

**THIRTEENTH ANNUAL
SOUTHERN SURETY AND FIDELITY CLAIMS
CONFERENCE**

**Charleston, SC
April 25 - 26, 2002**

RECENT DEVELOPMENTS IN FIDELITY LAW

PRESENTED BY:

**DAVID T. KNIGHT, ESQ.
GREGORY P. BROWN, ESQ.
HILL, WARD & HENDERSON, P.A.
101 EAST KENNEDY BLVD., SUITE 3700
TAMPA, FLORIDA 33602
(813) 221-3900**

David T. Knight

David T. Knight received his J.D. degree (with honors) from the University of Florida College of Law in 1974. David joined Hill, Ward & Henderson in 1991 and is a shareholder in the firm and is a member of the litigation group. His areas of practice include litigation in all federal and state courts, arbitrations and administrative proceedings. He concentrates his practice in commercial litigation, including business disputes, construction law, and fidelity and surety matters.

Gregory P. Brown

Gregory P. Brown joined Hill, Ward & Henderson in 1996 and is an associate in the firm. He received a B.A. degree in English Literature from the University of Pennsylvania in 1991, and his J.D. degree (with honors) from the University of Florida College of Law. While at the University of Florida, Greg served as a member of the Justice Thornal Campbell Moot Court Board. He is admitted to practice in the United States District Court for the Northern, Southern and Middle Districts of Florida.

Greg is a member of the creditors' rights and bankruptcy group. Greg represents secured and unsecured creditors as well as debtors in bankruptcy and state courts. He has also practiced in the area of commercial litigation, primarily representing contractors and sureties in construction cases and has published articles on various related topics. Greg is a member of The Florida Bar and the Hillsborough County and American Bar Associations.

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1. DISCOVERY AND NOTICE

a. In Gulf USA Corporation v. Federal Insurance Company, 259 F.3d 1049 (9th Cir. 2001) we find a tale of intrigue, involving shell corporations from the far-away Cook Islands and a host of other dastardly acts of legerdemain committed by a slippery CEO, who owned a controlling interest in the insured company. He caused the company to make significant investments in real estate properties from Europe to the South Pacific. While it was apparently undisclosed that the CEO was the indirect owner of the shell companies to whom many millions of dollars in "fees" were paid in connection with the procurement of these properties, it was strongly suspected. In fact, several shareholder derivative actions were filed and later dismissed. In one, the Complaint accused the corporate insiders of receiving these millions of dollars in fees, but the suit was subsequently dismissed after the minority shareholder was paid off by the company buying his stock at double its market value. Later, Forbes published an article exposing the allegation that the CEO had received over \$7,000,000 of these procurement fees.

Several years later, the CEO sold his controlling interest in the insured to another company. A new CEO was appointed, who quickly began an investigation of his predecessor. During the course of this investigation, the new CEO and his staff wrote memos characterizing one of the questionable real estate acquisitions engineered by the former CEO as an "outrageous fraud," and concluded that the company had "been consistently looted" by the former CEO and "his mob." The company then approached its former CEO and his affiliates, and demanded a financial settlement. This was agreed to, and the former CEO bought back some of the real estate investments of the company at their full original purchase price, which effectively allowed the company to rescind the transactions.

Following all of these events, the company applied for a crime policy with Federal Insurance Company, and in response to a question asking for a listing of all employee dishonesty over the last six years, answered "none." Almost one year after obtaining the policy, and several years after the settlement with the former CEO, the company filed a Proof of Loss stating that it had just obtained information that a possible theft may have occurred because the company had just sold one of its properties for less than its original purchase price. After a lengthy investigation, Federal Insurance Company denied coverage on several grounds, including failure to provide timely notice and lying on the application.

The company then filed suit in the United States District Court in Idaho, and Federal Insurance filed a motion for summary judgment. The court granted the motion on the grounds that timely notice had not been provided.

The relevant policy language required notice be given within 60 days after "knowledge or discovery . . . of loss or of an occurrence which may become a loss . . ." The District Court stated that the company "was required to give Federal notice once it possessed knowledge of some event or events short of actual knowledge of a theft that nonetheless . . . may involve a loss by theft," and since it had failed to do so its claim was untimely filed.

An appeal was taken by the company to the 9th Circuit Court of Appeals, which reversed the District Court, finding that it had adopted the incorrect legal standard for discovery of loss.

The court stated that "discovery of loss does not occur until the insured discovers facts showing that dishonest acts occurred and appreciates the significance of those facts; suspicion of loss is not enough." The court justified its ruling based upon long-standing precedent, and further elaborated that public policy supported this view. In this regard, the court stated that this was the appropriate standard from a policy standpoint because a careful and prudent person should not lightly charge another with committing fraud or dishonesty. Charges of that nature could "disrupt the fabric of the employer's work place and may often set in motion further investigations by responsible governmental agencies and affected parties." If the charge later proved to be erroneous, the employer could be subject to a defamation action. For those reasons, the court thought it reasonable to interpret "the Fidelity bond's contractual language in a manner permitting the employer to be careful and cautious before asserting that a fraud or dishonesty has occurred."

The court then applied the legal standard to the facts of the case and found that while the company, and its officers, may have "believed" that the former CEO perpetrated frauds based upon evidence at their disposal, the evidence did not necessarily establish a theft loss. The court found that there were too many disputed issues of fact, and reversed the summary judgment. The court also declined to find that the record established as a matter of law that the company had lied on its application. As a result, the summary judgment for the insurer was reversed.

b. In Nike, Inc. v. Northwestern Pacific Indemnity Co., 999 P.2d 1197 (Or.Ct.App. 2000), *appeal denied*, 27 P.3d 1034 (Or. 2001), Nike brought suit under an employee theft policy to recover losses attributed to an account representative located in Taiwan. In contravention of company policy, the employee had allegedly accepted post-dated checks from a customer, failed to require sufficient collateral for transactions, granted improper discounts on products and processed excessively large orders for the customer. Nike also suspected that the employee was receiving kickbacks from the customer. The customer defaulted resulting in a loss to Nike.

The insurer denied coverage on the ground that Nike's claim was untimely. Once suit was filed, the insurer asked the court to *just do it* – enter a summary judgment that is, and the trial court just did, holding that the two year limitations under Oregon law for filing such a claim barred Nike's claim.

Unfortunately, the Oregon appellate court reversed the judgment on appeal based upon a rather intricate analysis of the "discovery rule." The court ruled that the two-year limitations period would not begin to run until the insured had gained "sufficient knowledge, greater than mere suspicion, which would justify a reasonable and prudent person to believe that an act of dishonesty...and loss within the policy coverage had taken place." The insurer pointed to a criminal complaint Nike had filed outside the two-year statute of limitations period in arguing that Nike had clearly discovered the act of dishonesty at that time, and its claim was thus untimely. In rejecting the argument, the court noted that the criminal complaint alleged only a breach of fiduciary duty under Taiwanese law, not a theft or unlawful taking as required for coverage under the policy. The court held that a jury could reasonably conclude that Nike had only suspected that the account representative had engaged in unlawful conduct when it filed its criminal complaint, and summary judgment on this basis was therefore inappropriate.

Nike lived to fight another day, and the insured no doubt was disappointed by the “theft” of its summary disposition (apparently no one thought to check what kind of sneakers the appellate judge had on under his robe when he left the bench). All was not lost, however. As discussed below in section 3(c), the court’s additional findings, while supporting summary judgment, at the same time sent some rather strong signals that Nike ought not ultimately prevail in the case.

2. DEFINITION OF EMPLOYEE

a. In Securities and Exchange Commission v. Bancorp Ltd. 147 F. Supp. 2d 238 (S. D. N. Y 2001), an investment company of dubious origin and unclear business lines (“risk free arbitrage”) obtained policies of insurance from a Lloyds syndicate, including a crime policy, professional malpractice and directors and officers coverage. About six months after the policy was issued, the company filed a claim against the crime coverage. The claim was investigated and paid. Following this claim, the underwriters began to do more due diligence concerning the business of the company. In the course of this investigation, the underwriters learned that: (a) the company was misrepresenting its insurance coverage to its customers to make the coverage look like it was a financial guarantee; (b) there were “severe doubts about the viability” of the company; (c) the company “was believed to be operating a fraudulent scheme,” and (d) no evidence could be found that the company was licensed to conduct business in any jurisdiction. Nonetheless, the policies were not canceled, although several members of the syndicate bailed out and had to be replaced.

Some months after the investigation was concluded, the Securities Exchange Commission filed an enforcement action against the company and placed it in receivership. The receiver filed claims against the insurers, who asserted various affirmative defenses, including the assertion that the company was actually the alter ego of its controlling shareholder, and therefore, there was no coverage under the policy for his misconduct.

With respect to the insurers’ “alter ego” defense, the insurers asserted that the controlling shareholder so dominated and controlled the company that he was its “alter ego,” and therefore was not an “employee” within the policy definition of that term. The court analyzed the policy and found that coverage was provided for “losses resulting from the dishonest or fraudulent acts by Employees of the Assured . . .” The policy defined “Employee” to include officers of the company. Since the controlling shareholder of the company was also its president, the court found that he clearly fit this definition. Significantly, the policy did not require that the company have the right to “direct and govern” any covered employee, nor did it exclude employees from coverage if they controlled the company. Based on the absence of this language from the policy, the court refused to follow Fidelity cases where the alter ego defense was upheld because those cases involved policy language which specifically excluded from coverage the misdeeds of persons whom the insured did not have the ability to “govern and direct.”

b. In Beck v. State Farm Fire & Casualty Co., et al., 2001 WL 482449 (N. D. Cal. 2001), plaintiffs, a group of individuals, profit sharing plans and trust, retained a corporation to invest in mortgage loans. The company serviced the mortgage loans and ordinarily paid to the plaintiffs the principal and interest due on the loans. Nevertheless, when some of the loans

were repaid in full, the company did not distribute the escrow funds to the plaintiffs, but instead kept the funds and concealed that the loans had been repaid. The company was owned by one shareholder, who also served as its sole officer and director.

Upon learning of the embezzlement, the plaintiffs sued the company and its sole officer, director and shareholder, and obtained a default judgment in the amount of about \$2.5 million. Next, the plaintiffs brought an action against Commercial Union, seeking to recover the judgment based upon the fidelity bond coverage it had provided to the company. Commercial Union denied coverage because the sole officer, director and shareholder of the company was not “an employee” within the meaning of the policy. In this regard, the policy defined an “employee” as “any natural person . . . whom you compensate directly or by salary, wages or commissions; and . . . whom **you have the right to direct and control** while performing services for you . . .” (emphasis added)

Commercial Union filed a motion for summary judgment based upon this defense, which was granted by the court. In finding for Commercial Union, the court found that the undisputed facts showed that the sole officer, director and shareholder of the company operated as the president, chief executive officer, and chief financial officer for the company, and he did not have an immediate supervisor. As a result, no reasonable jury could have found him to be an employee within the meaning of the policy.

c. In Hudson United Bank v. Progressive Casualty Ins. Co., 152 F. Supp. 2d 751 (E. D. Pa. 2001), a bank had as one of its lines of business loaning money to a high-risk drivers to pay their automobile insurance policies. It then retained a data processing and servicing firm to provide most of the services in connection with the administration of these loans, including periodic reports on the profitability of the business.

The bank sustained significant losses in this line of business, and after investigation, presented a proof of claim to its fidelity insurance carrier, claiming that the losses were a result of the data processing firm’s misrepresentation that the business was profitable, and its concealment of the fact that the line of business was highly unprofitable. It was claimed that the firm engaged in the alteration of computer data to show that the line of business was making money rather than losing significant sums. Progressive denied coverage, and the lawsuit followed. Among the claims asserted, the bank claimed that Progressive had liability under the fidelity insuring agreement of the policy. Progressive moved to dismiss this claim, and the court denied the motion.

Progressive argued that this claim should be dismissed because under its fidelity insuring agreement, it was only liable for losses resulting directly from dishonest or fraudulent acts committed by “an employee.” Progressive argued that the data processing firm was not an employee and, therefore, no liability of this portion of the insuring agreement existed. The bank argued that the definition of “employee” under the insurance agreement included “each natural person, partnership or corporation authorized to perform services as data processor of checks or other accounting records of the Insureds . . .” Since this language did not exclude the data processors, it argued that the data processing firm came within the definition of “employee.” The court also accepted this theory, and denied the motion to dismiss.

d. In Orleans Parish School Board v. Chubb Custom Ins. Co., 162 F. Supp.2d 506 (E.D.La. 2001), a fidelity insurer issued a crime insurance policy, which covered employee theft, to a group insurance administrator ("GIA-LA") that handled school board employees' medical claims. After GIA-LA filed bankruptcy, the school board sued various parties, including the fidelity insurer that had issued the crime insurance policy. In its claim against the insurer, the board argued that the president of GIA-LA had illegally co-mingled funds between parent company and the insured subsidiary. The insurer moved for summary judgment arguing that the president was not an employee as defined by the policy.

The policy defined an employee as a person "in the regular service of" GIA-LA whom GIA-LA "has the right to govern and direct in the performance of such service." The district court found the opposite to be true. Because the president owned 100% of the voting stock in GIA-LA, made all the decisions concerning GIA-LA and its subsidiaries and did not answer to anyone, including his board of directors, the court found that *he in fact controlled GIA-LA* and GIA-LA did not have the right to govern and direct his service. The insurer's motion for summary judgment was granted. Fortunately, the district court recognized the clear intent of the policy definition of "employee" – to exclude what are often manufactured claims arising out of the conduct of individuals over whom the corporation has little or no oversight.

3. EMPLOYEE DISHONESTY

a. In Banclnsure, Inc. v. BNC National Bank, 263 F.2d 766 (8th Cir. 2001), a loan officer of a bank made various loans to an individual customer and his company, Top Dog Productions, totaling several million dollars. The loans ranged from imprudent and foolish to directly contrary to the instructions given by the loan officer's superiors. Unbeknownst to the bank was the fact that the loan officer and her husband formed a company with the bank customer, and that company bought products directly from the customer. Several of the bank's loans to the customer were made specifically to finance the manufacture of the products it was selling to the loan officer's company.

Later, the loans went into default, the loan officer's relationship with the customer was discovered, and a claim was made against the financial institution bond. Interestingly, the financial institution bond was provided by Banclnsure Insurance Company, a captive insurance company created by the banking industry, so the bank probably expected a warm reception to its claim. This was not to be. The insurer not only paid just a fraction of the claim - approximately \$900,000 on a \$3 Million claim, but did so under a reservation of rights. After making the partial payment, the insurer filed a declaratory judgment action concerning its liability under the bond and sought a refund from its customer.

The court largely sided with the insurer, and rejected the argument of the bank that manifest intent to harm the bank should be found on every loan because each loan was "infected" by virtue of the loan officer's secret business relationship with the customer. The court first defined "manifest intent" to mean "clearly evident intent." The court next separately analyzed each loan to determine whether it met the policy requirements, and only found two that involved a manifest intent by the loan officer to harm the bank. These were the two loans used to finance the manufacture of products to sell to the loan officer's company, and which also caused the bank officer to exceed her approved lending limits to the customer. As a result, the court found that the insurer only owed the bank approximately half of the money it had

actually paid on the claim. To rub salt in the wound, the insurer then persuaded the court to order the bank to refund the other half of the money it had paid on the claim.

b. In F.D.I.C. v. National Union Fire Ins. Co. of Pittsburgh, PA., 146 F.Supp.2d 541 (D.N.J.), after taking over a failed bank, the FDIC sued the bank's fidelity insurer National Union, arguing that the bank's loan officer had concealed from the bank's executive committee reports and appraisals concerning a ruinous construction project. National Union moved for summary judgment, arguing among other things that the FDIC had failed to prove that the alleged dishonest employee had acted with the requisite manifest intent as required by the terms of its bond.

In considering National Union's motion, the court ruled that to establish "manifest intent" the plaintiff had a "double burden" - the plaintiff must show that the loan officer had acted with the *specific intent* to cause the bank a loss and with the *specific intent* to obtain a financial benefit for himself or a third party. In doing so, the court joined a growing list of federal courts that place such an onerous burden on an insured. Among other cases, the court cited General Analytics Corp. v. CNA Ins. Cos., 86 F.3d 51, 53 (4th Cir.1996) in support. In General Analytics, the Fourth Circuit Court had described manifest intent as "specific intent, analogous to that required by criminal law. Thus if a dishonest act has the *unintended* effect of causing a loss to the employer or providing a benefit to the employee, the act is not covered by the policy." The court also recognized that bonds like the one at issue were "designed to provide coverage for a specific type of loss characterized by embezzlement, which involves the direct theft of money."

After considering the facts, the court concluded that in nearly five years of litigation, the FDIC had failed to establish sufficient evidence to show that the loan officer had acted with the specific intent to cause the failed bank a loss, nor could the court infer that the loan officer manifestly intended to obtain an improper benefit for a third party. The court wrote, "[t]ake away all of the legalese, and it is clear that the reality of this case is simply mismanaged banking. Plaintiff is seeking to convert this bad banking into egregious employee dishonesty in order to collect on its large losses." Being unwilling to convert what it concluded was at best negligence into intentional acts of fraud, the district court was also unwilling to sit through a trial on the matter, and therefore entered summary judgment in favor of National Union.

c. The Nike case discussed *supra*, bears some additional treatment here. As mentioned in section 1(b), Nike brought suit under an employee theft policy to recover losses attributed to an account representative located in Taiwan. The account representative had allegedly accepted post-dated checks from a customer, failed to require sufficient collateral for transactions, granted improper discounts on products and processed excessively large orders. Nike also suspected that the employee was receiving kickbacks from the customer. The customer defaulted resulting in a loss to Nike.

While Nike clearly has its finger on the pulse of the basketball shoe and jogging bra purchasing population, it apparently missed the boat on traditional Taiwanese business practices -- which the appellate court actually suggested were "not necessarily at odds" with the account representative's conduct. The appellate court held that the fact that the account representative's conduct may have amounted to violations of internal policies and procedure was not sufficient to establish an unlawful taking as required by the policy. The court therefore

found that the knowledge of the existence of those violations alone was insufficient to trigger the statute of limitations, and summary judgment was inappropriate. Violations of internal policies, the court added, might have been the result of "no more than *negligence* or *incompetence*." (emphasis added). On the other hand, an unlawful taking, the court explained, required the insured to prove that its account representative had the intent to cause the employer to sustain a loss.

Although the appellate court's determination allowed Nike to survive summary judgment, it also suggests that Nike's underlying claim, which appeared to rest exclusively on the conduct that might *only amount to a company violation and not an intentional unlawful taking*, would not carry the day on remand. The fact that the date upon which Nike discovered that the account representative had the requisite dishonest intent could not be determined, leads one to wonder if Nike will be able to prove the existence of such intent *at all*.

4. ON PREMISES

In California Korea Bank v. Virginia Surety Co., 225 F.3d 661, 2000 WL 713789 (9th Cir.(Cal.) 2000) (unpublished opinion), a wrongdoer altered the amount of a check and used it to withdraw funds belonging to a bank customer. Upon discovery of the fraud, the customer brought a breach of contract action against the bank for the amount of the loss plus interest.

After settling the customer's claim, the bank brought a *third-party* insurance claim against its insurer under a financial institution bond, arguing that the "on premises" provision of that policy afforded coverage. The district court disagreed and entered summary judgment.

On appeal, the Ninth Circuit Court affirmed, citing in support its prior decision First American Title Ins. Co. v. St. Paul Fire and Marine Ins. 917 F.2d 215, 218 (9th Cir. 1992). The circuit court found that the loss that the bank suffered was not covered under the terms of the on premises coverage in the policy. The court ruled that in order to make out a third-party insurance claim, the insured must show that the conduct covered by the policy *culminates* in the lawsuit of the third-party. In this instance that was not the case. The customer had brought a breach of contract action for the recovery of the deposit and it was the bank's breach (and not the underlying fraud) that proximately caused the eventual loss.

5. IN TRANSIT

In KMC Management Corp. v. Certain Underwriters at Lloyd's London, 2000 WL 1742096 (Minn. App. 2000), a mortgage banker made payments to a mortgage loan originator, instead of to the banks that were entitled to receive the payments, doing so at the behest of the loan originator. Instead of transmitting the payments to the banks, an officer of the mortgage loan originator company diverted them. The banks sued the mortgage banker and the case was settled. The mortgage banker then brought an action against its fidelity insurer to recover the cost of the settlement. The fidelity insurer was granted summary judgment after the district court concluded that there was no coverage under the policy. The Court of Appeals of Minnesota affirmed.

The appellate court noted that the bond coverage provisions only covered lost property occurring "in transit anywhere in the custody of any person or persons acting as messenger...."

The court found that "neither logic nor the facts" supported the mortgage bank's argument that the funds were somehow in transit. The mortgage originator was never acting as a messenger on behalf of the mortgage bank to deliver money to the banks. Further, and perhaps more importantly, the appellate court found that the funds were not in transit because they had reached the destination to which the mortgage banker had transmitted them.

6. FORGERY/ALTERATION

a. In Universal Bank v. Northland Ins. Co., 2001 WL 435072 (9th Cir. 2001), a bank appealed a trial court's dismissal of its breach of contract and breach of implied covenant of good faith and fair dealing claims brought to recover against a fiduciary bond. The circuit court affirmed the dismissal and, in doing so, again affirmed the need for stringent limiting language in forgery provisions contained in all fidelity policies.

The Ninth Circuit based its decision on four grounds; all of them relating to limiting language in the bond. First, the court found that the forged signature did not "purport" to be that of a bank customer under the common understanding of that term, and therefore fell outside the bond's coverage provision. Second, the court found that the purchase agreement and escrow instruction in which the alleged fraudulent signature appeared did not fall within the bond's definition of "instruction." Third, the court found that because the purchase agreement and escrow instructions were not "directed to the insured" they failed to meet additional coverage provisions. Finally, the court found that the purchase agreement and escrow instructions were not "mortgages and deeds of trust" or "like instruments pertaining to realty," in that they did not express a debtor-creditor relationship between the buyer and a third party.

While the bank's claim appears to have been somewhat of a stretch from the start, Universal Bank points out how well-drafted exclusionary language can render a bond impenetrable to forgery claims that were never intended to fall within the scope of coverage terms.

b. In Georgia Bank and Trust v. Cincinnati Insurance Co., 538 S.E.2d 764 (Ga. App. 2000), a bank brought an action against a financial institution bond after a borrower forged the signatures on credit union confirmations, which assured the existence of minimum balances in a savings account pledged as collateral for a loan. The claim arose after the borrower defaulted on the loan. The trial court entered summary judgment in favor of the insurer, and the appellate court affirmed.

The appellate court found that the issues in the case presented a matter of first impression in the State of Georgia. Fortunately for the fidelity insurers with exposure in the state, the court elected to follow well-settled federal decisional law strictly construing forgery provisions. The court found that the loss was not caused by the forged signatures on the confirmations. To the contrary, the court concluded that even if the signatures were authentic, the bank still would have suffered a loss because the assets pledged as collateral did not exist. The court explained that the bond did not protect the lender from its bad business deal nor delegate to the insurer the responsibility of checking the borrower's assets.

7. LIMITS OF LIABILITY

a. In Valley Furniture Interiors, Inc. v. Transportation Ins. Co., 26 P. 3d 952 (Wash. App. Ct. 2001), a furniture company paid its employees on a monthly basis, but allowed them mid-month advances against their paychecks on request. Furthermore, the furniture company allowed its employees to purchase furniture at a discount, the payment of which would be deducted from their month-end paycheck. Over a period of six years, a payroll manager issued a number of advances to herself and to two other employees, but failed to deduct these from the paychecks. In addition, the payroll manager purchased furniture in the company at a discount, but again failed to deduct these purchases from her paycheck. In all, these losses totaled approximately \$200,000.

Upon discovery, the furniture company made a claim against its insurance carrier for employee dishonesty. Since the policy limit was \$50,000, the furniture company claimed that there were multiple occurrences, entitling it to recover multiple policy limits. The policy defined an "occurrence" as "all loss or damage . . . involving a single act or series of related acts." The insurance carrier determined that only one occurrence had occurred, since all of the acts were related. The furniture company disagreed and filed suit.

The court entered summary judgment in favor of the insurance company. The court looked to the Webster's dictionary for definitions of the words "series" and "related." Combining these definitions, the court concluded that a "series of related acts" as used in the policy means "a succession of logically or causally connected acts, linked by time, place, opportunity, pattern and method." The court found that this is exactly what had occurred. The thefts by the three employees, who benefited from receiving employee advances were all part of a series of related acts, as was the payroll manager's purchase of furniture at a discount without deducting these purchases from her payroll. Thus, the court limited the furniture company's recovery to \$50,000.

b. In Shemitz Lighting, Inc. v. Hartford Fire Ins. Co., 2000 WL 1781840 (Conn. Super. Ct. 2000), a company engaged in the sale of light fixtures obtained a business insurance policy from Hartford Fire Insurance Company. The policy contained an insuring agreement for employee dishonesty, and limited the amount of coverage to \$10,000 for "each occurrence." The initial policy was for one year, and it was renewed for an additional year.

Apparently displeased with her compensation, the insured's bookkeeper embarked upon a scheme of forging checks payable to herself, and diverting checks payable to her employer and depositing them in her account. These activities occurred during both policy periods, and resulted in a loss in excess of \$200,000 to the insured.

The insurer tendered \$10,000 to the insured as full satisfaction of its obligations. Needless to say, suit was filed. Both parties moved for summary judgment, and the court correctly noted that the controlling issue was whether the bookkeeper's thefts constitute a single "occurrence" or multiple "occurrences." The relevant policy language provided that all loss or damage "involving a single act or series of related acts" is considered one "occurrence." The court spent a great deal of time in its opinion reviewing the case law around the country, but ultimately concluded that the term was ambiguous. The court stated that an insured may reasonably interpret a policy which limits liability based on "each occurrence" to mean that their

recovery is limited to \$10,000 for each act of dishonesty; \$10,000 for each employee; \$10,000 for each policy; or \$10,000 for each coverage period. The court therefore concluded that since the term is susceptible of more than one reasonable interpretation, it must be construed against the insurer and in favor of the insured as a matter of law. Accordingly, the court accepted the insured's interpretation of the contract, and found that a separate \$10,000 liability limit applied to each act of theft.

c. In Ran-Nan, Inc. v. General Accident Insurance Company of America, 252 F.3d 738 (5th Cir. 2001) two employees of a convenience store, acting independently, stole money from their employer. The employer made a claim under its Employee Dishonesty policy for both losses. The losses occurred over two consecutive policy periods. The insurer claims that there had been only one occurrence under the policy, and therefore tendered the policy limit of \$25,000 on one of the policies. The insurer cited the policy language which defines an "occurrence" as "all loss caused by, or involving one or more 'employees', whether the result of a single act or series of acts ...", arguing that the thefts by the two separate employees fell squarely within this definition. The insurer argued that this language means that regardless of how many employees steal from the insured, and whether or not their acts are independent of one another, there is only one loss of cash and therefore only one "occurrence." The Fifth Circuit Court of Appeal, however, rejected this argument finding that the "more natural reading of the policy, however, is that the 'involving' clause signifies a group of employees conspiring together to steal." Accordingly, the Court found that there were two separate "occurrences," and hence, the insured was entitled to \$50,000.

d. In Shared-Interest Management, Inc. v. CNA Financial, 725 N.Y.S.2d 469, (N.Y. App. Div. 2001) an employer filed a proof of loss for a series of thefts committed by its employee between April, 1994 and April, 1997. The original crime policy was issued in 1990, and the relevant renewals were for the premium terms from June, 1993 to June, 1996, and again from June, 1996 through June, 1999. During the period of the second renewal, Fireman's Insurance Company merged with CNA Financial, who issued a Notice of Renewal of the policy, but changed the policy number in accordance with CNA's numbering system.

After reviewing the insured's claim, CNA determined that its insured had sustained a loss in excess of \$400,000 and paid its policy limit of \$100,000 for the 1996 through 1999 policy period, which the insured accepted in full satisfaction of its claim. The insured later discovered that its loss was greater than anticipated, and filed another \$100,000 claim for the 1993-96 policy period. This claim was denied because CNA contended that the policy did not allow the recovery of more than one policy limit during the effective period of the policy. The insured then filed suit.

Both sides moved for summary judgment, and the lower court granted the plaintiff's motion for summary judgment reasoning that the 1993 - 1996 and 1996 - 1999 renewals were separate policies as a result of the CNA Financial merger with Fireman's. CNA appealed and argued that the policy in effect during Fireman's policy period and the one in effect during CNA's policy period constituted the same policies of insurance, and the appellate court agreed, finding "illogical" the insured's argument that Firemen's somehow became a different insurance company, following the merger, from the one that had originally issued the policy. Accordingly, the appellate court ordered that judgment be entered in favor of CNA.

e. In Spartan Iron & Metal Corp. v. Liberty Ins. Co., 2001 WL 301111 (4th Cir. 2001), the Fourth Circuit Court of Appeal upheld the summary judgment entered against Liberty Insurance Company on an employee dishonesty issue. Liberty had issued two successive one-year policies to its insured, and each policy was separately numbered and a single annual premium was paid for each. The policy limit for each insurance policy was \$100,000.

During each of the two years for which Liberty provided coverage, a single employee of the insured stole in excess of \$100,000. The insured filed a claim with Liberty for \$200,000, alleging covered losses for \$100,000 in each of their two policy years. Liberty offered only \$100,000, asserting that the acts in question constituted a single occurrence within the meaning of the policy. The policy provided that "occurrence means all loss caused by or involving, one or more employees, whether the results of a single act or a series of acts." In interpreting this provision of the policy, the court found it to be ambiguous because the definition does not affirmatively indicate whether a series of acts includes acts occurring outside of the policy term. The court further concluded that conditions 13(b), which provided that Liberty was only liable for "loss [sustained] through acts committed or events occurring during the Policy Period . . ." also supported a reasonable construction of the contract that the "series of acts" constituting an "occurrence" was only intended to apply to acts occurring within the policy period.

Of note, the court also rejected the insurer's argument that the noncumulation clause in the policy was unambiguous and barred the insured from recovering two policy limits. The court also found this provision to be ambiguous for the same reason.

8. EXCLUSIONS

a. In Hudson United Bank v. Progressive Casualty Ins. Co., 152 F. Supp. 2d 751 (E. D. Pa. 2001), a bank had as one of its lines of business loaning money to a high-risk drivers to pay their automobile insurance policies. It then retained a data processing and servicing firm to provide most of the services in connection with the administration of these loan, including periodic reports on the profitability of the business.

The bank sustained significant losses in this line of business, and after investigation, presented a proof of claim to its fidelity insurance carrier, claiming that the losses were a result of the data processing firm's misrepresentation that the business was profitable, and its concealment of the fact that the line of business was highly unprofitable. It was claimed that the firm engaged in the alteration of computer data to show that the line of business was making money rather than losing significant sums. Progressive denied coverage, and the lawsuit followed. Among the claims asserted, the bank alleged that the computer system's Computer Service Rider to the bond imposed liability on Progressive because the data processing firm had altered and concealed information in its data processing information. Progressive moved to dismiss this claim.

Progressive argued that the bank's losses were excluded from coverage because they stemmed directly or indirectly from non-payment or default of the bank's loans to its customers, and not from the alleged acts of dishonesty of the data processing firm. The bank, however, successfully argued that the bank's losses as described in the complaint resulted from the data processing company's concealment of altered accounting data. In short, it argued that the bank would have exited this line of business and would not have suffered losses had the data

processing firm not concealed the data. The court accepted this theory, and rejected Progressive's arguments.

b. In Bidwell & Company v. National Union Fire Insurance Company, 2001 WL204843 (D.Or. 2001), a national discount securities brokerage firm secured a financial institution bond from National Union Fire Insurance Company. The insured's clients established individual user accounts with the brokerage firm, and deposits into those accounts were kept in a general account maintained by the brokerage firm with Wells Fargo Bank. Three checks were deposited into individual accounts at the brokerage firm which were later determined to have been altered or forged. The checks were initially honored and paid by Wells Fargo Bank. Nevertheless, after affidavits of alteration or forgery were presented to Wells Fargo, it paid the banks which finally accepted the checks. Wells Fargo then debited the brokerage firm's account for the amount of the three altered or forged checks. In turn, the brokerage firm then presented a claim to National Union for the amount of these losses. Litigation followed.

With respect to two of the three checks, the Court granted summary judgment in favor of the brokerage firm. These checks involved clear instances where the check had been intercepted and the name of the payee was altered. With respect to the third checks, involving a forged endorsement, the court found that the facts were sufficiently disputed as to whether the endorsement was genuine so as to preclude summary judgment for either party. With respect to the two altered checks, however, the court made short work of National Union's innovative defenses.

First, National Union argued that since its policy had exclusion (O), that excludes coverage for losses which involve "items of deposits which are not finally paid for any reason" it was not liable for the two altered checks. The argument was that under the applicable UCC, since Wells Fargo ultimately debited the brokerage firm's account, no "final payment" was ever made by Wells Fargo on the checks, and hence, no coverage. The brokerage firm argued that "final payment" under the UCC occurs when the payor bank has "paid the item in cash" or when it provisionally accepts the item, and does not return it or give a notice of dishonor by the "midnight deadline." The court accepted the Plaintiff's argument and found that exclusion (O) was inapplicable.

Secondly, and building on its first argument, National Union argued that since its bond only covered a loss "resulting directly from" a forgery or alteration, the losses in question were not covered. The argument was that if the payments were final and exclusion (O) is inapplicable, then Wells Fargo acted improperly in debiting the brokerage firm's account. Accordingly, National Union took the position that the brokerage firm's loss was not "directly from" the forgery or alteration, but rather was caused by the intervening, superseding cause of Wells Fargo's improper actions. In its counter-argument, the brokerage firm contended that Wells Fargo's actions in debiting its account were based upon its common law right of offset, which is a remedy available to it for the brokerage firm's actions in breaching its transfer warranties. The Plaintiff's unavoidable breach of its transfer warranties occurred when it negotiated the checks. Because the breach proximately caused Wells Fargo's right to setoff, the loss resulted directly from the forgery or alteration. Again, the court found the brokerage firm's argument persuasive and rejected the arguments of National Union.

c. First Ins. Funding Corp. v. Federal Ins. Co., 2001 WL 293967 (N.D. Ill. 2001), illustrates some of the creative arguments fidelity insureds will use to avoid exclusionary provisions. In First Insurance, the fidelity policy in question contained an "agency exclusion" which excluded from coverage any "loss caused by any agent, broker, commission merchant, independent contractor, intermediary, finder or other representative of the same general character of the [insured]." The insured was a large insurance finance company that made loans to business customers, designed to finance the expense of paying annual premiums for property and casualty insurance. The insured typically employed the service of independent insurance agents or brokers who initially acted on the customer's behalf.

After suffering a loss in excess of \$4 million at the hands of one of its brokers, the insured filed a claim against its fidelity policy. The insurer denied the claim. In an eventual lawsuit, the insurer moved to dismiss, arguing that the loss was excluded under the agency exclusion. While the insured did not contest that the broker was a "finder" or "intermediary," it still argued that the agency exclusion did not apply. The insured urged that because it did almost all of its business through its brokers, the agency exclusion should only be applied when the broker actually acts as a finder or intermediary, and not when the broker performs other services. To hold otherwise, the insured suggested, would render the coverage itself illusory. The court, however, prudently disagreed. The court simply found that under the plain meaning of the terms "finder" or "intermediary" the exclusions applied, and the court dismissed the insured's claim.

d. In Benchmark Printing, Inc. v. American Mfrs. Mut. Ins. Co., 2001 WL 66310 (N.D.N.Y. 2001), a commercial printing company discovered that its former sales manager had misrepresented to two of its clients that the company was unable to perform their printing jobs and that the jobs would be subcontracted to third parties. The sales manager explained to the printing company that he had lost the accounts to competitors. The sales manager then arranged for other printing companies to perform the jobs for a kickback.

Plaintiff claimed that as a result of its sales manager's conduct it lost the kickbacks that the subcontractor paid to the sales manager as well as "other and further losses including but not limited to lost profits" and submitted a proof of loss to its fidelity insurer. The insurer denied the claim, and a lawsuit ensued.

As one would expect, the case involved straight-forward contract construction. The policy insured against the loss of "money, securities, and properties other than money and securities resulting directly from employee dishonesty." The policy excluded from coverage indirect losses "including but not limited to, loss from [the insured's] inability to realize income that [the insured] would have realized had there been no loss of, or loss from damage to, Covered Property." The district court found that the printing company was simply trying to fit lost "business opportunity" or "lost profits" under the terms of a policy that did not cover those type of losses.

Although "not necessary to [its] disposition," the court also found that the "indirect exclusion" did not apply because the Plaintiff was not claiming the loss of income or lost profits from the loss of covered property, but rather was claiming that the lost profits *were themselves actually covered property*. The court dismissed the case and directed the clerk to enter judgment against the printing company without providing it an opportunity to replead.

e. While many trial courts have recently chipped away at the enforceability of inventory computation exclusions, Schledorn v. United Fire and Casualty Co., 2001 Wisc. App. LEXIS 809 (August 14, 2001) proves that such exclusions can still carry the day for a fidelity bond surety. In Schledorn, an automobile dealer discovered employee dishonesty and made a claim against its fidelity bond. To prove its claim, the dealer submitted invoices purporting to show that its dishonest employee had removed auto parts from its electronic inventory. The dealer, however, primarily relied upon a comparison of a physical versus electronic inventory, an estimate of its losses supported by inventory shortages, and an affidavit of one of its own employees documenting a telephone interview with the dishonest employee, during which he allegedly admitted the theft.

The trial court entered summary judgment in favor of the fidelity bond surety, and the dealer appealed. The appellate court made short shrift of the dealer's claims on appeal, affirming the lower court's judgment. Although the appellate court acknowledged that inventory computation exclusions are unenforceable where "independent evidence first shows" the dishonest act (citing Tri-Motors Sales, Inc. v. Travelers Indemnity Co., 119 N.W. 2d, 327, 331 (1963)), the court found that the dealer had made no such independent evidentiary showing. Other than the affidavit, the court found that the dealer clearly relied upon inventory computations to prove its claim. The affidavit failed to get the dealer over the hump. The Court found that the affidavit contained inadmissible hearsay which could not be used to support the dealer's claim.

Schledorn continued the very favorable trend of courts, both state and federal, strictly construing tight exclusionary language in fidelity bonds.

9. THIRD-PARTY CLAIMS

In Mellon Bank v. National Union Fire Ins. Co. of Pittsburgh, P.A., 768 A.2d 865 (Pa. Super. Ct. 2001), the appellate court opened the door a little wider for third parties to make direct equitable claims against fidelity insurers.

In 1996, National Union's insured, Kaiser Aluminum, brought an action against Mellon Bank, alleging that an unknown third party had forged two checks drawn on one of its accounts at a bank branch, and Mellon was liable for honoring the checks. Things got interesting when, during his deposition, Kaiser's representative indicated that the loss was not covered by insurance. To the contrary, the loss was covered, and later that year National Union reimbursed a portion of the claim pursuant to the commercial crimes policy it had issued to Kaiser. Upon receiving payment, Kaiser partially assigned its rights against Mellon to National Union pursuant to an assignment and release agreement.

At trial, Mellon was found liable to the insured for the forgery losses and judgment was entered against it. Shortly thereafter however, Mellon learned that the insured indeed had coverage for the loss and had received payment from National Union. Mellon therefore instituted an action against the Kaiser and National Union. The court granted National Union's motion for judgment on the pleadings and dismissed Mellon's claim against it, finding that Mellon was not a covered insured or an intended beneficiary of the Kaiser-National Union policy. Victory was short lived, however.

Mellon immediately appealed the dismissal arguing that the lower court erred when it found that Mellon was not an insured (or intended beneficiary) under the Kaiser-National Union policy and erred where it failed to find that Mellon was entitled to recover under the compensated surety rule.

With respect to the first issue, the appellate court strictly construed the language in the policy, which would have allowed Mellon to make a claim so long as it had been an insured or had been "included in [Kaiser's] proof of loss." Mellon did not offer any evidence at trial that it had been included in Kaiser's proof of loss, but did offer some half-baked theory on appeal. To support its claim, Mellon pointed to correspondence attached to the proof of loss, where Kaiser discussed potential legal action *against Mellon* for the forgery losses. The appellate court found this argument less than compelling (in fact, the court used such descriptive adjectives as "contrived" and "strained" to describe Mellon's interpretation). Clearly Kaiser did not intend Mellon to receive any proceeds from the policy, and so the court quickly dispensed with the first of Mellon's two arguments. Unfortunately, the appellate court was not quite as abrupt with the latter of the two issues.

Unfortunately, after six thoughtful pages of fine jurisprudence, the appellate court breathed new life into Mellon's case, using the superior equities doctrine to do so. The trial court had found that Mellon's equitable claims rested upon whether it was first found to be an insured. Without expressly saying so, the appellate court disagreed.

Bleeding the "compensated surety rule" and "superior equities doctrine" together, Mellon essentially argued that because unlike Mellon, National Union was paid to bear the risk of loss at issue, Mellon's equitable rights were superior. Unfortunately, the appellate court bought in, but only to a limited extent. The appellate court refused to adopt any bright line rule that would allow Mellon to recover simply because National Union was paid a premium for coverage. The court remanded to the trial court to "balance the equities between Mellon and National Union;" however, it requested that the trial court "consider any role the bank may have had in causing the loss, plus any relevant policy considerations underlying the statute upon which Mellon was found liable...."

Before reaching this holding, the appellate court discussed several analogous state and federal decisions, where the cited courts all had suggested that a balancing of the equities must include some consideration of the role the third party claimant played in the loss. With the cases it discussed, the appellate court appeared to signal to the trial court that it should ultimately rule in National Union's favor. Nonetheless, the Mellon case appears to leave the door wide open for third parties to make equitable claims against fidelity insurers even where the subject policies were not issued to cover their losses.

10. SETTLEMENT AND "RECOVERIES" PROVISIONS

Pacific Coast District v. Travelers Casualty and Surety Company, 782 A.2d 269 (D.C. App. 2001), points out the often treacherous interplay between settlement agreements and "recoveries" provisions in fidelity bonds. In Pacific Coast, Traveler's predecessor had issued a fidelity bond to a labor union insuring against employee embezzlement. In 1996, the union submitted a \$5.4 million bond claim for losses attributed to the embezzlement of salary and severance benefits by union officers. The union claimed that the officers had fraudulently

procured their elections thereby embezzling salary and benefits. The union also claimed that the officers had caused the union to merge with another labor union so as to obtain illegal severance payments.

While Travelers disputed the salary component of the claim, it settled the severance component for \$1 million. In the settlement agreement ("Agreement"), Travelers agreed to pay for the severance pay embezzlement by three union officers. The union in turn released Travelers and assigned to it its claim "for the amount of the aforesaid payment which it may have against (the three officers) and any other parties who acted in concert therewith..." Travelers agreed that with respect to the three officers only, it would take only a 75% share of any future recoveries. The Agreement also contained a provision that eventually caused Travelers considerable heartburn. The provision acknowledged that the 75%/25% sharing of restitution was "(s)ubject to the excess loss provision in the bond," – a clear reference to the "recoveries" provision contained in the bond.

In a subsequent civil lawsuit and related criminal proceedings, the union received restitution from two of the officers and a third co-conspirator. The union refused, however, to allocate any of the recovery to Travelers.

As one might imagine, Travelers sued to enforce compliance with the agreement. In its defense, the union argued that under the recoveries provision of the fidelity bond, which was specifically incorporated into the Agreement, *it was entitled to keep all of the funds until it reached the total of its bond claim*, which would of course include the salary losses Travelers had not reimbursed. In an eventual summary judgment motion, the union argued that the recoveries provision of the fidelity bond required that it be "made whole" before Travelers was entitled to any reimbursement.

Travelers, on the other hand, argued that the wrongly procured salaries were not covered by the terms of the fidelity bond and that, in any case, the union had waived any claim that those salaries were covered -- by settling for less than the total loss. Travelers thus asserted that there was no excess loss remaining to be setoff against its right of reimbursement. The trial court granted Traveler's motion for summary judgment, but awarded considerably less than the total amount requested. The court found that the recoveries provision in the bond referred only to excesses over *severance* pay losses, not the union's total loss.

The issue on appeal was the proper allocation of the Union's total recovery under the Agreement. The appellate court rejected the union's "made whole" argument. The court relied upon the assignment language in the Agreement, which assigned to Travelers all claims "against [the Union's] officers and...employees...by reason of conduct upon which its claims against [Travelers] had been made and pursuant to which [Travelers] makes the aforesaid payment." The court found that because the payment was the "*quid pro quo*" for this release and assignment, "exactly what the sum was meant to cover [was] clearly probative of the rights the parties understood [the union] to be transferring and those it was reserving." Based upon the terms chosen by the parties, the court found that the union and Travelers clearly intended to incorporate the recoveries provisions of the bond *only to the extent that it covered severance pay loss*.

The court also noted that if it were to apply the "made whole" theory offered by the union, this would completely undermine the evident purpose of the sharing arrangement in the Agreement. If the union were to be made whole before the insurer was to recover any of its losses, the union's 25% share would amount to a bonus or windfall, and the union failed to offer an acceptable reason concerning why it would be entitled to such a bonus.

While the court remanded for a trial on the issue of apportionment relating to the one officer's restitution payment, it affirmed on the most significant portion of the trial court decision, finding that Traveler's was entitled to its proportionate share of the subsequent recovery from the officers, and the "recoveries" section of the bond did not undermine the right of recovery conveyed in the Agreement.

Looking behind the scene in Pacific Coast, it is clear that both the trial court and the appellate court recognized that the labor union was attempting to take advantage of loosely worded provisions in the Agreement. The lessons to take away from this case are both 1) know thy enemy when settling with him, and 2) carefully consider likely future events when crafting your settlement agreement with a dubious opponent.

11. INTERPLEADER ACTIONS

Progressive Cas. Ins. Co. v. Belmont Bank Corp., 2001 WL 92338 (S.D. Ohio 2001), may provide additional arrows to the quiver for fidelity bond sureties facing opposition to their interpleader actions. In Progressive, an insurer issued a bank a fidelity bond covering employee dishonesty or fraud. After the occurrence of some alleged fraud involving a former bank officer, several parties, including the bank and aggrieved shareholders, brought state court actions to recover for the fraud.

With the Progressive case, the fidelity insurer attempted to bring an interpleader action against the holding company, bank, bank officers and subsidiaries linked with the state court actions, presumably in part to avoid the future litigation expense attendant to defending itself in the several state court actions. The defendants argued for dismissal of the interpleader action on various grounds, including the somewhat novel "no independent liability doctrine."

The no independent liability doctrine bars interpleader actions if the plaintiff is more than a mere stakeholder, and has made independent, personal agreements with some of the claimants regarding the subject matter claimed. Not only did the court find that the insurer had not made any independent personal agreements with the claimants (beyond the terms of the policy), the court also found that the no independent liability doctrine had "outlived its usefulness" and the court therefore refused to recognize it any longer in its jurisdiction.

The district court, recognizing not only the usefulness but also the necessity of insurer's interpleader action, denied the motion to dismiss. The outcome in the Progressive case and other recent federal decisions reinforce the notion that, where there is clear liability, a federal interpleader action under 28 U.S.C § 1335 remains a useful mechanism to prevent both duplicative exposure and the often astronomical litigation expense associated with piecemeal state and federal court litigation.

12. MISCELLANEOUS

a. In Securities and Exchange Commission v. Bancorp Ltd. 147 F. Supp. 2d 238 (S. D. N. Y 2001), a company of dubious origin and unclear business lines ("risk free arbitrage") obtained policies of insurance from Lloyds, including a crime policy, professional malpractice and directors and officers coverage. About six months after the policy was issued, the company filed a claim against the crime coverage. The claim was investigated and paid. Following this claim, the underwriters began to do more due diligence concerning the business of the company. In the course of this investigation, the underwriters learned that: (a) the company was misrepresenting its insurance coverage to its customers to make the coverage look like it was a financial guarantee; (b) there were "severe doubts about the viability" of the company; (c) the company "was believed to be operating a fraudulent scheme," and (d) no evidence could be found that the company was licensed to conduct business in any jurisdiction. Nonetheless, the policies were not canceled.

Some months after the investigation was concluded, the Securities Exchange Commission filed an enforcement action against the company and placed it in receivership. The receiver filed claims against the insurers, who asserted various affirmative defenses, including (a) the appointment of the receiver terminated coverage, and (b) the policies were void because they contained misrepresentations by the company.

With respect to the termination provisions in the policy, it provided that the policy would "immediately cease to afford any coverage . . . in the event of . . . the Appointment of a Receiver or Manager." The insurers argued that the appointment of the receiver immediately terminated coverage, and as soon as the coverage terminated pursuant to this provision any claims about which they were subsequently given notice were barred. The notice provision in the Fidelity section of the policy required notice "of a loss or claim (or of circumstances which could give rise to a loss or claim) . . ." In analyzing this language, the court concluded that the Securities Exchange Commission Complaint, which preceded the appointment of the receiver, and the contents of which were known to the insurers shortly after suit was filed, contained a description of the circumstances that could give rise to future claims, and thereby constituted notice of all claims based on the same facts. The court reasoned that notice of the discovery of a loss were circumstances which could lead to a loss, and that is all that the policy required. Notice of each separate claim is not necessary under the policy.

With respect to the insurers' affirmative defense of misrepresentations in the policies, the court concluded that while misrepresentations may have existed, the insurers, by their conduct after issuing the policies, ratified them. The court cited to the facts gathered and opinions reached in connection with the insurers' investigation of the company after it had filed its Fidelity claim. The court rejected the insurers' argument that they were not fully aware of the company's fraud, finding that there was no dispute that the insurers "were put on notice of evidence indicating fraud." The court, in granting the Receiver's motion for summary judgment on this issue, stated that a finding of ratification will defeat a claim for misrepresentation "where the party seeking to avoid the contract does not take prompt action after discovery of the alleged false statement."