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FIDELITY CLAIMS: THE YEAR IN REVIEW

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For the most part, the past year once again saw courts faithfully enforcing the plain language of fidelity bonds, financial institution bonds, and commercial crime policies. Below is a summary of the past year's significant reported decisions.

Manifest Intent

In *Auto Lenders Acceptance Corp. v. Gentilini Ford, Inc.*,¹ the New Jersey appellate court awarded summary judgment to the insurer on several different claims, one of which required analysis of a "manifest intent" issue.² The bond provided coverage for "employee dishonesty" where the employee acts with the manifest intent to cause the insured to sustain a loss and to obtain a financial benefit for "any employee" or "any other person or organization".³ In the claim involving the manifest intent issue, a salesperson of the insured, a car dealership, submitted fraudulent applications to a lender (the plaintiff), to induce the lender to finance car purchases of high risk customers. A result of the salesperson's fraud was that the dealership made sales it would not otherwise have made, profiting thereby.

When a number of the high risk borrowers defaulted, the lender learned of the scheme and brought suit against the dealership to recover its losses. The dealership brought a third-party action against its fidelity insurer, seeking defense and indemnity for the lender's claims.

The New Jersey appellate court reversed the trial court and awarded the insurer summary judgment on this claim, finding manifest intent lacking because the dealership profited from the scheme as the "unintended beneficiary of the fraud by receiving the proceeds of the illicit sale."⁴ The appellate court reaffirmed that the intention of employee dishonesty coverage is to insure against embezzlement-type acts, which

necessarily intend[] to cause the employer the loss, since the employee's gains are directly at the employer's expense. At the other end of the continuum, not triggering fidelity coverage, is the situation where the employee's dishonesty at the expense of a third-party is intended to benefit the employer, since the employee's gain results from the employer's gain. Under such circumstances, even if the employer suffers a loss, fidelity coverage is not triggered.⁵

In *Federal Deposit Insurance Corp. v. National Union Fire Insurance Co.*,⁶ the Third Circuit affirmed an award of summary judgment in the insurer's favor because the insured failed to show that the employee acted with the manifest intent to cause the employer to sustain a loss. In *National Union*, the insured, a bank, made more than \$19 million in loans to a construction project based allegedly upon the concealment of certain critical information by its executive vice president, Mikula. The insured contended that the

¹ 358 N.J. Super. 28, 816 A.2d 1068 (App. Div. March 5, 2003).

² *Gentilini Ford* involved a number of different claims and issues. The others are discussed infra.

³ *Id.*, 358 N.J. Super. at 32, 816 A.2d at 1070.

⁴ *Id.*, 358 N.J. Super. at 34, 816 A.2d at 1072.

⁵ *Id.*, 358 N.J. Super. at 35, 816 A.2d at 1072.

⁶ ___ F.3d ___, 2003 U.S. App. LEXIS 2096 (3d Cir. Feb. 6, 2003).

information, if disclosed, would have led its executive committee to decline the loans. The executive committee had the final responsibility and authority for all lending decisions.

There was no dispute that Mikula did not benefit financially from the loans. The insured claimed that Mikula obtained a financial benefit for third parties, specifically, the construction project's principals and the subcontractors who had performed work on the project, as the loan proceeds were used to pay the subcontractors for work that they had already performed, with the remainder of the money being paid to the project's principals.

The FDIC (after taking over the insured) sought indemnity for the insured's losses from the insured's financial institution bond. The insurer moved for summary judgment on the ground that Mikula did not act with the necessary "manifest intent". The relevant portion of the bond stated that, in order to give rise to a covered loss, the dishonest or fraudulent acts must have been committed with the manifest intent (a) to cause the insured to sustain a loss, and (b) to obtain financial benefit for the employee or a third party. In response to the insurer's motion, the FDIC argued that Mikula's manifest intent could be inferred from the fact that he concealed information indicating that approval of the loans likely would result in a loss.

The trial court rejected the FDIC's arguments and granted summary judgment to the insurer. The Third Circuit affirmed, holding that the FDIC did not show that Mikula acted with the manifest intent to cause the Bank to sustain a loss for the following reasons:

- Most of the facts Mikula supposedly concealed were already known by many of the insured's executives;
- The facts Mikula allegedly concealed showed only that the project had problems, not that it was a failure;
- Mikula could make only recommendations to the executive committee and did not have the authority to disburse loan funds; and
- The funds paid to subcontractors – for work that they had already performed but for which they had not been paid – were merely to keep them from leaving the job.⁷

Another case that discussed the requirement that an employee act with the manifest intent to obtain a financial benefit is *Mortgage Associates, Inc. v. Fidelity & Deposit Co.*⁸ This case involved a fraudulent scheme whereby a third party, with the assistance of two employees of the insured, obtained loans from the insured for "purchasers" of real property, which the third party sold to these "purchasers" at inflated prices. The "purchasers", however, were real people who were not involved in and did not know anything about the transactions. Since they did not know that they had purchased the properties or taken out the loans, they ultimately defaulted on the loans.

⁷ *Id.*, ___ F.3d at ___, 2003 U.S. App. LEXIS 2096 at * 7.

⁸ 105 Cal. App. 4th 28, 129 Cal. Rptr. 2d 365 (2d Dist. December 23, 2002).

The insured's employee dishonesty coverage required that the defalcating employee have acted with the manifest intent to cause the insured to sustain a loss and to obtain a financial benefit for himself or another, with one caveat: if the loss resulted from loans (which it did), the loss would not be covered unless the employee received a financial benefit of at least \$2500.⁹ While the insured alleged that its two employees received "significant financial benefits" from the third party,¹⁰ it failed to submit anything more than what the California court "generously construed"¹¹ as circumstantial evidence of the amount of the benefit the employees received.¹² The court held that the insured bore the burden of proving that its claim fell within the coverage provisions and rejected the insured's contention that the \$2500 limit constituted an exclusion that shifted the burden to the insurer to prove that the exclusion applied.¹³

The court also cogently explained the importance of the financial benefit requirement and the \$2500 limit:

The financial benefit requirement is an essential part of these coverage provisions as it narrows coverage to loss incurred by the insured as a result of acts by an employee which are motivated by financial gain for the employee or an intended third party and not by an intent to benefit the employer (whether exclusive of or conjunctive with an intent for collateral benefit to the employee).

* * *

Not only does the financial benefit requirement limit coverage to that intended under the policy or bond, it also helps to focus coverage on truly dishonest conduct and not conduct which is merely improper, negligent, or incompetent. An employee who causes his employer to incur a loss without receipt of any financial benefit rarely acts with the intent or malice which is implicit in the employee dishonesty coverage. The financial institution bond is not intended to guarantee against bad loans made by the insured. The \$2,500 minimum excludes claims where a loan officer received a small gift which is less likely to motivate the employee to make a fraudulent loan.¹⁴

Direct/Covered Loss

⁹ *Id.*, 105 Cal. App. 4th at 33, 129 Cal. Rptr. 2d at 368.

¹⁰ *Id.*, 105 Cal. App. 4th at 32, 129 Cal. Rptr. 2d at 367.

¹¹ *Id.*, 105 Cal. App. 4th at 35, 129 Cal. Rptr. 2d at 370.

¹² The insured's "evidence" consisted of the assumption "that [the employees] would not have acted had they not received a significant benefit, and that they quit their employment when the insured began its investigation"

Id.

¹³ *Id.*, 105 Cal. App. 4th at 35, 129 Cal. Rptr. 2d at 369-70.

¹⁴ *Id.*, 105 Cal. App. 4th 34, 129 Cal. Rptr. 2d 369.

Another always-fertile topic, and one that flows from manifest intent, is whether a particular loss constitutes a “direct loss” or a “covered loss”. *Gentilini Ford*¹⁵ also involved the issue of “direct loss”. As a result of the employee’s fraudulent scheme (the details of which are discussed above), the lender sued the insured dealership to compel it to repurchase the installment contracts that had been assigned to the lender. The parties’ contract required the insured to repurchase any such contract in the event of a default. The insured settled the lender’s suit for \$215,000 and sought indemnity from the insurer for this payment. The bond provided coverage for “direct loss of or damage to . . . money and securities resulting from dishonest acts committed by any of your employees”¹⁶

The New Jersey appellate court reversed the trial court and awarded summary judgment to the insurer on this issue. The court stated that in order for a loss to be covered by the bond, “the employee’s action must be directed against the employer, i.e., embezzlement, theft or destruction of business property.”¹⁷ Payment to settle a third-party claim is not a “direct loss”:

To find coverage under these circumstances would convert this direct loss policy into a third party indemnity policy. This was not the risk the insured agreed to cover nor the coverage purchased by the insured.

* * *

The words: “direct loss of or damage to Business Personal Property and money and securities resulting from dishonest acts committed by any of [the insured’s] employees . . . with the manifest intent to cause you to sustain loss or damage” cannot be transformed into “damages sustained as a result of a third party liability suit brought against you by the victim of your employee’s dishonesty.”¹⁸

This decision is important because it contradicts earlier cases from the Third Circuit that interpret “direct loss” more broadly. In *Resolution Trust Corp. v. Fidelity & Deposit Co.*,¹⁹ the Third Circuit concluded that the New Jersey Supreme Court likely would interpret “direct loss” in terms of “proximate cause”,²⁰ referencing an earlier decision applying Pennsylvania law.²¹ The Third Circuit applied its tort analysis to “direct loss” a few months before *Gentilini Ford* in *Scirex Corp. v. Federal Insurance Co.*,²² (applying Pennsylvania law). The viability of the Third Circuit’s interpretation of “direct loss” seems to now be called into question, at least where New Jersey law is to be applied.

¹⁵ 358 N.J. Super. 28, 816 A.2d 1068.

¹⁶ *Id.*, 358 N.J. Super. at 32, 816 A.2d at 1070.

¹⁷ *Id.*, 358 N.J. Super. at 36, 816 A.2d at 1073.

¹⁸ *Id.*, 358 N.J. Super. at 36-38, 816 A.2d at 1073-74.

¹⁹ 205 F.3d 615 (3d Cir. 2000).

²⁰ *Id.* at 656.

²¹ *Jefferson Bank v. Progressive Casualty Ins. Co.*, 965 F.2d 1274 (3d Cir. 1992).

²² 313 F.3d 841 (3d Cir. Dec. 23, 2002).

*Firemen's Fund Insurance Co. v. Special Olympics International, Inc.*²³ focused predominantly on “direct loss” in awarding summary judgment to the insurer. In *Special Olympics*, a representative of the Special Olympics, the insured, embarked upon a “fund-raising” effort without authorization and in violation of the Special Olympics’ rules. The representative ultimately used almost all of the funds he raised through donations to pay personal expenses. The representative ultimately diverted more than \$1 million for personal use. Whether the Special Olympics actually reimbursed the donors is unclear.

The bond provided coverage for “direct loss” arising from employee dishonesty and expressly excluded “indirect loss”, which the bond defined to include:

- a. Your ability to realize income that you would have realized had there been no loss of, or loss from damage to, Covered Property.
- b. Payment of damages of any type for which you are legally liable. But, we will pay compensatory damages arising directly from a loss covered under this insurance.
- c. Payment of costs, fees or other expenses you incur in establishing either the existence or the amount of loss under this insurance.²⁴

The Massachusetts federal court awarded the insurer summary judgment dismissing the Special Olympics’ claim, primarily on grounds that the Special Olympics did not sustain a covered “direct loss”. The court defined “direct loss” as “the actual depletion of bank funds caused by the employee’s dishonest acts.”²⁵ In other words, for a loss to be “direct”, “the assets of the insured must be diminished as a result of the dishonest act of the insured’s employee.”²⁶ Since it was the assets of third parties – the donors – and not those of the Special Olympics that were diminished, the court held that there was no coverage: “Thus, the critical issue in the instant case is whether the funds stolen by [the representative] resulted in a diminution of [the Special Olympics] assets. The undisputed facts establish they were not.”²⁷ The court also noted that, even if the Special Olympics reimbursed any of the donors, the reimbursement would not be a covered “direct loss”.²⁸

In *United General Title Insurance Co. v. American International Group, Inc.*,²⁹ the Ninth Circuit held that the subject bond did not provide coverage for payments the insured was required to make to a statutory fund. The bond covered “loss resulting directly from dishonest or fraudulent acts committed by a Title Agent.”³⁰ Universal Title, a title agent, was placed into conservatorship for deficiencies in its escrow accounts. Presumably, the deficiencies resulted from dishonest conduct by the title agent. Under California law, when a title agent is placed into conservatorship, the California Department of Insurance creates

²³ 249 F. Supp. 2d 19 (D. Mass Jan. 24, 2003).

²⁴ *Id.* at 25.

²⁵ *Id.* at 27.

²⁶ *Id.*

²⁷ *Id.* at 28.

²⁸ *Id.*

²⁹ ___ F.3d ___, 2002 U.S. App. LEXIS 23993 (9th Cir. Nov. 14, 2002).

³⁰ *Id.*, ___ F.3d ___, 2002 U.S. App. LEXIS 23993 at * 4.

a statutory fund to make up the deficiency.³¹ The statute requires that title insurers that had a contractual relationship with the title agent placed in conservatorship contribute to the fund.³²

The insured was one such title insurer. It was required to pay \$828,150 to the statutory fund as a result of its relationship with Universal Title and sought indemnity for this payment from its fidelity bond. The Ninth Circuit affirmed an award of summary judgment to the insurer, holding that the statutory payments did not constitute a “direct loss” as required by the policy, as the loss resulting from the dishonest conduct was sustained by third parties and not the insured:

[T]he shortfalls in the escrow account of Universal Title caused injury to third parties. The statutory scheme which imposed liability on [the insured] was put in place to compensate the third parties for potential shortfalls. Pursuant to a statutory obligation imposed upon [the insured] as a cost of doing business in California as a title insurer, it was required to contribute to a Section 12376 fund whose proceeds were used to pay escrow losses suffered by third parties.

The payments made by [the insured] pursuant to their statutory obligation . . . are not losses resulting directly from the dishonest or fraudulent acts of a title agent, and therefore fall outside the scope of coverage of the [insurer’s] Bond.³³

One of the claims in *Performance Autoplex II Ltd. v. Mid-Continent Casualty Co.*,³⁴ involved determining whether the insured demonstrated that it sustained a “covered loss”. The controller of the insured, an auto dealership, fraudulently transferred title in a new car to her mother, purportedly in exchange for a \$2000 down payment and the trade-in of the mother’s old car. Neither the down payment nor the trade-in was ever received. The insured submitted a claim against its employee dishonesty coverage, seeking reimbursement for both the \$2000 and the trade-in, which the insured valued at \$12,700. The bond provided that the insured must establish a “loss of . . . Covered Property resulting directly from the Covered Cause of Loss.”³⁵

The \$12,700 figure was the value that the controller, the defalcating employee, placed on the trade in. Apparently, the car was never seen by anyone at the insured (other than the controller), so not only could the value of the car not be independently verified, but nobody could say that the car even existed. In its claim, the insured simply adopted the value placed on the car by the controller.

The insurer paid the \$2000 and denied the rest of the claim on grounds, *inter alia*, that the value of the trade-in was not a covered loss. The insured sued and the insurer moved for summary judgment. The Fifth Circuit agreed with the insurer that the insured did

³¹ California Insurance Code § 12376.

³² *Id.*

³³ *United Gen'l Title*, ___ F.3d ___, 2002 U.S. App. LEXIS 23993 at * 5-6.

³⁴ 322 F.3d 847 (5th Cir. Feb. 20, 2003).

³⁵ *Id.* at 856.

not prove that it sustained a covered loss because it failed to establish the value of the trade in. It held that the insured had the burden of proving that coverage existed, which burden includes establishing the value of the supposedly covered property.³⁶ The insured's complete reliance upon the value that the defalcating employee ascribed to the car – without anyone from the insured being able to verify or corroborate such a claim independently – was insufficient.

In *Ernst & Young LLP v. National Union Fire Insurance Co.*,³⁷ the New York Appellate Division affirmed the trial court's rejection of a claim against a fidelity bond for fees, costs, interest, and tort damages. In this case, an employee of the insured stole approximately \$4.4 million while performing accounting services for clients of the insured. The \$4.4 million had been made available to him to pay the clients' tax liabilities. The insured asserted a substantial claim against its fidelity bond, much of which was paid. The litigation centered upon whether there was coverage for \$2.9 million in losses sustained by the insured's clients for interest and penalty assessments asserted by the taxing authorities, attorneys' fees, internal business costs, interest for the loss of use of the money stolen, and damages for emotional distress.³⁸

The bond contained the following provision, pursuant to which the insurer agreed to indemnify clients of the insured, so the fact that the loss was sustained by third parties was not material:

CLIENT PROPERTY COVERAGE

1. The company will indemnify any client of the Insured for loss sustained by such client as the direct result of a dishonest or fraudulent act(s) committed by an employee, acting alone or in collusion with others, while performing professional or contracted services for such client and while this Policy is in force as to the Employee(s) causing such loss.
2. Client's property means Money, Securities or other property owner by the Client, held by the Client in any capacity, or for which the client is legally liable.³⁹

The insured made two arguments based upon the foregoing language, both of which were rejected by both the trial court and the Appellate Division. First, the insured argued that "loss sustained by such client" is a broad term that includes losses of the type the insured sought to recover. Both the appellate court and the trial court held that such an interpretation would "impermissibly transform indemnity policies into liability policies."⁴⁰

³⁶ *Id.*

³⁷ 304 A.D.2d 410, 758 N.Y.S.2d 304 (1st Dep't Apr. 15, 2003)

³⁸ A discussion of the facts of the case is contained in the trial court's decision, *Ernst & Young, LLP v. National Union Fire Ins. Co.*, Index No.: 605422/00 (N.Y. Cty. Feb. 6, 2002) (Ramos, J.), *aff'd*, 304 A.D.2d 410, 758 N.Y.S.2d 304 (1st Dep't 2003) (hereinafter referred to as the "Ernst & Young trial court decision").

³⁹ *Id.* at 2-3 (emphasis in original).

⁴⁰ *Ernst & Young*, 304 A.D.2d at ___, 758 N.Y.S.2d at 305.

The second argument the insured made was that, at the least, the penalties and interest should be covered because the clients were “legally liable” for them. As the trial court said, however: “‘legally liable’ refers to situations where the insured or client is a bailee or trustee of property.”⁴¹

Employee/Alter Ego

*East Attucks Community Housing, Inc. v. Old Republic Surety Co.*⁴² is a valuable case that addresses (a) whether employee dishonesty coverage exists where the “employee” is an “alter ego” of the insured, and (b) the proof needed to establish an “alter ego” defense. The insured was a property management company, retained to operate a public housing project. Redd, who was the insured’s sole shareholder, president and managing officer, stole more than \$50,000 from a bank account maintained by the insured for tenant security deposits. He used this money to cover up his embezzlement from a tax account of the insured.

The inevitable employee dishonesty claim was denied, a lawsuit ensued, and the insurer moved for summary judgment. The trial granted the motion, but the appellate court reversed.

First, the appellate court held that, under Missouri law, an “alter ego” defense to a claim of employee dishonesty is viable. The bond defined “employee” as:

Any natural person:

- (1) While in your service (and for 30 days after termination of service); and
- (2) Whom you compensate directly by salary, wages or commissions; and
- (3) Whom you have *the right to direct and control* while performing services for you.⁴³

Based upon the “direct and control” language in the definition of “employee” (there being no dispute that Redd satisfied the first two prongs of the definition), the court concluded:

There is no dispute that given the express terms of the policies, the policies were solely intended to indemnify [the insured] for the dishonest acts of its employees. They were not intended to protect [the insured] from its own acts, which applying the alter ego rule of this state, would include the acts of an alter ego. Thus, when read in context . . . the reference to the “right to govern and direct” in the policies must mean something more

⁴¹ Ernst & Young trial court decision at 5.

⁴² 2003 Mo. App. LEXIS 936 (W. Dist. June 24, 2003).

⁴³ *Id.* at * 19 (emphasis in original).

than an ephemeral right inhering generally in the corporate form; rather, it must have some grounding in reality. Hence, we find that the policies in question do, in fact, incorporate the alter ego defense or exclusion.⁴⁴

The next question was whether the insurer established that Redd was, in fact, an “alter ego” of the insured such that he was not subject to the insured’s “direction” or “control”. The court found that the insurer failed to do so and should not have been awarded summary judgment. In order to demonstrate that Redd was an “alter ego” of the insured, the insurer had to establish that Redd had “complete domination, not only of finances, but of policy and business practice in respect to the transaction attacked so that the corporate entity as to this transaction had at the time no separate mind, will or existence of its own.”⁴⁵

All the insured showed was that Redd was “President, Managing Officer, Director, and sole Shareholder of” the insured.⁴⁶ Judging this evidence to be insufficient to establish the defense, the court continued:

Thus, the fact that Redd was the sole shareholder of [the insured] in and of itself was not sufficient to invoke the alter ego rule. And, the fact that in addition he was the managing officer and a director of [the insured] does not conclusively establish that he completely dominated [the insured’s] finances, policies and business practices with respect to its management of [the subject property] such that [the insured] at the time of the thefts had no separate mind, will or existence of its own.⁴⁷

Of note was the fact that the insurer failed to show that Redd was the sole director of the insured or that the insured’s board of directors had “ceased to function” with respect to the insured’s management of the subject property.⁴⁸ Due to this failure, the court concluded:

we fail to see how the trial court could have found that Redd was not subject to the control and direction of [the insured’s] board to the extent that [the insured] had no separate mind, will or existence of its own in its management of [the subject property] simply on the basis that Redd was the managing officer, a board member and sole shareholder of [the insured].⁴⁹

*Utica Mutual Insurance Co. v. Precedent Cos., LLC*⁵⁰ presented a simpler case, at least on the issue of whether the defalcator was an “employee”. The insured issued a check made payable to Fidelity Title Company for purposes of funding a residential

⁴⁴ *Id.* at * 26.

⁴⁵ *Id.* at * 31.

⁴⁶ *Id.* at * 30.

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.* at * 32.

⁵⁰ 782 N.E.2d 470 (Ind. App. Jan. 31, 2003).

mortgage loan. The check contained a statement specifically directing that the check was not to be deposited for any purpose other than the funding of the loan. Of course, the loan did not close, but Fidelity deposited the check anyway and converted the proceeds, in clear violation of the check's express directions. By the time the insured learned that the loan had not closed, Fidelity was out of business. The insured made a claim against its fidelity bond, alleging, among other things, that Fidelity's actions fell within the bond's employee dishonesty coverage.

The bond defined "employee" in a variety of manners, including a person or business "authorized by the Insured to perform services as data processor of checks or other accounting records of the Insured".⁵¹ The insured claimed that Fidelity was an "employee" because it "was performing services to process the checks for the ultimate borrowers."⁵² The court rejected this argument. Since the bond did not define "data processing", the court relied upon a dictionary definition: "[c]onversion of data into a form that can be processed by computer; the storing or processing of data by computer."⁵³ The court also cited the definition of "data processor": "[a] device, such as a calculator or computer, that performs operations on data; [a] person who processes data."⁵⁴

The Court found that what Fidelity did was not "data processing". It did not "process" checks for others; the check was made payable to Fidelity and deposited into Fidelity's account. To hold that Fidelity was an "employee" under the bond would "expand the plain meaning of an unambiguous policy, which we cannot do."⁵⁵

"In Transit" Coverage

Another of the claims asserted by the insured in *Utica Mutual*⁵⁶ was that the bond's "in transit" coverage covered Fidelity's theft of the proceeds of the check. The bond's "in transit" provision provided coverage for

[l]oss of property resulting directly from robbery, common-law or statutory larceny, misplacement, mysterious unexplained disappearance, being lost or made away with, and damage thereto or destruction thereof, while the Property is in transit anywhere in the custody of

(a) a natural person acting as a messenger of the Insured . . .

⁵⁷

Again, the court relied upon dictionary definitions of key phrases, particularly "in transit". Based upon this definition – "conveyance of . . . goods from one place to another"⁵⁸ – the court rejected the insured's claim that Fidelity "misplaced [the insured's]

⁵¹ *Id.* at 474.

⁵² *Id.* at 475.

⁵³ *Id.* at 475 (citation omitted).

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ 782 N.E.2d 470

⁵⁷ *Id.* at 473.

⁵⁸ *Id.* at 476.

funds while the funds were in transit to the ultimate recipient”⁵⁹ The check was made payable to Fidelity, and there was no contention that the check was misplaced “in transit” to Fidelity. The funds thus were not “in transit” when misappropriated by Fidelity. In addition, the court found that Fidelity was neither a “messenger” nor a “natural person”, as the bond required.⁶⁰

“On Premises” Coverage

We return again to *Utica Mutual*.⁶¹ The bond defined “on premises” coverage as

Loss or Property resulting directly from

(a) robbery, burglary, misplacement, mysterious unexplainable disappearance and damage thereto or destruction thereof, or

(b) common-law or statutory larceny, committed by a person present in an office of the Insured covered by this bond while the Property is lodged or deposited within

(i) any of the Insured’s offices covered under this bond, or (ii) offices of any financial institutions, or (iii) any premises where the Insured leases safe deposit boxes.⁶²

The Insured argued that this coverage applied because Fidelity’s theft of the check constituted “loss of Property resulting directly from . . . misplacement . . . while the property is lodged or deposited within . . . offices of any financial institution.”⁶³ The “misplacement” allegedly occurred when Fidelity disregarded the check’s instructions and deposited the check.⁶⁴ As with the insured’s other arguments, this argument was rejected.

The court again looked to dictionary definitions in the absence of definitions in the policy, with specific reference to the definition of “misplaced”: “[t]o put into a wrong place.”⁶⁵ The court found that the insured’s funds were not “misplaced”, as the check was given to Fidelity, the intended recipient. The court went further, however, and said that even assuming that the check could be considered to have been “misplaced” when Fidelity wrongly deposited it, the “misplacing” of the check did not occur while the check was within the offices of a financial institution, as the bond requires. If there was any “misplacement”, such occurred when Fidelity deposited the check into its account. At that moment, the check was not yet “lodged or deposited within the offices of any financial institution”.⁶⁶

Counterfeit/Forgery/Alteration

⁵⁹ *Id.*

⁶⁰ *Id.* at 477.

⁶¹ 782 N.E.2d 470.

⁶² *Id.* at 473.

⁶³ *Id.* at 475.

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

In *State Bank of the Lakes v. Kansas Bankers Surety Co.*,⁶⁷ the insured loaned money to a marina to finance its inventory. The insured typically would take possession of a “Manufacturer’s Statement of Origin”, which established that the boat that was a particular loan’s collateral was in the insured’s possession. The insured would release the Statement of Origin to the marina – for delivery to the boat’s purchaser – upon the marina’s repayment of the advance. The insured also would check the marina’s property to ensure that the inventory identified by the Statements of Origin was present.

In 1997, the marina went out of business. Shortly thereafter, the insured learned that, on multiple occasions, the marina’s owner obtained advances from multiple sources on the same Statement of Origin. One of the lenders would be provided with the real Statement of Origin, and the others (including the insured) would get fakes. The marina’s owner diverted the ill-gotten advances for his personal use.

The insured sustained a substantial loss on account of the advances that proved to be uncollateralized. It sought indemnity from its fidelity insurer for these losses.

The relevant provisions of the bond provided coverage for:

Loss resulting directly from the Insured having, in good faith, for his own account or for the account of others,

1) acquired, sold or delivered, or given value, extended credit or assumed liability, on the faith of, any original

* * *

d) Certificate of Origin or Title,

* * *

which

i) bears a signature of any maker, drawer, issuer, endorser, assignor, lessee, transfer agent, registrar, acceptor, surety, guarantor, or of any person signing in any other capacity which is a Forgery, or

ii) is altered; . . . or

* * *

(3) acquired, sold or delivered, or given value, extended credit or assumed liability, on the faith of any item listed in (a) through (d) above which is a Counterfeit.⁶⁸

⁶⁷ 328 F.3d 906 (7th Cir. May 12, 2003).

⁶⁸ *Id.* at 907.

The bond contained a typical definition of “counterfeit”: “an imitation which is intended to deceive and to be taken as an original”.⁶⁹

The insurer denied the claim on two grounds, each of which was rejected by the Seventh Circuit in affirming an award of summary judgment to the insured. First, the insurer contended that the Statements of Origin could not be “counterfeits” because some of them were unsigned. The court held that this argument lacked merit because the bond’s definition of “counterfeit” did not require that a document be signed in order to be a “counterfeit”. All that was required was that the document be an “imitation intended to deceive”. The court noted that the insurer never established that a signature was critical:

It is possible that [the marina president] left some of the fakes unsigned because otherwise they would be too perfect. A skilled swindler creates documents with the same degree of variability as the originals – for example, some signed clearly, others in an illegible scrawl, and some not at all. Perhaps [the president] followed the originals to the last detail, omitting signatures when the originals had none. (The record unfortunately does not permit a test of this hypothesis.) A trier of fact was entitled to conclude that a phony that looks like an original is an “imitation” whether or not signed, and thus is a counterfeit. The bond itself implies this possibility. Section (1) deals with documents that have either forged (subsection (i)) or altered (subsection (ii)) signatures. Section (3), covering counterfeits, does not mention signatures. This confirms the district court’s understanding (and ours) that an unsigned document may be “an imitation which is intended to deceive and to be taken as an original” and thus be a “counterfeit.”⁷⁰

Second, the insurer argued that the insured failed to act in “good faith” when it accepted unsigned Statements of Origin, as the bond required. The insurer equated “good faith” with “due care”, which the court found to be illogical. Since a counterfeit is an imitation “that will bilk a person using ordinary care”,⁷¹ arguing that “good faith” equals “due care” adds little to the definition of “counterfeit”. Having concluded that the phony Statements were counterfeits, both the appellate court and the trial court had already concluded (impliedly) that the insured did use due care.⁷² The Seventh Circuit thus rejected the argument.

In *Utica Mutual* (again),⁷³ the insured contended that Fidelity’s (the title agent’s) act of cashing the check contrary to the check’s explicit instructions fell within the bond’s forgery and alteration coverage. The relevant provision of the bond provided coverage for

⁶⁹ *Id.*

⁷⁰ *Id.* at 908.

⁷¹ *Id.* at 909.

⁷² *Id.* The court then reiterated the actions taken by the insured demonstrating that it had used due care in accepting and relying upon the phony Statements.

⁷³ 782 N.E.2d 470.

“loss resulting directly from Forgery or alteration of, on or in any Negotiable Instruments . . . made or drawn by . . . the Insured.”⁷⁴

Under the applicable law (Indiana), an “alteration” requires some type of physical change to the check.⁷⁵ Because the insured did not allege that Fidelity altered the check in any such manner, and because there was no such evidence, the court rejected the insured’s argument. The act of depositing the check in violation of the instructions printed on the check did not constitute forgery or alteration.⁷⁶

Salary Exclusion

In *Jamie Brooke, Inc. v. Zurich-American Insurance Co.*,⁷⁷ the insured, a clothing manufacturer, was victimized by an employee who, attempting to obtain a bonus, forged purchase orders for custom-made clothes that the insured’s customers did not order. The employee, however, did not realize that the insured did not pay bonuses. After the insured discovered the fraud, it sold the specially-manufactured clothes at a loss, and sued its fidelity insurer to recover the loss when the insurer denied its employee dishonesty claim.

In affirming summary judgment in the insurer’s favor, the appellate court, like the trial court, rejected the argument that the salary exclusion did not apply because the insured did not pay bonuses. The bond contained typical language, insuring against loss caused by the dishonest employee that acts “with the manifest intent to . . . obtain financial benefit . . . (other than employee benefits earned in the normal course of employment, including: salaries, commissions, fees, bonuses, promotions, awards, profit sharing or pensions).”⁷⁸ The court stated held that the insured’s argument that the exclusion did not apply

overlooks that the exclusion depends not on the employee’s entitlement to or receipt of a bonus or other normal form of employee financial benefit, but on the employee’s “manifest intent” to obtain such a benefit. Since [the insured] acknowledges that its employee’s dishonesty was apparently motivated by the hope of obtaining some form of extra compensation for the extra volume, the exclusion applies, and it does not avail [the insured] that its employee was apparently misinformed as to his compensation arrangement.⁷⁹

The Maryland appellate court reached a similar result in *ABC Imaging of Washington, Inc. v. The Travelers Indemnity Co.*⁸⁰ In this case, an innocent data entry error led to an employee being grossly overpaid. When the insured discovered the error and asked the employee to return the overpayment, he fled. The insured submitted an employee dishonesty claim, which the insurer denied.

⁷⁴ *Id.* at 477.

⁷⁵ *Id.*

⁷⁶ *Id.* at 478.

⁷⁷ 298 A.D.2d 145, 748 N.Y.S.2d 145 (1st Dep’t Oct. 3, 2002).

⁷⁸ *Id.*, 298 A.D.2d at 145, 748 N.Y.S.2d at 6.

⁷⁹ *Id.* 298 A.D.2d at 145-46, 748 N.Y.S.2d at 6.

⁸⁰ 150 Md. App. 390, 820 A.2d 628 (Mar. 31, 2003).

The Maryland court affirmed an award of summary judgment in the insurer's favor. The bond contained language similar to the bond in the *Jamie Brooke* case described above.⁸¹ The insured argued that the loss should be covered, and the exclusion should not apply, because the payments were made in the "honest belief" that they were for salary, an argument that the court squarely rejected.

The court started by noting that the purpose of the salary exclusion is to allow insurers to avoid becoming involved in "employer-employee disputes about entitlement to salary, commissions, or benefits, for in all such cases the conduct of the employee is within the internal control of the insured employer."⁸² The "earned in the course of employment" language makes the character of the payment constituting the loss the key consideration. If the payment was made in a form covered by the exclusion, then the exclusion applies, irrespective of the employer's "honest belief" or "honest error" in making the payment.⁸³

The court distinguished the recent New York case of *Klyn v. Travelers Indemnity Co.*,⁸⁴ in which the employee controller, through overt dishonest acts, obtained additional "salary" and "benefits" to which he was not entitled. The New York court concluded that, because of the controller's overt dishonest acts, the moneys stolen could not legitimately be considered "salary" or "benefits".⁸⁵ The New York decision described the employee's actions as embezzlement. In *ABC*, however, there were no overt dishonest acts by the employee. The moneys were mistakenly paid voluntarily by the insured as salary, and thus the exclusion was applied.

The Fifth Circuit in *Performance Autoplex*⁸⁶ went even further and rejected the holding in *Klyn*. In *Performance Autoplex*, one of the claims involved the controller embezzle[ing] funds from the insured by giving herself and another employee unauthorized pay increases.⁸⁷ These allegations are similar to the facts of *Klyn*. The insurer denied the claim based upon the salary exclusion,⁸⁸ and the Fifth Circuit affirmed summary judgment for the insurer. It said that the majority interpretation of the salary exclusion – accepted by Texas, the law that applied to the case – is that unauthorized salaries obtained through employee dishonesty are expressly excluded.⁸⁹ The court explained the rationale behind the majority interpretation thusly:

Looking at the plain language of the policy, the interpretation rejecting coverage makes sense. If "in the normal course of employment" means "not obtained through employee dishonesty," the policy language excluding salaries would become mere surplusage. That is, the language excluding salaries presumes that there are acts of employee dishonesty

⁸¹ See *id.*, 150 Md. App. at 395, 820 A.2d 628.

⁸² *Id.*

⁸³ *Id.* 150 Md. App. at 399-400, 820 A.2d 628.

⁸⁴ 273 A.D.2d 931, 709 N.Y.S.2d 780 (4th Dep't 2000).

⁸⁵ See also *Cincinnati Ins. Co. v. Tuscaloosa Cty. Parking & Transit Auth.*, 827 So.2d 765, 768 (Ala. Feb. 22, 2002) (definition of "salary" excludes amount that exceeded compensation due for services provided; "salary" does not mean "all sums designated as salaries").

⁸⁶ 322 F.3d 847.

⁸⁷ *Id.* at 852.

⁸⁸ The language of the salary exclusion was similar to that in *Jamie Brooke*, *supra*.

⁸⁹ *Id.*

that result in increased employee benefits that the insured and insurer agreed to exclude from coverage. Further, as one court noted, “unearned salaries and commissions are nevertheless still salaries and commissions and therefore belong to the generic category of employee benefits that are normally earned in the course of employment.”⁹⁰

Trade Secrets

In *Avery Dennison Corp. v. Allendale Mutual Insurance Co.*,⁹¹ the Ninth Circuit held that losses arising from the theft of trade secrets are not covered under a fidelity bond. The simple facts of this case are that one of the insured’s employees misappropriated trade secrets⁹² and sold them to a competitor. The bond provision cited in the decision, entitled “Covered Property”, provided coverage for, *inter alia*, “Property other than Money and Securities”, which phrase was defined as “any tangible property other than ‘money’ and ‘securities’ that has intrinsic value”⁹³

The Ninth Circuit, affirming the District Court, held that the misappropriated trade secrets were not covered because they are not “tangible property . . . that has intrinsic value”. “Tangible property” is property that “may be felt or touched”.⁹⁴ Since trade secrets “cannot be touched, seen, or smelled”, the theft of them was not covered.

The court rejected the argument that, because the trade secrets were embodied on tangible property, the loss was covered: “[T]he insured does not seek to be compensated for the intrinsic value of some sheets of paper. It seeks to be compensated for the value of its trade secrets, which is by no means intrinsic in the pieces of paper by which some of them may have been transmitted.”⁹⁵

An alternative basis for granting summary judgment to the insurer appears to have been that the insured did not actually suffer the “theft” of the trade secrets. The decision merely mentions this issue in a footnote, but it deserves discussion. While the decision does not discuss the relevant language of the bond, typically a bond defines a “theft” as a “deprivation” of “covered property”. The insured was not “deprived” of the trade secrets; “they have merely been shared with a competitor.”⁹⁶ While the court concluded that the resulting loss – “the exclusivity of the knowledge represented by those trade secrets”⁹⁷ – was not a loss of “tangible” property, and thus not a covered loss, the mere loss of “exclusivity” also does not appear to satisfy the bond’s definition of “theft” such that summary judgment for the insurer was appropriate.

⁹⁰ *Id.* at 858 (citation omitted).

⁹¹ ___ F.3d ___, 2002 U.S. App. LEXIS 20551 (9th Cir, Sept. 25, 2002).

⁹² The lower court’s decision lists the trade secrets as “research and development techniques and reports; adhesive formulas; test methods; technology on silicone release and high speed converting; paper specification; moisturization techniques; silicone test methods; removable adhesive technology; plastic film label construction; and battery label technology.” *Avery Dennison Corp. v. Allendale Mut. Ins. Co.*, 2000 U.S. Dist. LEXIS 22472 (C.D. Cal. 2000), *aff’d*, ___ F.3d ___, 2002 U.S. App. LEXIS 20551 (9th Cir, Sept. 25, 2002).

⁹³ *Id.*, ___ F.3d at ___, 2002 U.S. App. LEXIS at *3.

⁹⁴ *Avery Dennison*, ___ F.3d at ___, 2002 U.S. App. LEXIS at *4.

⁹⁵ *Id.*, ___ F.3d at ___, 2002 U.S. App. LEXIS at * 5.

⁹⁶ *Id.*, ___ F.3d at ___, 2002 U.S. App. LEXIS at * 5 n. 2.

⁹⁷ *Id.*

The Scirex case

We conclude with a discussion of *Scirex Corp. v. Federal Insurance Company*,⁹⁸ a problematic decision from the Third Circuit in several respects.

The facts of *Scirex* are as follows: the insured performed clinical testing of new drugs; its clients are the pharmaceutical companies that manufacture the drugs. The insured contracted with three clients to perform four clinical studies. The studies' protocol – prepared by the clients – required patients (the test subjects) to remain under the observation of the insured's nurses for at least eight hours after being given their first dose of the medication that was the subject of each respective study. They also addressed the circumstances under which a patient would receive a second dose of medication, after a particular period of time, known as “rescuing”. During the course of the patients' eight hour stay, the insured's nurses were to observe the patients and record their observations. In order to comply with FDA regulations, the studies had to proceed in strict conformity with the relevant protocol.

The nurses, however, did not strictly adhere to the protocols. The protocol for the first study eventually was changed by the client manufacturer to allow “rescued” patients to leave before their eight hours was up, subject to a follow-up telephone call, because observations of patients after “rescuing” were of little value to the studies. The nurses, however, applied this change to the three subsequent studies, although the protocols for those studies were not similarly changed. In addition, in many instances the nurses permitted “non-rescued” patients to leave early, but followed up to obtain the required information by phone. The fact that patients left early was not always reflected in the nurses' records. To the contrary, the records generally showed that the patients left at the scheduled time, even when they had not.

Upon receiving a tip from a former employee, the insured performed an audit and determined that the nurses had provided inaccurate information in their records. As a result, the studies failed to comply with strict FDA regulations and were unusable. The insured ultimately agreed to rerun the studies, at no charge.

The insured sought to recover the cost of redoing the studies under its employee dishonesty coverage. The bond provided coverage for “direct loss caused by any fraudulent or dishonest acts committed by [the insured's employees].”⁹⁹ Its limit of \$280,000 applied per “occurrence”, which the bond defined as “all losses resulting from an actual or attempted fraudulent or dishonest act or series of related acts at the premises . . . whether committed by one or more persons”¹⁰⁰ According to the lower court's decision, the bond required that “the loss must occur to money, securities or other property.”¹⁰¹ Neither the appellate court decision nor the trial court decision make any reference to a manifest intent requirement, and it does not appear that the bond contained any such language.

⁹⁸ 313 F.3d 841 (3d Cir. Dec. 23, 2002).

⁹⁹ *Id.* at 845.

¹⁰⁰ *Id.*

¹⁰¹ *Scirex Corp. v. Federal Ins. Co.*, 2001 U.S. Dist LEXIS 19088 (E.D. Pa. 2001), *rev'd*, 313 F.3d 841 (3d Cir. Dec. 23, 2002) (hereinafter referred to as the “Scirex trial court decision”).

For reasons that do not seem at all clear, the insurer's claim adjuster conceded that the studies constituted "property" under the terms of the bond.¹⁰² This concession seems to be a significant cause of the problems with this decision. Neither the appellate court decision nor the trial court decision indicate whether the bond required that "property" be "tangible", as is typical.

The insured submitted a claim totaling \$1.23 million across the four studies, alleging that each study/loss was a separate occurrence. When the insurer denied the claim, the insured sued. After a bench trial, the trial court entered judgment for the insurer, primarily on the ground that the nurses' actions did not constitute "dishonesty". The trial court held that "dishonesty" requires intent by the actor.¹⁰³ Based upon its view of the evidence, "the nurses honestly believed that they were substantially complying with the various protocols . . . Obviously, [their] attitude is at odds with the meticulous requirements of the clinical studies involved in this case, but I am persuaded that the record reflects, at most, a stubborn belief that the nurses were right and that the drug companies were imposing unreasonable and unnecessary requirements."¹⁰⁴

On appeal, the Third Circuit reversed. The first issue it addressed was whether the nurses' actions were "dishonest", a discussion that probably would not have been necessary had the bond contained a typical "manifest intent" requirement. It rejected the trial court's statement that "dishonesty" requires an element of intent, holding quizzically that "motive and intent [are] irrelevant to the concept of dishonesty."¹⁰⁵ The court said that, since the terms of the bond should be construed against the insurer, "dishonesty" includes "any acts which show a want of integrity or a breach of trust."¹⁰⁶

The problem with the Third Circuit's interpretation of "dishonesty" is that the word's plain, dictionary meaning (a resource to which other courts frequently resort, as demonstrated above) involves an element of intent to deceive.¹⁰⁷ To conclude that negligence or even a simple breach of duty, without more, can constitute "dishonesty" seems to expand the bond's coverage to acts not intended to be covered.

The apparent lack of manifest intent language may have been the key to the Third Circuit's conclusion. The insurer cited a 1936 Pennsylvania case in support of its (and the generally accepted) "dishonesty" definition.¹⁰⁸ The Third Circuit distinguished this case because the bond there "covered only 'acts done for the purpose of harm or with a view to personal profit,' qualifying language that does not exist" in the subject bond.¹⁰⁹

Based upon the definition of "dishonesty" accepted by the court, it determined that the nurses' conduct was "dishonest" for purposes of determining coverage. The court deemed irrelevant the possibility that the nurses' actions were a mere "error in judgment" or

¹⁰² See *id.* at * 11.

¹⁰³ *Id.* at * 9.

¹⁰⁴ *Id.* at * 8-9.

¹⁰⁵ *Id.* at * 15.

¹⁰⁶ *Id.* at * 16.

¹⁰⁷ See, e.g., Am. Heritage Dictionary (2d ed. 1982) at 405 (defining "dishonest" as "disposed to lie, cheat, defraud, or deceive"); Couch on Insurance § 161:27 (mere irregularities, mistakes, negligence, errors in judgment or incompetence are not "fraud" or "dishonesty" where there is no intent to deceive).

¹⁰⁸ *Universal Credit Co. v. United States Guar. Co.*, 321 Pa. 209, 183 A. 806 (1936).

¹⁰⁹ *Scirex*, 313 F.3d at 847.

an honest belief that they were complying with the protocols. Even if the nurses were merely negligent, their actions constituted “dishonesty” because they submitted “fictionalized” records that “made it virtually impossible to discover the fictionalization . . . in a field characterized by strict adherence to procedure”¹¹⁰

More curious is the Third Circuit’s conclusion that the insured’s losses were “direct”. As discussed above, the prevalent interpretation of a “direct loss” is one arising from theft, embezzlement, or some other act directed specifically at the employer that diminishes its assets. In *Scirex*, the nurses did not take money or another asset from the insured. In fact, the nurses did not gain any substantive benefit from their “dishonesty”.¹¹¹ The insured’s loss – redoing the studies – was the product of an accommodation it made to its clients. The loss really was sustained by the clients – third parties – and not the insured; and the insured was making its clients whole by doing the studies again. The loss does not seem to be “direct” under the prevailing interpretation of the term.

That is not, however, how the Third Circuit saw it. It concluded that the loss was “direct”, citing the insured’s argument that “it made a substantial investment in [the] studies, and up to the time of the employee falsifications, those studies were valuable. When the employees falsified data in the studies, however, those studies became worthless, and [the insured’s] investment was lost.”¹¹² The underpinning for this conclusion was an implied rejection of the predominant view of “direct loss” and a reliance, instead, upon tort concepts of “direct cause” and “proximate cause”. The Third Circuit explained that the losses resulting from the nurses’ actions were “direct” because they “were directly tied to [the] studies, and by rendering those studies worthless, the nurses’ behavior proximately, and therefore directly, caused Scirex’ losses.”¹¹³

As mentioned above, the Third Circuit’s view of “direct loss” seems to stem from two prior decisions, *Jefferson Bank v. Progressive Casualty Insurance Co.*¹¹⁴ (applying Pennsylvania law) and *Resolution Trust*¹¹⁵ (applying New Jersey law). While *Jefferson Bank* does not appear to have been weakened in Pennsylvania, the *Gentilini Ford* decision out of New Jersey rejected this approach to “direct loss”. The pertinent language from *Gentilini Ford*, discussed above, bears repeating:

The words “direct loss” must be afforded their plain and ordinary meaning. Accordingly, we decline to adopt the proximate cause analysis embodied in the Appelman’s Rule. The policy involved here provides coverage to employers for losses sustained as a direct result of the illegal acts of employees, without any intervening event. To be afforded coverage, the employee’s action must be directed against the employer, i.e., embezzlement, theft or destruction of business property.

¹¹⁰ *Id.* at 848.

¹¹¹ *Scirex* Trial Court Decision at * 9 (the nurses “gained no personal benefit from their actions, except perhaps a slight reduction in paperwork, yielding an earlier end of their workday . . .”).

¹¹² *Scirex*, 313 F.3d at 849.

¹¹³ *Scirex*, 313 F.3d at 850.

¹¹⁴ 965 F.2d 1274 (3d Cir. 1992).

¹¹⁵ 205 F.3d 615.

In this context, payment by the insured to settle a third party claim does not constitute a direct loss triggering coverage under the policy's "Employee Dishonesty" provisions. To find coverage under these circumstances would convert this direct loss policy into a third party indemnity policy. This was not the risk the insurer agreed to cover nor the coverage purchased by the insured. In the absence of any ambiguity, courts should not write for the insured a better policy of insurance than the one purchased.¹¹⁶

Under *Gentilini Ford*, the loss sustained by the insured in *Scirex* would not have been "direct". By agreeing to rerun the studies, the insured, in effect, was making a payment to settle a third party claim – the claim of its clients. The Third Circuit did not have the benefit of *Gentilini Ford* at the time it issued the *Scirex* decision. Since *Scirex* involved the application of Pennsylvania law, however, it is quite possible that *Gentilini Ford* would not have made any difference.

Another problem with *Scirex* is that the bond's valuation provision could not easily be applied to the studies. The bond valued "property" as the least of: "(1) actual cash value of the property on the day the loss was discovered; (2) cost to repair; or (3) cost of replacing the property with material of like kind of quality."¹¹⁷ This difficulty arises because (1) the studies do not fit neatly into the intended definition of "property" and (2) the loss does not seem to be "direct". Both the appellate court and the trial court summarily concluded that the studies were covered "property" with little discussion, relying upon the concession of the insurer's adjuster.¹¹⁸

The Third Circuit rejected the insurer's contention that the valuation provision required that the studies be valued at zero. According to the insurer, by the time the insured learned of the "dishonesty", the studies were worthless, requiring the application of the first of the valuation methods listed. The Third Circuit said that such an interpretation made the protections of the bond illusory because it "would render recovery almost impossible for any producer of custom-made products, a clearly counter-intuitive result that we are unwilling to reach."¹¹⁹ Instead, the court simply discarded the valuation provision.¹²⁰

This problem would not have arisen had the conditions of the bond previously discussed been applied properly. The more appropriate definition of "direct loss" limits coverage to cases of theft, embezzlement, and similar acts. One must reasonably assume that an employee does not generally steal or embezzle "property" that does not have a value, either to the employee specifically or via sale on the open market. In fact, the court noted that the valuation provision addresses assets that have a market value.¹²¹ Thus, the legitimacy of the Third Circuit's concern about "custom-made" products seems questionable. Concluding that the loss was "direct" and that the studies were "property"

¹¹⁶ *Gentilini Ford*, 358 N.J. Super. at 36, 816 A.2d at 1073.

¹¹⁷ *Id.*

¹¹⁸ *Scirex*, 313 F.3d at 850; *Scirex* trial court decision, 2001 U.S. Dist. LEXIS 19088 at * 11.

¹¹⁹ *Scirex*, 313 F.3d at 851.

¹²⁰ *Id.*

¹²¹ *Scirex*, 313 F.3d at 851.

seems inconsistent with the various policy provisions and the intent of the bond and, not unexpectedly, gave rise to problems applying the bond's valuation provision.

The compromise came in the court's determination that all of the "dishonesty" was one occurrence, pursuant to the definition set forth above, and that the insurer's liability was limited to the bond's face amount, \$280,000. The Third Circuit affirmed the trial court's conclusion that

"as to all of the four studies in question, plaintiff's losses resulted from a 'series of related acts': The same nurses were involved in all of the alleged wrongdoing, they acted in concert, and all of the alleged wrongful acts constituted a series of related acts." This finding is not clearly erroneous, for the nurses themselves did not seem to distinguish among the four studies in terms of their responsibilities. We therefore conclude that their conduct caused a single loss.¹²²

As a result, the insurer was held to be liable for one loss at the bond limit, \$280,000.00.

¹²² *Id.* at 852, quoting the Scirex trial court decision, 2001 U.S. Dist. LEXIS 19088 at *14.