TWELFTH ANNUAL
SOUTHERN SURETY AND FIDELITY CLAIMS CONFERENCE

RECENT DEVELOPMENTS IN FIDELITY LAW

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RECENT DEVELOPMENTS IN FIDELITY LAW

A. Interpretations of Fidelity Bond Terms and Conditions

1. Discovery and Notice of Claim

a. In **Karen Kane, Inc. v. Reliance Ins. Co.**,[1] the Ninth Circuit Court of Appeals was faced with the issue of whether an insurer for incidents of employee dishonesty properly refused to pay the coverage limit for the first two of three separate one-year policy periods, in connection with an employee's fraudulent scheme that spanned all three policy periods. The insurance company had issued a commercial crime policy renewable annually for three successive terms. The policy provided coverage for loss discovered no later than one year from the end of such policy. The employee defrauded the insured through numerous acts during a three year period. However, the insured did not discover the fraud until the third policy term. Such discovery was within the one year discovery provision for the second and third policy terms but did not fall within the one year discovery provision for the first policy term. The Court of Appeals held that the one year discovery clause was plain and unambiguous and that, under California law, the clause was not subject to "tolling" based on the fact that the discovery was not actually made until three years after the first loss was incurred.[2] The Court allowed the insured to recover the policy limit as to the second and third policy terms, but disallowed recovery for "occurrences" taking place under the first policy term due to the one year discovery clause.[3]

b. In **Resolution Trust Corp. v. Fidelity and Deposit Co. of Maryland**,[4] Fidelity and Deposit Co. of Maryland had issued the insured a Standard Form No. 22 Blanket Bond providing indemnification for losses suffered by the insured because of certain dishonest or fraudulent acts by its employees. During the effective period of the bond, several employees of the insured's mortgage subsidiary concealed knowledge of problems with a loan including its "workout" status and the borrower's technical default.[5] Moreover, the employees, in spite of their knowledge, encouraged the insured to continue extending credit to the borrower. Eventually, the insured, still unaware of problems with such loan, sought potential buyers for its mortgage subsidiary. The employees found a buyer and negotiated with the buyer for jobs and signing bonuses. Two days prior to the closing of the sale, the buyer excluded the problem loan from the purchase. After the closing, the insured discovered the former employees' concealment.[6] The borrower subsequently defaulted on the loan resulting in a seven million dollar loss to the insured. The insured was subsequently declared insolvent, closed and sent into receivership. The trial court granted summary judgment against the insured finding that no reasonable jury could find that discovery had occurred as of the bond's expiration date because there was no evidence in the record to indicate that, prior to the bond's expiration date, the insured was aware of any specific dishonest conduct by the employees which proximately caused the loss. The Court of Appeals reversed finding that a reasonable jury could conclude that the insured was aware of sufficient facts that would cause a

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[1] 202 F.3d 1180 (9th Cir. 2000).
[2] *Id.* at 1188-89.
[3] *Id.* at 1190.
[4] 205 F.3d 615 (3rd Cir. 2000).
[5] *Id.* at 622.
[6] *Id.* at 624-25.

reasonable person to assume that a loss covered by the bond had or would be incurred.[7] The Court went on to state that "discovery," in the context of section 4 of the Standard From No. 22 bond, occurs when the insured becomes aware of facts which would cause a reasonable person to assume that a loss covered by the bond has or will be incurred, even though the exact amount or details of the loss may have not then been known.[8]

c. In **Winthrop and Weinstine v. Travelers Casualty and Surety Co.**,[9] the Eighth Circuit addressed the issues of notice and the "prior insurance" clause arising under a fidelity bond as interpreted under Minnesota law. The case arose after the insured realized that a former employee had embezzled over $200,000, over a four year period. The insured had been covered during the first three years by policies issued by USF&G and the fourth year, the year the loss was discovered, the insured was covered by a policy issued by Travelers. The USF&G policy covered loss sustained during its policy period "discovered no later than one year from the end of the policy period" and required the insured to provide notice of a loss "as soon as possible."[10] The discovery of the full loss sustained was made over the span of a year. Although claims were made to Travelers; USF&G was not given notice of a potential claim until one year and eight months after the expiration of the third and final policy it had issued had expired. USF&G denied coverage.[11]

The Court addressed whether USF&G's denial of coverage was valid based upon the fact that the insured failed to give notice of the loss until eight months after the expiration of the one year "discovery period" of the final USF&G policy, and over a year after the insured's initial discovery of the loss. The Court held that under Minnesota law, late notice will preclude coverage only if there is prejudice to the insurer or notice is actually a condition precedent to coverage and that the insurer has the burden of proving prejudice.[12] The Court found that the late notice precluded coverage on the grounds that USF&G was prejudiced when the insured assigned all of its rights against the employee to Travelers before giving notice to USF&G. Furthermore, USF&G was precluded from recovering on the altered checks which the employee utilized in her theft because of the applicable statute of limitation on recovery from the accepting bank.[13]

The Court then turned its attention to the "prior insurance" clause and determined that Travelers was not liable under such provision for losses which fell within the one year discovery periods of the first two USF&G policies. The Court affirmed the trial court's finding that losses during USF&G's policy period must be excluded because the insured had failed to cause the Traveler's policy to go into effect before the expiration of the first two USF&G policies. In so holding, the Court recognized that each new USF&G policy was distinct from the former, thus each former policy became "prior insurance" when the new USF&G policy came into effect. Accordingly, only the last USF&G policy was actually replaced by the Travelers policy and thus, only losses discovered during its discovery period were recoverable from Travelers.[14]

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[7] *Id.* at 629.
[8] *Id.* at 629-30.
[9] 187 F.3d 871 (8th Cir. 1999).
[10] *Id.* at 872.
[11] *Id.* at 874.
[12] *Id.* at 874.
[13] *Id.* at 875.
[14] *Id.* at 876.

2. Definition of "Employee"

a. In **<u>Conestoga Title Ins. Co. v. Premier Title Agency, Inc.</u>**,[15] the Superior Court of New Jersey addressed issues arising under the "alter ego" doctrine. Robert Wurster was the sole director, president, and shareholder of the insured. In such capacity, Wurster supervised numerous title closings stealing money that was to be used to satisfy existing mortgages on the properties. Conestoga, as title insurer, reimbursed the insured's clients and obtained a judgment against the insured and an assignment of any rights of the insured under its fidelity bond. Conestoga in turn filed suit against the insurer to recover under such fidelity bond. In denying recovery by Conestoga, the Court found that the policy did not intend to cover an "alter ego," specifically the president of the insured with the right to direct and control the insured, as an employee for purposes of the fidelity bond.[16] The Court struck down Conestoga's argument that the application for coverage appeared to include the president as an "employee" based on its finding that the portions of the application relied on by Conestoga made no reference whatsoever to coverage and that an application may not be considered to determine the parties' intent when the application is not attached to, nor incorporated by reference in, the terms of the bond.[17]

b. In **<u>Hartford Fire Ins. Co. v. Conestoga Title Ins. Co.</u>**,[18] the Superior Court of New Jersey again addressed the issue of whether an insured's president was an "employee" for fidelity bond purposes or whether he was the insured's "alter ego" thereby precluding recovery. The insured's president formed and dominated every aspect of the insured company, while his wife was designated as the sole director and stockholder. However, the wife played no active role in the corporation. The insured's president then stole funds from the insured and ultimately from Conestoga Title, for whom the insured was an authorized agent. After receiving a judgment against the insured and its president, Conestoga Title sought the benefits of the bond proceeds.[19]

In ruling that no recovery could be had under the bond, the Court determined that the president was not an employee of the insured, but rather was its "alter ego."[20] Despite the fact that all of the insured's stock as well as its directorship was technically vested in the president's wife, the court rested its finding on the fact that it was the president who completely dominated every aspect of the insured. The Court further found it irrelevant that it was ultimately the judgment creditor, Conestoga Title, and not the insured, who was seeking coverage. The Court held that a judgment creditor is essentially in the position of an assignee and, as such, his rights cannot exceed those of the assignor.[21]

3. Employee Dishonesty / Manifest Intent

a. In **<u>Federal Deposit Ins. Corp. v. National Union Fire Ins. Co. of Pittsburgh</u>**,[22] the Second Circuit Court of Appeals, interpreting New York state law, addressed this case

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[15] 746 A.2d 462 (Super. Ct. App. Div. 2000).
[16] *Id.* at 464-65.
[17] *Id.* at 465.
[18] 746 A.2d 460 (N.J. Super. Ct. App. Div. 2000).
[19] *Id.* at 461.
[20] *Id.* at 461.
[21] *Id.* at 462.
[22] 205 F.3d 66 (2nd Cir. 2000).

involving bank losses which resulted from misappropriation of loans and theft by the construction manager of the project on which the insured had approved financing. A trustee of the insured, who served on the insured's Mortgage and Real Estate Committees, became aware of the dishonest conduct and allowed the insured to proceed to loan 8 million dollars to the project.[23] The trustee did take action to protect his personal business interests in two separate joint ventures he had formed with the construction manager.[24] The FDIC, as receiver, sought recovery under the insured's financial institution bond.

The Court first held that "[t]he failure to disclose fraudulent conduct that pertains to a loan is a dishonest act under a fidelity bond."[25] The Court then held that the trustee had the "manifest intent" to harm the insured as a matter of law. The Court noted that the majority of courts who have addressed the "manifest intent" requirement have attempted to discern the employee's subjective state of mind by reviewing the objective manifestations thereof.[26] The Court further referenced those cases which have held that "the employee's subjective state of mind should be determined by examining the employee's actions, words, and all of the surrounding circumstances."[27] Ultimately, the court, purporting to adopt a hybrid subjective/objective standard, concluded that the objective manifestations of an employee's intent could establish "manifest intent" as a matter of law. The Court stated:

> [A]ctions that amount to embezzlement or embezzlement-like conduct establish a fidelity bond's manifest intent element as a matter of law. Actions that will possibly result in the benefit of the employer do not, as a matter of law, establish manifest intent. Furthermore, evidence that the employee acted recklessly can be a manifestation of the employee's intent to cause the insured a loss. Finally, manifest intent does not require that the employee actively wish for or desire a particular result, but can exist when a particular result is substantially certain to follow from the employee's conduct.[28]

The Court found that the trustee's conduct was reckless and was substantially certain to cause the bank a loss. Utilizing the objective standard, the Court found there was coverage under the financial institution bond.

b. In **Resolution Trust Corp. v. Fidelity and Deposit Co. of Maryland**,[29] the Court addressed the meaning of manifest intent under Third Circuit and New Jersey law and adopted a subjective/specific intent standard for determining whether an employee acted with manifest intent as required by the fidelity bond. The Court provided a thorough survey of prior decisions implicating the interpretation of the manifest intent requirement. The Court noted that the courts are split between (1) a standard requiring the insured only to demonstrate that the employee's conduct was substantially certain to cause a particular result (objective standard) and (2) a standard requiring the insured to demonstrate that the employee acted with the

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[23] *Id.* at 68-69.
[24] *Id.*
[25] *Id.* at 71.
[26] *Id.*
[27] *Id.*
[28] *Id.* at 74.
[29] 205 F.3d 615 (3rd Cir. 2000).

specific intent to cause the particular result (subjective standard). The Court held that manifest intent requires that the insured prove that the employee engaged in dishonest or fraudulent acts with the specific purpose, object or desire both to cause a loss and to obtain a financial benefit for themselves or a third party.[30] The Court stated that the "purposefully" rather than "knowingly" better captures the meaning of "intent" as used in the fidelity bond. The Court further held that a jury could consider objective indicia of intent, including recklessness and/or the employee's knowledge of the likelihood that a loss was to result, in ascertaining whether the employee acted with the necessary manifest intent. However, the Court stated that the insured must prove that the employee acted with manifest intent as to both the loss and the financial benefit prongs, and disagreed with other circuits which allow merely a showing that the employee knew that the loss was substantially certain to occur.[31] The Third Circuit Court of Appeals provided a thorough and thoughtful discussion of the manifest intent requirement and adopted the subjective standard.

c. In **First Bank of Marietta v. Hartford Underwriters Ins. Co**.,[32]one of the insured's officers increased the credit line of a customer and approved advances to such customer without proper authorization. The customer was subsequently unable to repay the loan. In an affidavit, the insured's Chairman of the Board stated that the officer at issue had admitted to engaging in the transactions in order to "get even" with the insured. Such affidavit was contradictory to the insured's prior discovery responses. The Court therefore held that the affidavit was inadmissible and that without such affidavit there was no basis upon which to find that the officer had engaged in the activity with the necessary manifest intent to cause the insured a loss.

d. In **Williams Electronics Games, Inc. v. Barry**,[33] the plaintiff sued the defendant after one of the defendant's employees bribed one of the plaintiff's employees to purchase component parts from the defendant at inflated prices. The defendant counterclaimed against its insurer seeking a declaration that the plaintiff's claims against the defendant were covered losses under the defendant's Crimeguard and Comprehensive Dishonesty, Disappearance, and Destruction policies.

The Court stated that, under the Crimeguard policy, covered loss is defined as the direct deprivation of the insured resulting from the unlawful taking of money held by the insured to the deprivation of the insured. The Court held that any monies the defendant is ordered to pay to the plaintiff would not amount to an unlawful taking of money held by the defendant. In addition, the Crimeguard policy's coverage is limited to acts of dishonesty which the policy defines as theft. Because the employee's actions do not amount to theft as defined in the policy, the claimed loss is not covered by the policy in question. In regard to the "3-D Policy," the Court held that because the defendant's employee did not intend to cause the defendant to have to pay any money to the plaintiff, the employee did not act with the requisite manifest intent to cause the insured a loss and, therefore, the loss was not covered.

[30] *Id.* at 642-44.
[31] *Id.* at 643.
[32] 198 F.3d 245 (6th Cir. 1999).
[33] No. 97-C-3743, 2000 WL 106672 (N.D. Ill. January 13, 2000).

e. In **Provincial Hotels, Inc. v. Mascair**,[34] the Louisiana Court of Appeals held that the insured must not only prove that the dishonest acts were perpetrated by an employee during the coverage period, but must also prove the amount of the loss directly caused by those dishonest acts. In this case the court held that testimony of the insured hotel's owners of an out of court confession by the allegedly dishonest employee was not sufficient, by itself, to establish that the theft actually occurred, or to establish the amount of damage.[35]

f. In **Peoples Bank & Trust Co. v. Aetna Casualty & Surety Co.**,[36] the insured bank was sued after its employees' dishonesty led to losses to a customer of the insured. The customer borrowed money from the bank based on representations made by the employees regarding the business the money was being used to buy. Such business failed and the customer ultimately filed for bankruptcy. The customer then sued the insured. After the insured settled the suit, the insured sought coverage under its fidelity bonds. The insurers denied coverage. The Court held that losses resulting from frauds on third parties will rarely be covered under a 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. The Court stated that the "migratory route would need to be short, certain, and obvious to support an inference (in the absence of direct evidence) that dishonest employees harbored such knowledge or expectation."[37] The Court held that manifest intent requires more than a mere probability, it exists when a particular result is substantially certain to follow from conduct. When the employees here made misrepresentations to the customer for the employees' own benefit, there was no substantial certainty that a loss would flow to the insured.

4. Financial Benefit

a. In **Resolution Trust Corp. v. Fidelity and Deposit Co.**,[38] the insured obtained a Standard Form No. 22 Blanket Bond that provided indemnification for losses suffered by the insured due to dishonest or fraudulent acts of its employees. The court was faced with the question of whether the evidence could sustain a finding by a reasonable jury that the employees acted with the manifest intent to obtain a financial benefit for themselves that was not set out in subsection (b) of the Fidelity Agreement. Subsection (b) requires that the employee engage in the dishonest or fraudulent conduct with the manifest intent "to obtain financial benefit for the Employee. . ., other than salaries, commissions, fees, bonuses, promotions, awards, profit sharing, pensions or other employee benefits earned in the normal course of employment."

The Court first addressed the "golden handcuff" payments received by the employees from the insured. The Court ruled that the phrase "earned in the normal course of employment" was unambiguous and that subsection (b) prevents coverage where the employee's purpose in engaging in the misconduct that caused the loss was to receive some type of financial benefit that, generally speaking, the insured provides knowingly to its employees as part of its compensation scheme and as a result of the employment relationship.

[34] 734 So.2d 136 (La. Ct. App. 1999).
[35] *Id.* at 139.
[36] 113 F.3d 629 (6th Cir. 1997).
[37] *Id.* at 634.
[38] 205 F.3d 615 (3rd Cir. 2000).

The Court held that the “golden handcuff payments” fell within subsection (b) because they fit squarely into the category of “bonuses” or “awards” or, in the alternative, qualify as a type of benefit earned in the normal course of employment.[39] However, the Court held that subsection (b) would not preclude coverage where the employees engaged in dishonest and fraudulent acts with the manifest intent to secure future lucrative employment opportunities, salaries and signing bonuses from a third party to the employee’s employment relationship with the insured.[40]

b. In **Klyn v. Travelers Indemnity Co.**,[41] the insurer denied a property loss claim submitted under an “employee dishonesty” endorsement to the insured’s policy. The insured’s comptroller embezzled funds from a payroll account over which he had sole control by secretly and fraudulently paying himself unauthorized and excessive salary, commissions, and bonuses. The Court rejected the insurer’s contention that recovery under the policy was barred by exclusion provision f which excludes coverage for “salaries, commissions, fees, bonuses . . . or other benefits earned in the normal course of employment.”[42] The Court held that where the employer does not knowingly pay funds to its employee with the belief that such funds have been honestly earned, but, instead, the employer is unaware of the employee’s receipt of the funds or pays the funds for some purpose other than the employee’s compensation, the employee has committed embezzlement and such embezzlement is recoverable under the policy.

5. Direct Loss

a. In **City of Burlington v. Western Surety Co**.,[43] the Supreme Court of Iowa addressed the issue of whether an insured who incurs expenses to avoid a third-party liability claim can recover its payment under a fidelity bond. The insured city’s fire department lost the master key to the locks of all of the school buildings in the city’s school district. These buildings were owned by the school district, not the city. As a result of the loss of the key and in order to avoid any liability to the school district in the event someone used the key to vandalize or steal from a school building, the city voluntarily paid to have all of the locks on all of the schools changed. The insured city then filed a claim under its public employee’s blanket bond for reimbursement of the cost of changing the locks. In upholding the insurer’s denial of coverage, the Court held that a fidelity bond is direct insurance procured by the insured in favor of himself and that the city’s potential liability for the school district’s expenses or damages merely caused an indirect loss to the city. Therefore, the court held that such loss was not covered under the bond.[44]

b. In **Vons Co., Inc. v. Federal Ins. Co.**,[45] the Ninth Circuit Court of Appeals addressed the issue of whether the employee dishonesty policy issued to the insured, which insured it against “direct losses…caused by….any employee,”[46] covered losses sustained as a result of vicarious liability to third parties. The claims against the insured arose out of fictitious

[39] *Id.* at 646.
[40] *Id.* at 649.
[41] 709 N.Y.S.2d 780 (N.Y. App. Div. 2000).
[42] *Id.* at 781.
[43] 599 N.W.2d 469 (Iowa 1999).
[44] *Id.* at 472.
[45] 212 F.3d 489 (9th Cir. 2000).
[46] *Id.* at 490.

transactions which an employee, posted on the insured's property by a trading company, participated in for the purpose and effect of defrauding investors in the sham transactions. The insured settled the two lawsuits in which it was sued based upon derivative liability for the employee's tortious acts. The insured contended that such loss was covered based on language found in Section 11 of the policy which states, in pertinent part, that coverage "shall apply only to Money, Securities or other property owned by the Insured or for which the Insured is legally liable, or held by the Insured….whether or not the insured is liable."[47] The Court stated that this argument was flawed because it is founded on the interest clause of the policy ("ownership") rather than the insuring clauses. These insuring clauses provide that the insured is covered only for direct losses to the insured caused by its employee's dishonesty, not for vicarious liability for losses suffered by others arising from its employee's tortious conduct. In precluding recovery, the Court held "that 'direct' means 'direct' and that in the absence of a third party claims clause, [the insured's] policy did not provide indemnity for vicarious liability for tortious acts of its employee."[48]

c. In **Federal Deposit Ins. Corp. v. National Union Fire Ins. Co**.,[49] the FDIC sought recovery of losses sustained by the insured when one of its trustees failed to inform the insured of a borrower's misappropriation of loan proceeds and, instead, acted to protect his own interests and allowed the insured to continue lending money to the borrower. The Court held that a loss is directly caused by the dishonest or fraudulent act of an employee, within the meaning of the bond, where the insured can demonstrate that it would not have made the loan in the absence of the fraud.[50] The Court, relying on evidence establishing that the insured would not have made the loans if they had known of the trustee's actions, held that the trustee's dishonest act was a direct cause of the insured's loss.

d. **Nelson v. ITT Hartford Fire Ins. Co.**,[51] addressed the issue of whether the bankrupt estate of a title company is entitled to recover under a fidelity insurance policy for dishonest acts of such company's employees where such acts have not yet resulted in actual loss to the estate, but for which the estate is potentially liable. The insured had purchased employee "crime coverage" insurance in which the insurer contracted to pay "compensatory damages arising directly from a loss covered under this insurance" and defined "interests covered" as property that the insured owns, holds or for which the insured is legally liable. The Court held that the policy provided coverage for the losses when and if the insured's liability for those losses is established. The Court pointed out that the policy did not state that the insured had to actually pay back losses before the insurer became liable for such losses. The Court therefore held that the policy was an indemnity policy from liability and not solely an indemnity policy from loss. The Court further held that the insurer is liable to pay claims for the losses against the insured as those losses are established by the defrauded clients and/or creditors of the estate.

e. In **Fireman's Fund Ins. Co. v. Puget Sound Escrow Closers, Inc.**,[52] the Washington Court of Appeals addressed the issues of whether an insured's fidelity policy represented a debt owed to the insured which would be subject to garnishment by a judgment

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[47] *Id.* at 491.
[48] *Id.* at 492-93.
[49] 205 F.3d 66 (2nd Cir. 2000).
[50] *Id.* at 76.
[51] 216 F.3d 1088 (10th Cir. 2000).
[52] 979 P.2d 872 (Wash. Ct. App. 1999).

creditor, and whether the insured had suffered a loss under the fidelity policy. The case arose from a fraudulent loan transaction between a private party and a wholly owned subsidiary of the insured. Employees of both the parent and subsidiary misrepresented to the lending party the priority of their security interest and number of encumbrances existing on the property pledged as collateral. As a result of this misrepresentation, the lenders loaned the money, but took a fourth place lien instead of the second priority security interest to which they had agreed. Eventually the holder of the first priority security interest filed a notice of default on its deed of trust, and shortly thereafter, the parent corporation was dissolved by the Secretary of State. The lenders then obtained a judgment against the parent corporation for damages arising out of the loan transaction. In order to collect this judgment, the lenders served a writ of garnishment on the fidelity bond insurer.

The Court first had to determine whether a "loss" had even occurred under the policy which would create a potentially garnishable debt due to the insured. In determining that a "loss" had not been sustained under the terms of the policy, the Court first interpreted the meaning of "loss" as used in the policy. The Court held that a "loss" occurs the moment that the employee misappropriates the insured's funds or property and that there is no requirement that the insured pay the damages for which it is liable to a third party.[53]

However, the Court pointed out that in this case the employees did not misappropriate any funds or property from the insured, but rather, the employees practiced fraud on the lenders for their own personal benefit. Thus, the court concluded, no loss had occurred or would occur until the insured actually paid money to the judgment creditor in satisfaction of its liability stemming from the acts of the employees.[54] The Court held that the insured did not suffer an indemnifiable "loss" under its fidelity bond that created a garnishable debt due to the insured.

f. In **Aetna Casualty & Surety Co. v. Kidder, Peabody & Co., Inc.**,[55] an employee of the insured, a broker-dealer company, was involved in several insider-trading schemes which resulted in several lawsuits against the insured. Such lawsuits were filed by public shareholders of companies that were the subject of the insider trading. The insured settled these actions and then sought coverage under its fidelity bond. The court held that, by their clear terms, the fidelity bonds require that the unfaithful employee must intend to cause the employer a loss directly and solely relating to the faithless act, classically describing embezzlement or another type of theft from the employer or even retaliation against an employer that benefits a third-party in collusion with the employee. The Court held that there is no evidence at all that the employee's manifest intent here was to cause the employer a loss.

The Court further held that coverage was not triggered by the nature of the loss under the clear exclusions of the bonds. The bonds specifically excluded "damages of any type for which the insureds is legally liable, except direct compensatory damages arising from a loss covered under this bond."[56] Those terms, according to the Court, do not describe indirect and consequential injuries to the employer resulting from legal settlements with third parties who

[53] *Id.* at 876.
[54] *Id.* at 877.
[55] 676 N.Y.S.2d 559 (N.Y. App. Div. 1998).
[56] *Id.* at 563.

were the actual targets of the employee's acts. The putative loss to the insured arose in part from a settlement with third parties, but the settlement was not the direct result of the employee's dishonest conduct; the employee's dishonesty only caused pricing irregularities in the stock, which caused losses to the customers which then led to the litigation concluding in settlement. As such, the settlement would not constitute a covered loss under the policy.

6. Limits of Liability

a. In **Ran-Nan, Inc. v. General Accident Ins. Co. of America**,[57] the insured purchased a commercial crime coverage policy that included an employee dishonesty coverage blanket policy. The policy was in effect for two one year terms and each had a limit of insurance of $25,000 per occurrence during the policy periods. The insured suffered losses resulting from the conduct of two employees. After the insured submitted two sworn proofs of loss to the insurer, the insurer decided to pay the insured the policy limit of $25,000.00 per occurrence under the second policy finding that one of the employee's actions were a continuation of the loss begun by the other employee and, as such, only constituted one "occurrence." The policy defined "occurrence" as "all loss caused by, or involving, one or more 'employees,' whether the result of a single act or series of acts." The policy further provided that "no Limit of Insurance cumulates from year to year or period to period." The Court held that there was a question of fact regarding whether the two employees' conduct constituted only one "occurrence" and denied the insurer's motion for summary judgment.

b. In **Universal Underwriters Ins. Co. v. Ford**,[58] the Supreme Court of Mississippi addressed the issue of whether each act of embezzlement by a single employee constituted one occurrence or several occurrences. The Court upheld the trial court's finding that the policy was ambiguous as to this issue, and as such, the provisions should be strictly construed against the insurer and liberally in favor of the insured. The applicable provision relied upon by the insurer in arguing that the series of related thefts by one employee constituted one occurrence provided: "the most WE will pay: (a) under EMPLOYEE DISHONESTY, is the limit stated in the declarations as applicable to a LOSS caused by one or more EMPLOYEES, or to all LOSS caused by one EMPLOYEE or in which the EMPLOYEE is concerned or implicated."[59] The Court noted that the above provision is subject to the definition of "loss" as found in the insuring agreement which states that "loss" is: "LOSS of MONEY….which YOU sustain resulting directly from any fraudulent or dishonest act committed by an EMPLOYEE."[60]

The Court noted that that the policy provisions regarding the limits of liability were subject to two reasonable interpretations and that, in light of the rule requiring ambiguities to be construed in favor of the insured, the policy should be read as allowing recovery for each act of embezzlement as a single occurrence.

The Court rejected the insurer's argument that, under existing case law, courts have ruled that a series of related thefts may constitute one occurrence. The Court noted that under those prior decisions, the policy itself was unambiguous and contained language to that effect (for example: "[a]s respects any one employee, dishonest or fraudulent acts of such employee

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[57] No. CIV.A.3:99-CV-0586-G, 2000 WL 554206 (N.D. Tex. May 5, 2000).
[58] 734 So.2d 173 (Miss. 1999).
[59] *Id.* at 174-75.
[60] *Id.* at 176.

during the policy period shall be deemed to be one occurrence for the purpose of applying the deductible"), as opposed to the present policy which was ambiguous. In so rejecting the insurer's contention, the Court held that "[u]nder the law, therefore, a factual issue of whether multiple acts are sufficiently related to constitute one occurrence of loss only arises where the applicable policy language unambiguously states that multiple acts may be so treated."[61]

c. In **Karen Kane, Inc. v. Reliance Ins. Co.**,[62] the Ninth Circuit Court of Appeals, applying California state law, addressed the question of whether an insured is entitled to recover the limit of liability for each year a fidelity policy is in effect, when an employee's dishonesty takes place in each year. The main issue was whether the employee's acts of fraud were considered one occurrence, thereby entitling the insured to only the liability limit of the most recent policy, or whether the term "occurrence" was temporal as to each year a separate policy was issued, thereby entitling the insured to the limit of recovery for each policy during which an "occurrence" took place.

In answering this question, the Court of Appeals, guided by the case of *A.B.S. Clothing Collection, Inc., v. Home Ins. Co.*,[63] held that an insurer seeking to limit the amount of its liability to the insured for losses incurred during successive years of coverage must show by clear and unambiguous policy language that the parties intended to enter into one continuous insurance contract. An insurer will be liable up to the policy limit for each separate period unless it can show clear intent by the parties to enter into a single continuous insurance contract. In this case, the insurer conceded that it had issued three distinct policies to the insured.[64]

The policy defined "occurrence" as "all loss caused by, or involving, one or more 'employees,' whether the result of a single act or series of acts."[65] The policy further provided that "[t]he most [Reliance] will pay for loss in any one 'occurrence' is the applicable Limit of Insurance shown in the Declarations [$25,000.00]." The Court found that these provisions created an ambiguity as to whether "occurrence" refers to a single act or series of acts within a single policy period or across multiple policy periods. In light of such ambiguity, the Court held that the term must be construed in favor of liability for each policy period. The Court found that the insured was entitled to recovery for the limit of each separate policy period subject to the policies' one year discovery provision.

7. Subrogation

a. In **KPMG Peat Marwick v. National Union Fire Ins. Co. of Pittsburgh**,[66] the Florida Supreme Court addressed the issue of whether a fidelity bond insurer could recover from an independent auditor, as an insurer/subrogee or an insurer/assignee, monies paid to the insured as a result of the auditor's malpractice. The Court held that a claim of an independent auditor's professional malpractice in preparation of an audit can be asserted by an assignee or subrogee.[67] The Court distinguished its ruling from the rule against the assignment of

[61] *Id.* at 178.
[62] 202 F.3d 1180 (9th Cir. 2000).
[63] 41 Cal.Rptr.2d 166 (Cal. Ct. App. 1995).
[64] 202 F.3d at 1185.
[65] *Id.* at 1186.
[66] 765 So.2d 36 (Fla. 2000).
[67] *Id.* at 39.

personal tort and legal malpractice claims on the reasoning that the nature of an auditor's duties are largely for the good of the public and that as such the duty of an auditor is to the public trust and not to the client.[68]

8. Forgery and Alteration

a. **First Union Corp. v. United States Fidelity and Guar. Co.**,[69] involved the lending of over $300 M to a person who, by virtue of forged "incumbency certificates," purported to be the chief operating officer of a Phillip Morris subsidiary engaged in a top secret off shore research project to develop "harmless tobacco." The lending bank, the insured, sought to recover sums lost as a result of the fraud under its fidelity bond coverage. The insured attempted to recover under section (D)(2) and, alternatively, section (E) of the Standard Form 24 Insuring Agreements.

The Court found that the certificates were not "evidences of debt" as required for recovery under (E), but rather, they merely represented that the forger was a high ranking official of Phillip Morris authorized to act on its behalf. The Court stated that in determining whether a forged document qualifies for coverage under Insuring Agreement (E), a court's inquiry should be the contents of the document; i.e., what is the relationship between the forged document and the instrument of debt.[70]

The Court further ruled that the forged incumbency certificates were not "written instructions" as required under Insuring Agreement (D)(2). The Court noted that the "instructions and advices" have typically been held to refer to commercial paper. As the forged incumbency certificates in this case were clearly not commercial paper, the Court held that they did not constitute "instructions or advices." Additionally, the incumbency certificates did not authorize or acknowledge the payment or transfer of money or property, as required by Insuring Agreement (D)(2). Finally, the Court found further support for refusing recovery under both sections because the loan was not made "on the faith of" the forged certificates.

b. In **First Philson Bank, N.A. v. Hartford Fire Ins. Co**,[71] the insured bank brought an action against its fidelity insurer seeking to recover for losses it incurred because of an employee's alleged fraudulent acts in connection with a floor plan financing system set up between an employee of the bank and an automobile dealer. The plan involved a complex system of drawing checks on a zero balance account at the insured bank, depositing those drafts into the business account of the car dealership at another bank in order to pay for the car dealership's "purchase" of non-existent cars. A copy of the draft was also forwarded to the insured which would then place the necessary funds into the car dealership's zero balance account and the vehicle would be assigned to the car dealership's floor plan. The car dealership would then issue drafts on its other account to the insured bank to pay off the fictitious floor planned vehicles. This payment was not from the sale of vehicles but rather from the funds transferred from the car dealership's zero balance account to its other account. Essentially, the insured bank was being paid with its own money.

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[68] *Id.* at 38.
[69] 730 A.2d 278 (Md. Ct. Spec. App. 1999).
[70] *Id.* at 283.
[71] 727 A.2d 584 (Pa. Super. Ct. 1999)

The Court found that the scheme was actually a series of fraudulent loans, rather than a check kiting scheme as argued by the insured bank, and accordingly, under the fidelity bond policy, the resultant losses were unrecoverable absent proof that the employee received a $2,500 benefit. In ruling that the losses resulted from loan transactions instead of a check kiting scheme, the Court pointed to several aspects of the transactions: (1) the insured held a security interest in the non-existent cars, (2) the insured expected the sums to be paid back at some point in the future, and (3) the Insuring Agreements between the insured and the insurer referred to the floor-plan financing system as "loans."[72]

As to the issue of whether the employee received at least $2,500 of personal financial benefit, the insured pointed to several "benefits" including the employee's purchase of the stock of another bank before it merged with the insured, the receipt of stock under an ESOP, the receipt of bonuses and salary increases and the fact that the employee lived an extravagant life-style. The Court found that these allegations lacked merit based on the lack of evidence, the lack of actual gain regarding the stocks and the exception for employee benefits from bond coverage.

c. In **Mark VII, Inc. v. Lumbermens Mutual Casualty Co.**,[73] the District Court granted the defendants' motion for summary judgment finding that their policies did not cover the system of payment used by the insured. The insured, a transportation brokerage company, used a computer system called the Quick Pay system that allowed expedited payment to certain pre-approved vendors that shipped freight for the insured's other customers. The Quick Pay system involved the entry of shipping information in the insured's billing system creating an account payable. The accounts payable department then generated a report that listed each shipment entered into the billing system for a particular Quick Pay vendor from the previous week and listed the amount payable to the vendor for shipping the freight. The insured would then write a check to the Quick Pay vendor based on such report without any additional information or documentation. The insured entered into an agency agreement with a third party (the "agent") who was primarily contracting with the insured on behalf of his own trucking company. The company was one of the insured's Quick Pay vendors. The agent began submitting false billing system entries for shipments that did not exist and covered the false entries by altering shipping invoices for legitimate shipping contracts. During the time of these acts, the insured was covered by two separate, but consecutive, insurance policies.

Under the first policy, the insured had "Forgery or Alteration Protection" which stated that the insurer would "pay for loss resulting directly from forgery or alteration of a check, draft, promissory note or similar written promises or directions to pay money that are: made or drawn by you; drawn upon you; made or drawn by someone acting as your agent; or claims to have been so made or drawn." The second policy stated that the insurer would "pay for loss involving Covered Instruments resulting directly from the Covered Causes of Loss." The policy defines "Covered Instruments" as "checks, drafts, promissory notes, or similar written promises, orders or directions to pay a sum certain in "money" that are: a. Made or drawn by or drawn upon you; b. Made or drawn by one acting as your agent; or that are purported to have been so made or drawn." The policy defines "Covered Causes of Loss" as "forgery or alteration of, on, or in any Covered Instrument."

[72] *Id.* at 589.
[73] No. 99-2612 M1/A (W.D. Tenn. 2000)(pending appeal by the 6th Cir.).

The Court found that if the insured was to be covered by the policies, it would be through the "similar" clauses of the contracts, i.e. that the agent's entries into the billing system that were then printed on the report and paid through the Quick Pay system constituted a similar order or direction to pay money under the insurance contracts. The Court held that the Quick Pay System was not an order, direction, nor a promise to pay similar to that of a check, draft or promissory note. Nothing about the material submitted by The agent into the billing system could be construed as a negotiable order or even an order. Nor could the material be considered a direction to pay according to the Court. The Court likened the Quick Pay system to an expedited invoice system whereby the agent sends to the insured the information that would normally be on an invoice that requests payment. An invoice does not rise to the level of an order or direction to pay that is similar to a check, draft or promissory note nor is it an unconditional order or promise to pay money. As such, the billing system and Quick Pay system was not considered by the Court to be a covered instrument under the policies. The Court therefore granted the defendants' Motion for Summary Judgment and dismissed the plaintiffs' case.

d. In **Georgia Bank & Trust v. Cincinnati Insurance Co.**,[74] the insured bank made a claim under its blanket bond after borrowers defaulted on their obligations to the insured. The borrowers had assigned their interests in a savings account with a credit union as collateral for the renewal of their obligations with the insured. The insured twice obtained documents from the credit union confirming the minimum amounts in the account. When the borrowers defaulted, the insured found out that the account confirmations by the credit union were false and, instead, the account had a negative balance. Additionally, the credit union's representative's signature on the confirmations was forged by one of the borrowers who was the president of the credit union at the time of the forgery. The trial court determined that under these circumstances, the insurer is not liable when the loss is caused by the nonexistence of assets purported to be assigned by a forged instrument, as opposed to a loss caused by the lack of authenticity of the instrument.

In upholding the ruling of the trial court, the Georgia Court of Appeals held that a banker's blanket bond is not a policy of credit insurance and does not protect the bank when it simply makes a bad business deal. In the present case, even if the signature on the confirmation had been authentic, the insured still would have suffered the loss because the assets did not exist. Furthermore, the insured's responsibility to investigate the assets of its borrowers was never delegated to the insurance company. The Court reasoned that the bond insures that the documents submitted to the insured in connection with a loan are genuine and authentic. If they are not, and a loss is caused thereby, the insurer guaranteed such loss. However, the insurer does not guarantee the truth of such documents. If said documents are not truthful and a loss results therefrom, such loss is not guaranteed.

[74] 538 S.E.2d 764 (Ga. App. 2000).