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FIDELITY LAW UPDATE

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A. BAD FAITH AND IMPROPER TRADE PRACTICES

In *USAlliance Fed. Credit Union v. CUMIS Ins. Soc'y, Inc.*, 2004 WL 2758665 (S.D.N.Y. Oct. 2, 2004), the Insured submitted a proof of loss in June 2002 for approximately \$6.9 million resulting from the alleged dishonest conduct of the Insured's former Vice President. After the Insurer denied coverage, its Insured filed suit seeking punitive damages and claiming, *inter alia*, bad faith. The Court granted the Insurer's motion to dismiss, as New York does not recognize an independent tort for the bad faith denial of insurance coverage. New York also does not award punitive damages for breach of contract in the absence of an independent tort. Finally, for the Insured to succeed on its claim of deceptive business practices, the conduct of the Insurer must be considered "consumer oriented." Private contract disputes between policy holders and insurance companies typically lack the consumer impact to state such a claim.

In *Newton & Assoc., Inc. v. Labrasca*, 2004 WL 335193 (Conn. Super. Ct. Feb. 4, 2004), the Insured's claim under a commercial crime policy was denied. The Insured filed suit claiming the Insurer's denial constituted a violation of the Connecticut Unfair Insurance Practices Act (CUIPA), a violation of the Connecticut Unfair Trade Practices Act (CUTPA), and a breach of the covenant of good faith and fair dealing. All three claims were dismissed.

A private cause of action under the CUIPA is only permissible as a vehicle through which to bring a CUTPA claim. One element of a CUIPA violation, however, is a pattern or practice of unfair insurance settlements, which the Insured failed to prove. Therefore, the CUIPA claim, as well as the derivative CUTPA claim, was dismissed. "It is well-settled law in Connecticut that in a CUPTA claim against an insurance company, the plaintiff must allege and prove a CUIPA claim." Finally, the Court dismissed the Insured's bad faith claim for failing to allege facts sufficient to support the claim.

B. CANCELLATION OR TERMINATION OF COVERAGE

In *First Nat'l Bank in Manitowoc v. Cincinnati Ins. Co.*, 321 F. Supp. 2d 988 (E.D. Wis. 2004), the Insured cancelled its financial institution bond effective October 1, 2001. On October 22, 2001, the Insured discovered a loss potentially covered under the bond. and the Insured asserted a claim under the recently-terminated bond. In granting the Insurer's motion for summary judgment, the Court noted that the bond stated that "Company agrees to indemnify the Insured against any loss covered by this Bond which is sustained by the Insured at any time but *discovered during the Bond Period.*" The Insured admitted that Insurer is not

liable once the bond is terminated, but argued that the bond was never properly terminated since the Insurer gave no notice to the Wisconsin Department of Financial Institutions ("Department"), as required by a rider in the bond. The bond rider was included because of a Wisconsin statute requiring such notice prior to cancellation of a financial institution bond issued to a state chartered bank.. As a national bank, however, the Insured was not regulated by the Department and notice to the Department would have legally been a meaningless act. Therefore, the Court ignored the literal requirement of the rider.

In *Home Sav. Bank, SSB v. Colonial Am. Cas. & Sur. Co.*, 598 S.E.2d 265 (N.C. Ct. App. 2004), the Insured learned in 1985 that one of its employees had embezzled company funds from a prior employer. When the Insured applied for a financial institution bond in 2001, the application did not ask about, nor did the Insured offer, any information regarding employees with a history of dishonesty. The Insured later learned that its employee had also been embezzling from its customer accounts. The Insured made a claim under the bond, which the Insurer denied based on the provision that "This bond terminates as to an employee . . . as soon as any director, titled officer or risk manager of any Insured not in collusion with such person learns of any dishonest or fraudulent act committed by such person at any time." The trial court granted summary judgment for the Insured, construing the provision to mean that coverage only terminates when the Insured discovers the history of dishonesty *after* the bond takes effect. The Court of Appeals affirmed, finding this construction to be reasonable. The Court admitted, though, that the Insurer's proposed construction – that the bond terminated upon inception as to the employee since bank knew of prior acts of dishonesty – was also reasonable, leading to an ambiguity in the bond. Because ambiguities are construed against the drafter, the Court ruled that the bond covered the Insured's loss.

C. **COMPUTER CRIME**

In a thus-far unreported case, *Morgan Stanley Dean Witter v. Chubb Group of Ins. Co.*, (N.J. Super. February 17, 2004), the Court granted summary judgment to the Insurer regarding claims under the computer systems, voice initiated transfers, and facsimile transfer instructions insuring agreements of an electronic and computer crime policy. All of the instructions were made by an authorized official of the Insured's customer. Therefore, the Court determined that the loss was caused by an authorized transaction and not fraud perpetrated on the Insured or its customer.

In *Hudson United Bank v. Progressive Cas. Ins. Co.*, 2004 WL 2309885 (3rd Cir. Oct. 14, 2004), a predecessor of the Insured funded a loan program for high-risk automobile drivers in which the predecessor directly paid the insurance provider each month's premium for the term of the contract. The driver, meanwhile, paid the Insured a significant down payment and assigned his interest in the unearned premium to the Insured as collateral. If the driver defaults on the loan, the Insured is entitled to recover the unused portion of the annual premium previously paid after notifying the insurance carrier of the cancellation. From a practical standpoint, the Insured often made more profit on a cancellation than if all payments were timely made, but only if a default was identified and the policy promptly cancelled. The Insured's predecessor contracted with K-C Premium Finance Company ("K-C") to administer the loans. The computer program used to identify defaults proved ineffective, however, resulting in nearly \$4 million in collateral deterioration and nearly \$1 million in overpaid profit

sharing payments to K-C. Most significantly, the computer system was incapable of charging off defaulted loans. K-C's computer system also generated incomplete and inaccurate data that was then supplied to Regent.

The Insured asserted coverage under its Computer Systems Fraud Rider ("Rider") which provided coverage for loss resulting from the fraudulent entry of data into the Insured's computer system. The Court determined that the Insured was not entitled to coverage under the bond's Rider. The erroneous data produced by K-C's computer system was merely sent to the Insured's employees, who then unsuspectingly input such information into the Insured's computer system. Moreover, the Rider only provided coverage for computer systems operated by the Insured. K-C had no access to the Insured's computers, and was incapable of directly transmitting data to the Insured's computers. The fact that Insured entered the data into its own computer system after receiving it from K-C in hard copy form did not provide coverage.

D. CONTRACTUAL LIMITATIONS

In *Wall Street Disc. Corp. v. Hartford Fire Ins. Co.*, 2004 WL 951074 (S.D.N.Y. May 4, 2004), the United States District Court granted the Insurer's summary judgment motion against the Insured for its failure to commence legal action within two years following discovery of loss. The Insured swore under oath in January 2003 that "the loss was discovered in April 2001." The Insured did not file suit until July 2003.

Additionally, the Court discussed the Insured's failure to provide its Insurer with timely notice of a potential loss. Under New York law, the Insured must have complied with the contract's notice provision as a condition precedent to for coverage. The bond provided that the Insurer should be notified of a potential loss within thirty (30) days of its discovery, yet the Insured did not alert Hartford of a potential loss until approximately ten (10) months after discovery. Because the Insured failed to give timely notice, the Insurer was deprived of the opportunity to investigate the fraud or utilize its contacts within law enforcement to locate the assets before they were fully dissipated. The Court also found the Insured's contentions that Hartford waived this defense by not initially asserting it in its letter denying coverage to be without merit.

E. CUMULATION OF LIMITS

In *Sherman & Hemstreet, Inc. v. Cincinnati Ins. Co.*, 594 S.E.2d 648 (Ga. 2004), the Insured purchased a commercial insurance policy from Cincinnati Insurance Company ("Cincinnati") providing coverage for, *inter alia*, employee dishonesty. The policy had a three year term from September 1, 1997 to September 1, 2000, and was renewed for another three year term from September 1, 2000 to September 1, 2003. The policy contained a \$50,000 Limit of Insurance, and provided that "Regardless of the number of years this insurance remains in force or the number of premiums paid, no Limit of Insurance cumulates from year to year or period to period."

Four years after the original policy took effect, the Insured submitted a proof of loss \$160,670: \$50,000 for each year of the original policy and \$10,670 for the first year of the

renewed policy. Cincinnati successfully argued that the original policy was a single three-year policy, as opposed to three one-year policies, and paid only \$50,000. The Court of Appeals, however, ordered Cincinnati to pay an additional \$10,670 under the renewed policy. The Georgia Supreme Court affirmed finding that the non-accumulation provision clearly prevented the “stacking” of limits of liability over numerous policy years within one policy. The Court also noted that the non-accumulation provision was ambiguous as to whether it prevented the “stacking” of limits under separate policies. Therefore, it also affirmed the finding that the second policy provided coverage in addition to the coverage under the first policy.

In *Auto Lenders Acceptance Corp. v. Gentilini Ford, Inc.*, 854 A.2d 378 (N.J. 2004), the New Jersey Supreme Court found that the anti-cumulation provision in the policy was found to be ambiguous. Therefore, the Court found that each of the 27 fraudulent loan applications prepared by the same employee of the Insured was a separate occurrence and, therefore, subject to separate \$5,000 limits of liability. “Occurrence” was defined as follows: “[a]ll loss or damage: (1) [c]aused by one or more persons; or (2) [i]nvolving a single act or series of related acts; is considered one occurrence.” The Court found that this provision intended to make it clear that one loss was subject to one limit of liability even if multiple employees were involved. The court viewed each of the 27 loan applications as giving rise to a separate loss, therefore giving rise to 27 separate occurrences.

In *The Times Picayune Publ’g Corp. v. Zurich Am. Ins. Co.*, 2004 WL 169823 (E.D. La. Jan. 26, 2004), the Insured purchased a crime insurance policy from Federal Insurance Company (“Federal”) for successive one-year periods from July 1, 1990 to July 1, 2001. For two successive one-year policies beginning July 1, 1996, the Insured purchased excess crime insurance policies from Federal. These excess policies provided coverage for \$1.5 million, payable only after the \$1 million limits of the primary policy had been paid. For three successive one-year periods beginning on July 1, 1998, the Insured purchased similar excess crime policies through Zurich American Insurance Company (“Zurich”). After learning an employee embezzled over \$2.2 million from January 1995 to December 2000, the Insured then made claims under its primary policy with Federal and its excess policy with Zurich. The Insured suffered over \$1 million in loss prior to the effective date of the excess policy, which Zurich refused to pay.

The excess policy provided that Zurich is liable only if (1) the Insured was continuously insured under a prior policy providing the same insurance as the current policy, and (2) the Insured cannot recover because the prior policy was terminated and its discovery period has run out. Even then, Zurich is only liable if the excess policy would have covered the Insured’s loss had it been in effect at the time the acts causing the loss occurred, and if the Insured discovered the loss within one year after the prior excess policy is terminated. According to the Court, to have been “continuously insured” means the Insured was covered by an excess policy or policies for as long as that excess coverage was in effect without interruption. Therefore, the Insured was continuously insured by excess crime policies since July 1, 1996. The Court granted partial summary judgment to Zurich because Zurich’s policy would not have “been in effect at the time the acts that caused the loss occurred.” The Court found that the loss during the policy periods in which excess coverage was in place (1996 to 1998) did not exceed the primary insurance limit of liability (\$1 million). Therefore, excess coverage was never triggered. The Court rejected the Insured’s argument that Zurich was liable for the total

aggregate loss which exceeded \$1 million (including loss which occurred prior to 1996 when only primary insurance was in place). In dicta, the Court held that the “continuously insured” provision extended back as far as the Insured has coverage under a like policy. Applied in the context of primary insurance, this could significantly broaden the scope of coverage under the policy in place when a loss is discovered. .

In *Wausau Bus. Ins. Co. v. US Motels Mgmt., Inc.*, 341 F. Supp. 2d 1180 (D. Colo. 2004), the Insured possessed two commercial crime policies covering successive one-year periods beginning August 1, 2000. In June 2002, the Insured discovered an employee had been embezzling funds since 1998. The Insurer determined the loss to be a single “occurrence,” and tendered payment of \$100,000, the limit of the policy. The Insurer then filed for a declaratory judgment that it had satisfied its obligation under the policy, which the Insured opposed. The Court agreed with the Insurer that the numerous acts of embezzlement constituted one “occurrence.” The Court also interpreted the non-cumulation provision to mean that the Insurer was not required to pay the Insured \$100,000 for each policy period. The relevant policy provision stated that whenever a loss spanned two policy periods, “the most we will pay is the larger of the amount recoverable under this insurance or the prior insurance.” The Court said “this provision could not be clearer.” Finally, no additional payment was due for loss sustained during the term of prior insurance from another company, because the current policy clearly provides that the prior coverage is part of, not in addition to, the coverage under the current policy.

F. DEFINITION OF EMPLOYEE

In *Humboldt Bank v. Gulf Ins. Co.*, 323 F. Supp. 2d 1027 (N.D. Cal. 2004), the Court determined that Michael Schwartz (“Schwartz”), the owner of several automated teller machines (ATMs), was not the Insured’s employee. The Insured entered an agreement whereby it provided cash to Schwartz to place into his ATMs. Schwartz in turn prepared and submitted to the Insured an Inventory Summary regarding the amount of cash left in each ATM. After Schwartz stole over \$5 million of the Insured’s money, the Insured submitted a claim under its financial institution bond, which was denied. The Insurer argued successfully that Schwartz was not an employee. The Insured argued that Schwartz was an employee as part of the definition of employee included “electronic data processor . . . of accounting records.” The Court found that Schwartz “merely recorded the balances for particular ATMs on a standard form and faxed that form to Humboldt.” The Court said this activity was not paramount to “data processing,” as that term was used in the Bond.

G. ERISA

In *re Healthsouth Corp.*, 219 F.R.D. 688 (N.D. Ala. Feb. 3, 2004) denied the motion to intervene filed by several plan participants. Several insurers sought to rescind various policies, including ERISA fidelity policies, on the grounds of fraud and misrepresentation during the underwriting process. The plan participants argued that they had a “direct, significant, and legally protectable interest in the outcome of this litigation,” but the Court ruled that their interest was only economic, which is insufficient to support an intervention. The Court called the plan participants’ interest in securing a pool of funds from which to draw “not only purely economical, but also theoretical, considering no judgments have been obtained against the

insureds.” Furthermore, the Court determined that any legal interest the movants have in this litigation was adequately represented by the insureds. This case is instructive on who must be joined in an insurer’s action to rescind or otherwise interpret an ERISA bond or policy.

H. EXCLUSIONS

In *Harrah’s Entm’t, Inc. v. ACE Am. Ins. Co.*, 2004 WL 1193958 (6th Cir. May 27, 2004), Jing Li cashed two forged cashier’s check totaling \$1.5 million at one of the Insured’s casinos in Las Vegas, in exchange for gambling credit. In a matter of hours, Jing Li had lost all but \$38,200 of that amount. The casino then paid Jing Li the \$38,200 balance in cash, bringing the casino’s losses to \$1.5 million. The casino asserted a claim under a Blanket Crime Policy. The District Court granted summary judgment for the Insurer, and the Sixth Circuit affirmed.

The Court first determined that the Insured’s loss was excluded under a clause denying coverage for “loss (1) due to the giving or surrendering of Money or Securities in any exchange or purchase.” The Insured gave Jing Li gambling credit, which qualifies as Money or Securities, in exchange for the forged checks. The Court found that the Insured’s interpretation of the exclusion “at best creates an ambiguity . . . that we must construe against the drafter of the policy,” in this case the Insured. The Insured asked the Insurer to issue a specific policy form (which was a standard crime policy). This, the Court concluded, required the policy to be construed against the Insured as the drafter.

The Court also ruled that a clause providing coverage for loss due to acceptance of money orders issued by the post office or an “express company” did not apply. The cashier’s check presented by Jing Li was clearly not issued by the post office, and if a cashier’s check constitutes a money order it is better defined as a “bank money order.” At a minimum “ambiguity clouds the meaning of the phrase,” so that the document must be construed against the drafter. Finally, the Court agreed with the District Court’s striking of two expert affidavits submitted by the Insured interpreting the provisions at issue. The affidavits contained only legal conclusions such as “In my opinion, the [policy] was intended to provide coverage in the present situation.” The Court’s mention of ambiguity clouds its finding that the policy provisions did not provide coverage. There was no express finding of ambiguity, but merely acknowledgment that even if the policy language was subject to multiple interpretations, it would be construed against the Insurer.

In *Humboldt Bank v. Gulf Ins. Co.*, 323 F. Supp. 2d 1027 (N.D. Cal. 2004), the Court granted the Insurer’s motion for summary judgment. A predecessor to the Insured entered into an agreement whereby it provided cash to Michael Schwartz (“Schwartz”), the owner of several automated teller machines (ATMs), in exchange for various fees and interest. The agreement provided that the cash was to remain property of the Insured until legally withdrawn by a valid customer. In most situations like this, an armored car company would take the cash from the Insured to the ATMs so that Schwartz never had direct contact with it. In this case, though, the Insured permitted Schwartz to use an armored car company that he owned and operated.

The Insured eventually notified Schwartz that he would be unable to continue using his own armored car service and gave 120 days to terminate the agreement. For those 120 days, however, the Insured continued to service Schwartz’s ATMs using the owner’s armored car

company. During that time, the Insured delivered approximately \$5.25 million that Schwartz stole before disappearing. Schwartz was eventually found dead in Florida, and the Insured recovered all but \$1.3 million of its money. The Insured's claim under the Bond was denied.

An exclusion under the Bond was for loss resulting from loans or "transactions in the nature of loans," or from extensions of credit. The Court agreed with the Insurer that "a reasonable lay person looking at Humboldt's ATM Cash Program would conclude that the money given to Schwartz which forms the basis of this action was 'in the nature of a loan' or an 'extension of credit.'" Therefore, the loan exclusion applied.

I. FORGERY

In *Lusitania Sav. Bank, FSB v. Progressive Cas. Ins. Co.*, 328 F. Supp. 2d 514 (D.N.J. 2004), Theresa Leuzzi ("Leuzzi") opened a bank account in the name of TCS America and deposited a check made payable to the same. In actuality, TCS America was a New York company with whom Leuzzi has no affiliation or authority. Leuzzi endorsed the check by writing "Deposit Only TCS" and signing her name underneath it. Under the warranty of endorsement, Insured bank paid the drawee bank the full amount of the deposited check – \$198,124.00. Leuzzi, via later withdrawals, actually received \$59,801, the amount of loss claimed. The bond covered losses resulting from forgery, which was defined as "the signing of the name of another person or organization with intent to deceive; it does not mean a signature which consists in whole or in part of one's own name signed with or without authority, in any capacity, for any purpose." In a matter of first impression in New Jersey, the Court ruled that this definition of forgery excluded coverage in this case. Since the endorsement on the check included Leuzzi's true name, it was not a forgery as defined in the bond.

J. LOSS

In *Auto Lenders Acceptance Corp. v. Gentilini Ford, Inc.*, 854 A.2d 378 (N.J. 2004), the New Jersey Supreme Court overruled an entry of summary judgment for the Insurer, stating that issues of material fact prevented a proper entry of summary judgment for either party. The Insured had an agreement with Auto Lenders Acceptance Corp. ("Auto Lenders") to fund the installment sales contracts of high credit-risk buyers. Auto Lenders had recourse, however, if any credit information they received from the Insured regarding the purchaser was false. After it was discovered that an employee of the Insured falsified twenty-seven (27) credit applications, Auto Lenders sued the Insured. The New Jersey Supreme Court determined that the Insured did in fact suffer a "direct loss of Business Personal Property." The Insured was induced by its employee's fraudulent acts to hand over automobiles in exchange for installment sales contracts signed by non-creditworthy customers. This exposed the Insured to a risk of default it was not willing to accept, meaning that any loss suffered from defaulting purchasers was directly the result of its employee's actions.

In *Cargill, Inc. v. Nat'l Fire Union Ins. Co. of Pittsburgh, Pa.*, 2004 WL 51671 (Minn. Ct. App. Jan. 13, 2004), the employees of a marketer, processor, and distributor of hybrid corn seed misappropriated a competitor's intellectual property. The Insured's executives possibly had knowledge of their employee's actions. The Insured eventually settled with its competitors for over \$400 million, and then sought indemnity from its Insurer. The Court upheld summary

judgment for the Insurer by first determining that the Insured suffered no direct loss. The loss was indirect since incurred in defending and eventually settling claims brought by third-parties. "That the insureds may be liable to a third-party for a loss of money resulting from [employee] theft does not transform a policy covering the insureds against a direct loss into one indemnifying them against liability." Since the employees did not steal any property of the Insured's, there was no direct loss. In fact, the Court determined that the Insured did not sustain any actual "loss." To the contrary, it initially benefited from its employee's actions. The "settlements were restitutionary in nature – serving only to offset Cargill's prior gain from the misappropriated germplasm – and did not therefore represent a financial detriment." The Court also observed that coverage should be excluded as loss resulting from "accessing" any confidential information or trade secrets. Despite the Insured's claim that the term "accessing" is ambiguous, the Court ruled that misappropriating trade secrets equates to "accessing" them.

In *Oriental Fin. Group v. Fed. Ins. Co.*, 309 F. Supp. 2d 216 (D.P.R. 2004), the Insured's employees engaged in conduct causing numerous transactions to be misplaced or lost. The Insured wrote off millions of dollars in order to balance their accounting records, but made no claims that the employees absconded any funds. The Insurer moved for summary judgment on the grounds that the Insured suffered no direct or actual loss. The contract between the parties did not define "loss," but the Court noted that a majority of jurisdictions interpret it to mean "direct loss or actual depletion of bank funds caused by the employee's dishonest acts." The Court further stated that "bookkeeping or theoretical losses, not accompanied by actual withdrawals of cash or other pecuniary loss is not recoverable." Although the Insured's employees did not actually steal any property from their employer, summary judgment was denied. The Court stated that it is a question of fact whether the Insured incurred a "loss."

In *Pine Bluff Nat'l Bank v. St. Paul Mercury Ins. Co.*, 2004 WL 2750154 (E.D. Ark. Oct. 20, 2004), the Insured established a revolving line of credit for Ralph Croy & Associates ("Croy"), a commercial lessor of copy machines. To secure the line of credit, Croy assigned the Insured the payments due under Croy's leases with his customers. The Insured calculated the amount of credit it afforded Croy based in part on the length of the leases. After Croy defaulted in 2002, the Insured discovered that several leases were falsified to lengthen the lease periods. As a result, the Insured lost more than \$1.1 million in unpaid credit it would not have otherwise offered Croy.

The District Court first ruled that the clause insuring loss suffered by the forgery of negotiable instruments did not apply, since the leases in question contained no promise to pay sum certain, and contained other obligations besides payment. The Insured was similarly not covered because the leases were not a Certificated Security, Document of Title, Deed, or Certificate of Origin or Title. The leases were also not "forged" since the signatures on each lease were authentic, even if other terms were not. Finally, the Court noted that the forgery did not have to be the *sole* cause of the loss for the Insured to trigger coverage.

In *RBC Mortgage Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 812 N.E.2d 728 (Ill. Ct. App. 2004), the Illinois Court of Appeals upheld a trial court's dismissal of the Insured's claim on the grounds that the Insured did not suffer a direct loss. Brandon Earl ("Earl") worked as a loan officer at First City Financial Corporation ("First City"), a wholly owned subsidiary of the Insured. Earl prepared loan packages for potential borrowers. Once a package was

complete, Earl submitted it to Evergreen Moneysource Mortgage Company (“EMMC”), which funded the loans. Under the terms of their agreement, EMMC paid First City a brokerage fee, while the Insured agreed to indemnify EMMC for any loss suffered as the result of a false statement in a loan package. In 1999, Earl originated a fraudulent loan package for himself in the amount of \$450,000. To conceal the fraud, Earl contemporaneously submitted numerous other fraudulent loan packages. Once the fraud was discovered, EMMC brought suit, and a settlement was reached wherein the Insured paid EMMC \$175,000 for losses already incurred, and agreed to indemnify EMMC for future losses traceable to the fraud. The Insured then made a claim under its financial institution bond, which the Insurer denied.

The trial court granted the Insurer’s Motion to Dismiss on the grounds that its Insured suffered no direct loss. “[T]o suffer a direct loss[,] it’s got to be a situation where the employee puts his hand in the employer’s pocket.” The Court of Appeals affirmed, observing that “direct loss” typically means the actual depletion of bank funds caused by a dishonest employee. “If an employee dishonestly causes losses to a third party, which then leads to litigation concluding in a judgment or settlement, the insured has not incurred a ‘direct loss’ under a fidelity bond.” In the absence of a third-party claims clause, a fidelity bond does not provide indemnity for vicarious liability to others arising from an Insured employee’s dishonesty. The Court also stated that the phrase “losses resulting directly from” has a narrower meaning than “losses proximately caused by.” A proximate cause analysis, the Court reasoned, is too broad to accurately capture the intent of the provision.

In *Roberts v. Maichl*, 2004 WL 1948718 (Ohio Ct. App. Sept. 3, 2004), the Insured added employee dishonesty coverage that became effective on July 27, 2000. On July 31, 2000, the Insured was informed that his business partner was falsifying financial records to show fictitious profits. The Insured's claim was denied, and the Ohio Court of Appeals affirmed. “[T]he policy covered only those losses sustained through acts committed during the policy period, beginning July 27, 2000. The evidence in the record indicated that the misconduct here occurred before July 27, 2000.”

K. **MANIFEST INTENT**

In *Auto Lenders Acceptance Corp. v. Gentilini Ford, Inc.*, 854 A.2d 378 (N.J. 2004), The Court concluded that “manifest intent” does not require that the employee actually intend to cause a loss. Instead, manifest intent is satisfied if the loss suffered is the natural and probable consequence of the employee's actions.

In *Hudson United Bank v. Progressive Cas. Ins. Co.*, 2004 WL 2309885 (3rd Cir. Oct. 14, 2004), the Court held that the Insured’s losses were excluded from coverage because there was no intent to obtain a “financial benefit” from the Insured. Financial benefits exclude normal payments such as salary, bonuses, commissions or other “benefits earned in the normal course of employment.” Because commissions were the only benefit received, there was no coverage even though the commissions were procured by fraud.

In *Investors Trading Corp. v. Fid. & Deposit Co. of Maryland*, 2004 WL 3045196 (N.D. Tex. Dec. 22, 2004), two employees violated the Insured's policy prohibiting the trade of uncovered index options in their personal trading accounts. Each employee made the trades

in hopes of making money for themselves. The trades were ultimately unsuccessful, however, and both employees' accounts dipped into a negative balance. The Insured thus claimed a loss under its financial institution bond stemming from its employees' activities.

The Court granted summary judgment for the Insurer because the employees made the transactions with the intent to profit, not to cause a loss. The Court characterized this as "dishonest acts by employees which can only benefit the employee when the employer also benefits. These do not as a matter of law reflect a manifest intent to cause a loss to the employer." Mere knowledge that the Insured would ultimately bear responsibility for any losses suffered does not equate to a manifest intent to cause the Insured a loss.

L. PRIVILEGED DOCUMENTS AND TESTIMONY

In *Bank of China, New York Branch v. St. Paul Mercury Ins. Co.*, 2004 WL 2624673 (S.D.N.Y. Sept. 18, 2004), the District Court decided several motions in a suit filed by the Insured to recover under a financial institution bond. The Court ruled on several of the Insurer's motions to compel regarding, *inter alia*, the discoverability of the allegedly dishonest employee's personnel files and the bank's Suspicious Activity Reports (SARs). The Court held that (1) personnel files must be produced subject to a confidentiality agreement between the parties and (2) precluded discovery of a SARs and related documents filed with or submitted to the Office of the Comptroller of Currency. The Court discussed circumstances pursuant to which the bank examiner and other similar privileges applicable to the SARs and related documents may be overcome.

In *Continental Cas. Co. v. Marsh*, 2004 WL 42364 (N.D. Ill. Jan. 6, 2004), Britamco Underwriters, Inc. ("Britamco") moved to compel the production of documents that plaintiff Continental Casualty Company ("Continental") withheld on privilege grounds. The Court discussed the exception to the attorney-client privilege often seen in insurance cases, in which the attorney acts first as a claims investigator or claims adjustor before acting as legal counsel. Following an *in camera* viewing of the documents by the Court, it ruled that in each document, certain redacted portions were produced by the attorney as a claims supervisor or claims adjustor, and therefore were not privileged. Conversely, certain portions of each document were produced by the attorney as a legal counsel, and were privileged.

Additionally, there were two documents that Continental claimed were protected under the work product doctrine. The Court observed the special difficulty in insurance cases of determining what documents were prepared in the ordinary course of business, and what documents were prepared in anticipation of litigation. The Court relied upon a presumption that materials which are part of a factual evaluation of an insured's claim and that were prepared *prior to* a final coverage decision are not work product. To overcome this presumption, Continental had to demonstrate that there was a reasonable anticipation of litigation when the documents were created, and that the *primary* reason for creating them was in preparation of litigation. Continental failed to meet this burden for either document.

In *Travelers Cas. & Sur. Co. v. J.D. Elliott & Co., P.C.*, 2004 WL 2339549 (S.D.N.Y. Oct. 5, 2004), an Insurer hired a consultant to review a fidelity claim and make recommendations as to salvage. After settlement, the Insurer sought recovery from third-parties who contributed

to the loss. The Insurer moved for a protective order preventing the Defendants from deposing its consultant, who was not going to testify at trial. The Court granted the protective order in part and denied it in part, stating that a line clearly exists when a consultant's work transforms from mere investigation in the ordinary course of business into preparation for trial that is protected as work product. Factors to consider include whether the consultant was retained prior to the coverage decision on a claim, whether an actual threat of litigation existed at the time the consultant was hired, and whether the Insurer or its counsel actually retained the consultant. Because the Court did not have enough facts to determine when that line was crossed, it permitted the consultant's deposition.

M. ON PREMISES

In *The PrivateBank & Trust Co. v. Progressive Cas. Ins. Co.*, 2004 WL 1144048 (N.D. Ill. May 18, 2004), a man representing himself as Lawrence Goodman ("Goodman") entered the Insured's bank and opened a checking account for BBI Enterprises, Ltd. ("BBI"). Goodman deposited two checks totaling more than \$460,000 into the account, but did not endorse or otherwise alter the checks. An employee of the Insured endorsed the two checks with a stamp. Two days later Goodman phoned the Insured and requested a transfer from the BBI account to another account in the amount of \$400,200. Soon thereafter the Insured discovered that Goodman was a false identity, that the checks were stolen, and that BBI was created as a means to deposit the stolen checks.

The Insured did not claim coverage under the Forgery section of the bond, since the checks, though stolen, were legitimate and did not contain any forgeries or alterations. The Insured instead sought coverage under the On Premises section of the bond, which covered losses resulting from actions "committed by a person present in an office or on the premises of the Insured while the Property is lodged or deposited within the offices or premises located anywhere." The Court granted summary judgment to the Insurer since Goodman was not "on premises" when the loss occurred. Goodman was only on the premises to deposit the stolen checks, and no loss occurred at that time. The loss occurred when the funds were transferred, which only occurred when Goodman *phoned* the bank. Moreover, the Court determined that the Erroneous Credits Exception barred recovery because accepting the checks for deposit without the proper endorsement made such deposit erroneous. The "mend and hold" doctrine also afforded no relief to the Insured, despite the Insurer's failure to reference the Erroneous Credits Exception in its denial of coverage letter, since the Insurer pled the Exclusion in its Answer.

O. SALVAGE

In *BancInsure v. BMB Elec. Co.*, 2004 WL 765124 (N.D. Ill. Apr. 8, 2004), the Insurer issued a financial institution bond in favor of Osceola Bancoportation d/b/a Riverbank ("Riverbank"). Osceola Medical Center ("Osceola") maintained an account at Riverbank, and issued check number 48887 to a corporation in Cincinnati. A few months later, Bruce Burks ("Burks") deposited a forged check purporting to be check 48887 into an account in the possession of BMB Electric Company ("BMB") at Great Lakes Bank ("Great Lakes"). Great Lakes presented the check to Riverbank, which honored the check and subsequently deducted funds from Osceola's account. Osceola learned of this deduction and informed Riverbank,

who replaced the funds. Riverbank informed the Insurer of its loss, and the Insurer settled with Riverbank and was assigned all claims and rights against third parties causing or contributing to the loss.

The Insurer in turn moved for summary judgment for conversion and unjust enrichment against BMB and Burks. The Court stated that the Insurer had not made out a *prima facie* claim for conversion since BMB and Burks converted money belonging to Osceola, not Riverbank. Nevertheless, summary judgment was granted for unjust enrichment, as BMB and Burks had undoubtedly retained a benefit to Plaintiff's detriment. "There is no reason for BMB and Burks to retain the funds conveyed to them [R]etention by BMB and Burks of the funds in question violates principles of justice, equity, and good conscience."

P. SECURITIES

In *Brady Nat'l Bank v. Gulf Ins. Co.*, 2004 WL 734884 (5th Cir. Apr. 6, 2004), Brian Stearns ("Stearns") was convicted for operating a Ponzi scheme to defraud investors out of at least \$50 million. Stearns used some of the fraudulently-obtained money to purchase certificates of deposit ("CD") from the Insured, which Stearns used as collateral for two personal lines of credit from the Insured. After Stearns' arrest, the government initially obtained a forfeiture order regarding the CDs, but never enforced it. The Insured eventually liquidated the CDs to pay off Stearns' other debts. The defrauded investors filed suit against the Insured, which eventually settled with the investors and then sought recovery from its Insurer.

After the District Court granted summary judgment for the Insured, the Fifth Circuit affirmed the portion of the judgment rendered under the clause covering losses incurred when the Insured "Purchased or otherwise acquired, accepted or received, or sold or delivered, or [gave] any value, extended any credit or assumed any liability on the faith of any Certified Security which . . . is lost or stolen." The Court determined that the term "stolen" was ambiguous and could reasonably include certified securities that were acquired with stolen money. The Insurer also claimed that the loss directly resulted from the settlement of the investor's claim, not the actions of Stearns. In Texas, however, "mere settlement of a claim resulting from a harm that would be covered by an insurance policy does not mean that the loss came from the settlement as opposed to the covered harm." An award of attorney fees and court costs incurred in the investor's suit and the government's forfeiture proceeding was also upheld. The Court did not, however, award fees and costs incurred when the Insured joined a suit against Stearns' former law firm.

In *Washington Mut., Inc. v. Gulf Ins. Co.*, Civil Action No. H-02-2265 (S.D. Tex. July 7, 2004), the Insurer was sued for breach of contract following its refusal to pay a \$25 million claim. The loss was occasioned by a fraudulent scheme perpetuated by Atlantic International Mortgage Company ("Atlantic"). The Insured would advance funds to Atlantic, which would use the funds to acquire or originate mortgage loans for single-family residences. A promissory note evidenced Atlantic's obligation to pay principal and interest on all advances made by the Insured. As security, Atlantic assigned all rights and claims under the mortgages to the Insured. These were "wet settlement" advances, in that the Insured advanced funds upon a mere electronic request by Atlantic, while the actual mortgage and note was sent to the

Insured within five days. In 2000, the Insured learned of approximately 191 forged promissory notes resulting in \$25 million in losses.

The parties agreed that the fraudulent notes and mortgages constitute a "forgery," but the Insurer claimed the notes were not a negotiable instrument. The notes contained a representation that the mortgagor would inform the noteholder in writing when making prepayments, a representation the Court said was not an "additional promise." The Insurer's argument that each note was an Evidence of Debt was also rejected. The Insured's customer was the payee on the note, and the fact that Atlantic forged other names on the note did not warrant treating them as "evidencing the customer's debt to the Insured."

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