

MEALEY'S

# Emerging Insurance Disputes

## Insurance Coverage For Subprime-Related Liabilities

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# Commentary

## Insurance Coverage For Subprime-Related Liabilities

By  
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During the past two years, class actions have been filed against more than 80 companies seeking damages based on alleged violations of the federal securities laws relating to subprime mortgages.<sup>1</sup> During the class periods at issue in these cases, the total market capitalization of the defendants declined by approximately \$650 billion.<sup>2</sup> Recent events — including the appointment of conservators for Fannie Mae and Freddie Mac, the failure of Lehman, and the federal bail-out of AIG — suggest that financial losses relating to subprime mortgages are not yet fully realized. More litigation appears to be inevitable. The companies and firms that have been or may be sued in connection with such matters include issuers of mortgage-backed securities, lenders, brokers, rating agencies, investment managers, hedge funds, fiduciaries of benefit plans, accountants, and law firms.

Any company that is or may become a defendant in such litigation should make sure that it takes appropriate steps to obtain the full benefit of any insurance policies that provide coverage for defense costs, settlements or judgments incurred in connection with such claims. This article discusses what companies should

do after they have been sued to protect their insurance assets.<sup>3</sup> It may also be instructive for companies that have not yet been sued by suggesting points that such companies should keep in mind when they next renew their insurance policies.

### A. What Policies Apply?

Whenever a company becomes a defendant in a lawsuit, one of the first things that it should do is evaluate whether it has any insurance that is potentially applicable to the claim. This sounds obvious, but many companies fail to take this step and — as a result — have lost the benefit of insurance coverage that would otherwise be available. Accordingly, every company that is sued should consult with its risk management department, its insurance brokers, and — in complex cases — with coverage counsel, to make sure that it has identified all of the potentially applicable insurance policies so that it can take the appropriate steps to secure the benefit of available insurance coverage. Defense counsel for such firms should recommend that their client take such steps.<sup>4</sup>

In the case of subprime-related claims, the policies that are most likely to apply are professional liability or errors and omissions (“E&O”) policies, directors and officers (“D&O”) or management liability policies, and fiduciary or ERISA liability policies.<sup>5</sup> Depending on the circumstances, other types of policies may also apply. For example, in a situation involving deliberate wrongdoing, it is possible that a crime policy, dishonesty policy, or fidelity bond may provide coverage. In addition, some companies have purchased blended or multiline policies that provide

a wide variety of different kinds of coverage. It is often the case that lawyers in the legal departments of major corporations are not aware of the full array of insurance protection that has been purchased by their institutions. It is a mistake simply to assume that there is no insurance coverage for a particular type of claim, even a claim that at first blush does not appear to fit into any of the standard categories of risk for which corporations have traditionally purchased insurance.<sup>6</sup>

### **B. Providing Notice Of Claims Or Circumstances**

It is critical that companies quickly identify the insurance policies potentially applicable to claims made against them because insurance policies typically require that prompt notice of claims be provided to the insurer. A delay in providing notice of a claim can result in loss of insurance coverage. While the law in some states provides that a delay in giving notice will not result in a loss of coverage unless the insurer was prejudiced, that is not true in other states, particularly under E&O and D&O policies that are written on a claims made basis. In any event, it is always better to provide prompt rather than late notice so as to be able to avoid expensive litigation over the timeliness of notice.

When considering notice issues, companies should evaluate whether they should not only provide notice of claims to the insurers whose policies are applicable to the particular claims that have been filed, but also whether they should provide notice of circumstances under other policies that would be applicable if other related claims are filed in the future. For example, shareholder class actions alleging violations of the federal securities laws are typically eligible for coverage under D&O policies. When such lawsuits are filed, it has become increasingly common that other class actions will be filed alleging violations of ERISA based on substantially similar conduct. Accordingly, it may be prudent for a company that has been sued in a securities case to give notice of claim to its D&O insurers and notice of circumstances likely to give rise to a future claim to its ERISA insurers. That will reduce the risk that coverage under the ERISA policies will be lost based on insurer coverage defenses such as late notice<sup>7</sup> or the application of exclusions for prior notice or prior litigation.<sup>8</sup>

### **C. Consent To Defense Costs And Defense Counsel**

Under most E&O, D&O and ERISA policies, the insurer does not have a duty to defend the insureds but does have an obligation to pay for defense costs, subject perhaps to exhaustion of an applicable deductible. Such policies often include terms that prohibit incurring defense costs or retaining defense counsel without the consent of the insurer. Some policies expressly provide that such consent may not unreasonably be withheld; in others such a restriction is implied.<sup>9</sup> Accordingly, prudent policyholders should inform their insurers about the identity of the lawyers who have been retained to defend claims and should seek consent both to the selection of counsel and to the incurring of defense costs. If — as is often the case — the insurer reserves the right to deny coverage for a claim, the policyholder may have the right to select defense counsel and incur defense costs without the consent of its insurer. The law on this point varies from state to state, however. It is often better to make this a non-issue by obtaining consent.

### **D. Duty To Cooperate**

Most insurance policies provide that the policyholder has an obligation to cooperate with its insurer and to provide information about underlying claims. Many insurers assert that the duty to cooperate includes an obligation to disclose to the insurer privileged and confidential information relating to the defense of underlying claims. Most well-advised policyholders disagree, particularly in cases where the insurer has reserved the right to deny coverage for the claim. The disclosure of privileged information to an insurer that is potentially adverse to the policyholder with respect to coverage matters may result in claims by third parties, including the plaintiffs in the underlying claims, that there has been a waiver of privilege protection.<sup>10</sup> Moreover, it may be unwise to disclose such information to an insurer if the insurer has reserved the right to deny coverage on grounds that are related to the merits of the underlying claims. The insurer may be hoping that privileged information relating to the defense of an underlying claim will help it sustain a denial of insurance coverage.

As a practical matter, it is usually necessary to share some information that is privileged or arguably privileged, including, for example, invoices for defense costs. Moreover, in connection with efforts to obtain

insurer consent to settlements (discussed below), it is almost always desirable to be able to discuss with the insurers the strengths and weaknesses of the case and the potential range of damages. Accordingly, most policyholders must consider carefully what privileged information is essential to share with their insurers, and then take appropriate precautions before doing so. Before sharing any such information, for example, it will often be prudent to enter into a written confidentiality agreement that includes non-waiver provisions and that expressly limits the insurer's use of privileged information to purposes with respect to which the insurer and the policyholder share common interests — such as the defense and resolution of the underlying claims.

### **E. Consent To Settlement**

Most E&O, D&O and ERISA policies provide that underlying claims covered by such policies cannot be settled without the consent of the insurer. As with consent to defense counsel and defense cost provisions, some policies provide that consent may not unreasonably be withheld; even if such language is missing most courts will imply such a restriction as a matter of law. Accordingly, it is important to inform insurers before making settlement proposals, and critical to seek their consent — or at least to give them an opportunity to object — before agreeing to a final settlement. This point should be obvious, but many corporations have found themselves in an awkward position by engaging in extensive settlement negotiations or even entering into settlements without involving their insurers.<sup>11</sup>

In almost all cases, policyholders should seek insurer consent to settlements. Ideally, the insurer will provide consent and agree to fund the settlement. If the insurer is reserving the right to deny coverage for other reasons, it may be willing to provide written assurance that it will not assert coverage defenses based on lack of consent or reasonableness of the settlement. If the insurer is reserving the right to deny coverage for other reasons, but also states that it is opposed to the settlement and that it will be contesting coverage for the additional reason that it did not consent and that the settlement is not reasonable, the policyholder should carefully evaluate the law in the applicable jurisdiction. In some jurisdictions, if an insurer has refused to consent to a reasonable settlement, the policyholder has the right to make

the settlement without losing coverage. Other jurisdictions hold that entering into such a settlement results in a loss of coverage unless the insurer has been offered, but has declined, the opportunity to defend the claims on the merits. In some jurisdictions, the policyholder may settle without insurer consent in circumstances where the insurer is reserving the right to deny coverage for other reasons. In those jurisdictions, the lack of insurer consent will usually not defeat coverage so long as the settlement was made in good faith, was not collusive, and was reasonable. In other jurisdictions, the law may differ or may be unclear.

In some jurisdictions, if the insurer withholds consent to a settlement within the limits of its policy it may become liable for any resulting verdict even if the amount of the verdict is in excess of the limits of its policy. In other jurisdictions, insurer liability for a verdict in excess of the limits of its policy may depend on proving that the insurer's refusal to consent to a settlement was made in bad faith.

Because the law on these issues varies from state to state, and the outcome in particular cases may depend on exactly what was done when, it is important to consider these kinds of issues carefully and obtain advice from sophisticated coverage counsel before making any settlements over an insurer's objections.

### **F. Coverage Defenses**

Unfortunately, most insurers do not respond to notices of potentially expensive claims by acknowledging coverage without qualification and working with their policyholders to resolve the claims on a mutually acceptable basis at a reasonable cost. Instead, insurers typically respond by sending letters reserving the right to deny coverage for as many reasons as the insurer can conceive and reserving the right to deny coverage for other reasons that may occur to the insurer in the future. What are the types of coverage defenses that insurers can be expected to raise in the context of subprime litigation?

Some common defenses have been discussed above — late notice, prior notice, prior litigation, consent to defense counsel and defense costs, duty to cooperate, consent to settlement, reasonableness of settlement. Other common defenses are discussed below.

### 1. Deliberate Crime Or Fraud

Most E&O, D&O, and ERISA policies have exclusions for deliberate wrongdoing. The language of these exclusions varies, and the differences in wording may well matter. The best policies have exclusions that apply only to deliberate crime or deliberate fraud, and require that such conduct be established in a final adjudication. Such policies also provide that the exclusion applies separately to each individual insured, and that one individual cannot lose coverage based on the conduct or knowledge of another. They also provide that a corporation can only lose corporate reimbursement or entity coverage if certain specified senior officers engaged in deliberate crime or fraud.

Most courts have concluded that the “final adjudication” must occur in the underlying case and that the issue cannot be litigated later in a coverage case. As a practical matter, that means that the exclusion will not apply if there is a settlement. *See, e.g., Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Xerox Corp.*, 792 N.Y.S.2d 772, 775-76 (N.Y. Sup. Ct. 2004), *aff'd* 807 N.Y.S.2d 344 (1st Dep't 2006); *Little v. MGIC Indem. Corp.*, 836 F.2d 789, 792-94 (3d Cir. 1987).<sup>12</sup>

Some policies do not have the “final adjudication” requirement. Some say that the final adjudication may occur in the underlying claim or in another proceeding. Some say only that the deliberate crime or deliberate fraud must have “in fact” occurred; mere allegations are not enough. Others say that any crime will do, whether or not it was deliberate. These variations in language matter. It is important to pay close attention when purchasing policies. There is much less standardization of language in E&O, D&O and ERISA policies than is the case, for example, with general liability policies.

### 2. Wrongful Profit

Most E&O, D&O and ERISA policies also have exclusions for wrongful profit or advantage. As with the deliberate crime or fraud exclusion discussed above, there is considerable variation in language among policies. For example, is a “final adjudication” required in the underlying case or in any case? Is it sufficient, if the wrongful profit was “in fact” obtained? Can the conduct of one individual be imputed to another individual or to the corporation?

### 3. Restitution

Some insurers attempt to deny coverage for sums that they characterize as restitutionary in nature, asserting that such amounts do not qualify as “loss” or “damages” within the meaning of their policies, or that it would be against public policy to provide insurance coverage for such amounts. Unfortunately for policyholders, insurers have had some success with such arguments.<sup>13</sup> Fortunately, more recent court decisions have started to recognize that it is also against public policy for insurers to refuse to provide the coverage they promised when they issued a policy in return for the payment of substantial premiums.<sup>14</sup> In addition, sophisticated insurers are beginning to realize that their restitution-based coverage defenses will be self-defeating in the long run. Many insurers, for example, are now willing to endorse their policies to provide that they will never argue that it is against public policy to provide insurance coverage for settlements or damages incurred in connection with claims under Section 11 or 12 of the Securities Act of 1933.

### 4. Rescission

Most applications for E&O, D&O, and ERISA policies include or incorporate by reference the policyholder's SEC disclosure documents such as 10-Ks, 10-Qs, and proxy statements. Accordingly, to the extent that underlying securities claims allege that such documents contained material misrepresentations or omissions, insurers are tempted to try to rescind their policies or deny coverage for such claims based on assertions that they relied on the accuracy of the documents when they were underwriting the policies. Insurers have rarely made such claims in court, perhaps because they realize that such arguments defeat the purpose of the policies and will dry up the market for the purchase of such policies.<sup>15</sup> Indeed, in one recent appellate decision in New York, the court ruled that it would be unreasonable as a matter of law for a D&O insurer to rely on the accuracy of the policyholder's financial statements when underwriting a policy whose principal purpose is to provide coverage for claims alleging that such statements are not accurate. *Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Xerox Corp.*, 25 A.D.3d 309, 310 (1st Dep't 2006); *see also Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Xerox Corp.*, 6 Misc.3d 763, 774 (N.Y. Sup. Ct. 2004) (observing that if the policy did not provide coverage for such claims it would be “phantom' insurance.”).

Nonetheless, insurers may use the threat of rescission claims as a basis for attempting to negotiate a discount in a settlement of coverage claims with their policyholders.

Many modern policies include contractual protection against insurer rescission claims. Such contractual provisions may make it impossible for insurers to rescind their policies or deny coverage for claims.<sup>16</sup> There is considerable variation in the language of such provisions, and they have been evolving over time. It is important to review the applicable provisions of the policies when claims are made. It is also important to consider these issues at the time of policy renewal. The best contractual restrictions on rescission provide: (1) that coverage can never be rescinded for any insured based on misrepresentations or omissions in the application; (2) that coverage for particular claims can never be denied for individual insureds based on misrepresentations or omissions in the application (with the result that such individuals lose coverage only if they fall within the exclusions of the policy, such as exclusions for deliberate crime or fraud established by a final adjudication); (3) that coverage for particular claims can never be denied for the corporation to the extent that it indemnifies an individual (corporate reimbursement coverage) who was not aware that a document included in the application contained a material misrepresentation or omission; and (4) that coverage for particular claims can never be denied for the corporation itself (entity coverage) unless certain specified senior officers were aware that a document included in the application contained a material misrepresentation or omission.<sup>17</sup>

### G. Coverage Settlements

Most coverage claims under E&O, D&O and ERISA policies are settled rather than litigated. Policyholders who are considering settling such claims should be aware of a risk created by two recent coverage decisions in Michigan and California in the *Comerica* and *Qualcomm* cases.<sup>18</sup> In these cases, the courts held that a policyholder had forfeited all coverage under its excess policies because the policyholder had made a settlement with its primary insurer under which the primary insurer paid less than the full limit of its policy. In our view, these cases were wrongly decided. In most jurisdictions, courts have held that a policyholder does not forfeit excess coverage by settling with

the primary insurer for less than full limits so long as the policyholder is willing to pay the difference between the amount paid by the primary insurer and the limit of the primary policy.<sup>19</sup>

To avoid the risk of a *Qualcomm* or *Comerica* result, a policyholder should carefully review the relevant language of all of its excess policies and applicable law in the relevant jurisdiction before making any settlements. If any of the excess policies provide that coverage depends on payment by the underlying insurers of the full limits of their policies (rather than payment by the insurers or the insured of such amounts), and the law in a particular jurisdiction is unclear, the policyholder should be careful about making settlements with the primary insurer or any of the underlying excess insurers for less than the full amount of the limits of those policies.

One way to avoid the problem is to settle with all of the insurers at the same time. Another way to avoid the problem is to get all of the excess insurers to agree that they will not use such language as a basis for denying coverage so long as the full amount is paid either by underlying insurers or the policyholder. Still another way is to structure settlements so that the underlying insurers pay their full limits in return for other concessions, such as the payment by the policyholder of additional premium.

The best solution for this problem is to negotiate better language with the insurers at the time of policy renewal. Many insurers have already prepared endorsements to solve this problem on a going-forward basis and will offer such endorsements free-of-charge upon request at the time of renewal. It is important to make the request, however.

### H. Coverage Disputes

Some coverage disputes cannot be settled on mutually acceptable terms and have to be litigated. If there are coverage disputes, it is important to evaluate at an early stage the litigation alternatives that are available. Most policies issued by US insurers in the US do not contain a choice of forum or a choice of law clause. Some contain non-binding mediation clauses. Some contain clauses that give a policyholder a choice between non-binding mediation and binding arbitration. Some contain binding arbitration clauses (although this is relatively rare).

Almost all policies issued by Bermuda insurers, and many policies issued in Europe by European insurers or by affiliates of US insurers doing business in Europe, contain binding arbitration clauses. Such policies typically provide for arbitration in London or Bermuda. Most also have choice of law clauses that specify that New York law applies to disputes about the interpretation of the policy, but that UK or Bermuda law applies to arbitration procedure.

Most practitioners believe that — in the absence of consent of all parties — it is not possible to have a single consolidated arbitration in one forum with the same arbitrators when disputes arise under separate contracts with separate arbitration clauses. Accordingly, if the relevant insurance policies include some policies with no arbitration clauses and other policies, each with its own arbitration clause, it may be necessary to litigate coverage disputes with insurers in multiple fora. Another complicating factor is whether or not excess follow form policies follow form to arbitration provisions in underlying policies.

The possible need to litigate related coverage questions against multiple insurers in multiple fora is not a desirable feature of an insurance program. Unfortunately, many risk managers and brokers pay very little attention to this problem when policies are purchased. They are much more concerned about purchasing the required total limits within the budget. They do not realize that a policy with small limits and an arbitration provision that requires a separate arbitration in London is less valuable than a policy without an arbitration clause. The time, effort and expense of pursuing a separate arbitration substantially reduces the value of such a policy.<sup>20</sup>

The best solution for US policyholders is to eliminate policies with arbitration clauses from their insurance programs, and to purchase only policies with terms that permit disputes to be resolved through litigation in court in the US. The next best solution is to put all policies with arbitration clauses at the top of the coverage tower, where they are least likely to be needed, and to have them all endorsed with a common endorsement providing for a single consolidated arbitration in a more convenient and less expensive forum (e.g., Canada). To be enforceable, all of the excess insurers would have to be parties to the same arbitration agreement which would have to be at-

tached to, or incorporated by reference in, each of the relevant policies.

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## Endnotes

1. Cornerstone Research, Securities Class Action Filings — 2008 Mid-Year Assessment, available at [www/securities.stanford.edu](http://www/securities.stanford.edu).
2. *Id.*
3. The author of this paper is a partner in Covington & Burling LLP who regularly represents policyholders in coverage disputes with insurers. The views expressed in this paper are those of the author.
4. Courts in California and New York have suggested that a law firm retained to defend a claim against a corporation is subject to potential malpractice liability if it fails to recommend that its client evaluate whether or not any insurance coverage is available for the claim. See *Darby & Darby PC v. VSI International Inc.*, 95 N.Y.2d 308 (2000); *Jordache Enterprises, Inc. v. Brobeck, Phleger & Harrison*, 18 Cal. 4th 739 (1998).
5. Such policies are almost always “claims made” policies that provide coverage for claims made during the period of the policy, provided that prompt notice is provided to the insurer in accordance with the terms of the policy (depending on the language of the policy, notice may have to be provided during the period of the policy or within 30 days after the end of the policy period). Most such policies also provide coverage if notice of circumstances likely to give rise to future claims is provided during the policy period. If such policies are not renewed, there may be a provision that extends coverage to claims made within a specified period of time after the end of the original policy period provided that the claim relates to conduct that occurred prior to the end of the policy period.
6. Companies may also have other types of insurance or contracts designed to protect them against the risk of incurring losses as a result of a decline in the

value of subprime mortgages, such as mortgage or credit risk insurance, or derivative contracts (credit default swaps). Such contracts differ in significant respects from traditional types of third party liability and first party loss policies. Questions have been raised about the solvency of some insurers that issued such policies or contracts. There may well be future disputes about the interpretation of such policies or contracts but, to date, there do not appear to be any reported US decisions.

7. Some policies require not only notice of claims but also notice of circumstances likely to give rise to claims. Failure to provide notice of the latter can result in loss of coverage.
8. Many D&O and ERISA policies have exclusions for claims that are related to claims that were made prior to the inception of the policy (or some other specified date), or that were the subject of a notice given to another insurer prior to the inception of the policy. While such exclusions were originally intended only to prevent more than one D&O (or ERISA) policy from applying to the same or related claims, and are likely still interpreted by most policyholders to have that meaning, some insurers argue that there is no coverage under an ERISA policy if the policyholder provided notice of a related D&O claim to a D&O insurer prior to the inception of the ERISA policy.
9. All policies should say that consent may not unreasonably be withheld. Some lower court decisions have held that — in the absence of such language — an insurer can avoid any obligation to pay defense costs simply by withholding consent. Such cases are wrongly decided, but it is better to fix the problem at the time of policy renewal than to litigate about it later.
10. See *In re Imperial Corp. of America*, 167 F.R.D. 447 (S.D. Cal. 1995).
11. See, e.g., *Vigilant Ins. Co. v. Bear Stearns Cos.*, 10 N.Y. 3d 170 (2008) (Insured barred from recovery of \$45 million claim due failure to seek prior consent of insurers when settling underlying action).
12. See also, *Atl. Permanent Fed. Sav. and Loan Ass'n v. Am. Cas. Co.*, 839 F.2d 212, 216-17 (4th Cir. 1988); *Nat'l Union Fire Ins. Co. v. Brown*, 787 F. Supp. ;1424, 1429 (S.D. Fla. 1991), *aff'd*, 963 F.2d 385 (11th Cir. 1992); *Nodaway Valley Bank v. Cont'l Cas. Co.*, 715 F. Supp. 1458, 1459 (W.D. Mo. 1989), *aff'd* 916 F.2d 1362 (8th Cir. 1990); *Nat'l Union Fire Ins. Co. v. Cont'l Ill. Corp.*, 666 F. Supp. 1180, 1197-98 (N.D. Ill. 1987); *Nat'l Union Fire Ins. v. Seafirst Corp.*, 662 F. Supp. 36, 238-39 (W.D. Wash. 1986); *PepsiCo, Inc. v. Cont'l Cas. Co.*, 640 F. Supp. 656, 660 (S.D.N.Y. 1986); *Graham v. Preferred Abstainers Ins. Co.*, 689 So.2d 188, 190 (Ala. Civ. App. 1997).
13. See, e.g., *Level 3 Commc'n Inc. v. Fed. Ins. Co.*, 272 F.3d 908, 911 (7th Cir. 2001); *CNL Hotels & Resorts, Inc. v. Houston Cas. Co.*, No. 6:06-cv-324-Orl-31JGG, 2007 WL 788361, at \* 5 (M.D. Fla. March 14, 2007), *aff'd* No. 07-12706 (11th Cir. August 18, 2008) (holding that there is no coverage for losses incurred in connection with claims arising under Section 11 of the Securities Act of 1933 because — as a result of the violation — the policyholder obtained property at a price lower than the policyholder should have paid); *Vigilant Ins. Co. v. Credit Suisse First Boston Corp.*, 10 A.D.3d 528, 528-59 (1st Dep't 2004); see also *Reliance Group Holdings Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 188 A.D.2d 47, 55 (1st Dep't 1993); *Vigilant Ins. Co. v. Bear Stearns Co. Ins.*, 814 N.Y.S.2d 566, 2006 WL 118368, at \* 4 (N.Y. Sup. Ct. Jan. 11, 2006).
14. See *Bank of America Corp. v. SR International Bus. Ins. Co.*, 2007 NCBC 36 (N.C. Super. Ct. 2007) (settlement payments in response to Section 11 claims are covered by the policy).
15. But see *ClearOne Commc'ns, Inc. v. Nat'l Union Fire Insur. Co. of Pittsburgh, Pa.*, 494 F.3d 1238, 1244 (10th Cir. 2007); *TIG Insur. Co. of Mich. v. Homestore, Inc.*, 137 Cal. App.4th 749, 762 (2006); *Fed. Insur. Co. v. Homestore, Inc.*, 144 Fed. App'x 641, 646 (9th Cir. 2005); *Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Sablen*, 999 F.2d 1532, 1536 (11th Cir. 1993); *Cutter & Buck, Inc. v. Genesis Ins. Co.*, 306 F. Supp. 2d 988, 1016 (W.D. Wash. 2004), *aff'd* 144 Fed. App'x 600 (9th Cir. 2005); *Am. Int'l Specialty Lines Ins. Co. v. Towers Fin. Corp.*, No. 94-Civ-2727(WK)(AJP), 1997 WL 906427, at \*8 (S.D.N.Y. Sept. 12, 1997).

16. *See, e.g. In re HealthSouth Corp. Ins. Litig.*, 308 F. Supp. 2d 1253, 1281-85, 1289, 1290 (N.D. Ala. 2004) (granting summary judgment and holding that severability provision in D&O policy precluded rescission of that policy as to individual officers and directors, precluded rescission of Side B (corporate reimbursement) coverage under one policy stack, and precluded rescission of Side B or Side C (entity) coverage under other policy stack.).
17. Such endorsements usually say that it does not matter whether or not the individual knew that the document was included in the application. It is important, however, that the insurer be required to prove that the individual knew that such a document — such as an SEC disclosure document that is incorporated by reference in the applica-  
tion — contained a material misrepresentation or omission.
18. *See Qualcomm, Inc. v. Certain Underwriters at Lloyd's*, — Cal. Rptr.3d —, 2008 WL 763483 (Cal. App. Ct. March 25, 2008); *Comerica Inc. v. Zurich Am. Ins. Co.*, 498 F. Supp. 2d 1019 (E.D. Mich. 2007).
19. The leading case is *Zeig v. Mass. Bonding & Ins. Co.*, 23 F.2d 665 (2d Cir. 1928) (August Hand, J.).
20. Although a prevailing policyholder is entitled to an award of legal fees and other arbitration expenses under UK and Bermuda law, such awards typically do not result in recovering all of the fees and expenses of arbitration. ■

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