PERFECTING AND PURSUING LIABILITY INSURANCE COVERAGE: A PRIMER FOR POLICYHOLDERS ON COMPLYING WITH NOTICE OBLIGATIONS

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I. INTRODUCTION

By purchasing broad liability insurance coverage, companies seek to protect themselves from the risk of liability due to injury or damage suffered by third parties. Liability policies obligate the carrier not only to pay judgments and settlements concerning such injury or damage, but also to pay for the insured's defense. Most companies' liability insurance programs provide coverage for some or most kinds of toxic tort liability, environmental liability, products liability, premises liability, intellectual property liability, antitrust or unfair business practices liability, advertising liability, and employment practices liability. Given the extraordinary breadth of standard policy language, companies enjoy a real prospect of obtaining a defense paid for by insurance carriers, even if some or all of the carriers ultimately will not be required to fund an eventual settlement or judgment.[1]

Perhaps because of the broad coverage provided by liability policies, when a claim involves significant amounts of money, as the past fifteen years of insurance coverage battles have demonstrated, insurers are likely to seek to deny coverage

1. This favorable prospect of obtaining defense coverage is due in part to the fact that the duty to defend is broader than is the duty to indemnify. Where there is any possibility that a claim could result in a covered judgment, courts in most states will impose an obligation on the carrier to defend. As stated by the California Supreme Court:

> To prevail [in establishing the duty to defend], the insured must prove the existence of a *potential for coverage*, while the insurer must establish *the absence of any such potential.* In other words, the insured need show only that the underlying claim *may* fall within policy coverage; the insurer must prove it *cannot.*

Montrose Chem. Corp. v. Superior Court, 861 P.2d 1153, 1161 (Cal. 1993). For a comprehensive review of duty-to-defend coverage, see Marc S. Mayerson, *Insurance Recovery of Litigation Costs*, 30 TORT & INS. L.J. 997 (1995).

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if an insured did not strictly comply with every policy provision, even if the noncompliance is a harmless technical breach.[2] In recent years, courts have upheld carriers' coverage denials for breach of the insured's obligations under a policy where, for example, the insured did not provide timely notice of underlying claims to its insurer—even when it was clear that all the carrier would have done had it received notice earlier is deny coverage that much earlier.[3]

Despite broad policy language and generations of advertisements inculcating the belief that the insurer's cavalry will rescue an insured in need, insurance policies are not self-executing, and the cavalry will not come just because a policyholder faces covered liability. In view of the apparent increased willingness of some courts to deny commercial policyholders coverage on "late" notice grounds, it is vital for policyholders to know and comply with what courts consider to be their policy obligations. Only by being cognizant of the changing legal standards and by establishing management procedures to comply with these new standards can policyholders receive the benefits of the insurance policies they purchased.

II. NOTICE-RELATED OBLIGATIONS UNDER THE POLICY

All liability policies contain provisions requiring the policyholder to notify the insurer of certain potentially covered events. Insurance companies typically argue that insureds' compliance with notice provisions is important because prompt notice gives them the opportunity to investigate occurrences and (potentially) to participate from the outset in the defense of a claim or suit.[4]

Liability insurance policies typically contain three distinct notice-related obligations. Two of these are set forth expressly and are the true "notice" provisions, and the other, which suggests that the policyholder solicit the carrier's input on settlements, is hidden. The insured's promises to provide these distinct types of notice are discussed separately below.

A. *Policyholder's Promise to Provide Notice of Occurrence, Claim, or Suit*

The two traditional notice requirements are commonly set forth as follows:

> [1] In the event of an occurrence, written notice containing particulars sufficient to identify the insured and also reasonably obtainable information with respect to the

2. *See* Rhonda D. Orin, *The Wrong War, the Wrong Time, the Wrong Enemy: Insurers' Allegations of Late Notice are Untimely When Underlying Actions are Pending*, 31 TORT & INS. L.J. 711, 711-12 (1996).

3. *See, e.g., In re* Texas E. Transmission Corp. PCB Contamination Ins. Litig., 15 F.3d 1249 (3d Cir. 1994) (denying coverage for PCB cleanup costs on late notice grounds); Olin Corp. v. Insurance Co. of N. Am., 966 F.2d 718 (2d Cir. 1992) (denying coverage on late notice grounds for more than 10,000 DDT toxic tort claims).

4. *See* ROBERT H. JERRY, UNDERSTANDING INSURANCE LAW 405 (1987).

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> time, place, and circumstances thereof . . . shall be given by or for the insured to the company . . . as soon as practicable.
>
> [2] If claim is made or suit is brought against the insured, the insured shall immediately forward to the company every demand, notice, summons, or other process received by him. . . .

Both of the quoted clauses come from the standard general liability policy established by the insurance industry in 1966. More modern policies contain similar provisions.[5]

Under these provisions, the policyholder promises essentially the same performance: first, to provide the insurer with notice *as soon as practicable* of an *occurrence*, which can be any circumstance that may lead to a claim against the policyholder covered under the policy; and second, to provide the insurer with *immediate* notice of *claim or suit* actually filed against the policyholder.[6] These are separate obligations, and although it is rare for an insured to be denied coverage for breach of the notice of occurrence obligation alone, a policyholder can conceivably lose coverage for the breach of either depending on the circumstances and jurisdiction.[7]

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5. For example, the 1992 Insurance Services Office, Inc. (ISO) Commercial General Liability form policy provides that:

> 2. Duties In The Event Of Occurrence, Offense, Claim Or Suit.
>
> a. You must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim. To the extent possible, notice should include:
>
> (1) How, when and where the "occurrence" or offense took place;
>
> (2) The names and addresses of any injured persons and witnesses; and
>
> (3) The nature and location of any injury or damage arising out of the "occurrence" or offense.
>
> b. If a claim is made or "suit" is brought against any insured, you must:
>
> (1) Immediately record the specifics of the claim or "suit" and the date received; and
>
> (2) Notify us as soon as practicable.
>
> You must see to it that we receive written notice of the claim or "suit" as soon as practicable.

See 1 SUSAN J. MILLER AND PHILIP LEFEBVRE, MILLER'S STANDARD INSURANCE POLICIES ANNOTATED 415 (1995).

6. In addition to primary insurance coverage, most companies purchase excess or umbrella coverage to supplement the limits available under the primary policy. Excess or umbrella policies provide additional coverage once the primary policy is exhausted. Unlike primary insurance, these policies often provide limited or no defense coverage, and as a result the insurer faces less potential prejudice from late notice. Accordingly, most, but not all, excess policies provide that the policyholder has an obligation to provide notice when it is reasonably likely that the claim will implicate the excess coverage. Two fairly typical formulations of the notice provisions found in excess policies are:

> Upon the happening of any occurrence *reasonably likely to involve any of the coverages of this policy*, written notice containing particulars. . . .

1 MILLER & LEFEBVRE, *supra* note 5, at 626.

> Whenever the Assured has information from which the Assured may reasonably conclude that "an occurrence" covered hereunder involves injuries or damages which, in the event that the Assured should be held liable, *is likely to involve this Policy*, notice shall be sent. . . .

For excess policies, then, the policyholder generally need not give notice until it appears reasonably likely that damages will reach the excess layer of coverage.

7. *See, e.g.*, Olin Corp. v. Insurance Co. of N. Am., 966 F.2d 718 (2d Cir. 1992) (denying coverage despite timely notice of suit because notice of underlying occurrence was not timely); *but cf.* Continental Ins. Co. v. MGM, 107 F.3d 1344 (9th Cir. 1997).

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From the early 1960s through the mid-1980s, courts in most states did not strictly enforce these notice provisions. Courts in these states required the insurer to prove *prejudice* from late notice before its performance would be excused.[8] Recent trends in the law in some jurisdictions have not been as favorable to policyholders, especially corporate policyholders. For example, some courts have found that an insured in effect waives its right to recovery for prenotice costs, including defense costs, without requiring the insurer to demonstrate prejudice.[9] Although the soundness of such a per se waiver rule is doubtful,[10] carriers commonly raise this issue in settlement discussions, even where the carrier voluntarily assumes the defense.

Increasingly, some courts appear to be using the notice rubric to winnow "deserving" insureds from the "undeserving." These courts appear to apply much stricter notice rules to large companies than they do to individuals or to small businesses. For example, in 1990 the Sixth Circuit held that a carrier was prejudiced by its corporate policyholder's late notice of an environmental claim because the carrier was not given the opportunity to inspect a leaking underground storage tank that was removed and destroyed before the insured gave notice.[11] There is clearly something to the court's concern: an insurer should have the opportunity to investigate an occurrence. But the Sixth Circuit did not care that the insurer did not inspect the site after receiving notice, or that the insurer did not inspect two other sites where the policyholder gave timely notice of similar problems. Nor did the court care that an independent laboratory had inspected the tank after exhumation, and the insurer had been provided with a copy of its report. The Sixth Circuit effectively *presumed* that the insurer was prejudiced and denied coverage.[12]

8. *See, e. g.*, Action Auto Stores v. United Capitol Ins. Co., 845 F. Supp. 428, 443 (W.D. Mich. 1994) (Michigan law); Estes v. Alaska Ins. Guar. Ass'n, 774 P.2d 1315, 1317 (Alaska 1989) (Alaska law); Healy Tibbitts Constr. Co. v. Foremost Ins. Co., 482 F. Supp. 830, 835 (N.D. Cal. 1979) (California law); Hague v. Liberty Mut. Ins. Co., 571 F.2d 262, 267 (5th Cir. 1978) (Mississippi law). Put somewhat differently, in order for the carrier to be excused from performing for breach of the policyholder's covenant to provide notice, the carrier must establish that the late notice rises to the level of a material breach of the entire insurance contract. Even in states where a primary insurer can be excused from performing in the absence of prejudice, other insurers may still be required to demonstrate prejudice from supposedly "late" notice. *See* American Home Assur. Co. v. International Ins. Co., 641 N.Y.S.2d 241 (App. Div. 1996).

9. *See, e.g.*, Fireman's Fund v. Ex-Cello Corp., 790 F. Supp. 1318, 1329-33 (E.D. Mich. 1991) (insurer must pay postnotice, but not prenotice, defense costs); LaFarge v. Hartford Cas. Ins. Co., 61 F.3d 389, 399-400 (5th Cir. 1995) (insurer not liable for costs incurred prior to its tender of the defense).

10. *See* TPLC, Inc. v. United Nat'l Ins. Co., 44 F.3d 1484, 1493 (10th Cir. 1995) (holding that the duty to defend includes the duty to reimburse prenotice defense costs); Shell Oil Co. v. National Union Fire Ins. Co., 52 Cal. Rptr. 2d 580, 588 (Cal. App. 1996).

11. Steelcase, Inc. v. American Motorists Ins. Co., 907 F.2d 151 (table case), 1990 U.S. App. LEXIS 11310 (6th Cir. July 3, 1990).

12. In another case, a federal court in Oregon stated in dictum that, once the policyholder knew that a leaking underground storage tank was going to be removed, "a delay of even a week [before notifying the insurer] would have been inexplicable." Port Servs. Co. v. General Ins. Co. of Am., No. 91-464-JU, slip op. at 6 (D. Or. Oct. 6, 1992), *reprinted in* 6 MEALEY'S LITIG. REP.: INS., Oct. 27, 1992, at A-1.

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Courts are becoming more strict not only regarding notice of actual claims and suits filed against the policyholder, but also regarding notice of an "occurrence." Consider the *Olin* case decided by the Second Circuit five years ago.[13] The relevant facts follow:

July 1979:	Olin is sued in a number of bodily injury and cleanup cases involving its DDT plant in Alabama (the "first wave" suits).
March 1980:	Olin notifies two of its insurers of the suits.
Nov. 1981:	Olin discovers that it was also covered by Hanover, a third insurer, and Olin gives notice to Hanover.
Dec. 1982:	Olin settles the first wave of DDT suits. A second wave of DDT suits is filed involving 10,000 plaintiffs who live further from the plant. Olin promptly notifies all three insurers, including Hanover, of the second-wave suits.[14]

The Second Circuit denied coverage for the second-wave suits because of Olin's late notice of the initial occurrence. There was no dispute that Olin's notice of the second-wave suits was timely. But the court found that Olin should have notified Hanover of the entire problem in July 1979 at the latest, and that its November 1981 notice was therefore unreasonably late. The court reasoned:

> Although toxic torts may expose insurers to liability founded on acts that occurred decades before and cause their loss reserves to be inadequate, we see no reason to increase that burden by allowing insureds to give late notice because they lost the relevant policies.[15]

The *Olin* court found that the insured irredeemably violated notice provision in the Hanover policy by giving "late" notice of the first-wave suits without considering whether the insurance company would have done anything, let alone anything different, had notice of the first-wave events been immediate.[16] Nor did the court consider whether the policyholder's handling of the first-wave suits somehow (1) prompted the second-wave claims, or (2) prejudiced the insured's ability to defend the second-wave claims. Instead, citing no authority in support, the *Olin* court invoked an implicit "poisonous tree" rule barring coverage for subsequent related claims.

B. *"Hidden" Notice Provisions: The Promise to Solicit the Carrier's Input on Settlement*

Under most policies, the insured promises not only to notify its carrier of claims and suits, but it may also be obligated to provide advance notice of settlements of claims and suits. The following policy language is typical:

13. Olin Corp. v. Insurance Co. of N. Am., 966 F.2d 718 (2d Cir. 1992).
14. *See id.* at 720-21.
15. *Id.* at 725.
16. *See id.* at 723-24.

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> [The insurer] may at [its] discretion investigate any "occurrence" and settle claim or suit that may result.[17]
>
> No insureds will, except at their own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent.[18]
>
> No action shall lie against the [insurance] company unless, as a condition precedent thereto, . . . the amount of the insured's obligation to pay shall have been finally determined . . . by written agreement of the insured, the claimant, and the company.[19]

There are three different provisions to note: (1) the ceding to the carrier of the right to make such settlement as it deems expedient; (2) the no-voluntary-payments provision; and (3) the no-action clause. In view of these provision, where the insurer is not actually handling or adjusting the claim, a prudent insured should provide prior notice of proposed settlements although insurers generally have not been successful in denying coverage for breach of these provisions alone.[20]

After an insured provides notice of an occurrence, claim, or suit, as a practical matter the insurer has a duty to provide its consent to a reasonable settlement because it would be unreasonable for the insurer not to do so; thus, even if a carrier objects to the settlement, if the insured later establishes coverage under the policy, the carrier at best will be excused from paying only those amounts it proves to be unreasonable.[21] Courts are divided, however, as to whether an insurer must demonstrate prejudice to defeat coverage when the policyholder settles the claim or suit with no prior notice to the insurer. In *Roberts Oil Co. v. Transamerica Insurance Co.*,[22] for example, the New Mexico Supreme Court held that, even if the policyholder breached the voluntary payments provision, the insurer had to demonstrate that it was substantially prejudiced by the breach in order to defeat

17. 1 MILLER & LEFEBVRE, *supra* note 4, at 409.

18. *Id.* at 416.

19. INSURANCE SERVS. OFF., COMPREHENSIVE GEN. LIAB. POLICY (1966).

20. If an insurer that has received proper notice then denies coverage, this denial suspends the policyholder's duty to comply with further notice obligations, such as providing notice of potential settlements or other proof-of-loss requirements. *See, e.g.*, Waste Mgmt., Inc. v. International Surplus Lines Ins. Co., 579 N.E.2d 322, 334 (Ill. 1991); Franklin v. Oklahoma City Abstract & Title Co., 584 F.2d 964, 968 (10th Cir. 1978); Bunge Corp. v. London & Overseas Ins. Co., 394 F.2d 496, 497 (2d Cir. 1968). An insurer that does not respond to the insured's notice may not later claim that it has no obligation that it never consented to the settlement. *See* National Am. Ins. Co. v. Certain Underwriters at Lloyd's, 93 F.3d 529, 540 (9th Cir. 1996).

21. *See* National Am. Ins. Co. v. Certain Underwriters at Lloyd's, 93 F.3d 529, 540 (9th Cir. 1996); North River v. CIGNA Reinsurance Co., 52 F.3d 1194, 1208-09 (3d Cir. 1995) ("[T]he consent clause relieved the insurer 'of the obligation to pay unreasonable expenses only.' "); Coastal Iron Works, Inc. v. Petty Ray Geophysical, 783 F.2d 577 (5th Cir. 1986); Mullholland v. State Mut. Auto Ins. Co., 527 N.E.2d (Ill. App. Ct. 1988) (carrier must prove prejudice). Rather than objecting to the settlement, insurers will respond sometimes by stating that the policyholder should do whatever it believes to be in its best interests, that the insurer is not in a position to advise the policyholder, that the insurer consents to the settlement, or that the insurer is not in a position to advise the insured but will not invoke any defense based on a consent to settlement provision.

22. 833 P.2d 222 (N.M. 1992).

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coverage.[23] On the other hand, the Massachusetts high court held in *Augat, Inc. v. Liberty Mutual Insurance Co.*,[24] that a policyholder that settled a case before providing notice of the claim was not entitled to coverage. Although Massachusetts generally requires a carrier to demonstrate prejudice to avoid coverage on notice grounds, the court *presumed* prejudice as a matter of law when all that was left for the carrier to do was to "[write] the check."[25]

III. HOW TO COMPLY WITH NOTICE PROVISIONS

A prudent insured should provide: (1) notice of occurrence as soon as practicable; (2) notice of claim or suit immediately; and (3) notice of potential settlements. To ensure that coverage is not denied for alleged noncompliance with one or more of the corresponding policy provisions, corporate policyholders must have in place effective notice procedures to preserve the coverage for which they paid. Because courts that strictly enforce notice-related provisions in insurance policies appear to be looking in part for a conscious, *ex ante* expression of an intention to pursue insurance recovery, policyholders must know exactly how, when, and to whom to give notice in order to perfect their policy rights.

A. *Practical Implementation of a Notice Program*

An effective notice program assures that, when the corporate insured discovers an occurrence, claim, or suit, or when a settlement is imminent, some person will consider what, if anything, must be done to notify the company's insurance carriers. To this end, it is generally advantageous for the policyholder to centralize the notice process to ensure consistency and to assign responsibility for notice to specific people within the company.[26]

In addition to automatically invoking its internal notice procedures when a new occurrence, claim, or suit becomes known, or when a settlement first becomes a possibility, the insured should regularly review its existing inventory of claims to determine: (1) whether additional carriers should be given notice because potential damages look worse than initially anticipated; and (2) whether what appeared to be an uncovered claim has turned into a potentially covered one, such as when a

23. *See id.* at 231.

24. 571 N.E.2d 357 (Mass. 1991).

25. *Id.*

26. Policyholders commonly rely on their insurance brokers to provide notice for them. There are risks associated with the broker's serving this function. Even if notice is late solely because of the broker's delay, a court may not consider that a policyholder has met its obligations under the policy. It thus may be best not to build in additional delay by routing correspondence through the broker. A policyholder that does decide to use its broker to notify its insurers should establish an express understanding as to how quickly the broker will issue notice letters after being requested to do so and reach some agreement with the broker as to the form of those letters.

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suit by a customer moves from the realm of pure economic loss to potential tort liability.

More generally—and as part of the sound management of the insurance or law department—the policyholder should have in hand a list of all of its potential sources of insurance recovery. The policyholder should locate all policies for which its insurance department's copies are incomplete or nonexistent. The policyholder should also try to get copies of policies from those companies that it has contracted with to be included under *their* policies of insurance. In other words, if the company is an "additional insured" under someone else's coverage, it should get a copy of that policy for its files so that it will be aware of that potential coverage when it comes time to decide which carriers to notify of an occurrence, claim, suit, or potential settlement. Companies should also implement procedures for obtaining such policies, at the outset and as a matter of course, whenever they are to be covered by someone else's insurance. A certificate of insurance, which the "additional insured" may or may not receive, is not a substitute for the policy itself.[27]

B. *How and When to Give Notice*

Notice should be in writing and should invoke the appropriate "magic words." Although standard policy language requires no specific incantation, some courts seem to think there is such a requirement, so it is wise to choose language that will serve the purpose beyond dispute. The more stringent courts are looking for something beyond notice to the insurer of the occurrence, claim, or suit (although this is all the contract requires). These courts seem to want the policyholder to invite the insurer to defend or indemnify it and to state unequivocally that the policyholder is exercising its rights under the insurance policies.[28]

A notice letter should therefore include the following elements. First, it should track the policy language requiring notice of an occurrence, claim, or suit. *"We write to apprise you of an occurrence, claim, or suit implicating your coverage."* Second, it should invite the insurer to provide aid. *"We request that you evaluate your coverage obligations, pay [the insured's] defense costs,*[29] *and take action to safeguard [the insured's] interests."* Finally, it should notify the insurer that the policyholder is incurring costs that it will look to the insurer to cover. *"In the meantime, the company is taking appropriate responsive action, including hiring counsel and the like."*

Even when a carrier in response does not expressly and unequivocally acknowledge coverage, the policyholder should periodically update the carrier about the costs being incurred. These regular updates should describe the costs, request pay-

27. *See* Douglas R. Richmond & Darren S. Black, *Expanding Liability Coverage: Insured Contracts and Additional Insureds*, 44 DRAKE L. REV. 781, 796 (1996) ("Certificates of insurance are often inconsistent with the related policy, and a prudent [additional insured] should assume exclusions in the policy exist that do not appear on the certificate.").

28. *See, e.g.*, Institute of London Underwriters v. Hartford Fire Ins. Co., 599 N.E.2d 1311, 1313 (Ill. App. Ct. 1992) (finding no duty to defend where the policyholder kept the insurer apprised of the suit but never explicitly requested a defense).

29. For excess carriers that do not have defense obligations, omit the request for a defense.

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ment, and note that invoices are available for inspection or even enclose the invoices; a carrier that does not acknowledge coverage, but that is later held to provide coverage, may still contend that it does not owe prejudgment interest because it never received the related bills.

As settlement or trial approaches in any matter, it is important for the policyholder to determine whether the amount at issue is greater than what was anticipated when it originally provided notice for the matter. If the amount is greater, it may be necessary to provide first notice of the whole matter to excess or umbrella carriers whose coverage is now potentially implicated. Notice to such carriers is not "late" where the settlement process or litigation only recently revealed the reasonable possibility of reaching their layer of coverage, because excess policies typically require notice only when the insured "may reasonably conclude" that a claim "is likely" to reach the excess layer of coverage.[30]

If settlement discussions reach a juncture where the insured believes that a settlement is a reasonable probability, a prudent insured may wish to write its carriers to inform them that it is contemplating settlement. A letter providing notice of a potential settlement should include an explanation of the key terms of the proposed settlement; a brief explanation of why the settlement is sensible, such as possible exposure and mounting defense costs; an invitation of objections or suggestions; and finally, an indication that the insured looks to the carrier for coverage.

It is a good practice to provide notices of occurrences, claims, suits, and potential settlements to all affected carriers, even those that have denied coverage. Once a carrier denies coverage, an insured need not solicit its input on settlements; nevertheless, in coverage litigation, it is always helpful to establish a clear pattern demonstrating the policyholder's abiding view that the matter was covered. Finally, the insured should keep copies of all correspondence to and from its carriers, including correspondence sent or received by its broker, along with any attachments or enclosures, or—at a minimum—an identification of the enclosures to facilitate reconstruction later (i.e., in the event of litigation).

C. *To Whom to Give Notice*

The most basic question concerning notice is how to address the letter. Most insurance policies do not set forth a name and address to which notice should or may be sent. For policies that do contain a name and address, of course, the policyholder should write to that address. This mundane observation probably holds true even when the insured knows that the insurance company has moved, been merged out of existence, or become insolvent. In that circumstance, the policyholder may send notice letters to both the old and new entities: comply with the policy provision by sending notice to the address given, but also notify the

30. *See generally* Hatco Corp. v. W.R. Grace & Co.—Conn., 801 F. Supp. 1334, 1369-71 (D.N.J. 1992); Olin Corp. v. Insurance Co. of N. Am., 743 F. Supp. 1044, 1054 (S.D.N.Y. 1990), *aff'd*, 929 F.2d 62 (2d Cir. 1991); *see also supra* note 6.

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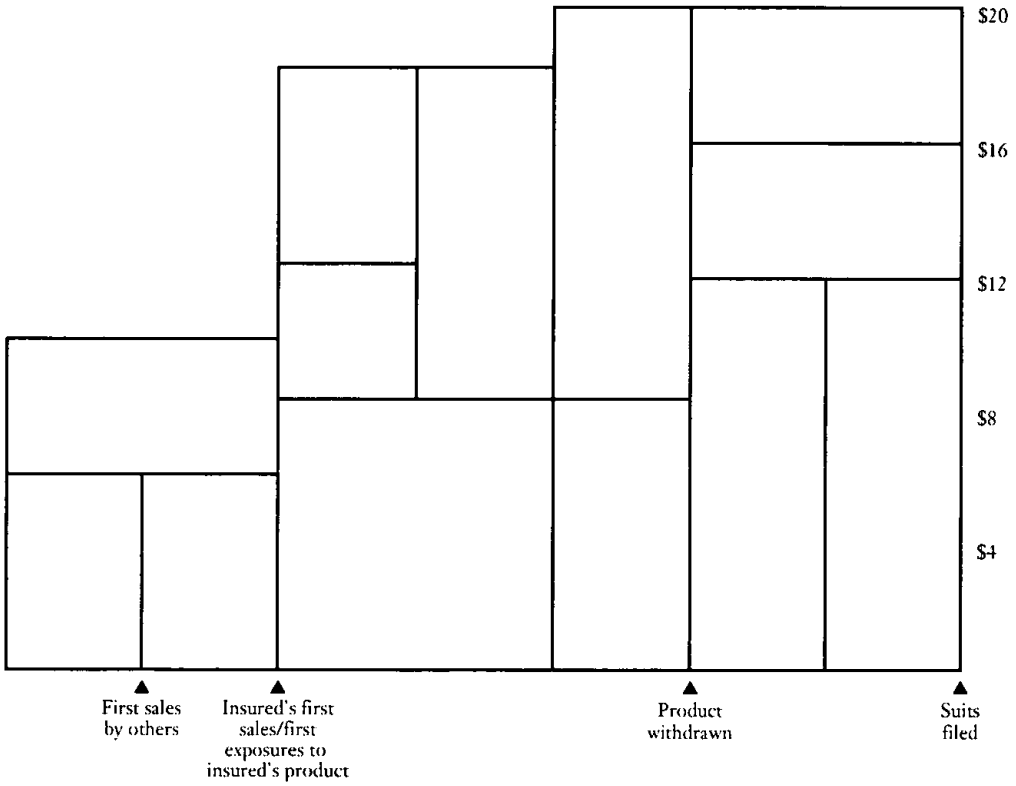
correct present entity. When an insured notifies a successor entity, it should include a statement that it understands the recipient to be the successor and ask the carrier to contact the insured immediately if it disagrees.

A more complex issue is deciding which insurance companies should be notified of a particular matter. Chart I represents a typical liability insurance program for a corporate policyholder. The X axis represents time, the Y axis represents the dollar amount of coverage, and each rectangle represents a separate insurance policy. The legal question of "trigger" determines which policies may apply to any given claim or suit.

Chart I



Consider a policyholder that formerly manufactured products containing asbestos; of course, forms of asbestos have been found to cause continuing injury to those exposed to it.[31] For a personal injury case filed by a plaintiff exposed only during Year Two (the year of the insured's first sales on the chart) and diagnosed

31. This example assumes that the relevant policies are "occurrence" policies, the most common type. Such policies apply if "bodily injury" or "property damage" occurs in the policy period. The meaning of "occurrence" has been the subject of fierce litigation. Which policies are arguably triggered by a particular set of facts varies from jurisdiction to jurisdiction depending on how courts have resolved these issues, but the discussion following provides some sense of the possibilities.

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with cancer in Year Seven, the trigger could be exposure (the Year Two policy responds), manifestation of the injury (the Year Seven policy responds), or a "continuous trigger" of all policies during the period when asbestos fibers persisted in the plaintiff's lungs (all policies from Years Two through Seven respond). If the policyholder is ultimately held liable in a mass tort action such as those that resolved many asbestos, breast implant, and other products claims, it may be jointly and severally liable for all the plaintiffs' damages, including damages attributable to harm occurring before the policyholder/tortfeasor even entered the market. In such an event, a policyholder may argue that policies from when the product was first placed on the market *by anyone* must respond, even though the policyholder had not yet begun to sell the product.[32] In this case, Years One through Seven would respond.

Although which policies may ultimately be required to pay particular liabilities of the insured (and in what amounts) may be uncertain due to disputed issues of fact and law, a basic grasp of the broad principles will suggest which policies *might* be implicated by a particular event. A policyholder, for example, should not assume that it need notify only its current liability insurer when a suit is filed against it; one or more past policies may well be triggered instead of, or in addition to, the current policy.

"Trigger" tells the insured in which years it should consider looking for coverage.[33] The legal question of "scope" or "allocation" of coverage tells the insured which carriers in the triggered years should be notified. The law in this area is currently in a radical state of flux and is conceptually very confused, involving issues of pro ration, "degrees of risk assumed," and "horizontal" and "vertical" exhaustion. Although most notice decisions need not delve deeply into the allocation morass, a basic grasp of the possibilities is important.

32. This is because CGL policies indemnify policyholders for "those sums that the insured becomes legally obligated to pay as damages" for injury within the policy period. Where the policyholder is jointly and severally liable, it is liable for indivisible injury and thus injury in all periods, even in those before it began selling the offending product in question.

33. The discussion in the text that follows focuses on "occurrence" policies, the predominant, although not the only, type of general liability coverage. Some companies' liability coverage is written on a "claims made" basis, meaning that its policies are triggered not by injury occurring but by the assertion of a claim against it. If a company only has claims-made coverage, the trigger/notice questions are different from those for "occurrence" policies and usually turn on the actual date of claim. For one type of claims-made policy, a "claims made and reported" policy, the insured must report (provide notice of) each claim during the policy period or forgo coverage altogether. Although a full discussion of notice-related questions in the claims-made context is beyond the scope of this article, I note that: (1) there is no impediment to collecting under *both* claims-made and occurrence policies (so appropriate notice should be provided under both); (2) some high-level excess policies such as those issued by ACE, X.L., and Starr, among others, require the insured to trigger coverage by declaring the existence of an occurrence; and (3) some claims-made policies permit the insured to self-trigger the coverage by providing "notice of circumstances" that may give rise to claims in the future, thus locking in coverage under the policy period in which such special notice is provided even if claims do not come to fruition until later. *See* Edward J. Beder, Jr. & Rebecca E. Kuehn, *It Is a Mistake to View Insurance Policies as Self-Executing*, NAT'L L.J., Nov. 4, 1994, at B5-B6.

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Chart II

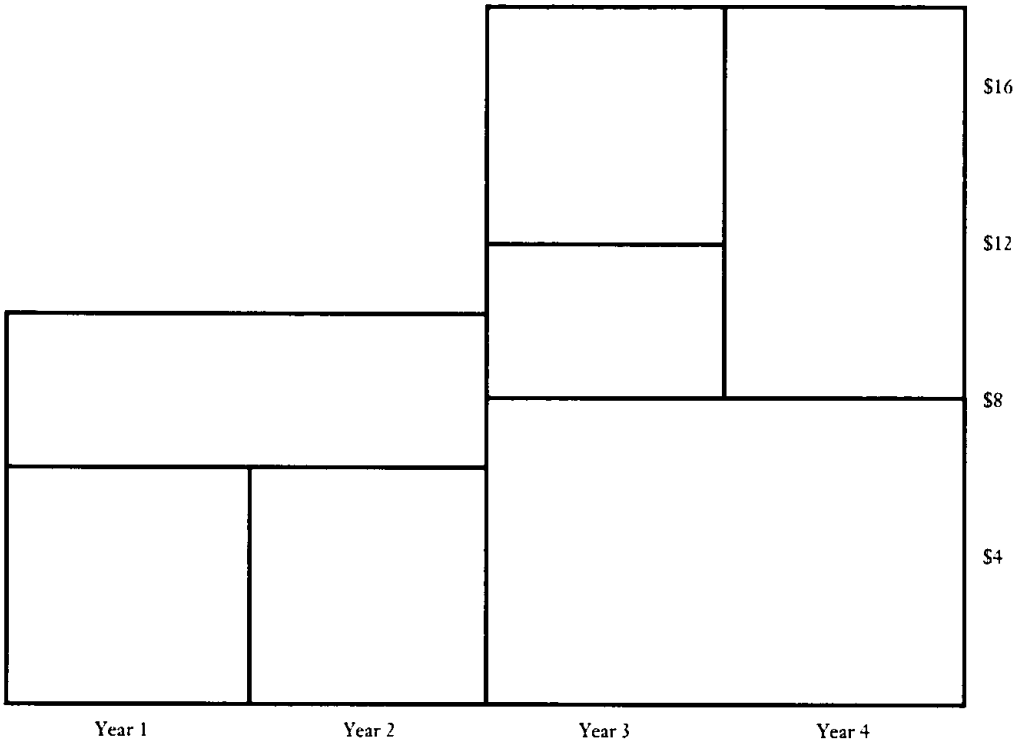

Chart II shows the first four years of Chart I. Consider that in planning its notice strategy in the wake of a covered event, a policyholder decides (applying "trigger" principles) that the policies in Years Two and Three are potentially responsible for an estimated liability of $15 million. Under "vertical" allocation, an insured may begin to collect the full amount of its loss from all policies in any single triggered policy year. Thus, if the policyholder decides to pursue vertical allocation, and the relevant jurisdiction's law permits this allocation,[34] it may choose to collect the entire $15 million from the Year Three policies (note that it could collect no more than $10 million from the Year Two policies). If it does, it will completely exhaust both its primary and first-layer excess policies, and tap the second-layer excess policy for $3 million. The policyholder should thus provide notice to all three Year Three insurers. If the policyholder decides or is required under governing law to instead divide liability between the two years (a form of horizontal allocation), the liability may be divided between the Year Two and Year

34. Because liability insurance policies almost never specify the governing law, a sensitive choice-of-law determination should be made bearing in mind the possible jurisdictions in which (and possible defendants against whom) a coverage case could be brought (e.g., location of claim, location of the policyholder's principal office, location of the insurance companies, etc.). Because the law on key issues varies significantly from state to state, choice of law and forum issues should be considered at the time of providing notice of any significant, or potentially significant, matter.

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Three insurers in any of the following combinations: (1) $10 million/$5 million; (2) $7.5 million/$7.5 million; or (3) $5.36 million/$9.64 million.[35]

Generally, the safest course is to provide notice in each triggered year up to the amount of the potential loss or applicable policy limits, whichever is lower. Sometimes, however, a coverage-maximizing strategy begins with the notice campaign, and it may be best to structure the notice on a given matter to best posture the insured for maximum insurance recovery.[36] The full range of strategic considerations is beyond the scope of this article, but, again, the policyholder's awareness of these issues will help it to avoid making serious mistakes, or at least will help the policyholder understand when it needs expert advice.

IV. WHAT THE INSURED CAN EXPECT TO HEAR FROM ITS CARRIERS

Once the policyholder provides written notice, the carrier should reply within a reasonable period. The insured should know how to respond to the various forms that these replies take. First, the carrier may simply deny coverage. When it does so, the policyholder must decide whether to litigate (and where and against whom).[37] More typically, and in what seems to be a feint to avoid bad-faith liability, the carrier will respond that it has insufficient information to make an evaluation.

Typically, an insurer asserting a lack of information also does one of two further things. First, it may offer a laundry list of reasons why the claim is probably not covered and threaten to close its file, but invite the policyholder to attempt to change its views. Second, instead of expressing a preliminary negative evaluation of coverage, the carrier may send what are in effect interrogatories comprising as many as thirty or forty individual questions, claiming that it needs the answers to these questions to evaluate coverage. A policyholder that has provided notice to numerous carriers may very quickly find such inquiries to be incredibly burdensome; however, the policyholder should not simply ignore the requests, because it may be obliged to cooperate with the insurers' reasonable investigation of a claim (and because the carrier also may be seeking to build a record). A reasonable response is to send general updates and more detailed information to all carriers, with a cover letter noting that their overlapping inquiries render separate responses impractical and adding that the policyholder presumes that its update sufficiently answers

35. Scenario (1) is based on chronological exhaustion (the earlier years are exhausted before later years are tapped), (2) on equal shares, and (3) on relative limits (each year's policies must pay in proportion to the amount of risk they underwrote). Because some states seem to commend an ad hoc approach to allocation, other allocation results certainly are possible.

36. Such strategic notice campaigns are sometimes employed to improve a policyholder's chances of recovery or even to increase the size of its potential recovery. Although this is not usually the case for run-of-the-mill products and environmental claims, a strategic campaign can make a large difference because the policyholder can thereby stake out a coverage position and establish its clear and consistent belief in that position.

37. *See generally* Marc S. Mayerson, *Managing Complex Insurance Coverage Disputes*, 32 TORT & INS. L.J. 53 (1996); Marc S. Mayerson, *Insurance Recovery of Litigation Costs*, 30 TORT & INS. L.J. 997 (1995).

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the carriers' questions. Alternatively or in addition, the insured may invite its carriers to a meeting to discuss the claim or claims. Either response constitutes a good-faith effort by the policyholder to cooperate under the policies and demonstrates the policyholder's abiding belief that the claims are covered, which is helpful in the event of litigation.

It is even possible that a carrier will respond to a notice letter by acknowledging possible coverage under the policy and undertaking the policyholder's defense. When the carrier does this, however, there are two points that the policyholder should bear in mind. First, when it agrees to defend, the insurer will almost certainly do so under a reservation of rights, stating that it may later deny coverage on any number of grounds. In some states, a reserving carrier is not permitted to appoint counsel to defend the insured, but instead must pay for counsel of the insured's choice.[38] Second, the carrier may say that it will pay for the policyholder's defense subject to its right to recover all the money it spends for defense if it is later determined that there is no coverage; such a response is not an acknowledgment of a duty to defend but instead is an offer to enter into a funding arrangement separate from the insurance policy. When a carrier tries to reserve such a right of recoupment, the policyholder should refuse to so agree, and state that it will construe any payment by the carrier as acknowledging the policyholder's objection to any right of recoupment. Most courts have refused to permit insurers to add additional terms or conditions to the performance required under the insurance contract; however, it is prudent to object to any claims of recoupment because some courts have found that a policyholder's failure to object establishes a contract that permits the carrier to get its money back.[39] If the carrier refuses to change its position, the policyholder has a decision to make: It may defend the liability action itself and in a separate coverage action sue the insurer, or it may accept the offer of interim funding of the defense subject to the insurer's recoupment claims. Which option is best depends upon the circumstances.

38. *See, e.g.,* American Motorists Ins. Co. v. Trane Co., 544 F. Supp. 669, 686 (W.D. Wis. 1982), *aff'd,* 718 F.2d 842 (7th Cir. 1983); Public Serv. Mut. Ins. Co. v. Goldfarb, 425 N.E.2d 810, 815 (N.Y. 1981). This rule is based on the fact that an insurer's reservation of its rights is likely to create a conflict of interest between it and its policyholder in the handling and defense of the claim with the insured preferring to lose the suit, if at all, on covered grounds and the carrier preferring to lose the suit on uncovered ones. If the insurer defends without issuing a reservation-of-rights letter or without entering into a nonwaiver agreement with its insured, it likely will be precluded from asserting exclusions to coverage applicable to the duty to indemnify, and thus it will be required to indemnify the insured. *See generally* National Mut. Ins. Co. v. McMahon & Sons, 356 S.E.2d 488, 493 (W.Va. 1987); Safeco Ins. Co. v. Ellingshouse, 725 P.2d 217, 221 (Mont. 1986). Note further that a proper reservation of rights (1) applies only to indemnity coverage, not defense coverage and (2) sets forth all grounds reasonably known to the carrier so as to alert the insured about the need to develop or avoid developing facts about the underlying claim for purposes of coverage. *See* D.E.M. v. Allickson (North Start Mut. Ins. Co.), 555 N.W.2d 596 (N.D. 1996).

39. *See* Omaha Indem. Ins. Co. v. Cardon Oil Co., 687 F. Supp. 502, 505 (N.D. Cal. 1988), *aff'd,* 902 F.2d 40 (9th Cir. 1990).

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V. CONCLUSION

One reason that companies buy liability insurance is for the peace of mind that it affords. An insurance policy is not self-executing, however, and a policyholder's failure to keep track of its rights and responsibilities can cause it to lose millions of dollars of coverage to which it was entitled. The cost of insurance does not end with the payment of the premium, and though there are genuine costs and burdens associated with notice obligations, as with the premium itself, such costs are the price of securing the protection provided by a company's insurance policies.

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