

**SEVENTEENTH ANNUAL  
NORTHEAST SURETY AND FIDELITY  
CLAIMS CONFERENCE**

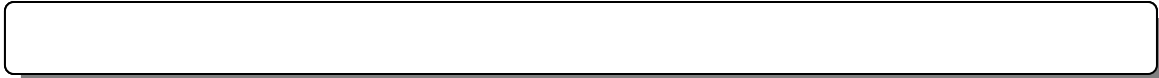
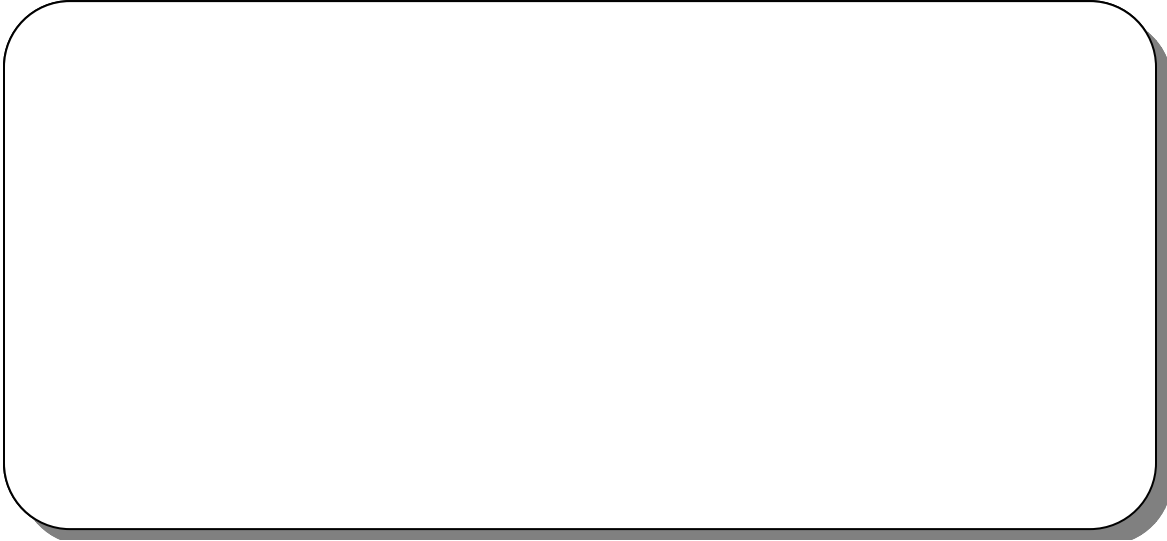
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**FIDELITY CLAIMS: THE YEAR IN REVIEW**

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**I. Introduction**

The past year has produced numerous significant decisions in fidelity law. This article surveys recent pronouncements concerning coverage issues and other important areas surrounding fidelity bonds.

**II. Alter Ego Defense**

In *Lutz v. St. Paul Fire & Marine Ins. Co.*,<sup>1</sup> an Ohio court determined that in order to be deemed an “employee” under the terms of a commercial crime insurance policy, the insured must demonstrate actual control over the worker, rather than simply the right to control in the abstract. In this case, the insured purchased a policy from St. Paul Fire & Marine Insurance Company which covered loss as a result of “employee dishonesty.” The policy defined “employee,” in pertinent part, as someone over “[w]hom you have the right to direct and control while performing services for you.”

The insured argued that a “compliance officer,” another employee of the insured, had the right to control the sole shareholder in his actions as a registered representative, and that the insurer had included the sole shareholder in calculating the premium and was now estopped from denying his “employee” status.

However, the court accepted St. Paul's position that an “employee” does not include a shareholder who dominates the corporation. Here, the dishonest person was the president and sole shareholder and either sole director or one of two directors on a board that had not met, participated in, or supervised the affairs of the insured. Accordingly, the court found that under the dominate shareholder theory, the insurer is not liable for coverage because “commercial crime policies were not designed to protect corporations from their own dishonest acts.”

**III. Automatic Termination and Knowledge of Prior Dishonesty**

In *Akins Foods, Inc. v. American and Foreign Ins. Co.*,<sup>2</sup> the employer grocery store filed suit against the insurer for indemnification of thefts committed by one of its employees. After an initial five month employment period, the insured's store manager

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<sup>1</sup> 2005 WL 2372871 (S.D. Oh. Sept. 26, 2005).

<sup>2</sup> 2005 WL 2090678 (W.D. Wash. August 30, 2005)

had the employee submit an application to the store's cashier/bookkeeper. The application disclosed the employee's prior conviction for "grand theft auto" to the cashier/bookkeeper. However, the store manager denied ever having seen the application or having knowledge of the employee's prior conviction. Later, the employee confessed to assisting in the planning of, and pled guilty as, an accomplice to first-degree robbery of the store for more than \$100,000. Due to the policy's Acts of Employees exclusion, the insured asserted a claim for Employee Theft.

The policy contained a provision which prohibited coverage upon the discovery of theft or any other dishonest act by the insured, or by "[a]ny of your [the insured's] partners, members, managers, officers, directors or trustees not in collusion with the employee." The court asserted that "discovery," under the terms of the policy, required actual, rather than constructive knowledge. Here, because of the uncertain factual scenario, the court refused to impute the actual knowledge of the cashier/bookkeeper to the insured. Accordingly, the court granted partial summary judgment. Additionally, the court found that the insurer had not acted in bad faith or in violation of the Consumer Protection Act or the Unfair Claims Settlement Practices Act and, accordingly, granted the insurer partial summary judgment.

While the court concluded that "the policy covers [the insured's] loss," it remains unclear whether this means that loss was in fact "covered" but that the prior dishonesty exclusion remained to be determined, or whether the insurer carried the burden to prove that the cashier/bookkeeper's actual knowledge transferred to the insured. In any event, because the insurer failed to establish the requisite knowledge, the court entered judgment for the insured.

In *Home Savings Bank, SSB v. Colonial American Cas. and Surety Co.*,<sup>3</sup> the insured brought suit for a declaratory judgment that its fidelity bond was not subject to automatic termination, even though the insured knew of its employee's embezzlement prior to the commencement of the bond period. The court nullified the policy's Automatic Termination clause and granted summary judgment to the insured bank.

In this case, the insured became aware that its employees had embezzled funds from a previous employer in 1985. However, when the insured applied for the fidelity bond in 2001, the application was silent as to the bank's knowledge that its employees had embezzled from others, nor did the bank mention this fact. Additionally, the facts did not indicate that the \$1.7 million the employee had currently embezzled were taken before the insured learned of the previous embezzlement. The insurer asserted that because the insured knew of the prior dishonest acts, coverage never commenced. However, the court erroneously held that the Automatic Termination clause was ambiguous since it could be read that coverage terminated where the insured "initially discovers [the dishonest act], after the coverage period's commencement."

#### **IV. Computer Crime**

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<sup>3</sup> 598 S.E.2d 265 (N.C. App. 2004), *Pet. for Rev. dismissed as moot*, 609 S.E.2d 770 (N.C. 2005).

In *Morgan Stanley Dean Witter v. Chubb Group of Ins. Companies*,<sup>4</sup> the court affirmed summary judgment for the insurer regarding the computer systems and facsimile transfer insuring agreements. In this case, the insured stock brokerage firm, Morgan Stanley, filed suit against several insurers, including Chubb Group of Insurance Companies. London/Bishopsgate, an investment advisor and customer of Morgan Stanley, established an account with the insured to hold securities for First Tokyo Index Trust. The insured asserted a claim for the roughly \$21 million spent in defending the suit against First Tokyo for alleged fraudulent transfers from the account.

This insurance policy contained six separate insuring agreements, indemnifying Morgan Stanley for losses arising out of fraudulent transfers of funds or property caused by instructions received from “computer systems,” “electronic computer[s],” “electronic communications,” “electronic transmissions,” “customer voice,” and “facsimile.” Accordingly, Morgan Stanley asserted a claim for fraudulent transfer under the policy. However, since all of the transfer instructions were authorized by Morgan Stanley’s customer, London/Bishopsgate, the trial court granted summary judgment because the acts were not committed by an imposter or hacker, and because there was no fraud directed at the insured or its customer.

The Court of Appeals reversed as to the voice initiated transfer coverage, but affirmed summary judgment regarding the facsimile transfer instructions and computer fraud insuring agreements.

The facsimile policy offered coverage for the “fraudulent FAX transfer instructions [that] fraudulently purport to have been made by a customer or other authorized representative but which FAX transfer instructions were not made by the customer or other authorized person.” Accordingly, the court held that the agreement “limits coverage unambiguously to situations where an unauthorized person poses as a customer or other authorized person to issue the fraudulent transfer instructions – the so-called ‘imposter’ coverage.” Thus, because the transactions were committed “through instructions sent by computer, fax, and voice to Morgan Stanley by persons associated with and specifically authorized by London/Bishopsgate to do its business,” there was no coverage liability for the insurer under the facsimile policy.

Additionally, the computer systems insuring agreement excluded loss caused by the entry of Electronic Data by customers or others who had authorized access to the customer’s authentication mechanism. However, the court rejected the insured’s assertions that First Tokyo was its “customer,” noting that all of Morgan Stanley’s agreements and contacts were through London/Bishopsgate, instead of First Tokyo. Accordingly, because the fraud was committed by a customer or other authorized persons, the computer systems coverage was also excluded.

However, the court permitted coverage under the voice initiated transfer agreement. The policy covered loss from voice transfer instructions that: “[1]

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<sup>4</sup> 2005 WL 3242234 (N.J. Super.A.D. Dec. 2, 2005).

fraudulently purport to have been made by a person authorized and appointed by a Customer to request by telephone the transfer of such funds but which instructions were not made by said Customer or by any officer, director, partner or employee of said Customer or [2] were fraudulently made by an officer, director, partner or employee of said Customer whose duty, responsibility or authority did not permit him to make, initiate, authorize, validate or authenticate customer voice initiated funds transfer instructions.” Under the first clause, the court agreed that the instructions did not fraudulently purport to have been made by an authorized person, since the persons were in fact authorized. However, under the second clause, the court asserted that because London/Bishopsgate employees violated First Tokyo’s instructions to cease further transactions, by having Morgan Stanley transfer the assets from First Tokyo’s account, the employees exceeded their authority and coverage applied for employees authorized to order transfers while defrauding a third party.

In *Brightpoint, Inc. v. Zurich American Ins. Co.*,<sup>5</sup> the court held that the insured’s policy did not provide for coverage of losses occasioned as a result of the fraudulent conversion of pre-paid mobile phone cards made by a Philippines subsidiary of the insured. In this case, the insured claimed coverage for losses of almost \$1.5 million caused by a scam by one of its subsidiaries involving prepaid phone cards.

The usual procedure with one of the insured’s customers involved the customer faxing a copy of its order and post-dating a check for the phone cards along with a bank guaranty of the check. Upon receipt, the insured would then purchase the phone cards and deliver them for the originals of the order, the check, and bank guaranty. On one occasion, following the receipt of a fax order from the customer, the insured purchased the requested phone cards and instructed its agent to deliver them to the customer’s representative for the originals. Later, the customer denied the transaction and claimed the post-dated check and bank guaranty were unauthorized. The insured then filed claim under its computer fraud coverage crime policy.

The coverage provision under the policy for computer fraud required “‘theft’ of property following and directly related to the use of any computer to fraudulently cause a transfer of that property from inside the... ‘premises’ or ‘banking premises’ to a person (other than a “messenger”) outside those ‘premises’ or to a place outside those ‘premises’. The means by which a fraudulent transfer is initiated include: written, telephonic, telegraphic, telefacsimile, electronic, cable, or teletype instructions.”

The insurer asserted four defenses: (1) that the phone cards were not the “property” of the insured; (2) that the phone cards were not “Property Other Than Money or Securities;” (3) that the transfer of phone cards did not occur from inside the “premises” or ‘banking premises’;” and (4) that the transfer was not the result of the faxed copies.

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<sup>5</sup> 2006 WL 693377 (S.D.Ind. March 10, 2006).

For the first two arguments, the court found that the phone cards, during the exchange with the customer's representative, were in fact the property of the insured, and that under the policy, there was no requirement that the phone cards be the property of the insured while the computer instruction was sent. Additionally, the court reasoned that because the phone cards were tangible property with inherent value, they could properly be deemed "Property Other Than Money and Securities."

However, notwithstanding the insured's assertion that because its employee was within the building of the phone cards issuer, the issuer's building should be deemed a "premises" defined under the policy as "the interior of that portion of any building you occupy in conducting your business," the court granted the insurer summary judgment reasoning that the phone cards were never on the "premises" of the insured or of a bank.

Further, the court held that "[t]he loss to Brightpoint that occurred here did not flow immediately from the use of the facsimile." Rather, the faxes simply made the insured aware that the customer wished to make a purchase and that the actual transfer of property occurred only in exchange for the originals.

Lastly, while the court questioned the notion that the fax machine should be considered a computer for purposes of the computer fraud coverage, it did not rule on that issue because the insurer had not relied on it as a defense to the claim.

## **V. Court Costs and Attorneys Fees**

In *Rothschild Investment Corp. v. Travelers Cas. and Surety Co. of America*,<sup>6</sup> the court erroneously interpreted the Court Costs and Attorneys Fees General Agreement provision of the insured's fidelity bond and held the insurer liable under a "duty to defend." In this case, the insured's customer sued the insured for the alleged actions of its dishonest employee. Namely, that the employee stole funds from the insured's customers' accounts by submitting forged checks or withdrawal orders.

In an amended complaint, the insured's customer asserted two counts: (1) ERISA violations; and (2) professional negligence. The insurer elected not to defend the insured and refused to reimburse defense costs. The insured ultimately settled with its customer and paid attorneys fees.

The court erred by construing the Court Costs and Attorneys Fees General Agreement as a duty to defend clause in a liability policy. The provision obligated the insurer to indemnify the insured for costs and fees in defending any suit "on account of any loss, claim or damages which, if established against [Rothschild] would constitute a loss sustained by [Rothschild] covered under the terms of this bond." However, the court held that the customer's complaint and the alleged facts encompassed potential

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<sup>6</sup> 2006 WL 1236148 (N.D. Ill. May 4, 2006).

coverage under the bond. Even though the Court Costs and Attorneys Fees General Agreement obligates the insurer to indemnify for costs and fees in a suit to establish a loss covered by the bond, the court reasoned that such a duty to defend was broader than the duty to indemnify. Consequently, the court held that “[b]ecause Travelers’ breached its duty to defend, it also has a duty to indemnify.”

In so doing, the court failed to address the underlying facts of the case or the scope of coverage of the bond. Rather, it concentrated only on the potential for coverage issues based upon the customer’s allegations. In response, the insurer asserted that insured’s settlement costs were an indirect loss and that the exclusion for transactions in a customer’s account prohibited such a claim. However, the court held that the exclusion for transactions must be “clear and free from doubt” and that the losses only need to be potentially direct. Indeed, the court asserted that it “expresses no opinion regarding whether the loss was, in fact, a ‘loss resulting directly from’ forgery’ under the Bond because we need not reach that issue.”

Finally, because the court reasoned that the exclusion was not “clear and free from doubt” and that the losses were potentially a direct loss, it held that the insurer breached the duty to defend and was estopped from contesting its obligation to indemnify. As such, the court held the insurer liable for breaching its duty to defend.

In *House of Finance, Inc. v. Financial Solutions Ins. Services, Inc.*,<sup>7</sup> the court held that attorneys fees and costs were not covered under the insured’s Lloyds policy, which provided coverage for a “direct financial loss” from employee dishonesty. The policy contained a \$15,000 deductible. The insured settled two suits for a total of \$6,000, but expended over \$82,000 in attorneys fees and costs. The court held that “[a]s per the policy’s plain language, court costs and attorney’s fees are clearly *separate* from “direct financial loss” under Insuring Clause A1, and holding otherwise would effectively result in re-writing the insurance policy, which this court cannot do.” As a result, while the attorneys fees and costs were connected with the insured’s claim, they were not a direct financial loss and the settlement amount was well within the deductible. Accordingly, the court affirmed summary judgment in favor of the insurer.

## **VI. Cumulation of Limits**

In *Harrington v. American Economy Ins. Co.*,<sup>8</sup> the court affirmed the district court’s decision in the 2003 case of the same name.<sup>9</sup> In this case, the insured had brought an action against his former insurer, and sought compensation for losses occasioned by employee theft which was allegedly covered under the insured’s policy. The court enforced the policy’s two year suit-limitation provision which barred losses caused by employee dishonesty more than two years before the insured filed suit. The policy applied to property losses, including fire, and thus, under Oregon law was

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<sup>7</sup> 2006 WL 1960855 (Hawaii July 13, 2006)

<sup>8</sup> 131 Fed.Appx. 573 (9th Cir. 2005).

<sup>9</sup> 2003 WL 23190177 (D. Ore. 2003).

required to provide that, “No one may bring a legal action against us under this insurance unless... [t]he action is brought within 2 years after the date on which the direct physical loss or damage occurred.” Additionally, the court stated that “[t]he Oregon Supreme Court has held that the suit-limitation provision mandated by § 742.240 is to be strictly interpreted” and is not subject to a “discovery rule.”

In *Acid Piping Technology, Inc. v. Great Northern Ins. Co.*,<sup>10</sup> the insured purchased a commercial insurance policy which covered losses due to employee dishonesty. The policy included a \$5,000 per loss limitation. The insured’s employee had submitted dozens of fraudulent invoices, which resulted in losses of several hundred thousand dollars for the insured. The main issue was whether the per loss limitation applied to each separate invoice, or the entire loss caused per employee. While the policy did not expressly define occurrence or loss, it did state that the insurer’s maximum liability was \$5,000 for “any loss caused by any employee whether acting alone or in collusion with others, either resulting from a single act or any number of acts, regardless of when those acts occurred, during the policy period or this insurance or prior insurance.” The court cited *Auto Lenders Acceptance Corp. v. Gentilini Ford, Inc.*<sup>11</sup> even though the policy language was different, and found that the language was ambiguous and its interpretation called for the \$5,000 limit upon each invoice and not per employee.

In *Reliance Ins. Co. v. IRPC, Inc.*,<sup>12</sup> the court affirmed summary judgment for the insurer where the insured’s controller embezzled almost \$5.1 million between August 1994 and May 2000. Even though there was only one policy, it was extended each year through an endorsement which changed the policy period for consecutive one-year terms until November 2000. The insurer tendered the single loss policy limit, and the insured demanded separate limits for each year. The trial court found for the insurer, holding that there was a single policy and a single limit. While the insured appealed, the Court of Appeals affirmed the summary judgment, finding that there was only one policy and only one limit, and rejected the insured’s assertion that the non-cumulation clause and prior insurance clause were ambiguous.

## **VII. Damages**

In *Pine Bluff Nat. Bank v. St. Paul Mercury Ins. Co.*,<sup>13</sup> the court provided a follow-up opinion to the 2004 case<sup>14</sup> of the same name. In this second order, the court ruled on motions in limine addressing the computation of the insured’s damages from loans made with falsified leases for photocopier machines as collateral. The insurer asserted that the damages should be calculated by what the remaining value of the leases would have been worth but for the falsifications. The insured argued that the damage should

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<sup>10</sup> 2005 WL 3008512 (E.D. Mo. Nov. 9, 2005).

<sup>11</sup> 181 N.J. 245, 854 A.2d 378 (N.J. 2004).

<sup>12</sup> 2006 WL 1738047 (Pa. Super. May 16, 2006).

<sup>13</sup> Case No. 5:03cv00400, (E.D. Ark. Aug. 30, 2005).

<sup>14</sup> 346 F. Supp.2d 1020 (E.D. Ark. 2004).

be calculated by the sum owed on the loan because the forged leases induced it to make such loans.

The court repeated its erroneous opinion that coverage includes losses which resulted from loans made in reliance on the forged documents, rather than losses resulting from forgery. The court then held that each side's damage theory was a question to be put before the jury in order to decide the amount of damage. Additionally, the court stated that, "[t]he language of the Bond does not, as a matter of law, limit the Bank's recoverable loss to the value of the leases held as collateral for the loan in question. The amount of the loss recoverable under the Bond is a question of fact for the jury, and the amount of the loan to Croy, as well as the value of the leases taken as collateral, are relevant and probative as to this issue."

### **VIII. Discovery**

In *Cellco Partnership d/b/a Verizon Wireless v. Certain Underwriters at Lloyd's London*,<sup>15</sup> the insured asserted a claim based on the theft and misappropriation of its PIN numbers and calling cards by a former employee. The insurer declined coverage under its Commercial Crime Policy. The court addressed disputes in this case revolving around discovery and attorney-client privilege. The court asserted that even though the insured's broker's employee was an attorney, documents which showed the insured's communications with its broker were not privileged material. Additionally, the court struck down (after in camera inspection) the insured's argument that certain documents were not privileged when the insurer's attorney was acting as a claim investigator, rather than providing legal advice.

### **IX. Discovery of Loss**

In *FDIC v. Fidelity and Deposit Co. of Maryland*,<sup>16</sup> the court established a standard for use when there is discovery of a loss under a fidelity bond. In this case, the insured's CEO had recorded loans for customers that it was later discovered, were bribing him. Before the policy ended, the insured learned that the CEO had been making purchases from the bribing customers in order to make profitable investments. Three days prior to the end of the policy period, an internal memorandum addressing the insured's concerns over conflict of interests related to the CEO's purchases was produced. Notwithstanding the memorandum, the court noted that the bank was not aware of the bribes at that time. Further, the court held that discovery of a loss occurs when the insured has knowledge, not mere suspicion, of facts that would justify a careful and prudent person to charge another with fraud or dishonesty. Moreover, here, the conflict of interest concerns alone were not enough to justify such a charge, and therefore the loss was not covered because its discovery occurred after the policy period.

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<sup>15</sup> 2006 WL 1320067 (D.N.J. May 12, 2006).

<sup>16</sup> 132 Fed. Appx. 139 (9th Cir. 2005).

In *The Investment Center v. Great American Ins.*,<sup>17</sup> the court held that the insured's knowledge of its former employee's fraudulent activity prior to the commencement of coverage under its fidelity bond constituted discovery, thereby barring coverage. In this case, the policy "immediately terminates as to any employee if and when [the insured] became aware of dishonest or fraudulent acts committed by the employee." Prior to the policy period beginning, two customer complaints to the insured were made, and an inquiry letter from the NASD regarding the employee was sent to the insured. Additionally, the employee's supervisor had requested the employee be removed from his supervision, the employee was advised to leave the brokerage or to resign, and he also had been arrested and charged with securities fraud. The court summarily concluded that, "[t]hese facts, combined with the circumstances leading to [the employee's] resignation and the NASD inquiry following it, would lead any reasonable person to believe that [the employee] had engaged in dishonest and fraudulent activities during his employment with [the insured]. All told, based on these facts, no reasonable jury could find that [the insured] had not discovered [the employee's] fraud prior to January 1, 1999."

#### **X. Employee Retirement Income Security Act (ERISA)**

In *Employers-Shopmens Local 516 Pension Trust v. Travelers Cas. and Surety Co. of America*,<sup>18</sup> the court attempted to "wad[e] into the veritable Sargasso Sea of obfuscation that is ERISA preemption law." Following the collapse of Capital Consultants, LLC, several union ERISA plans brought suit on ERISA bonds and the Plans' brokers. The Plans asserted that the bonds covered Capital Consultant's dishonesty despite the fact that they were not an employee, or that ERISA required the coverage and that the brokers were liable for failing to obtain "ERISA compliant" bonds. The court granted the Plans' motion to remand.

However, the court failed to address the merits of the Plans' theories, nor did it allude to the relevant statute – 28 U.S.C. § 1352, which grants original jurisdiction to the district courts over an action on a bond executed under any law of the United States. The court did note, however, that diversity jurisdiction did not exist because one of the Plans and one of the brokers were citizens of the same state. Moreover, the court stated that the appropriateness of federal jurisdiction turned on ERISA preemption, and that ERISA did not preempt applicable state law in the action. In any event, the court determined that remand would have nonetheless been appropriate because the timely notice of removal attached the complaint, but not the exhibits to the complaint. The exhibits were filed after the 30-day removal period expired.

In *Hartford Fire Ins. Co. v. Office and Professional Employees Int'l Union Local No. 11*,<sup>19</sup> the court dismissed the insurer's declaratory judgment action. In this case, the

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<sup>17</sup> 2006 WL 1074676 (D.N.J. Apr. 20, 2006).

<sup>18</sup> 2005 WL 1653629 (D. Ore. July 6, 2005).

<sup>19</sup> 2005 WL 1981291 (D. Ore. Aug. 15, 2005).

insurer filed suit in federal court seeking a declaratory judgment that the losses asserted as part of the Capital Consultants, LLC collapse were not covered by its bond. However, the insured and other ERISA plans filed suit in state court. The insurers removed the state case, but the federal court remanded it in *Employers-Shopmens*.<sup>20</sup> The federal court exercised its discretion not to hear the declaratory judgment action and left the resolution of the dispute to the state court in the remanded suit.

## **XI. Forgery**

In *Bell Gardens Bicycle Casino v. Great American Ins. Co.*,<sup>21</sup> the court affirmed summary judgment for the insurer regarding coverage under a commercial crime policy. The insured casino asserted a claim under the forgery and theft provisions of the policy. The forgery provision provided coverage for “loss caused by ‘forgery or alteration’ of a covered instrument that is drawn upon the Casino.” However, the withdrawal orders used by the criminal were not altered or forged, and theft coverage was barred by an exclusion for property that the insured was “induced” to part with voluntarily. Additionally, the court rejected the insured's promissory fraud count, which was based on its broker's use of a renewal summary, because the policy clearly controlled over the summary, and any reliance on the summary to vary the policy was unreasonable as a matter of law. Finally, the court affirmed the dismissal of the insurer's bad faith claims because no policy benefits were due.

In *Lusitania Savings Bank, FSB v. Progressive Cas. Ins. Co.*,<sup>22</sup> the court affirmed summary judgment for the insurer in a case involving the false endorsement of a check. In this case, the criminal, Leuzzi, obtained a legitimate check payable to a legitimate company in New York, and then formed a company of the same name in New Jersey, and used the New Jersey documents to open an account in the name of the New Jersey company at the insured bank. She endorsed the check with her company's name and her signature, and deposited the check. Progressive claimed that this case did not involve “forgery,” as that term is defined in the policy, since the thief endorsed the check with her real name and the real name of her own company. The court agreed with the insured and held that, “Leuzzi endorsed the check with the true name of her own business, her own true signature, and her own true account numbers. Under the definition [of forgery] in Lusitania's fidelity bond, this endorsement was not a forgery, and Lusitania is not entitled to coverage.”

## **XII. Insuring Agreement (D)**

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<sup>20</sup> 2005 WL 1653629 (D. Ore. July 6, 2005).

<sup>21</sup> 124 Fed.Appx. 551, 2005 WL 513520 (9th Cir. 2005)

<sup>22</sup> 2005 WL 1586618 (3d Cir. July 5, 2005).

In *First Integrity Bank, N.A. v. Ohio Cas. Ins. Co.*,<sup>23</sup> the court partially granted the insured's motion to dismiss in a case involving insurance coverage for bank fraud under a financial institution bond. In this case, a customer of the insured bank issued a check for \$91,432 to an individual, but the customer stopped payment on the check. Two weeks later, an imposter acting as an authorized officer of the customer called the bank, offered the customer's wire transfer authorization code, and requested a wire transfer of \$88,132 to the same individual. The insured made the transfer. When the customer later denied authorizing the transfer, the bank reimbursed the customer. The insured then claimed coverage under Insuring Agreement (D) or under a stop payment coverage, and also claimed unjust enrichment, misrepresentation, consumer fraud, and deceptive trade practices.

The insurer moved to dismiss the case for failure to state a claim upon which relief could be granted. While the court denied the motion as to the breach of contract and deceptive trade practices counts, it granted dismissal on the other counts.

The court side-stepped the problem of the telephone wire transfer instruction, which clearly was not a forged or altered document within the meaning of Insuring Agreement (D), by reasoning that the telephone wire transfer instruction and the earlier check were part of a single fraud. Although the check was neither forged nor altered, the court stated that, “[a]ssuming that the wire transfer and the check were related, it is possible that the check could have been ‘altered’ by a telephonic wire transfer request.”

Under the stop-payment provision of the policy, the insurer was obligated to indemnify the bank when it appropriately honored the stop payment order. The court found that, “the check and the wire transfer may be viewed as part of the same fraudulent transfer. Thus, Ohio Casualty [the court presumably meant the bank] may have improperly disregarded the stop-payment request when it honored the wire transfer two weeks later, making it liable for related losses.”

Additionally, the court denied the motion to dismiss as to the deceptive trade practices count because the insurer deprived the bank of “the services it had contracted for – namely that the terms of the bond would be interpreted fairly and evenly.”

### **XIII. Insuring Agreement (E)**

In *First Nat. Bank in Manitowoc v. The Cincinnati Ins. Co.*,<sup>24</sup> a used car dealer defrauded the insured bank by giving it carbon copies of phony leases on which the dealer had traced the signature of the supposed lessees. The dealer, who had a “lease line” of credit from the bank, would negotiate a lease with a customer and call or fax the bank with the lease terms. Once the bank accepted the terms, it approved the loan for the dealer to purchase and lease the car to the customer. However, the bank would

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<sup>23</sup> 2006 WL 1371674 (D.Minn. May 15, 2006).

<sup>24</sup> 2005 WL 2460719 (E.D. Wis. Oct. 5, 2005).

only disburse the funds once the dealer personally provided the bank with a pressure carbon copy of the signed leases and signed the loan paperwork. Here, the leased cars either did not exist or were worth far less than the documents represented. When the bank learned of the fraud, it submitted a claim under Insuring Agreement (E).

The court held for the insured on the issues of whether the loss was occasioned by the forgery or by the fact that there were no cars, whether the insured had physical possession of the written loan instruments, and whether the loss was caused by the insured's own employees' negligence and "sloppy" practices. While the court agreed that the forgeries did not cause the loss, it held that Insuring Agreement (E) covered losses from extending credit upon instruments containing a forgery, even if the forgery did not cause the loss.

Additionally, the court found that the insured had possession of the carbon copies before disbursing the funds and that there was no requirement for possession of an "original." And, even if an original were required, the carbon copies satisfied this requisite since they were the only signed versions of the leases.

Finally, the court reasoned that negligence or sloppiness did not bar coverage and was not tantamount to the insured's failure to act in good faith or in the regular course of its business as required by Insuring Agreement (E). In the same vein, the court found that the acts of employees exclusion did not bar the claim.

In *BancInsure, Inc. v. Marshall Bank, N.A.*,<sup>25</sup> the court affirmed a 2005 decision for the insurer by the lower court.<sup>26</sup> In this case, the insurer obtained summary judgment on an Insuring Agreement (E) claim because, at the time the bank disbursed the loan proceeds, it had possession of only a facsimile transmission of the forged personal guarantees.

The insured argued that under its financial institution bond, the phrase "[a] mechanically reproduced facsimile signature is treated the same as a handwritten signature" should be interpreted to mean that the signatures on the documents sent by facsimile transmission were equivalent with handwritten signatures and, therefore, the documents were originals. In any event, the court observed, the facsimile copies would have been enforceable against the guarantors but for the forgery.

The court stated that the purpose behind the requirement of possession of originals is to permit the bank to examine the signatures and identify forgeries, and that the enforceability of a copy was not the issue. The court held that the facsimile copies were copies of the originals, which barred coverage under Insuring Agreement (E). The court also rejected the bank's argument that under the doctrine of "illusory coverage," modern banking practice's literal enforcement of the original requirement would render the coverage promised by the Insuring Agreement illusory. The court also noted that the original documents could have simply been sent by overnight delivery. Additionally,

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<sup>25</sup> 2006 WL 1971959 (8th Cir. July 17, 2006).

<sup>26</sup> 400 F.Supp.2d 1140 (D.Minn. 2005).

the court described the bond as a standard form which was “created with input from the Surety Association of America and the American Bankers Association.”

#### **XIV. Intangible Property**

In *Duratech Indus., Inc. v. Cont'l Ins. Co.*,<sup>27</sup> the court granted summary judgment to the insurer on a crime policy regarding a trade secret loss claim. In this case, the claim involved alleged losses from the theft of customer lists and trade secrets. The insurer asserted that these materials were uncovered intangible property and that the named dishonest employees had no longer worked for the insured during the coverage period of the policy.

The court vaguely held that the insured did not submit prompt notice of the covered losses as required by the policies. The court ruled that the insurers were entitled to summary judgment to dismiss the consequential damages claims because the insurer’s policies either expressly excluded such claims or did not specifically cover them.

#### **XV. Inventory Exclusion**

In *HCA, Inc. v. American Protection Ins. Co.*,<sup>28</sup> the court thoroughly discussed the issue of inventory exclusion. In this case, the insured owned numerous hospitals and surgical facilities and brought suit for a claim under its “all-risk” policies, seeking coverage for losses that occurred in its linen inventory by a linen cleaning contractor. The alleged loss was between \$8 million and \$12 million. The trial court granted summary judgment to one set of insurers because the loss was incurred prior to commencement of their policies, and to the other set of insurers because of the inventory exclusion. After the court discussed what seemed to be an exhaustive list of every reported inventory exclusion case, it held that there was sufficient evidence of the discovery of the loss prior to taking the physical inventory by the insured, to survive a motion for summary judgment. The judgment for the second set of carriers was not appealed, but the judgment for the first set based on the inventory exclusion was vacated and the case remanded.

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<sup>27</sup> 21 A.D.3d 342 (N.Y. App. Div. 2005).

<sup>28</sup> 174 S.W.3d 184 (Tenn.Ct.App. 2005).

## **XVI. Jurisdiction & Venue**

In *Kimberly-Clark Corp. v. Cont'l Cas. Co.*,<sup>29</sup> the court denied the insurer's motion to dismiss for *forum non-conveniens*. The insured alleged it sustained losses caused by an employee of its Brazilian subsidiaries who purchased invalid third-party tax credits in exchange for bribes. The insured claimed an employee dishonesty loss of \$40 million and sought the \$20 million policy limit from the insurer. Until 1996, the policy required manifest intent to cause a loss, but in 1996, "manifest" was deleted and only an intent to cause a loss was required. As such, the insured argued that the issue was mostly one of contract interpretation, which would be controlled by Texas law. However, the insurer asserted that the primary issue was the employee's intent, and that the pertinent documents and witnesses on that issue were in Brazil. The court found that it could not, at that point, exclude contract interpretation as an issue. It reviewed a series of factors to be considered in deciding *forum non-conveniens* motions, and denied the insurer's motion, concluding that "the private and public interest factors do not adequately demonstrate that the case should be litigated in Brazil."

In *Banclnsure, Inc. v. Western Bancshares, Inc.*,<sup>30</sup> the insurer of two financial institution bonds filed a declaratory judgment suit in federal court. The insured counterclaimed and requested a declaration that the insured banks were under the domination of the allegedly dishonest employees and that their knowledge should not be imputed to the insured. In addition, the insured filed a suit in state court in which they named other defendants in addition to the insurers, and moved to dismiss the federal suit. The court held that the bonds were issued pursuant to federal regulations, citing 12 C.F.R. § 7.2013(a), 12 C.F.R. § 563.190(a), and 12 C.F.R. § 563.190(c), thus establishing original federal jurisdiction pursuant to 28 U.S.C. § 1352 – since the bonds were executed under a law of the United States. Alternatively, the court also found diversity jurisdiction. The court concluded that it need not abstain, since the federal suit was further along than the state suit, and because a declaratory judgment would not have the effect of an injunction against the state court. As a result, the court exercised its discretion to hear the declaratory judgment action.

## **XVII. Limitations Period**

In *Systems America, Inc. v. The St. Paul Travelers Co., Inc.*,<sup>31</sup> the insured submitted two employee dishonesty claims on its property policy. The policy, which was effective from September 21, 2000 to October 10, 2002, contained a clause that contractually limited the time within which a lawsuit may be brought: "Any lawsuit to recover on a property claim must begin within 2 years after the date on which the direct physical loss or damage occurred." One of the insured's claims was for \$9,132,000 allegedly taken by former employees who left in February or March 2002, of which

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<sup>29</sup> 2005 WL 2679698 (N.D.Tex. Oct. 19, 2005).

<sup>30</sup> Case No. P-05-CV-005 (W.D. Tex July 22, 2005).

<sup>31</sup> 2005 WL 2333755 (N.D. Cal. Sept. 22, 2005).

\$9,100,000 was the alleged replacement cost of a software program under development. The second claim was for \$6,786,711 which was an alleged overpayment by the payroll department between 1998 and 2001. The losses were discovered in March 2004 and the suit was filed in June 2005. The insurer asserted that if the loss occurred when the property was stolen, the suit was barred by the two year provision, but if the loss occurred when the injury manifested itself, (*i.e.*, when the insured knew or should have known about it), then the loss “occurred” after the policy had expired. Under the California delayed discovery rule, the court denied the motion because the two year period began to run when the loss was, or should have been, discovered – but it only applied to the issue of accrual of the cause of action, and not when the loss occurred for the purposes of coverage. Accordingly, the allegations in the complaint were sufficient to survive a motion to dismiss.

### **XVIII. Limit of Liability**

In *Times-Picayune Publ'g Corp. v. Zurich American Ins. Co.*,<sup>32</sup> the Fifth Circuit Court of Appeals reversed summary judgment for the defendant insurer on an excess employee dishonesty policy. Over a span of six years, the employee stole a total of \$2,205,879, during which none of the thefts exceeded the \$1 million per year limit of the primary policy. During the last three years of the six year time period, the insured obtained an excess policy with a \$1.5 million limit. The primary carrier only paid up to its \$1 million limit. Under these facts, the issue remained as to the outstanding amount owed by the excess carrier.

The district court disagreed with the excess carrier’s argument that it was required to cover only losses in excess of \$1 million per year. Next, the court found that the excess policy covered only those losses incurred after commencement of the excess policy, but only if the losses exceeded \$1 million. Here, the employee stole \$1,165,873 after commencement of the excess policy, thus totaling \$165,873 owed by the excess carrier. This amount did not include deductibles, recoveries, and partial payment. The insured demanded payment of \$1,205,879, representing the total loss minus the \$1 million paid by the primary carrier.

On appeal, the Fifth Circuit reversed the decision of the lower court and entered judgment in favor of the insured. The Fifth Circuit reached its decision via two separate interpretations of the excess policy. Under the first manner of interpretation, the court found that the primary policy limit was exhausted by payment of \$1 million for losses incurred prior to the commencement of the excess policy. Thus, based on the insuring clause and the “drop down” provision of the excess policy, it became primary, and covered the entire \$1,165,873 of losses post-commencement of the policy.

Under the first interpretation, \$40,006 of loss remains prior to commencement of the excess policy that exceeded the \$1 million limit. In addition, the insured had an additional excess policy during the last two of the three prior years; however, the

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<sup>32</sup> 421 F.3d 328 (5th Cir. 2005).

insured had no excess coverage for the first year of the thefts. Unlike the district court, the Fifth Circuit examined the last year prior to the commencement of the excess policy and held that the primary policy would have been completely exhausted, thus leaving the excess \$40,006 covered.

Alternatively, the Fifth Circuit held that the insuring clause containing the terms and conditions of the primary policy covered only losses that were covered by the excess policy. The court, disagreeing with the lower court, held that the excess policy covered losses incurred prior to the policy's commencement. The Fifth Circuit concluded that had the primary policy covered such loss or any part of such loss in excess of \$1 million, it became the obligation of the excess policy to cover that amount.

In *Armbrust Int'l, Ltd. v. Travelers Cas. and Surety Co. of America*,<sup>33</sup> an employee stole a total of \$323,203 over a three year period beginning in May 2000. When the loss was discovered in May 2003, the employee was terminated by May 8<sup>th</sup> of that year. During the period in which the thefts occurred, the employer had employee dishonesty coverage under three separate policies. The first and second policies were property policies which included an "additional coverage" of "additional benefit" for employee dishonesty. The last policy was a "wrap policy" which added employee dishonesty coverage.

The first policy (St. Paul 1), was implemented from October 20, 2001 until October 20, 2002 and contained a \$500,000 limit and a \$5,000 deductible. The second policy (St. Paul 2), was implemented from October 20, 2002 to October 20, 2003 and had a \$25,000 limit. The last and final policy (Travelers), was implemented from February 25, 2003 to March 12, 2004 with a \$25,000 deductible.

The court granted summary judgment to Travelers since the thefts during its policy period were less than the \$25,000 deductible. The insured asserted that, under Rhode Island law, the loss manifested itself and was covered by the policy when it was discovered in May 2003. The court rejected that argument based on the distinction between fidelity coverage and liability policies and the actual language of the Travelers policy that covered loss sustained during the term of the policy. Since the Travelers policy overlapped with the St. Paul 2 policy, the prior loss did not become effective at the time of cancellation or termination of prior insurance. The court also rejected the insured's estoppel argument based on the agent's belief as to the coverage of the Travelers policy. The insured admitted that the insurer never made any representations, and the court found that the agent was a dual agent acting for the insured as well in placing the coverage.

Regarding the first two policies, the insurer invoked the Rhode Island manifestation rule and paid the \$25,000 limit of the St. Paul 2 policy. The court reasoned that the manifestation rule did not apply to the first two policies for the same reasons it did not apply to the third policy. Finally, the court denied the insured's and St.

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<sup>33</sup> 2006 WL 1207659 (D.R.I. May 1, 2006).

Paul's summary judgment motions on the basis that genuine issues of material facts needed further development.

### **XIX. Loan Loss Exclusion**

In *Citizens Banking Corp. v. Gulf Ins. Co.*,<sup>34</sup> the court denied the insurer's motion for summary judgment where the insured bank sought to recover for the nonpayment of loans to two borrowers pursuant to its fidelity bond. While renegotiating the terms of the original bond, the insurer offered a proposed rider, "Rider 19," which was intended to cover for the insured's detrimental reliance on false and fraudulent financial documents from its borrowers. The court characterized Rider 19 as insuring "against losses resulting from fraudulent financial documentation submitted by a borrower and relied upon by the Bank. However, in order for documents to be classified as financial documentation, the bank must have had standard written procedures in place to verify the existence of the collateral the documents purport to represent and the bank must have actually exercised said procedures. Furthermore, Rider 19 indicates that actual physical possession of the *original* financial documentation is a condition precedent to any claim of coverage."

The loans were made pursuant to accounts receivable and inventory. The insurer argued that the bank did not hold the standard written procedures necessary to verify their existence and, if it did have such procedures, they were not followed and, in any event, in most instances the insured did not have originals. The court found that the broker drafted Rider 19 but did not construe any ambiguities against either party. However, the court held that the terms, "physically verify the existence of the underlying property," and "actual physical possession of the original Finance Documentation," were both ambiguous. The court reasoned that "physically verify" in the context of accounts receivable did not necessarily require the contacting of the account debtors to verify the amount owed, and that "original" did not necessarily mean a "wet ink" signature document. Further, the court held interpretation of both phrases were questions of fact for the jury, rather than questions of law for the court.

### **XX. Loss and Indirect Loss**

*Simon Mktg., Inc. v. Gulf Ins. Co.*,<sup>35</sup> involved the same dishonest transaction as the 2005 reported case of *Simon Mktg., Inc. v. PricewaterhouseCoopers, L.L.P.*<sup>36</sup> In this case, the employer sued the fidelity insurers for losses resulting from its employee's theft involving winning high-value tokens for games the insured administered for its customers. However, the losses were the value of the tokens or any other property taken from the insured. As such, the court granted summary judgment to the insurers because there was no direct loss and stated that, "Simon's claims in this case are not

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<sup>34</sup> 2005 WL 1983248 (E.D. Mich. Aug. 10, 2005).

<sup>35</sup> Case No. BC 310264, (Los Angeles County Superior Court, Sept. 29, 2005).

<sup>36</sup> 2005 WL 2293031 (Cal. App. 2005).

'direct' losses as they relate to litigation costs associated with various lawsuits brought against Simon by third parties...These lawsuits did not seek replacement of the stolen game pieces or compensation for their corresponding values; instead, these lawsuits sought recovery for subsequent losses arising as a result of the game pieces being stolen. In essence, Simon was held vicariously liable for third party losses associated with the tortuous acts of its employee."

In *Hartford Ins. Co. of the Midwest v. Mississippi Valley Gas Co.*,<sup>37</sup> the insurer successfully appealed a lower court's judgment for the insured. In this case, the insured gas company's coverage claim was under property insurance policies which covered natural gas produced by certain designated wells. The policy covered direct loss of, or damage to, covered property. And, while theft was a covered cause of loss, money was not covered property. Here, a dishonest seller of natural gas to the insured tapped into the pipe downstream of the meter and diverted the gas back into the line above the meter – causing the insured to pay multiple times for the same gas. The insured asserted this scheme was theft of the gas because there was no difference between a theft involving the stolen gas sold to a third party, and the theft of stolen gas re-sold to the insured. The trial court agreed and granted summary judgment to the insured. On appeal, the insurer argued that the insured had in fact received all of the gas produced by the wells, but it simply overpaid for it, characterizing the scheme as a theft of money, not gas. The Court of Appeals agreed, and reversed the judgment of the trial court and entered judgment in favor of the insurer.

In *BancInsure, Inc. v. Oakland State Bank*,<sup>38</sup> the insured bank's stock was devalued by the alleged acts of a dishonest employee. However, the court held that because the financial institution bond covered only the "actual depletion of bank funds," the decline of the insured's stock value was barred from coverage. Accordingly, the court granted the insurer's motion for partial summary judgment.

## **XXI. Manifest Intent**

In *Kansas Bankers Surety Co. v. Farmers State Bank, Yale, IA*,<sup>39</sup> the court held that factual issues precluded summary judgment for either party. In this case, a former bank employee made loans that were not repaid. The insured asserted a claim under Insuring Agreement (A). The court held that because the bond was secured in an effort to comply with an Iowa statute, the statute controlled. However, the court also reasoned that manifest intent, which it interpreted under a "results substantially certain to follow" standard, was consistent with the Iowa statute's requirement of coverage for fraud and dishonesty. While the insured argued for faithful performance coverage, the court recognized an intent component to fraud and the other violations mentioned in the statute. The court reasoned that the financial benefit provision of the bond was a stickier question, and followed federal precedent on a similar state statute and decided

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<sup>37</sup> 2006 WL 1489249 (5th Cir. 2006).

<sup>38</sup> Case No. 05-00015 (S.D. Iowa June 6, 2006).

<sup>39</sup> 408 F.Supp.2d 751 (D. Iowa 2005).

it did not conflict with the statute. Additionally, based on a state court decision finding no improper personal benefit to the employee in connection with one group of loans, the court rejected the insurer's argument for collateral estoppel.

In *Five Star Real Estate, LLC v. Kemper Cas. Ins. Co.*,<sup>40</sup> the court affirmed a summary disposition for the insurer by holding that the acts of an allegedly dishonest employee of the insured real estate firm, did not possess the manifest intent to cause the insured a loss. Unfortunately, while the insured was named the defendant in two underlying suits that alleged an employee and another individual committed various wrongful acts in connection with certain real estate transactions, the court did not describe the alleged dishonest acts.

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<sup>40</sup> 2006 WL 1294238 (Mich.App. May 11, 2006).

## **XXII. Other Insurance**

In *Heartland Payment Systems, L.L.C. v. Utica Mut. Ins. Co.*,<sup>41</sup> a coverage dispute arose when the insured lost \$1.8 million due to a number of “uncollectible chargebacks” to a telephone sales outfit. The insured held a “Merchant Chargeback Indemnity Policy” from the insurer, Utica Mutual, with a \$1.2 million limit and no deductible, in addition to a “Plastic Card Fraud Policy for Financial Institutions” from Banclnsure, Inc. with a \$10 million limit and a \$500,000 deductible. The insured and Banclnsure were under the impression that the Utica policy was primary and the Banclnsure policy was excess. And, while the Utica policy covered any uncollectible chargebacks, the Banclnsure policy covered only chargebacks resulting from fraud. However, the court found that the policies’ “other insurance” clauses were “mutually repugnant” and that the coverage should be prorated.

Nevertheless, the court affirmed judgment against Utica Mutual for the balance of its policy limit (Utica had already paid the prorated portion) since the insured had settled with Banclnsure and because the other insurance did not reduce either insurer’s obligation to the insured, but simply provided a possible cause of action against the other insurer in the case of overpayment.

## **XXIII. Prior Insurance Provisions**

In *Travelers Indemnity Co. v. Vas-Nes, P.C.*,<sup>42</sup> a doctor incorporated his medical practice under Missouri law in 1994 under the name Vas-Nes, P.C. In 1999 the doctor held an insurance policy that included employee dishonesty, but the insured was the doctor, rather than the corporation. On August 4, 2000, the policy expired, but was replaced by a virtually identical policy naming Vas-Nes, P.C. as the insured. On September 12, 2000, dishonesty by a former employee was discovered to have occurred from November 1999 through August 2000. The court held that Vas-Nes, P.C. was only insured under the policy in 2000, and that the policy’s previous insurance provision was inapplicable to any losses prior to the policy issued because only the doctor, and not Vas-Nes, P.C., could have recovered under the 1999 policy. The court also rejected arguments based on waiver or estoppel because “[w]aiver and estoppel may not be employed to create coverage where it otherwise did not exist.”

## **XXIV. Stop Payment Coverage**

In *First Integrity Bank, N.A. v. Ohio Cas. Ins. Co.*,<sup>43</sup> the court partially granted the insured’s motion to dismiss in a case involving insurance coverage for bank fraud under a financial institution bond. In this case, a customer of the insured bank issued a check

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<sup>41</sup> 185 S.W.3d 225 (Mo.App.E.D. 2006).

<sup>42</sup> 2005 WL 3107697 (W.D.Mo. Nov. 18, 2005).

<sup>43</sup> 2006 WL 1371674 (D.Minn. May 15, 2006).

for \$91,432 to an individual, but the customer stopped payment on the check. Two weeks later, an imposter acting as an authorized officer of the customer called the bank, offered the customer's wire transfer authorization code, and requested a wire transfer of \$88,132 to the same individual. The insured made the transfer. When the customer later denied authorizing the transfer, the bank reimbursed the customer. The insured then asserted a claim for coverage under Insuring Agreement (D) or under a stop payment coverage, as well as claims for unjust enrichment, misrepresentation, consumer fraud, and deceptive trade practices.

The insurer moved to dismiss the case for failure to state a claim upon which relief could be granted. While the court denied the motion as to the breach of contract and deceptive trade practices counts, it granted dismissal on the other counts.

The court side-stepped the problem of the telephone wire transfer instruction, which clearly was not a forged or altered document within the meaning of Insuring Agreement (D), by reasoning that the telephone wire transfer instruction and the earlier check were part of a single fraud. And, even though the check was neither forged nor altered, the court stated that, “[a]ssuming that the wire transfer and the check were related, it is possible that the check could have been ‘altered’ by a telephonic wire transfer request.”

Under the stop-payment provision of the policy, the insurer was obligated to indemnify the bank when it appropriately honored the stop payment order. The court found that, “the check and the wire transfer may be viewed as part of the same fraudulent transfer. Thus, Ohio Casualty [the court presumably meant the bank] may have improperly disregarded the stop-payment request when it honored the wire transfer two weeks later, making it liable for related losses.”

Additionally, the court denied the motion to dismiss as to the deceptive trade practices count because the insurer deprived the bank of “the services it had contracted for – namely that the terms of the bond would be interpreted fairly and evenly.”

## **XXV. Rescission**

In *In re Tri-State Armored Services, Inc.*,<sup>44</sup> the bankruptcy court held that the debtor's fidelity insurer was entitled to rescind its policies. In this case, the insured serviced automated teller machines (ATMs) by placing monies sent to it from various banks into the appropriate ATMs. The misappropriation of the banks' funds were carried out by the owners, officers, and employees of the insured, in order to the pay operating expenses of the insured and for their personal use. The policies' applications called for a description of all losses over \$5,000 and required the insured to disclose its losses regardless of whether or not they were filed as claims or losses that were covered.

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<sup>44</sup> 332 B.R. 690 (Bankr. D. N.J. 2005).

The insured failed to list any losses or occurrences even though it, and the officers who signed the applications, were aware of the diversions. In an exhaustive, 95 page opinion, the bankruptcy court held such untruthful answers were grounds to void the policies *ab initio*. Further, the court held that the insured did not deal fairly with the insurer in the disclosure of “facts material to the risk” and that the insurer reasonably relied on its untruthful answers in issuing the policies. Finally, the court dismissed various bad faith, consumer fraud, and spoliation of evidence claims against the insurer because the rescission of the policies provided no contractual basis for the claims or no damages from the alleged wrongful acts.

In *In re Payroll Express Corp.*,<sup>45</sup> the broker for Tri-State Armored Services, Inc., Marshall & Sterling, was also the broker for Payroll Express Corporation. In this case, similar to *In re Tri-State*, the bankruptcy court held the insurer liable for the liability limits of its policies and other damages as a result of the insurer’s actions. Specifically, the court held the insurer: (i) liable for negligence in procuring coverage and failure to fulfill its duties regarding Payroll Express’ applications; (ii) liable for misrepresentation; (iii) was required to return to Payroll Express all premiums, fees and commissions paid to it in connection with the Lloyd’s policies from 1989 to 1992; (iv) must perform an accounting to determine the amount of premiums, fees and commissions owed to Payroll Express; and (v) liable for \$21,000,000, representing the amount due Payroll Express under the Lloyd’s policies that Marshall & Sterling was hired to obtain, but failed to procure.

## **XXVI. Statutory Bond**

In *Kansas Bankers Surety Co. v. Farmers State Bank, Yale, IA*,<sup>46</sup> the court held that factual issues precluded summary judgment for either party. In this case, a former bank employee made loans that were not repaid. The insured asserted a claim under Insuring Agreement (A). The court held that because the bond was secured in an effort to comply with an Iowa statute, the statute controlled. However, the court also reasoned that manifest intent, which it interpreted under a “results substantially certain to follow” standard, was consistent with the Iowa statute’s requirement of coverage for fraud and dishonesty. While the insured argued for faithful performance coverage, the court recognized an intent component to fraud and the other violations mentioned in the statute. The court reasoned that the financial benefit provision of the bond was a stickier question, and followed federal precedent on a similar state statute and decided it did not conflict with the statute. Additionally, based on a state court decision finding no improper personal benefit to the employee in connection with one group of loans, the court rejected the insurer’s argument for collateral estoppel.

## **XXVII. Punitive Damages & Bad Faith**

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<sup>45</sup> 2005 WL 2438444 (Bankr. S.D.N.Y. March 30, 2005). See *In re Payroll Express*, 186 F.3d 196 (2d Cir. 1999).

<sup>46</sup> 408 F.Supp.2d 751 (D. Iowa 2005).

In *Federal Ins. Co. v. HSPC, Inc.*,<sup>47</sup> the court discussed the Massachusetts statutes on unfair claim settlement practices<sup>48</sup> and unfair business practices<sup>49</sup> in the context of an employee dishonesty claim. In this case, the policy application requested information as to whether employees, who were authorized to reconcile monthly bank statements, were also authorized to “either sign checks, handle deposits or have access to check signing machines or signature plates.” The insured, HSPC, Inc. (HSPC), simply answered “no” to the application question. In fact, the dishonest employee did have signing authority and had reconciled one petty cash account. But, while the insurer, Federal Insurance Co. (Federal), initially believed the employee had dual authority over all the involved accounts, it failed to follow up with the insured to obtain more information or to clarify the insured’s position on the account reconciliation issue.

The insurer later filed a declaratory judgment action seeking to rescind the policy and for a determination that the loss was not caused by “theft.” The latter claim was voluntarily dismissed. Four months after the suit was filed, the insured’s attorney advised the insurer that the employee had reconciled only the one account. Ultimately, the jury determined that the misrepresentation as to the one petty cash account bore no “materiality of any increase in risk.” Additionally, the court ruled on the issues of the unfair claims practices and unfair business practices claims.

The court held that: (1) the insurer’s initial determination that the insured’s misrepresentation relieved it of liability for the claim was “based on a good faith, albeit mistaken,” understanding of the facts; (2) the insurer’s decision to file suit seeking rescission without asking for the insured’s response or further investigation violated its obligation under the unfair claims practices statute to conduct “an investigation based upon all available information” before rejecting a claim; (3) the insurer’s failure to make a reasonable settlement offer after it learned that “the fundamental premise of its lawsuit was erroneous,” – that the employee reconciled only the one account – was a violation of its obligation “to effectuate prompt, fair and equitable settlements of claims;” (4) the insurer’s breach of its statutory duties constituted an unfair business practice; (5) as a result of the insurer’s breach, the insured was denied the \$1 million due under the policy; (6) the insurer’s conduct, “while not motivated by dishonest purpose, spite or ill will” was, after it learned that only the one account was misrepresented, “a knowing or willful breach of its duty of good faith.” Lastly, the court awarded the \$1 million policy limit (though the loss substantially exceeded the limit) plus attorneys fees and costs. It also held that attorneys fees and costs incurred subsequent to when the insurer learned that only the one account was misrepresented, would be treated as “actual damages” (the \$1 million plus the actual damages portion of the attorneys fees and costs), and that “[t]he total of actual damages will be doubled in calculating a final award.”

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<sup>47</sup> 2005 WL 2206071 (D. Mass. Sept. 12, 2005).

<sup>48</sup> MASS. GEN. LAWS ch. 176D § 3 (2005).

<sup>49</sup> MASS. GEN. LAWS ch. 93A § 11 (2005).

## **XXVIII. Salvage**

In *Federal Ins. Co. v. Gusmano*,<sup>50</sup> a subrogated fidelity insurer filed a three count complaint against a dishonest employee and her co-conspirators for fraud/conversion, RICO violations, and constructive trust. The insurer asserted that the employee caused the employer to overpay her co-conspirators for services never performed on items which were never manufactured. In return, the co-conspirators paid the employee slightly more than half the money as a kickback. The defendants asserted that they were paid to verify, as a third party, the quality of the employer's products shipped to Daimler Chrysler. But, while they never performed any actual verifications, they undertook liability to Daimler Chrysler if any of the parts would have been discovered to be defective. The defendants were paid \$25 per 1,000 parts (the insurer showed that they charged others \$6 to \$7 per 1,000 parts), and were paid for 25,000,000 parts even though only approximately 5,000,000 were produced. The defendants characterized the kickback as an interest free loan.

The insurer voluntarily dismissed the suit against the employee (likely because of a settlement), and moved for summary judgment on the constructive trust issue. The remaining defendants moved for summary judgment on all counts. The court granted the remaining defendants summary judgment on the fraud count for want of evidence that they made any representation to the employer. Further, the court denied the other summary judgment motions because of genuine issues of material fact. The court's opinion discussed at length the necessary requisites for proving each theory of liability.

In *Continental Cas. Co. v. Slonchka*,<sup>51</sup> a dishonest workers' compensation claim adjuster stole \$644,976 from his employer in 253 separate transactions over a five year period through the use of fraudulent checks. A fidelity insurer for the employer paid its portion of the loss and then filed suit against the former employee for fraud and RICO Act violations. The court denied the defendant's motion to dismiss the second amended complaint for failure to state a claim upon which relief could be granted. The court went on to detail the necessary elements to be pled in a fraud or RICO complaint, and found the insurer to have satisfied each requirement.

In *Simon Mktg, Inc. v. PricewaterhouseCoopers, L.L.P.*,<sup>52</sup> the plaintiff entered into a contract with McDonald's to design and administer promotions. The plaintiff's director of security was supposed to distribute the high-value game pieces (some worth as much as \$1 million). Instead, he managed to embezzle some of the pieces, and consequently, the plaintiff lost its contract with McDonald's. The suit alleged that PricewaterhouseCoopers was retained to supervise the dishonest employee's work, which included his handling of the high-value game pieces. The trial court dismissed the third amended complaint without leave to amend. However, the Court of Appeals reversed the lower court, and held that the complaint was sufficient to allege a breach of contract. Moreover, the court enunciated that the director of security's knowledge could

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<sup>50</sup> 2005 WL 1541098 (E.D. Mich. June 30, 2005).

<sup>51</sup> 2005 WL 2176834 (W.D. Pa. Aug. 18, 2005)

<sup>52</sup> 2005 WL 2293031 (Cal. App. Sept. 21, 2005).

not be imputed to the plaintiff. While there is no mention of a fidelity insurer, the decision is a persuasive precedent for subrogation suits against an insured's accountants.

In *Fidelity & Deposit Co. of Maryland v. Bizette*,<sup>53</sup> the court held that because stolen funds gained by a dishonest employee were deposited in a joint account and used for the benefit of the "community" created by marriage under Louisiana law, the husband was jointly liable for the funds. Additionally, the court concluded that "although [the] husband was not aware of his wife's embezzlement, nor that such funds were placed into their joint account, obligation to repay such funds was a community obligation under Louisiana law where there was no evidence of a matrimonial agreement and husband did not show that he did not receive any benefit from the funds."

In *Guyton v. Colonial American Cas. & Surety Co.*,<sup>54</sup> the court, basing its decision on statute of limitation grounds, reversed summary judgment for the insurer and entered summary judgment for the allegedly dishonest employee. In this case, after the insurer had paid the insured for losses caused by its former employee, the insurer took an assignment of the repayment from the employee in May 1997. Though the employee had agreed to repay \$30,886.75 by making payments of \$300 per week, he stopped after only having made a few payments, and the insurer brought suit. The court held that the four year limitations period ran separately for each installment. Because the last installment was due not later than June 18, 1999, the suit, which was filed in October 2003, was barred.

In *Continental Cas. Co. v. Fifth/Third Bank*,<sup>55</sup> the court conducted a careful analysis of a depository bank's responsibility for losses caused by the conversion of checks payable to an employer and deposited into the dishonest employee's bank account. The insurer paid its policy limit, and under a subrogation claim, sued the bank that accepted the deposited checks. The court rejected the bank's argument that the insurer was a volunteer and thus, not entitled to subrogation. The court held that the "voluntary payment doctrine" did not bar conventional subrogation, nor was it necessary for the insurer to force the insured to litigate its claim in order to assert subrogation rights.

The bank asserted defenses pursuant to U.C.C. § 3-405 (fraudulent endorsement by an employee with responsibility for checks) and U.C.C. § 3-406 (negligence contributing to forged signatures). The bank sought to apply comparative fault under the two sections to defeat all or part of the claim.

The court reasoned that sections 3-405 and 3-406 were not a defense for ten of the checks that had missing or illegible endorsements and another 127 checks that had restrictive endorsements permitting deposit only into the agency's account. The missing

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<sup>53</sup> 415 F.Supp.2d 673 (M.D.La. 2006).

<sup>54</sup> 2006 WL 412696 (Tex.App. 2006).

<sup>55</sup> 418 F.Supp.2d 964 (N.D.Ohio 2006).

or illegible endorsements were not forgeries, and the restrictive endorsements were not effective as the payee's endorsement. Additionally, U.C.C. § 3-206 imposed liability, without a comparative fault defense, for taking the checks in violation of restrictive endorsements. Accordingly, the court granted summary judgment for the insurer on those 137 checks.

However, the court held that sections 3-405 and 3-406 did apply and issues of fact precluded summary judgment on the remaining 142 checks which had forged endorsements, but not restrictive endorsements. The court denied the insurer's summary judgment motion as to those 142 checks and denied the bank's motion in its entirety.

In *Hartford Fire Ins. Co. v. Spall*,<sup>56</sup> the insured submitted a proof of loss for \$411,262.99 and the insurer paid the \$150,000 policy limit, in exchange for an executed "Full Release and Partial Assignment." Later, the insured settled with the dishonest employee for \$325,000. The insurer then sued the insured and the employee, and the court granted summary judgment dismissing the insured's claim. The insurer asserted that the Recoveries section of the policy and the Release assigned all recoveries to the insurer. While the court held that the insured retained the right to recover for losses in excess of the limit of liability, the Release subrogated the insurer to the insured's rights only to the extent of the \$150,000 payment.

Alternatively, the insurer argued that the total recoveries exceeded the \$411,262.99 set forth in the proof of loss. However, the insured submitted affidavits that his actual loss was greater than the total recovery, and the insurer failed to proffer anything in the record to contest that fact. The court held that the insured was not bound by the proof of loss submitted and was permitted to offer evidence of the actual amount stolen by the employee. Additionally, there is no mention in the opinion of any argument that the insured's settlement with the employee prejudiced the insurer's rights against her.

In *Continental Cas. Co. v. Compass Bank*,<sup>57</sup> the insured, a chain of funeral homes, was induced by its employee to issue approximately 1300 fraudulent checks over a span of six years, by falsely representing that they were for customer refunds. The employee then forged the payees' endorsements on the checks and deposited them into her personal account at the bank. The insured filed claim under its policy, the insurer paid the \$915,971 loss and then sued the bank.

The insurer asserted claims under the Alabama versions of U.C.C sections 3-405 and 3-406 and added separate counts for "money had and received," aiding and abetting a breach of fiduciary duty, and conversion facilitating a breach of fiduciary duty. Additionally, the insurer requested punitive damages under each count. The bank moved for partial summary judgment on the statutory count and summary judgment on the other claims.

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<sup>56</sup> 2006 WL 538938 (M.D.Pa. Mar. 3, 2006).

<sup>57</sup> 2006 WL 566900 (S.D.Ala. 2006).

The bank asserted that the three year limitation under the U.C.C. § 3-118 barred, save the last few months of the fraudulent scheme, any recovery for the claims. However, the court found that there were issues of fact regarding the application of the Alabama fraudulent concealment statute, which, if applicable, would toll running of the limitation period. Accordingly, the court denied the bank's motion for partial summary judgment on the claim under sections 3-405 and 3-406.

As to the second count for "money had and received," the court denied the bank's motion for summary judgment as premature because disputed issues of fact remained regarding what the bank still held, even if the bank was correct that mere collection of the funds was not sufficient to support the count.

Finally, the court granted the bank's motion for summary judgment regarding the remaining counts because there was no Alabama cause of action for aiding and abetting a breach of fiduciary duty, and the U.C.C. provisions have displaced any common law conversion claim. The court also dismissed the insured's claims for punitive damages because the U.C.C. does not permit an award of punitive damages for such claims.

In *Interior Crafts, Inc. v. Leparski*,<sup>58</sup> the court affirmed summary judgment for the insurer and held a bank strictly liable in conversion for failing to honor a restrictive endorsement on stolen checks deposited into its automated teller machine (ATM) by the dishonest employee.

In this case, the employee took checks payable to the insured, Interior Crafts, and endorsed them "for deposit only." He later deposited the checks into Pan American Bank's ATM with a deposit slip for the employee's personal account at Marquette Bank. Pan American had no way of knowing whether the name on the account at the depository bank matched the name of the payee on the check. But, while the deposit slip did not contain the Marquette Bank account holder's name, Pan American wire transferred the deposits to Marquette with instructions to credit the designated account, and then sent the checks through regular channels for collection. The insured and subrogated insurer sued the dishonest employee and both banks.

Under U.C.C § 3-206, liability for conversion arises against a "depository bank" that accepts a check with a restrictive endorsement if the proceeds are not credited in accordance with the endorsement. "Depository bank," as defined by the U.C.C. and Illinois code, is "the first bank to take an item even though it is also the payor bank, unless the item is presented for immediate payment over the counter." Under this definition, Pan American was the depository bank. Pan American argued that that U.C.C. definition conflicts, and is therefore preempted by, the federal regulation, 12 C.F.R. § 229.2(o), which states a: "[d]epository bank means the first bank to which a check is transferred even though it is also the paying bank or the payee. A check deposited into an account is deemed to

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<sup>58</sup> 2006 WL 1980108 (Ill.App. July 11, 2006).

be transferred to the bank holding the account into which the check is deposited, even though the check is physically received and endorsed first by another bank.”

Under that definition, Marquette could have been the depository bank even though it never received the check. However, the court rejected this argument, and held that the federal regulations were not intended to preempt the U.C.C. law of negotiable instruments.

Additionally, the court rejected Pan American’s argument for the applicability of comparative negligence. While U.C.C. §§ 3-405 and 3-406 permit a comparative negligence defense to liability based on a forged endorsement, a depository bank is strictly liable under § 3-206 for failing to honor a restrictive endorsement. Here, the court held that Interior Crafts, and not the dishonest employee, was the restrictive endorser, and that liability is based on the failure to honor the restrictive endorsement, and does not depend on who made the endorsement.

## **XXIX. Territorial Condition**

In *Bulk Pack, Inc. v. Fidelity & Deposit Co. of Md.*,<sup>59</sup> the territorial condition in the commercial crime policy limited coverage to “acts committed or events occurring within the United States of America, U.S. Virgin Islands, Puerto Rico, Canal Zone, or Canada.” In this case, an employee of the insured’s Mexican subsidiary caused excess funds to be sent to the insured’s account in Mexico, and later embezzled those funds by transferring them to his personal account. Since some of the process had occurred in the United States, and because an employee in the United States participated by sending the requested funds, the insured argued that the policy did not bar coverage. However, the court reasoned that because “there has been no allegation of dishonesty on the part of” the employee in the United States, and because that employee did not collude with the dishonest employee, the acts did not, for the purposes of this case, occur within the United States. Accordingly, the court affirmed summary judgment for the insurer and stated, “The dishonest acts – the request for inflated funds and the transfer of money from Bulk-Pack de Mexico’s Mexican Bank account to Garcia’s personal account – both occurred in Mexico.”

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<sup>59</sup> 163 Fed. Appx. 298 (5th Cir. 2006).