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3 Professional Liability Claims-Made Issues

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I. [3.1] HISTORICAL OVERVIEW

Following the significant increase in the number of civil actions brought against professionals beginning in the early 1970s, the insurance industry responded by providing insurance products that offered protection to various professionals (*e.g.,* lawyers, accountants, actuaries, and insurance agents, as well as physicians, whose exposure to civil lawsuits began to increase in the late 1960s). As initially developed by the insurance industry, professional liability policies in large part copied public-liability policies, both linguistically and conceptually. Typical public-liability policies in use at that time provided coverage for "occurrences" or "accidents" (discernible events causing injury). Consequently, many professional liability policies were originally written on an occurrence (accident) basis.

Over time, however, professional liability insurers learned that underwriting and pricing problems were frequently associated with the occurrence-based form of policies for professionals. The underwriting problem was that the application of a policy to repeated or similar negligent acts, or to a particular act that caused multiple harms, created conceptual and interpretive difficulties, just as long-tail claims, such as asbestos, have caused problems for public-liability insurers. The pricing problem was that the passage of time between the accident and the payout was too long. The product could not be priced accurately given increased litigation, inflation in general, and verdict inflation.

A policy form was needed that would lend certainty to the underwriting issues and also reduce the delay between premium collection and payment by the insurer on the policy. Less delay would, of course, lead to more certain pricing.

Thus, the claims-made policy was created. Under this form, the policy in force at the time the claim is first made against the insured is the policy that responds. When the act occurred, or when the harm was suffered, is irrelevant to a determination of coverage. One perceived advantage from the industry's perspective was that the timing or trigger problems associated with the occurrence policy would be alleviated. Moreover, at the end of the policy year, assuming prompt notice by the insured of all claims first made against him or her during the policy period, the underwriter could accurately price the next year's policy. *Uhlich Children's Advantage Network v. National Union Fire Company of Pittsburgh, PA,* 398 Ill.App.3d 710, 929 N.E.2d 531, 340 Ill.Dec. 880 (1st Dist. 2010) (discussing differences between traditional occurrence policies and claims-made policies); *Continental Casualty Co. v. Coregis Insurance Co.,* 316 Ill.App.3d 1052, 738 N.E.2d 509, 250 Ill.Dec. 293 (1st Dist. 2000).

Claims-made policies were in several cases attacked by insureds, who asserted that they were void under public policy. The insureds contended that the claims-made policies restricted their freedom to contract since, in order to maintain continuous coverage, the insureds were tied to one insurer for subsequent policy terms. The courts rejected this argument, however, stating that insurers have the right to limit coverage to claims made during the policy period and noting that no state legislature had outlawed claims-made coverage. *See Livingston Parish School Board v. Fireman's Fund American Insurance Co.,* 282 So.2d 478 (La. 1973); *Mission Insurance Co. v. Nethers,* 119 Ariz. 405, 581 P.2d 250 (App. 1978). *But see Jones v. Continental Casualty Co.,* 123 N.J.Super. 353, 303 A.2d 91 (1973) (claims-made coverage limitation was against public policy and void because it inhibited insured's freedom to contract).

II. [3.2] OCCURRENCE POLICIES

As noted in §3.1 above, using an occurrence-based policy to insure the liability of a professional was problematical. For example, some occurrence policies were not clear about whether the act or the resulting harm triggered coverage under the policy. And even assuming the policy contained clear language, what would happen if a single occurrence gave rise to multiple harms, either to one person or to multiple persons? Conversely, what was the result if repeated negligent acts caused a single harm to one person or to more than one person? Analogous issues have been litigated under public-liability policies in mass tort claims. These questions have also been litigated with respect to professional liability policies. *See, e.g., Village of Camp Point, Illinois v. Continental Casualty Co.,* 219 Ill.App.3d 86, 578 N.E.2d 1363, 161 Ill.Dec. 717 (4th Dist. 1991) (court focused on acts of negligence committed by law firm in determining that there were multiple occurrences under series of legal malpractice policies); *Doe v. Illinois State Medical Inter-Insurance Exchange,* 234 Ill.App.3d 129, 599 N.E.2d 983, 174 Ill.Dec. 899 (1st Dist. 1992) (court focused on separate acts committed by physician (*i.e.*, prescription of incorrect drug for diabetes and later mistreatment of diabetes causing patient to contract hepatitis and HIV) and held that they constituted more than one occurrence); *Aetna Casualty & Surety Co. of Illinois v. Medical Protective Company of Fort Wayne, Indiana,* 575 F.Supp. 901 (N.D.Ill. 1983) (court focused on harm suffered by patient and ruled physician's initial drug prescription and subsequent failure to monitor patient's use of drug properly, which resulted in patient's blindness, constituted single "occurrence" within meaning of medical malpractice policy); *Medical Malpractice Joint Underwriting Association of Rhode Island v. Lyons,* No. PC 00-5583, 2004 WL 3190049 (R.I.Super. Dec. 17, 2004) (court focused on separate acts committed by physician (*i.e.*, failure to properly treat diabetes and failure to properly treat infection) as two "medical incidents" under terms of professional liability insurance policy).

III. [3.3] CLAIMS-MADE AND HYBRID CLAIMS-MADE POLICIES

Today, only a few lines of professional liability insurance, localized to particular jurisdictions, are written on an occurrence basis. The vast majority are written on a claims-made basis.

As a general proposition, claims-made policies provide protection against errors, omissions, and acts of negligence that result in a claim first made against the insured during the time that the policy is in force. *See St. Paul Fire & Marine Insurance Co. v. Barry,* 438 U.S. 531, 57 L.Ed.2d 932, 98 S.Ct. 2923, 2926 n.3 (1978) ("An 'occurrence' policy protects the policyholder from liability for any act done while the policy is in effect, whereas a 'claims made' policy protects the holder only against claims made during the life of the policy.").

In its original form, a claims-made policy (sometimes referred to as a "pure claims-made policy") furnished coverage only for claims first made against the insured during the policy period. Neither the date of the insured's conduct nor the date of the claimant's harm was a consideration in determining whether the policy afforded coverage for the subject loss. What is more, whether the insured provided notice of the claim to the insurer during the policy period was irrelevant. *See Stine v. Continental Casualty Co.,* 419 Mich. 89, 349 N.W.2d 127 (1984) (providing thorough discussion of claims-made concept). Despite quite a few opinions in which

the courts stated simplistically (and without regard to the historical development of the claims-made form) that the overarching hallmark of a claims-made policy is that the claim first be made against the insured during the policy period and that the claim then must be reported to the insurance company during that same policy period, the industry-wide original claims-made forms required only that the claim be first made against the insured during the policy year.

Eventually, however, the insurance industry (perhaps because of the courts discussing policies whose language was unclear by virtue of the fact they did not plainly articulate whether the claim must first be made against the insured or against the policy (*i.e.*, the insurer) or because the first public-liability (commercial general liability) versions of claims-made forms promulgated by the Insurance Services Office provided that a claim first made could mean a claim asserted against the insured or brought to the attention of the insurer) developed a hybrid policy, which is a variation of the pure claims-made policy. These forms require two things: (a) that the claim first be made against the insured during the policy period; and (b) that notice of the claim be given to the insurance company during that policy period. These forms, though hybrids, have come to be known today generally as "claims-made policies," despite the substantive difference from the original claims-made contract. *See Graman v. Continental Casualty Co.*, 87 Ill.App.3d 896, 409 N.E.2d 387, 42 Ill.Dec. 772 (5th Dist. 1980) (loosely describing hybrid policy as claims-made policy). The hybrid policy now is, by substantial margin, the predominant form that is offered by the insurance industry to its customers and is referred to today in legal and insurance parlance as a "claims-made policy."

Both of the requirements in a hybrid policy's insuring agreement must be met for there to be coverage for a particular claim. *Continental Casualty Co. v. Cuda,* 306 Ill.App.3d 340, 715 N.E.2d 663, 239 Ill.Dec. 909 (1st Dist. 1999). *See also National Railroad Passenger Corp. v. Lexington Insurance Co.,* No. Civ.-01-1815(ESH), 2003 WL 24045159 (D.D.C. May 20, 2003) (discussing many variations of claims-made policies). An interesting problem, however, surfaces when a claim is made against an insured toward the end of the policy period but notice is not provided to the insurer until after the policy period expires. In *Gulf Insurance Co. v. Dolan, Fertig & Curtis,* 433 So.2d 512 (Fla. 1983), a claim was asserted against the insured on the last effective day of the policy, but notice was not given to the insurer until several days later. The court upheld the policy's requirement that the claim must be first made and reported during the policy period, finding that to engraft a longer reporting period onto the policy would be to provide coverage not paid for by the insured. A New Jersey court reached the same conclusion on similar facts in *Zuckerman v. National Union Fire Insurance Co.,* 194 N.J.Super. 206, 476 A.2d 820 (1984). *But see Cast Steel Products, Inc. v. Admiral Insurance Co.,* 348 F.3d 1298 (11th Cir. 2003) (holding that professional liability policy afforded coverage for claim made against insured, despite fact that claim was first made during prior policy period but not reported until inception of policy, because prior policy was ambiguous about whether reporting period automatically extended when policy was renewed with same carrier).

In *Catholic Medical Center v. Executive Risk Indemnity, Inc.,* 151 N.H. 699, 867 A.2d 453 (2005), the insureds brought a declaratory-judgment action against their professional liability insurer alleging that they gave timely notice of seven potential claims by sending the claims by overnight delivery on the day before expiration of their claims-made policy. The notices were delivered just over nine hours after expiration of the policy period. The court concluded that the phrase "gives [the underwriter] written notice," although not defined in the insurance policy, was

unambiguous and required that the notice be received in order for it to be effective. 867 A.2d at 457. Therefore, the insureds were held not to have complied with the written notice provision of their claims-made liability policy.

The validity of the hybrid policy has been challenged on several grounds. In *New England Reinsurance Corp. v. National Union Fire Insurance Co.,* 654 F.Supp. 742 (C.D.Cal. 1986), *vacated,* 829 F.2d 840 (9th Cir. 1987), the question presented was whether the notice requirement contained in the insuring agreement violated California law, which holds that, absent prejudice to the insurer, late notice is not a defense under the policy. Like the pure claims-made policy, the hybrid policy has also been challenged on the basis that it violates public policy. However, courts have upheld the hybrid language as long as it is clearly and unambiguously drafted so as not to violate the reasonable expectations of the insured. *Merrill & Seeley, Inc. v. Admiral Insurance Co.,* 225 Cal.App.3d 624, 275 Cal.Rptr. 280 (1990); *Esmailzadeh v. Johnson & Speakman,* 869 F.2d 422 (8th Cir. 1989); *Poirier v. National Union Fire Insurance Co.,* 517 So.2d 225 (La.App. 1987).

IV. [3.4] WHAT IS A CLAIM?

A "claim" is an actual assertion or a demand by a third party to enforce a right against the insured for money or property. *See, e.g., Insurance Corporation of America v. Dillon, Hardamon & Cohen,* 725 F.Supp. 1461 (N.D.Ind. 1988) (holding that claims were made under legal malpractice policy since each included demand for money or property or some specific relief); *Central Illinois Public Service Co. v. American Empire Surplus Lines Insurance Co.,* 267 Ill.App.3d 1043, 642 N.E.2d 723, 725, 204 Ill.Dec. 822 (1st Dist. 1994) (recognizing that term "claim" in context of insurance means "a demand for something due or believed to be due"). *But see Hill v. Physicians & Surgeons Exchange of California,* 225 Cal.App.3d 1, 274 Cal.Rptr. 702 (1990) (patient's expression of dissatisfaction with insured physician's treatment did not constitute claim since no monetary demand was made). *See also National Casualty Co. v. Great Southwest Fire Insurance Co.,* 833 P.2d 741 (Colo. 1992) (when claimant, former police officer suing for wrongful termination, wrote letter to city asking to be reinstated to her former position, it constituted claim for purposes of claims-made insurance because it was demand to enforce right).

Most professional liability policies now define what constitutes a "claim" for purposes of triggering coverage. *Chalk v. Trans Power Manufacturing, Inc.,* 153 Wis.2d 621, 451 N.W.2d 770, 772 (Wis.App. 1989) (holding that two governmental inquiries did not meet policy's definition of "claim," which was defined as "a demand received by the insured for money or services," because inquiries were merely seeking general information about insured attorney's files and did not charge attorney with any wrongdoing); *Westport Insurance Corp. v. Law Offices of Marvin Lundy,* No. Civ.A. 03-CV-3229, 2004 WL 555415 (E.D.Pa. Mar. 19, 2004) (holding that letter sent to law firm indicating intent to seek monetary damages from firm's malpractice insurer or from firm directly for firm's alleged malpractice fell within definition of "claim" found in firm's malpractice policy). However, when the subject policy does not define "claim," the courts will generally employ the ordinary meaning of the term. *See National State Bank, Elizabeth, N.J. v. American Home Assurance Co.,* 492 F.Supp. 393 (S.D.N.Y. 1980) (since "claim" was not defined in policy, its ordinary meaning (*i.e.,* assertion of legal right by third party

against insured) would be used); *Musmeci v. Schwegmann Giant Super Markets, Inc.,* 332 F.3d 339 (5th Cir. 2003) (term "claim" in self-insured retention provision was clear and unambiguous and provided that claim was assertion of legal right against insured by third party and not demand for coverage by insured against its insurer).

Definitions aside, what fact patterns constitute a claim made against an insured under a claims-made policy? The answer embodies an important distinction between actual assertions or demands and threatened or potential assertions or demands. A telephone call from a third party stating an intention to hold the insured accountable for repairs to a parking structure is a claim. *Continental Casualty Co. v. Enco Associates, Inc.,* 66 Mich.App. 46, 238 N.W.2d 198 (1975). Similarly, a client's demand to his or her attorney that the attorney work for free to cure defective legal documents is a claim. *Phoenix Insurance Co. v. Sukut Construction Co.,* 136 Cal.App.3d 673, 186 Cal.Rptr. 513 (1982). A letter from an attorney to an insured that clearly and unambiguously states the intention of a former client to bring a lawsuit against the insured also constitutes a claim. *Stiefel v. Illinois Union Insurance Co.,* 116 Ill.App.3d 352, 452 N.E.2d 73, 72 Ill.Dec. 141 (1st Dist. 1983). *See also Rentmeester v. Wisconsin Lawyers Mutual Insurance Co.,* 164 Wis.2d 1, 473 N.W.2d 160 (1991) (letter from attorney to insured asking insured to notify his professional liability insurer of negligently drafted contract constituted claim). An assertion against a design professional stating that the professional is going to be held responsible for correcting a condition caused by his or her defective design is a claim. *Williamson & Vollmer Engineering, Inc. v. Sequoia Insurance Co.,* 64 Cal.App.3d 261, 134 Cal.Rptr. 427 (1976). Even a letter from a customer to an engineering firm's insurer reaffirming the customer's insistence that the insured take immediate steps to remedy contractual shortcomings is a demand for services and, therefore, constitutes a claim. *International Insurance Co. v. Peabody International Corp.,* 747 F.Supp. 477 (N.D.Ill. 1990).

On the other hand, there are instances in which communications to the insured may portend the possibility of a claim but do not, by themselves, rise to the level of a claim. For example, an attorney's letter that merely inquires into the decision-making process of the insured and requests further information is not a claim. *Hoyt v. St. Paul Fire & Marine Insurance Co.,* 607 F.2d 864 (9th Cir. 1979). Similarly, a letter from an attorney to a hospital requesting medical records, ostensibly for the purpose of seeking alternative modes of treatment, is not a claim. *Columbia Casualty Co. v. Columbia Hospital for Women,* 633 F.Supp. 697 (D.D.C. 1986). *But see American Continental Insurance Co. v. Marion Memorial Hospital,* 773 F.Supp. 1148 (S.D.Ill. 1991) (hospital was put on notice of claim when well-known plaintiff's personal injury lawyer requested medical records concerning birth of baby). But a letter from a developer's attorney informing an insured construction company to cease working on a project due to substantial damages caused by the construction company's negligence is not a claim if the letter fails to indicate what acts of the construction company were done negligently. *Gibraltar Casualty Co. v. A. Epstein & Sons, International, Inc.,* 206 Ill.App.3d 272, 562 N.E.2d 1039, 150 Ill.Dec. 236 (1st Dist. 1990).

In sum, the courts generally recognize the following distinction: if a party formally asserts a right against, demands compensation from, or indicates that he or she will seek compensation from the insured, there is a claim. However, when a party merely indicates to an insured that the

party is seeking information or only requests from the insured an explanation of the insured's conduct, there is not a claim. For a good discussion of the distinction, *see Williamson & Vollmer Engineering, supra.*

V. [3.5] WHEN IS A CLAIM MADE?

As noted in §3.3 above, coverage under a claims-made policy is triggered on the date the claim is first made against the insured. Unless the policy specifically requires that the insured receive actual notice of the claim at the time it is first asserted, the date a lawsuit is filed can be the date the claim is made, even if the insured is not served with the suit until after the policy expires. *Employers Reinsurance Corp. v. Phoenix Insurance Co.,* 186 Cal.App.3d 545, 230 Cal.Rptr. 792 (1986). *See also Pizzini v. American International Specialty Lines Insurance Co.*, 210 F.Supp.2d 658 (E.D.Pa. 2002) (breach of contract claim was "first made" for purposes of claims-made professional liability policy when demand letter was received by insured claiming violation of state securities laws, demanding repayment, and threatening legal action, and not when subsequent lawsuit was filed against or served on insured).

It has been suggested that when an assertion of wrongdoing is followed by several years of silence and then reasserted, a fact question may exist as to when the claim was first made. *St. Paul Mercury Insurance Co. v. Statistical Tabulating Corp.,* 155 Ill.App.3d 545, 508 N.E.2d 433, 108 Ill.Dec. 272 (1st Dist. 1987). When a lawsuit is filed before the effective date of a claims-made policy, there is no coverage even if a second amended complaint is filed after inception since the amended complaint is based on the original suit. *Employers Insurance of Wausau v. Bodi-Wachs Aviation Insurance Agency, Inc.,* 39 F.3d 138 (7th Cir. 1994). *Cf. Highwoods Properties, Inc. v. Executive Risk Indemnity, Inc.,* 407 F.3d 917 (8th Cir. 2005) (holding that claims-made policy did not afford coverage for breach of fiduciary duty suit filed and reported during that policy period because claim was sufficiently related to predecessor suit filed before inception of policy). However, when a complaint is amended to add an insured as a defendant for the first time, coverage will be granted under the claims-made policy in effect when the amended complaint was filed. *Employers Insurance of Wausau, supra. But see Community Foundation for Jewish Education v. Federal Insurance Co.,* No. 98 C 7680, 2000 WL 520924 at *5 (N.D.Ill. Apr. 24, 2000) (claims-made insurance policy defined claim as being "commenced by the service of a complaint or similar pleading"; filing of original complaint and not later amendments constituted claim; since claim was made prior to policy period, no duty to defend existed, either initially or as amended).

The practitioner who has occasion to litigate claims-made policies should meticulously review the policy language to determine precisely what the insurer is and is not agreeing to insure. A drafting error may require the insurer to cover a claim about which the insured had knowledge prior to the inception date of the policy. *See, e.g., Perkins & Will v. Security Insurance Company of Hartford,* 219 Ill.App.3d 807, 579 N.E.2d 1122, 162 Ill.Dec. 308 (1st Dist. 1991). Although lacking justice (see the dissent by Justice Jiganti), the majority's result in *Perkins & Will* is supported by the policy's language. In *St. Paul Insurance Company of Illinois v. Armas,* 173 Ill.App.3d 669, 527 N.E.2d 921, 123 Ill.Dec. 283 (1st Dist. 1988), the policy

suggested a claim is made when a loss is suffered and did not define "loss." The court found the policy to be ambiguous because "loss" could mean the entry of judgment and finding of liability or could mean merely the filing of a complaint.

VI. [3.6] PRIOR ACTS/RETROACTIVE DATE

Because claims-made policies limit coverage to claims first made during the policy period, a problem, in the form of a moral hazard, may arise if the insured has knowledge of acts committed prior to the inception of the policy that may lead to a claim being asserted against him or her during the policy period. For example, a lawyer without insurance may know that he or she has failed to file an action within the applicable statute of limitations but may not have told his or her client of the error. What is to prevent the lawyer from purchasing a claims-made policy before notifying the client of his or her nonfeasance to ensure coverage when the claim is asserted against him or her during the policy period?

Underwriters have devised several ways to combat the aforementioned problem. One way is to insert a prior-acts exclusion in the policy, which simply states that there is no coverage for any act or omission that occurs prior to the referenced date, even if the claim is made during the policy term. *General Insurance Company of America v. Robert B. McManus, Inc.,* 272 Ill.App.3d 510, 650 N.E.2d 1080, 209 Ill.Dec. 107 (1st Dist. 1995) (holding that prior-acts exclusion precluded coverage for insurance broker who placed his client's business with unlicensed carrier more than two years before inception date of errors-and-omissions policy). *See also International Surplus Lines Insurance Co. v. Manufacturers & Merchants Mutual Insurance Co.,* 140 N.H. 15, 661 A.2d 1192 (1995); *Smith v. Neumann,* 289 Ill.App.3d 1056, 682 N.E.2d 1245, 225 Ill.Dec. 168 (2d Dist. 1997) (holding that "prior acts" language in policy, which provided coverage for negligent acts committed before effective date of policy only if no other insurer afforded coverage for loss, barred coverage for malpractice claim against attorney because attorney's prior insurer provided coverage for claim).

Executive Risk Indemnity, Inc. v. Pepper Hamilton LLP, 13 N.Y.3d 313, 919 N.E.2d 172, 891 N.Y.S.2d 1 (2009), involved a significant East Coast law firm. There the Court of Appeals for the State of New York (New York's highest court) interpreted a generic exclusion in a law firm's malpractice policy in which coverage was precluded for any act, error, omission, or circumstances occurring prior to the effective date of the policy if any insured knew or could have reasonably foreseen that such act, error, omission, or circumstance might be the basis for a claim. The court determined that the law firm was not entitled to coverage when it was sued in connection with securities violations perpetrated by a client of the law firm. The court held that the language of the exclusion required both subjective (actual) knowledge by the insured as well as an objective understanding as to what a reasonable insured attorney would understand. Because the law firm had actual knowledge of the fact that the firm might be subject to litigation, that knowledge, coupled with the insured's awareness of its role in the securitization of the loans, meant that the insured reasonably (*i.e.*, objectively) understood that it might be made a defendant in a lawsuit. Consequently, the exclusion applied, and no coverage was available under the particular claims-made policy for the lawsuit against the insured.

Another way to combat the problem — a functional equivalent, but not in the form of an exclusion — is a retroactive date. A retroactive date is simply a referenced date for which, if a claim arises from an act or omission prior to that date, coverage will not be available.

Yet another device used to obviate coverage for prior acts is a provision in the policy's insuring agreement that negates coverage if, at the policy inception date, the insured is aware of facts or circumstances that might reasonably give rise to a claim. *Stiefel v. Illinois Union Insurance Co.*, 116 Ill.App.3d 352, 452 N.E.2d 73, 72 Ill.Dec. 141 (1st Dist. 1983) (holding that insured attorney was not entitled to malpractice coverage for lawsuit by former client because insured received letter threatening legal action prior to inception of policy). *See also Gibraltar Casualty Co. v. A. Epstein & Sons, International, Inc.*, 206 Ill.App.3d 272, 562 N.E.2d 1039, 1043 – 1045, 150 Ill.Dec. 236 (1st Dist. 1990) (distinguishing *Stiefel* on grounds that subject insuring agreement required actual knowledge by insured of claim and not just reasonable expectation that claim may arise).

A case in which the court discussed the issues in relation to the moral hazard with which the insurer is faced is *Colliers Lanard & Axilbund v. Lloyds of London*, 458 F.3d 231 (3d Cir. 2006). In *Colliers Lanard & Axilbund*, the policy granted retroactive coverage for claims made against the insured "provided that the insured had no knowledge of any suit, or any act or error or omission, which might reasonably be expected to result in a claim or suit as of the date of signing the application for this insurance." 458 F.3d at 234. In holding that the policy did not provide coverage for the subject claim, the court opined:

> **[**T**]he plain language of the policy exclusion mandates a subjective test for the first part of the necessary inquiry — whether the insured had knowledge of a suit, act, error, or omission — and an objective test for the second part of the necessary inquiry — whether the suit, act, error, or omission might reasonably be expected to result in a claim or suit.** 458 F.3d at 233.

See also Carosella & Ferry, P.C. v. TIG Insurance Co., 189 F.Supp.2d 249 (E.D.Pa. 2001); *Smith, supra*, 682 N.E.2d at 1253 – 1255 (employing only objective test to determine whether insured had reason to believe his alleged errors may result in claim). *Colliers Lanard & Axilbund* contains a good summary of the considerations the courts use in evaluating the efficacy of policy provisions of this type, as well as an overview of various cases in which the courts discuss this as well as related questions.

Somewhat related to an insured's prior knowledge of a claim is the situation in which related or similar conduct gives rise to multiple claims or when a single act gives rise to multiple claims. Most underwriters of claims-made policies intend to treat all claims that are related, in one form or another, as a single claim, not only because the underwriter wants to telescope the limits of coverage to the smallest possible amount, but also because, by treating similar claims as a single claim, underwriting certainty is increased and, therefore, the ability to accurately price the business is enhanced. In *Continental Casualty Co. v. Howard Hoffman & Associates*, 2011 IL App (1st) 100957, 955 N.E.2d 151, 352 Ill.Dec. 975, a law firm was sued in connection with work done by one of its employees pertaining to the handling of numerous estates from which the employee had embezzled money. The ultimate question to be decided by the court was whether

the per-claim limit of $100,000 or the aggregate limit of $300,000 was available to satisfy several claims. The policy contained, as most professional liability policies do, a provision that stated that related claims would be treated as a single claim, which would fall under the policy in which the first of such claims was reported to the company. In a well-written decision, in which the court provides a comprehensive survey of relevant law, it concluded that the claims were in fact related in the fashion set forth by the policy language, such that the $100,000 per-claim limit applied to all of the claims against the law firm.

VII. [3.7] APPLICATION FOR INSURANCE

The moral hazard regarding prior acts by the insured mentioned in §3.6 above can also be alleviated by using specific questions in the application to seek information about facts or circumstances that might give rise to a claim. If the insured reveals facts in the application that may give rise to a claim, then the underwriter will exclude any claims made that relate to the information revealed.

It is, however, an uphill battle for an insurer to prove that an insured misrepresented facts in the process of obtaining an insurance policy. *See, e.g., Great West Steel Industries, Ltd. v. Northbrook Insurance Co.,* 138 Ill.App.3d 84, 484 N.E.2d 847, 92 Ill.Dec. 116 (1st Dist. 1985). But a court will rescind a policy for an intentional failure to reveal intentionally dishonest or criminal acts. In *Home Insurance Co. v. Dunn,* 963 F.2d 1023 (7th Cir. 1992), for example, the court voided a legal malpractice policy when it was discovered that the firm president failed to state on the application that he had embezzled funds from various client accounts. In general, though, courts are likely to be receptive to the insurer's position only when the insured knew or had reason to know that it had breached a professional duty or that a claim might be asserted against it. *See Stiefel v. Illinois Union Insurance Co.,* 116 Ill.App.3d 352, 452 N.E.2d 73, 72 Ill.Dec. 141 (1st Dist. 1983); *American Guarantee & Liability Insurance Co. v. Jaques Admiralty Law Firm, P.C.,* 121 Fed.Appx. 573 (6th Cir. 2005) (law firm's responses on application for professional liability insurance policy indicating that none of its attorneys had any knowledge of any circumstances that could result in claim amounted to material misrepresentations given law firm's concession that its president knew that his misappropriation of funds owed to clients exposed firm to potential liability; firm's representation that no attorney possessed such knowledge was false, and insurer had common-law right to rescind insurance policy).

In *TIG Insurance Co. v. Reliable Research Co.,* 228 F.Supp.2d 921 (S.D.Ill. 2002), an insurer brought an action against its insured to rescind a title and escrow professional liability insurance policy. The application asked the proposed insured whether it had been the subject of any claims or suits in the previous ten years. The insured responded to that question in the affirmative but failed to include a reference to a cause of action that sought a permanent injunction for the unauthorized practice of law. A permanent injunction ensued, and the insured was named in two lawsuits. The insured sought defense and indemnity from the insurer. The insurer argued that it was entitled to rescission of the insurance policy because of the insured's material misrepresentation in its failure to report the permanent injunction lawsuit. The insured argued that the omission was not a material misrepresentation because the phrase "claims/suits" in the application was ambiguous. 228 F.Supp.2d at 925 – 926. The court concluded that under the common, ordinary, and popular meaning of these terms, the action for a permanent injunction

was a "claim/suit" and therefore, should have been disclosed. 228 F.Supp.2d at 928. The court found that the insured made a misrepresentation on its insurance policy that entitled the insurer to rescind the insurance policy.

VIII. [3.8] DISCOVERY CLAUSE

An insured professional may face the following dilemma: Assume that an insured attorney has a current claims-made policy in force with insurer *A.* Assume also that the insured wants to switch to carrier *B* upon the expiration of *A*'s policy and that the insured will be purchasing claims-made coverage from *B.* In order to obtain the insurance from *B,* the insured will be required to fill out an application that will contain a question asking whether the insured is aware of facts or circumstances that might give rise to a claim (see §3.7 above). Assume further that the insured knows that a client has a problem with the way in which the insured has handled the client's file, that the client has expressed this to the insured, but that at the time the insured fills out its application, the matter is still unresolved.

If the insured says nothing about the matter and it later erupts into a claim at the time that the policy with insurer *B* is in force, *B* will avoid providing coverage when it learns that the insured was aware of the circumstances during the application process. If the insured turns to insurer *A* for coverage, that insurer will also deny coverage because, of course, a claim had not been asserted against the insured during the time that *A*'s policy was in force (*i.e.,* no claim was made during that coverage period).

In order to alleviate the perceived harshness inherent in this scenario, claims-made policies typically include a "discovery clause" or "awareness provision." Such a provision generally provides that if, during the term of a claims-made policy, the insured becomes aware of circumstances that may give rise to a claim, or the insured is told by a third person that the third person believes the insured has erred, and the insured gives notice of the circumstance or the possible claim to its current claims-made carrier, a claim made after the policy expires will relate back to the time that notice was given to the insurer and will be deemed to be a claim made during the policy period.

One Illinois court has recognized that such a provision is to be given effect if the later-asserted claim is connected with the notice previously given to the insurance company. *Harbor Insurance Co. v. Arthur Andersen & Co.,* 149 Ill.App.3d 235, 500 N.E.2d 707, 102 Ill.Dec. 814 (1st Dist. 1986). *But see KPFF, Inc. v. California Union Insurance Co.,* 56 Cal.App.4th 963, 66 Cal.Rptr.2d 36 (1997) (notice that would have triggered coverage for subsequent claims under awareness provision of policy held insufficient).

A recent case that deals with a discovery provision, albeit in the context of an excess products-liability policy, is *Federal Insurance Co. v. Lexington Insurance Co.,* 406 Ill.App.3d 895, 941 N.E.2d 996, 347 Ill.Dec. 127 (1st Dist. 2011). There, the insured, a manufacturer of explosives, became aware of an accident and at that time gave telephone notice to its broker. The excess policy contained a provision that if the insured became aware of circumstances that might involve the policy and gave written notice to the broker, then a claim later made against the insured involving the circumstances that were reported to the broker would be deemed to have

been a claim made against the insured during the policy period. Even though telephonic notice was given to the broker, written notice was not given to the broker. Under the circumstances, the court held that the excess insurer was excused from performing based on noncompliance with the strict requirements by which notice of circumstances could be reported to the insurance company.

Despite fears of nonrenewal, cancellation, or increased premiums, professional practitioners are advised to notify their claims-made carrier immediately upon learning of any negligence or of a possible claim. Failure to give notice may lead to a forfeiture of coverage if the circumstances later ripen into an actual claim. *Washington Casualty Co. v. Doctors' Co.*, 110 Wash.App. 1032 (2002) (text available in Westlaw) (under claims-made medical malpractice insurance policy, notice of claim alleging negligence in procedure used to move unborn baby out of breech position was not notice of potential claim against different doctor in same clinic arising from his delivery of baby week later; since negligence in delivery was not claimed until after clinic's policy period).

IX. [3.9] EXTENDED REPORTING/TAIL COVERAGE

Insureds who have claims-made policies must address another matter of concern. If the insured is, for example, going to retire from his or her practice, the insured faces an exposure for claims made in the future, but upon retirement, the insured is not likely to be able to purchase a new claims-made policy that will protect him or her for claims made after retirement.

The insurance industry's solution to this problem is to offer insureds, under limited circumstances, extended reporting, tail, or optional extension period endorsements. The endorsements provide the option, which usually must be exercised within a short period of time after expiration of the claims-made policy, to purchase additional coverage, usually for one to five years. Offered on a reduced premium basis, the tail responds to claims made after the expiration of the claims-made policy but applies only when the act or omission occurred before expiration of the last claims-made policy (*i.e.*, prior to the inception of the tail coverage).

In those circumstances when the insurer elects not to renew coverage or offers renewal on terms substantially different from the expiring policy (often considered a refusal to renew), the insured professional may be entitled to invoke the extended reporting provision. *Associated Physicians Insurance Co. v. Obasi*, 262 Ill.App.3d 343, 633 N.E.2d 752, 198 Ill.Dec. 911 (1st Dist. 1993); *American Casualty Company of Reading, Pennsylvania v. Rahn*, 854 F.Supp. 492 (W.D.Mich. 1994); *McCuen v. American Casualty Company of Reading, Pennsylvania*, 946 F.2d 1401 (8th Cir. 1991).

The courts have recognized that extended reporting and tail coverage provisions expand the otherwise limited coverage available under a claims-made form. As noted in §3.1 above, claims-made forms have been attacked on public policy grounds as being restrictions on the freedom to contract. In *Brander v. Nabors*, 443 F.Supp. 764 (N.D.Miss.), *aff'd*, 579 F.2d 888 (5th Cir. 1978), however, the extended reporting feature was an aspect of the contract that led the court to conclude that the claims-made form was not against public policy. It has been said that when an insured elects not to purchase the three-year extended reporting endorsement, the insured has no

standing to argue that his or her claims-made contract was so inadequate as to invalidate it as being against public policy. *Langley v. Mutual Fire, Marine & Inland Insurance Co.*, 512 So.2d 752 (Ala. 1987), *overruled on other grounds by Hickox v. Stover*, 551 So.2d 259 (Ala. 1989).

X. [3.10] NOTICE CONDITIONS IN CLAIMS-MADE POLICIES

Practitioners should be aware of the significance of a notice condition in the context of claims-made policies. Particularly, to obtain coverage under a hybrid claims-made policy, a claim must generally be made against the insured and reported to the insurer during the policy period. See §3.3 above. A notice condition, however, can further restrict the circumstances pertaining to the notice given to the insurer. Significantly, an insured may be denied coverage for a claim even if it is made and reported during the policy period if the insured did not promptly notify the carrier of the claim after the insured received notice of it.

In *St. Paul Reinsurance Co. v. Williams & Montgomery, Ltd.*, No. 00 C 5037, 2001 WL 1242892 (N.D.Ill. Oct. 17, 2001), the notice provision in the insured's claims-made policy required the insured to notify the carrier within 30 days from the date the insured received notice of a complaint or demand. The court held that the notice provision was a condition precedent to coverage, and, therefore, the insured's failure to timely notify the carrier of a claim and subsequent lawsuit was sufficient to excuse coverage under the policy. *See also American National Fire Insurance Co. v. Harold Abrams, P.C.*, No. 99 C 5807, 2002 WL 243455 (N.D.Ill. Feb. 19, 2002) (defendants failed to satisfy immediate notice and same policy period reporting requirements under claims-made professional liability insurance policy when they reported suit years after claims against them were first made); *American Motorists Insurance Co. v. Stewart Warner Corp.*, No. 01 C 2078, 2004 WL 1444889 at *3 (N.D.Ill. June 25, 2004) (11-month delay in reporting claim was unreasonable because insurance policy required "immediate" notice or notice "as soon as practicable"; three-month delay after receipt of claim letter was not unreasonable as matter of law).

What is more, an insured's compliance with the notice condition may not salvage an otherwise uncovered claim. Consider the following example: A doctor secures a hybrid claims-made policy, which provides coverage for claims first made against the doctor and reported to the insurer during the policy period. The policy also requires the doctor to notify the carrier as soon as practicable of any claim. A claim is made against the doctor on the eve of the policy's expiration, but the doctor is unable to report the claim until the following day. Although the doctor certainly complied with the policy's notice provision by promptly notifying the carrier, his claim would ostensibly be denied under a strict application of the reporting provision since it was reported after the policy expired. *Contra Root v. American Equity Specialty Insurance Co.*, 130 Cal.App.4th 926, 30 Cal.Rptr.3d 631 (2005) (holding that attorney's failure to report claim during policy's reporting period was excusable as matter of equity when attorney learned of claim shortly after expiration of policy).

An interesting recent decision that demonstrates how an insured can find itself without coverage due to how it reports a claim is *Atlantic Health System, Inc. v. National Union Fire Insurance Company of Pittsburgh*, 463 Fed.Appx. 162 (3d Cir. 2012). There, the insured had consecutive claims-made policies. The claim was not covered under the later policy because the

insured had knowledge of the claim prior to the inception of that policy. The claim was not covered under an immediately preceding policy, because the notice was not timely, *i.e.*, it was not sent during the policy period or within the 30-day grace period. In addition, renewal applications, which had alluded to the claims and which had been sent to the insurer, did not serve to provide proper notice to the insurer, because the notices were not sent to the address specified in the policy. Rather, the applications were directed to another office of the same insurance company that was located just one block away from the office to which the notice was supposed to have been addressed.