Insurance Coverage & BAD-FAITH LITIGATION

Connecticut Law Tribune

Special Section | February 16, 2015

AFTER THE STORM

Epic weather events offer vital lessons for insurers, policyholders

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Getting Schooled by Sandy and Irene

Major storms offer important lessons about insurance coverage

By REGEN O'MALLEY and STEVEN ZAKRZEWSKI

It is a simple premise, but many insurance coverage disputes, perhaps even a majority of them, could be completely avoided if policyholders would take the time to read their insurance policies. With winter storms upon us, now might be a good time.

No matter how complex the legal issues or controlling authorities are in any coverage case, the analysis almost always starts and ends with the express language of the insurance policy at issue. As the U.S. District Court in Connecticut often tells us, insurance policies are interpreted "in accordance with the parties' intent, as derived from the plain and ordinary meaning of the policy's terms." It nonetheless appears that many of the coverage disputes popping up on Connecticut's federal docket arise from a failure to follow the most basic commandment applicable to every insurance policy, or any other contract for that matter: Thou shalt read the policy, and read it in its entirety.

The words in an insurance policy have a legally binding effect, and they are therefore chosen very carefully. It behooves policyholders to read every single one of those words, no matter how tedious, lest they be caught unaware at the worst possible time.

Two cases recently decided by the district court in the wake of Hurricanes Irene and Sandy shine a spotlight on the importance of reading the entire insurance policy and reviewing your coverage with your agent or broker. These cases show that understanding the express language of the policy is not only crucial for the policyholder to anticipate which claims will be covered and which will not in order to ensure appropriate coverage, but also so that the policyholder knows exactly what must be done in order to properly present a claim for coverage after the damage has been done. In each case, the court granted summary judgment in the insurer's favor based on the plain language of the disputed policy.

Regen O'Malley

Steven Zakrzewski

Azoulay v. Allstate Insurance, No. 3:12-cv-1693(JBA), 2014 U.S. Dist. LEXIS 159177 (D. Conn. Nov. 12, 2014), arose from a coverage dispute between the plaintiff, Moshe Azoulay, and his insurer, Allstate Insurance Co., regarding his claim for flood damage to his property caused by Hurricane Irene. Azoulay's policy was a standard flood insurance policy, which was promulgated by the Federal Emergency Management Agency and which Allstate was not permitted to alter in any way. Every such policy requires an insured seeking compensation for a loss to send the insurer a "proof of loss," which is the insured's statement of the amount that he or she is claiming under the policy, within 60 days of the loss. This proof of loss must be "signed and sworn to by the insured."

Azoulay's property was damaged by Hurricane Irene in August 2011, and within two months he provided Allstate's assigned adjuster with receipts for cleanup costs totaling $5,000 and an itemized list of damages to the property totaling an additional $35,983. Allstate's adjuster provided Azoulay with a proof of loss concluding that the total cost of repairing his property was $2,044, leaving him with a covered claim of $44 after factoring out his $2,000 deductible. Azoulay signed, notarized and faxed Allstate this proof of loss, adding the notation "undisputed damages only." He also sent Allstate copies of receipts, a list of itemized damages, and pictures of the damaged property, none of which were signed or notarized. Azoulay then filed suit after Allstate failed to respond to him regarding his claims in excess of $44.

Allstate moved for summary judgment, arguing that Azoulay did not comply with his flood insurance policy's proof of loss requirement with respect to his additional claims because the only signed and sworn proof of loss that he submitted was for $44. The court accepted Allstate's argument, holding that Azoulay's attachment of itemized damages did not suffice as a supplemental proof of loss, because this document was neither signed nor notarized as required by the standard flood insurance policy. The court relied on the U.S. Court of Appeals for the Second Circuit's legal standard that "because the federal government is liable for claims brought under [standard flood insurance policies] issued by private insurers, the constitution mandates strict compliance with the [policy]," and granted summary judgment in Allstate's favor. The world will never know how much Azoulay might have recovered if he had only signed and notarized his itemized list of additional damages.

Warehouse Flooding

Despite the heightened standard applicable to standard flood insurance policies, the lesson is broadly applicable. The district court's holding in *Great Lakes International Trading v. Travelers Property Casualty Co. of America*, No. 3:13-cv-01522(JAM), 2014 U.S. Dist. LEXIS 165378 (D. Conn. Nov. 26, 2014), is literally the case in point.

The *Great Lakes* case arose from the plaintiff's disputed claim for over $1.5 million in damages to the insured's inventory of seeds, dried fruit

■ Continued on PAGE S4

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Insurer's Replacement Obligations Aren't Black and White

Storm-damaged buildings raise questions about materials used in repairs

By MICHAEL McCORMACK

The storms that have hit New England during the past few weeks serve as another reminder of the potential for property insurance claims arising from damage to homes and commercial business properties caused by weather-related events. With such claims comes the potential for disputes between insurance companies and property owners over the amount the insurer must pay to repair or replace damaged property under insurance policies that provide coverage to replace damaged property. A recent Minnesota Supreme Court decision provides some guidance to property owners and insurers concerning the extent of an insurance company's obligation to pay to replace damaged property under insurance policies in which the insurer agrees to pay for the cost of replacing damaged property with property of comparable material and quality.

Under most homeowner and commercial business property insurance policies, the insurer agrees to pay for loss caused by direct physical loss of, or damage to, the insured property caused by a risk of loss insured under the policy. Under the loss payment provision of most policies, the insurer generally has the right to choose one of the following remedies it will provide the insured: (1) it may pay the value of the lost or damaged property; (2) it may pay the cost of repairing or replacing the lost or damaged property; (3) it may take the damaged property at an agreed appraised value; or (4) it may repair, replace or rebuild the damaged property with other property of like kind and quality.

If the insurance company agrees to pay to replace the damaged property, the insurer is usually required to pay the cost to replace the damaged property with "like property" or property that is of "comparable material and quality" to the damaged property. When confronted with a dispute between a property owner and an insurance company over the insurer's obligation to pay replacement costs, courts usually rule that the insurance company is not required to pay to replace the damaged property with property identical to that which is damaged. The courts will often analyze whether the proposed repair can be accomplished with a replacement part that returns the property to like construction and result as before the loss and which is effective and provides an acceptable aesthetic result.

Damaged Siding

In *Cedar Bluff Townhome Condominium Association v. American Family Mutual Insurance*, 857 N.W.2d 290 (Minn. 2014), the Minnesota Supreme Court ruled that an insurance company was required to replace the entire siding on 20 damaged buildings when sections of damaged siding on each building could not be replaced with siding of a color that matched the existing siding. In *Cedar Bluff*, the insured condominium association maintained an insurance policy that provided property coverage to a number of multi-unit residential buildings that suffered damage to their roofs and siding in a hail storm. Under the policy, the insurer agreed to pay the cost to replace the damaged property with property of comparable material and quality. The roof of each building needed to be replaced, as well as at least one siding panel on each building due to the storm damage. While each of the buildings suffered damage to a portion of its siding panel, no building suffered damage to all of the siding. The siding on the buildings was 11 years old and the color of the panels had faded at the time of the loss. After the storm, it was determined that replacement panels of the same specifications were available from the manufacturer, but new panels were not available in the same color as the old panels.

The insured submitted a claim under its business property policy for the cost of replacing the entire siding on each building. The insurer contended that it was only obligated to replace the individual panels which were actually damaged in the storm. The insurer offered to pay to replace the damaged panels with panels that were slightly lighter or darker in color. The parties submitted the dispute over the amount of the loss to appraisal pursuant to the terms of the insurance policy, and the appraisal panel issued an award to the property owner for the cost to replace all of the siding on the buildings because the color of the original siding on the panels could not be matched with new siding of the same color.

The court affirmed the appraisal award and held that the insurance company was required to pay the cost to replace all of the siding with new siding. The court determined that the insurance company's obligation to provide replacement property of comparable material and quality did not require it to replace the damaged siding with siding of an identical color. The court interpreted the phrase "comparable material and quality" to mean that that the insurance company was required to replace the damaged property with property of a "reasonable color match." Because of the color mismatch between the replacement panels offered by the insurer and the siding that remained on the building, the court concluded that the color mismatch represented a direct physical loss of or damage to the entire buildings. The court held that each building had sustained a distinct demonstrable and physical alteration due to the color mismatch, and the entire siding on each of the buildings sustained direct physical damage for which the insurer was obligated to compensate the property owner for the cost of replacement under the terms of the insurance policy.

After the storm, it was determined that replacement panels of the same specifications were available from the manufacturer, but new panels were not available in the same color as the old panels.

Like Kind and Quality

The *Cedar Bluff* case provides guidance to property owners and insurance companies concerning the extent of an insurer's obligation to pay to replace damaged property with property of comparable material or quality or possibly of like kind and quality. Although an insurer may not be required to pay the cost to replace damaged property with identical property, the *Cedar Bluff* case demonstrates that an insurer may be required to pay the cost to replace the damage property with replacement property that is effective and acceptable from an aesthetic standpoint. This is particularly true when only a section of an insured building suffers damage due to a storm or some other covered event, but there are difficulties with matching the undamaged existing property with new property due to circumstances outside of the control of the parties to the insurance contract.

When faced with a dispute over the amount of loss to be paid by an insurance carrier under an insurance policy, property owners must ensure that they understand the terms and conditions of the entire policy when read as a whole in order to understand the meaning of certain sections of the policy. The property owners should also remember that an appraisal provision, which is contained in most policies, may provide an effective procedure to resolve disputes over the amount of an insured loss rather than litigating the dispute in court. Appraisal proceedings in Connecticut are governed by the Connecticut arbitration statutes and the scope of issues to be decided in appraisal proceedings is limited by the terms of the policy. Certain issues, such as a dispute over coverage, usually must be resolved by the courts. Regardless of whether a dispute between an insurer and a property owner over the amount of damage to property is resolved through appraisal or the courts, the insurer's obligation to pay the cost to replace damaged property is not limited to replacing the damaged property with identical property. The insurer may be required to look beyond the section of the property that is physically damaged in order to provide the property owner with replacement property which is just as effective as that which existed before the loss. ■

Michael McCormack

Michael McCormack is a business litigation and insurance coverage attorney at O'Sullivan McCormack Jensen & Bliss in Wethersfield, Conn. He has represented clients in insurance coverage matters for more than 20 years, including counseling clients about their rights and obligations under their insurance policies and pursuing recovery of insurance benefits due under their insurance policies.

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Court Sides With Policyholders in Complex Case

Rulings on allocation obligations could have impact in Conn.

By RACHEL SNOW KINDSETH

A 2014 New Jersey Appellate Court decision, addressing pro rata allocation obligations among the policyholder and multiple insurers, made at least three significant rulings favorable to policyholders. The rulings in *IMO Industries v. Transamerica*, 101 A.3d 1085 (2014), may provide persuasive authority here since the Connecticut Supreme Court adopted pro rata allocation in *Security Insurance Co. of Hartford v. Lumbermens Mutual Casualty*, 264 Conn. 688 (2003), and did so by relying on New Jersey authority.

IMO Industries Inc. was a defendant in thousands of mass tort cases involving personal injury claims from exposure to asbestos. IMO, together with its insurers, vigorously defended the cases. Although several insurance companies had provided indemnity and defense coverage over several decades under sharing arrangements, a claim of exhaustion of policy limits by various insurers led to the declaratory judgment action against numerous primary and excess insurers regarding allocation of indemnity and defense costs.

The insurers refused to pay defense costs for claims that the policyholder successfully defended or for which it managed to obtain a dismissal.

As to the first significant ruling in *IMO*, the New Jersey Appellate Court rejected certain insurers' "covered claims" argument. In essence, these insurers contended that they were not obligated to reimburse or indemnify defense costs unless those costs were attributable to a "covered occurrence." The insurers then interpreted a "covered occurrence" as a loss that the policyholder becomes obligated by adjudication or compromise to pay under their respective definitions of "ultimate net loss." In other words, the insurers refused to pay defense costs for claims that the policyholder successfully defended or for which it managed to obtain a dismissal. The policyholder maintained that the "effective defense of meritless claims is part and parcel of the defense of covered claims" when faced with mass tort litigation. The court held that the excess insurers had an obligation to cover IMO's ultimate net losses, which include all defense costs, because the payments relate to an "occurrence" that triggered the insurers' policies.

The *IMO* court reasoned, in part, that the nature and purpose of pro rata allocation was developed "to reduce the litigations costs and judicial inefficiencies attendant to resolving insurance coverage for long-term environmental damages." Tracking defense costs as to each individual claim would be burdensome and defy the objective for efficiency. Allowing insurers to categorize claims as covered and uncovered would potentially add a layer of dispute that "would increase litigation and require additional judicial attention." Therefore, the appellate court affirmed the trial court's ruling that defense costs are subject to pro rata allocation "even if a portion of them ultimately were devoted to defending against claims that were determined not to be covered under the insurance policies."

As to the second significant ruling favorable to policyholders, the *IMO* court affirmed the trial court in its determination that, with respect to a declaratory judgment as to exhaustion of the primary policy limits, coverage issues would not be re-litigated for each individual underlying asbestos claim. The court held that allowing excess insurers that either failed or refused to be involved in the defense of the underlying claims to contest coverage is "not feasible for long-tail, multi-claim coverage cases." Moreover, such an approach would compromise the allocation methodology mandated by the New Jersey Supreme Court in *Owens-Illinois v. United Insurance*, 138 N.J. 437 (1994). *Owens-Illinois* was cited favorably by the Connecticut Supreme Court in its *Security* case.

Because the policyholder typically bears the burden of establishing that a claim lies within a policy's scope of coverage, the excess insurers argued that, for purposes of establishing trigger of their policies, the policyholder needed to prove that claims that had been paid by primary insurers were covered under the terms of their policies. The trial judge had found that it was reasonable for the policyholder and the insurers to have settled the underlying claims. Of the tens of thousands of asbestos-related claims that had been filed, IMO obtained a dismissal twice as often as it paid a settlement. In 1989, when there was still ample primary insurance coverage available, the policyholder started putting its excess insurers on notice of the asbestos-related suits. The excess insurers had declined to involve themselves in the defense of claims, although their policies permitted them to be associated in the defense. That declination was considered "tantamount to a refusal" by the excess insurers to involve themselves in presented-claims defense.

Rachel Snow Kindseth

The court noted that, in *Owens-Illinois*, while primary and excess insurers were involved in the case, the New Jersey Supreme Court did not explicitly condition its directive prohibiting re-litigation of coverage issues to the primary insurers' affirmative duty to defend. Rather, the *Owens-Illinois* court stated: "In future cases insurers aware of their responsibility under the continuing-trigger theory might minimize their costs by assuming responsibility for or involving themselves in the defense of the actions." The Appellate Court further noted that: "It stands to reason that accommodating a challenge to coverage in tens of thousands of individual claims would not only prove daunting but would compromise the integrity of the framework *Owens-Illinois* offers for efficient and equitable allocation of losses among policies."

Third, the *IMO* court addressed policy limits. Specifically, the court held that the imposition of a single policy limit for multiyear policies would contravene the goals of pro rata allocation. Certain insurers argued that their multiyear policies provided a single per-occurrence limit for the duration of the policy, although the policies provided aggregate limits for each annual period. IMO sought a blanket ruling that every year of a multiyear policy should be treated as if a separate annual limit is available for asbestos claims. The court agreed with the policyholder and affirmed the trial court's ruling: The single occurrence position of the insurers contravened the premise of continuous trigger theory that the progressive injury constitutes an occurrence within each of the triggered policy years, as set forth in *Owens-Illinois*, and accordingly, is unenforceable.

Additionally, the court affirmed the trial court's holding that the policy limits of a "stub policy" should not be pro-rated and that the full policy limits are available for pro rata allocation across the shorter policy timeframe. (A "stub policy" is so-called because the policy is issued or extended for only part of a year.) The court reasoned that treating such a stub policy as providing only a pro-rated limit would result in the loss allocated to the policy being reduced twice, once by its time on the risk and a second time by the pro-rating of the policy limit. The court also noted that the policy did not include specific policy language to indicate that the annual aggregate limits are pro-rated.

The issues decided in *IMO* have not been specifically addressed by the Connecticut Supreme Court. Given the logic of *IMO* and the history of *Security*'s reference with approval to the New Jersey Supreme Court's *Owens-Illinois* case, the *IMO* case has potentially broad implications for the developing law on pro rata allocation here in Connecticut and elsewhere. ■

Rachel Snow Kindseth is an attorney at Murtha Cullina. She is a member of the firm's litigation department and insurance recovery practice group.

■ From GETTING on **PAGE S2**

and edible nuts caused by Hurricane Sandy. The plaintiff, a food importer, had several insurance policies with Travelers, including a marine open cargo policy that contained a warehouse coverage endorsement providing up to $5 million in coverage for damage to goods stored in the plaintiff's warehouse. Unfortunately for the insured, however, the warehouse coverage endorsement provided that "the peril of flood is excluded" from coverage. After Sandy hit the plaintiff's New Jersey warehouse, Travelers paid nearly $900,000 for damages caused by rainwater entering the warehouse through openings in the roof, but Travelers refused to pay an additional $650,000 claimed by the plaintiff, stating that these damages were attributable to rising flood waters from a nearby river, and were therefore excluded from coverage. The plaintiff filed suit, and Travelers moved for summary judgment, arguing that the plain language of the policy precluded coverage.

While claimants often attack policy exclusions as being ambiguous, the language of the exclusion at issue—which stated, "It is further understood and agreed that the peril of flood is excluded for the following location," then listed the name and address of the plaintiff's New Jersey warehouse—was too clear for the plaintiff to even attempt to argue that any ambiguity existed. Facing Travelers' motion for summary judgment, the plaintiff mustered the best argument at its disposal: that the flood exclusion did not apply because it was tacked on at the very end of the warehouse coverage endorsement, and did not have its own subheading. The exclusion appeared as the final paragraph under the subheading "Earth Movement Sublimit and Deductible," following several paragraphs referring to coverage sublimits and deductibles for losses stemming from "earth movements." The plaintiff argued that the placement of the flood exclusion indicated that it only applied if the flood was caused by an earthquake or other earth movement.

While noting that "an insurance company should know better" than to place the flood exclusion in the policy so "awkwardly," the court nonetheless enforced the exclusion. First, the court observed that the wording of the exclusion itself was clear. Next, the court held that the opening words of the exclusion, stating, "It is further understood," made it sufficiently clear that the flood exclusion stood apart from the remainder of the preceding paragraph regarding earth movement-related sublimits and deductibles. Lastly, the court succinctly rejected the argument that the flood itself arose from a covered cause, a storm, holding that damages caused by the flood nevertheless fell within the scope of the flood exclusion. The court granted summary judgment in the insurer's favor, and Great Lakes was left holding a bag of soggy nuts.

Neither Azoulay nor Great Lakes International Trading appear to have been lazy, unsophisticated or dilatory. In fact, both demonstrated some acumen when it came to dealing with insurance. Azoulay actually took the time to save and organize all of his receipts, to take photographs documenting his property damage, and to create an itemized list of all of the damage that Hurricane Irene caused. These tasks were all probably more time-consuming than simply reading through his entire insurance policy, word for word. If Azoulay had only signed and notarized his own itemized list of damages at the same time that he signed and notarized Allstate's proof of loss, he would likely have been able to recover additional insurance proceeds and avoid litigation entirely.

Sophisticated Consumer

Great Lakes, for its part, appears to have been a sophisticated consumer of insurance. The court observed that Great Lakes had more than one policy with Travelers, as well as the fact that Great Lakes had procured a separate warehouse coverage endorsement to insure the goods stored in its facilities that would not have been covered by its marine open cargo policy. It stands to reason that a business like Great Lakes may have worked with a broker to procure its insurance and that it should have been made aware of the flood exclusion in the first instance. Nonetheless, if Great Lakes had simply read its own insurance policy, it would have seen the exclusionary language and presumably procured additional insurance to guard against the risk of a flood. Great Lakes learned an important lesson to be sure, but unfortunately that lesson came at the cost of over half-a-million dollars in damaged fruit. Yet, we can all learn from it now.

The words in an insurance policy have a legally binding effect, and they are therefore chosen very carefully. It behooves policyholders to read every single one of those words, no matter how tedious, lest they be caught unaware at the worst possible time, like Azoulay or Great Lakes. So the next time a nor'easter arrives to give us a snow day, we should all turn off the Netflix for a minute and take the time to read through our insurance policies from cover to cover. Maybe after just one more episode. ■

Regen O'Malley is of counsel at Gordon & Rees, where she focuses on insurance coverage, including counseling regarding complex coverage issues and representation of insurers in defending and prosecuting declaratory judgment actions in coverage disputes. She also serves as chair of the Connecticut Bar Association's Insurance Law Section. Steven Zakrzewski is an associate at the firm and a member of the insurance practice group. He is also member of the CBA's Insurance Law Section.

2015 and the Employer Health Care Mandate

New provisions could lead to ERISA liability entanglements

By DOVE A.E. BURNS

Employers are finding themselves stuck with a holiday gift they can't return: increased responsibility for providing insurance to employees.

As of Jan. 1, employers with more than 100 full-time employees are required to provide health insurance to their workforce. While the Patient Protection and Affordable Care Act (ACA) was signed into law on March 23, 2010, the employer mandate only became effective as of 2015. The goal is that by 2019, 31 million uninsured Americans will have health insurance.

The complexities are in how we will get there. The individual mandate requires both U.S. citizens and legal residents to procure health insurance. The employer mandate not only requires "large" employers to provide insurance, it also contains provisions that will result in employer liability should employers fail to offer adequate and affordable insurance or should employees perceive different treatment based on the plan being offered or the process of providing coverage. The House Ways and Means, Education and the Workforce, and Energy and Commerce committees estimate that the cost of complying with the ACA for employers and families is 190 million man-hours.

Despite the host of potential liabilities facing them, an alarming number of employers last year were still unaware of the requirements and obligations of the act, let alone the provisions that allow employees to seek redress for perceived mistreatment based on benefits or the lack thereof. According to a survey of 800 corporate decision-makers performed by Travelers in cooperation with Nielsen in March 2014, only 67 percent of employers were somewhat, not very, or not at all familiar with the ACA requirements. Moreover, the results indicated that 27 percent of employers were not preparing for the ACA and the mandate at that time.

Now that we've crossed into the new year, employers with 100 or more full-time employees, or full-time equivalents, are subject to penalty if: 1) they fail to offer minimum essential coverage to 70 percent of employees and their dependents (not spouses); 2) they fail to offer enough coverage or do not ensure affordability; and 3) even one full-time employee receives a subsidy via a governmental health exchange or a tax credit. The coverage that is provided must cover at least 60 percent of the expenses. If employees are required to pay more than 9.5 percent of their family income to their employers for the coverage, it is not deemed affordable pursuant to the act and thus penalties will be assessed. As of 2016, employers with 50 or more full-time employees must offer coverage to 95 percent of employees and dependents.

Beyond the common fines and penalties, employers face liability for the way in which they report and respond to the new requirements and employee questions or actions resulting from the mandate. The two most widely anticipated areas of liability employers are likely to face is fiduciary liability pursuant to the Employee Retirement Income Securities Act (ERISA) and employment and director and officer liability as a result of whistleblower and retaliation claims that will be brought pursuant to the ACA and the Fair Labor Standards Act (FLSA).

Long Reach

While ERISA is commonly understood to regulate pensions, it also regulates employer-sponsored health care plans. The advent of the employer mandate will subject fiduciaries to the long reach of ERISA. While ERISA does not require companies to offer health care plans, the adoption of the Affordable Care Act means that the requirements of ERISA will extend to health plans.

Similarly, the ACA requirements for health plans will now be enforceable via direct causes of action pursuant to Section 502 of ERISA. Pursuant to Section 502, employee health care participants can recover benefits, enforce rights or clarify future benefits of health plans. Employee participants will have a private cause of action to pursue their rights, including such things as denial of benefits, limitation of plan options or the way in which plans are limited to certain employee participants. Attorney fees will be recoverable and class action litigation is likely. ERISA reporting requirements will also be an avenue for employer liability.

The ACA expands ERISA's disclosure requirements by adding the summary of benefits and coverage requirements. Health plan sponsors are required to produce a four-page summary titled the "SBC" that describes the benefits and coverage available. The summary of benefits must be provided to applicants and enrollees before enrollment or re-enrollment. Fines and penalties will be assessed for improper reporting, especially if plans or benefits are changed and not reported properly.

Dove A.E. Burns

Almost half of employers (47 percent) are not familiar with the ACA's whistleblower protections, according to the 2014 Travelers/Nielsen survey. Section 1558 of the ACA amended the FLSA to add Section 18C, which provides for extensive whistleblower and anti-retaliation protections in two broad categories. Section 18C(a)(1) protects employees who receive governmental subsidies as a result of accessing the health care exchange. Sections 18C(a)(2)-(5) extend protections to employees who perceive that they were treated differently in light of their conduct and were retaliated against for engaging in "protected activity."

Protection for those employees receiving tax subsidies or cost sharing was included in order to dissuade employers from retaliating, as those benefits will expose the employer to fines and penalties. Employees who receive a tax credit under Section 36B of the Internal Revenue Code of 1986 or a tax subsidy under Section 1402 of the ACA will fall under the protections of this section. Protection under 18c(a)(1) at this point is interpreted as limitless in that the statute places no temporal requirements on an employee bringing a cause of action for whistleblowing pursuant to this section. Therefore, employees who can avail themselves of this section of the act may enjoy membership to protected class status in perpetuity.

"Protected activity" under FLSA sections 18C(a)(2)-(5) and the ACA include providing (or causing to provide) information to the employer or state or federal government concerning an actual ACA violation or an act or omission the employee believes to be a violation. If an employee assists an employer or governmental agency in the investigation of an actual or purported violation, that will also be deemed "protected activity."

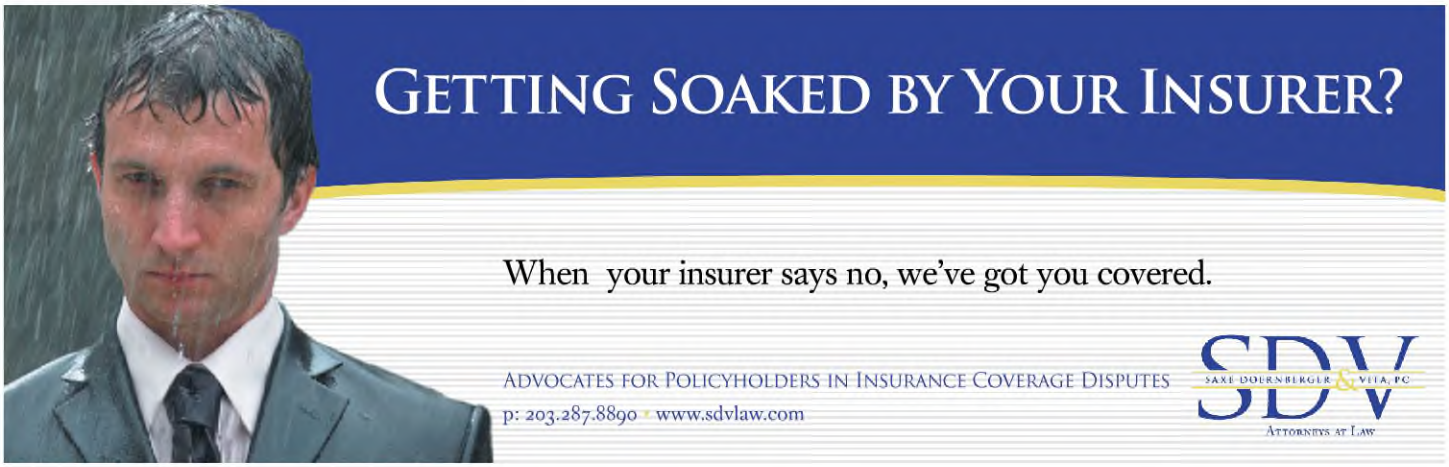
The Occupational Safety and Health Administration is responsible for enforcing the whistleblower provisions of this section. Unlike Title VII retaliation claims, which must be proved according to the but-for standard of causation, under these laws retaliation need only be proved to be a "contributing factor." The lesser standard will undoubtedly make it all the more likely that employers will face significant liability for whistleblower and retaliation claims.

Employers should explore the extent of their fiduciary liability, employment practices liability and directors and officers liability policies in light of the ACA's inherent expansion of employer liability. A comprehensive risk analysis and holistic approach are necessary because whistleblower and retaliation claims raise potential liability far beyond EPL policies. Employers must take note that those looking to restructure, reduce hours or use layoffs to avoid compliance with the ACA will only further face liability in the form of additional ERISA, FLSA and IRS regulation and penalties.

Giving back the ACA outright might be wishful thinking, but a thorough coverage analysis—and taking the appropriate proactive measures—will go a long way toward reducing the potential for liability as employers adjust to life under the ACA. ■

Beyond the common fines and penalties, employers face liability for the way in which they report and respond to the new requirements and employee questions or actions resulting from the mandate.

Dove A.E. Burns is a partner in Goldberg Segalla's employment and labor and professional liability practice groups in Hartford. She defends corporate clients and executives in high-exposure employment and professional negligence matters, and is a frequent speaker to national audiences on employment liability topics. She may be reached at dburns@goldbergsegalla.com.



Ruling Focuses on Uninsured Motorists Coverage

Plaintiff tried to collect damages beyond policy limits

By SANDRA L. SNADEN and MICHAEL F. LETTIERO

The Connecticut Supreme Court recently issued two important decisions affecting commonly litigated aspects of insurance coverage. In the first case, *Guarino v. Allstate Property and Casualty Insurance*, 315 Conn. 249 (Jan. 6, 2015), the court clarified and reaffirmed a central tenet of underinsured motorist law. In the second case, *Electrical Contractors v. Insurance Company of the State of Pennsylvania*, 314 Conn. 749 (Dec. 16, 2014), the court addressed a critical aspect of surety law.

A typical underinsured motorist claim follows a routine pattern. An injured party is involved in an accident, and after exhausting the at-fault motorist's limits of liability insurance through settlement or judgment, seeks recovery from his or her own underinsured motorist carrier. The amount recovered from the tortfeasor is subtracted from the limits of the plaintiff's underinsured motorist coverage, leaving available to the plaintiff the difference between what he or she has already recovered and the amount of his or her policy limit.

The plaintiff in *Guarino* sought to add another dimension to these claims by arguing that her policy limits should not be reduced by what she had already recovered from the tortfeasors because there had been no actual finding of fault and apportionment of damages. If the plaintiff in *Guarino* had been successful, underinsured motorist claims would have been mired in litigation and difficult to resolve.

In another recently decided case, the state Supreme Court clarified a critical question for sureties: whether a surety waives its coverage defenses by failing to respond to a claim within the 90 days required under state statute.

In *Guarino*, the decedent's vehicle was struck after it proceeded through an intersection without stopping at a stop sign. Michelle Guarino, as administratrix of the estate of the decedent, brought suit against Anton Paving LLC and Lombardi Tire and Auto Repair, the owners of two vehicles that she claimed were parked on the side of the road and obstructed the decedent's view of the stop sign.

The decedent had $100,000 of underinsured motorist coverage from Allstate Property and Casualty Insurance Co. The policy provided that "the limits of this coverage will be reduced by … all amounts paid by or on behalf of the owner or operator of the uninsured auto or underinsured auto or anyone else responsible."

Sandra L. Snaden

Michael F. Lettiero

The plaintiff settled the claim against Anton for $20,000 and then brought suit against Allstate seeking recovery of the decedent's underinsured motorist benefits. The plaintiff then settled with Lombardi for $225,000. Allstate subsequently moved for summary judgment, claiming that it did not owe the plaintiff underinsured motorist benefits because she received payments in excess of the $100,000 policy limit. The plaintiff objected, arguing that Allstate could not reduce the underinsured motorist benefits without a finding of fault and apportionment of damages.

The trial court granted Allstate's motion for summary judgment and the plaintiff appealed. The Appellate Court affirmed. On appeal to the Connecticut Supreme Court, the plaintiff argued that the trial court and Appellate Court failed to follow *Collins v. Colonial Penn Insurance*, 257 Conn. 718 (2001), which in turn relied on *Garcia v. ITT Hartford Ins.*, 72 Conn. App. 588 (2002).

The Connecticut Supreme Court affirmed the granting of summary judgment in favor of Allstate. Initially, the court confirmed that the decedent's underinsured motorist policy with Allstate conformed with Connecticut's underinsured motorist statutory and regulatory scheme because it reduced the $100,000 policy limit by the amounts paid by or on behalf of the owner or operator of the underinsured auto or anyone else responsible. The court relied on *Buell v. American Universal Insurance*, 224 Conn. 766 (1993), and *Hartford Casualty Insurance v. Farrish-LeDuc*, 275 Conn. 748 (2005).

It stated that *Buell* and *Hartford Casualty* continued to stand for two principles: (1) settlement payments received in exchange for the relinquishment of a claim constitute a permissible reduction of coverage as a payment "by or on behalf of any person responsible for the injury"; and (2) in the multitortfeasor context, coverage is reduced by the aggregate sum of the settlement payments without any relationship to the tortfeasors' proportionate fault in causing the accident.

The court went on to distinguish the cases put forth by the plaintiff, *Collins* and *Garcia*, as inapplicable to the present circumstances. The court noted that in those two cases the underinsured motorist carrier stood as a surrogate for, or in the shoes of, an unidentified motorist, akin to the position of a tortfeasor, rather than as a underinsured motorist carrier like Allstate. The court made clear that a tortfeasor's right to pay only his share of damages for injuries he caused is "entirely different" than an insurer's contractual right to reduce coverage as a result of payments made to a claimant.

The court determined that the present circumstances were more akin to *Buell* and *Hartford Casualty* and held that "an underinsured motorist carrier is entitled to judgment as a matter of law when all alleged tortfeasors settle the insured's claims against them for the injuries giving rise to the underinsured motorist claim in an aggregate sum in excess of the policy limits."

The import of *Guarino* is that there is a distinction between cases where an underinsured motorist carrier is a surrogate or proxy for a tortfeasor, and thus treated like one, and cases like *Guarino*. Practitioners should be aware that in a typical underinsured motorist situation like that presented in *Guarino*, the policy limits can be reduced by payments made to a claimant without a finding of fault or apportionment of damages.

Failure to Respond

In *Electrical Contractors*, the court clarified a critical question for sureties: whether a surety waives its coverage defenses by failing to respond to a claim within the 90 days required by Connecticut General Statutes §49-41. C.G.S. §49-42 requires a surety to issue payment within 90 days of the receipt of a claim except where a good-faith dispute exists as to the claim; it also requires the surety to issue a denial of any unpaid portions of the claim within 90 days.

Electrical Contractors Inc. was a subcontractor of Morganti Group Inc., which was hired to renovate and expand Newtown High School. Pursuant to C.G.S. §49-41(a), Morganti obtained a $33.7 million labor and materials payment surety bond from the Insurance Company of the State of Pennsylvania for the project. Electrical Contractors submitted to Morganti Group requests for equitable adjustment to its subcontract price for $746,300. Morganti Group did not respond substantively to the requests.

On June 3, 2011, Electrical Contractors sent the insurance company a notice of claim against the bond pursuant to General Statutes §49-42(a). Ten days later, the surety acknowledged receipt and requested additional information from Electrical Contractors regarding its claim. Electrical Contractors provided the additional information. On July 6, 2011, the surety acknowledged receipt of the additional information and indicated that it was going to address the claim with the Morganti Group.

However, the claim was not paid or denied within the required 90-day period. Therefore, on Sept. 16, 2011, Electrical Contractors brought suit against the surety in U.S. District Court in Connecticut, claiming that the surety was liable for the full sum of $746,300 and that it had acted in bad faith.

The parties cross-moved for summary judgment. The district court determined that resolution of the claims turned on the proper interpretation of C.G.S. §49-42(a). The court certified two questions to the Connecticut Supreme Court: (1)(a) Is a surety's failure to meet the 90-day deadline under C.G.S. §49-42 deemed to be an exhaustion of remedies entitling claimants to bring suit; (1)(b) does the failure to meet the 90-day deadline operate as a waiver of a surety's defenses directing the court to enter judgment for the claimant in the full amount of the claim; and (2) does a surety's request for additional information constitute a "denial" of the claim or a "good faith dispute" of the claim under C.G.S. §49-42?

In answering the certified questions, the Supreme Court determined that the 90-day requirement was directory, rather than mandatory. The court stated "that the legislature did not intend that a surety that fails to pay or to deny a claim by the statutory deadline thereby waives any substantive defenses and forfeits its right to contest the merits of the claim." The court reiterated at multiple points that a surety was subject to the whims of other parties to provide it information to make an informed decision. Therefore, the Supreme Court held that a surety's failure to make payment on or serve notice denying liability within 90 days pursuant to C.G.S. §49-42(a) "is tantamount to a denial of the claim and does not constitute a waiver of the surety's right to defend the claim on the merits."

Notwithstanding the court's decision, the court noted that a surety was still incentivized to comply with its statutory obligations. The court noted that C.G.S. §49-42(a) provided that a court may award attorney fees if a denial or defense is asserted "without substantial basis in law or fact." It also stated that a surety that has failed to respond to a claim within 90 days has effectively denied the claim, allowing a claimant to bring an action against the surety. Finally, the court stated that a surety may be subject to a bad-faith claim should it not promptly and diligently investigate a claim within the 90-day period.

Electrical Contractors is beneficial to sureties. A surety will not be required to make a rushed decision based on less than all of the available information within 90 days of a claim out of fear of waiving all coverage defenses. However, the court explicitly recognized the potential for bad-faith claims and other consequences should a surety not "promptly and diligently" investigate a claim within 90 days, such as the potential for a lawsuit. Therefore, following *Electrical Contractors*, a surety can undertake the time necessary to investigate claims fully without fear of waiving its coverage defenses. However, a surety must be aware that a lack of a thorough investigation may lead to a bad-faith claim and that it may be open to suit after 90 days. ■

Sandra L. Snaden, a partner in Goldberg Segalla's global insurance services practice group in Hartford, counsels insurers on coverage matters and defends them in contractual and extra-contractual litigation, including bad faith. She may be reached at ssnaden@goldbergsegalla.com. Michael F. Lettiero is an associate in the insurance services group. He handles cases involving complex issues of insurance coverage and allegations of bad faith and prepares coverage opinions, reservation of rights letters and denial letters. He may be reached at mlettiero@goldbergsegalla.com.

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No Coverage for Period When Policy Has Lapsed

Court backs insurer that accepted payment following policyholder's fire

By THOMAS C. BLATCHLEY

In a case of first impression, the Connecticut Appellate Court recently held that when an insurance policy has been canceled for premium nonpayment, and the insured seeks to reinstate that policy, the insurer may reinstate coverage effective only for future losses. In *Brown v. State Farm Fire & Casualty*, 150 Conn. App. 405, cert. denied, 315 Conn. 901 (2014), the court held that the insurer's acceptance of a late premium payment does not waive its right to deny coverage for a loss suffered between the time of the lapse and the reinstatement.

Looking to the viewpoint followed in the majority of jurisdictions and applying the concept of fortuity, the court barred the insured from recovering on a residential fire loss that occurred between the time of lapse and reinstatement. The court's decision is significant because, consistent with public policy underpinning all insurance, it protects insurers from covering known losses and, in effect, "buying a claim."

Background

In September 2004, the plaintiff purchased a homeowner's insurance policy from the defendant. The premium on the policy was to be billed on a quarterly basis. The plaintiff subsequently purchased a business policy from the defendant in September 2005. At plaintiff's request, defendant agreed to bill the plaintiff quarterly on the same date for both policies, rather than on each policy's anniversary date. The plaintiff did not pay the full amount for that quarter, instead making a partial payment of $257 in person at the defendant's office on Sept. 16, 2005.

On Feb. 16, 2006, the plaintiff was billed $730 for the quarter beginning in March 2006, payable on or before April 6, 2006. On March 22, 2006, the defendant sent a cancellation notice to plaintiff indicating that his policies would be canceled on April 6, 2006, if he failed to pay that amount by that date. The plaintiff did not tender payment before April 6, 2006.

On April 21, 2006, the plaintiff's home was lost because of a fire. After the fire, and on discovering a March 22, 2006, cancellation notice sent from defendant (the plaintiff admitted to finding the notice in the debris after the fire), the plaintiff mailed defendant the missing payment. The defendant credited the plaintiff's account $730 on April 22, 2006, the day after the fire.

The plaintiff filed an insurance claim with the defendant for the house fire, which the defendant denied. The plaintiff thereafter filed a one-count complaint alleging breach of contract against defendant. The court rendered judgment for the defendant after a bench trial, and the plaintiff appealed.

Plaintiff's Arguments on Appeal

On appeal, the plaintiff argued that defendant waived the right to deny coverage for the loss when it accepted payment after the April 21, 2006, fire and then declined to provide coverage retroactive to the date of loss. More specifically, the plaintiff asserted that the trial court erred in concluding that plaintiff's post-loss premium payment operated to reinstate his coverage prospectively only.

The plaintiff also argued that the trial court erred in finding that the homeowner's policy was not in effect on April 21, 2006, the day of the fire, because of nonpayment of premiums. The Connecticut Appellate Court rejected these arguments.

Lapse and Reinstatement

As with most insurance policy disputes, the court began its analysis by looking to the language of the insurance contract. Among the declarations in the subject homeowner's policy was the proviso: "You agree, by acceptance of this policy, that ... you will pay premiums when due and comply with the provisions of the policy." The policy further provided: "We may cancel this policy only for the reasons stated in this condition ... (1) When you have not paid the premium, we may cancel at any time by notifying you at least 10 days before the date cancellation takes effect."

Notably, the policy that the defendant issued to the plaintiff was in conformance with the Connecticut statutory form of standard fire insurance policy under Connecticut General Statute §38a-307.

Lastly, the defendant's March 22, 2006, cancellation notice to plaintiff, which set a cancellation date of April 6, 2006, stated: "Should you wish to reinstate these policies, please forward your payment immediately. ... If paid after [the] date and time [of cancellation] you will be informed whether your policies have been reinstated and if so, the exact date and time of reinstatement. There is no coverage between the date and time of cancellation and the date and time of reinstatement."

The court next embarked on analyzing the law. Recognizing the dearth of Connecticut case law addressing whether late premium payments should be applied retroactively, or whether the late payment merely reinstates coverage prospectively, the court looked to the majority view in other jurisdictions. According to the majority view, when a lapsed insurance policy is reinstated, losses suffered between the time of the lapse and the reinstatement are not covered. The court found that this rule effectuates an important principle of insurance law: the concept of fortuity. The court explained the fundamental requirement in insurance law that an insurer will not pay for a loss unless the loss is fortuitous, meaning that the loss must be accidental, e.g., losses that are certain to occur, or which have already occurred are not fortuitous. Indeed, this principle explains why a person cannot suffer a loss and then subsequently procure insurance coverage for that loss. It is axiomatic that a known loss that has already occurred is not uncertain to occur.

Recognizing the dearth of Connecticut case law addressing whether late premium payments should be applied retroactively, or whether the late payment merely reinstates coverage prospectively, the court looked to the majority view in other jurisdictions.

The court found this reasoning and related public policy component compelling. The court stated that one purchases insurance because he might suffer a loss, and a loss that has already occurred is not fortuitous and thus not insurable. Explaining the related public policy component, the court stated: "Without such a rule, one could allow his coverage to lapse by not paying his premiums timely and then, upon suffering a loss, force his insurer to 'buy a claim' by quickly making the missed premium payments to reinstate his lapsed coverage retroactively."

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The court further stated that such a rule would allow the insured to consciously shift the burden of his known loss from himself onto his insurer, and, ultimately, onto those policyholders who have dutifully paid their premiums on time and maintained continuous insurance. Thus, the court determined that when an insurance policy has been canceled because of nonpayment of premiums, and the insured seeks to reinstate that policy, the insurer is within its rights to reinstate coverage effective only for losses going forward.

Synthesizing the law, public policy and facts, the court found that plaintiff was not entitled to any coverage for the loss of his home on April 21, 2006. The plain language of the policy and cancellation notice foreclosed coverage during the cancellation period. Further, the court determined that it would be contrary to public policy to allow plaintiff to reinstate insurance coverage on his property at a time when he knew that he had already suffered a loss. Accordingly, the court rejected plaintiff's arguments that (1) defendant waived its right to deny coverage for plaintiff's loss by its acceptance of the late premium and (2) the homeowner's policy was not in effect on April 21, 2006, the day of the fire, because of nonpayment of premiums.

Coverage Litigation Implications

Brown is significant since it establishes favorable precedent for an insurer, following a lapse for premium nonpayment, to reinstate coverage effective only for losses going forward. The decision also is significant for insurers insofar as the acceptance of a late premium payment does not waive its right to deny coverage for a loss suffered between the time of the lapse and the reinstatement. Although the Connecticut Appellate Court articulated a clear rule for prospective coverage only, insurers should review policy and cancellation notice language to ensure they are consistent with each other and with any statutory requirements, e.g., C.G.S. §38a-307, and that they clearly state the intent to reinstate coverage effective only for future losses. ■

Thomas C. Blatchley is senior counsel in Gordon Rees Scully Mansukhani's Connecticut office. He represents insurance clients in complex insurance-related litigation and business clients in litigation arising out of contract disputes in federal and state courts. He may be reached at tblatchley@gordonrees.com or via LinkedIn.

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Finding the Right Cyberrisk Insurance

Many commercial general liability policies don't cover data breach incidents

By WILLIAM GODDARD and BENJAMIN NISSIM

Cyberrisk coverage is the concern of the day. The reasons are obvious. Cybersecurity incidents are frequent and enormously costly. A 2014 PricewaterhouseCoopers LLP report reveals three of four businesses responding to its U.S. State of Cybercrime Survey detected a security event in the past 12 months. A 2014 Ponemon Cost of Cyber Crime Study echoes PricewaterhouseCoopers conclusions, finding the average cost of cybercrime for U.S. companies climbed by "more than 9 percent to $12.7 million" over the course of the year.

Although the public policy debate over cyberrisk insurance is far from fully developed, the need for answers is immediate. In hopes of illuminating this dilemma, this article will explore two issues: what coverage exists now, and, maybe more important, where we are headed.

The proliferation of data breaches and attendant costs has meant more businesses are turning to their insurers seeking defense and indemnification. The need for coverage has given rise to a debate over whether a standard commercial general liability policy (CGL) protects an insured against liability for cyberharm. Some insurers have taken the position that a standard CGL's grant of coverage (i.e., for bodily, property or personal injury) does not encompass cyberrisks. Several recent court cases reinforce the insurers' view, confirming ordinary CGL policies do not cover cyberrisk. Much remains in flux, however.

In *Recall Total Information Management v. Federal Insurance*, 147 Conn. App. 450 (Conn. App. Ct. 2014), the Connecticut Appellate Court concluded the plaintiff's CGL policy did not provide coverage for a data breach. In *Recall*, the plaintiff provided transportation for IBM's data tapes. Recall Total Information Management was an additional insured under a $2 million CGL and $5 million umbrella liability policy. The lawsuit arose when a cart containing IBM's data tapes fell out of the back of a van. An unknown person removed the tapes (which contained private employee information), and they were never recovered. IBM spent significant sums responding to the data loss and recouped those costs from Recall. Recall then sued its insurers for coverage. The trial court ultimately ruled the insurers had no duty to defend and no coverage existed, because the losses were not personal injuries.

William Goddard

Benjamin Nissim

After Recall appealed, the Appellate Court considered whether the losses fell within the policy's definition of personal injury: "injury, other than bodily injury, property damage or advertising injury, caused by an offense of … electronic, oral, written or other publication of material that … violates a person's right to privacy." In resolving that issue, the court stated personal injury was "not the loss of the physical tapes themselves; rather it is whether the information in them has been published" that guided whether an injury occurred. In the absence of any evidence the tapes had ever been accessed, the court found there was no publication and, thus, no personal injury.

The Appellate Court also considered the significance of a state statute requiring notification to the individuals whose personal information was compromised. In particular, the court evaluated whether triggering the statutory obligation to notify these individuals created a presumption of an invasion of privacy. The court responded in the negative, stating, "merely triggering a notification statute is not a substitute for personal injury."

When buying specialized policies, a policyholder must carefully review the coverage purchased, with a particular eye toward sublimits, to ensure that the coverage being provided is adequate for the needs of a particular business.

The fact that the statute required the business merely to notify an affected person rather than provide compensation corresponded to the absence of injury. This conclusion is significant. Although a business might not need to anticipate that its data tapes would fall off the back of a truck, it should expect to have to notify those impacted by a data breach. Currently, 47 states have data breach notification laws. Twenty-three states considered new security breach notification legislation in 2014. This patchwork of rules and interpretations means the Connecticut court's refusal to create a presumption might not be applied in other states. Another court may find a notification statute does create such a presumption, with untold consequences.

Settled Law?

When hackers invaded the Sony PlayStation Network and other Sony networks, Sony argued its CGL policy contained a broad grant of coverage for publication in any manner that violates a right to privacy. *Zurich Insurance v. Sony of America*, 651982/2011 (N.Y. Supr. Ct. N.Y. County). The insurers, including Zurich Insurance Co., argued the publication was the result of third-party actions, therefore, they had no liability. The trial judge agreed, finding the relevant policy coverage applied only to acts of the policyholder.

The trial judge understood the significance of his ruling and stressed the need for immediate appellate review. On appeal, the amicus brief filed on behalf of the insurance industry argued "finding coverage would flout decades of settled law in New York and elsewhere on the meaning and scope of widely used personal and advertising injury coverage provisions in CGL policies." The ultimate resolution of this case will have a far-reaching impact on CGL coverage for data theft.

In the pending case *Travelers Indemnity of Connecticut v. P.F. Chang's China Bistro*, 2:14-cv-01458 (D. Conn.), Travelers seeks a declaratory judgment that it does not have to defend or indemnify the restaurant group in litigation resulting from the theft of customer credit card data. A number of lawsuits were initiated against P.F. Chang's China Bistro after it was reported the Secret Service had identified a security issue involving the potential release of credit card data at a number of restaurants operated by the chain. The insured sought coverage under its CGL policy for "personal injury." The insurer argues P.F. Chang's CGL policies do not provide coverage for this type of class action because the damages do not fall within the policy definitions for bodily, advertising, and personal injury and property damage. The failure to find coverage under these broad coverage grants generally implies that coverage for the cyberharms are not covered by the CGL policy.

In response to the rise in disputes over cyberrisks, the Insurance Services Office (ISO) has promulgated new endorsements to its standard CGL policy. These new endorsements, first released in mid-2014, explicitly exclude coverage for access or disclosure of confidential or personal information and data-related liability (including, for instance, damages arising from notification costs, credit monitoring, and public relations expenses) under coverage grants for bodily, personal, and advertising injury and property damage (with or without a bodily injury exception), and exclusions of coverage for access or disclosure of confidential or personal information under a coverage grant for personal or advertising injury alone. (See Insurance Journal, "ISO Comments on CGL Endorsements for Data Breach Liability Exclusions," July 18, 2014).

Some policyholders have argued the new exclusions represent an implicit admission that standard CGL policies have previously covered cyber-related harms. But, as the ISO has explained, standard CGL policies were developed at a time when cyberrisks were not prevalent. Thus, these risks "were not necessarily contemplated under the policy." The endorsements are therefore an effort to clarify more precisely the scope of the standard CGL policy. The exclusions give further momentum to the growing market for specialized cyberrisk insurance policies. Currently, both major carriers and specialty markets are offering cyberpolicies that cover losses ranging from notification costs to malware removal. When buying specialized policies, a policyholder must carefully review the coverage purchased, with a particular eye toward sublimits, to ensure that the coverage being provided is adequate for the needs of a particular business.

Top Priority

To facilitate proper underwriting and risk assessment, insurers are attempting to gain a greater understanding of the scope and cost of data breaches. At the same time, all businesses (insurers included) are seeking to be more secure and responsive. At the November 2014 Federal Advisory Committee on Insurance meeting, New York Department of Financial Services (DFS) Superintendent Benjamin Lawsky declared cybersecurity issues will be a top priority for his agency. Consistent with this focus, DFS will soon release examination guidance for insurers that will expand examination procedures in the cybersecurity area. This guidance will likely mirror the guidance the DFS provided to other financial institutions in 2014.

The new angles of inquiry will likely include insurers' 1) detection and response processes for cyberissues; 2) cybersecurity management across both business functions and corporate governance; 3) testing, monitoring and training of staff; and 4) cyberrisk management procedures already in place (among other things). As an example of the increased scrutiny of cyberpractices by insurance regulators, members of the National Association of Insurance Commissioners have called for a multistate examination of Blue Cross Blue Shield operator Anthem Inc. following the recent attack on Anthem's network resulting in the theft of personal information of tens of millions of customers and employees. Lawsky also responded to the Anthem breach, reiterating the DFS' position that insurers must strengthen their cyberdefenses. He also confirmed that the DFS will soon be undertaking regular assessments of insurer cybersecurity preparedness and issuing regulations consistent with his prior remarks.

Yet, insurers are not just subject to regulations, they are also working to improve them. A number of insurers through the U.S. Chamber of Commerce have joined in a letter to the U.S. Senate urging legislators to pass a cybersecurity information-sharing bill. They ask that they be allowed to share private information to facilitate real-time responsiveness to cyberattacks. The industry is seeking to help standardize and develop the cyberrisk lines of business in a way that benefits those seeking the specialized coverage. Only time will tell whether Congress will respond to these concerns.

Just as threats of cyberharm are evolving, so too is the insurance industry. The insurance industry's position has generally been that standard CGL policies do not provide coverage for cyber-related harms. What little case law is available appears to confirm this view. Going forward, insurers are seeking to engage with cyberrisks by developing new specialty coverage programs. Insurers are also working with policymakers to ensure that both insurers and insured are able to identify, respond to, and quantify the harms associated with cybersecurity risks. How insurers, insured and policymakers act together may influence how viable these programs become. ■

William Goddard is a partner in the Hartford office of Day Pitney, where he concentrates on insurance, reinsurance and insurance insolvency matters. Benjamin Nissim is an associate in the firm's commercial litigation department.

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An Exhausting Question for Insurers

Courts consider when excess carrier's duty to defend kicks in

By MICHAEL P. THOMPSON

Excess insurance policies are typically written so that excess coverage is triggered only by "exhaustion" of specified underlying insurance. The questions of how and when an underlying policy is "exhausted," thereby triggering an excess carrier's duty to defend, are commonly litigated issues. One particular issue that parties routinely dispute is whether a primary carrier's tender of its policy limits through an offer of settlement before the claim against the insured is settled or judgment has been entered constitutes "exhaustion" of the underlying policy.

This very question was posed as a matter of first impression before a Connecticut federal court in *Cambridge Mutual Fire Insurance v. Ketchum*, No. 3:11-CV-00743 VLB, 2012 WL 3544885 (D. Conn. Aug. 16, 2012). However, that court decided not to answer it. Instead, *Cambridge*, adopting a minority view, found that there was exhaustion of the primary policy where the claim for damages in the underlying action exceeded the primary carrier's liability limits, thereby triggering the excess carrier's duty to defend, regardless of whether the primary carrier tendered its policy limits.

While it is tempting to construe *Cambridge* as effectively converting an excess carrier into a "co-primary insurer" with a concurrent duty to defend, it appears that courts in Connecticut instead will look to policy language and consider the "total policy insuring intent" in determining the order of coverage as between insurers, even when both carriers' duties to defend have been triggered.

Cambridge involved a coverage dispute under a homeowner's umbrella policy. The claim related to a personal injury lawsuit arising out of a motorcycle accident, seeking damages between $400,000 and $500,000. The umbrella policy provided that the excess carrier "agree[d] to pay on behalf of the Insured the ultimate net loss which: 1) The insured becomes legally obligated to pay because of personal injury or property damage; and 2) is in excess of the retained limit." The policy further provided that the excess carrier shall provide "additional coverage" for an occurrence which is covered under the policy and "is either: 1) not covered by any primary insurance shown in the schedule or any other insurance which applies; or 2) covered by a primary policy under which one of these additional coverages has been exhausted."

At the time of the accident, the insured had primary coverage through an automobile liability policy with liability limits of $250,000. Although the primary carrier offered to partially settle the underlying claim for its policy limits, the claimant argued that the settlement offer could not practically be effected until the excess carrier agreed to assume the defense of the insured for the balance of the claim or participated in an overall settlement. The excess carrier refused to assume the defense, arguing that its duty to defend was never triggered because an offer of settlement up to the policy limits did not constitute an exhaustion of the automobile policy.

In considering whether the automobile policy had been exhausted, *Cambridge* acknowledged that "a majority of states to have addressed this issue have held that the excess carrier's duty to defend is not triggered until the policy limit of the primary carrier is exhausted by settlement or tender of payment, even if the claim for damages in the underlying action exceeds the primary carrier's limit and the excess carrier's policy will necessarily be implicated in the action." According to the majority view, this is so because the terms of the contract should be enforced as written, and it would be inappropriate for courts to alter the parties' respective obligations and economic expectations.

In contrast to the majority view, the court wrote that a "minority of states have found that the excess carrier's duty to defend is triggered once the excess carrier becomes aware that the claim for damages in the underlying action will exceed the primary carrier's policy limit." As *Cambridge* acknowledged, no Connecticut court had squarely addressed the issue and therefore it was a matter of first impression. *Cambridge* ultimately found the rationale of the minority view more persuasive and concluded that an "excess carrier has a duty to defend where there is a reasonable possibility that a defendant's excess coverage may be reached despite the fact that a primary insurer has undertaken the defense as well."

Established Standards

To date, the decision is the only case to directly consider this issue in Connecticut. By contrast, a recent Superior Court decision disagreed with *Cambridge*, albeit in dicta, finding the "majority position more persuasive and more consistent with our well-established standards of insurance policy interpretation." *R.T. Vanderbilt v. Hartford Accident & Indemnity*, No. X02UWYCV075016321, 2014 WL 1647133, at *3 (Conn. Super. Ct. March 28, 2014) (J. Shaban) (appeal pending). *R.T. Vanderbilt*'s disagreement with *Cambridge* portends that a split of authority may develop in Connecticut on this issue.

If Connecticut courts adhere to the minority view adopted in *Cambridge*, an excess carrier's duty to defend would in theory be triggered on the initiation of any action where the damages sought exceed the primary policy's limits. As a consequence, *Cambridge* can be interpreted to transform an excess carrier into a co-primary insurer with a co-extensive duty to defend. However, in Connecticut, the mere existence of the duty to defend on the part of an excess carrier does not necessarily mean that an excess carrier will be required to concurrently contribute to a loss on a pro rata basis with a primary carrier. In determining the order of coverage between insurers, Connecticut courts will consider the language of the triggered policies, including competing "other insurance" clauses, as well as the "total policy insuring intent" of those policies.

If Connecticut courts adhere to the minority view adopted in *Cambridge*, an excess carrier's duty to defend would in theory be triggered on the initiation of any action where the damages sought exceed the primary policy's limits.

The Connecticut Supreme Court has recognized that "other insurance' clauses are valid for the purpose of establishing the order of coverage between insurers, as long as their enforcement does not compromise coverage for the insured." *Aetna Casualty & Surety v. CNA Insurance*, 221 Conn. 779, 783, 606 A.2d 990, 992 (1992). It is not uncommon for "other insurance" clauses between responding policies to compete and conflict with each other. In interpreting competing "other insurance clauses," the Connecticut Supreme Court has instructed courts to carefully read the language of policies in their entirety to reconcile any conflict or ambiguity that "may arise when identical or similar 'other insurance' clauses exist and if enforcement of clauses would not produce adverse consequences for the insured, clauses should be enforced as written to establish order of coverage between insurers."

Michael P. Thompson

However, where two "other insurance" clauses are truly "mutually repugnant" and incapable of being reconciled, courts should look to the "total policy insuring intent" test wherein the "function and intent of the various policies are examined to determine whether logic dictates that they be ranked in a particular order." *Scottsdale Ins. v. Underwriters at Lloyd's London*, No. CV064022710S, 2009 WL 3284231, at *7 (Conn. Super. Ct. Sept. 8, 2009). The court in *Scottsdale* added: "Under the 'total policy insuring intent' test, a policy designed to cover the risk in question takes precedence over a policy which only incidentally covers that risk."

In instances where both the "other insurance" clauses are mutually repugnant and the "total policy insuring intent" is the same between policies, courts often require both policies to jointly contribute their pro rata share based on the total limits of insurance. Indeed, the U.S. Court of Appeals for the Second Circuit, interpreting Connecticut law, has found that where two policies contemplate the same risk equally, such as where two policies both purport to be true excess policies, the policies will be found to provide concurrent coverage. *Continental Casualty v. Aetna Casualty & Surety*, 823 F.2d 708, 712 (2d Cir. 1987).

However, true excess policies seldom have the same insuring intent as a primary policy, as those policies do not contemplate the same risk equally. Under this analysis and reasoning, an excess carrier will likely not be required to contribute pro rata to a loss concurrently with a primary carrier, but may be required to respond to a loss concurrently with other excess carriers.

While *Cambridge* may not always convert an excess carrier into a co-primary insurer, one potential outcome of the decision is to encourage early settlement of claims by ensuring that all potentially responding carriers—both primary and excess—are actively involved from the inception of the claim. ■

Michael P. Thompson is a partner in Wiggin and Dana's litigation department and a member of the insurance practice group. He advises insurers and reinsurers worldwide concerning complex contentious matters.

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Limits on Duty to Defend Under Conn. Law

Clear contractual language key to restricting insurers' obligations

By JOSEPH J. BLYSKAL and GREIL ROBERTS

Assessing whether the duty to defend terminates on policy exhaustion can become a complex analysis when a claim involves multiple plaintiffs and exposure unquestionably exceeds the policy limits, yet the insured desires a continuing defense.

It is well-established that the duty to defend and duty to indemnify are separate and distinct obligations of an insurer. Insurers can limit their duty to indemnify by monetary policy limits and terms, conditions and exclusions. The exercise of contractual limitations on the duty to defend, such as provisions terminating the defense obligation on policy exhaustion, however, are harder to enforce because of the breadth of the duty to defend. Nonetheless, in appropriate circumstances, the obligation of an insurance company to defend its insured can be contractually limited with clear and unambiguous language.

Connecticut appellate courts have not squarely addressed in what circumstances exhaustion of policy limits will terminate the duty to defend. Despite the lack of appellate authority, persuasive case law from the Connecticut Superior Court supports the enforceability of exhaustion provisions as a means to limit the duty to defend. Additional support can be found in cases considered by New York courts and other jurisdictions. While under Connecticut law such provisions are likely enforceable from a contract perspective, circumstances in which exhausting policy limits and terminating the defense would leave the insured exposed to excess risk still require careful consideration under good-faith standards.

Persuasive case law from the Connecticut Superior Court supports the enforceability of exhaustion provisions as a means to limit the duty to defend.

The duty to defend is assessed based on the four corners of the insurance policy and the four corners of the pleading giving rise to the claims. *Travelers Casualty and Surety v. Netherlands Insurance*, 312 Conn. 714, 739 (2014). The rule, often referred to as the "eight corners" rule, is applied to determine whether the complaint has "stated facts which bring the injury within the coverage" without respect to whether the stated claims will ultimately be successful. *DaCruz v. State Farm Fire & Casualty*, 268 Conn. 675, 687 (2004). For this reason, it is a ubiquitous principle of insurance law that the duty to defend is broader than the duty to indemnify.

A common policy provision provides that an insurer has a duty to "settle or defend" a covered claim but that on payment of the policy limits for "judgment or settlement" the insurer no longer has an obligation to provide a defense. At least one Superior Court has recognized that exhaustion of policy limits would terminate the duty to defend based on the following language in a commercial policy: "Our duty to defend or settle ends for a coverage when the Limit of Insurance for that coverage has been exhausted by payment of judgment or *settlements*." *Aetna Life & Casualty v. Gentile*, No. 0122259, 1995 Conn. Super. LEXIS 3444, 5 (Dec. 12, 1995) (emphasis in original). There, the insurer sought a declaratory judgment that it did not have a duty to defend following payment of the policy limits in response to seven separate claims. The court ultimately concluded that the payment was not the result of a "settlement" because the insurer failed to obtain a full release of the insured for one of the seven claims.

Joseph J. Blyskal

Greil Roberts

Despite its conclusion, however, the court plainly recognized that "if [the payment was a 'settlement,'] the policy limits are exhausted and there is no further duty to defend." Turning to the common law on the meaning of "settlement," the court concluded that the failure to obtain a release as to one of the claims precluded a finding that the payment was the result of a "settlement." Thus, even though the insurer had made a payment for the policy limits, the duty to defend was not terminated.

In further concluding that the insurer still had a duty to indemnify in such circumstances despite the payment of an amount equaling policy limits, *Gentile* stated: "The relationship between insurer and insured is extremely complex in dealing with incidents involving multi-claimants wherein the total amount of the claims asserted have the prospect of exceeding the policy limits. It may be argued, from a simplistic standpoint, that the mere payment of the policy limits, in whatever fashion and in whatever amount the insurer may choose, in accordance with its sole discretion under the terms of the policy, satisfies the requirements of the policy. When, however, it is understood that the exhaustion of the policy exposes the insured to the financial jeopardy of payment of any excess sums from the insured's own funds, and bearing in mind the implications of unsatisfied judgments, the relationship between insurer and insured assumes a different complexion."

Though *Gentile* initially acknowledged the potential enforceability of the exhaustion provision to terminate the duty to defend, the fact that the insurer left the insured to face excess exposure resulted in a finding that it had a continuing duty to defend and indemnify. Notably, the court denied declaratory relief to the insured and awarded attorney fees to the insured for both the underlying action and the declaratory judgment action.

Ambiguous Terms

Another instructive case is *Chicago Title Insurance v. Kent School*, 361 F. Supp. 2d 4, 7 (D. Conn. 2005). In that case, the U.S. District Court in Connecticut addressed whether a policy of title insurance permitted the insurer to tender its policy limits to its insured and thereby terminate its duty to defend. The policy provided that the insurer "may terminate its liability hereunder by paying or tendering the full amount of this policy."

Despite this clause, because the policy provided that "the costs and expenses of defending the title" were in addition to the policy limits and the policy was ambiguous in its failure to define the term "liability," the court found that the insurer had a continuing duty to defend. In so concluding, however, the court did not rule out a different conclusion based on clearer policy language. Significantly, the court cited to a New York case that addressed the policy language of "our payment of liability insurance limit ends our duty to settle or defend," and stated that "such clear language specifically stating that [the insurer's] duty to defend can be terminated upon payment of the amount of the policy is absent from the policy [here]."

While it does not appear that any Connecticut court has actually applied the rule permitting an insurer to terminate its duty to defend by making full payment of policy limits to enforce such a result, both *Gentile* and *Chicago Title* clearly recognize this rule and the enforceability of exhaustion clauses. Such recognition is found in other jurisdictions, as well. Further, though such decisions are presently absent from Connecticut jurisprudence, courts in other jurisdictions have allowed an insurer to exhaust limits and terminate its duty to defend.

For instance, in *In Re: East 51st Street Crane Collapse Litigation*, the Supreme Court of New York for New York County declared that an insurer could pay its policy limits to one plaintiff in a multiplaintiff suit and thereby extinguish its duty to defend. No. 769000/08, 2010 N.Y. Misc. LEXIS 6310 (N.Y. Sup. Ct. Feb. 18, 2010). In that case, the policy contained the following language: "Our right and duty to defend ends when we have used up the applicable limit of insurance in the payment of judgments." In the policy before the court "there [was] no provision that such payment must cover all judgments or settlements in a multi-party litigation."

Noting the sparseness of New York law, the court looked to other jurisdictions that permit an insurer to terminate the duty to defend on tender of policy limits. The court ultimately held that "[a]bsent an allegation of bad faith, or a claim that a settlement is unreasonable, an insurer who pays the entire proceeds of its policy in settlement of a claim in multi-party litigation, can be released from the continuing obligation to defend where the policy's language clearly and unambiguously provides for such result." See also *American Employers Insurance v. Goble Aircraft Specialties*, 131 N.Y.S.2d 393 (N.Y. Sup. Ct. June 9, 1954) (insurance company could reserve the right to cease defending claims pending after payment of the total amount for which it indemnified its insured, or could refuse to defend any action commenced after such payments, "if it is so stated clearly and unambiguously in the policy as would be clear and comprehensible to the average businessman without legal assistance"). ■

Joseph J. Blyskal is an associate in the Hartford office of Gordon Rees Scully Mansukhani, where he is a member of the insurance, commercial litigation, employment law and tort practice groups. Greil Roberts is an associate in the firm's Hartford office and a member of the insurance practice group.

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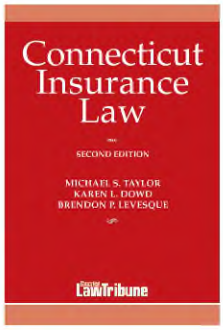

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Pollution Policies May Provide Unexpected Coverage

PARTIES OFTEN HAGGLE OVER WHAT SUBSTANCES ARE CONSIDERED POLLUTANTS

By CRISTINA M. LOPEZ

Insurers have had no problem arguing that almost anything can be a pollutant when seeking to disclaim coverage on the basis of the "absolute pollution exclusion" contained in general liability policies. However, they do not take such an expansive view of what constitutes a pollutant under a pollution liability policy. Because many of the coverage arguments construing pollution liability policies are based on comparisons between it and the absolute pollution exclusion, insurers have inadvertently created a broad class of substances that can considered pollutants.

Brief History

Insurers first attempted to eliminate coverage for pollution-related claims from general liability policies by adding what is now referred to as the "standard pollution exclusion." This exclusion, however, did not apply to bar coverage for any "sudden or accidental" pollution-related losses. Because the terms "sudden and accidental" were often held to be ambiguous, policyholders frequently found coverage for pollution-related claims under their general liability policies. During the 1970s and early '80s, several newly passed statutes concerning pollution and its cleanup ushered in an era of heavy pollution-related litigation. Because of the increase in litigation, insurers once again sought to limit their exposure for environmental claims and, in 1985-86, introduced the "absolute pollution exclusion." This exclusion, as its name suggests, further curtailed coverage under a general liability policy for pollution-related claims.

Even substances that are not traditionally considered 'pollutants' may be deemed pollutants if they end up someplace they are not supposed to be.

Around the same time, insurers realized that they could sell stand-alone policies to address the gap in coverage caused by the inclusion of the absolute pollution exclusion in general liability policies; and so, the pollution liability policy (sometimes called contractor's pollution liability or environmental liability policy) was born.

Understanding Your Policy

The three most important parts of any pollution liability policy are the insuring agreement, the definition of a "pollution event" and the definition of a "loss."

A typical policy's insuring agreement will state that the insurer "will pay for any 'loss' an 'insured' is obligated to pay as a result of a 'claim' caused by a 'pollution event' resulting from covered operations." Another common insuring agreement states that the insurer will "pay … all sums that the insured shall become legally obligated to pay as loss as a result of claims for bodily injury, property damage or environmental damage caused by pollution conditions resulting from covered operations." See *Spirco Environmental v. American International Specialty Lines Ins.*, 2007 U.S. Dist. Lexis 35991 (E.D. Mo. 2007).

With some minor variations, a "pollution event" or a "pollution condition" is defined as "the discharge, dispersal, release, or escape of any solid, liquid, gaseous or thermal irritant, contaminant or pollutant including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste." This definition mirrors the language of the absolute pollution exclusion and the definition of a "pollutant" in a general liability policy. Some policies add terms to the definition requiring that the discharge be onto the land, the atmosphere, or any body of water, and require that the pollutant is not naturally present in the environment. See *Minkoff v. Action Remediation*, 958 N.Y.S.2d 308 (2010). The inclusion of these geographic terms into the definition of a "pollution event" is likely influenced by opinions construing—you guessed it—the general liability policy's pollution exclusion.

More specifically, many courts have attempted to limit the application of the absolute pollution exclusion by applying it only to situations that involve losses caused by discharges into the environment and not for losses resulting from everyday commercial activities. See *Pepsico v. Winterhur International American Insurance*, 78 N.Y.S.2d 142 (N.Y. App. Div. 2004) (losses from the use of faulty ingredients in making soda not barred by pollution exclusion); *Stoney Run v. Prudential-LMI Commercial Insurance*, 47 F.3d 34 (2d Cir. 1995) (losses for carbon monoxide poisoning in apartment building because of faulty heating and ventilation not barred by pollution exclusion).

Finally, the definition of "loss" is often a critical aspect of any case involving a pollution liability policy because this is often an area where there is significant variation between policies. Some pollution liability policies broadly define "loss" to include any bodily injury, property damage (including loss of use), cleanup expenses, remediation and natural resource damages. Some policies, however, define a "loss" to only include hazardous remediation and natural resource damages. Under these types of policies, a pollution event that only resulted in nonhazardous cleanup would not be covered by the pollution liability policy's insuring agreement.

There is very little case law specifically addressing the terms or scope of coverage under pollution liability policies. For example, a recent search on a legal research website for "contractor's pollution liability" resulted in only 15 hits, and fewer than five of those cases had any significant discussion regarding the coverage provided by the policy. For this reason, an attorney involved in coverage litigation involving a pollution liability policy will be faced with having to make analogies between the pollution liability policy's definition of a "pollution event" and the general liability's absolute pollution exclusion and definition of a "pollutant." This becomes somewhat complicated when one factors in a basic premise of insurance coverage: exclusions are construed narrowly while coverage grants are construed broadly in order to maximize coverage.

What Are 'Pollutants?'

If you can think of a substance, chances are that a court somewhere has held it to be a pollutant under the absolute pollution exclusion. For example, the traditional idea of "pollutant" is reflected in *Heyman Associates No. 1 v. Insurance Company of Pa.*, 231 Conn. 756 (1995), in which the Connecticut Supreme Court held that coverage for claims resulting from fuel oil leaked into a harbor was barred by the absolute pollution exclusion. A somewhat more nuanced notion of "pollutant" is reflected in *Space v. Farm Family Mutual Insurance*, 652 N.Y.S.2d 357 (N.Y. App. Div. 1997), in which a New York Appellate Court held that the absolute pollution exclusion barred claims that occurred when a natural, organic fertilizer (liquid cow manure) that was purposefully used as intended leached into a neighboring property's well. The court acknowledged that although the fertilizer may not have been a pollutant when it was applied, it became an "irritant or contaminant" when it leached into the well.

Finally, a nontraditional idea of a "pollutant" is reflected in *Ortega Rock Quarry v. Golden Eagle Ins.*, 141 Cal. Rptr. 3d 517 (Cal. Ct. App. 2006), in which the court held that the total pollution exclusion barred coverage for claims resulting from a company's placement of dirt and rocks in a river embankment. In reaching its conclusion, *Ortega Rock* specifically relied on the definitions of "pollutants" contained in several environmental statutes.

The takeaway from cases such as *Space* and *Ortega Rock* is that even substances that are not traditionally considered "pollutants" may be deemed pollutants if they end up someplace they are not supposed to be. The implication for coverage under a pollution liability policy is that the coverage provided may be quite broad. A policyholder may be able to make the case that a "pollution event" occurred even when a substance not traditionally thought of as a "pollutant" is released into the environment. Because more and more general liability policies are including exclusions for things that policyholders would not normally associate with pollution, such as silica, dust, vapor and smoke, it is important to keep in mind that a pollution liability policy may provide coverage for those risks.

Cristina M. Lopez

As always with insurance coverage cases, the types of losses covered under a particular pollution liability policy is a factually driven inquiry that must begin with the policy language and the facts of your case. ■

Cristina M. Lopez is of counsel at Saxe Doernberger & Vita in Hamden, where she focuses her practice in commercial litigation and insurance coverage on behalf of policyholders.

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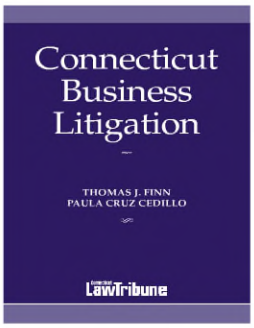

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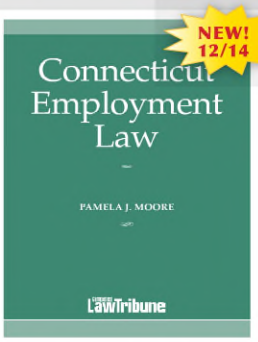

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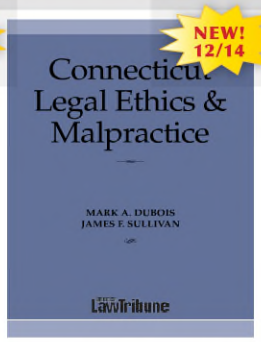

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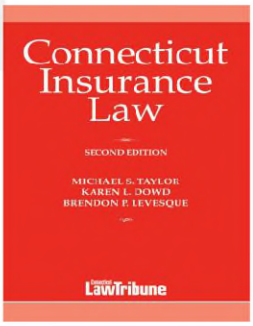

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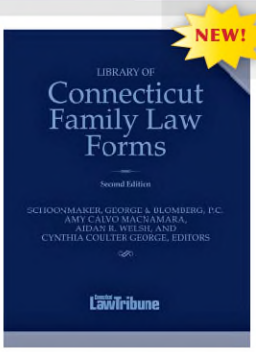

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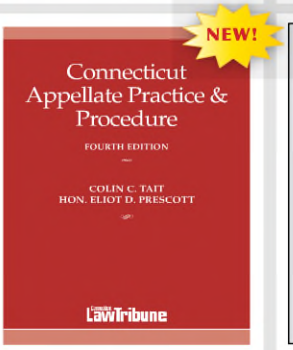

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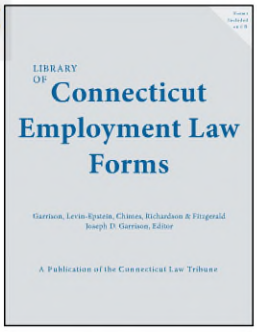

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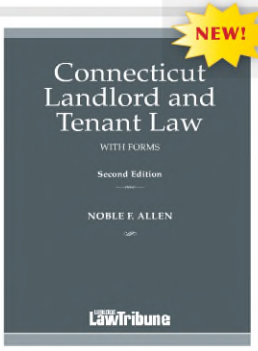

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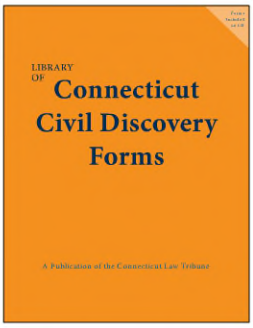

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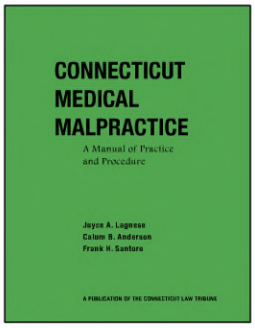

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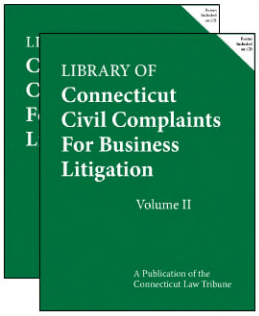

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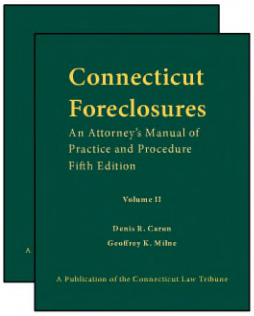

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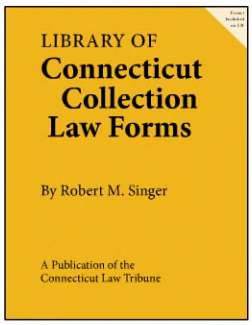

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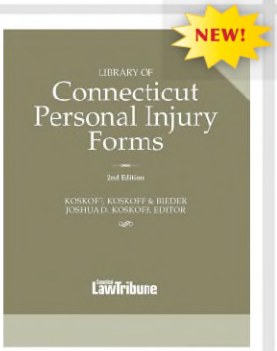

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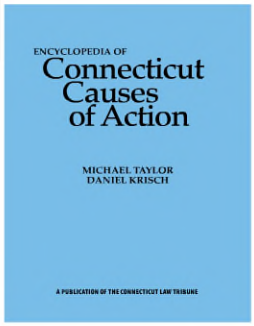

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