

**NINTH ANNUAL
SOUTHERN SURETY AND FIDELITY CLAIMS
CONFERENCE
APRIL 23 - 24, 1998**

RECENT DEVELOPMENTS IN FIDELITY LAW

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A. Interpretation of Fidelity Bond Terms and Conditions

1. Discovery and Notice of Claim

a. Newpark Resources, Inc. v. Marsh & McLennan of Louisiana, Inc.¹ involved the question of when “discovery” of a claim took place. Newpark Resources had comprehensive crime policies in effect from January 1, 1977 until January 1, 1985. Thereafter, Aetna issued a blanket crime policy effective January 1, 1985. The dishonest acts complained of were set forth in a lawsuit filed in 1982 against a subsidiary of Newpark Resources alleging that the subsidiary, through one of its employees, had engaged in deceptive acts and practices. In 1986 an amended petition was filed naming the employee as a defendant. A jury eventually returned a verdict against Newpark, which then submitted a claim to Aetna. Aetna denied coverage of the claim because subsidiaries were not covered by the policy. This suit was filed by Newpark Resources against Newpark’s insurance agent for failure to procure coverage for Newpark’s subsidiaries.²

The blanket crime policies required that the insured provide the insurer with prompt notice of any claims asserted against the insured, as well as notice of any occurrences that may potentially cause the insured loss. The court found that the initial petition filed in 1982 identified the employee and the actions he took which gave rise to the lawsuit. Thus, the court held that Newpark discovered the claim at that time, not in 1986 when the petition was amended to add the employee as a named defendant. Since discovery occurred during the period in which INA provided coverage, Newpark could not “discover” the claim again during the Aetna policy period.³ Thus, Newpark’s agent could not be held liable for failure to obtain the requested coverage during the Aetna policy period.

b. Similarly, in USF&G v. Maxicare Health Plans and Maxicare Louisiana, Inc.,⁴ the question of when discovery took place for purposes of a “Loss Sustained During Prior Insurance” clause in a commercial crime policy was at issue. USF&G filed this suit seeking a declaration that no coverage existed for Maxicare’s claims regarding the alleged dishonesty of Maxicare’s former vice-president and general manager in connection with a contract he negotiated with Denta-Max to provide dental coverage to members of Maxicare. Under USF&G’s policy, no coverage was provided for losses discovered under prior policies and before the effective date of the USF&G policy. The court determined that in order to constitute discovery under the terms of the policy, the insured had to have knowledge of dishonest acts which would lead a reasonable person to infer that a loss had been suffered.⁵ The court found that the facts indisputably established that Maxicare had discovered its loss during the previous policies. It found that prior to the issuance of USF&G’s commercial crime policy, Maxicare had knowledge of a substantial discrepancy between the supposed contract price and the actual amount paid, resulting in considerable losses. Second, that Maxicare learned that its former officer had been a co-owner of Denta-Max and had sold his shares of stock a few weeks after negotiations between Maxicare and Denta-Max started. Finally, Maxicare knew that its former officer had not advised Maxicare of his prior involvement with Denta-Max.⁶ Consequently, the court granted USF&G’s motion for summary judgment.

c. In Community Savings Bank v. Federal Insurance Company,⁷ the court granted summary judgment in favor of Federal Insurance Company (“Federal”), the issuer of a financial institution bond, for the failure of Community Savings Bank (“CSB”), its insured, to timely notify Federal of its losses. The court determined from the minutes of a board of directors meeting that CSB was aware of the dishonesty of its president by August 22, 1990 and that notice of its intent to file a claim given in September of 1992 was not timely under Section 6a of the bond.⁸ Section 6a requires notice at the earliest practicable date, not to exceed thirty days after discovery of the loss. The court held that “[t]he timely giving of notice and filing of a proof of loss are conditions precedent to coverage, and the insured’s failure to comply with the notice provisions is a complete defense to a bond claim.”⁹ The court also held that the insurer did not have to demonstrate prejudice in order for late notice or a late proof of loss to constitute a defense to coverage.¹⁰

d. Prejudice, however, had to be shown by USF&G in Winthrop and Weinstine, P.A. v. Travelers Casualty and Surety Company.¹¹ In that case, USF&G issued three successive employee dishonesty policies to Winthrop covering the periods February 1, 1990 to February 1, 1991 (“Period 1”), February 1, 1991 to February 1, 1992 (“Period 2”), and February 1, 1992 to February 1, 1994 (“Period 3”). Thereafter, employee dishonesty coverage was provided by Aetna, now Travelers. On July 5, 1994, Winthrop discovered that one of its former employees had stolen money in June of 1994 by altering the “payee” on Winthrop checks. A proof of loss was filed with Aetna documenting the fact that the former employee had altered the “payee” on twenty-three checks between September 1993 and June 1994. USF&G was not notified of the loss. Aetna paid the claim of \$47,330.51 and obtained an assignment of all of Winthrop’s rights against the former employee. On January 3, 1995, Winthrop learned that additional checks had been altered by its former employee and it filed a second proof of loss with Aetna on April 5, 1995 documenting losses incurred between July 31, 1993 and May 23, 1994. Aetna paid the loss of \$82,994.88. USF&G was not notified of any loss before the expiration of the one-year discovery window on February 1, 1995. In June of 1995, Winthrop learned of additional losses as a result of the dishonesty of its former employee. An accounting firm hired by Winthrop uncovered an additional 153 checks going back as early as 1990 and totaling \$215,781.01. On November 13, 1995, Winthrop provided proofs of loss to both Aetna and USF&G. Winthrop failed to notify any bank that the checks had been altered.

USF&G moved for summary judgment following the institution of this suit by Winthrop. USF&G argued that Winthrop’s claim was barred because it did not discover and provide notice of the loss as required by the policy. USF&G argued that the policy was a claims made policy, not an occurrence policy, and that it was not required under Minnesota law to show prejudice as a result of the late notice. After reviewing the policy, the court concluded that the policy was not a claims made policy and that USF&G had to establish prejudice.¹² The court, however, concluded that USF&G had been prejudiced by the late notice. It observed that Winthrop had assigned all of its rights against its former employee to another insurance company and had foreclosed any right of recovery against the banks that paid the altered checks by failing to notify them of the alterations.¹³ The court also held that under Minnesota law a finding of actual prejudice was a complete bar to recovery, rejecting Winthrop’s argument that the amount lost by their failure to notify the banks in question should act only as a deduction. Thus, the court found summary judgment in favor of USF&G to be appropriate.¹⁴

Travelers also moved for summary judgment. With the exception of the “Loss Sustained During Prior Insurance” provision, the Travelers policy provided coverage only for losses incurred while its policy was in effect. It argued that it was not responsible for losses which were incurred during the USF&G policy periods but discovered during the effective period of its policy. The court agreed that under the “Loss Sustained During Prior Insurance” clause of its policy there was no coverage for losses incurred during the first two policy periods covered by the USF&G policies because that clause applies only when the Travelers’ insurance becomes effective at the time of cancellation or termination of the prior insurance. In this case, the Travelers policy did not go into effect until after the third USF&G policy.¹⁵ Travelers also argued that it had over paid Winthrop on the first proof of loss because six of the altered checks were loss items incurred during USF&G’s prior policy period. The court, however, held that it would be inequitable to reduce the amount owed by Travelers by the amount it had erroneously paid Winthrop. The court noted that because Travelers paid the claim, Winthrop had no reason to notify USF&G of the loss. If it had denied the claim, Winthrop likely would have notified USF&G. It was now too late as USF&G had established that it had been prejudiced by the late notice. The court, however, was careful not to find Travelers estopped. It noted that under Minnesota law insurance coverage cannot be enlarged by the doctrine of estoppel.¹⁶

e. The court in Bank Saderat Iran New York Agency v. National Union Fire Insurance Company of Pittsburgh, PA.¹⁷ affirmed a lower court ruling that under the “single loss” discovery and notice provisions of the bond in question, additional proofs of loss submitted for additional losses caused by the same employee and discovered some two years after the initial proof of loss was submitted were untimely. The bond provided that all dishonest transactions involving a particular employee are considered as a single loss for which proof of loss had to be given within six months of discovery of the employee’s dishonesty.¹⁸

f. Applying Massachusetts law, the First Circuit in Federal Deposit Insurance Corporation v. Insurance Company of North America,¹⁹ refused to extend the notice prejudice rule to a financial institution bond. After concluding that the bank’s notice of a potential loss from employee misconduct was given more than thirty days after discovery and therefore untimely, the court was required to determine whether the common law notice-prejudice rule applied by Massachusetts to liability policies also should be applied to financial institution bonds.²⁰ After analyzing Massachusetts law and noting the differences between the bond and liability insurance, and after determining that the policy considerations underlying the notice prejudice rule of protecting the consumer with no bargaining power are not applicable to a financial institution bond, the court refused to apply the rule to the bond.²¹

2. Direct Loss

a. The court in ITT Hartford Life Insurance Company v. Pawson Associates, Inc.²² held that the insured’s liability to a third party which resulted from the dishonesty of the insured’s employee was not a direct loss under the fidelity bond in question. The facts reveal that the insured, an insurance agency, had a sales agreement with ITT to sell annuity contracts and that one of its employees retained the annuity premium payments on five annuity contracts he purportedly sold. ITT reimbursed the buyers after learning of the theft of the agency’s employee. The agency refused to reimburse ITT and ITT brought this suit. The agency filed a third party

demand against Aetna, issuer of a fidelity bond, seeking indemnification for any judgment that may be rendered against it. Aetna successfully argued that the withholding of ITT's annuity payments caused no direct loss to the insured agency.²³ The court observed that the bond in question was a contract of indemnity against loss, not a contract against liability. The fact that the insured may be held liable to a third party for a loss of money resulting from employee dishonesty does not convert the policy from one insuring against a direct loss to one indemnifying against liability.²⁴ The insured will suffer a loss only if it is held liable to ITT. The conditional nature of the loss indicates that the insured has not suffered any direct, covered loss from its employee's actions. Rather, it might suffer an indirect loss if ITT is successful.²⁵

b. The court in United Security Bank v. Fidelity & Deposit Company of Maryland²⁶ refused to interpret the phrase "loss resulting directly from" in a fidelity bond as including "loss proximately caused by". The court concluded that "direct loss" is much narrower than proximately caused loss. Consequently, the expenses incurred by the bank after its employees violated an IRS levy were not covered by the bond.²⁷

[Note: This opinion is not appropriate for publication and can be cited to courts in the Ninth Circuit only as provided in R. 36-3].

3. Definition of Employee

a. The court in Transit Management of Southeast Louisiana, Inc. v. Group Insurance Administration, Inc.²⁸ held that the fraudulent actions of a 95% stockholder who also was the sole director of the insured corporation were the actions of the corporation, not those of an employee under the Chubb policy at issue in that case.²⁹ Consequently, there was no coverage under the policy and summary judgment was granted in favor of Chubb.

b. In re Payroll Express Corporation,³⁰ was a suit brought by the Chapter 11 trustee of the estate of Payroll Express Corporation ("PEC") against Aetna and a group of London Excess Underwriters ("LEC"), issuers of various dishonesty and crime policies. The facts disclose that Barbara and Robert Felzenberg were the sole shareholders of PEC and Robert Felzenberg was its founder, president and chief executive officer. PEC operated a payroll check cashing service. Customers of PEC transferred funds representing their payroll for a particular period of time into PEC bank accounts. These funds were used by PEC to handle the on-site distribution of cash in exchange for endorsed payroll checks. Funds representing checks which had not been cashed were to be returned to customers. Robert and Barbara Felzenberg began diverting customer funds for their own benefit and for the benefit of other companies they controlled as early as the mid-1980's. Over a several year period of time, PEC suffered millions of dollars in losses as a result of the dishonesty of the Felzenbergs. Initially, their dishonesty involved their failure to return unused funds. Later, they engaged in a massive check-kiting scheme.

Among the issues in this case was who was an employee for purposes of Aetna's 3D Policy. The plaintiff did not seek coverage for losses caused to PEC by Robert Felzenberg. It did, however, seek to recover the losses caused by Barbara Felzenberg and other dishonest employees. Aetna argued that both Robert and Barbara were the alter egos of PEC and therefore not employees. The court rejected Aetna's alter ego defense, finding that Aetna had failed to

demonstrate that PEC had no other purpose than to further the personal interests of the Felzenbergs. The court found that PEC had functioned as a legitimate business for over 20 years and it could not be said that it had been reduced to a mere instrumentality for the transaction of the Felzenberg's own affairs.³¹

Although the court refused to pierce the corporate veil, it followed the unopposed majority rule that an employee is an individual whom the corporation has the right to govern and direct. The court found that because Barbara Felzinberg dominated and controlled PEC and because no one at PEC governed and directed her in the performance of her services, Barbara was not an "employee" as defined by the Aetna policy and therefore granted Aetna's motion for summary judgment as to Barbara.³² As to some of the other employees, however, the court refused to grant Aetna's motion, finding material issues of fact as to whether they caused losses covered by the policy.³³

4. Fraudulent or Dishonest Acts

a. Manifest Intent

The issue of manifest intent to cause harm to the insured was also in question in Peoples Bank & Trust Company of Madison County v. Aetna Casualty & Surety Company.³⁴ In that case, two directors of a bank who had an ownership interest in a failing business offered a finders fee to the executive vice president of the bank if he found a buyer for the business. The executive vice president convinced two customers of the bank to purchase the business. He then offered to share his finder's fee with the president of the bank if the bank loaned the customers the money to purchase the business. The president agreed to the loan, but not without first obtaining a small business administration guarantee for 90% of the loan.³⁵ The business failed and the purchasers were eventually discharged in bankruptcy. When the facts came to light, the small business administration sought reimbursement from the bank. The bank notified the issuer of the Standard Form 24 policy in place and eventually settled its claim. The bank thereafter replaced its policy with one issued by Aetna. Several years after the bank settled with the first insurer, the purchasers filed suit against the four bank executives and the bank. Both the previous insurer and Aetna denied coverage. After settling the suit with the plaintiffs, the bank brought this declaratory action against the insurers.³⁶

The district court found that the officers of the bank did not have the manifest intent to cause loss to the bank, particularly in light of the fact that they had obtained an SBA guarantee of the loan. Thus, it granted summary judgment in favor of the insurers and the bank appealed.³⁷ The appellate court agreed with the lower court that there was no manifest intent on the part of the officers to cause loss to the bank in connection with the loan. The court, however, noted that the bank was only seeking indemnification for the losses resulting from the filing of the lawsuit by the purchasers, not the losses incurred in connection with the default of the loan. The court nevertheless held that too many uncertainties and contingencies intervened between the time of the fraud and the filing of the lawsuit to conclude that the officers intended to cause a loss to the bank by way of an award of damages to the purchasers. It concluded that "there was no substantial certainty that a loss would flow to [the bank]."³⁸ The court observed that as a practical matter, "losses resulting from frauds on third parties will rarely be covered by Standard Form 24.

These policies will cover a loss suffered by a third party only where the dishonest employees intended to cause the third-party loss, and knew or expected that the loss would migrate to the bank.³⁹

b. Financial Benefit

i. The issue before the court in Auburn Ford Lincoln Mercury, Inc. v. Universal Underwriters Insurance Company⁴⁰ was the interpretation of the exclusion in a fidelity bond which limits recovery for employee dishonesty to situations in which the employee receives a benefit other than “salaries, commissions, fees, bonuses, promotions, awards, profit sharing, pensions, and other EMPLOYEE benefits earned in the normal course of employment.”⁴¹ In this case, the insured was a Ford Motor Company dealership. Its employee, Kears, managed the fleet sales program which provided government price concessions to qualified government agencies and corporations. Ford’s approval of the concessions was required. If Ford denied approval, the concession was charged back to the dealer. Substantial chargebacks were incurred by the insured as a result of the dishonest actions of Kears who allegedly entered incorrect state codes while applying for the concessions in order to offer customers lower prices. He also allegedly sold vehicles at concession rates to individuals who were not authorized to purchase them. Universal denied coverage on several grounds, including the fact that the only financial benefit to Kears was an increase in commissions. Such dishonest acts are excluded from coverage. The court agreed with Universal and granted summary judgment in its favor. The court noted that all courts considering this definition of dishonest and fraudulent acts have found it unambiguous and have excluded recovery for losses resulting from an employee’s intent to obtain the financial benefit of increased commissions.⁴²

ii. In a per curiam opinion, the Sixth Circuit in Insurance Company of North America v. Liberty United Bancorp, Inc.⁴³ affirmed a motion for summary judgment in favor of the insurer finding no coverage under the policy for losses incurred by the insured because of certain fraudulent acts of its employees. In affirming the decision, the court emphasized that the definition of manifest intent in the Sixth Circuit “does not require that an employee actually receive any personal monetary benefit in order to demonstrate the “manifest intent” required by the language of the bond; rather, the employee must simply have intended to receive such a benefit.”⁴⁴ The court was concerned that certain language in the district court opinion on this issue could be interpreted to the contrary and wanted to clarify the law in that circuit.

[Note: Not recommended for full-text publication].

iii. In Dickson v. State Farm Lloyds,⁴⁵ losses suffered from employees’ manipulation of a time card system in order to obtain additional wages were excluded by the manifest intent definition of the fidelity bond in question. The issue before the court was res nova in Texas so the court looked to cases in other states and found that when an employee has dishonestly or fraudulently obtained only salary or other similar employee benefits, other courts have found similarly worded policies to unambiguously exclude coverage. Thus, the court affirmed the grant of summary judgment in favor of the insurer.⁴⁶

5. Forgery

a. Federal Deposit Insurance Corporation v. Fireman's Insurance Company of Newark New Jersey⁴⁷ involved interpretation of a fraudulent mortgages rider to the Standard Form Number 22 Savings and Loan Blanket Bond. The court observed that the purpose of the rider is to indemnify financial institutions for losses incurred from the receipt of mortgage and similar instruments which are defective because a signature is obtained by fraud.⁴⁸ In this case, the FDIC, as successor in interest to an insured savings association, argued the ambiguity of the rider and attempted to show the reasonableness of its argument in favor of coverage by establishing that the signature of the savings and loan on the mortgages in question was obtained fraudulently by false representations made as to the nature of the liens securing the mortgages. Applying Texas law, the court found the rider to be unambiguous and upheld the summary judgment of the district court in favor of the insurer. The court held that an instrument does not automatically become defective because it contains a signature that was obtained by fraud. The court found that, although the mortgages were defective, the defect was not caused by the fraudulently obtained signatures.⁴⁹ "When the fact that the signature is fraudulently obtained has no impact on the instrument's value to the insured, as in the present case, the Rider does not provide coverage."⁵⁰

b. KW Bancshares, Inc. v. Syndicates of Underwriters at Lloyd's⁵¹ involved the application of Insuring Agreements (D) and (E) under a standard banker's blanket bond. Supporting a request for a loan of \$450,000 to an executive at a mortgage company, were several forged documents including a letter purportedly signed by the comptroller of the mortgage company which reflected the fact that the executive was entitled to an annual bonus of over \$800,000 out of which the loan would be repaid. The loan was made to the executive who signed a promissory note for the amount of the loan which was secured by an instrument assigning his bonus payment. The assignment of bonus, which provided that the executive had assigned a portion of his bonus to the bank and which also provided that the executive was to receive the bonus, was signed by the executive and by the comptroller of the mortgage company. The comptroller's signature on the assignment was genuine. The executive defaulted on the loan and when the bank sought to enforce the assignment of the bonus it learned of the forgeries and also that the executive was not entitled to receive a bonus.⁵²

The bank attempted to recover under Insuring Agreements (D) and (E). The court, however, held that the bank had failed to establish its right to recover under either insuring agreement. As to Insuring Agreement (D), the court held that the comptroller's letter, which was forged, could not be construed as written instructions or advices because the letter neither ordered nor directed the bank to do anything. Furthermore, the bank failed to establish that the mortgage company was a banking institution as defined in the bond.⁵³

The court also rejected the bank's argument under Insuring Agreement (E), finding that the bank's loss did not result directly from the forged comptroller's letter. The court found that even if the comptroller's signature on the letter had been genuine, the loss nonetheless would have occurred because the assets purportedly represented by the letter did not in fact exist. The letter was worthless, not because the signature was forged but because there were no assets. Thus, the court concluded that the bank's loss did not result directly from its having made the loan on the faith of the comptroller's letter.⁵⁴

The court also questioned the bank's argument that the comptroller's letter could be construed as an original security agreement, i.e. "an agreement which creates an interest in personal property or fixtures and which secures payment or performance of an obligation."⁵⁵ The letter had no value to the bank which is why it obtained the assignment of the bonus. It was the assignment, which was not forged, that created the interest of the bank in the alleged bonus.⁵⁶

6. Definition of Occurrence

The court in Maxicare Health Plans and Maxicare Louisiana, Inc. v. Reliance Ins. Co.⁵⁷ denied a motion for summary judgment filed by Reliance following institution of this suit by Maxicare for coverage under a crime policy issued by Reliance. Maxicare filed this suit after learning of the alleged dishonesty of Maxicare's former vice-president and general manager, Alan Preston, in connection with his negotiation of a contract between Maxicare and Denta-Max, a corporation in which Preston held 50% of the stock. The contract between Maxicare and Denta-Max was executed in December 1993 and became effective on February 1, 1994. Maxicare discovered the conflict of interest in June of 1995, however, the proof of loss stated that discovery occurred in November of 1995 when Maxicare obtained copies of six canceled checks issued to Preston by Denta-Max evidencing payments to Preston. Three crime policies were in effect during the period in which the events giving rise to this claim occurred. National Union Insurance Company issued a policy effective September 30, 1991 through September 30, 1994 with tail coverage for losses discovered through September 30, 1995. Reliance issued its policy effective September 30, 1994 through September 30, 1995 and included tail coverage for losses discovered within one year of the end of the policy. Finally, USF&G issued a policy effective September 30, 1995 through September 30, 1996. Reliance took the position that the acts giving rise to the loss did not occur during its policy period, September 30, 1994 to September 30, 1995, arguing that the agreement was signed in December of 1993. The court, however, disagreed. It found that the actions of Preston following execution of the contract raised an issue of material fact as to whether Preston committed a "series of acts" within the Reliance policy period that could constitute an "occurrence" under Section 13(b) of the policy.⁵⁸ Consequently, the motion for summary judgment filed by Reliance was denied.

7. Noncumulation Clause

In Landico, Inc. v. American Family Mutual Insurance Company.⁵⁹ the court held that coverage for an employee's dishonesty which occurred in two consecutive years was limited to \$100,000. The policy provided coverage of \$100,000 per occurrence. The non-cumulation provision of the policy provided that "[r]egardless of the number of years this insurance remains in force or the number of premiums paid, no Limit of Insurance cumulates from year to year or period to period."⁶⁰ During the first annual term, an employee embezzled \$47,424.48. The same employee embezzled \$102,697.88 during the second annual term. The plaintiff argued that the definition of occurrence was ambiguous in light of the fact that the policy provided coverage for acts occurring during the policy period which was defined as one year. The court, however, concluded that the policy was unambiguous and limited recovery for claims arising from one employee to the stated policy limit of \$100,000.⁶¹

8. Termination

a. In In re Payroll Express Corporation,⁶² the bankruptcy trustee of Payroll Express Corporation sought recovery under various crime policies, including a policy issued by Federal Insurance Company and the Chubb Group of Companies (collectively referred to as “Federal”). The Federal policy was issued effective February 7, 1986. Endorsements to the policy provided that no change or cancellation of the policy would be effective unless 45 days prior written notice was given by registered mail to the Department of Finance of the City of New York and the New York City Transit Authority, presumably both customers of Payroll, a company which provided check cashing services. On December 6, 1988, Payroll advised its broker that it did not intend to renew the Federal policy and sought, and later secured, identical coverage with Lloyd’s. On the same date, the CEO of Payroll purportedly sent by certified mail letters to the City and Transit Authority advising them of the change in insurance. The authorities, however, claimed that they never received notice and that the return receipt cards were fraudulent. On February 10, 1989 the Federal policy was canceled.

The trustee argued that the alleged failure to send notice to the City and Transit Authority had the effect of extending the time in which they could provide notice of loss by more than three years. The court, however, disagreed. First, neither Payroll nor the City loss payees paid any premiums after February 7, 1989 and they cannot recover a benefit for which Payroll never paid. Second, no applicable statute or contractual provision provided an automatic extension of coverage. The court noted that statutes which provide for automatic extensions contemplate the payment of additional premiums and no additional premiums were paid in this case. Finally, the court reasoned that the notice of cancellation is required to protect the insured from unwitting exposure to liability which was not the case here. Here, the insured initiated cancellation of the policy. Moreover, the City payees were not damaged even if they did not have notice because identical coverage was secured through Lloyd’s. The court noted that “[t]he spirit of the cancellation notice provision was followed even if the letter of the provision was not.”⁶³

b. The court in Community Savings Bank v. Federal Insurance Company⁶⁴ found that the president and chief executive officer of Community Savings Bank (“CSB”) had violated banking policies and federal regulations in connection with nine loans. It was also revealed in the minutes of a meeting of the Board of Directors of CSB held on August 22, 1990 that the Board was aware of the dishonesty of its president in connection with the first of the nine loans. Section 12aa of the bond terminates coverage as to any employee immediately upon discovery of the employee’s dishonesty. Since certain members of the board of directors of CSB, who were not in collusion with the president, knew of his dishonesty by August 22, 1990, coverage under the bond as to the president automatically terminated from that point forward.⁶⁵

9. Exclusions

i. The court in The Stop & Shop Companies, Inc. v. Federal Insurance Company⁶⁶ reversed a decision by the lower court which had concluded that the authorized representative exclusion in the Federal crime policy at issue was ambiguous. The facts giving rise to this case involved a scheme concocted by the executives of a payroll tax service company to steal checks earmarked for the IRS resulting in millions of dollars in losses to clients of the payroll service company. One of those clients was Stop & Shop. Stop & Shop had in place a crime insurance policy issued by Federal. The policy excluded coverage for loss due to the “theft or any other

fraudulent, dishonest or criminal act . . . by any employee, director, trustee or authorized representative of the Insured whether acting alone or in collusion with others’.”⁶⁷ Federal claimed that the clause barred coverage for the losses sustained by Stop & Shop. Stop & Shop argued that the authorized representative exclusion was inapplicable because the executives at Hamilton Taft diverted funds for their personal gain and not for the benefit of the company. The appellate court disagreed with Stop & Shop’s interpretation of the term “authorized representative”. It concluded that the exclusion covered all inappropriate use of funds irrespective of who benefits from the improper use.⁶⁸ The court reasoned that the policy underlying the exclusion clause is based on an effort to place on the insured the risk of selecting a faithless agent.⁶⁹ The court held that the exclusion specifically states that the policy does not cover theft by an authorized representative. It “does not restrict the scope of ‘authorized representative’ to acts benefitting Hamilton Taft, the record contains no evidence that such a restriction was contemplated, and no case law applies such a restriction.”⁷⁰ Having found that the diversion of funds by the officers of Hamilton Taft fell within Federal’s authorized representative exclusion, it reversed the decision of the district court.⁷¹

ii. In Golden Door Jewelry Creations, Inc. v. Lloyds Underwriters Non-Marine Association,⁷² the court was called upon to interpret a jeweler’s block policy. In this case, Lloyd’s issued a jeweler’s block policy to Sanford Credini, doing business as Golden Door Jewelry Creations, Inc. (“Golden Door”) and Suisse Gold Assayer and Refinery, Inc. (“Suisse”). Credini and his wife each owned 50% of the two companies. Both companies obtained their gold supplies from third parties. Leach and Garner Company (“Leach”) consigned refined gold to Golden Door. Westway Metals Corp. (“Westway”) consigned scrap gold to Suisse. Golden Door retained a warehouse to store the consigned gold which was stored in two safes on the property of Golden Door and Suisse. On February 10, 1983, Credini stole \$9,000,000 of goods from Golden Door, Suisse and the safes containing the consigned gold of Leach and Westway. In an attempt to conceal his theft, Credini initially filed a claim with Lloyd’s. At issue in this appeal, was whether certain policy exclusions precluded recovery by the consignors. The court, in a previous appeal of this case, had held that the “property insured” provision of the policy which included “[p]roperty as above described, delivered or entrusted to the Assured by others who are dealers in such property . . . but only to the extent of the Assured’s own actual interest therein because of money actually advanced thereon, or legal liability for loss or damage thereto,” led to the inescapable conclusion that the policy included coverage for the legal liability of the assured as a result of the loss of the property.⁷³ Thus, the court held that the consignors could recover against Lloyd’s provided recovery was not precluded by other policy provisions.⁷⁴ The court considered three exclusions that Lloyd’s argued precluded recovery. The court first noted that the policy provisions were severable. Thus, although Credini, Golden Door and Suisse were precluded from recovering their losses because of their failure to maintain an inventory of their property as required by the policy, the court found this provision inapplicable to the legal liability provision of the policy.⁷⁵ The court also rejected Lloyd’s argument that coverage was excluded by a provision which barred recovery where the loss is due to the dishonesty of the insured or one of its employees. It held that Credini was an officer, not an employee, finding that the policy distinguished between corporate officers and employees.⁷⁶ Finally, the court refused to impute the dishonesty of Credini to the insureds. Consequently, Lloyd’s could not rely on an exclusion which precludes coverage where a false or fraudulent claim is knowingly made.⁷⁷ Thus, the court held that the consignors were entitled to

recover their losses under the legal liability provisions of the policy and affirmed the summary judgment in their favor on the coverage issues.

10. Subrogation and Recovery

a. Fidelity & Deposit Co. of Maryland v. Gaspard⁷⁸ was a suit brought by F&D to recover \$251,250.52 it paid to its insured, C.F. Bean, following losses caused by the dishonesty of one of its employees. F&D sued not only the employee, but also her husband contending that \$28,702.88 of the insured's funds was deposited into the couple's joint account. F&D argued that the money deposited into the joint account represented a community obligation under Louisiana law for which the husband was solidarily liable. The court agreed. It applied the presumption contained in La. Civ. Code art. 2361, which the husband failed to successfully rebut, that all obligations incurred during the existence of a community property regime are presumed to be community obligations, and granted F&D's motion for summary judgment.⁷⁹

b. The facts giving rise to Lumbermens Mutual Casualty Company v. State of Iowa⁸⁰ present an interesting subrogation issue. An employee of the Iowa Department of Revenue and Finance, aided by her husband and friends, embezzled \$692,468 from the department. Lumbermens, the issuer of a fidelity bond covering employee dishonesty, paid the department \$592,468, the amount embezzled less the \$100,000 deductible. Thereafter, the department, in its capacity as taxing authority, recovered \$145,000 in taxes on the embezzled funds. Lumbermens then brought this declaratory judgment action for reimbursement under the insurance contract.⁸¹ The court held that the money collected by the department for delinquent taxes was not subject to Lumbermens' subrogation claim. As to the insurer's argument that the department had been unjustly enriched, the court reasoned that the department had suffered two losses: a direct loss of embezzled funds, and a loss of tax revenue on the embezzled funds. Lumbermens had only furnished coverage for the embezzlement loss and because the department had not been fully compensated for either loss, there had been no unjust enrichment.⁸² The court also refused to reduce the insurer's liability by the amount the department recovered on the embezzler's debts because none of the amounts recovered satisfied the department's direct loss from the embezzlement.⁸³ The court also held that the insurer's right of subrogation to all of the department's rights against the employee was limited to the department's rights as an insured employer against losses resulting from the actions of the dishonest employee. Thus, "any loss" was limited to only those losses covered by the policy.⁸⁴ The court also rejected Lumbermens' argument that by seizing the assets of the embezzlers, the department had impaired the insurer's right of recovery. The court noted that under the subrogation clause the insurer had only a right to seek recovery, not a right to recover. It noted that Lumbermens was still free to seek a judgment against the embezzlers or to pursue its subrogation rights in the event that recovery is made by the department for the direct loss of the embezzled funds.⁸⁵

11. Assignment

The court in Heritage Federal Credit Union v. Cumis Insurance Society, Inc.⁸⁶ enforced the assignment provisions of the bond in question. Cumis issued a credit union fidelity bond to the Greyhound Credit Union in 1976. After Greyhound was placed in liquidation, Heritage Credit

Union agreed to purchase the assets of Greyhound in August of 1991. Cumis sent the National Credit Union Administration, the liquidating agent for Greyhound, notice that the bond would be canceled effective December 31, 1991 because of the liquidation of Greyhound. Cumis, however, sent Greyhound a premium statement in January of 1992 extending the discovery period for losses for one year. Heritage, not Greyhound, paid the additional premium which Cumis accepted. After reviewing the Greyhound loan portfolio, Heritage submitted a proof of loss to Cumis under the bond. Cumis denied the claim on the basis of a provision in the bond which provided that the bond could not be assigned without the written consent of Cumis, which consent was never given. In Wisconsin insurance claims can be assigned without consent where the loss has already occurred. The court refused to apply that rule to this case, which involved a discovery bond, because no loss had been discovered at the time of the assignment.⁸⁷ Heritage argued that although Cumis had not consented to the assignment of the bond, by accepting the payment of an additional premium for the extended discovery period, Cumis had waived the assignment provision. The court disagreed. It held that although Cumis was aware of the liquidation of Greyhound and the identity of the liquidating agent that did not mean that Cumis knew that Heritage had purchased Greyhound's accounts from the agent or that it had waived its right to reject Heritage as an insured. There was simply no evidence to show that Cumis knew of the relationship between Heritage and Greyhound. Consequently, summary judgment in favor of Cumis was appropriate.⁸⁸

[Note: This case is of limited precedent and publication in the official reports was not recommended].

B. Waiver

_____ In Peoples Bank & Trust Company of Madison County v. Aetna Casualty & Surety Company,⁸⁹ the court rejected the insured's argument that the insurers were barred from asserting the absence of manifest intent on the basis of waiver and estoppel. Although the insurers each denied coverage for the loss in question on a single specific ground in the years 1985 and 1986, respectively, and did not raise any other defenses until this suit was filed in 1994, under Kentucky law, the insured had failed to show that it had been sufficiently prejudiced by the insurers' failure to raise this defense earlier. Thus, it could not support a claim for either waiver or estoppel.⁹⁰

C. Material Misrepresentations in Application

_____ Misrepresentations contained in an application for crime coverage were held material and the court voided coverage in In re Payroll Express Corporation.⁹¹ Suit was brought by the Chapter 11 trustee of the estate of Payroll Express Corporation ("PEC") against Aetna and a group of London Excess Underwriters ("LEC"), issuers of various dishonesty and crime policies. The facts disclose that Barbara and Robert Felzenberg were the sole shareholders of PEC and Robert Felzenberg was its founder, president and chief executive officer. PEC operated a payroll check cashing service. Customers of PEC transferred funds representing their payroll for a particular period of time into PEC bank accounts. These funds were used by PEC to handle the

on-site distribution of cash in exchange for endorsed payroll checks. Funds representing checks which had not been cashed were to be returned to customers. Robert and Barbara Felzenberg began diverting customer funds for their own benefit and for the benefit of other companies they controlled as early as the mid-1980's. Over a several year period of time, PEC suffered millions of dollars in losses as a result of the dishonesty of the Felzenbergs. Initially, their dishonesty involved their failure to return unused funds. Later, they engaged in a massive check-kiting scheme.

LEU issued three policies, a primary and two excess policies. In response to question 10 of the application for the policies which inquired as to whether PEC had suffered a loss during the last five years, Robert Felzenberg answered yes and explained that a burglar had stolen \$1.5 million from a safe in 1988. In truth, however, PEC had suffered 17 other theft and robbery losses totaling over \$3 million during the five years preceding the date of the application. Under New Jersey law, the court noted that a misrepresentation by an insured voids its rights under the policy "if it is untruthful, material to the particular risk assumed by the insurer, and reasonably relied upon by the insurer issuing the policy."⁹² The court further found that under New Jersey law a misrepresentation is material if it is "reasonably related to the estimation of the risk or assessment of the premium."⁹³ The court reasoned that common sense tells us that an applicant's loss history is material to a reasonable insurance company's decision on whether to insure an applicant and its determination of the premium. The court concluded that reasonable minds would not differ on the materiality of the misrepresentations made in this case and held them material as a matter of law.⁹⁴ The court also found that Robert Felzenberg's answer of "none" to question 36, a catch-all question asking for any information which is or may become material to the proposed insurance, provided additional grounds to void coverage. Although the court found that the question was broad and provided little guidance, it rejected the plaintiff's argument that the question was ambiguous. The court held that given the fact that the Felzenbergs had embezzled continuously for years and that Robert Felzenberg was aware that others who might fall under the proposed policy definition of "employee" had assisted him in his defalcations, it was "beyond cavil that Robert Felzenberg knew or should have known that knowledge of the existence of his scheme . . . would be reasonably related to LEU's calculation of the risk it would bear under the LEU Policies."⁹⁵

D. Bad Faith of Insurer

A claim for bad faith against the London Excess Underwriters was denied by the court in In re Payroll Express Corporation.⁹⁶ The facts of this case were discussed in the previous section. The court noted that the New Jersey Supreme Court had recently recognized a cause of action for consequential damages for an insurer's bad faith refusal to pay a first-party claim in Pickett v. Lloyd's.⁹⁷ Under Pickett, the plaintiff must show that the insurer was without a debatably valid reason for its failure to pay, and that the insured's consequential damages were within the contemplation of the insurer. In connection with the fairly debatable standard, if a claimant could not have established as a matter of law a right to summary judgment on a substantive claim, he is not entitled to assert a claim for an insurer's bad faith refusal to pay the claim.⁹⁸ In this case,

because the court held that the LEU policies were void ab initio, the bad faith claim against LEU was dismissed.⁹⁹

ENDNOTES

1. 691 So.2d 208 (La. App. 1st Cir.), writ denied, 692 So.2d 1094 (La. 1997).
2. Id. at 210.
3. Id. at 213.
4. 1997 U.S. Dist. Lexis 12045, (E.D. La. Aug. 12, 1997).
5. Id. at 12-14.
6. Id. at 14-15.
7. 960 F. Supp. 16 (D. Conn. 1997).
8. Id. at 21.
9. Id.
10. Id.
11. 1998 U.S. Dist. Lexis 1874 (Minn. Feb. 17, 1998).
12. Id. at 18-21.
13. Id. at 22.
14. Id. at 22-23.
15. Id. at 23-25.
16. Id. at 23-26.
17. 665 N.Y.S. 2d 79; 1997 N.Y. App. Div. Lexis 12794 (Dec. 9, 1997).
18. Id. at 1-2.
19. 105 F.3d 778 (1st Cir. 1997).
20. Id. at 783.
21. Id. at 784-87.
22. 1997 Conn. Super. Lexis 1646 (June 16, 1997).
23. Id. at 3.
24. Id. at 5.
25. Id. at 6.
26. 1997 U.S. App. Lexis 27965 (9th Cir. Oct. 9, 1997).
27. Id. at 2-3.

28. 1997 U.S. Dist. Lexis 16379 (E.D. La. Oct. 16, 1997).
29. Id. at 7-9.
30. 1997 U.S. Dist. Lexis 15519 (S.D.N.Y. Oct. 7, 1997).
31. Id. at 47-48.
32. Id. at 53-54.
33. Id. at 61.
34. 113 F.3d 629 (6th Cir. 1997).
35. Id. at 631.
36. Id. at 633.
37. Id. at 634.
38. Id. at 635.
39. Id. at 634.
40. 967 F. Supp. 475 (M.D. Ala.), affirmed without op., 130 F.3d 444 (11th Cir. 1997).
41. Id. at 477.
42. Id. at 478.
43. 1998 U.S. App. Lexis 3781 (6th Cir. March 3, 1998).
44. Id. at 3.
45. 944 S.W.2d 666 (Tex. App.1997).
46. Id. at 668.
47. 109 F.3d 1084 (5th Cir. 1997).
48. Id. at 1086.
49. Id. at 1088.
50. Id. at 1089.
51. 965 F. Supp. 1047 (W.D. Tenn. 1997).
52. Id. at 1049-50.
53. Id. at 1052.
54. Id. at 1053-54.
55. Id. at 1055.

56. Id.
57. 1997 U.S. Dist. Lexis 12362 (E.D. La. Aug. 19, 1997).
58. Id. at 12-14.
59. 559 N.W. 2d 438 (Minn. App. 1997).
60. Id. at 439.
61. Id. at 440.
62. 1997 U.S. Dist. Lexis 11614 (S.D.N.Y. Aug. 8, 1997).
63. Id. 10-13.
64. 960 F. Supp. 16 (D. Conn. 1997).
65. Id. at 20.
66. 1998 U.S. App. Lexis 2028 (1st Cir. Feb. 12, 1998).
67. Id. at 2.
68. Id. at 13.
69. Id. at 17.
70. Id. at 18.
71. Id. at 19.
72. 117 F.3d 1328 (11th Cir. 1997).
73. Id. at 1335.
74. Id. at 1336.
75. Id. at 1336-37.
76. Id. at 1337-38.
77. Id. at 1339.
78. 1997 U.S. Dist. Lexis 8689 (E.D. La. June 18, 1997).
79. Id. at 10-15.
80. 564 N.W.2d 431 (Iowa 1997).
81. Id. at 433.
82. Id. at 434.
83. Id. at 435.

84. Id.
85. Id. 435-36.
86. 212 Wis. 2d 639, 571 N.W.2d 203 (Wis. App. 4th Dist. 1997).
87. Id. at 7-8.
88. Id. at 10-13.
89. 113 F.3d 629 (6th Cir. 1997).
90. Id. at 638-39.
91. 1997 U.S. Dist. Lexis 15519 (S.D.N.Y. Oct. 7, 1997).
92. Id. at 26, n. 6 (citing FDIC v. Moskowitz, 946 F. Supp. 322, 329 (D.N.J. 1996)).
93. Id. at 31 (citing Massachusetts Mutual Life Ins. Co. v. Manzo, 122 N.J. 104, 117, 584 A.2d 190 (1991)).
94. Id. 33-37.
95. Id. at 40.
96. 1997 U.S. Dist. Lexis 15519 (S.D.N.Y. Oct. 7, 1997).
97. 131 N.J. 457, 461, 621 A.2d 445 (1993).
98. 1997 U.S. Dist. Lexis 15519 at 62.
99. Id. at 63.