1976), “it is the insurance company which has the responsibility of making its intention clearly known.” *Stainless, Inc. v. Emp’rs Fire Ins. Co.*, 69 A.D.2d 27, 33, 418 N.Y.S.2d 76 (1st Dep’t 1979).

[12] Where, as here, an insurer “claims that an exclusion in the policy applies to an otherwise covered loss,” the “insurer bears the burden of proof” to demonstrate that the exclusion applies. *Morgan Stanley Group, Inc. v. New Eng. Ins. Co.*, 225 F.3d 270, 276 n. 1 (2d Cir.2000); see also *MBIA Inc. v. Fed. Ins. Co.*, 652 F.3d 152, 158 (2d Cir.2011) (“[T]he insured bears the burden of showing that an insurance coverage covers the loss, but the insurer bears the burden of showing that an exclusion applies to exempt it from covering a claim.”); *Bianchi v. Lorists’ Mut. Ins. Co.*, 422 F. App’x 56, 58 (2d Cir.2011) (summ.order) (citing *Critchlow v. First UNUM Life Ins. Co. of Am.*, 378 F.3d 246, 256–57 (2d Cir.2004)); *Town of Massena v. Healthcare Underwriters Mut. Ins. Co.*, 98 N.Y.2d 435, 444, 749 N.Y.S.2d 456, 779 N.E.2d 167 (2002) (in context of insurer’s duty to defend, “[w]hen an exclusion clause is relied upon to deny coverage, the burden rests upon the insurance company to demonstrate that the

allegations of the complaint can be interpreted only to exclude coverage”); *Consol. Edison Co. of N.Y. v. Allstate Ins. Co.*, 98 N.Y.2d 208, 220, 746 N.Y.S.2d 622, 774 N.E.2d 687 (2002) (“Once coverage is established, the insurer bears the burden of proving that an exclusion applies”). “[T]o ‘negate coverage by virtue of an exclusion, an insurer must establish that the exclusion is stated in clear and unmistakable language, is subject to no other reasonable interpretation, and applies in the particular case.’” *Inc. Vill. of Cedarhurst v. Hanover Ins. Co.*, 89 N.Y.2d 293, 298, 653 N.Y.S.2d 68, 675 N.E.2d 822 (1996) (quoting *Cont’l Cas. Co. v. Rapid-American Corp.*, 80 N.Y.2d 640, 652, 593 N.Y.S.2d 966, 609 N.E.2d 506 (1993)). “Policy exclusions ‘are not to be extended by interpretation or implication, but are to be accorded a strict and narrow construction.’” *Inc. Vill. of Cedarhurst*, 89 N.Y.2d at 298, 653 N.Y.S.2d 68, 675 N.E.2d 822 (quoting *Seaboard Sur. Co. v. Gillette Co.*, 64 N.Y.2d 304, 311, 486 N.Y.S.2d 873, 476 N.E.2d 272 (1984)); see also *Fed. Ins. Co. v. Int’l Bus. Machs. Corp.*, 18 N.Y.3d 642, 649, 942 N.Y.S.2d 432, 965 N.E.2d 934 (2012).

*16 [13] Finally, an insurer’s “duty to pay ‘arises at the time the insured becomes legally obligated to pay.’” *Fed. Ins. Co. v. Kozlowski*, 18 A.D.3d 33, 42, 792 N.Y.S.2d 397 (1st Dep’t 2005) (quoting *Little v. MGIC Indem. Corp.*, 836 F.2d 789, 793 (3d Cir.1987)). Once that duty attaches, “under a directors and officers liability policy calling for the reimbursement of defense expenses ... ‘insurers are required to make contemporaneous interim advances of defense expenses,’ “ while reserving the right to seek recoupment if the facts ultimately show that no coverage was afforded. *Kozlowski*, 18 A.D.3d at 42, 792 N.Y.S.2d 397 (quoting *Nat’l Union Fire Ins. Co. v. Ambassador Grp., Inc.*, 157 A.D.2d 293, 299, 556 N.Y.S.2d 549 (1st Dep’t 1990)); see also *Axis Reinsurance Co. v. Bennett*, No. 07–cv–7924 et al., 2008 U.S. Dist. LEXIS 53921, at *7 (S.D.N.Y. June 26, 2008) (Lynch, J.); *Trs. of Princeton Univ. v. Nat’l Union Fire Ins. Co.*, 839 N.Y.S.2d 437, 2007 N.Y. Misc. LEXIS 2350, at *16, 2007 WL 1063870 (Sup.Ct.N.Y.Cnty. Apr. 10, 2007), *aff’d*, 52 A.D.3d 247, 859 N.Y.S.2d 174 (1st Dep’t 2008). Thus, an insurer may be obligated to fund the criminal defense of an insured, but in the event of a conviction, may have the right to seek recoupment if the conviction establishes a lack of entitlement to coverage (e.g., under a “prior acts” or “intentional acts” exclusion).

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

3. Does the Prior Knowledge Exclusion Apply ?

As noted, Question 8.b on the Application reads:

Is any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which might afford valid grounds for any claim such as would fall within the scope of the proposed insurance? (If "Yes," please explain by attachment to this Application.)

The Prior Knowledge Exclusion, which immediately follows, provides:

Without prejudice to any other rights and remedies of the Insurer, any Claim arising from any claims, facts, circumstances or situations required to be disclosed in response to 8.a) or 8.b) above is excluded from the proposed insurance.

For purposes of this motion, the parties agree that (1) Adondakis was a "person[] ... proposed for this insurance"; (2) Adondakis, at the time of Level Global's application, was "aware of a[] fact, circumstance, or situation which ... afford[ed] valid grounds for a[] claim" under the proposed insurance; and (3) the Government Actions arise from the "claims, facts, circumstances, or situations" known to Adondakis.^{FN12}

The dispute between the parties as to whether the Prior Knowledge Exclusion applies here centers on the clause "required to be disclosed." XL argues that clause is defined solely with reference to the text of Question 8.b, such that, if any prospective insured was aware of a "fact, circumstance or situation" which could give rise to a claim, that claim is excluded. In the absence of other language in the Policy that arguably modified that clause, XL's argument (like the insurer's in *Gluck*) would be strong.

*17 However, the Insureds argue that there is modifying language in the Policy: the Reasonable Inquiry Provision. It appears just after the Exclusion, and reads:

FOR THE PURPOSE OF THIS APPLICATION, THE UNDERSIGNED AUTHORIZED AGENT OF THE PERSON(S) AND ENTITY(IES) PROPOSED FOR THIS INSUR-

ANCE DECLARES THAT TO THE BEST OF THEIR KNOWLEDGE AND BELIEF AFTER REASONABLE INQUIRY, THE STATEMENTS HEREIN ARE TRUE AND COMPLETE. THE INSURER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. SIGNING THIS APPLICATION DOES NOT BIND THE INSURER TO COMPLETE THE INSURANCE.

The Insureds argue that the Provision informs the Exclusion, such that Level Global was

"required to ... disclose" *only* the information responsive to Question 8.b known to its signatory, Bohrer, after his "reasonable inquiry." Insureds' Br. 17–18. On this reading, the Exclusion would not apply, because—as the parties agree for purposes of this motion—Adondakis did not reveal his crimes to Bohrer, and a reasonable inquiry would not have revealed them.

[14] The Court has carefully considered the parties' competing constructions of the Policy, and their respective arguments why those constructions accord with the Policy's text and yield rational results. In so doing, the Court has been mindful that "the cardinal principle for the construction and interpretation of insurance contracts—as with all contracts—is that the intentions of the parties should control. Unless otherwise indicated, words should be given the meanings ordinarily ascribed to them and absurd results should be avoided." *World Trade Ctr. Props., L.L.C. v. Hartford Fire Ins. Co.*, 345 F.3d 154, 184 (2d Cir.2003), *overruled in part on other grounds by Wachovia Bank, N.A. v. Schmidt*, 546 U.S. 303, 126 S.Ct. 941, 163 L.Ed.2d 797 (2006).^{FN13}

[15] In the Court's assessment, both parties have articulated colorable textual arguments as to the interplay (or lack thereof) between the Prior Knowledge Exclusion and the Reasonable Inquiry Provision. Both have cogently explained why their constructions achieve rational ends. The Court is mindful that, at this early stage, it has not yet received in-depth briefing on this point, the parties have not engaged in discovery, and, to the extent extrinsic evidence may prove relevant, as XL suggests it may, *see* note 11, *supra*, the parties have not had the opportunity to bring it to bear. With those qualifications, the Court's determination is that the Insureds have raised

--- F.Supp.2d ---, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

a “sufficiently serious claim” on the merits of contractual ambiguity—*i.e.*, whether the Exclusion applies—“to make [the merits] a fair ground for litigation.” *Citigroup Global Mkts., Inc.*, 598 F.3d at 35. Thus, although XL has advanced a reasonable argument in favor of its construction of the Policy, at this stage, the Court is not prepared to say that it is the only reasonable one.

In reviewing the parties' textual arguments, the Court examines the Reasonable Inquiry Provision first. XL has argued that that Provision and the signatory's attestation to it are devoid of legal force. Rather, XL argues, the Provision and attestation merely exist to give “comfort” to the insurer “that we are dealing with a serious prospective insured out there.” Hg. Tr. 50. The Court disagrees. There is good reason to view the Provision and attestation as a meaningful part of the Application, not an idle collection of words of mere “comfort” to the insurer. Hg. Tr. 50. The Provision does not say that it is merely precatory. And the context suggests otherwise. The Provision and attestation are part of the insured entity's Application; and, according to XL's General Terms and Conditions, the Application “form[s] part of this Policy.” *See* Naunton Decl. Ex. A, at p. 21 (General Terms and Conditions, at I(A)(1)). The Provision also occupies a prominent place in the Application: It follows the final question which the applicant must answer (Question 9); the attestation to it is the first attestation listed; and the Provision is followed by others with obvious legal consequence (*e.g.*, the applicant's acknowledgments as to the calculation of liability limits and the definition of “claims made”). *See id.* Ex. C, at p. 3. Further, the Reasonable Inquiry Provision is presented entirely in boldface and capital letters.^{FN14} Given its placement and presentation, a reader would reasonably regard the Provision and accompanying attestation as consequential.

*18 XL's contrary claim that the Provision is irrelevant is in tension with the principle that, in interpreting a contract, courts seek to give “[e]ffect and meaning ... to every term of the contract, and reasonable effort must be made to harmonize all of its terms.” *Reda v. Eastman Kodak Co.*, 233 A.D.2d 914, 915 (4th Dep't 1996) (citing *Facet Indus., Inc. v. Wright*, 95 A.D.2d 262, 265, 465 N.Y.S.2d 941 (1st Dep't 1983), *rev'd on other grounds*, 62 N.Y.2d 769, 477 N.Y.S.2d 316, 465 N.E.2d 1252 (1984)); *see also*

India.com, Inc. v. Dalal, 412 F.3d 315, 323 (2d Cir.2005). As the New York Court of Appeals has put the point: “An insurance contract should not be read so that some provisions are rendered meaningless.” *Cnty. of Columbia v. Cont'l Ins. Co.*, 83 N.Y.2d 618, 628, 612 N.Y.S.2d 345, 634 N.E.2d 946 (1994); *see also Vassar Coll. v. Diamond State Ins. Co.*, 84 A.D.3d 942, 945, 923 N.Y.S.2d 124 (2d Dep't 2011); *Simplex diam, Inc. v. Brockbank*, 283 A.D.2d 34, 38, 727 N.Y.S.2d 64 (1st Dep't 2001); *Bank of N.Y.*, 607 F.3d at 914 (court must view particular terms from the perspective of one who “has examined the context of the entire integrated agreement”).

The Court turns, then to the issue of whether the Provision informs the meaning of the Prior Knowledge Exclusion. There is a strong argument that it does. The Provision requires the signatory, “after reasonable inquiry,” to declare, as to the Application, that “the statements herein are true and complete.” The Exclusion, which is part of the Application, contains such a “statement” by the signatory: In response to Question 8.b, the signatory states, “yes” or “no,” whether any person proposed for the insurance was “aware of any fact, circumstance, or situation” that could give rise to a claim. Textually, it is, therefore, reasonable to regard the answer to Question 8.b not as an omniscient statement that no proposed insured knew of a disqualifying “fact, circumstance, or situation.” Rather, as the Insureds posit, the signatory's answer is, logically, bounded by the signatory's knowledge after conducting a “reasonable inquiry.” That construction jibes with common sense: After all, to what more can the signatory fairly be expected to attest?

XL counters this reading by arguing that, even if the Reasonable Inquiry Provision informs the Exclusion, a clause in the Provision supports XL's view that the knowledge of all proposed insureds, even if concealed from the corporate signatory, is “required to be disclosed.” XL notes that the Provision states that “to the best of their knowledge and belief,” the statements in the Application are “true and complete.” XL argues that “their” must refer to *all* of the proposed insureds, and argues that the signatory is thereby attesting, omnisciently, that each proposed insured knows of no fact or circumstance on which a claim could be made. The Insureds counter that the clause, in totality, is properly read to reflect the signatory's knowledge after his due diligence inquiry.

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

This is so either because the word “their” refers only to the signatory,^{FN15} or, more persuasively in the Court's view, because, even if “their” refers to the proposed insureds, the immediately ensuing phrase, “after reasonable inquiry,” necessarily limits the meaning of the attestation to the awareness of the proposed insureds' “knowledge and belief” which the signatory possessed following that inquiry. In the Court's view, the parties' respective attempts to harmonize (1) a clause (“required to be disclosed”) that is not self-defining and (2) the awkwardly-phrased Provision and attestation are each plausible. Neither party's construction is clearly correct or incorrect.

*19 Turning to the language of the Exclusion, XL is certainly correct that, even if the answer to Question 8.b on the Application reflects only the signatory's subjective awareness, it does not necessarily follow that the Exclusion that immediately follows the answer is similarly bounded. The clause “required to be disclosed,” can reasonably be read to mean (as XL urges) “required to be disclosed by the proposed insured to the attesting signatory.” On that reading, the Exclusion would bar coverage here. But that clause can also reasonably be read to mean (as the Insureds urge) “required to be disclosed by the applicant, as personified by the attesting signatory, in response to Question 8.b.” On that reading, the Exclusion would not be triggered here. The text of the Exclusion simply does not rule out the Insureds' construction, although it would have been easy for XL to draft such an exclusion.^{FN16} And, as noted, under New York law, where more than one plausible construction exists as to an exclusion, that ambiguity must be resolved in favor of the insured and a narrower exclusion. See, e.g., *White*, 9 N.Y.3d at 267, 848 N.Y.S.2d 603, 878 N.E.2d 1019; *Woodhams*, 748 F.Supp.2d at 218.

The Court, finally, examines whether either proposed construction of the Exclusion leads to an “absurd” or irrational outcome, so as to be inconsistent with the parties' presumed intent. See *World Trade Ctr. Props., L.L.C.*, 345 F.3d at 184. Neither construction fails under this standard.

The Insureds are correct that XL's construction would put insureds in jeopardy of losing the insurance protection for which they bargained, because they could, as here, suddenly lose their professional liability coverage deep into a litigation if it later came

to light that a renegade employee had once engaged in (but never disclosed) misconduct that gave rise to the litigation. Insureds' Br. 7 (“XL's position is that if anyone insured under a policy like the one at issue here—even a secretary in a corporation with thousands of employees—knows of facts that might give rise to a valid claim, then coverage is barred for all other insureds even though none of them knew, should have known, or even *could* have known such facts.”).^{FN17} And, under the Insureds' construction, an insurer could still (on other grounds) exclude a malefactor, such as Adondakis, from coverage. The Insureds' construction thus clearly realizes a rational outcome.

On the other hand, as cases like *Gluck, MDL Capital Management*, and *Shapiro* hold, valid purposes can be served by prior knowledge exclusions, and they are not inherently against public policy. These cases explain that such exclusions are simply a “bargained for” method of limiting the insurer's exposure based on pre-Policy events, *Gluck*, 680 F.Supp.2d at 418, and that, while their operation may seem draconian in certain circumstances, “there is nothing unconscionable or inequitable about [an] exclusionary clause [...] contained in [a] contract,” just as “there is no legal barrier to the making of contracts of insurance that would protect innocent insureds against loss of coverage because of the fraud of another.” *Shapiro*, 584 F.Supp. at 1253. Other cases have similarly upheld clearly-worded prior knowledge exclusions. See, e.g., *XL Specialty Ins. Co. v. Agoglia*, Nos. 08-cv-3821 et al., 2009 U.S. Dist. LEXIS 36601 (S.D.N.Y. Mar. 2, 2009), *aff'd sub nom Murphy v. Allied World Assur. Co. (U.S.)*, 370 F. App'x 193 (2d Cir.2010) (summary order). Thus, XL's construction cannot be condemned, either, as yielding an absurd result or one contrary to public policy.^{FN18}

*20 For the above reasons, the Court holds that the Insureds have demonstrated that there are sufficiently serious claims going to the merits on the question of whether the Prior Knowledge Exclusion in XL's Policy is ambiguous as applied here.^{FN19}

E. Does XL Have A Duty to Advance Defense Costs Prior to a Final Ruling?

[16] In an alternative argument, Level Global asserts that, even if it cannot justify preliminary relief based on its claim of ambiguity as to the Exclusion,

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
 (Cite as: 2012 WL 2138044 (S.D.N.Y.))

an injunction is merited because XL has a duty to advance defense costs until a court has decided with finality that there is no coverage. Insureds' Br. 20–23; Insureds' Reply 8–9.

The Insureds' broad argument that an insurer has an invariable duty under New York law to advance defense costs pending resolution of a dispute the applicability of an exclusion is unconvincing. There is indeed a line of cases requiring an insurer, unless the policy language is to the contrary, to advance defense costs until the insurer's attempt to *rescind* a policy has been adjudicated to conclusion. *See, e.g., Worldcom*, 354 F.Supp.2d at 463 (collecting cases); *Wedtech*, 740 F.Supp. at 221. However, the Court has not located comparable authority setting out a background norm of mandatory advancement where the parties dispute not the existence of a binding policy but whether a particular claim is covered, as opposed to excluded, under it. On the contrary, many cases hold, or state, that advancement is required only when a claim is covered, *see, e.g., Kozlowski*, 18 A.D.3d at 42, 792 N.Y.S.2d 397 (citing *Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Ambassador Grp.*, 157 A.D.2d 293, 556 N.Y.S.2d 549 (1st Dep't 1990), *lv. dismissed*, 77 N.Y.2d 873, 568 N.Y.S.2d 915, 571 N.E.2d 85 (1991)), and that is, of course, the subject of the dispute here.

This distinction is important. As the *Worldcom* court aptly explained, where an insurer pursues the dramatic remedy of voiding a contract *ab initio*, it is appropriate that advancement continue until a neutral arbiter has resolved this dispute. *See* 354 F.Supp.2d at 463. But the calculus is different when an insurer's basis for non-payment is that a claim is not covered by its policy. Mandating advancement while even dubious assertions of coverage are resolved would invite abuse. It would permit an insured to gain advancement, potentially for many months, of his or her costs in an underlying proceeding, until a court resolved claims as to coverage. This would be so even where the insured's claim to coverage was sketchy or even risible.

Imagine, for example, that in this case, Adondakis had sought advancement of the legal fees he has incurred following his guilty plea in the criminal case against him. (He has not.) Had XL disputed a duty to cover Adondakis based on the Prior Knowledge Exclusion, under the Insureds' argument, Adondakis

would have had the right to advancement pending a dispositive court ruling. The insurer in such circumstances would not have any assurance that it would later be able to claw back the costs it advanced to such an undeserving putative insured. XL is quite correct that such a rule of law would serve only to drive up the costs of insurance, by forcing insurers to internalize the cost to them of a materially increased volume of coverage litigation. Hg. Tr. 58–59. The contrary rule does not leave an insured at the insurer's mercy. Instead, it puts the onus on an insured who believes the insurer is disclaiming it in error, to seek relief, based on a credible claim of coverage, as the Insureds have done here.

*21 The two cases on which the Insureds principally rely are not to the contrary. In *Kozlowski*, the First Department substantially affirmed a judgment compelling the insurer to advance funds to pay for Kozlowski's defense. As the Insureds note, the court there stated that insurers are “required to make contemporaneous interim advances of defense expenses where coverage is disputed, subject to recoupment in the event it is ultimately determined no coverage was afforded.” 18 A.D.3d at 42, 792 N.Y.S.2d 397. Notwithstanding this broad language, however, *Kozlowski* does not stand for the proposition that there is invariably a duty to advance funds where coverage is disputed. Rather, as the court emphasized, Kozlowski's conduct spanned “both excluded and covered behavior,” and it was not possible to allocate defense costs, during the litigation, as between these “intertwined” categories. *Id.* at 41, 792 N.Y.S.2d 397. “Since this allocation cannot be made at this juncture,” the court held, the insurer was required to “pay all defense costs as incurred, subject to recoupment when Kozlowski's liabilities, if any, are determined.” *Id.* at 42, 792 N.Y.S.2d 397.

Although *Rigas* presents a closer question, it, too, is not determinative. First, the issue there was governed by Pennsylvania, not New York, law. ^{FN20} *See* 382 F.Supp.2d at 692. Second, the *Rigas* court relied substantially on language in the particular knowledge exclusion at issue, which, the court held, “could reasonably be read” to mean that the exclusion would “not ... operate until it is judicially determined” that the exclusion applied. *Id.* at 699. This ambiguity in the policy language was required to be read in favor of the insureds. *See id.* at 701 (“if an insurer wants the unilateral right to refuse a payment

--- F.Supp.2d ---, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

called for in the policy, the policy should clearly state that right"). Third, *Rigas* arose in a quirky procedural posture. As the court noted several times, the insureds were covered by a potentially-lengthy bankruptcy stay, which was likely to prevent the court, until after the insureds' criminal trial was over, from adjudicating with finality whether the exclusion applied. See *id.* at 700. The court noted, as a "public policy factor," that the insureds were presumed innocent in that case, *id.*, and this consideration appears to have been relevant to its analysis.

The Court is also unpersuaded by the Insureds' argument that their exclusion in this case is tantamount to rescinding the Policy, because, during the Policy's pendency, Level Global made no other claims on XL. The happenstance of whether unrelated claims were made on the Policy is irrelevant to the Insureds' rights in this case. The exclusion vs. rescission calculation turns instead on the insurer's stated basis for denying coverage, and here, XL relies exclusively on the Exclusion in the Policy.

Finally, the Court notes, the Insureds have not pointed to language in the Policy that would support, or at least arguably support, their claim of a duty to advance pending a judicial determination of whether the Exclusion applies. See *Rigas*, 382 F.Supp.2d at 692; *Axis Reinsurance Co.*, 2008 U.S. Dist. LEXIS 53921, at *5-10.

F. Does XL Have A Duty, Based on the Insureds' Reliance, to Reimburse Defense Costs Which the Insureds Incurred Before March 5, 2012?

*22 Notwithstanding its conclusion that there is no broad duty to advance costs while the applicability of an exclusion is litigated, the Insureds may have a separate, much narrower, claim available to them, based on the events in this case. The outlines of this claim emerged at the hearing in this case. If valid, it would entitle the Insureds to advancement of either all or part of the sum remaining to be advanced on the XL Policy.

As it acknowledged at argument, XL learned of Adondakis's guilty plea "within a couple of days" of its being unsealed (January 18, 2012). It appears, however, that at no point between then and March 5, 2012, more than six weeks later, did XL even notify the Insureds that it was considering invoking the Exclusion, even though, by its own account, XL was,

from that point forward, actively doing so. Hg. Tr. 62-64; *id.* at 80.^{FN21}

During this interim period, the Insureds doubtless incurred substantial defense costs. Importantly, these would have included Anthony Chiasson's defense costs during the possibly-pivotal first six-plus weeks of his defense of the Criminal Action, filed contemporaneously with the unsealing of Adondakis's guilty plea, and his and Level Global's defense costs in the SEC Action, filed the same day. Although the record does not address this issue, it is reasonable to assume that, during this six-week period, XL well knew or appreciated that the Insureds were incurring significant defense costs on the Government Actions, and that Chiasson in particular was mobilizing his defense at a critical juncture. The parties agree that the defense expenses which the Insureds had collectively accrued on the Government Actions as of March 5, 2012, but which XL has not advanced, exceed the approximately \$2.7 million remaining on XL's Policy. Hg. Tr. 9-11, 64. The record does not reflect the total amount of unpaid defense expenses accrued as of March 5, 2012, nor the amount of such expenses accrued (1) through January 18, 2012, when Adondakis's guilty plea became public; and (2) between January 18, 2012 and March 5, 2012. See Hg. Tr. 80.

[17] Under these circumstances, the Insureds may well have a substantial claim, based on detrimental reliance on XL, for advancement of the Insureds' defense costs incurred either (1) up until March 5, 2012, or, more narrowly, (2) between January 18, 2012, and March 5, 2012. Such a claim might conceivably be based on, *inter alia*, general principles of promissory estoppel or principles specific to insurance law.^{FN22} Conceivably, the Insureds may also have a claim to the same end based on the language of the Agreement.^{FN23}

It is premature for the Court to resolve this claim. The parties did not brief it. Nor have they presented the Court with agreed-upon potentially relevant facts, or, alternatively, taken relevant discovery.

In the event that XL elects not to appeal the Court's Order mandating advancement, there will be no occasion to address this claim at this time. If, however, an appeal of that Order is to be taken, it is proper and efficient that this claim be resolved expe-

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

ditionally, so that the Court's order with respect to them can be subject to the same appeal.

*23 The Court, accordingly, directs the parties to meet and confer within five days of the date of this Order, to (1) identify agreed-upon assumed facts relevant to this claim, or, failing agreement, identify discovery to be taken forthwith on relevant factual issues that are disputed; and (2) set a schedule for briefing on these discrete issues, under which all briefing is to be completed within 21 days of the date of this Order. If this issue is to be litigated, the parties are directed to submit to the Court a proposed Order addressing discovery and briefing as soon as possible, and in all events, within 10 days of the date of this Order.

III. Security Bond

Federal Rule of Civil Procedure 65(c) provides: "The court may issue a preliminary injunction or a temporary restraining order only if the movant gives security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained." This Rule "thus allows a preliminary injunction to become effective only upon the applicant's posting of an amount that the district court determines adequate." *Worldcom*, 354 F.Supp.2d at 469 (quoting *Corning Inc. v. PicVue Electronics, Ltd.*, 365 F.3d 156, 158 (2d Cir.2002)). However, it is in the discretion of the district court to decide that, under the circumstances, no security is required. *Worldcom*, 354 F.Supp.2d at 469; see also *ASA v. Pictometry Int'l Corp.*, 757 F.Supp.2d 238, 247 (W.D.N.Y.2010); *Rex Medical L.P. v. Angiotech Pharms. (US), Inc.*, 754 F.Supp.2d 616, 626 (S.D.N.Y.2010).

XL has requested that, if the Insureds are granted advancement of defense costs pending resolution of XL's declaratory judgment action, they be compelled to post a security bond for such costs. The Court denies this request. Advancing defense costs does not place an undue hardship on XL, because its liability is capped under the Policy at the remaining \$2.7 million. In addition, the Policy requires defense costs to be repaid if the Insureds are ultimately not entitled to such payments, and XL is at liberty, upon such a determination, to pursue repayment from the individual Insureds as well as Level Global. See *Worldcom*, 354 F.Supp.2d at 469.^{FN24} Finally, the posting of a secu-

rity bond, and the attendant dislocations of doing so, would undermine the very protection that XL's professional liability policy offered to the Insureds, particularly the individual Insureds, when they purchased that Policy. Cf. *Worldcom*, 354 F.Supp.2d at 470 (declining to order insured to post a bond for a preliminary injunction); *Pendergest-Holt v. Certain Underwriters at Lloyd's of London*, 681 F.Supp.2d 816, 835 (S.D.Tex.2010) (same).

CONCLUSION

For the foregoing reasons, the Insureds' motion for a preliminary injunction is granted. XL is ordered to resume the advancement of defense costs. To permit XL the opportunity to consider its appellate options, however, this Order will be stayed for 14 days, after which point, barring further order of this Court, this stay will terminate. The Clerk of Court is directed to terminate the motion at docket number 4.

*24 As noted in § II.F of this Order, the Court has identified a potential alternative ground for relief, based on what may have been the Insureds' detrimental reliance on XL. The Court directs counsel to meet and confer, on the schedule it has set forth herein, with respect to (1) developing the facts needed to resolve the issues relevant to this alternative ground, and (2) setting an expedited briefing schedule, consistent with the dates set forth herein. See pp. 42-44, *supra*. However, if XL decides not to appeal, there will be no need for expedited attention to these issues.

SO ORDERED.

^{FN1}. The following account of the facts is drawn from the Complaint ("Compl.") (Dkt.1) and the exhibits thereto; the parties' briefs on the instant motion (Dkt.5, 19, 23); the Declaration of Shawn Naunton in Support of Defendants' Motion for a Preliminary Injunction ("Naunton Deck") and the exhibits thereto (Dkt.6); the Declaration of Brett Goodman in Opposition to Defendants' Motion for a Preliminary Injunction ("Goodman Deck") and the exhibits thereto (Dkt.20); the Complaint in *SEC v. Spyridon Adondakis et al.*, No. 12-cv-409 (S.D.N.Y.2012) ("SEC Compl."); the Indictment in *United States v. Todd Newman et al.*, No. 12-cr-121 (S.D.N.Y. Feb. 7, 2012) ("Ind't"); the In-

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

formation filed by the United States Attorney's Office against Adondakis ("Adondakis Inf'n"); and counsel's factual representations at the May 10, 2012 hearing in this case ("Hg.Tr").

FN2. See, e.g., Peter Lattman and Azam Ahmed, *Insider Inquiry Pivots Its Focus To Hedge Funds*, N.Y. Times, Feb. 9, 2011, at A1 ("Government investigators have been increasingly examining hedge fund traders' use of so-called expert network firms. These research firms are essentially matchmakers, connecting hedge funds with employees at public companies and other specialists who are paid to provide the funds with insight into their businesses and industries"); David S. Hilzenrath and Jia Lynn Yang, *The Federal Dragnet on Wall Street's Inside Game*, WASHINGTON POST, Feb. 13, 2011, at G1 ("The current wave of investigations has focused largely on hedge funds—investment vehicles for wealthy individuals and institutional investors that often deliver outside returns. It also has cast a spotlight on employees of public companies who allegedly feed information to investment firms for a price—sometimes through 'expert network firms' that specialize in matching insiders with traders.").

FN3. The SEC charged Adondakis, alongside Level Global and Anthony Chiasson, in the lawsuit it filed that same day.

FN4. XL has acknowledged that, at the time it terminated advancement, it knew that the Insureds would respond by moving for injunctive relief. Hg. Tr. 65.

FN5. Although XL's opposition brief was silent on the subject, at argument, XL conceded the point:

The Court: Putting aside the scale of the irreparable harm, I take it you are not disputing that there is irreparable harm to the insureds, here, are you?

Mr. Duchelle: We are not raising that defense on this motion.

The Court: And what about the balance of the equities?

Mr. Duchelle: We are not raising that defense on this motion.

Hg. Tr. 65–66.

FN6. The Court uses the term "subject" in the vernacular, not the technical sense used in the United States Attorney's Manual. The record does not disclose whether the government has classified the Insureds under that Manual, or, if so, how (e.g., witnesses, subjects, or targets). Hg. Tr. 16–17.

FN7. See January 18, 2012 Press Release, available at <http://www.justice.gov/usao/nys/pressreleases/January12/newmantoddetailcharges.html> (last visited May 30, 2012). As described by the government, that inquiry, known as Operation Perfect Hedge, focuses "on a circle of research analysts at different investment firms who obtained Inside Information directly or indirectly from employees who worked at public companies, and then shared it with each other and with the Hedge Fund portfolio managers for whom they worked." *Id.*

FN8. Level Global itself is no longer actively managing investor funds or rendering investment advisory services. It is today essentially "in runoff." Hg. Tr. 19 (representation by Level Global's counsel); *id.* at 71 (XL's counsel, not disputing this). It is unclear to what extent Level Global, were it unable to call upon its D & O policies to pay defense costs, would be able to fund the defense of a protracted investigation or prosecution.

FN9. As the Honorable Lewis A. Kaplan has chronicled, the cost of defending complex cases of white-collar crime in the era of electronic discovery can be astronomical. The defense of Sanjay Kumar, former CEO of Computer Associates, against securities fraud charges cost nearly \$15 million; the

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

defense of Dennis Kozlowski, former CEO of Tyco International, spanning two trials, cost more than \$25 million; the defense of John Rigas and his sons, former executives of Adelphia Communications, cost \$25 million; the defense of Richard Scrushy of Health South, spanning two trials, against charges, *inter alia*, of bribery and extortion cost \$32 million; and the defense of Kenneth Lay and Jeff Skilling, of Enron, cost \$25 million and \$70 million, respectively. See United States v. Stein, 495 F.Supp.2d 390, 424 (S.D.N.Y.2007).

FN10. The insurance carriers responsible for the additional layers of coverage have not, to date, asserted that provisions akin to XL's Prior Knowledge Exclusion preclude them from advancing defense costs. See Hg. Tr. 12.

FN11. As XL correctly observed at the hearing, see Hg. Tr. 47, "if the language of [an] insurance contract is ambiguous ... the parties may submit extrinsic evidence as an aid in construction, and the resolution of the ambiguity is for the trier of fact." State v. Home Indem. Co., 66 N.Y.2d 669, 671, 495 N.Y.S.2d 969, 486 N.E.2d 827 (1985); see also Green Harbour Homeowners' Assn., Inc. v. Chicago Title Ins. Co., 74 A.D.3d 1655, 1658, 905 N.Y.S.2d 304 (3d Dep't 2010). Only if the extrinsic evidence fails to cure the ambiguity, must "the ambiguity ... be resolved against the insurer which drafted the contract." State, 66 N.Y.2d at 671, 495 N.Y.S.2d 969, 486 N.E.2d 827; see also Green Harbour Homeowners' Assn., 74 A.D.3d at 1658, 905 N.Y.S.2d 304. At this preliminary stage, however, XL has not identified the extrinsic evidence that it proposes to bring to bear. Accordingly, for purposes of this motion, the Court must construe any ambiguity in the Policy in favor of the Insureds, without prejudice to XL's right to adduce extrinsic evidence as the case progresses.

FN12. The parties agree that only Adondakis' s knowledge is relevant to this motion. The Court therefore disregards Adondakis's

claim that others at Level Global were complicit.

FN13. See also Gorman v. Consol. Edison Corp., 488 F.3d 586, 596 n. 9 (2d Cir.2007) ("canons of construction forbid contractual interpretations that lead to absurd results"); Bank Julius Baer & Co. v. Waxfield Ltd., 424 F.3d 278, 283 (2d Cir.2005); Vector Capital Corp. v. Ness Techs. Inc., No. 11-cv-6259, 2012 U.S. Dist. LEXIS 36847, at *8-9 (S.D.N.Y. Mar. 16, 2012) (under New York law, "a court should not interpret a contract in a manner that would be absurd, commercially unreasonable, or contrary to the reasonable expectations of the parties") (internal quotation marks omitted); Bank of N.Y. Trust, N.A. v. Franklin Advisers, Inc., 674 F.Supp.2d 458, 463-64 (S.D.N.Y.2009) ("[A]n interpretation that gives a reasonable and effective meaning to all of a contract is generally preferred to one that leaves a part unreasonable or of no effect.").

FN14. By contrast, the Prior Knowledge Exclusion is in boldface, but is not capitalized. Question 8.b is neither.

FN15. In arguing that "their" may refer to the signatory, not the proposed insureds, the Insureds note that, although historically used to refer to plural entities, "their" increasingly has been pressed into use as a gender-neutral singular pronoun. This is especially so in contexts, like form documents, in which the gender of the future referent is unknowable in advance. Insureds Reply 4-5; see also Oxford English Dictionary, available at <http://www.oed.com/view/Entry/200291?redirectedFrom=their#eid> (last visited June 12, 2012) (stating, of the pronoun "their": "Often used in relation to a singular n[oun] or pronoun denoting a person ... Also so used instead of 'his or her', when the gender is inclusive or uncertain."); Free Merriam-Webster Dictionary, available at <http://www.merriam-webster.com/dictionary/their?show=0&t=1337206803> (last visited June 12, 2012) (defining "their" as "his or her: his, her, its-

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
(Cite as: 2012 WL 2138044 (S.D.N.Y.))

used with an indefinite third person singular antecedent.”). See *Barney Greengrass, Inc. v. Lumbermens Mut. Cas. Co.*, 445 F. App'x 411, 414 (2d Cir.2011) (summ.order) (“Under New York law, insurance policies are read in light of ‘common speech’ and the reasonable expectations of a businessperson”) (quoting *Belt Painting Corp. v. TIG Ins. Co.*, 100 N.Y.2d 377, 383, 763 N.Y.S.2d 790, 795 N.E.2d 15 (2003)); see also *Ace Wire & Cable Co. v. Aetna Cas. & Sur. Co.*, 60 N.Y.2d 390, 398, 469 N.Y.S.2d 655, 457 N.E.2d 761 (1983).

FN16. The key is to delete the confusing clause “required to be disclosed.” For example: “Any claim arising from facts or circumstances known to any person proposed to be insured, whether or not that knowledge is shared by any other person proposed to be insured, is excluded from coverage for all insureds.” See Hg. Tr. 43.

FN17. At argument, Level Global's counsel represented that between 60 and 70 individuals at Level Global are covered by the Policy. Hg. Tr. 45.

FN18. To be sure, XL overstates its case in arguing that the Prior Knowledge Exclusion here was necessary to accomplish its goal of insuring only against “fortuitous losses,” as opposed to losses based on circumstances that predate the Policy. See Hg. Tr. 48; XL's Br. 9–11. The same goal can be achieved, more cleanly, by a “prior acts” exclusion, on which exclusion is triggered by revelation of pre-Application events or misconduct, rather than revelation of any insureds' knowledge. Such exclusions are clearly permissible. See *Axis Reinsurance Co. v. Bennett*, Nos. 07–cv–7924, 08–cv–3242, 2008 U.S. Dist. LEXIS 47697, at *52–54, 2008 WL 2485388 (S.D.N.Y. June 18, 2008) (Lynch, J.); *Champlain Enters. v. Chubb Custom Ins. Co.*, 316 F.Supp.2d 123, 127–29 (N.D.N.Y.2003); *Hugo Boss Fashions, Inc. v. Fed. Ins. Co.*, No. 98–cv–6454, 1999 U.S. Dist. LEXIS 22462, at *2–4 (S.D.N.Y. Nov. 20, 1999). And the Prior Knowledge Exclusion here only partially achieves XL's stated

goal of not insuring against claims based on pre-application events. The Exclusion would not apply, for example, if the only persons who knew the “fact” or “circumstance” giving rise to a potential claim were not among those “proposed for insurance.” See, e.g., Hg. Tr. 55–56 (conceding that Exclusion would not be triggered if the person who had previously been aware of the problematic fact or circumstance was deceased at the time the policy was issued).

FN19. The Court is unpersuaded by the Insureds' alternative argument that Condition K renders the Policy ambiguous as applied. In asserting that the Prior Knowledge Exclusion excludes the Government Actions, XL has not imputed the knowledge of one insured to another, as Condition K prohibits. Instead, XL is claiming that, under the language of that Exclusion, Adondakis's knowledge alone operates to exclude the Government Actions. Further, on its face, Condition K is addressed to XL's right to rescind based on falsehoods or inaccuracies in the application, not to Policy exclusions. Condition K states that the Policy was “issued in reliance of the truth” of Level Global's representation “that the statements and particulars contained in the Application are true, accurate and complete”; it addresses XL's right to “void,” *i.e.*, rescind, the Policy based on untruthful statements in the Application. In that context, Condition K protects against rescission those Insureds who were unaware of untruths or inaccuracies in the Application, by limiting rescission to “Insureds who had actual knowledge of the untruth [or] in any material respect knew of such untruth.” See *Am. Int'l Specialty Life Ins. Co. v. Towers Fin. Corp.*, No. 94–cv–2727, 1997 U.S. Dist. LEXIS 22610, at *33–34 (S.D.N.Y. Sept. 12, 1997); *Wedtech*, 740 F.Supp. at 218; *cf. In re HealthSouth*, 308 F.Supp.2d at 1284–85; *Agoglia*, 2009 U.S. Dist. LEXIS 36601, at *40–42. XL has not sought to rescind the Policy here as to the Insureds, and assuming *arguendo* as the parties have that the defendant Insureds were all unaware of Adondakis's crimes at the time of the Application, Condition K would bar XL from doing so.

--- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)
 (Cite as: 2012 WL 2138044 (S.D.N.Y.))

FN20. Although the Policy here does not have an express choice of law provision, it references New York law in various places, *see, e.g.*, Naunton Decl. Ex. A at p. 2 (stating that policy forms “meet the minimum standards of the New York Insurance Law”), and the parties have treated the Policy as governed by New York law.

FN21. XL has not explained why it did not notify the Insureds of a possible disclaimer of coverage during this period. At argument, counsel for XL stated that it experienced difficulty obtaining Adondakis's plea allocation from the Clerk of Court, but that, despite knowing the name of the assigned prosecutor from the outset, it did not call the USAO to obtain the allocation until “early to mid-February.” Hg. Tr. 62–63.

FN22. In the context in which an insurer provides a defense to the insured, under New York law, the insurer may be estopped from disclaiming coverage where it has unreasonably delayed in doing so, and where that delay has prejudiced the insured. “As a general rule, where an insurer defends an action on behalf of its insured with knowledge of a defense to the coverage, it is thereafter estopped from asserting that the policy does not cover the claim.” *Nat'l Indem. Co. v. Ryder Truck Rental*, 230 A.D.2d 720, 721, 646 N.Y.S.2d 169 (2d Dep't 1996) (citation omitted). “The recognition of such an estoppel has as its basis the detrimental reliance suffered by the insured in the loss of the right to control its own defense.” *Id.*; *see also Yoda, LLC v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 88 A.D.3d 506, 508, 931 N.Y.S.2d 18 (1st Dep't 2011); *Topliffe v. U.S. Art Co., Inc.*, 40 A.D.3d 967, 970, 838 N.Y.S.2d 571 (2d Dep't 2007); *Federated Dep't Stores, Inc. v. Twin City Fire Ins. Co.*, 28 A.D.3d 32, 39, 807 N.Y.S.2d 62 (1st Dep't 2006); *cf. Phila. Indem. Ins. Co. v. City of New York*, No. 09-cv-10432, 2011 U.S. Dist. LEXIS 31318, at *22 (S.D.N.Y. Mar. 24, 2011). Under this line of cases, the “prejudice” required to estop an insurer from disclaiming may be found where “the in-

surer's control of the defense [was] such that the character and strategy of the lawsuit can no longer be altered.” *Yoda, LLC*, 88 A.D.3d at 508, 931 N.Y.S.2d 18; *Federated Dep't Stores*, 28 A.D.3d at 39, 807 N.Y.S.2d 62. The role of XL here is plainly more limited than in these cases (funding of defense costs, not provision of a defense). So, too, however, is the relief sought by the Insureds (re-payment of defense costs incurred in reliance on the expectation of coverage).

FN23. *Cf. Axis Reinsurance Co.*, 2008 U.S. Dist. LEXIS 53921, at *15–16 (quoting *Rigas*, 382 F.Supp.2d at 701) (“if an insurer ‘wants the unilateral right to refuse a payment called for in the policy, the policy should clearly state that right’”).

FN24. Because Level Global is presently in runoff, to the extent XL might seek to recoup the outlays made to XL as opposed to individual Insureds, XL might need to pursue Level Global's partners individually. Hg. Tr. 20.

S.D.N.Y., 2012.
 XL Specialty Ins. Co. v. Level Global Investors, L.P.
 --- F.Supp.2d ----, 2012 WL 2138044 (S.D.N.Y.)

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Only the Westlaw citation is currently available.

United States District Court,
E.D. Arkansas,
Western Division.
PLATTE RIVER INSURANCE COMPANY, Plain-
tiff,
v.

BAPTIST HEALTH, and as interested parties, Dr. Bruce E. Murphy And Bruce E. Murphy, M.D., P.A., Dr. Scott L. Beau and Scott L. Beau, M.D., P.A., Dr. David C. Bauman and David C. Bauman, M.D., P.A., Dr. D. Andrew Henry and D. Andrew Henry, M.D., P.A., Dr. David M. Mego and David M. Mego, M.D., P.A., Dr. William A. Rollefson and William A. Rollefson, M.D., P.A., Dr. Paulo Ribeiro and Paulo Ribeiro, M.D., P.A., Little Rock Cardiology Clinic, P.A. and Dr. Janet R. Cathey, Defendants.

No. 4:07cv0036 SWW.
April 17, 2009.

West KeySummaryInsurance 217  2998

217 Insurance217XXIV Avoidance217XXIV(B) Particular Kinds of Insurance217k2998 k. Liability Insurance. MostCited Cases

Health services provider made a material misrepresentation on its application for directors and officers insurance coverage in answering that it knew of no pending legal matters. Therefore, the insurance policy was void ab initio and rescinded as if it were never in effect. The hospital had recently passed an economic conflicts of interest policy (ECIP) that restricted clinical privileges for staff members that had interests in other medical facilities. This policy was the subject of at least four legal challenges at the time the health provider answered questions on the insurance application. The question answer had a substantial impact on the acceptance of the risk and to the hazard assumed by the insurance company the ultimately approved the policy unknowingly.

Jim L. Julian, Chisenhall, Nestrud & Julian, P.A.,

Little Rock, AR, Karen Ventrell, Whitney Lindahl, Troutman Sanders LLP, Washington, DC, for Plaintiff.

Steven W. Quattlebaum, Bradley G. Dowler, E. B. Chiles, IV, Quattlebaum, Grooms, Tull & Burrow PLLC, Janet L. Pulliam, Benjamin David Brenner, Williams & Anderson, PLLC, Little Rock, AR, for Defendants.

MEMORANDUM AND ORDER

SUSAN WEBBER WRIGHT, District Judge.

*1 Platte River Insurance Company (“Platte River”) brings this action against Baptist Health, a nonprofit corporation that operates hospitals in Arkansas, seeking a declaratory judgment that there is no coverage under an insurance policy it issued to Baptist Health for three underlying actions (collectively, the “Underlying Actions”) filed against Baptist Health arising out of its adoption and implementation of an Economic Conflicts of Interest Policy (“ECOI Policy”), commonly referred to as “economic credentialing.” Platte River seeks a determination that Baptist Health was required but failed to disclose information that adoption of an ECOI Policy may lead to claims against it and did in fact lead to the Underlying Actions. Platte River asserts the following claims in its complaint: that the Underlying Actions are not covered by virtue of Baptist Health's misrepresentations in the applications submitted to Platte River; that the prior knowledge exclusion in the insurance policy bars coverage for any loss, including defense expenses, incurred in connection with the Underlying Actions; and that Baptist Health's retention of defense expenses previously advanced by Platte River in connection with the Underlying Actions constitutes unjust enrichment.

Baptist Health, in turn, has filed a counterclaim seeking a declaration that the insurance policy issued by Platte River is valid and enforceable, that it provides coverage for the Underlying Actions, and that Platte River is obligated to pay defense expenses on a current basis. Baptist Health also seeks reimbursement from Platte River for Baptist Health's defense expenses incurred in connection with the Underlying Actions, claiming that Platte River breached its obligations under the insurance policy by failing to reim-

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(Cite as: 2009 WL 2015102 (E.D.Ark.))

burse Baptist Health on a current basis for its defense expenses.

The matter is before the Court on cross-motions of Platte River and Baptist Health for summary judgment [doc.# 's 33, 36]. Responses to these motions have been filed and Baptist Health has filed a reply to Platte River's response to its motion for summary judgment. Having carefully considered the matter, the Court grants Platte River's motion for summary judgment and denies Baptist Health's motion for summary judgment.^{FN1}

^{FN1}. The Court deferred ruling on these motions pending a settlement conference before a Magistrate Judge that proved unsuccessful. Following that settlement conference, the Court, by Order dated November 25, 2008, granted a motion and supplemental motion of interested parties Dr. Bruce E. Murphy, Bruce E. Murphy, M.D., P.A., Dr. Scott L. Beau, Scott L. Beau, M.D., P.A., Dr. David C. Bauman, David C. Bauman, M.D., P.A., Dr. D. Andrew Henry, D. Andrew Henry, M.D., P.A., Dr. David M. Mego, David M. Mego, M.D., P.A., Dr. William A Rollefson, William A. Rollefson, M.D., P.A., Dr. Paulo Ribeiro, Paulo Ribeiro, M.D., P.A., and Little Rock Cardiology Clinic, P.A. (the "LRCC defendants"), to unseal Baptist Health's amended answer and counterclaim and the summary judgment pleadings filed by Baptist Health. The LRCC defendants stated that they intended to file a response to Baptist Health's motion for summary judgment once it was unsealed and requested 30 days in which to do so. The Court granted the LRCC defendants' request and accordingly ordered that the LRCC defendants file their response to Baptist Health's motion for summary judgment within 30 days from the date of entry of Baptist Health's unsealed motion for summary judgment (as redacted by the Court) on the Court's public docket, which was December 18, 2008. The LRCC defendants never filed a response to Baptist Health's motion for summary judgment, however.

I.
A.

On May 22, 2003, the Baptist Health Board of Trustees adopted an ECOI Policy, or "economic credentialing policy." This policy provides that no physician who, directly or indirectly, acquires or holds an ownership or investment interest in a competing hospital shall be eligible to apply for initial or renewed appointment or clinical privileges in the professional staff of any Baptist Health hospital. The policy further requires that physicians disclose such financial interest, treats such interest as a "failure to meet preliminary eligibility requirements" for staff appointment or clinical privileges, and provides that a physician failing to meet such eligibility requirements is not entitled to any hearing or appellate review.

*2 After Baptist Health adopted the ECOI Policy, the following Underlying Actions were filed against Baptist Health challenging the ECOI Policy: *Bruce E. Murphy, M.D. et al. v. Baptist Health*, No. 4:04cv0011 (E.D.Ark.), later refiled as case No. CV-2004-2002, Circuit Court of Pulaski County, Arkansas (the "*Murphy* action"); *Little Rock Cardiology Clinic, P.A. et al. v. Baptist Health, et al.*, United States District Court for the Eastern District of Arkansas, Case No. 4:06cv001594 JLH (the "*LRCC* action"); and *Janet Cathey, M.D. v. Baptist Health*, Circuit Court of Pulaski County, Arkansas, Case No. CV-2005-5701 (the "*Cathey* action").

The *Murphy* action was filed by a group of cardiologists who held professional staff appointments at Baptist Health. These cardiologists, Doctors Murphy, Beau, Bauman, Henry, Mego and Rollefson, are shareholders of Little Rock Cardiology Clinic ("LRCC") and directly or indirectly hold an ownership interest in Arkansas Heart Hospital ("AHH"). As a result of such interest, application of the ECOI Policy to them would result in their not being eligible for staff appointment or clinical privileges at Baptist Health. In their lawsuit, the cardiologists asserted *inter alia* that Baptist Health's ECOI Policy violated federal anti-kickback and Medicaid statutes, Arkansas Medicaid Fraud and False Claims Act, and constituted tortious interference with their business relationships.^{FN2}

^{FN2}. The *Murphy* action was tried to the state court in March 2008. On February 27, 2009, the court issued a decision finding that Baptist Health's ECOI Policy violated public policy, tortiously interfered with contracts

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(Cite as: 2009 WL 2015102 (E.D.Ark.))

and business expectancies, and was an unconscionable trade practice under the Arkansas Deceptive Trade Practices Act. The court permanently barred Baptist Health from denying the plaintiff doctors professional staff appointment and clinical privileges on the basis of its ECOI Policy.

The LRCC itself subsequently filed suit against Baptist Health. The LRCC plaintiffs alleged in their action that Baptist Health and Arkansas Blue Cross and Blue Shield ("Blue Cross") engaged in anticompetitive acts including *inter alia* removing LRCC physicians from Blue Cross's provider networks, refusing AHH's repeated requests to be admitted into the Blue Cross network, and adopting and implementing the ECOI Policy to prohibit the LRCC plaintiffs from retaining staff privileges at Baptist Health.^{FN3}

FN3. The LRCC action was dismissed pursuant to Fed.R.Civ.P. 12(b)(6) on August 29, 2008, and has been appealed to the United States Court of Appeals for the Eighth Circuit.

Dr. Janet Cathey, a gynecologist, filed her action against Baptist Health seeking a declaration that the ECOI Policy was illegal and unconscionable and resulted in tortious interference with contract. Dr. Cathey had been advised by Baptist Health that her staff membership and clinical privileges at Baptist Health would be terminated because of her husband Dr. Steve Cathey's ownership of an interest in a competing hospital.^{FN4}

FN4. The Cathey action was settled by the parties. Having settled her action, interested party Dr. Cathey was dismissed from this action by Order of the Court pursuant to a stipulation of dismissal. The Court notes that the state court in the *Murphy* action found that Baptist Health's ECOI Policy violated policies that protect the institution of marriage given Baptist Health's attempt to bar Dr. Cathey on the basis of her husband's stake in a competing hospital.

B.

Prior to Baptist Health's adoption of the ECOI Policy, Baptist Health's CEO and President, Russell

Harrington ("Harrington") was aware that the Office of the Inspector General ("OIG") of the Department of Health and Human Services had in December 2002 issued a request for comments in response to an inquiry by the American Medical Association to issue guidance regarding the legality, under the federal anti-kickback laws, of credentialing practices based on economic criteria. Harrington asked Doug Weeks ("Weeks"), Senior Vice President and the administrator of Baptist Health Medical Center in Little Rock, to research economic credentialing or conflict of interest policies.

*3 By February 2003, this research was underway and Weeks reported on it at a February 11, 2003, meeting of the Executive Committee of the Baptist Health Board of Trustees. According to the minutes from that meeting:

Mr. Weeks initiated discussion on economic credentialing of physicians investing in specialty hospitals and research that is underway at other healthcare facilities that have instituted e-credentialing, centered around conflict of interest. Physicians who invest in specialty hospitals such as the proposed North Little Rock spine hospital would not be allowed to join the staff at BAPTIST HEALTH.... Prior to any discussion with physicians, e-credentialing must undergo legal review....

As part of his investigation, Weeks specifically obtained information regarding the experiences of several hospitals, including OhioHealth and Sioux Falls (South Dakota) with economic conflict of interest policies. Weeks was aware that courts had upheld economic conflict of interest policies adopted by hospitals in other states. Weeks testified that he was aware of "at least four cases throughout the nation which had been challenged in the courts" and "the courts in all four cases had determined that it was the right of the hospital to implement such a policy." Weeks discussed with Harrington his investigation of other hospitals' experiences with economic credentialing policies.

In addition to Weeks' investigation, Baptist Health retained outside counsel, Harold Simpson ("Simpson"), to draft an economic credentialing policy. Weeks provided Simpson with all the materials he had compiled on economic credentialing. Weeks testified that Baptist Health retained outside counsel

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(Cite as: 2009 WL 2015102 (E.D.Ark.))

because one of its concerns was to ensure that any economic credentialing policy adopted by Baptist Health did not violate anti-kickback laws or antitrust laws. Harrington likewise understood that Simpson was retained *inter alia* to undertake a legal review of an economic credentialing policy in the context of the anti-kickback laws.

Simpson attended a March 11, 2003, Executive Committee meeting during which the ECOI Policy was discussed and made the Executive Committee aware that courts had upheld economic conflict of interest policies that had been challenged in other jurisdictions.^{FN5} Harrington testified that although the Executive Committee can act on the Board's behalf, Harrington believed that it was appropriate to submit to the full Board the decision whether to adopt the ECOI Policy because it was a "major" and "significant" policy.

^{FN5}. Prior to the Executive Committee meeting, Weeks had seen a written legal review prepared by Simpson.

Following the March 2003 Executive Committee meeting, Harrington testified at an April 11, 2003, hearing held by the Federal Trade Commission ("FTC") and the Antitrust Division of the Department of Justice. Also testifying at this hearing was Dr. James J. Kane, Jr., CEO of AHH and LRCC. Concerning economic credentialing, Dr. Kane testified as follows:

Apparently word got out we were having this meeting, I got some calls from some of the orthopedic surgeons in town who are planning or have been planning to open an orthopedic specialty hospital, and it's upset, Mr. Harrington and others, to absolutely no end, and I only have one side of the story. The other side of the story is here, but the orthopedic surgeons tell me that the Baptist board has voted that if they open the hospital, they will be de-credentialed at Baptist Hospital. I don't know whether that's true or not, but perhaps we can pursue that.

*4 This has been done in other towns. Here's an article in one of the trade publications from Ohio where doctors opened a single specialty hospital and they were removed from the staff of the community hospital. So, it's not a-it's not Mr. Harrington's

idea or the Baptist Hospital's idea, it's been done in other places.

Now, this is how they can exert this sort of pressure. They've been amazingly successful.

Dr. Kane went on to express concern about the relationship or network developed between Baptist Health and Blue Cross and "this trend toward a single payor system that's closely allied with Baptist Hospital":

[F]rankly, where the B is for Baptist, you could substitute Blue. You might worry a little about what the M means. Now I'm not going to use any of the M words, ... but you have to worry a little bit about how large this system is getting ... We [AHH] worry about the dominance of segments of the market by the BlueCross/Baptist alliance. We fret because we're still excluded from the Arkansas BlueCross BlueShield providers, despite the fact that we have doctors who go to Baptist Hospital every day of the week and we have patients in Baptist Hospital every day of the week. We're concerned because other payors have left the state and ... [w]e're concerned now about what we might call economic credentialing. This is how working at a single specialty hospital might affect the doctor working there in terms of being credentialed at Baptist Hospital....

Harrington, in turn, stated:

... as of today, at least, we don't do economic credentialing, but I'm sure glad that Dr. Kane gave me the idea, because we're going to go back and look at it. I like to think of it more in terms of conflict of interest credentialing, or community credentialing. I think the purpose of it, as I've studied it, because a number of my colleagues were doing that, and court rulings have been supportive of it and the American Hospital Association has studied it and taken the right position, I believe.^{FN6}

^{FN6}. As indicated by his testimony, Harrington did not get the idea of economic credentialing from Dr. Kane but had been studying the issue prior to the FTC meeting and had previously attended meetings where such policies were discussed. Harrington also was aware of litigation that had challenged such policies and been upheld by courts.

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(Cite as: 2009 WL 2015102 (E.D.Ark.))

In a letter to Harrington dated April 26, 2003, Dr. John Wayne Smith, a member of Baptist Health's Board of Trustees, expressed concerns regarding the proposed ECOI Policy, including a concern whether the legalities of the ECOI Policy had been explored.^{FN7} Dr. Smith raised a concern that the policy would create a negative relationship between Baptist Health and physicians. Harrington understood Dr. Smith to be objecting to the ECOI Policy. Harrington responded in writing to Dr. Smith's letter, stating: "Of course we have checked the legal status of this proposal. It is being implemented at several hospitals across the country and courts have upheld hospitals' right to implement." Dr. Smith expected that Baptist Health would be sued as a result of the ECOI Policy.

FN7. Dr. Smith was not an actual voting member of the Baptist Health Board of Trustees when the ECOI Policy was adopted.

The minutes of the May 13, 2003, Executive Committee state that Harrington reported to the committee the concerns expressed by Dr. Smith and his response. The minutes go on to state that "[o]ther than the reference to Dr. Smith, there have been no real negatives expressed by members of the professional staff in that it has been stated that the policy does not apply to ambulatory centers or diagnostic centers and that the board has no intent for the policy to go beyond that of a competing hospital."

*5 At the May 22, 2003, meeting of the Baptist Health Board of Trustees, Weeks reported to the Board his understanding of the case law on economic conflict of interest policies. The minutes from that Board meeting state:

The steps taken in developing the policy were reviewed to include the studies of other institutions across the country where a similar policy has been implemented, legal review to include court upholding, and discussions with members of the professional staff leadership. Members of the professional staff have been assured that the policy does not go beyond that of a competing hospital....

By the time Baptist Health adopted the ECOI Policy at its May 22, 2003, Board of Trustees meeting, Weeks had prepared a document which identified by

name a number of physicians who may be affected by the ECOI Policy, including Doctors Murphy, Beau, Bauman, Rollefson, Mego, cardiologists affiliated with LRCC, as well as potential investors in a spine hospital, such as neurosurgeons Steve Cathey and Zach Mason. According to Harrington, Baptist Health adopted the ECOI Policy because it was "the right thing to do." When asked in the *Murphy* action if Baptist Health adopted the ECOI Policy "knowing that it could result in this lawsuit?," Harrington answered "Yes, sir."^{FN8}

FN8. In his affidavit submitted in support of Baptist Health's summary judgment papers, Harrington states that "[a]t no time prior to the lawsuit filed by Dr. Bruce Murphy against Baptist Health in February 2004 did I believe that it was likely that the ECOI Policy would result in any lawsuit, nor did I have knowledge that any other officer or director of Baptist Health believed that it was likely that the ECOI Policy would result in any lawsuit." Harrington Aff. at ¶ 3. Platte River subsequently moved to strike Harrington's affidavit as contradictory to his testimony given under oath in the *Murphy* action. By Order entered May 16, 2008, the Court denied Platte River's motion to strike Harrington's affidavit but stated that "upon consideration of the parties' motions for summary judgment," the Court "will take into account Platte River's contention that Harrington's affidavit contradicts his sworn testimony and give the affidavit its due weight, if any."

Following its adoption of the ECOI Policy, Baptist Health required physicians to complete forms disclosing any ownership interest in any competing hospital. In August 2003, Doctors Beau, Bauman, Rollefson and Mego returned their forms to Baptist Health, indicating that they had read the ECOI Policy and did hold ownership interest in a competing hospital. However, the forms signed by each of these doctors and returned to Baptist Health had blacked out the following statement on the form that they were required to sign and acknowledge:

I understand and agree that, if I hold such an interest [in a competing hospital], I am ineligible to apply for, reapply for, or hold Appointment and

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(Cite as: 2009 WL 2015102 (E.D.Ark.))

Clinical Privileges and, accordingly am not entitled to any hearing or appellate review rights upon denial.

These same doctors filed suit when Baptist Health sought to deny them privileges pursuant to the ECOI Policy.

Harrington and Weeks both testified that Weeks received complaints from certain physicians who had concerns about the ECOI Policy-Weeks testified he specifically recalled two physicians that were not in favor of the ECOI policy-and Dr. Janet Cathey testified that Weeks said Baptist Health was "expecting probably about 20 other lawsuits over ... [the] policy." Weeks, however, testified that his "recollection of that comment, based on 20 lawsuits, is that if we didn't apply that [ECOI Policy] fairly and equally, that certainly the people who had been affected by the policy so far might-you know, might be upset with the fact that we didn't apply it equally and fairly based on the way the policy was written."

C.

Before December 16, 2003, Baptist Health had directors and officers liability insurance coverage through Executive Risk Indemnity, Inc. ("Executive Risk"). This policy-Directors, Officers and Trustees Liability Insurance Including Healthcare Organization Reimbursement Policy Number 8168-7661 (the "ERII Policy")-was issued by Executive Risk to Baptist Health for the coverage period December 16, 2002, to December 16, 2003.^{FN9} Kim Lloyd ("Lloyd") was the underwriter with the ERII Policy. Lloyd joined Executive Risk in 1998 as an underwriter for insurance coverage in the healthcare industry.^{FN10} Ramsey Krug Farrell & Lensing ("Ramsey Krug") was one of 30 insurance brokers assigned to Lloyd's geographic territory at Chubb, and Lloyd performed the underwriting function on applications that came to Chubb through Ramsey Krug, including Baptist Health's applications.

^{FN9} Chubb Specialty Insurance Company ("Chubb") purchased Executive Risk in 1999. Nevertheless, Executive Risk "paper" continued to be used at Chubb.

^{FN10} Prior to joining Executive Risk, Lloyd worked for six years as a recreational therapist.

*6 In August 2003, Lloyd left her employment with Chubb and went to work for Darwin Professional Underwriters, Inc. ("Darwin") as a senior underwriter for insurance coverage in the healthcare industry. Darwin serves as an underwriter and claims handler for certain insurance companies, including Platte River. When Lloyd went to work at Darwin, it was a start-up company, having been founded in March 2003, less than six months before Lloyd went to work there.

At her previous employment, Lloyd had been one of 150 to 200 underwriters in the company and one of 35 to 40 underwriters in the healthcare area alone. Darwin, however, had only about 16 total employees. Lloyd was the only senior underwriter for healthcare in the entire company, the only other underwriter for healthcare in the company working in connection with medical-malpractice coverage. Only two other employees worked in the healthcare area in any capacity.

Lloyd used rating plans in her previous employment, which she describes as a process of entering in information regarding an account and developing a summary that relates what the premium for insurance coverage should be based on the factors entered regarding the account. The methodology included a combination of manual rates and a computer worksheet. When Lloyd went to work at Darwin, there was no specific training. However, Lloyd states she had five years of experience in health care underwriting at Executive Risk/Chubb and received specific training in Health Care D & O and Managed Care E & O underwriting while there. She states she used a rating plan at Darwin similar to the rating plan used at Executive Risk/Chubb and neither company had any other written underwriting guidelines, directives, or manuals for health care professional lines insurance.

Although Darwin initially had no written underwriting guidelines, Lloyd and another former Chubb employee, Paul Romano ("Romano"), developed rating plans based on the manual rates used at Chubb and did not involve the computer program used at Chubb. Lloyd testified that the rating plans used at Darwin and Chubb were an "industry commonality" and that "[i]t wasn't an actual technology platform of any sort, it was applying debits and credits based on

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(Cite as: 2009 WL 2015102 (E.D.Ark.))

the underwriter's call." It was not until sometime in approximately 2007 that Darwin instituted lengthy written underwriting guidelines.

Darwin hired people to market the new start-up company to brokers and attempt to obtain their business, and Lloyd provided Ramsey Krug's name to those people. In October 2003, two months after Lloyd went to work at Darwin, Ramsey Krug submitted to Darwin an application for directors and officers insurance coverage on behalf of Baptist Health. Darwin did not initially have its own application for healthcare directors and officers liability insurance company and Baptist Health submitted to Darwin a renewal application for directors and officers insurance from Executive Risk.^{FN11} The submission included the renewal application for directors and officers liability insurance from Executive Risk (the "ERII Application") and also a copy of the ECOI Policy in response to a question on the ERII Application asking, "Has there been any change in the Applicant's peer review and credentialing processes within the last year?"

FN11. Darwin did not finish developing its own application for healthcare directors and officers coverage until sometime later in 2004.

*7 The ERII Application was signed by Harrington on July 28, 2003, and contained the following question and answer:

22. No **Entity** nor any individual proposed for coverage is aware of any fact, circumstance, situation, transaction, event, act, error, or omission which they knew or should reasonably have known may result in a claim that may fall within the scope of the proposed insurance, except as follows. If answer is "None," so state:

None.

The ERII Application then set forth a "Prior Knowledge Exclusion":

Without prejudice to any other rights and remedies of the Underwriter, it is agreed that any claim arising from any fact, circumstance, situation, transaction, event, act, error or omission required to be

disclosed in response to Question 22 is excluded from the proposed insurance.

Lloyd testified that she would "guess" that the prior knowledge question requires an applicant "to use their judgment as to what's a known circumstance" but that "[she's] not a lawyer" and "can't answer how somebody else interprets the wording that signed the application."^{FN12}

FN12. Baptist Health represents that Lloyd "*admits* that the prior knowledge question *requires* 'the applicant to exercise the applicant's judgment about what information should or should not be disclosed' " (emphasis added), but Lloyd's testimony, as just noted, was not so unequivocal as Baptist Health represents.

Lloyd states she reviewed Baptist Health's submission (noting that Romano would not have) but that she didn't know how much in detail and was not confident that she read every page of the submission. In this respect, Lloyd cannot recall whether she did any specific evaluation of the risk associated with the ECOI Policy attached to the ERII Application and that the first time she heard the term "economic credentialing" was in this case.

In connection with Baptist Health's application for insurance, Lloyd prepared an "underwriting worksheet" that reflected the thought process behind her evaluation of the risk associated with providing insurance coverage to Baptist Health. The underwriting worksheet did not reference the ECOI Policy. The "executive summary" section of the underwriting worksheet provided as follows: "Summary of Underwriters thoughts on D & O Risk (include strengths & weaknesses of organization, your assessment of key exposures and the rationale for your proposal)". Lloyd indicated that the Baptist Health application was brokered by Ramsey Krug, with which she had "a great deal of success ... in the past." She wrote that Ramsey Krug was frustrated with Chubb and was looking to move all of its business to Darwin, and that Baptist Health was "one of the largest D & O Healthcare accounts" Ramsey Krug had. Lloyd predicted that "[i]f we can get this one they will give us looks at all of their business."^{FN13}

FN13. Baptist Health states Lloyd's execu-

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(Cite as: 2009 WL 2015102 (E.D.Ark.))

tive summary included none of the information called for by the underwriting worksheet but Platte River states the underwriting worksheet speaks for itself and notes as well that Lloyd testified regarding the rating, premium, and other information included on the underwriting worksheet.

At the bottom of the underwriting worksheet, Lloyd noted that Darwin was “manuscripting the Chubb expiring policy to match coverage.” ^{FN14} Lloyd ultimately determined that Baptist Health was a “good risk” for Platte River, concluding the insurance premium that would be received-nearly \$100,000-was good from the insurance company’s perspective.

^{FN14}. As previously noted, Darwin did not have a directors and officers insurance policy it could use and so it incorporated language from the directors and officers policy Chubb previously issued to Baptist Health to create a directors and officers policy to issue to Baptist Health that matched the coverage Chubb provided.

In November 2003, Lloyd provided a quote for Baptist Health’s directors and officers insurance coverage and forwarded to Ramsey Krug the Chubb policy Darwin had manuscripted. Lloyd also sent to Ramsey Krug a blank application Darwin had developed for for-profit organizations, even though Baptist Health was admittedly a not-for-profit organization, because Darwin had no application for non-profit companies.

*8 Having received the information in the ERII Application and the materials submitted to Darwin, Platte River provided a premium quotation coverage subject to certain terms and conditions. After communications between Platte River and Baptist Health’s insurance broker, Platte River agreed to bind coverage effective December 16, 2003, subject to Platte River’s receipt of certain documents, including a completed application by Darwin (“Darwin Application”) signed and dated by Baptist Health.

Baptist Health submitted the Darwin Application signed by Allen F. Smith (“Smith”), a Senior Vice President of Baptist Health, on December 31, 2003. The Darwin Application states *inter alia* that the un-

dersigned declares, to the best of his knowledge and belief after diligent inquiry, that the statements set forth in and attached to the Darwin Application are true.

Smith had attended meetings of Baptist Health’s Senior Leadership Team, Executive Committee, and Board of Trustees at which economic credentialing and the ECOI Policy were discussed. The Darwin Application contained the following question and answer:

Does anyone for whom insurance is intended have any knowledge or information of any act, error, omission, fact or circumstance which may give rise to a Claim which may fall within the scope of the proposed insurance? Yes No

The Darwin Application then set forth the following “Prior Knowledge Exclusion”:

IT IS UNDERSTOOD AND AGREED THAT, WITHOUT LIMITING ANY RIGHTS OF THE UNDERWRITER, IF SUCH KNOWLEDGE OR INFORMATION EXISTS, ANY CLAIM ARISING THEREFROM IS EXCLUDED FROM THIS PROPOSED INSURANCE.

The Darwin Application also states:

IT IS UNDERSTOOD THAT THE STATEMENTS IN THIS APPLICATION, INCLUDING MATERIALS SUBMITTED TO OR OBTAINED BY THE UNDERWRITER ARE MATERIAL TO THE ACCEPTANCE OF RISK, AND RELIED UPON BY THE UNDERWRITER.

The ERII Application signed by Harrington was among the materials submitted to Darwin.

Having received the ERII Application and the materials submitted to Darwin, and subject to Platte River’s receipt of the Darwin Application, Platte River issued Directors, Officers and Trustees Liability Insurance Including HealthCare Organization Reimbursement Policy Number 0303-0461 (the “Policy”) to Baptist Health for the claims made policy period December 16, 2003, to December 16, 2004.

Not Reported in F.Supp.2d, 2009 WL 2015102 (E.D.Ark.)
(Cite as: 2009 WL 2015102 (E.D.Ark.))

This was the first healthcare directors and officers liability insurance policy bound by Darwin.

D.

In February 2004, the *Murphy* action was filed. Approximately two weeks later, by letter dated February 25, 2004, coverage counsel for Platte River, John Duchelle (“Duchelle”), communicated with Baptist Health concerning the *Murphy* action. In his letter, Duchelle *inter alia* acknowledged receipt of the complaint in the *Murphy* action, identified potential coverage issues, and asked to be kept apprised of all significant developments in the litigation.

In August 2004, Baptist Health sought to renew its insurance coverage and Lloyd noted on the executive summary on her underwriting worksheet that “[i]f the account continues to grow and reflect the claim history that it has today we will need to re-evaluate the desire for us to maintain this size of a risk in our book of business.” Lloyd stated that Darwin’s healthcare directors and officers business had by that time grown to nearly a million dollars but that she was not sure of the exact number. Darwin renewed the Policy for the period December 16, 2004, to December 16, 2005.

*9 In April 2005, the *Cathey* action was filed. As a result of the *Murphy* and *Cathey* actions, Lloyd notified Baptist Health that the Policy would not be renewed. Lloyd stated that it was because of the claims that the decision was made not to renew the Policy and that this decision was reached in a “round-table.”

Following the filing of the *Murphy* and *Cathey* actions, Baptist Health and its attorneys communicated with Platte River regarding these actions, including providing Platte River with estimates of expenditures and status updates for the *Murphy* and *Cathey* actions. Baptist Health provided its last update in the *Murphy* and *Cathey* actions to Platte River on June 19, 2006.

By letter dated June 27, 2006, Duchelle notified Baptist Health that there were issues regarding prior knowledge allegedly not disclosed on the applications. Duchelle noted *inter alia* that Platte River had recently been supplied with a copy of the Third Amended Complaint in the *Cathey* action which he stated “demonstrate[d] that Baptist Health was appar-

ently intent on adopting the Conflict of Interest Policy as early as February 2003.” Duchelle further stated that “[w]e also recently learned that Russell D. Harrington, then CEO of Baptist Health, and James J. Kane, Jr., M.D., CEO of Arkansas Heart Hospital and Little Rock Cardiology Clinic, participated in April 2003 in hearings on competition law and policy in the health care industry that were sponsored by the Federal Trade Commission and the Department of Justice” and that “[w]e understand Dr. Kane raised the issue of ‘Economic Credentialing’ during those hearings and that he in fact formally objected to what he described as Baptist Health’s ‘threat’ to employ such a policy against Arkansas Physicians who were considering opening allegedly competing hospitals.” Duchelle stated that “[i]n view of Dr. Kane’s statements during the above-referenced April 2003 hearings, which took place well before the inception of the Policy on December 16, 2003, Darwin respectfully reserves the right to deny coverage for these Claims to the extent any insured had knowledge or information, prior to December 31, 2003, of the facts and circumstances which could-and ultimately did-give rise to the Claims.”

In November 2006, the *LRCC* action was filed. Baptist Health subsequently submitted to Platte River written requests for reimbursement of defense expenses incurred in the Underlying Actions. ^{FN15}

FN15. The Policy provides that Platte River “will pay on behalf of the **Insured Entity Loss** from **Claims** first made against it during the **Policy Period.**” The Policy defines “**Loss**” to include “**Defense Expenses,**” and provides that Platte River “shall, upon written request by an **Insured,** pay on a current basis **Defense Expenses** which are otherwise payable under this Policy ...”

In December 2006, Platte River decided to decline coverage under the Policy for the Underlying Actions but did not communicate that decision to Baptist Health at that time. Rather, Platte River sought a legal review of the ECOI Policy undertaken by Baptist Health that was referenced in the May 22, 2003, minutes of the Baptist Health Board of Trustees that Baptist Health claimed was privileged. Platte River stated that it would be willing to enter into a confidentiality agreement if necessary to obtain the review. Apparently, no such agreement was en-

Not Reported in F.Supp.2d, 2009 WL 2015102 (E.D.Ark.)
(Cite as: 2009 WL 2015102 (E.D.Ark.))

tered into and Platte River claims that Baptist Health declined to provide a copy of that legal review in whole or in part.

*10 On January 17, 2007, Platte River denied coverage under the Policy for the Underlying Actions and declined to continue to advance defense expenses. Platte River filed this complaint for declaratory judgment that same day after which Baptist Health filed its counterclaim for declaratory judgment and breach of contract.

II.

Platte River moves for summary judgment on grounds that the Policy is void, or alternatively that it has no duty to indemnify Baptist Health for the claims asserted against it in the Underlying Actions. Platte River argues Baptist Health made misrepresentations in its application for insurance which were relied upon by Platte River in determining whether to accept the risk and that under Arkansas law, these material misrepresentations render the Policy void as a matter of law and vitiate coverage for the Underlying Actions. Platte River additionally argues that as an independent ground for denying coverage, the prior knowledge exclusion contained in the application and incorporated into the Policy operates to bar coverage for the Underlying Actions, and as a result, Baptist Health was not entitled to payment of defense expenses advanced by Platte River, and must reimburse such advancements to Platte River.

Baptist Health, in turn, moves for summary judgment on the following grounds: the undisputed facts demonstrate that Baptist Health made no misrepresentation and show that Platte River cannot prove that any alleged misrepresentation was material; Platte River cannot establish that the Policy contained a prior knowledge exclusion and, assuming that the prior knowledge exclusion was incorporated into the Policy, the undisputed facts demonstrate that Baptist Health did not have knowledge sufficient to trigger application of the prior knowledge exclusion; as Platte River's misrepresentation and prior knowledge exclusion claims fail, the Policy provides coverage for the Underlying Actions and Baptist Health was entitled to the advancement of defense expenses; and as the undisputed facts show that the Policy provides coverage for the Underlying Actions, Platte River breached the Policy by declining such coverage.

A.

Summary judgment is appropriate when “the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.” Fed.R.Civ.P. 56(c). As a prerequisite to summary judgment, a moving party must demonstrate “an absence of evidence to support the non-moving party's case.” Celotex Corp. v. Catrett, 477 U.S. 317, 325, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). Once the moving party has properly supported its motion for summary judgment, the non-moving party must “do more than simply show there is some metaphysical doubt as to the material facts.” Matsushita Elec. Indus. Co. v. Zenith Radio, 475 U.S. 574, 586, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986). The nonmoving party may not rest on mere allegations or denials of his pleading, but must “come forward with ‘specific facts showing that there is a *genuine issue for trial.*’” Id. at 587 (quoting Fed.R.Civ.P. 56(e) and adding emphasis). See also Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 256, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). The inferences to be drawn from the underlying facts must be viewed in the light most favorable to the party opposing the motion. Matsushita, 475 U.S. at 587 (citations omitted). However, “[w]here the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no ‘genuine issue for trial.’” Id. (citation omitted). “Only disputes over facts that might affect the outcome of the suit under the governing law will properly preclude the entry of summary judgment.” Anderson, 477 U.S. at 248. “Factual disputes that are irrelevant or unnecessary will not be counted.” Id.

B.

*11 Resolution of the claims in the parties' motions for summary judgment center on Question 22 on the ERII Application and Question 6 on the Darwin Application and Baptist Health's answers to those questions. Before addressing those claims, however, the Court first addresses Baptist Health's argument that the Darwin Application is not part of the Policy and its argument that the prior knowledge questions in the ERII Application and the Darwin Application are ambiguous.

1.

Not Reported in F.Supp.2d, 2009 WL 2015102 (E.D.Ark.)
(Cite as: 2009 WL 2015102 (E.D.Ark.))

Baptist Health argues that given the documents produced by Platte River in this litigation, it does not appear that the Darwin Application was physically attached to the Policy as the Policy requires and that the Darwin Application therefore was not incorporated into the Policy. The Policy provides:

The **Insureds** represent that the particulars and statements contained in the **Application** are true and agree that (1) those particulars and statements are the basis of this Policy and are to be considered incorporated into and constituting part of this Policy; (2) those particulars and statements are material to the acceptance of the risk assumed by the Insurer; and (3) this Policy is issued in reliance upon the truth of such representations....

As used in the Policy, “ ‘Application’ means the application attached to and forming part of this Policy, including any materials submitted therewith, which are on file with the Insurer and are a part of the Policy, as if physically attached.”

Baptist Health acknowledges the Darwin Application is included with the Policy that was filed with the complaint for declaratory judgment and Baptist Health does not identify anything indicating that the submission of the underwriting materials, including the Darwin Application and the ERII Application, in a certain order or Platte River's production of the underwriting materials in a certain order is of any legal significance in these circumstances. Baptist Health knew that prior knowledge was an issue at least as early as the June 2006 Duchelle letter, and it is undisputed that Platte River agreed to bind coverage subject to Platte River's receipt of certain documents, including a completed Darwin Application signed and dated by Baptist Health, and that the particulars and statements in the Darwin Application are the basis of the Policy and are to be considered incorporated into and constituting part of the Policy. Baptist Health does not contend that it did not already have the Darwin Application it completed, signed and provided to Platte River, and Baptist Health understood that the statements in the Darwin Application, including materials submitted to or obtained by the underwriter, were material to the acceptance of the risk and relied upon by Darwin. Baptist Health thus was on notice that the Darwin Application was to be considered part of the Policy and the Court finds that the Darwin Application and, as well, the

ERII Application are in these circumstances incorporated into the Policy. *Cf. Cutter & Buck, Inc. v. Genesis Ins. Co.*, 306 F.Supp.2d 988, 997-98 & n. 3 (W.D.Wash.2004) (where policy stated that “information contained in and submitted with this application is on file with the insurer and along with the application ... is considered physically attached to the policy and will become part of it,” insured had “unequivocal notice” that certain items that were not actually physically attached to the policy were relied upon in issuing policy).^{FN16}

^{FN16.} Ark.Code Ann. § 23-79-119(a) requires that an insurance contract is to be construed “according to the entirety of its terms and conditions as set forth in the policy and as amplified, extended, or modified by any rider, endorsement, or application made part of the policy.” See *American Pioneer Life Ins. Co. v. Allender*, 18 Ark.App. 234, 713 S.W.2d 249, 251-52 (1986).

2.

*12 The Court now turns to Baptist Health's argument that the two prior knowledge questions-Question 22 on the ERII Application and Question 6 on the Darwin Application-are ambiguous. Baptist Health seemingly is making two separate, although related, arguments concerning ambiguity: first, that the language differs significantly between the two prior knowledge questions making it uncertain what level of probability is required to trigger a duty to respond affirmatively to one or both of these questions; and second, Question 6 of the Darwin Application contains subjective language (unlike Question 22 on the ERII Application) and the Court therefore should apply a subjective standard to the question. The Court will address these arguments in turn.

i.

Claiming that the language differs significantly between the two applications-“which they knew or should reasonably have known may result in a claim” (Question 22 on the ERII Application) and “may give rise to a claim” (Question 6 on the Darwin Application)-Baptist Health argues that the language is susceptible to more than one interpretation and, thus, ambiguous. Baptist Health argues the Court should therefore interpret the application questions to ask whether the insured knows a claim “likely” or “probably” will result.

Not Reported in F.Supp.2d, 2009 WL 2015102 (E.D.Ark.)
(Cite as: 2009 WL 2015102 (E.D.Ark.))

If language of the policy is unambiguous, courts will give effect to the plain language of the policy without resorting to the rules of construction. Elam v. First Unum Life Ins. Co., 346 Ark. 291, 57 S.W.3d 165, 169 (2001). On the other hand, if language of the policy is ambiguous, courts will construe the policy liberally in favor of the insured and strictly against the insurer. *Id.* “Language is ambiguous if there is doubt or uncertainty as to its meaning and it is fairly susceptible to more than one reasonable interpretation.” *Id.* The intent of the parties is to be determined from the whole context of the agreement, and the courts must consider the instrument in its entirety, not merely disjointed or particular parts of it. Nash v. American Nat. Property & Cas. Co., 98 Ark.App. 258, 254 S.W.3d 758, 760 (2007). Whether language of the policy is ambiguous is ordinarily a question of law to be decided by the court. Castaneda v. Progressive Classic Ins. Co., 357 Ark. 345, 166 S.W.3d 556, 561 (2004).^{FN17}

^{FN17}. However, when the parties go beyond the contract and submit disputed extrinsic evidence to support their proffered definitions of the term, this is a question of fact for the fact finder and summary judgment is not proper. McGrew v. Farm Bureau Mut. Ins. Co. of Arkansas, Inc., 371 Ark. 567, 268 S.W.3d 890, 896 (2007). Here, both parties agree that the question of ambiguity may be resolved by the Court on summary judgment.

The Court determines that the prior knowledge questions in the ERII Application and Darwin Application do not contain significantly different language from one another, thereby creating uncertainty as to what level of probability is required to trigger a duty to respond affirmatively. Rather, both questions ask for knowledge of any facts or circumstances that “may result in a claim” (the ERII Application) or “may give rise to a claim” (the Darwin Application). The prior knowledge inquiry in each question is clear and is followed by a plainly worded statement that any claim resulting from Baptist Health’s knowledge of facts or circumstances is excluded from coverage. The Court does not, as argued by Baptist Health, interpret these questions to create confusion as to when disclosure is required, for example when claims “possibly may result,” “likely may result,” or “probably may result,”^{FN18} and other courts have determined that policy provisions requiring notice of occurrences that “may result in” or “may give rise” to a claim are not ambiguous. *See, e.g., LaForge v. American Cas. Co. of Reading, Pennsylvania*, 37 F.3d 580 (10th Cir.1994) (provision requiring written notice of an occurrence “which may subsequently give rise to a claim being made against the Directors and Officers ... for a Wrongful Act” not ambiguous); Elrod v. P.J. Pierre Marine, Inc., 663 So.2d 859 (La.App.1995) (policy provision requiring prompt notice by the insured to the insurer of any “occurrence which may result in a claim under this Policy” not ambiguous); Morgan and Bro. Manhattan Storage Co., Inc. v. GRE Ins. Group, 220 A.D.2d 236, 632 N.Y.S.2d 17 (N.Y.A.D. 1 Dept.1995) (plaintiff’s obligation to give defendant written notice of “every loss, damage or occurrence which may give rise to a claim under this policy” is not rendered ambiguous by policy provision authorizing plaintiff to itself adjust any claim for less than \$750). Accordingly, the Court rejects Baptist Health’s argument that the language is susceptible to more than one interpretation and, thus, ambiguous.^{FN19}

^{FN18}. In support of this assertion, Baptist Health cites Stratford School District v. Employers Reinsurance Corporation, 105 F.3d 45 (1st Cir.1997). In *Stratford*, the ambiguity was the result of contrasting language in the policy (“could in the future result”) and in the application (“probability of a claim or action”). 105 F.3d at 47. The First Circuit determined that reading the policy along with the application questionnaire, it was unclear what matters were excluded: those that *possibly* could result, those that *reasonably* could result, or those that *probably* could result. *Id.* (emphasis in original). There is no such contrasting language in the Policy in this action, however, and *Stratford* thus is distinguishable. Baptist Health also argues the policy language could be interpreted to require disclosure when claims “reasonably may result” but that question goes more to whether the prior knowledge questions are to be judged under an subjective or objective standard, which will be addressed below.

^{FN19}. Baptist Health also cites International

Not Reported in F.Supp.2d, 2009 WL 2015102 (E.D.Ark.)
(Cite as: 2009 WL 2015102 (E.D.Ark.))

Surplus Lines Ins. Co. v. University of Wyoming Research Corporation, 850 F.Supp. 1509 (D.Wyo.1994), *aff'd* 52 F.3d 901 (10th Cir.1995), in arguing this Court should “interpret the phrases ‘may result in’ and ‘may give rise to’ in the prior knowledge questions ... as ‘likely to result in’ and ‘likely to give rise to.’” “The court in *International Surplus* did note that “may” is defined as “in some degree likely to.” *Id.* at 1522 (citing *Websters Third New International Dictionary*, at 1396). But this definition by its terms presupposes something that is less than likely, *i.e.* “some degree,” and the terms “may” and “likely” thus are not synonymous as Baptist Health argues. In this respect, stating that something “may” happen is “used to express possibility,” *see* *Websters Unabridged Dictionary* (2nd ed.) at 1189, which common sense dictates is less certain or forceful than something that is “likely” to happen, “likely” being defined as “probably or apparently destined” or “seeming like truth, fact, or certainty.” *See id.* at 1114. For this reason, Baptist Health’s alternative argument that the Court should interpret the application questions to ask whether the insured knows a claim “likely may result” or “probably may result” would arguably render those questions ambiguous.

ii.

*13 The question remains whether the prior knowledge questions are to be judged under an objective or subjective standard. Most of the courts considering the issue have adopted the objective approach. *American Special Risk Management Corp. v. Cahow*, 286 Kan. 1134, 192 P.3d 614, 624 (2008) (collecting cases). “Generally, these decisions focus upon the fact the ‘prior knowledge’ clause includes the phrase ‘reasonably foreseeable,’ ‘reasonably believe,’ or similar language.” *Id.* Some courts, however, have applied the objective standard even without any reasonably foreseeable language in the insurance policy. *Id.* (citing *International Ins. Co. v. Peabody Intern. Corp.*, 747 F.Supp. 477, 482 (N.D.Ill.1990) (question on insurance application asking whether insured was “‘aware of any circumstances, occurrence or condition ... which may result in the ... assertion of a claim’ “ was deemed to be objective, not subjective); *Ratcliffe v. Int’l Surplus Lines Ins. Co.*, 194 Ill.App.3d 18, 141 Ill.Dec. 6, 550

N.E.2d 1052 (1990) (prior knowledge clause providing for disclosure of “any circumstances which might give rise to a claim being made ...” held to require “disclosure of any facts which, objectively considered, might have given rise to a claim, regardless of the applicant’s subjective belief”)).

“Despite the widespread use of the objective standard, more recently some courts have chosen to apply exclusionary provisions according to an ‘intermediate’ standard utilizing a two-prong, subjective-objective test.” *Id.* Under this inquiry, courts first ask the subjective question of whether the insured knew of certain facts and then ask the objective question of whether such facts could reasonably have been expected to give rise to a claim. *Id. Cf. Westport Ins. Corp. v. Lilley*, 292 F.Supp.2d 165, 171 (D.Me.2003) (whether defendants could have reasonably foreseen malpractice claim is an objective test that can be determined as a matter of law, but it must be determined based only on those facts and circumstances that the defendants were subjectively aware of).

Here, Baptist Health’s knowledge of the facts pertinent to this action is essentially undisputed. Accordingly, the Court need not consider application of the intermediate, subjective-objective test, but need only determine whether the prior knowledge questions should be judged under a subjective or objective standard.

Baptist Health argues that Question 6 on the Darwin Application asks subjectively whether “anyone for whom insurance is intended ha[d] any knowledge or information of any act, error, omission, fact or circumstance which may give rise to a Claim....” Baptist Health argues that no language in this prior knowledge question raises the specter of an objective, reasonable person, and that the Court therefore should apply a subjective standard to the question.

It is true that some courts have held that language similar to that of Question 6 on the Darwin Application is judged under a subjective standard. *See, e.g., Chicago Ins. Co. v. Lappin*, 1998 WL 1181164 (Mass.Super.1998) (application question asking “[H]ave any new claims or circumstances which may result in a claim arisen in the past policy period?” cannot be construed as calling for more than an opinion, or a statement to the best of the appli-

Not Reported in F.Supp.2d, 2009 WL 2015102 (E.D.Ark.)
(Cite as: 2009 WL 2015102 (E.D.Ark.))

cant's knowledge and belief); *First American Title Ins. Co. v. Lawson*, 177 N.J. 125, 827 A.2d 230 (2003) (question asking whether an applicant "is aware of any circumstances which may result in a claim being made against the firm" called for subjective information). As previously noted, however, other courts have held that such language is judged under an objective standard. *International Ins. Co.*, 747 F.Supp. 477; *Ratcliffe*, 194 Ill.App.3d 18, 141 Ill.Dec. 6, 550 N.E.2d 1052. Having considered the matter, the Court will in these circumstances follow the majority position and apply the objective approach.

*14 Baptist Health does not dispute that Question 22 on the ERII Application contains objective "knew or should reasonably have known may result in a claim" language and Question 6 on the Darwin Application asks for the same information—that which "may give rise to a claim"—and should be judged under an objective standard as well. Question 6 calls for "any" knowledge or information of "any" act, error, omission, fact or circumstance which "may give rise to a claim," following which it is provided that if such knowledge or information exists, "any" claim arising therefrom is excluded from the proposed insurance. The plain language of the application, then, excludes coverage for *any* claim, regardless of merit, that an applicant could have reasonably foreseen at the time the policy issued and the policy language thus invokes an objective standard of foreseeability. *Cf. Culver v. Continental Ins. Co.*, 11 Fed.Appx. 42 (4th Cir.1999) (question for malpractice coverage asking "Does any attorney for whom coverage is sought know of any circumstance, act, error or omission that could result in a claim or suit against the applicant or any predecessor or any of the former or current members of the applicant?" excluded coverage for *any* claim, meritorious or otherwise, that an applicant could have reasonably foreseen at the time the policy issued, thereby invoking an objective standard of foreseeability).^{FN20} Accordingly, even were the Court to consider the language in Question 6 on the Darwin Application without reference to the objective language in Question 22 on the ERII Application, and it will not, see *Nash*, 98 Ark.App. 258, 254 S.W.3d at 760 (courts must consider the instrument in its entirety, not merely disjointed or particular parts of it); *Stratford*, 105 F.3d at 47 ("it makes business sense here to construe the exclusion clause together with the application questionnaire"), the Court would apply an objective standard to Question 6. *Cf.*

Home Indem. Co. Manchester, New Hampshire v. Toombs, 910 F.Supp. 1569 (N.D.Ga.1995) (answer to question asking "Does any lawyer ... know of any circumstances, acts, errors or omissions that could result in a professional liability claim against any attorney of the firm, the firm or its predecessors?" judged under objective standard); *Mt. Airy Ins. Co. v. Thomas E. Angst & Assoc., P. C.*, 954 F.Supp. 1040 (E.D.Pa.1997) (same).

FN20. The term "could," like "may," is "used to express possibility." Websters Unabridged Dictionary (2nd ed.) at 460.

The Eighth Circuit's decision in *Citizens Bank of Jonesboro, Arkansas v. Western Employers Ins. Co.*, 865 F.2d 964 (8th Cir.1989), does not dictate a contrary result. In *Citizens Bank*, the applicant had responded "No" to a question on the policy application asking if he was "aware of any fact, circumstance or situation which he has reason to believe might result in any future claim which would fall within the scope of the proposed insurance [.]" 865 F.2d at 965. The Eighth Circuit noted that in calling for the applicant's "belief" about whether any known fact or circumstance might give rise to a future claim, the question contained "a judgmental component and implicitly acknowledge[d] the lack of absolute certainty in the answer." *Id.* at 966. The Eighth Circuit focused on the fact that the question required a statement of personal belief, a statement which would be inherently subjective, and determined that "when a question calls for an answer based on an interpretation of known facts and circumstances, as distinguished from a simple disclosure of historical facts, the response is measured under Arkansas law by whether the individual answering the question was justified in the belief expressed." *Id.*

*15 In *Citizen's Bank*, there was no language raising the specter of an objective, reasonable person, *i.e.* the classic objective standard, see *American Special Risk*, 286 Kan. 1159, 192 P.3d at 624, whereas in this action, Question 22 on the ERII Application contains such objective language. Although Question 6 on the Darwin Application does not explicitly contain "reasonable person" language, it nevertheless does not call for a statement of personal belief or an "interpretation" of known facts as did the question at issue in *Citizens Bank*. Rather, Question 6, as previously noted, simply calls for disclosure of "any"

Not Reported in F.Supp.2d, 2009 WL 2015102 (E.D.Ark.)
(Cite as: 2009 WL 2015102 (E.D.Ark.))

knowledge or information of “any” act, error, omission, fact or circumstance which “may give rise to a claim,” thus invoking an objective standard of foreseeability. *Culver*, 11 Fed.Appx. at 45-46. ^{FN21} Accordingly, the Court finds *Citizen's Bank* to be distinguishable in these circumstances and it is an objective standard that will be applied to the prior knowledge questions.

FN21. Cf. *International Surplus Lines Ins. Co. v. Wyoming Coal Refining Systems, Inc.*, 52 F.3d 901 (10th Cir.1995) (clause providing that “No person proposed for insurance is cognizant of any fact, circumstance or situation which said person has reason to suppose might afford valid grounds for any future claim against said person and/or the Organization” is unambiguous and calls for a simple disclosure of facts indicating the probability of a covered claim; it calls for an objective assessment regardless of the subjective belief of the insured) (citing *Evanston Ins. Co. v. Security Assurance Co.*, 715 F.Supp. 1405, 1414 (N.D.Ill.1989)). But cf. *James River Ins. Co. v. Hebert Schenk, P. C.*, 523 F.3d 915 (9th Cir.2008) (question calling for circumstances of which lawyers were aware “may result” in a malpractice action fairly viewed as a matter of opinion) (citing *Citizen's Bank* as addressing “similar” language)); *Shaheen, Cappiello, Stein & Gordon, P.A. v. Home Insurance Company*, 143 N.H. 35, 719 A.2d 562 (1998) (provision in lawyer's professional liability policy requiring disclosure of any incident, act or omission which “might reasonably be expected to be the basis” of a claim or suit ambiguous in that it does not indicate whether notice to the insurer is required when all elements of a malpractice claim are present, or when, based on the parties and the circumstances, a malpractice claim on the merits is likely).

3.

Having resolved the question of ambiguity, the Court now turns to Platte River's claim that coverage for the Underling Actions is barred based on misrepresentations in Baptist Health's Application materials, specifically Baptist Health's answer “None” to Question 22 on the ERII Application and “No” to Ques-

tion 6 on the Darwin Application. To prevail on its claim that Baptist Health's answers were misrepresentations, Platte River has the burden of proving that Baptist Health made misrepresentations of material facts, the knowledge of which would have caused Platte River to decline to issue the Policy. *Ferrell v. Columbia Mut. Cas. Ins. Co.*, 306 Ark. 533, 816 S.W.2d 593, 597 (1991); *Brooks v. Town & Country Mut. Ins. Co.*, 294 Ark. 173, 741 S.W.2d 264, 265 (1987). Under Arkansas law, material misrepresentations made in an application for an insurance policy and relied upon by the insurance company will void the policy. *Countryside Cas. Co. v. Orr*, 523 F.2d 870, 872 (8th Cir.1975). See also *Neill v. Nationwide Mut. Fire Ins. Co.*, 355 Ark. 474, 139 S.W.3d 484, 487 (2003) (an insurance company may retroactively rescind a policy because of fraud or misrepresentation of the insured). “A misrepresentation is a statement of fact that is untrue or a failure to disclose a fact in response to a specific question.” *Shipley v. Arkansas Blue Cross and Blue Shield*, 333 F.3d 898, 904 (8th Cir.2003). The insurance company has no duty to investigate the accuracy of the facts set forth in the application and the good faith or lack of knowledge by the insured of the misrepresentations is irrelevant. *Twin City Bank v. Verex Assur. Inc.*, 733 F.Supp. 67, 71 (E.D.Ark.1990). See also *Countryside*, 523 F.2d at 873.

Baptist Health was specifically aware of the following facts and circumstances when it answered “None” to Question 22 on the ERII Application and “No” to Question 6 on the Darwin Application:

- ***16** • Baptist Health knew of legal challenges to at least four hospitals' economic credentialing policies and had investigated other hospitals' experiences with economic credentialing policies.

- Baptist Health was aware of OIG's solicitation of public comments on economic credentialing policies, which specifically sought comments regarding the legality of such policies under federal anti-kickback statutes—one of the grounds upon which the physicians eventually challenged Baptist Health's ECOI Policy.

- Baptist Health retained outside counsel to conduct a “legal review” of economic credentialing policies, which included research regarding the legalities of such a policy under federal and state

Not Reported in F.Supp.2d, 2009 WL 2015102 (E.D.Ark.)
(Cite as: 2009 WL 2015102 (E.D.Ark.))

law, including anti-kickback and antitrust laws, and courts upholding of other hospitals' policies.

- Baptist Health knew that Dr. Kane of LRCC and AHH expressed concerns about economic credentialing and the threat posed to LRCC by the ECOI Policy and the monopoly on the market he perceived to exist as the result of an allegiance between Blue Cross and Baptist Health.^{FN22}

FN22. Baptist Health states that nothing Dr. Kane said at the FTC hearing threatened litigation or raised concerns in Harrington's mind regarding the ECOI Policy. Dr. Kane did, however, clearly express concern about economic credentialing and Baptist Health's Board of Trustees voting to decredential certain surgeons if they opened a specialty hospital. Dr. Kane's expression of concern certainly does not appear to have been idle thought given the involvement of AHH and LRCC in the *Murphy* and *LRCC* actions, and Harrington later testified in the *Murphy* action that Baptist Health adopted the ECOI Policy knowing it "could" result in that lawsuit, even if he stated in his affidavit that at no time prior to that lawsuit did he believe it was "likely" that the ECOI Policy would result in any lawsuit. In any case, the standard here is not what Harrington subjectively believed, but whether a reasonable person would foresee that adoption of the ECOI Policy "may" result in or give rise to a claim.

- Baptist Health considered the ECOI Policy to be a "major" and "significant" policy such that it was appropriate to send it to the entire Baptist Health Board of Trustees for a vote rather than the Executive Committee.
- Concern was expressed to the Baptist Health Board of Trustees by Dr. Smith that the ECOI policy would create a negative relationship between members of the professional staff and the Board. Harrington viewed this concern as an objection to the Policy.
- Baptist Health had received complaints from certain doctors who had concerns about the ECOI Policy and Baptist Health had identified the doctors,

including the *Murphy* plaintiffs, who would be affected by the ECOI Policy. Several of those same doctors blacked out any agreement or acknowledgment of the ECOI Policy's attempt to abrogate their review and hearing rights regarding credentialing decisions.

Given these facts and circumstances known to Baptist Health, the conclusion that Baptist Health's answers to Question 22 on the ERII Application and Question 6 on the Darwin Application were misrepresentations seems inescapable. Baptist Health adopted the ECOI Policy knowing that similar policies adopted by other hospitals had led to litigation. A reasonable person would foresee that adoption of Baptist Health's ECOI Policy in these circumstances may or might result in or give rise to a claim. Claims were indeed filed and Harrington acknowledged that the ECOI Policy was adopted knowing that a claim could result. Baptist Health was not required to predict the precise nature of any such claim or specifically by whom the claim would be brought but it was required to notify Platte River that a claim may result in or arise out of its adoption of the ECOI Policy. *Tewell, Thorpe & Findlay, Inc. v. Continental Cas. Co.*, 64 Wash.App. 571, 825 P.2d 724, 728 (1992). This, Baptist Health failed to do. As the particulars and statements contained in the applications were by the terms of the Policy "material to the acceptance of the risk assumed by the Insurer" and acknowledged as such by Baptist Health's Senior Vice President (at least in terms of the Darwin Application, Smith stating he understood that Darwin would rely on the statements therein and materials submitted to or obtained by Darwin). Baptist Health's misrepresentations in Question 22 on the ERII Application and Question 6 on the Darwin Application were material to the acceptance of the risk and to the hazard assumed by Platte River. *Multi-Craft Contractors, Inc. v. Perico, Ltd.*, 96 Ark.App. 133, 239 S.W.3d 33, 42 (2006). See also Ark.Code Ann. § 23-79-107(a) ("[m]isrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under [a] policy or contract unless either: (1) Fraudulent; (2) Material either to the acceptance of the risk or to the hazard assumed by the insurer; or (3) The insurer in good faith would not have issued the policy or contract or would not have issued a policy or contract in as large an amount or at the same premium or rate or would not have provided coverage with respect to the hazard resulting in the loss if the facts had been made known to the insurer as re-

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(Cite as: 2009 WL 2015102 (E.D.Ark.))

quired by the application for the policy or contract or otherwise”).^{FN23}

FN23. Baptist Health argues that if it had subjectively believed that a claim would “likely” result from the ECOI Policy, reason dictates it would have reported that claim to Executive Risk under the following provision: “If during the Policy Period an insured first becomes aware of any circumstances which may subsequently give rise to a Claim against any Insured and, as soon as practicable thereafter but before the expiration or cancellation of the Policy, gives the Underwriter written notice by certified mail of such circumstances with full particulars of the specific Wrongful Act involved, then any Claim subsequently made against an Insured arising out of such Wrongful Act shall be deemed made during the Policy Period.” Again, however, the standard here is not what Baptist Health subjectively believed, but whether a reasonable person would foresee that adoption of the ECOI Policy “may” result in or give rise to a claim. Baptist Health certainly was aware of such circumstances, regardless of whether Baptist Health thought any such claim would fail.

*17 Platte River also argues Baptist Health falsely answered “No” to Question 11 on the ERII Application that asked, “Within the last year, has the Applicant closed or restricted staff admissions to any patient service department for reasons other than professional competence?” and falsely answered “No” to Question 16 on the ERII Application asking, “Has any Entity proposed for insurance retained outside counsel to provide an opinion as to whether or not a certain course of conduct would be in violation of ... the Physician Ownership and Referral Law (Stark Self-Referral Law) (42 U.S.C. § 1395 nn); the Medicaid/Medicare Civil Money Penalties (including false claims and kickbacks) (42 U.S.C. § 1320a-7a)...” Although Questions 11 and 16 on the ERII Application are not a central focus of the parties' motions for summary judgment, Baptist Health's answers to these questions are reflective of an apparent tendency on the part of Baptist Health to contort language to its own purposes.

Concerning Question 11, Baptist Health argues

that it was justified in answering “No” to this question because *inter alia* Baptist Health did not deny any application for privileges under the ECOI Policy until February 2, 2004, after the question had been answered. But when Question 11 was answered, Baptist Health had already adopted the ECOI Policy and had identified those doctors that would be affected by it. Baptist Health's explanation of its answer to Question 11 on this point is disingenuous.

Concerning Question 16, Baptist Health argues it was justified in answering “No” to this question because it referenced specific statutes, not generalized concepts like “anti-referral laws” and “anti-kickback statutes.” But Weeks testified that Baptist Health retained outside counsel because one of its concerns was to ensure that any economic credentialing policy it adopted did not violate anti-kickback laws or anti-trust laws, and Harrington likewise understood that outside counsel was retained *inter alia* to undertake a legal review of an economic credentialing policy in the context of the anti-kickback laws. Certainly, the statutes referenced in Question 16 would fall within the rubric of the matters for which outside counsel was retained to review, and Baptist Health's defense of its answer to Question 16 reflects a parsing of language that might properly be characterized as a misrepresentation.

Baptist Health, however, argues that any alleged misrepresentation was not material to the acceptance of risk. Noting that it provided the ECOI Policy to Platte River when it answered “yes” to a question asking “Has there been any change in the Applicant's peer review and credentialing process within the last year?” Baptist Health points out that Lloyd cannot recall whether she reviewed the ECOI Policy and stated that the first time she heard about economic credentialing was in this case. Baptist Health argues the ECOI Policy did not even register to Lloyd as an issue in her underwriting process and that Platte River was more interested in making sure it gained Baptist Health's business than in assessing the risk of insuring Baptist Health.

*18 Regardless of Lloyd's alleged lack of underwriting experience or that Darwin was a “start-up” company when she went to work there, the fact remains that Baptist Health selected Platte River for coverage, which in turn issued insurance to Baptist Health based on inaccurate and false information

Not Reported in F.Supp.2d, 2009 WL 2015102 (E.D.Ark.)
(Cite as: 2009 WL 2015102 (E.D.Ark.))

provided by Baptist Health.^{FN24} Baptist Health states that nothing prevented Platte River from researching economic credentialing policies or inquiring about Baptist Health's ECOI Policy which it disclosed to Platte River, but there is no affirmative duty in Arkansas upon an insurance carrier to make an independent investigation to ascertain the truthfulness of the facts as set forth in an insured's application, Countryside, 523 F.2d at 873; Twin City Bank, 733 F.Supp. at 71, and Lloyd had not heard of such policies until this litigation. It was Baptist Health's responsibility, as set forth in the prior knowledge questions, to alert Platte River to the fact that such a policy may result in or give rise to a claim based on the circumstances surrounding the adoption of the ECOI Policy. Instead, Baptist Health denied having any knowledge or information of circumstances that may result in or give rise to a claim and its answers to Question 22 on the ERII Application and Question 6 on the Darwin Application (and, likely, its answer to Question 16 on the ERII Application) thus were misrepresentations and material to the acceptance of risk.^{FN25} Accordingly, the Policy is void *ab initio* and rescinded as if it were never in effect. Ferrell, 306 Ark. 533, 816 S.W.2d at 597; Douglas v. Nationwide Mut. Ins. Co., 323 Ark. 105, 913 S.W.2d 277, 279 (1996).^{FN26}

^{FN24}. Of course, Lloyd's underwriting judgment cannot be considered without reference to the information which Baptist Health denied her.

^{FN25}. "Applications and information obtained from potential insureds may, out of practicality, be limited in scope," and "[u]nderwriters may strike a balance between gathering endless volumes of detailed information, on the one hand, and limiting initial information requests so as to be accessible and easy to work with, on the other. Cedar Hill Hardware and Construction Supply, Inc. v. Insurance Corporation of Hannover, No. 07-1026, slip. op. at 30-31 (8th Cir. Apr. 17, 2009). "As such, insurers and underwriters are entitled to rely upon the responses and information provided by potential insureds and to presume the insured has provided responses that are true and complete." *Id.* at 31 (decision under Missouri law).

^{FN26}. Were the Court to conclude that the prior knowledge questions asked whether Baptist Health knew of circumstances that "likely" or "probably" would result in a claim, and were the Court to apply a subjective standard to those questions, the Court, based on the same facts and circumstances set forth above, would determine that Baptist Health did in fact know of facts and circumstances that likely or probably would result in a claim and that Baptist Health was not justified in the belief expressed to the contrary.

4.

Even if the Court determined that Baptist Health's answers to Question 22 on the ERII Application and Question 6 on the Darwin Application were not misrepresentations, the Court would determine that the prior knowledge exclusion incorporated into the Policy operates to bar coverage for the Underlying Actions. Specifically, because Baptist Health had knowledge of facts and circumstances that a reasonable person would foresee may give rise to or result in a claim-regardless of Baptist Health's belief, unfounded as it turns out, that no claim would be filed or, if one were, that it would fail-, the failure to disclose those facts and circumstances triggered the prior knowledge exclusion providing that any claim resulting from Baptist Health's knowledge of facts or circumstances required to be disclosed is excluded from coverage. American Special Risk, 286 Kan. 1159, 192 P.3d at 630. *See also Professional Managers, Inc. v. Fawer, Brian, Hardy & Zatzkis*, 799 F.2d 218 (5th Cir.1986) (finding policy language providing that "no insured had knowledge of any circumstance which might result in a claim" at the effective date of the policy to be unambiguous and pointing out that "some information may be so clearly sufficient to instill knowledge to a party that a verdict to the contrary cannot stand").^{FN27}

^{FN27}. Baptist Health argues that most rational persons would not pursue costly litigation to mount a challenge that would probably fail and, given that courts uniformly had upheld economic conflict of interest policies in other states, Baptist Health reasonably did not anticipate any legal challenge here. But each action depends on facts

Not Reported in F.Supp.2d, 2009 WL 2015102 (E.D.Ark.)
(Cite as: 2009 WL 2015102 (E.D.Ark.))

and legal theories unique to it and the Court cannot say that the Underlying Actions were irrational simply because courts in other states have upheld economic conflict of interest policies. Certainly, the *Murphy* action cannot be said to have been pursued irrationally given the success achieved by the plaintiffs in that action. Moreover, actions that could be characterized as irrational or frivolous are routinely filed in courts and the prior knowledge questions at issue here ask for “any” knowledge or information which “may” result in or give rise to a claim, not just those claims that Baptist Health believes to have merit. In any case, the good faith or lack of knowledge by the insured of the misrepresentations is irrelevant, see *Twin City Bank*, 773 F.Supp. at 71, and Baptist Health's claim that it did not reasonably anticipate any legal challenge here is of no consequence. See *American Special Risk*, 286 Kan. 1159, 192 P.3d at 630 (“it is not necessary that the Bank have actually formed an expectation that a claim would be filed”); *Minn. Lawyers Mut. Ins. Co. v. Hahn*, 355 F.Supp.2d 104 (D.D.C.2004) (failure to give insurer notice of a letter identifying potential claim “cannot be excused by a well-founded belief in non-liability”).

5.

*19 The Court now turns to Platte River's claim that Baptist Health's retention of defense expenses previously advanced by Platte River in connection with the Underlying Actions constitutes unjust enrichment. Unjust enrichment is an equitable doctrine that allows a party to recover benefits conferred on another. *Ashley County, Ark. v. Pfizer, Inc.*, 552 F.3d 659, 665 (8th Cir.2009). To find unjust enrichment, a party must have received something of value, to which he was not entitled and which he must restore. *Guaranty Nat. Ins. Co. v. Denver Roller, Inc.*, 313 Ark. 128, 854 S.W.2d 312, 317 (1993). There must also be some operative act, intent or situation to make the enrichment unjust. *Id.* Unjust enrichment is restitutionary in nature and focuses on the benefit received. *Pfizer*, 552 F.3d at 665.

Although it is rudimentary that one who is free from fault cannot be held to be unjustly enriched

merely because one has chosen to exercise a legal or contractual right, *Denver Roller*, 313 Ark. 128, 854 S.W.2d at 317 (internal quotation marks and citation omitted), the advancement of defense expenses to Baptist Health was pursuant to a contract that was based on misrepresentations. As such, the Policy is void *ab initio*; Platte River had no duty to Baptist Health under the Policy, including the advancement of defense expenses, and Baptist Health's retention of those defense expenses would be unjust. Accordingly, Platte River is entitled to recover the amount of defense expenses advanced to Baptist Health under the Policy for the Underlying Actions. ^{FN28}

FN28. Baptist Health cites *Medical Liability Mut. Ins. Co. v. Alan Curtis Enterprises, Inc.*, 373 Ark. 525, 285 S.W.3d 233, 2008 WL 2205868 (2008), as barring Platte River from recouping defense expenses already reimbursed to Baptist Health. In *Medical Liability*, the Arkansas Supreme Court held that an insurer who obtained a declaratory judgment that it owed the insured no duty to defend or pay any judgment could not rely on its unilateral reservation of rights letter to the insured to recoup attorney fees and costs that it expended in defense of suit against the insured absent statutory rule or authority allowing an insurer to recoup attorney fees under a unilateral reservation of rights, of which there was none. The Arkansas Supreme Court in *Medical Liability* was not addressing an insurance contract that was void *ab initio* as a result of misrepresentations in procuring the policy. *Medical Liability* thus has no application to this case.

In addition, although the parties do not address the issue, the Court determines in these circumstances that because the Policy is void *ab initio* and rescinded as if it were never in effect, Baptist Health is entitled to a refund of the premiums tendered to and received by Platte River. Cf. *Monarch Life Ins. Co. v. Donahue*, 708 F.Supp. 674 (E.D.Pa.1989) (where insurance policy was voided for misrepresentations in application, insurer was obliged to refund premium and interest earned on the premium); *Douglass v. Nationwide Mutual Ins. Co.*, 323 Ark. 105, 913 S.W.2d 277, 282 (1996) (rescission of a contract at law occasioned by fraud may be accomplished without court action by prompt restoration of

Not Reported in F.Supp.2d, 2009 WL 2015102 (E.D.Ark.)
(Cite as: 2009 WL 2015102 (E.D.Ark.))

benefits to the contracting party and by a clear statement that rescission is intended).

6.

Finally, the Court denies Baptist Health's motion for summary judgment on its counterclaim seeking a declaration that the Policy is valid and enforceable, that it provides coverage for the Underlying Actions, and that Platte River breached the contract in connection with defense expenses incurred in the Underlying Actions. For the reasons stated previously, the Court determines that the Policy is void *ab initio* thus precluding Baptist Health's counterclaim; the Policy is rescinded as if it were never in effect. *Ferrell*, 306 Ark. 533, 816 S.W.2d at 597; *Douglas*, 323 Ark. 105, 913 S.W.2d at 279.

III.

*20 For the foregoing reasons, the Court grants Platte River's motion for summary judgment [doc.# 33] and denies Baptist Health's motion for summary judgment [doc.# 36]. Platte River is entitled to recover the amount of defense expenses advanced to Baptist Health under the Policy for the Underlying Actions and Baptist Health is entitled to a refund of the premiums tendered to and received by Platte River. Judgment will be entered accordingly.^{FN29}

FN29. Although Platte River does not specifically move for summary judgment on Baptist Health's counterclaim, today's decision necessarily renders the counterclaim as without merit. Accordingly, the Court *sua sponte* dismisses Baptist Health's counterclaim for the above reasons.

IT IS SO ORDERED.

E.D.Ark.,2009.
Platte River Ins. Co. v. Baptist Health
Not Reported in F.Supp.2d, 2009 WL 2015102
(E.D.Ark.)

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848 F.2d 1243, 1988 WL 58031 (C.A.9 (Cal.))
 (Table, Text in WESTLAW), Unpublished Disposition
 (Cite as: 848 F.2d 1243, 1988 WL 58031 (C.A.9 (Cal.)))

▷
 NOTICE: THIS IS AN UNPUBLISHED OPINION.

(The Court's decision is referenced in a "Table of Decisions Without Reported Opinions" appearing in the Federal Reporter. Use FI CTA9 Rule 36-3 for rules regarding the citation of unpublished opinions.)

United States Court of Appeals, Ninth Circuit.
 PLM, INC.; PLM Railcar Maintenance Company;
 PLM Financial Services, Inc.; PLM Transportation
 Equipment Corporation; PLM Investment Manage-
 ment, Inc.; PLM Securities, Inc.; Mark G. Hunger-
 ford; Steven L. Pease; George Tedesco; James Dawe;
 Herbert Montgomery, Plaintiffs-Appellants,
 v.
 NATIONAL UNION FIRE INSURANCE COM-
 PANY OF PITTSBURGH, PA, a capital stock com-
 pany, Defendant-Appellee.

No. 87-1590.
 Argued and Submitted Nov. 12, 1987.
 Decided May 31, 1988.

N.D.Cal.

AFFIRMED.

Appeal from the United States District Court for the Northern District of California; William W. Schwarzer, District Judge, Presiding.

Before SNEED, POOLE and BOOCHEVER, Circuit Judges.

MEMORANDUM ^{FN*}

*1 Appellants (collectively "PLM") appeal from the District Court's grant of summary judgment in favor of defendant-appellee, National Union Fire Insurance Company ("National"), in an action alleging breach of director and officer liability insurance contracts, breach of the implied covenant of good faith and fair dealing, and violation of § 790.03 of the Cal.Ins.Code. We affirm.

I.

National issued director and officer liability insurance policies to two of the corporate appellants. The policies had separate insuring provisions for (1) director and officer liability ("D & O provision") and (2) corporate reimbursement ("reimbursement provision"). When five of PLM's directors and officers were named among the twelve defendants in a lawsuit brought by Pillsbury Company, National provided interim defense funding at the rate of 5/12 of the total defense costs. The corporate appellants, who were also named defendants, eventually negotiated a \$1.75 million settlement with Pillsbury, without the participation or approval of National. Tax considerations dictated the form of the settlement, which contemplated merger of two of the corporate appellants. PLM, Inc. made an immediate payment of \$250,000 and issued a promissory note for \$1.5 million. The note was guaranteed by the individual directors and officers, but no obligations arose under the guarantees because the note was eventually paid by one of the other corporate appellants.

PLM informed National of the contemplated settlement in a letter mailed to National's office in New York, from California, 15 days before the settlement was consummated. The letter stated that a settlement demand had been made, gave the amount of the demand, stated that a counteroffer was being formulated, and sought National's agreement to contribute. Having received no response, PLM sent a telegram and another letter to National during the week prior to the August 30 settlement. The telegram stated that PLM would proceed under the assumption that National did not object to contributing 5/12 of the settlement payment. At no time during this period did PLM refer to a settlement deadline, disclose the agreed upon settlement amount, or attempt to contact National by telephone. On September 13, National's counsel, unaware that a settlement agreement had been reached, informed PLM by telegram that National did not agree to contribute to the settlement on the proposed basis. PLM filed this action 10 days later.

II.

We review a grant of summary judgment *de novo* and will uphold it if there are no genuine issues of material fact and the moving party is entitled to

848 F.2d 1243, 1988 WL 58031 (C.A.9 (Cal.))
(Table, Text in WESTLAW), Unpublished Disposition
(Cite as: 848 F.2d 1243, 1988 WL 58031 (C.A.9 (Cal.)))

judgment as a matter of law. *Berg v. Kincheloe*, 794 F.2d 457, 459 (9th Cir.1986).

III.

PLM contends that the district court erred in finding that the insureds did not suffer a covered loss. In the reimbursement provision of the policies "loss" was defined as "any amount the Company shall be required or permitted by law to pay to a Director or Officer as indemnity for a claim ... which payment by the Company may be required or permitted according to the applicable law..." In order to recover under this provision, PLM had to comply with Cal.Corp.Code § 317 which requires that indemnification be authorized by (1) majority vote of disinterested directors, or (2) majority vote of disinterested shareholders, or (3) court order. It is undisputed that PLM did not meet any of these requirements. The District Court correctly found that the settlement payments were not a covered loss under the reimbursement provision.

In the D & O provision of the policies loss was defined as "any amount which the [Directors and Officers] are legally obligated to pay for a claim ... made against them for wrongful acts..." PLM contends that the guarantees obligated the directors and officers to pay, even though the condition precedent to payment-default by the corporations-never occurred. The cases cited by PLM to support this proposition, *Oakland Bank of Commerce v. Wash.*, 6 Cal.App.3d 793, 799 (1970) and *Palm Springs S. & S., Inc. v. Bering*, 213 Cal.App.2d 177, 181 (1963), are inapposite. In neither case did the court address the question whether a guarantor is legally obligated to pay if the guarantee is extinguished prior to occurrence of the condition precedent for payment. We think it clear that in this case execution of the guarantees created only a contingent obligation on the part of the directors and officers. It was not an obligation to pay, and it never became an obligation to pay. Hence, there was no loss as defined by the D & O provision.

*2 PLM claims that the words "legally obligated to pay" include situations in which a payment is made by third persons on behalf of a director or officer. Since the payments made by the corporate appellants eliminated potential liability of all defendants in the Pillsbury lawsuit, a portion of the payments arguably was made on behalf of the directors and offi-

cers. Nonetheless, PLM's argument fails because potential liability is not equivalent to a legal obligation to pay. The directors and officers were not legally obligated to make payments to Pillsbury and therefore the payments made on their behalf were not recoverable under the D & O provision.

IV.

The district court did not err in not finding as a matter of law that National was estopped from asserting that there was no loss as defined by the policies, or that there existed genuine issues of fact material to the estoppel claim. The elements of estoppel are: the party to be estopped (1) knew the true facts, and (2) intended that his conduct be acted upon, or acted in such a manner that the party asserting estoppel could reasonably believe that the party to be estopped intended his conduct to be acted upon; the party asserting estoppel was (3) ignorant of the true facts, and (4) relied, to his detriment, on the conduct of the party to be estopped. *Driscoll v. Los Angeles*, 67 C.2d 297, 305 (1967).

We need not decide whether the first three elements were met, because we find that PLM failed to raise any genuine issues of fact concerning its reliance on National's delay in voicing its specific objections to the proposed settlement contribution. PLM acknowledged that it considered the terms of the settlement offer attractive and was prepared to accept the offer even if National did not contribute. It suggests, however, that had it known the precise grounds on which National would ultimately deny coverage, it could have taken steps to transform the settlement payments into a loss which would have been covered by the policies.

First PLM suggests it could have structured the settlement so that the directors and officers were required to make part of the payments. But Pease's deposition reveals that the tax aspects of the arrangement made the settlement attractive and were what motivated the structuring of the agreement so that the corporations, rather than the individuals, undertook the entire settlement obligation. No evidence shows either that these tax benefits would have been preserved had the individuals made the payments or that PLM would have sacrificed the tax benefits in order to recover some portion of the settlement under the insurance policies. Consequently, PLM has failed to carry its burden of showing reliance on National's

848 F.2d 1243, 1988 WL 58031 (C.A.9 (Cal.))
 (Table, Text in WESTLAW), Unpublished Disposition
 (Cite as: 848 F.2d 1243, 1988 WL 58031 (C.A.9 (Cal.)))

silence in structuring the agreement.

*3 Next PLM suggests that it could have complied with Cal.Corp.Code § 317, had National notified it earlier that it was necessary to do so. However, a letter by PLM's counsel on October 4, 1984, implicitly acknowledged that PLM would have to comply with § 317 following final adjudication of the Pillsbury action if it wished to collect under the reimbursement provision of the policies. PLM thus was not induced to believe that compliance was unnecessary.

Nor does the record show that as a result of National's silence the corporations forbore the possibility of creating a covered loss by suing the individual directors and officers for part of the settlement. See Nat'l Union Fire Ins. Co. v. Continental Illinois Corp., 666 F.Supp. 1180 (N.D.Ill.1987). The telegram sent by National less than two weeks after the settlement was completed informed PLM that nothing in the policies "would indicate that a 5/12 allocation is remotely relevant to the involvement of the directors and officers." This statement should have put the corporations on notice that some action was required. Thus there is no basis upon which to infer reliance from the mere fact that the corporations did not seek recovery from the individuals.

PLM's suggestion that the corporate appellants could have claimed under the D & O provision as subrogees of the directors and officers, pursuant to Atlantic Permanent Federal Savings & Loan Ass'n v. Am. Casualty Co., 670 F.Supp. 168 (E.D.Va.1986), is incorrect. As subrogees, the corporations could have asserted only those claims which the individuals could have asserted in their own right. Id. at 171. Since the directors and officers were not legally obligated to make the settlement payments, neither they nor their subrogees could have collected under the D & O provision. In Atlantic the officers had entered into a settlement agreement themselves and therefore had a right to proceed against the insurer for the settlement costs they incurred. Id. at 171.

V.

PLM's final claim against National was for breach of the duties summarized by the California Supreme Court in Frommoethelydo v. Fire Ins. Exch., 42 Cal.3d 208, 214-15 (1986). PLM contends that National breached the implied covenant of good faith

and fair dealing by failing to communicate with PLM and failing to assist in settling the Pillsbury action, and that it breached its fiduciary duty by failing to pass on information which PLM needed in order to obtain benefits under the policies. PLM further contends that National violated Cal.Ins.Code § 790.03 by failing to act promptly on communications with respect to the claim, by failing to affirm or deny coverage within a reasonable time after proof of loss, and by failing to promptly explain the basis for denying the claim.

Contrary to PLM's contention, the district court did not hold that either the absence of coverage or PLM's own bad faith barred the bad faith claims against National. We construe the holding to be that because of PLM's conduct, the duties which National allegedly breached actually never arose.

*4 All of PLM's bad faith arguments fail. The facts are virtually undisputed, and the only valid inference which can be drawn from those facts is that National did not act in bad faith or breach its statutory or common law duties to PLM. National responded to PLM's communications about the Pillsbury suit and asked to be kept informed. PLM did not keep National informed about the progress of the suit, about the details of settlement discussions which were taking place, or about the terms of the proposed settlement and the negotiation timetable, even while making a demand for contribution. The district court did not err in granting summary judgment on the bad faith claims.

The judgment is AFFIRMED.

FN* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by 9th Cir.R. 36-3.

C.A.9 (Cal.),1988.
 PLM, Inc. v. National Union Fire Ins. Co. of Pittsburgh, Pa.
 848 F.2d 1243, 1988 WL 58031 (C.A.9 (Cal.))

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Not Reported in F.Supp., 1986 WL 74358 (N.D.Cal.)
(Cite as: 1986 WL 74358 (N.D.Cal.))

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Only the Westlaw citation is currently available.

United States District Court, N.D. California.
PLM, INC., et al., Plaintiffs,
v.
NATIONAL UNION FIRE INSURANCE COM-
PANY OF PITTSBURGH, PA., Defendant.
and Related Cross-Action.

No. C-85-7126-WWS.
Dec. 2, 1986.

MEMORANDUM OF OPINION AND ORDER
SCHWARZER, District Judge.

*1 In August 1985, plaintiffs in this action settled an action brought against them by The Pillsbury Company ("Pillsbury") charging breach of contract and fraud and seeking to impose liability on the individual defendants as corporate officers, directors, and principals. Plaintiffs then sought reimbursement of a portion of the settlement payment from defendant National Union Fire Insurance Company ("National"), which had issued to them certain Directors and Officers Liability and Corporation Reimbursement Policies. National declined and this action followed. Jurisdiction exists by reason of diversity of citizenship.

Plaintiffs have made a motion for partial adjudication of issues. Defendant National in turn has moved for summary judgment on the policy coverage issue. None of the facts material to the coverage issue are in dispute. The parties agree that the issue is ripe for decision by summary judgment. Defendant's motion is granted for the reasons stated below.

STATEMENT OF FACTS

Plaintiffs are a group of related corporations and some of the directors and officers of those corporations. The principal corporate plaintiffs are PLM, Inc. (PLM), PLM Financial Services, Inc. (FSI), and PLM Railcar Services, Inc. (RSI).

In early 1978, PLM entered into a joint venture with Trinity Industries, Inc., to own and lease railcars. The joint venture leased cars to Pillsbury. As

part of the leasing arrangement, RSI agreed at Pillsbury's option to sublease the railcars for a five-year term.

In May 1982, Pillsbury notified RSI that it was exercising the option. RSI asserted that Pillsbury was not then entitled to exercise the option. In November 1983, Pillsbury again notified RSI that it would make the cars available to RSI pursuant to the option. In February 1984 RSI informed Pillsbury that it was financially unable to perform.

In June 1984, Pillsbury filed an action against the present plaintiffs in the Minnesota federal court. The action alleged that the defendants (plaintiffs here) had fraudulently transferred RSI's assets to avoid exposure of RSI to breach of contract liability to Pillsbury. The complaint sought to hold the other corporate plaintiffs liable on the basis of their relationship to RSI and charged the individual plaintiffs with liability as directors and officers of the corporations.

In 1983, National had issued to PLM and to FSI identical Directors and Officers Liability and Corporation Reimbursement ("D & O") policies. Like most D & O policies, National's provided two types of coverage. One section of the policies provided coverage to individual directors and officers for loss incurred in their capacity as directors and officers. The other section provided reimbursement to the corporations for any indemnity they were required or permitted by law to pay to directors or officers. Each policy had a one year term and a \$3,000,000 limit.

When Pillsbury's action was served on the present plaintiffs in June 1984, they sent copies of the summons and complaint to National. Subsequently, plaintiffs demanded that National provide interim funding of defense costs. In February 1984, PLM and National negotiated an Interim Funding Agreement. Under that agreement, National agreed to reimburse PLM for 5/12 of the defense costs incurred in the Pillsbury action. The ratio was based on the fact that five of the twelve defendants in that action were officers or directors covered by the policies. The agreement specifically "preserv[ed] all questions regarding the application of the Policy to any Loss that may

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(Cite as: 1986 WL 74358 (N.D.Cal.))

arise from the Pillsbury Action.”

*2 Little litigation activity ensued following the making of this agreement. Instead Pillsbury and the plaintiffs entered into settlement negotiations. National was not informed of these negotiations until August 15, 1985 when PLM's attorney wrote a letter to National. In the letter he stated that PLM had received a settlement demand from Pillsbury of \$1,750,000 which PLM believed to be “in the ball park.” To be able to formulate a counter offer, PLM wished to be advised whether National was “prepared to contribute to settlement on the same basis that it has agreed to defense costs (i.e. 5/12 of the total)....” A reply within ten days was requested. Not having received a response from National, PLM on August 22 advised National by telegram that negotiations were proceeding very quickly and that PLM was proceeding on the assumption National would contribute 5/12 of the settlement. On August 30, Pillsbury and the plaintiffs entered into a settlement agreement under which Pillsbury agreed to dismiss its action against all of the instant plaintiffs in return for a payment by PLM of \$250,000 immediately and the balance of \$1,500,000 by February 28, 1986, guaranteed by the individual plaintiffs. The full amount has since been paid. National did not respond until September 13, 1985 when it rejected the 5/12 allocation.

Plaintiffs' statement of undisputed facts states:

As of the time of the August, 1985 settlement negotiations with Pillsbury, plaintiffs believed that they had a valid claim against National Union for indemnification of the individual parties, but decided that the terms of the proposed settlement with Pillsbury were sufficiently advantageous to plaintiffs that the settlement should be consummated even if National Union did not participate in the settlement at that time.

DISCUSSION

A. Coverage Under the D & O Policies

National has moved for summary judgment, contending that plaintiffs' claim is not covered by the D & O policies. The motion turns on the interpretation and application of the policies. Since the underlying historical facts are undisputed, the issue is properly resolved by summary judgment. *See Continental Casualty Co. v. City of Richmond*, 763 F.2d 1076, 1079 (9th Cir.1985); *Poland v. Martin*, 761 F.2d 546,

548 (9th Cir.1985).

As already stated, the policies consist of two parts. The first part—Company Reimbursement—provides in relevant part that National will reimburse the insured companies (PLM and its subsidiaries and FSI) for any loss as defined in the policies. Loss is defined as follows:

(c) The term “Loss” shall mean any amount the Company shall be required or permitted by law to pay to a Director or Officer as indemnity for a claim or claims against him arising out of those matters set forth in the Insuring Clause above whether actual or asserted and subject to the applicable limits and conditions of this policy shall include damages, judgments, settlements, costs, charges and expenses (excluding salaries of Officers or employees of the Company) incurred in the defense of actions suits or proceedings and appeals therefrom for which payment by the Company may be required or permitted according to applicable law, common or statutory, or under provisions of the Companys Charter or By-Laws effective pursuant to such law....

*3 It is not seriously disputed that plaintiffs are not entitled to recover under the Company Reimbursement provision. National's liability is limited to reimbursement of payments made by the company in accordance with law. The insuring clause provides that it will pay losses arising from claims against directors and officers “only when the directors or officers shall have been entitled to indemnification ... pursuant to law.” Loss is defined as any amount the company is required or permitted “by law” to pay a director or officer as indemnity, and includes damages, settlements, and expenses “for which payment by the Company may be required or permitted according to applicable law.”

Under Cal.Corp.Code § 317(e) (West Supp.1986), indemnification of directors and officers is permitted only if authorized (1) by the majority vote of disinterested directors, or (2) by the majority vote of disinterested shareholders, or (3) by court order. It is undisputed that plaintiffs did not comply with any of these requirements. That the companies may not have had disinterested boards does not excuse them from pursuing one of the alternate means of securing authority. Hence the payments made by PLM and FSI do not qualify as a loss under the Com-

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pany Reimbursement policy.

National is not estopped from asserting this objection to coverage, as plaintiffs contend. A party claiming that another party should be estopped from asserting certain facts must have been ignorant of those facts at the time he relied on the other party's representation or conduct. Crestline Mobile Homes Manufacturing Co. v. Pacific Finance Corp., 54 Cal.2d 773, 356 P.2d 192, 8 Cal.Rptr. 448, 452 (1960). Plaintiffs do not and could not claim to have been ignorant of the provisions of the policy and of California corporate law or to have been misled by National.

Plaintiffs contend that coverage exists, however, under the second part of the policy for Directors and Officers liability. Plaintiffs' argument seems to be that because a loss occurred within the meaning of the Company Reimbursement policy (albeit not covered), they are entitled to recover under the Directors and Officers policy. To state the proposition is to refute it. Each policy has a different definition of loss and hence has different coverage. To recover under the Directors and Officers policy, plaintiffs must bring themselves within its insuring provisions. Under those provisions, National agreed to pay losses incurred by the individual insureds, defined as directors or officers of the company, arising out of claims against them in their capacities as directors or officers. Loss is defined as follows:

(c) The term "Loss" shall mean any amount which the Insureds are legally obligated to pay for a claim or claims made against them for Wrongful Acts, and shall include damages, judgments, settlements, costs, charges and expenses (excluding salaries of officers or employees of the Company) incurred in the defense of actions, suits or proceedings and appeals therefrom....

*4 Both parties attempt to rely on MGIC Indem. Corp. v. Home State Sav. Ass'n, 797 F.2d 285 (6th Cir.1986). In that case, a corporation avoided criminal prosecution for fraud by agreeing to make restitution of fees it had wrongfully obtained from commercial customers. In return for restitution, the government agreed not to prosecute the corporation or its directors or officers. The corporation claimed that the amounts it paid in restitution constituted indemnification of its directors and officers and sued to recover

under a company reimbursement policy similar to that issued by National. *Id.* at 286. In affirming the district court's grant of summary judgment in favor of the insurer, the court of appeals rejected the district court's reasoning that the claim was not covered because the directors and officers never made and were never legally obligated to make restitution. Rather, according to the court of appeals, the relevant question was whether the corporation paid the settlement for claims made against the directors and officers. *Id.* at 287. The court ruled against the corporation because no claims against the directors and officers had been made. *Id.* at 288.

Under the reasoning of *MGIC* the payments made by PLM and FSI on account of claims made against officers and directors would qualify as a loss under National's Company Reimbursement policy (although coverage is precluded for other reasons). But *MGIC* has no bearing on whether those payments entitle the individual plaintiffs to reimbursement under the Directors and Officers policy. That policy undertakes to "pay on behalf of ... [Directors or Officers] ... loss arising from any claim ... against the Insureds." It defines loss as "any amount which the Insureds are legally obligated to pay for a claim ... made against them ... and shall include ... settlements ... incurred...." The individual plaintiffs suffered no loss, did not become legally obligated to pay and paid no claim, and incurred no obligations. It is true that the corporate payments were in settlement of all claims, including those against the individuals, but the payments were made by the corporations and not by any of the insureds under the Directors and Officers policy. While those individuals might have been called on under their guarantees, the guarantees were discharged without loss to them when FSI paid the balance due on the settlement. Having suffered no loss, the individual plaintiffs are therefore not entitled to coverage under the terms of the Directors and Officers policies.

The undisputed facts thus establish that plaintiffs may not recover under either coverage provided by National's policies. National is entitled to summary judgment on its counterclaim for a declaration that it has not breached the policies.

B. Estoppel of National to Deny Coverage

In August 1985, plaintiffs sent National a letter followed by a telegram asking National to indicate

Not Reported in F.Supp., 1986 WL 74358 (N.D.Cal.)
(Cite as: 1986 WL 74358 (N.D.Cal.))

whether it would reimburse plaintiffs for 5/12 of a settlement with Pillsbury. National did not respond until September 13, 1985, after the settlement agreement had been executed. Plaintiffs argue that National's late response was a breach of its statutory and common law duties and should estop National from asserting that plaintiffs' claim is not covered by the D & O policies. Plaintiffs' argument must fail. Far from establishing estoppel as a matter of law, the evidence submitted shows that National did not breach its duties and that plaintiffs did not rely on National's failure to respond to the August communications.

*5 Silence may give rise to an estoppel when there is a duty to speak. Dettamanti v. Lompoc Union School District, 143 Cal.App.2d 715, 721, 300 P.2d 78 (1956). California law imposes a duty to speak on an insurer in certain circumstances. Insurers are required "to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies." Cal.Ins.Code § 790.03(h)(2) (West Supp.1986). In addition, an insurer breaches its implied covenant of good faith and fair dealing when it denies an insured's claim without conducting a thorough investigation. Egan v. Mutual of Omaha Ins. Co., 24 Cal.3d 809, 598 P.2d 452, 157 Cal.Rptr. 482, 487 (1979), *appeal dismissed*, 445 U.S. 912 (1980).

National's duty to investigate, however, did not arise until its insureds made a good faith effort to comply with its claims procedures. Paulfrey v. Blue Chip Stamps, 150 Cal.App.3d 187, 197 Cal.Rptr. 501, 508 (1984). Plaintiffs provided National with no information regarding the settlement, other than the statement that a \$1,750,000 offer had been received from Pillsbury and was "in the ballpark." In fact plaintiffs had kept National wholly in the dark about their settlement negotiations until the August 15 letter. That letter had the earmarks of a contrived effort to place National at a disadvantage in meeting a later claim for contribution to the settlement. While it sought a commitment to make a contribution it did not inform National of the terms of the settlement under discussion and did not invite National to participate in the negotiations, much less to give its approval. In the light of what appears to have been a studied effort by plaintiffs to keep National out of the settlement discussion, it ill behooves them now to complain about a failure to conduct a prompt investigation.

Plaintiffs' argument fails for another reason. Detrimental reliance is a necessary element of any estoppel claim. In re Lisa R., 13 Cal.3d 636, 532 P.2d 123, 119 Cal.Rptr. 475, 481, *cert. denied*, 421 U.S. 1014 (1975). As National points out, plaintiffs' statement that "the terms of the proposed settlement were sufficiently advantageous to plaintiffs that [they decided] the settlement should be consummated even if National Union did not participate" establishes that plaintiffs did not rely on National's failure to respond and suffered no detriment. Plaintiffs' argument in their reply brief that they had no choice but to enter into the agreement does not help them. If accepted, that argument would only make it clearer that there was no reliance. Plaintiffs' estoppel claim must be rejected.

For the reasons stated, National's motion for summary judgment on its counterclaim is granted and plaintiffs' motion for partial summary judgment is denied.

IT IS SO ORDERED.

N.D.Cal., 1986.
PLM, Inc. v. National Union Fire Ins. Co. of Pittsburgh PA.
Not Reported in F.Supp., 1986 WL 74358 (N.D.Cal.)

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Only the Westlaw citation is currently available.

United States District Court,
E.D. New York.
ST. PAUL FIRE & MARINE INSURANCE COM-
PANY, Plaintiff,
v.
SLEDJESKI & TIERNEY, PLLC, Thomas Sledjeski,
Mary Tierney, and Brian Andrews, Defendants.

No. 08-CV-5184 (JFB)(ETB).
July 17, 2009.

West KeySummaryInsurance 217  3571

217 Insurance

217XXXI Civil Practice and Procedure

217k3571 k. Pleading. Most Cited Cases

Insurer was not required to plead that insureds failed to notify insurer of the potential malpractice claim, and therefore insureds' motion to dismiss insurer's declaratory judgment claim which sought a declaration that insurer was not obligated to defend insureds in the underlying state malpractice action was denied. Insureds argued that insurer was unable to assert a prior knowledge defense because insurer was notified twice of the alleged error, prior to the inception date of the professional liability protection policy. However, the language of the policy made no reference to the issue of notification of the potential claim. The correct inquiry was whether insureds knew or could have reasonably foreseen prior to the inception date of the policy that the alleged error could have lead to the malpractice action, and that did not depend on whether or not notice of the alleged error was provided to insurer prior to the inception date of the policy. 28 U.S.C.A. §§ 2201, 2002.

Andrew Seth Kowlowitz of Furman, Kornfeld & Brennan LLP, New York, N.Y. and Christopher J. Bannon of Aronberg Goldgehn Davis & Garmisa, Chicago, IL, for plaintiff.

Kurt Andrew Schaub, Robert & Robert PLLC, Melville, NY, for defendants.

MEMORANDUM AND ORDER

JOSEPH F. BIANCO, District Judge.

*1 St. Paul Fire & Marine Insurance Company (hereinafter, "St. Paul" or "plaintiff") brings this action against defendants Sledjeski & Tierney, PLLC ("the firm" or "S & T"), Thomas Sledjeski ("Sledjeski"), Mary Tierney ("Tierney"), and Brian Andrews ("Andrews") (collectively, "defendants"), seeking a declaratory judgment pursuant to 28 U.S.C. §§ 2201, 2002 for purposes of determining the parties' rights and liabilities with respect to a lawyers professional liability protection policy number 507JB0207 issued by plaintiff to S & T, effective December 20, 2006 until December 20, 2007 (hereinafter, "the 2007 policy" or "the policy") and currently implicated in a state court action, captioned *The Estate of Jeffrey Scott Nelson, et al. v. Brian A. Andrews, et al.*, Suffolk County Supreme Court, Index. No. 08-12187 (hereinafter, "the malpractice action"), which was initiated by a former client of S & T against defendants. Specifically, in the instant action, plaintiff claims that, because S & T and one or more of the individual defendants knew or could have reasonably foreseen that the error, omission, or negligent act alleged in the malpractice suit might be expected to be the basis of a "claim" or "suit," the policy affords no coverage to them for their defense or indemnification of their defense in the malpractice action. Plaintiff thus seeks a declaration stating that it is not obligated to defend or indemnify any defendant to the underlying state malpractice action under the 2007 policy as to any claims asserted in those proceedings.

Defendants now move to dismiss the complaint pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure. For the reasons stated herein, defendants' motion is denied in its entirety.

I. BACKGROUND**A. Facts**

The following facts are taken from the complaint ("Compl."), documents incorporated by reference in the complaint, and documents that were in plaintiff's possession and/or of which plaintiff had notice, or relied upon in bringing the instant action, all of which the Court may consider. These facts are not findings of fact by the Court, but rather are assumed to be true for the purpose of deciding this motion and are con-

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(Cite as: 2009 WL 2151425 (E.D.N.Y.))

strued in a light most favorable to plaintiff, the non-moving party.

St. Paul is an insurance company incorporated in Minnesota and having its principal place of business there. (Compl.¶ 3.) S & T is a New York professional limited liability corporation incorporated under the laws of New York that, at all relevant times, operated as a law firm with its principal place of business in Riverhead, New York. (Compl.¶ 4.) Sledjeski, Tierney, and Andrews, all residents of New York, were employed as attorneys at S & T at all relevant times. (Compl.¶¶ 5–7, 16.)

St. Paul issued a lawyers professional liability protection policy to S & T under policy number 507JB0207, effective December 20, 2006 until December 20, 2007. (Compl.¶ 10.) The insuring agreement section of the policy states:

*2 We will pay on behalf of an insured “damages” and “claims expenses” for which “claim” is first made against an insured and reported to us within the “policy period”, any subsequent renewal of the policy by us or applicable Extended Reporting Period. Such “damages” must arise out of an error, omission, negligent act or “personal injury”, in the rendering of or failure to render “legal services” for others by you or on your behalf. The error, omission, negligent act or “personal injury” must occur on or after the retroactive date stated in the Declarations, if any.

(Compl.¶ 11.) However, the policy does not apply to “claims”:

G. Arising out of any error, omission, negligent act or “personal injury” occurring prior to the inception date of this policy if any insured prior to the inception date knew or could have reasonably foreseen that such error, omission, negligent act or “personal injury” might be expected to be the basis of a “claim” or “suit”.

(hereinafter, “Exclusion G” or the “prior knowledge exclusion”). (Compl.¶ 13.)

Further, in the policy, a “claim” is defined as follows:

“Claim” means a demand received by an insured

for money alleging an error, omission or negligent act in the rendering of or failure to render “professional legal services” for others by you or on your behalf.

(Compl.¶ 14.) A “suit” is defined as follows: “Suit” means a civil proceeding in which “damages” to which this insurance applied are alleged

(Compl.¶ 15.)

In August 2003, Sledjeski and Tierney were members of the law firm of Michael T. Clifford & Associates, PLLC, and Andrews was employed as an associate of that firm. (Compl.¶ 16.) At that time, Candice Nelson retained that firm to represent her and the Nelson estate for recovery of damages resulting from the death of her husband, Jeffrey Nelson, in a July 26, 2003 motor vehicle accident. (Compl.¶ 16.) The firm of Michael T. Clifford & Associates thereafter dissolved, and S & T assumed the representation of Candice Nelson and the Nelson estate. (Compl.¶¶ 17–18.) The applicable statute of limitations for recovery of damages for the wrongful death of Jeffrey Nelson expired on July 26, 2005, two years after the death. (Compl.¶ 19.) On July 26, 2005, S & T filed a summons and complaint in the Supreme Court, Suffolk County, captioned *Candice Nelson as proposed Administratrix for the Estate of Jeffrey Nelson, and Candice Nelson, individually, v. Bonnie A. Rubin and Maier A. Rubin* (hereinafter, “the wrongful death action”). (Compl.¶ 20.)

On March 28, 2008, the Nelson estate commenced the malpractice action against defendants, alleging that S & T filed a defective summons and an unverified complaint that was defective and never served in the wrongful death action in 2005 (hereinafter, “the alleged error”). (Compl.¶¶ 22–23.) A verified complaint was served on August 15, 2008 in the malpractice action. (Compl. ¶ 22 .)

*3 Prior to the filing of the malpractice action, in October 2007, Tierney mailed a letter to S & T’s broker, which St. Paul received on November 8, 2007, regarding the alleged error that could potentially lead to the legal malpractice action. (Defs.’ Exhs. E, H.) The information regarding the alleged error was also included in a Supplemental Claim Form attached to S & T’s renewal application form dated October 31,

Not Reported in F.Supp.2d, 2009 WL 2151425 (E.D.N.Y.)
(Cite as: 2009 WL 2151425 (E.D.N.Y.))

2007. (Def.'s Exh. F.) St. Paul has provided defendants a defense in the malpractice suit subject to a full reservation of its rights to (a) deny coverage, (b) seek judicial determination of the parties' rights and obligations, and (c) seek reimbursement of all defense expenses paid in connection with the malpractice suit. (Compl.¶ 26.)

B. Procedural History

On December 24, 2008, plaintiff filed its complaint in the instant action. On May 8, 2009, defendants filed their motion to dismiss. The opposition was submitted by plaintiff on June 11, 2009, and defendants' reply was filed on June 19, 2009. Oral argument was held on July 16, 2009. This matter is fully submitted.

II. STANDARD OF REVIEW

In reviewing a motion to dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6), the court must accept the factual allegations set forth in the complaint as true and draw all reasonable inferences in favor of the plaintiff. See Cleveland v. Caplaw Enters., 448 F.3d 518, 521 (2d Cir.2006); Nechis v. Oxford Health Plans, Inc., 421 F.3d 96, 100 (2d Cir.2005). The plaintiff must satisfy "a flexible 'plausibility standard.'" Iqbal v. Hasty, 490 F.3d 143, 157 (2d Cir.2007), *rev'd on other grounds sub nom. Ashcroft v. Iqbal*, — U.S. —, 129 S.Ct. 1937, 173 L.Ed.2d 868 (2009). "[O]nce a claim has been stated adequately, it may be supported by showing any set of facts consistent with the allegations in the complaint." Bell Atl. Corp. v. Twombly, 550 U.S. 544, 563, 127 S.Ct. 1955, 167 L.Ed.2d 929 (2007). The Court, therefore, does not require "heightened fact pleading of specifics, but only enough facts to state a claim to relief that is plausible on its face." *Id.* at 570.

The Supreme Court recently clarified the appropriate pleading standard in Ashcroft v. Iqbal, setting forth a two-pronged approach for courts deciding a motion to dismiss. — U.S. —, 129 S.Ct. 1937, 173 L.Ed.2d 868 (2009). The Court instructed district courts to first "identify[] pleadings that, because they are no more than conclusions, are not entitled to the assumption of truth." 129 S.Ct. at 1950. Though "legal conclusions can provide the framework of a complaint, they must be supported by factual allegations." *Id.* Second, if a complaint contains "well-pleaded factual allegations, a court should assume their veracity and then determine whether they plausibly give

rise to an entitlement to relief." *Id.* "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged. The plausibility standard is not akin to a 'probability requirement,' but it asks for more than a sheer possibility that a defendant has acted unlawfully." *Id.* at 1949 (quoting and citing Twombly, 550 U.S. at 556–57) (internal citations omitted).

III. DISCUSSION

*4 Defendants argue for dismissal of the complaint on the following grounds: (1) St. Paul can only disclaim coverage for an insured's "prior knowledge" of a potential claim where the insured fails to give notice of such potential claim before the policy's inception date and, in this case, defendants did provide such notice; (2) any ambiguity in the policy concerning the circumstances under which notice of an alleged error triggers coverage of a subsequently filed claim must be resolved as a matter of law in favor of the defendants; (3) St. Paul is precluded as a matter of law from rescinding the policy because it accepted premiums from the defendants after the defendants renewed their policy; and (4) St. Paul's disclaimer was untimely as a matter of law.^{FN1} The Court examines each argument in turn.

^{FN1}. Defendants also argue that St. Paul has waived all defenses to coverage other than the "prior knowledge" defense. St. Paul does not argue that any other defenses apply, and so the Court need not address this argument.

A. Notice of Potential Claim

Defendants first argue that plaintiff fails to plead that S & T "failed to notify" plaintiff of the potential claim before the inception date of the policy that was effective December 20, 2007 until December 20, 2008 (hereinafter, the "2008 policy"), and such a pleading is necessary to assert a "prior knowledge" defense to coverage. Moreover, defendants argue that plaintiff is unable to assert such a defense because St. Paul was notified twice in October and November 2007 of the alleged error, prior to the inception date of the 2008 policy, *i.e.* December 20, 2007.^{FN2} (See Def.'s Mem. of Law, at 3.)

^{FN2}. St. Paul does not dispute the notification received in November 2007 of the alleged error.

Not Reported in F.Supp.2d, 2009 WL 2151425 (E.D.N.Y.)
(Cite as: 2009 WL 2151425 (E.D.N.Y.))

As an initial matter, the inception date of the policy set forth in the complaint is December 20, 2006, not December 20, 2007. In fact, nowhere in the complaint is the 2008 policy mentioned, and plaintiff has made clear that it does not seek a declaration of the parties' rights with respect thereto. The policy pursuant to which plaintiff seeks a declaratory judgment in this case is the one that was effective December 20, 2006 and expiring December 20, 2007. Because plaintiff does not seek any declaration of rights pursuant to the renewed policy beginning December 20, 2007 and ending December 20, 2008, any arguments based on such a policy are irrelevant for the purposes of a motion to dismiss the complaint. Accordingly, the proper inception date for the analysis herein is December 30, 2006, and any actions undertaken by defendants to notify St. Paul in the fall of 2007 of the possible forthcoming malpractice action were taken after the inception date of the policy. Thus, to the extent that defendants argue that notification of the alleged error was made to St. Paul and such notification thereby ensures coverage under the 2007 policy, that argument fails.

In any event, the language of Exclusion G makes no reference to the issue of notification of a potential claim. Indeed, on its face, the clear language of the provision excludes coverage if the insured knows or should have reasonably foreseen, prior to the inception date of the policy, that any omission, error, or negligent act committed prior to that inception date could lead to a possible claim or suit. The alleged error here occurred in connection with the wrongful death action filed in 2005, well before the inception date of the 2007 policy. Thus, the correct inquiry with respect to Exclusion G is whether or not defendants knew or could have reasonably foreseen prior to the inception date of December 20, 2006 that the alleged error could lead to the malpractice action. That question, by the plain terms of Exclusion G, does not depend upon whether or not notice of the alleged error was provided to St. Paul prior to the inception date. "As with the construction of contracts generally, unambiguous provisions of an insurance contract must be given their plain and ordinary meaning, and the interpretation of such provisions is a question of law for the court[.]" *Vigilant Ins. Co. v. Bear Stearns Cos., Inc.*, 10 N.Y.3d 170, 177, 855 N.Y.S.2d 45, 884 N.E.2d 1044 (N.Y.2008); accord *Teichman v. Comm. Hosp. of Western Suffolk*, 87

N.Y.2d 514, 640 N.Y.S.2d 472, 663 N.E.2d 628 (N.Y.1996); see also *Parks Real Estate Purchasing Group v. St. Paul Fire and Marine Ins. Co.*, 472 F.3d 33, 42 (2d Cir.2006) ("When the provisions are unambiguous and understandable, courts are to enforce them as written."). Although ultimately, to obtain the relief it seeks in this case, plaintiff must " 'establish that the exclusion is stated in clear and unmistakable language, is subject to no other reasonable interpretation, and applies in the particular case[.]" ' *Belt Painting Corp. v. TIG Ins. Co.*, 100 N.Y.2d 377, 383, 763 N.Y.S.2d 790, 795 N.E.2d 15 (N.Y.2003) (quoting *Continental Cas. Co. v. Rapid-Am. Corp.*, 80 N.Y.2d 640, 652, 593 N.Y.S.2d 966, 609 N.E.2d 506 (N.Y.1993)), defendants have not shown that plaintiff cannot make this showing as a matter of law, based on the argument that failure to provide notification of an alleged error is a prerequisite to invocation of the prior knowledge exclusion defense. Thus, defendants' contention that St. Paul was required to plead that defendants failed to notify it of the potential claim is without merit.

*5 Although the 2008 policy is not before the Court, to the extent that defendants argue that no claim for coverage arises under the 2007 policy as a matter of law because the malpractice suit was filed in 2008 (and notice thereof provided to St. Paul in 2008), the Court also finds this argument unpersuasive. The Court cannot conclude, as a matter of law, that S & T's notification of the alleged error did not trigger coverage of the claim under the 2007 policy period.

Relevant to this analysis is Section IX(B) of the policy, which provides that

[i]f, during the "policy period", any insured first becomes aware of a circumstance which may give rise to a "claim" (i.e., any act, error, omission or "personal injury" which might reasonably be expected to be the basis of a "claim" against any insured under this policy), the insured must give written notice in accordance with SECTION IX—CONDITIONS C, Insured's Duties in the Event of a "Claim", "Suit" or Circumstances Which May Give Rise to a "Claim". Any claims subsequently made against any insured arising out of that circumstance shall be considered to have been made and reported during the "policy period".

Not Reported in F.Supp.2d, 2009 WL 2151425 (E.D.N.Y.)
(Cite as: 2009 WL 2151425 (E.D.N.Y.))

(Hereinafter, “Section IX(B)” or the “potential claim provision”). (Defs.’ Exh. B.) Under the plain terms of this provision, an insured is permitted to give notice of a potential claim or suit during the pending policy period, which triggers coverage under that policy period. Here, defendants’ notification in October and November 2007 of the alleged error, which undisputedly formed the basis of the 2008 malpractice suit, may have triggered its coverage under the 2007 policy period, pursuant to Section IX(B) of the policy. Therefore, the Court cannot conclude, as a matter of law, that the appropriate policy governing the defense of the malpractice action is not the policy in effect at the time of S & T’s notice.

Despite defendants’ insistence that the policy is a “claims-made,” as opposed to “occurrence-based” policy, discussed in more detail *infra*, that fact does not change the analysis; although the general rule of a claims-made policy may be that coverage is triggered upon filing of a claim or suit against an insured and/or notice to the insurer thereof, that does not mean that the potential claim provision cannot provide for an earlier policy period under certain circumstances. It also does not mean that all claims filed during that period are automatically covered by the policy, as then any exclusion policy would be meaningless, and it is clear under New York law that the policy should be interpreted to give meaning and effect to all of the provisions, if possible. *See Raymond Corp. v. Nat’l Union Fire Ins. Co.*, 5 N.Y.3d 157, 162, 800 N.Y.S.2d 89, 833 N.E.2d 232 (N.Y.2005) (“We construe the policy in a way that affords a fair meaning to all of the language employed by the parties in the contract and leaves no provision without force and effect.”) (quoting *Consolidated Edison Co. of New York v. Allstate Ins. Co.*, 98 N.Y.2d 208, 221–22, 746 N.Y.S.2d 622, 774 N.E.2d 687 (N.Y.2002) (internal quotation marks and citations omitted)).

B. Alleged Ambiguity in the Potential Claim Provision

*6 In this case, the Court further disagrees with defendants that the potential claim provision, read separately or in conjunction with Exclusion G, the insuring agreement section, or the definition of “claims” in the policy, is sufficiently ambiguous so as to be construed in defendants’ favor and to warrant dismissal of plaintiff’s claim as a matter of law.

Defendants rely extensively on the argument that the potential claim provision in the policy is “occurrence-based” language that is contrary to the “claims-made” nature and intent of the policy and the definition of “claim” as set forth in the policy. As background, defendants explain that an occurrence-based policy covers injuries that occur during the policy period, usually with a requirement that such injuries be reported as soon as is practicable, while a claims-made policy covers liability for bodily injury or property damage only if a claim is asserted during the policy period. (*See* Defs.’ Reply Mem. of Law, at 2.) Defendants’ main contention is that because the malpractice claim against them was filed and reported to St. Paul in 2008, that claim is not covered by the 2007 policy, which terminated coverage on December 20, 2007.

In an apparent attempt to circumvent the plain language of Section IX(B), discussed *supra*, defendants argue that that section “contradicts the entire intent of a ‘Claims-Made’ policy and conflicts with the definition of a ‘claim’ which is given in the Definitions Section (Sec.VIII) of the policies which says a ‘claim’ is a ‘demand received by an insured for money alleging an error, omission or negligent act ...’” (Defs.’ Reply Mem. of Law, at 3–4.) More specifically, defendants argue that the reporting requirement contained in Section IX(B) is “occurrence based” policy language that is inconsistent with the “claims-made” policy language elsewhere contained in the policy. According to defendants, this inconsistency, in turn, has created two ambiguities that defendants seek to be construed in their favor: (1) an ambiguity as to whether or not the policy was claims-made or occurrence-based, and (2) an ambiguity as to whether the 2007 policy period applies to this case.

Under New York law, insurance policy exclusions are given a “strict and narrow construction,” and any ambiguity will be resolved against the insurer if the exclusion provision is found to be ambiguous. *Belt Painting Corp.*, 100 N.Y.2d at 383, 763 N.Y.S.2d 790, 795 N.E.2d 15. The same is true more generally of any ambiguous terms within an insurance policy. *See, e.g., Tower Ins. Co. of New York v. Diaz*, 58 A.D.3d 495, 495, 871 N.Y.S.2d 123 (N.Y.App.Div.2009); *Antoine v. City of New York*, 56 A.D.3d 583, 584, 868 N.Y.S.2d 688 (N.Y.App.Div.2008).

Not Reported in F.Supp.2d, 2009 WL 2151425 (E.D.N.Y.)
(Cite as: 2009 WL 2151425 (E.D.N.Y.))

Before a court may resolve any ambiguity in favor of the insured, however, it must first determine whether there is in fact any ambiguity. Whether a provision in an insurance policy is ambiguous is a threshold question of law for the court to determine. *E.g., Duane Reade Inc. v. St. Paul Fire and Marine Ins. Co.*, 411 F.3d 384, 390 (2d Cir.2005); *Nick's Brick Oven Pizza, Inc. v. Excelsior Ins. Co.*, 61 A.D.3d 655, 656, 877 N.Y.S.2d 359 (N.Y.App.Div.2009). "An ambiguity exists where the terms of an insurance contract could suggest 'more than one meaning when viewed objectively by a reasonably intelligent person who has examined the context of the entire integrated agreement and who is cognizant of the customs, practices, usages and terminology as generally understood in the particular trade or business.'" *Morgan Stanley Group Inc. v. New Eng. Ins. Co.*, 225 F.3d 270, 275 (2d Cir.2000) (quoting *Lightfoot v. Union Carbide Corp.*, 110 F.3d 898, 906 (2d Cir.1997)); see also *Nick's Brick Oven Pizza, Inc.*, 61 A.D.3d at 656, 877 N.Y.S.2d 359 ("The test for ambiguity is whether the language in the insurance contract is susceptible to two reasonable interpretations.") (internal citations and quotation marks omitted). In particular, "[t]he language of a contract is not made ambiguous simply because the parties urge different interpretations." *Seiden Assocs., Inc. v. ANC Holdings, Inc.*, 959 F.2d 425, 428 (2d Cir.1992). "Simply put, a contract provision is not ambiguous where it has a definite meaning, and where no reasonable basis exists for a difference of opinion about that meaning." *Allstate Ins. Co. v. Am. Home Products Corp.*, No. 01 Civ. 10715(HBP), 2009 WL 890078, at *6 (S.D.N.Y. Mar.31, 2009) (internal quotation marks, alterations and citations omitted).

*7 After careful review of the provisions at issue, the Court does not find any ambiguity in the language of Section IX(B), or any contradiction or ambiguity when it is read in conjunction with Exclusion G or the claims-made language of the policy. Indeed, defendants do not argue that the language in Section IX(B) stating that "[a]ny claims subsequently made against any insured arising out of that circumstance shall be considered to have been made and reported during the 'policy period' " is itself ambiguous. It is certainly not susceptible to two reasonable, yet different, interpretations, in light of common speech. Instead, defendants argue that because such language is inconsistent with the general concept of a claims-made policy, it is ambiguous in light of the whole

of the policy or when read in conjunction with other provisions, such as the definition of "claims" as contained in the policy, and effectively converts the claims-made policy into an occurrence-based policy or at best, a quasi-claims-made, quasi-occurrence-based policy.

The Court is not persuaded by defendants' interpretation, however. In fact, this Court's conclusion regarding the unambiguous nature of this language is consistent with other courts applying New York law that have construed the plain language of similar reporting requirements of potential claims in the context of a claims-made policy. See, e.g., *Hunt v. Galaxy Ins. Co.*, 223 A.D.2d 821, 822, 636 N.Y.S.2d 194 (N.Y.App.Div.1996). Importantly, the Second Circuit, in *Morgan Stanley Group Inc. v. New England Ins. Co.*, 225 F.3d 270 (2d Cir.2000), analyzed a potential claims provision in a claims-made insurance policy and determined that certain claims may have been triggered in an earlier policy period pursuant to the potential claims provision, despite renewal of that policy during the period in which the actual claim was filed.^{FN3} See *id.* at 280–81. As another example, in *JPMorgan Chase & Co. v. Travelers Indem. Co.*, No. 600674/06, 2009 WL 137044, at *2–3 (N.Y.Sup.Ct. Jan. 12, 2009), the court applied a strikingly similar provision to Section IX(B) in this case, also in the context of a claims-made policy:

FN3. In addition, in that case, the Second Circuit further vacated and remanded the judgment of the district court that concluded that a later policy applied to the claims at issue, where, as here, notice of the potential claim may have been provided in the preceding policy period pursuant to a provision requiring notice of circumstances possibly giving rise to a future claim. In doing so, the court made clear that under New York law, "[b]y renewal or other means of extension, this claims-made insurance is a perennial contract that includes an arrangement for allocating claims to particular policy years" and thus the contracts should not be construed as separate yearly policies. See *id.* at 280–81.

In order to trigger coverage under the extended claims-made 97–01 Insurance Program, JPMC was required to give notice of claims during the policy

Not Reported in F.Supp.2d, 2009 WL 2151425 (E.D.N.Y.)
(Cite as: 2009 WL 2151425 (E.D.N.Y.))

period. Additionally, § IV. D. of the 97–01 Insurance Program permitted JPMC to preserve coverage for potential claims that may arise after the policy's expiration by providing written notice of “Wrongful Acts” that it believed may give rise to a claim. This provision states:

“If during the policy period ... the Risk and Insurance Management Department shall become aware of any [Wrongful Act] which may subsequently give rise to a claim being made against an Insured and shall during the Policy Period ... give written notice of such [Wrongful Act], then any claim which is subsequently made against the Insured arising out of such act, error or omission [Wrongful Act] shall for the purpose of this policy be treated as a claim made during the policy period” (97–01 Insurance Program, § IV. D. [2]).

*8 2009 WL 137044, at *2–3. Although in that case, the definition of a “claim” was expanded to include written notice to the insurer “describing circumstances that may reasonably be expected to give rise to a Claim,” *id.*, the definition of “claim” in this case is not inconsistent with the reporting requirement contained in Section IX(B).

Tellingly, although defendants argue that various cases cited by plaintiff in support of its opposition are inapposite and involve policy language distinct from that in this case, defendants fail to cite to any case authority in support of their claim that a notice requirement like that in Section IX(B) for potential claims is ambiguous or inconsistent with a claims-made policy. Specifically, defendants fail to point to any cases holding that policies containing, as defendants suggest, so-called “mixed” language that combines language of a claims-made policy with an occurrence-based reporting provision are ambiguous or invalid as a matter of law, whether in whole or in part. Defendants even conceded at oral argument that no such case authority exists.

Instead, defendants' misplaced argument seems to rest on a failure to distinguish between language requiring notice of an occurrence in an occurrence-based policy and language requiring notice of a potential claim in a claims-made policy. They are not the same, nor do they serve the same purpose, although at times they are not clearly differentiated by courts. See *Chiera v. Liberty Ins. Underwriters, Inc.*,

No. 7825/07, 2008 WL 4140581, at *9 (N.Y.Sup.Ct. Sept. 9, 2008). At least one New York court has expounded at length on this distinction and concluded that dual provisions in a claims-made context—one requiring notice of an actual claim and one permitting notice of an act that could lead to a potential claim—are not inconsistent because they serve different purposes. See *id.* at *9–11. In that case, the analogous provision to Section IX(B) in this case was called the “Discovery Clause.”^{FN4} This court explained:

FN4. Notice under the Discovery Clause in that case was optional and not required, as it appears to be in the 2007 policy, but such a distinction does not matter for purposes of this decision. In both cases, notification provided by the insured regarding an alleged error that could give rise to a later claim triggered coverage under that policy, even if a claim was filed in a subsequent time period. Furthermore, in that case, notice of a “potential claim” was required under the policy at issue, but the court construed such a “potential claim” as distinct from a “wrongful act” as used under Discovery Clause. See *id.* at *11. The Discovery Clause in *Chiera* is closer to the language of Section IX(B) here. The Court notes that the term “potential claim” is not used in Section IX(B), and such a phrase is used by the Court for the purposes of describing that provision in this Memorandum and Order.

Here, the Liberty policies are “claims-made” policies which, as set forth in the declarations on page 1, affords coverage only for claims first made within the policy or extended reporting period. The Notice of Claims provision and the Discovery Clause address two distinct issues. The Notice of Claims paragraph requires that prompt notice be given of any “claim(s) or potential claim(s) made against the insured.” By complying with this requirement, the insured attorney may obtain coverage for claims asserted against the insured during the policy period.

The Discovery Clause, on the other hand, has a different mission. Since the Liberty policies are claims-made policies, the insured would not have coverage for a claim which is first made after the policies expire. However, the Discovery Clause

Not Reported in F.Supp.2d, 2009 WL 2151425 (E.D.N.Y.)
(Cite as: 2009 WL 2151425 (E.D.N.Y.))

permits the insured to obtain coverage for a claim first asserted post-policy by notifying the insurer of a wrongful act.

*9 Plaintiffs argue that the Discovery Clause makes disclosure of wrongful acts committed during the policy period optional. In one sense, this is true; an insured need not make the disclosure, though the consequence would be that no coverage would be afforded if a claim is first brought after the expiration of the policy for a undisclosed wrongful act first brought to the insured's attention during the policy period. In another sense though, the disclosure is mandatory; if the insured wants coverage for claims first made after the expiration of the policy, the insured must make the disclosure.

Nevertheless, it remains that the Notice of Claims provision requires notice of claims or potential claims, as to which the insured would be entitled to coverage, while the Discovery Clause permits notification of wrongful acts so that coverage will be provided should a claim be made later, after the policy expires.

Liberty would have this Court read the term “potential claim” in the Notice of Claims provision as the functional equivalent of “occurrence” or, as used in the Discovery Clause, “wrongful act”. Indeed, Liberty elides over the distinction between notice of claim and notice of occurrence

Chiera, 2008 WL 4140581, at *11. Defendants' position here is essentially the same as that rejected by the court in *Chiera*. By providing notice of the alleged error in the fall of 2007, defendants were potentially able to obtain coverage for any claim arising out of that alleged error during the policy period, even if such a claim was made after the expiration of that policy period.^{FN5} If S & T had not renewed its policy after December 20, 2007, it is possible that the 2008 malpractice claim would have nonetheless been covered by the 2007 policy. However, this issue is distinct from whether or not Exclusion G also operates to exclude coverage for prior knowledge of the alleged error. Indeed, plaintiff in this case seeks a declaratory judgment regarding the applicability of Exclusion G in the policy; since the Court finds that S & T's notification of the alleged error may have triggered coverage for the malpractice action under the 2007 policy,

the question of whether or not the prior knowledge exclusion further applies to bar such coverage remains.

FN5. In this regard, defendants' contention that their purchase of a “tail” policy following S & T's dissolution in 2008—which is also not at issue in this case—demonstrates that the 2007 policy was not intended to cover any claims subsequently filed, even if notice was given thereof in 2007, is also unpersuasive. Any subsequent policy would presumably ensure coverage for any claims that arise in subsequent years and were *not* reported during an earlier policy period under Section IX(B). Thus, the existence of any subsequent policy, including a tail policy, does not defeat plaintiff's claim that coverage may have been triggered in this case under the 2007 policy.

In sum, given the plain language of these various provisions and in an effort to give meaning and effect to all of them, the Court finds no ambiguity or inconsistency within or among them, as defendants suggest. *See, e.g., Flynn v. Timms*, 199 A.D.2d 873, 606 N.Y.S.2d 352, 354 (N.Y.App.Div.1993) (“A court will not strain to find an ambiguity where words have a definite and precise meaning, nor will it create policy terms by implication to rewrite a contract.”) (citation omitted). Accordingly, defendants' motion to dismiss, on the grounds that the language of Section IX(B)—specifically, its reporting requirement and the possible trigger of a policy period expiring before an actual claim is made—is inconsistent with certain other provisions of the 2007 policy and/or renders the claims-made nature of the policy or the potential applicability of that provision ambiguous, is denied.

C. Rescission

*10 Defendants further argue that St. Paul accepted premiums from S & T following the notice of the alleged error in October and November 2007 and is thus estopped from rescinding the policy. The Court rejects this argument as an insufficient basis in this case on which to seek dismissal of the complaint.

Again, the 2008 policy is not at issue in this case. Second, neither is rescission of the 2007 policy at issue. As plaintiff makes clear in the complaint, its opposition papers, and during oral argument, it is not

Not Reported in F.Supp.2d, 2009 WL 2151425 (E.D.N.Y.)
(Cite as: 2009 WL 2151425 (E.D.N.Y.))

seeking rescission of the 2007 policy. To the contrary, it is actually seeking a declaration of rights pursuant to such a policy and is thus seeking to enforce its interpretation of the prior knowledge exclusion provision, as applied to the underlying malpractice suit.

In response, defendants contend that although plaintiff asserts that it is not attempting to rescind the policy, St. Paul's claim is nonetheless "based on an alleged 'material misrepresentation of the facts' made by S & T prior to the inception date of the policy, namely, an alleged omission of notification about the potential claim by S & T's former client." (Defs.' Mem. of Law, at 3.) Although an insurer may void an insurance contract if the contract was induced by a material misrepresentation, N.Y. INS. LAW § 3105, for the reasons discussed *supra*, the Court finds the issue of S & T's notification of the alleged error is not determinative of the issue of Exclusion G's applicability and, in any event, there was in fact no alleged notification by defendants of the alleged error prior to December 20, 2006, the inception date of the 2007 policy. As for St. Paul's acceptance of premiums following the notification in fall 2007 of the alleged error, defendants admit that there is no legal authority deeming acceptance of such premiums a waiver of a prior knowledge defense. Thus, the Court concludes that dismissal on this ground is unwarranted.

D. Timeliness of the Disclaimer

Defendants also argue that St. Paul waited too long before bringing this lawsuit and disclaiming coverage and, thus, the complaint should be dismissed on timeliness grounds. As support for this proposition, defendants cite New York Insurance Law § 3420(d)(2) ("Section 3420(d)(2)"). That statutory provision provides:

If under a liability policy issued or delivered in this state, an insurer shall disclaim liability or deny coverage for death or bodily injury arising out of a motor vehicle accident or any other type of accident occurring within this state, it shall give written notice as soon as is reasonably possible of such disclaimer of liability or denial of coverage to the insured and the injured person or any other claimant.

N.Y. INS. LAW § 3420(d)(2).

By the plain terms of this statute, however, this provision applies only to disclaimer of liability or coverage for death or bodily injury arising out of a motor vehicle accident or other accident. Whether Section 3420(d)(2) applies to a case is question of law for the Court. *See, e.g., Koegler v. Liberty Mut. Ins. Co.*, 623 F.Supp.2d 481, 2009 WL 1176612, at *1 (S.D.N.Y. Apr.21, 2009). Because the underlying action in this case was a legal malpractice suit under which no death or bodily injury arose, Section 3420(d)(2) is inapplicable. *See Sirignano v. Chicago Ins. Co.*, 192 F.Supp.2d 199, 206–07 (S.D.N.Y.2002) ("By its terms, Section 3420(d) does not apply to claims for legal malpractice.") (citing *Vecchiarelli v. Continental Ins. Co.*, 277 A.D.2d 992, 716 N.Y.S.2d 524 (N.Y.App.Div.2000); *Incorporated Village of Pleasantville v. Calvert Ins. Co.*, 204 A.D.2d 689, 612 N.Y.S.2d 441 (N.Y.App.Div.1994)). Defendants do not point to any case authority suggesting otherwise and conceded at oral argument that they are not aware of any such authority, and this Court's own research has found no case applying Section 3420(d)(2) to a disclaimer of coverage for a legal malpractice lawsuit.

*11 "Where, as here, the underlying claim does not arise out of an accident involving bodily injury or death, the notice of disclaimer provisions set forth in Insurance Law § 3420(d) are inapplicable and, under the common-law rule, delay in giving notice of disclaimer of coverage, even if unreasonable, will not estop the insurer to disclaim unless the insured has suffered prejudice from the delay." *Vecchiarelli*, 277 A.D.2d at 992, 716 N.Y.S.2d 524 (internal quotation marks, alteration, and citations omitted). Not only is the unreasonableness of St. Paul's alleged delay an issue of fact that the Court cannot determine on a motion to dismiss, *see, e.g., id.* ("In the absence of an explanation for the delay, a delay of over two months is unreasonable as a matter of law ... An insurer's explanation may excuse the delay, however, and the reasonableness of the explanation is generally an issue of fact."), defendants must demonstrate prejudice as a result of the alleged delay of St. Paul's disclaimer, which is also an issue of fact and not presumed where an insurance company undertakes a defense subject to a reservation of its right to disclaim, which is what is alleged to have occurred in this case. *See Silverman Sclar Byrne Shin & Byrne P.C. v. Chicago Ins. Co.*, No. 03 Civ. 0308(DLI)(MDG), 2005 WL 2367709, at *5–6 (E.D.N.Y. Sept. 27, 2005) ("Prejudice is presumed

Not Reported in F.Supp.2d, 2009 WL 2151425 (E.D.N.Y.)
(Cite as: 2009 WL 2151425 (E.D.N.Y.))

where an insurer, though in fact not obligated to provide coverage, without asserting policy defenses or reserving the privilege to do so, undertakes the defense of the case, in reliance on which the insured suffers the detriment of losing the right to control its own defense [W]here the insurer has reserved its right to disclaim on the basis of a particular defense later asserted, the insured must show that (1) the delay in disclaiming was unreasonable, and (2) actual prejudice ensued as a result The next element required for estoppel to apply, that prejudice has ensued, is generally a question of fact.”) (internal citation and quotation marks omitted). Accordingly, defendants' motion to dismiss is denied on this ground as well.

IV. CONCLUSION

In sum, the only issue in this case is whether or not the prior knowledge exclusion applies to bar coverage under the policy effective December 20, 2006 until December 20, 2007 for the defense or indemnification of the defense of defendants by plaintiff in connection with the underlying state court malpractice action. This question involves factual issues that cannot be resolved on a motion to dismiss, and defendants have provided no legal basis warranting dismissal of the complaint at this juncture.

For the foregoing reasons, defendants' motion to dismiss the complaint, pursuant to Fed.R.Civ.P. 12(b)(6), is denied.

SO ORDERED.

E.D.N.Y., 2009.
St. Paul Fire & Marine Ins. Co. v. Sledjeski & Tierney, PLLC
Not Reported in F.Supp.2d, 2009 WL 2151425
(E.D.N.Y.)

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CERTIFICATE OF SERVICE

The undersigned certifies that on this 10th day of October, 2012, I caused the foregoing to be served on:

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STATE OF WASHINGTON
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SIGNED this 10th day of October, 2012.



Connie Enns Jory