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FIDELITY CLAIMS: THE YEAR IN REVIEW

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FIDELITY CLAIMS: THE YEAR IN REVIEW

In the past year or so, the exposed misdeeds of employees that would have better been distrusted again gave courts ample cause to contribute to the ever-expanding body of fidelity law. This article surveys those recent decisions and explores the potential instructional value, if any, that fidelity insurers may derive from them to better navigate the legal environment in which they operate. As in years past, cases turning on direct loss, manifest intent and exclusion issues comprised the greater portion of the decisions of note. Issues involving the cumulation of policy limits produced three cases worthy of mention. Although categorized under separate headings below, in both the *Fireman's Fund Insurance Co. v. Special Olympics International, Inc.* and *Auto Lenders Acceptance Corp.* cases, the courts were similarly inclined to identify and prevent the wrongful use of fidelity coverage for liability purposes. Also noteworthy was the *Cargill, Inc. v. National Union Fire Insurance Co. of Pittsburgh, Pa.* case, where the court found settlement payments claimed against the fidelity insurer to actually represent royalties for misuse of intellectual property. In the sole case concerning ERISA litigation, the court denied a motion to intervene where the movants, who were also class-action plaintiffs in another matter, sought to protect their attenuated interests in fidelity coverage. Many other interesting cases are discussed herein.

A. Loss and Indirect Loss

In *Atlas Metals Product Co., Inc. v. Lumbermans Mutual Casualty Co.*,¹ a dishonest bookkeeper employed by the insured, Atlas Metals Product Company ("Atlas"), also had access to the funds of a realty business partially under the same management; two officers of the insured were also trustees of the realty trust. The bookkeeper wrote checks to herself, stealing a small amount from the insured metal company, which the company later recovered under a fidelity bond. The bookkeeper also stole a significantly larger sum from the realty concern, a loss for which the realty firm asserted it was legally liable to the insured. The claim for the larger loss sustained by the realty trust was denied by the insurer, as the trust was unnamed on the policy.

In the subsequent suit to recover, summary judgment was granted in favor of the insurer on the bases that (1) there was no direct loss to the insured; (2) the insured's payment to the realty trust was an indirect loss; (3) the insured was not a bailee of the realty company's funds; and (4) the bookkeeper's confession negated any thought that she had acted with the requisite "manifest intent" to bring about the coverage demanded for Atlas. The bookkeeper's voluntary statement established that she was cognizant of her theft from the uninsured realty business as distinguished from Atlas. In its brief opinion, the trial court clearly conveyed that, regardless of whether the payment was Atlas' legal obligation, it did not fall under the policy's terms for coverage because fidelity bonds do not serve the same purposes as liability policies.

In *Tri City National Bank v. Federal Insurance Co.*,² two bank employees undertook a scheme to fraudulently secure loans for unqualified borrowers by confirming to mortgage lenders false balances on deposit and subsequently issuing stolen cashier's checks for use

¹ No. 00-1904B, 17 Mass. L. Rep. 75, 2003 Mass. Super. LEXIS 376 (Mass. Dist. Ct. July 31, 2003).

² 674 N.W.2d 617 (Wis. App. Dec. 9, 2003).

as down payment at closing. After closing, the loan proceeds were used to cover the cashier's checks. Once uncovered, the misled mortgage lenders filed suit against the bank. Following settlement of that claim, the insured bank sought recovery from the insurer for the loss.

The Wisconsin Court of Appeals held that the payments made by the insured for settlement of third party claims were not direct losses resulting from the employees' dishonest acts because they did not accrue until the settlement with the lenders. In further supporting its decision, the court found the bond's terms in Insuring Agreement (A) to be unambiguous, justifying no reasonable expectation of coverage by the banker. The court considered it significant that industry groups nationwide need the certainty of uniform interpretations of such terms and declined to tinker with their meanings. Further, the court ruled that "direct" cause, as used in the policy, could not be used interchangeably with "proximate" cause in cases where third party losses are claimed.

Closely adhering to the reasoning of the *Tri City* court was the court in *RBC Mortgage Co. v. National Union Fire Insurance Co. of Pittsburgh, Pa.*³ In this factually similar case to *Tri City*, the dishonest employee prepared a loan application package containing numerous financial misrepresentations under his wife's name for concealment, but ultimately for his own benefit. In an ill-conceived effort to further veil his wrongdoing, the employee repeated this procedure for other borrowers as well. Once uncovered, the private funding company and the insured eventually settled, the insured agreeing to pay several losses sustained by the lender and its investors and also to indemnify the lender for any additional losses sustained due to the fraud. The insured, RBC, then submitted a claim for these losses to the insurer, which denied coverage.

Citing *Tri City*, the *RBC Mortgage Co.* court explained that the insured's losses did not result directly from the dishonest employee's acts, but rather from the "intervening cause:" the settlement with the lender.⁴ The court also placed importance on the temporal aspect of the loss; there was no loss realized until a year and a half after the fraud, suggesting that the loss was not a direct product of that behavior. Also as in *Tri City*, the appellate court rejected the insured's attempt to use proximate cause in the direct loss analysis for a third party, explaining that the proximate cause concept is too broad and far-reaching to past events to be neatly used in such a situation. As underscored in this opinion, such treatment of losses resulting from a dishonestly arranged loan, particularly in the avoidance of the proximate cause doctrine, is the majority position. Such decisions promote certainty in fidelity bond litigation and serve the ends of cost-effective coverage for insured parties and profitable, efficient operation for sureties.

In another case where a banking institution settled with investors, *Brady National Bank v. Gulf Insurance Co.*,⁵ an individual, Stearns, devised a "Ponzi" scheme whereby he misdirected investors' funds to his personal account to purchase certificates of deposit ("CDs") and secure letters of credit to borrow against them. In an earlier action, the government obtained a forfeiture order on the CDs as Stearns had purchased them with

³ No. 1-03-0776, 2004 Ill. App. LEXIS 795 (Ill. App. June 30, 2004).

⁴ *Id.* at *22.

⁵ No. 03-50464, 94 Fed. Appx. 197, 2004 U.S. App. LEXIS 6638 (5th Cir. Apr. 6, 2004).

misappropriated funds. After Brady National, the insured bank, settled with defrauded investors, it intervened in a suit against Stearns' lawyers, which had allegedly participated in his fraudulent activities, to recover its loss for the CDs and attorneys' fees.

In adjudicating the provisions of the financial institution bond, the first inquiry was whether the CDs were "stolen" within the meaning of the bond. If so, the second question was whether the theft of the CDs directly caused the resulting losses. In addressing whether the CDs were "stolen," the court found no definition in the policy and observed that no common law definition exists for the term. In light of this, the court resorted to Black's Law Dictionary to conclude that "stolen" is an ambiguous term which could include an acquisition by a "wrongful or dishonest act."⁶ The court referred to its prior decision in *Bank of the Southwest v. National Surety Co.*,⁷ where a central factor it used in ascertaining whether the property was stolen was whether it was subject to forfeiture.

As the CDs were definitely subject to forfeiture, they were held to be "stolen," and the court proceeded to consider whether the misdeed caused a "direct loss." The direct loss analysis consisted of refuting two arguments raised by the insurer. The insurer first argued that there was no direct loss because the required defect in title at the point when the CDs were pledged as collateral to Brady National was lacking. The court rejected this argument, determining that Stearns never had any right to the CDs, which constituted the requisite defect in title.

Second, the insurer maintained that the losses flowing from the settlement with investors were not direct losses, but were instead "indirect." In stark contrast to its favorable reception in *Tri City National Bank and RBC Mortgage Co.*, this argument was wholly rejected under Texas law by the Fifth Circuit sitting in diversity. Texas law, as the court made clear, will view a settlement with third parties resulting from dishonest employees' acts as a loss directly caused by the covered harm rather than the settlement. Accordingly, the Fifth Circuit affirmed the district court's summary judgment for the insured.

*Cargill, Inc. v. National Union Fire Insurance Co. of Pittsburgh, Pa.*⁸ concerned a coverage dispute in the context of dishonest practices in the sale of a business unit. Cargill, the insured, an agriculture business, sold its seed division and did not disclose its improper use of competitors' intellectual property in the seed sciences and the attendant potential liability. Pioneer was among the companies which suffered misappropriation of its intellectual property in the seed sciences. After the sale was complete, with senior management likely knowing of the wrongdoing, Pioneer sued Cargill and the division purchaser, Monsanto. In settling the various claims, Cargill paid approximately \$435 million to Monsanto and Pioneer. The insured submitted claims to its fidelity insurers for the amount and subsequently sued the insurer.

The appellate court affirmed the summary judgment below for the insurer because the settlement payments did not constitute a loss; but instead were royalties and other payments "restitutionary in nature" for wrongful use of intellectual property. The insured

⁶ *Id.* at 201, 2004 U.S. App. LEXIS at *11-12 (citing BLACK'S LAW DICTIONARY (7th ed. 1999)).

⁷ 477 F.2d 73 (5th Cir. 1973).

⁸ No. A03-187, 2004 Minn. App. LEXIS 33 at *1 (Minn. App. Jan. 13, 2004).

was merely required to fairly distribute the profits to those rightfully entitled, thus taking no loss. Also weighing against the insured was the failure to show deprivation, an element needed to establish a theft under the policy which, in any event, excluded coverage for trade secrets. The insured also failed to show a particularized proof of loss statement within the mandatory six-month period.

*Ernst & Young, LLP v. National Union Fire Insurance Co. of Pittsburgh, Pa.*⁹ involved an employee of the insured, a public accounting firm, who stole \$4.4 million in monies with which he was to pay clients' taxes. The fidelity insurer refused to pay \$2.9 million in additional damages flowing from the thefts, including lost interest income, attorneys' fees and compensation for emotional distress. Although the bond provided for coverage to the insured's clients, the court determined that to pay losses under such a broad construction of the term would effectually turn indemnity policies into liability insurance.

The authors submit that imposing liability for consequential damages upon a fidelity insurer is injurious to the practical ability of insurers to bear risk from many policyholders. If courts were to freely award damages arising from events with only an attenuated relation to covered losses, these incidental costs would threaten the affordability and, therefore, the viability of fidelity insurance as a whole. In addition, to cover losses with such a distant connection to the dishonest acts is incongruent with American judicial practice of not assessing attorney's fees and litigation costs to the losing party; costs of defending an action are incidental to the inconvenience of being unfairly sued or accused of a crime one did not commit. Likewise, being victimized by a dishonest act will inevitably have some detrimental impact on an organization beyond the losses contemplated in the policy.

Flagrantly dishonest acts were at issue where a middle manager in a charity organization conducted fundraisers over eight years and diverted the fruits to his personal use in *Fireman's Fund Insurance Co. v. Special Olympics International, Inc.*¹⁰ The trial court determined that the stolen monies did not belong to the insured but, rather, to the deceived donors, thus resulting in no "direct loss" under the fidelity policy at issue. On appeal, the First Circuit affirmed the summary judgment for the insurer because the commission of the dishonest acts, in addition to not causing a direct loss, also lacked the "manifest intent" necessary to create such a loss to the employer. The court observed that the manager solicited funds under the guise of the charity, but did not actually deplete the organization's assets in order to avoid detection. As such, the element of "manifest intent" needed to establish a "loss" was lacking.

In *Performance Autoplex II Ltd. v. Mid-Continent Casualty Co.*,¹¹ the controller of an auto dealership fraudulently transferred a new car to her mother in return for a down payment of \$2,000, which was never remitted, and a "trade-in" vehicle, valued at \$12,700, which probably never existed. The insured dealership filed claims for the two sums under its employee dishonestly policy. The insurer honored the \$2,000 claim, but denied the claim for \$12,700 because that amount was based on the dishonest employee's valuation of a likely-fictitious auto. The Third Circuit ruled that to establish that coverage existed, the

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

¹⁰ 346 F.3d 259 (1st Cir. Oct. 10, 2003).

¹¹ 322 F.3d 847 (5th Cir. Aug. 26, 2003).

value of the loss must be proven; here the proof was insubstantial to do so. Accordingly, the trade-in value was not a “covered loss.” In light of this, the district court granted summary judgment for the insurer.

Although common today in fidelity bond litigation, as seen in the following case, some matters are not suitable for summary judgment disposition. Although the district court wrote at length, it declined to grant summary judgment to the insurer in *Oriental Financial Group v. Federal Insurance Co.*¹² because findings of fact would be necessary as to motive, intent and design; issues properly reserved to the trier of fact. Several accounts at the insured’s bank had been out of balance and contained suspicious credits and debits apparently made in an effort to conceal the wrongdoing. The bank sought recourse for the written-off losses with its fidelity insurer. Issues of fact inappropriate for summary judgment included whether a loss occurred and whether the actor (1) was an employee (2) had motive and (3) directly caused such a loss or misappropriated a benefit. In denying summary judgment, the court reasoned that “trial by affidavit” does not equate to trial by jury.

B. Cumulation of Limits

At issue in *Robben & Sons Heating, Inc. v. Mid-Century Insurance Co.*,¹³ was whether repeated thefts in excess of the \$50,000 limit of liability by one employee under each of two successive ISO Business Owners policies constituted a “single occurrence.” The trial court viewed the acts as a solitary occurrence and awarded only one \$50,000 payment. In reversing, the appellate court decided that a new contract arose from the policy renewal. Because there was payment of an additional premium for coverage in a different period of time, the court viewed the series of related acts in the two policy terms as forming separate occurrences. As a result, the court permitted the insured recovery in the amount of two policy limits for one employee’s dishonest acts.

In *Sherman & Hemstreet, Inc. v. Cincinnati Insurance Co.*,¹⁴ the Georgia Supreme Court found the policy terms in question to be clear that, for a three-year policy, the most an insured could recover was the one \$50,000 “per occurrence” limit. Importantly, the bond policy contained a “non-cumulation” clause that explicitly set forth that no cumulation of limits could occur across the years in effect. The court refuted the insured’s argument that the payment of an annual premium entitles it to new coverage limits yearly, observing that multiple-year policies with limits refreshing annually state this explicitly. The court judged the fraudulent acts to be a “single occurrence” for purposes of the insuring agreement, thereby entitling the insured to just one policy limit for the three-year term.

A bookkeeper stole over a thirteen year span in *Harrington v. American Economy Insurance Co.*¹⁵ Upon discovery of the fraud in 2001, the insurer agreed to pay only one

¹² 309 F. Supp.2d 216 (D. P.R. Mar. 11, 2004).

¹³ 74 P.3d 1141 (Ore. App. Aug. 13, 2003), *rev. denied*, 82 P.3d 626 (Ore. Dec. 9, 2003).

¹⁴ 594 S.E.2d 648.

¹⁵ No. 03-712-MO, 2003 WL 23190177 (D. Ore. Nov. 20, 2003).

limit under the policy in force for that year, refusing to pay under the other policies renewed annually since 1989. Referring to *Robben & Sons Heating*, the court found that acts during successive yearly policies could constitute separate occurrences, allowing insured parties to recover the limit in each term. As such, the insured was not barred from recovery due to the meaning of “occurrence.” The insurer prevailed on its summary judgment motion due to the policy’s period of limitation.

C. Period of Limitation

The court in *Harrington*, discussed above, granted summary judgment for the insurer because the insured did not bring an action within two years of the date of the loss, as the policy required. Failing to do so barred claims arising prior to the effective date of the policy on which it already paid. Although the insured also contended that the two-year suit limitation provision was not reasonable, the district court disagreed, explaining that it is necessary to enable insurers to ascertain liabilities and close old files.

In *Empire Blue Cross & Blue Shield v. Various Underwriters at Lloyd’s*,¹⁶ the insured sued after its claims were denied, alleging that it was “lulled into not filing suit earlier by Lloyd’s conduct” in failing to issue a disclaimer letter until the allowable period to file suit had run. The appellate court was unpersuaded by the insured’s arguments because even after the issuance of the disclaimer letter no suit to recover was filed for an additional seven months. The court also found no indication of affirmative or passive conduct on Lloyd’s part to forestall the initiation of an action by the insured.

Further, as the insurer made no assurances that the claim would be paid once the investigation ended, the court rejected the insured’s estoppel argument due to lack of detrimental reliance. Interestingly, the court observed that the insured was “also an insurance company;” plainly suggesting that it should have pursued its own claim more skillfully.¹⁷ This point should be instructive to insurance companies. In managing the risk of their own dishonest employees, insurers of any kind should wisely tap into in-house expertise to help to avoid a disadvantageous position in subsequent litigation.

D. Riders

In *Jefferson Pilot Financial Insurance Co. v. Marsh USA, Inc.*,¹⁸ a North Carolina appellate court considered whether employees appended to a company in a merger become covered, despite a merger clause which requires notice beforehand and consent from the insurer to secure such additional coverage. In this case, Hartford Fire Insurance Company (“Hartford”) had provided a fidelity bond for Jefferson Pilot Financial Insurance Company (“Jefferson”) through independent insurance broker Marsh, which issued binders for Hartford. Following a merger adding 6,000 employees, Jefferson discovered embezzlement by a newly-added employee. Jefferson submitted a claim for coverage,

¹⁶ 1 A.D.3d 291, 767 N.Y.S.2d 432 (N.Y. App. Div. 1st Dep’t Nov. 25, 2003).

¹⁷ *Id.* at 292, 767 N.Y.S.2d at 432.

¹⁸ 582 S.E.2d 701 (N.C. Ct. App. July 15, 2003).

which was denied. Over the arguments of Marsh, that the language contained in General Agreement 'A,' Additional Offices or Employees – Consolidation, Merger or Purchase of Assets, was inapplicable to coverages arranged by rider, the court ruled that all specific riders become fully integrated into the original bond. Thus, Jefferson was required to give notice and obtain approval for the coverage of new employees – which it did not. Justly, the merger clause operated to prevent insured parties from unilaterally adding more risk to a policy, through mergers, than was agreed upon for fair consideration at issuance.

In *First National Bank in Manitowoc v. Cincinnati Insurance Co.*¹⁹ the rider provision at issue was deemed legally insignificant. In this case the insured did not discover its loss until after it had requested cancellation of its financial institution bond. That the bank was required to give notice of loss while the bond was in effect was uncontested. Although the insurer had already returned the unearned portion of the premium, the insured contended that the insurer had not finalized the requested cancellation by notifying state authorities as called for in a rider to the bond, thereby entitling it to recovery. The district court, in considering the requirement to notify state banking authorities, found it ineffective as to the insurer because no state agency had regulatory authority, for fidelity bonding purposes, over nationally-chartered banks. As such, the court granted summary judgment to the insurer, finding no unfulfilled obligation on its part. In denying the insured's subsequent motion for reconsideration,²⁰ the court reiterated that the requirement for notification to an agency which would have no power to act on it was an "immaterial term of the agreement."

E. Bad Faith

The Connecticut Superior Court ruled on a Motion to Strike certain counts in the action *Newton & Associates, Inc. v. LaBrasca*.²¹ The movant insurer argued that the allegations pleaded in the fourth count, asserting a violation of the Connecticut Unfair Insurance Practices Act,²² were inadequate to establish a claim under the statute. The court agreed, finding that the facts pleaded did not depict a pattern of unfair claim settlement practices but merely alleged isolated occurrences of such conduct. As to the sixth count, the court again found insufficient facts to establish a claim for Breach of the Covenant of Good Faith and Fair Dealing.

F. Manifest Intent

The New Jersey case of *Auto Lenders Acceptance Corp. v. Gentilini Ford, Inc.*²³ concerned a dishonest scheme of an automobile dealership's employee who falsified credit applications in an effort to gain loan approvals for high-risk borrowers to increase his own personal earnings while, as a secondary effect, enlarging the revenues of the insured. The

¹⁹ No. 03-C-241, 2004 U.S. Dist. LEXIS 12137 (E.D. Wis. March 2, 2004).

²⁰ No. 03-C-241, 2004 U.S. Dist. LEXIS 12150 (E.D. Wis. May 2, 2004).

²¹ No. CV-0303828720S, 2004 WL 335193 (Conn. Super. Ct. Feb. 4, 2004).

²² CONN. GEN. STAT. § 38-816(a) (2004).

²³ 816 A.2d 1068 (N.J. App. Div. Mar. 5, 2003).

fraud was uncovered as a result of several of these borrowers predictably defaulting in payments to the deceived lenders. The lenders sued the dealership, which in turn sued the insurer for coverage and defense of these claims.

The Appellate Division explained that the purpose of fidelity bond coverage is to protect employers from losses arising from a misappropriation intended by an employee to detrimentally affect the employer economically. Where the employee steals from, or defrauds, third parties, fidelity bond coverage is not triggered, according to the appellate court, regardless of incidental losses suffered by the insured. The Appellate Division reversed the trial court's summary judgment for the insured and remanded the case to enter judgment for the insurer. The case was appealed and argued to the New Jersey Supreme Court which, as of this writing, has not rendered a decision.

A senior officer of the insured bank allegedly misrepresented loan applicants' financial condition to its executive committee in *Federal Deposit Insurance Corp. v. National Union Fire Insurance Co. of Pittsburgh, Pa.*²⁴ The FDIC took over the insured after the bank failed. While the insured conceded there was no manifest intent on the part of the senior officer to gain a benefit for himself, it argued that the officer misappropriated a benefit to third parties, including subcontractors on the financed projects. To establish a covered loss, the bond terms required manifest intent to (1) cause the insured a loss and (2) obtain a benefit for the dishonest actor or a third party.

The Third Circuit affirmed the district court's summary judgment for the insurer because manifest intent on the senior officer's part had not been exhibited. In reaching that decision, the court reasoned that (a) other executives of the bank were familiar with the supposedly concealed facts; (b) the facts in question would not have conclusively demonstrated the project's doom; and (c) the senior officer merely advised the committee; he did not unilaterally approve the loans. In its opinion, the court debunked the assertion that the supposedly scheming senior executive actually knew any information not shared by others or that he was improperly motivated to keep such facts secret. The court's undoubted awareness of practical considerations driving this action, such as an insolvent bank's desire to recover a portion of its losses through a bond, may have rightly aroused skepticism as to the allegations in the record.²⁵

G. Employee Status/Alter Ego

*East Attucks Community Housing, Inc. v. Old Republic Surety Co.*²⁶ concerned thefts in excess of \$50,000 from the insured, a property management company, by Redd, its president and sole stockholder. The funds stolen were public housing tenants' security deposits. The court determined that the bond's terms, which required the insured to have

²⁴ 57 Fed. Appx. 965, 2003 U.S. App. LEXIS 2096 (3d Cir. Feb. 6, 2003).

²⁵ The court wrote: ". . . most of the facts that [the senior executive] allegedly concealed from the Board were well known by many other City Federal executives . . . they showed simply that the project had problems." *Id.* at 967, 2003 U.S. App. LEXIS 2096 at *7.

²⁶ 114 S.W.3d 311 (Mo. Ct. App. June 24, 2003), *reh'g denied*, 2003 Mo. App. LEXIS 1234 (Mo. Ct. App. July 24, 2003) .

the “the right to direct and control” the dishonest actor, “were not intended to protect the [the insured] from its own acts.” Next, the court considered whether the dishonest corporate president was actually the alter ego of the insured. The court concluded that, because the other members of the board continued to function in managing the property and overseeing the company, Redd was not the alter ego of the insured.

H. Civil Procedure/ERISA

In the case of *In re Healthsouth Corp.*,²⁷ the district court denied a third-party motion to intervene by class action plaintiffs from a separate suit against Healthsouth in a consolidated action between three insurers and Healthsouth regarding the validity of policies. The movants wished to intervene to oppose rescission of the insurers’ policies because it would have eliminated a possible source of coverage in their separate class action litigation. However, the court explained that the movants’ interest in insurance coverage is not sufficient for intervention of right under Federal Rule of Civil Procedure 24. In addition, the current parties to the action adequately represented interests the movants sought to protect, another critical factor in the Rule 24 analysis.

I. Jurisdiction

In the unreported decision of *National Union Fire Insurance Co. of Pittsburgh, Pa. v. Bank of Saipan*,²⁸ an insurer, who had issued a financial institution bond, sought declaratory judgment regarding anticipated litigation in the U.S. District Court for the Northern Mariana Islands. Once suit was filed against the dishonest employee and the insurer over one year later, the insured bank’s receiver chose the Superior Court of the Northern Mariana Islands as the forum. The insured likely made the dishonest employee a party to the Commonwealth action as a tactic to foreclose removal to the federal system. The insured moved the U.S. District Court to decline from taking jurisdiction, pursuant to 22 U.S.C. § 2201, in the declaratory judgment action. Under its discretionary jurisdiction for declaratory actions, the district court granted the receiver’s motion to dismiss, permitting the action to proceed in the Commonwealth court. In so deciding, the court observed that federal courts should avoid needlessly deciding issues of state law and should minimize “duplicative litigation.” The court found no suggestion of impermissible “forum shopping” as the parties simply preferred different courts to settle the local matter. In its analysis, that this suit was “intertwined” with the related action in Commonwealth court weighed heavily on the district court’s decision to abstain.

J. Exclusions

In *Hudson United Bank v. Progressive Casualty Insurance Co.*,²⁹ the insured bank made loans as part of a venture with a premium finance company (“PFC”). Before long,

²⁷ 219 F.R.D. 688 (N.D. Ala. Feb. 3, 2004).

²⁸ No. Civ. A. 03-0010, 2003 WL 22997231 (D. N. Mar. I. July 9, 2003).

²⁹ 284 F. Supp.2d 249 (E.D. Pa. Sept. 29, 2003).

difficulties with computerized storage and tracking of data lead to financial failure for the enterprise. The insured's claim under its bond was denied after extensive deliberations between the insurer and the insured. In the subsequent litigation, the bank alleged that it was defrauded by the operations manager of the PFC, but offered no substantiating evidence or showing of economic gain to any employee. In fact, the PFC had not properly recorded delinquencies and defaults on loans, preventing the insured from becoming aware of its losses. The insurer contended that the loan loss exclusion contained in section 2(e) of the Fidelity Bond Insuring Agreement barred the insured's claims. Also, the bond terms provided that to overcome the loan loss exclusion, there must be collusion and financial benefit greater than \$2,500, neither of which was shown by the insured. The district court concluded that losses sustained by the bank did not directly result from employee dishonesty, but rather stemmed from defaults on the premium loans, excluded as a "loan loss." Thus, no factual issue existed, and the court granted the insurer's motion for judgment as a matter of law.

The loan loss exclusion was also at issue in *Humboldt Bank v. Gulf Insurance Co.*,³⁰ where an automated teller machine ("ATM") operator stole monies entrusted to it by the insured. In this case the insured entered into a Cash Services Agreement to supply cash for ATMs with a company that was wholly owned by one individual. This individual was also the sole proprietor of an armored car company, which the bank injudiciously permitted to transport the funds to the ATMs, giving the owner of the two businesses unmonitored access to the bank's funds. As banks will not prudently allow such an arrangement, the insured notified the dishonest operator that the agreement would be terminated within 120 days unless he cured this problem by contracting a third-party armored car service. During this 120-day period, the ATM operator diverted \$5.25 million from his venture with the bank and subsequently disappeared.

The court construed the loan loss exclusion and examined the advances to the ATM operator to determine that the transactions were "at the very least 'in the nature of a loan,'"³¹ despite the bank's treatment of the advances in its ledgers as non-loans. The court was also unpersuaded by the insured bank's argument that the ATM operator was an "employee" or "electronic data processor" for purposes of the employee exception to the loan loss exclusion, as the only data captured and transmitted was a faxed record of cash withdrawn from the ATMs. Accordingly, the court denied summary judgment to the insured on its claim for coverage. Further, the court granted summary judgment to the insurer on the insured's assertion of bad faith as it judged the insurer's handling of the claim to be reasonable.

In deciding *Humboldt Bank*, the Northern District of California strove to ascertain the true character of the transaction, focusing on its "economic substance" rather than labels and even treatment given it by the bank.³² To the *Humboldt Bank* court, the touchstone of identifying a loan seemed to be the extension of credit. However, the nearly reckless manner in which the bank managed its venture with the ATM operator may have detracted from the court's willingness to grant relief to the insured as well. That the bank, under these

³⁰ No. C-03-1799 SC, 2004 U.S. Dist. LEXIS 11989 (N.D. Cal. June 3, 2004).

³¹ *Id.* at *16 (citing Exclusion (e)).

³² *Id.* at *19-20.

unique facts, may have taken comfort in its fidelity bond is a sound proposition; certainly one that jurists could have pondered in deciding this case.

In *PrivateBank & Trust Co. v. Progressive Casualty Insurance Co.*,³³ a man using the alias “Goodman” misappropriated authentic checks payable to one business and deposited them, unendorsed, into an account of a sham company with a slightly different, but materially identical name.³⁴ After making these deposits, the bank rubber-stamped the checks, which totaled some \$461,000, for endorsement purposes. Subsequently, as instructed by Goodman over the telephone, the bank transferred \$420,000 of the cleared funds to a gold dealer to affect his purchase of the corresponding value in gold coins.

The court first considered whether the loss resulted “directly” from “theft or false pretenses” committed by an actor “present in an office or on the premises” of the insured.³⁵ The court looked to cases with nearly identical facts and bond language to determine that the standard crime insurance policy requires physical presence on premises to exclude coverage for fraud by electronic media. Because the fraud was committed using a telephone connection, this provision was not satisfied. The insured also contended that the depositing of the checks on premises constituted “false pretenses,” which would be covered. The court also rejected this argument because the deposits “merely provided the opportunity for the loss to occur,” and was not its direct cause.³⁶

The insured was further barred from recovery under Exclusion (n) because the deposits were “erroneous” and thus were not covered. While the insured argued that “Goodman’s” false pretenses negated the bank’s error, the court disagreed, explaining that the conduct of the bank, in honoring unendorsed checks, was “erroneous” regardless of “Goodman’s” conduct. The court relied on *Alpine State Bank v. Ohio Casualty Co.*,³⁷ where the Seventh Circuit decided a nearly identical case in which the unauthorized depositor similarly did not endorse his checks, but allowed the bank to rubber-stamp them, constituting erroneous conduct that lead to an unrecoverable loss. The *PrivateBank* court also found the insurer to be unfettered in asserting the applicability of Exclusion (n) by the “mend the hold”³⁸ doctrine, which it ruled inappropriate here because the insurer had only failed to assert this exclusion *before* any litigation commenced, not afterwards. This case reflects the fairness of judicial interpretation that defers to the purposes behind exclusions and limits of coverage provided.

³³ No. 03-C-6031, 2004 U.S. Dist. LEXIS 8938 (N.D. Ill. May 18, 2004).

³⁴ The company incorporated to perpetrate the fraud was “BBI Enterprises, Ltd.,” whereas the defrauded business was simply “BBI Enterprises.” *Id.* at *5.

³⁵ *Id.* at *11.

³⁶ *Id.* at *12.

³⁷ 941 F.2d 554 (7th Cir. 1991).

³⁸ In its strongest form, this doctrine “appears to bar a contracting party from changing his reason for nonperformance during litigation, rather than before litigation.” 2004 U.S. Dist. LEXIS 8938 at *16.

In *Utica Mutual Insurance Co. v. Precedent Cos., Inc.*,³⁹ the locus of certain events was again at issue. In this case, the insured, Precedent, issued a check to fund a mortgage that subsequently did not close. The named payee, Fidelity Title, nonetheless deposited the check before going out of business, prompting the insured to seek recovery under its financial institution bond. The court examined four provisions under which the insured claimed coverage. The first, that the dishonest payee was a “data processor,” falling under the employee fidelity provision, was rejected with minimal discussion for the apparent reason that its role was to accept a check from the insured, not process data.⁴⁰

Next, the court considered whether the loss was covered by the “on premises” provision of the policy, which applied to losses from property “misplac[ed] . . . while the property is lodged or deposited within . . . offices of any financial institution.”⁴¹ Although the court found some support for this argument in the plain meaning of “misplace,” it concluded that the misplacement did not occur while the funds were held by the institution, but rather beforehand. The court also dismissed the insured’s argument that the loss was covered by the “in transit” provision because the payee was not a “natural person” and was not “acting as a messenger,” as required by that section.⁴² The Indiana appellate court reversed the trial court’s summary judgment for the insured and remanded with instructions to find in favor of Utica, the insurer.

In *ABC Imaging of Washington, Inc. v. Travelers Indemnity Co. of America*,⁴³ the insurer denied coverage for accidental overpayment of earnings under the policy’s “salary” exclusion when the employee refused to return the undeserved income. In the subsequent case to recover against the insurer, the appellate court held that the fidelity policy, which included the standard industry exclusion, unambiguously excluded employee dishonesty that solely seeks to misappropriate salary or commissions. In reaching this decision, the court recognized the divergence of precedent on this issue, but observed that no mandatory authority in Maryland dictated the outcome. In support of its affirming summary judgment for the insurer, the court examined the principles underlying the salary exclusion: to avoid miring insurers in compensation entitlement disputes; and to counter the liberal interpretation of terms that prevailed before the advent of the standard exclusion. The court’s policy-based reasoning proved more valuable to the opinion’s instructive value than its torturous and largely fruitless discussion of conflicting precedent.

K. Public Officials

In *City of Concordia v. American States Insurance Co.*,⁴⁴ the insured city pledged a CD on behalf of its new city manager to assist him in purchasing a residence. The city

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

⁴⁰ *Id.* at 475.

⁴¹ *Id.*

⁴² *Id.* at 476-77.

⁴³ 820 A.2d 628 (Md. Ct. Spec. App. Mar. 31, 2003), *cert. denied*, 827 A.2d 112 (Md. June 20, 2003).

⁴⁴ No. 89,200, 2003 WL 21948009 (Kan. App. August 8, 2003).

manager then misused the collateralized loan proceeds to satisfy personal debts, leading to his resignation. In this resulting action for recovery from the insurer, the appellate court was called upon to interpret a policy exclusion for losses flowing from acts of employees required by law to be individually bonded. In fact, a Kansas statute⁴⁵ requiring public officials to be bonded applied to the city manager, but did not specify whether an individual bond was necessary to fulfill the requirement or if it could be satisfied by the city's blanket bond.

The insured city asserted that "individually bonded," as used in the exclusion, required a separate bond for the specific city manager. The argument followed, that because no separate bond was held for the city manager, the loss sustained from the city manager's dishonest acts were not subject to exclusion. Countering, the insurer showed that where other state's codes allowed blanket bonds to satisfy an individual bonding requirement, it was explicitly stated. As it was, the insurer argued that the statute applicable to the city manager should be interpreted as requiring a separate bond. The appellate court found in favor of the insured, concluding that the exclusion language was ambiguous.

L. Subrogation

*BancInsure v. BMB Electric Co., Inc.*⁴⁶ arose from the forgery of a check drawn on a corporate customer, Osceola's, account at the insured RiverBank, neither of which were parties to this action. The insurer paid for the loss claimed under the financial institution bond arising from the bank repayment of the amount fraudulently drawn. The subrogee insurer then sued the entity and person responsible, BMB Electric Co. and its owner Bruce Burks. Sitting in diversity, the Northern District of Illinois considered the insurer's claim, asserted under theories of conversion and unjust enrichment.

The district court concluded that the conversion count was inappropriate because the funds converted belonged to the customer, Osceola, rather than RiverBank. Nonetheless, the court found the facts to warrant relief under the unjust enrichment theory as it would have been inequitable for BMB Electric Company to retain the funds it fraudulently appropriated. As in *Atlas Metals Product Co.*, in this case the court distinguished between losses directly suffered by the insured and losses sustained by parties to which the insured is legally obligated.

In *Royal Insurance Co. of America v. Citibank, N.A.*,⁴⁷ the appellate court overturned the summary judgment below for the insured bank. In this case the insured bank honored a forged check. UCC § 4-401(1), which the court deemed applicable here, imposes strict liability on banks that make payment on forged checks because it failed to observe "reasonable commercial standards."⁴⁸

⁴⁵ KAN. STAT. ANN. § 12-1013 (2003).

⁴⁶ No. 03-C-2692, 2004 U.S. Dist. LEXIS 5936 (N.D. Ill. April 9, 2004).

⁴⁷ 306 A.D.2d 158, 763 N.Y.S.2d 539 (N.Y. App. Div. June 19, 2003).

⁴⁸ *Id.*

An insurer's Rule 24⁴⁹ motion to intervene as of right or, alternatively, by leave of court was at issue in *Mortgage Lender's Network, Inc. v. Rosenblum*.⁵⁰ In this case, losses were sustained by the insured plaintiff as a result of alleged breach of fiduciary duty, breach of contract and legal malpractice by the defendant attorney it employed to close mortgages. The would-be intervener, insurer Travelers, reimbursed the insured for the losses suffered and in return received an assignment of rights against the attorney. The court considered the factors for granting intervention as of right, that a movant must (1) timely file; (2) show an interest in the action; (3) demonstrate that the interest would be impaired if there were an unfavorable disposition; and (4) seek to protect an interest otherwise not adequately represented.

Although the court noted that movant Travelers' failure to file for six months after learning of its interest was significant, the court was compelled to view this in light of the totality of the circumstances. In its analysis, the court made findings that (a) there was no opposition to the motion to intervene; (b) the timing was sufficiently early in the progression of the action to spare the existing parties any prejudice by granting the motion; and (c) Travelers would be prejudiced if the motion were denied. Additionally, as the underlying acts of the defendant attorney gave rise to both parties' grievances, the defendant may have been subject to inconsistent rulings if the motion were denied. Further, Travelers' interests were not adequately represented without intervention. All these factors were important to the court's decision to grant intervention to the subrogee insurer.

M. Forgery and False Instruments

In *Harrah's Entertainment, Inc. v. Ace American Insurance Co.*,⁵¹ the Sixth Circuit considered whether gambling credit given by the insured, Harrah's, for two forged checks totaling \$1.5 million was a covered loss under its blanket crime insurance. The district court had found in favor of the insurer because although the fraud was a "wrongful abstraction" which was covered, the acts also fell under the exception to coverage for "the giving or surrendering of Money or Securities in any exchange or purchase."⁵² On appeal, the Sixth Circuit agreed that the gambling credit was "Money or Securities" and was properly excluded from coverage. The court rejected Harrah's argument that the exclusion was meant to include check fraud because it was "loosely worded." On the contrary, the court was bound to construe the exclusion against the drafter, which was the insured. Next, the court examined whether the forged checks could be categorized as "express money orders," which were covered by the policy, concluding that they could not. There was also inquiry as to whether the issuer of the checks, Bank of America, was an express company.

The court outlined fundamental differences between express companies, which mainly transported valuable freight by railroads, canals and stagecoaches and modern banking institutions which, the court opined, sought to make express companies obsolete.

⁴⁹ FED. R. CIV. P. 24

⁵⁰ 218 F.R.D. 381 (E.D.N.Y. Nov. 24, 2003).

⁵¹ No. 02-6519, 2004 U.S. App. LEXIS 10663 (6th Cir. May 27, 2004).

⁵² *Id.* at *5.

Again, the court was constrained to interpret the policy against the drafting party, finding the “express company” label inapplicable to Bank of America because the insured created the ambiguous provisions. In its analysis, the court had great difficulty in defining terms like “express money order” and “express company,” leading it to necessarily find against the drafter, Harrah’s. Although most fidelity bonds are non-negotiable industry forms, where the opportunity presents itself, this case should prompt the draftsman to periodically review standard language in order to identify terms which have migrated from the modern lexicon and replace them with words in current usage that embrace the intended subject matter. As the drafting party may be at a disadvantage in interpretation by the judiciary, the draftsman must be keenly aware of the importance of seizing the opportunity to control the language at the policy’s inception.

An insured bank sued to recover losses on loans where the purported collateral had been deceptively pledged by counterfeit documents to multiple lenders in *State Bank of the Lakes v. Kansas Bankers’ Surety Co.*⁵³ In this case a marina owner forged title documents to boats, called Manufacturer’s Statements of Origin (“MSOs”), and received advances for inventory purposes from banks in return. In similar fashion to the original documents, some of the forged MSOs were not signed to enhance their authentic appearance. Based on this fact the insurer asserted that the unsigned MSOs were not properly covered as a “counterfeit,” as required by the bond. The Seventh Circuit rejected this argument, ruling that the bogus documents met the common definition of counterfeit, “an imitation which is intended to deceive and to be taken as an original,” and the bond’s simpler definition that it merely be an “imitation . . . intended to deceive.”⁵⁴

As it was apparent to the court that the dishonest borrower intended to defraud, the court focused instead on the MSOs’ status as counterfeits. The court likened the unsigned fake MSOs to a counterfeit Federal Reserve Note, which would lose none of its counterfeit status if the federal treasurer’s signature were omitted. As such, the court determined that the trier of fact was right in deeming the MSOs “counterfeit.” Rejecting the insurers’ other arguments, the court affirmed the district court’s judgment for the insured.

In *Utica Mutual Insurance Co.*,⁵⁵ discussed *supra*, the insured, Precedent, also argued that the dishonest payee, Fidelity Title, forged or altered its check by wrongly depositing it, causing a covered loss. The court disagreed, ruling that Fidelity Title’s acts may have been unauthorized, but did not alter the check under the statutory definition. Although Fidelity Title made no requisite “change” to the instrument to fulfill the state’s statutory definition of “alteration,”⁵⁶ the insured nevertheless argued that the unauthorized deposit “modified the parties’ obligations.” In dismissing this assertion, the court stated that no modification of obligations occurred as the check clearly contained a provision that mandated its destruction and return to the insured in the event it was not needed for its proper purpose of funding a mortgage.

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

⁵⁴ *Id.* at 908.

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

⁵⁶ IND. CODE §26-1-3.1-407 states that “Alteration” means: (1) an unauthorized change to an instrument that purports to modify in any respect the obligation of a party; or (2) an unauthorized addition of words or numbers or other change to an incomplete instrument relating to the obligation of the party.

In *Lusitania Savings Bank, FSB v. Progressive Casualty Insurance Co.*,⁵⁷ a check made payable to a consulting firm was deposited in an account opened under a slightly different business name in order to divert the proceeds of the instrument. The insured bank recovered a portion of the stolen check amount under its financial institution bond's "on premises" coverage. The insurer, however, contended that because the endorsement on the deposited check contained the authentic signature of the supposedly authorized person, the losses resulting from checks drawn off-premises were not recoverable under forgery coverage. The endorsement in question read "Deposit Only TCS, Theresa Leuzzi," followed by two nine digit codes.⁵⁸ Thus, at issue was whether the signature of the defrauding party constituted a forgery. Attempting to secure coverage, the insured contended that Leuzzi's signature was included merely because of the insured's internal policy and was not really a portion of the endorsement. However the bond's definition of forgery excluded any purported forgery where the forger signed his or her own name for any reason. The district court found this exception to forgery coverage applicable as Leuzzi's signature was present as an apparent part of the endorsement. Regardless of the purpose for Leuzzi signing her actual name, this caused her fraudulent acts to not qualify under the bond's definition.

N. Prior Loss Clause

In *Times Picayune Publishing Corp. v. Zurich American Insurance Co.*,⁵⁹ the insured's previous insurer, Federal, had issued two one-year \$1 million crime insurance policies to the insured publishing company, Times Picayune, in 1990 to 2000. Federal also provided two one-year excess crime insurance policies to Times Picayune in 1996 to 1997. Zurich, the insurer that would later be sued for coverage in this action, then provided a three-year excess crime insurance policy to Times Picayune, beginning in 1998. Zurich's policy provided coverage, with conditions, for losses in excess of \$1 million suffered prior to its effective date but not discovered until after the policy term began. The insured discovered in late 2000 that the defalcating employee misappropriated approximately \$2.2 million between 1995 and 2000. It was established that \$1.04 million had been stolen before the Zurich excess policy took effect.

In defending the action, Zurich asserted that the insured did not sustain a loss exceeding the \$1 million limit that would have triggered the excess coverage in any single policy period before the Zurich policy took effect in 1998. On the issue of whether three years' losses, those from 1995 to 1998, could be aggregated to reach the excess trigger threshold, the court ruled that the Prior Loss clause applied to the two earlier policy periods in which the insured maintained excess loss coverage; 1996 and 1997, but not 1995. The court awarded summary judgment to Zurich as it was not liable for the losses occurring prior to the beginning of the 1998 policy.

⁵⁷ No. 03-2902 (WHW), 2004 WL 1746711 (D.N.J. July 30, 2004).

⁵⁸ *Id.* at *2.

⁵⁹ No. 02-3263 § M(2), 2004 U.S. Dist. LEXIS 1027 (E.D. La. Jan. 26, 2004).

Conclusion

Many of the cases decided the past year demonstrate the effectiveness of our American adjudicative process in ascertaining the truth. Courts this year exhibited an unwillingness to order recovery on fidelity bonds where a legal obligation to repay a third party, rather than a “direct loss,” generated the injury to the insured. As seen in *Hudson United Bank*⁶⁰ and *Federal Deposit Insurance Corp. v. National Union Fire Insurance Co. of Pittsburgh, Pa.*,⁶¹ courts halted the efforts of foundering business to recoup from fidelity insurers funds lost through poor management, rather than employee dishonesty. The *Humboldt Bank*⁶² court rejected the insured’s argument that its advances to an ATM operator were not loans under the loan loss exclusion, instead focusing on the “economic substance” of the transactions to reach the truth. For those who practice in fidelity law, there is reason to be pleased; the proper disposition of these cases marks just another year of vigorous representation of fidelity insurers by the members of its well-established bar.

⁶⁰ See discussion *supra* at Part J.

⁶¹ See discussion *supra* at Part F.

⁶² See discussion *supra* at Part J.