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**FIDELITY UPDATE**

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## A. DIRECT LOSS

1. *Front Line Processing Corp. v. American Economy Insurance Co.*, 149 P. 3d, 906 (Mont. 2006).

In this case, the Plaintiff was a credit card processing company. Its chief financial officer allegedly engaged in dishonest acts, including forging the authorized signature on company checks, using the company credit card for his own purposes, and deliberately failing to file company's payroll taxes and corporate income taxes.

In addition to its other losses, the company was also seeking from its fidelity carrier the expenses of forensic experts in computer science, handwriting and accounting. In addition, it was seeking costs, interest, penalties and fees assessed by the Internal Revenue Service as a result of the failure to pay company taxes. With respect to these identified expenses, the fidelity carrier refused coverage. Thereafter, suit was filed in the United States District Court, which in turn, certified the following question to the Montana Supreme Court:

*“Was the term ‘direct loss’ when used in the context of employee dishonesty coverage afforded under a business owner’s liability policy, include consequential damages that were proximately caused by the alleged dishonesty, or is the construction of the term ‘direct loss’ limited to those damages that directly resulted from the alleged employee dishonesty?”*

This certified question clearly set forth the respective positions of the company and the fidelity carrier.

It is important to note that on this certified question it was assumed, for purposes of the Montana Court addressing the issue, that the losses in question had been “proximately caused” by the dishonest employee’s conduct and that there was the requisite “manifest intent” on the part of the dishonest employee.

In addressing the question, the Montana Supreme Court carefully considered both respective positions, and clearly drew the distinction between a “fidelity policy,” the purpose of which is to indemnify an employer against “a loss rising from the lack of integrity or honesty of an employee,” and a liability policy, which by contrast, indemnifies an insured for “liability to a third party claimant.” The court also correctly noted that the policy in question was a fidelity policy.

Nonetheless, after an analysis of the relevant case law, the court noted that the cases cited by the fidelity carrier principally involved situations in which

the insured had been forced to pay claims to third parties for liabilities arising out of the conduct of its dishonest employee.

The court made an effort to contrast this case with other cases, which had employed a “proximate cause” analysis, in which the claims involved “costs incurred to investigate the extent of alleged dishonest conduct and to mitigate and remedy the discovered damage.” The court’s ultimate ruling, however, appears to be broader than this analysis. It ultimately held that “the term ‘direct loss’ when used in the context of employee dishonesty coverage afforded under a business owner’s liability policy, applies to consequential damages incurred by the insured that were proximately caused by the alleged dishonesty.”

2. *Citizens Bank v. Kansas Bankers Surety Company*, 149 P.3d, 25 (App. Ct. Kansas 2007).

In this case, a bank customer, who maintained his business loans and personal accounts at the bank, also was given a Power of Attorney for a money market savings account at the bank opened on behalf of his aunt. The customer, who was in the used car business, met with the bank president on the bank premises and advised that he was having cash flow problems with his business. He told the president that his aunt had agreed to loan him money from her trust funds until the financial problems were resolved. Thereafter, the customer drew 26 checks on the aunt’s trust account, in an amount in excess of \$1,000,000.00. Thereafter, once the losses were discovered by a co-trustee, the customer’s trustee powers were revoked, and the remaining trustee filed suit against the bank. The basis of this suit was a Kansas statute preventing a customer from depositing fiduciary funds into his personal and business accounts.

The bank notified its insurer of the claim, and was told there was no coverage. Thereafter, summary judgment was entered against the bank in the amount of approximately \$1.2 million. The bank paid the judgment and then filed suit against its bonding company. The basis of the suit was the “on-premises” provision, in which the bonding company agreed to indemnify the bank for “loss of property resulting directly from theft, false pretenses, common law or statutory larceny, 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 of the insured.”

The trial court determined that *Citizens* had sustained a “loss resulting directly from” the customer’s theft, and entered summary judgment in favor of the bank. On appeal, the appellate court stated that whether the bank sustained a loss of property resulting “directly” from the customer’s theft is the main issue in the case. The court initially observed that it is obvious that the bond covers theft of property **from** the bank. The court noted that what is not obvious is whether the bond covers the bank’s loss when the proceeds of a theft are deposited into

the bank, and the bank later becomes liable to a third party from whom the money was stolen.

The appellate court noted that the trial court had utilized the “but for” causation analysis, finding that a theft occurred which ultimately caused a loss to the bank was all that mattered. The appellate court disagreed, finding that the bank did not sustain a loss of property resulting directly from the customer’s theft. To the contrary, the proceeds of the theft from the trust were deposited **into** the bank, and the bank did not sustain any loss of property until it subsequently paid a judgment in favor of the trustee.

3. *Palm Desert National Bank v. Federal Insurance Co.*, 473 F. Supp. 2d 1044 (C.D. Cal. 2007).

In this case, a bank located in California engaged in the business of supplying “bulk cash” for ATM machines throughout the country. When, for example, an ATM machine located in Pennsylvania needed funds, the bank would wire funds to its correspondent bank in the area. The bank then contracted with an armored services company to pick up the funds from the correspondent bank and retrieve the bulk cash. It would then, through a series of steps, place the money in the ATM machine, which was loaded in a “cassette.” In placing the new cassette of cash in the ATM machine, it would retrieve the “old” cassette, take it back to its offices and, deposit what residual cash remained in the old cassette into the bank’s account.

Ultimately, the armored car service went into bankruptcy, a substantial loss of the bank’s money was discovered -- millions of dollars. In the bankruptcy proceeding, employees of the armored car service stated that no money was stolen while inside an armored vehicle, but all thefts occurred at the armored car company’s offices. They further testified that the armored car company officers borrowed customers’ monies for deposit in their personal accounts and to use for the armored car company’s corporate accounts and operating and payroll expenses. The armored car company also altered balance sheet reports they provided to their customers in order to conceal the shortages resulting from their thefts.

The bank filed a claim against its fidelity insurer and the claim was denied. A lawsuit ensued.

The claim was based upon the “in transit” clause in the insuring agreement, which among other things, requires that there be a “loss of property resulting directly from” the covered events. The only argument that the fidelity insurer could muster on this point was that because the armored car company handled the accounts of many different banks, and commingled the funds of those banks, it was “impossible” for the bank to establish whether the claimed loss represents the **actual** loss of currency by the bank. In response, the bank

put in an affidavit clearly articulating the date, time and place of all of its losses. The court made short work of the fidelity insurer's argument, finding that "it is difficult to imagine how [the bank] could establish its loss any more thoroughly than it already has, or establish any more clearly that [the armored car company's] theft **directly** caused the loss."

4. *Union Planters Bank v. Continental Casualty Company*, 478 F. 3d 759 (6th Cir. 2007).

In this case, a bank entered into a warehouse line of credit with a mortgage lender. Under this arrangement, the mortgage lender would generate residential mortgages, which were frequently thereafter resold in the secondary market. When this mortgage banker lacked sufficient capital to originate a residential mortgage, it would use a warehouse line of credit with the bank, pursuant to which it would obtain funding necessary to make the mortgage loan, and would offer as collateral, the underlying mortgage documents. Once the mortgage lender sold the mortgages on the secondary market, the bank would be repaid, such that the commercial bank's collateral would rotate continuously. Apparently there are two types of warehouse lending procedures. One is called "wet," when the lender advances funds before it has in hand the original mortgage documents. By contrast, a "dry" transaction is one in which the bank only advances funds after it possesses these documents. In this particular case, the advances by the bank to the mortgage lender were made in "wet" transactions.

After several years of doing business with one another, the mortgage lender stopped making payments to the bank and defaulted on the loans. It was soon discovered that the mortgage lender had been involved in an elaborate bank fraud. While many of its mortgages were legitimate, toward the end of the relationship with the bank, most were not. The mortgage lender generated fraudulent mortgages by forging borrowers' signature on new loan forms, etc. Thus, when the mortgage lender defaulted, the bank was left with worthless collateral in the form of forged promissory notes, mortgages and assignments of security interests. All tolled, the bank suffered losses in excess of \$25 million.

The bank then looked to its insurance carriers for indemnity. It had an initial layer of coverage with one bank, and three successive layers of coverage, up to \$100 million, with three "excess" insurers. The policies of the three excess insurers required that they be given notice of loss "simultaneously" with any notice to the primary carrier.

All four carriers denied coverage and suit was filed in the United States District Court in Tennessee. Coverage was sought under the forgery or alteration sections of the policy. That provision provided, in part, that the insurer shall indemnify the bank for "Loss resulting directly from" the bank's good faith reliance on a forgery.

In this case, the insurance company argued against the fact that the losses had directly resulted from the forgeries because the real cause of the bank's loss was its own "commercially unreasonable conduct which included such failures as: to verify the information on the loan; to investigate the mortgage lender's credit; to inquire into the alleged property purchases; and to follow the procedures in its agreement with the mortgage lender." The court dismissed this argument because it, at most, established that the bank had been negligent, and if negligence was the result in the exclusion of coverage, it should have been spelled out in the insuring agreement. Since it was not, the defense of the insurance company failed.

5. *Flagstar Bank v. Federal Insurance Company*, 2006 W.L. 3343765 (E.D. Mich. 2006).

In this case, a bank was involved in a mortgage warehousing arrangement with a mortgage lender. Upon receipt by the bank of an executed promissory note, mortgage and other documents, the bank would disburse funds to the mortgage lender in the amount of 99% of the face value of the loan. Once the mortgage lender sold the mortgage to a permanent lender, the commercial bank would be repaid.

In this case, the bank imposed additional restrictions, whereby it would send the money directly to a title company which would hold the funds in escrow pending the closing. Thereafter, in 39 separate transactions, the same permanent lender purportedly agreed to purchase each of the mortgages.

This was all later determined to be a huge fraud. The same people controlled the mortgage lender, the title company, and the permanent lender. Further, all of the transactions in question were fictitious, bearing forged promissory notes and mortgages.

A claim was submitted under insuring agreement D, which provided coverage for "loss resulting directly" from forgery. The fidelity insurer denied coverage, stating that the alleged forgeries were not the cause of the loss, because the loss would have been sustained even had the notes contained genuine signatures because the collateral was fictitious.

On the other hand, the bank urged the court to construe the phrase, "resulting directly from" to mean "proximately caused by." The bank argued that the forgeries caused its loss because it would not have advanced the funds to the mortgage lender had it not received the promissory notes bearing forged signatures.

After analyzing case law presented by the parties on both sides of the issue, the court sided with the fidelity insurer. The court ultimately concluded that

direct loss, the term in the insuring agreement, which the parties are bound by, “implies a closer nexus between the forgery and the loss than mere proximate cause.”

6. *Simon Marketing v. Gulf Insurance Co.*, 57 Cal. Rptr. 3d 49 (Ct. App. Cal. 2007).

In this case, the company had a long standing relationship with MacDonald’s, whereby the company was responsible for the “seating” of high value winning game tickets across the country and MacDonald’s give-away contest. One of the company’s employees, who was involved in this process, organized a network of accomplices and co-conspirators to funnel high value winning game tickets to specific individuals. Those individuals would then redeem the tickets from MacDonald’s, and pay a kick-back to the dishonest employee. Over the course of many years, the dishonest employee stole about \$21 million worth of winning tickets.

After the fraud was discovered MacDonald’s severed its relationship with the company. The company then sued its fidelity insurer claiming that it had lost its entire business as a result of the employee dishonesty. It was very important to note that the company was not seeking compensation for the value of the prizes stolen by its dishonest, the reason for that was that it was MacDonald’s who paid for the stolen winning tickets, not the company. Thus, the “direct loss” flowing from the dishonest employee’s conduct was borne by MacDonald’s, not the employer.

The trial court entered summary judgment in favor of the fidelity insurers finding that there was no “direct loss” suffered by the employer as a result of the dishonest conduct of its employee.

On appeal, the court stated that the “threshold requirement for recovery under a contract of property insurance is that the insured property has sustained physical loss or damage.” The court then ruled that the termination of the employer’s business because MacDonald’s canceled its contract with the employer is “not the physical loss, or damage, to insured property.” The court concluded by saying “simply put, it was MacDonald’s and not [the employer] who paid for the stolen prizes.”

7. *Agrium, Inc. v. Chubb Ins. Company of Canada*, 2007 ABQB 140 (Ct. of Queens Bench of Alberta, 2007).

This case involves multiple issues of fidelity law and may well take the prize for the lengthiest case decided in this area in 2007. Here, Chubb issued an Executive Protection Policy that protected the employer against employee theft and dishonesty.

The employer was a company located in Alberta, Canada which produced fertilizer products. One of the main components of fertilizer is phosphate. In order to obtain supplies of phosphate, the company had traditionally obtained its raw materials from the country of Togo in Africa. The term and pricing of supply contracts with the supplier in Togo were important to the profitability of the employer. Two employees of the employer were tasked with the responsibility of negotiating various extensions and pricing adjustments to the contract between the employer and the supplier over a several year period. During this several year period, much was going on with the employer. It was in the process of evaluating the opening of its own mine in Canada to supply its needs for phosphate, depending on whether the economics were more beneficial than the prices it would have to pay for Togo phosphate, and it was also involved in the process of merging with another company.

Against this backdrop, two employees of the employer engaged in a series of negotiations with the Togo supplier which resulted in several extensions, and pricing adjustments, to the supply contract. Neither of these employees had the authority to bind the company, and all of their actions and tentative agreements had to be reviewed and approved by senior management. In fact, on one of the critical amendments made to the supply contract, the senior officer of the employer noted that the employees had done a “good job” and commended them for their efforts.

Unknown to the employer, however, was the fact that the employees were also dealing for themselves. One of the employees received approximately \$1 million in bribes from the Togo officials. He resigned his post during one of the two year period of coverage, at issue in the case. The other employee, who remained employed during the second year of coverage, supplied the first employee with confidential information which the first employee then used to assist the Togo supplier on its continuing negotiations with the employer.

The result of the various amendments during this two year period was that a longer term contract was secured, but favorable pricing which had existed in earlier years was significantly increased over the longer term of the extension. An opportunity to secure more favorable pricing was also lost during the two year period.

Upon learning of its employees’ duplicity, the employer made a claim for approximately \$20 million in losses due to the increased pricing that it would be paying in the future. The insurer denied coverage on a number of separate bases, suit was filed, and proceeded to trial. At trial, the court considered a number of separate issues raised by the parties, not all of which are discussed here. The more material points are as follows:

## **B. INTERPRETATION OF MATERIAL POLICY PROVISIONS**

First, the court noted that the provision under which coverage was being sought provided coverage for “direct losses of Money, Securities, or other property caused by Theft ...” The court first addressed the issue of whether there was a theft of “money” which was defined by the policy as “only currency, coin, bank notes or bullion.” The court concluded that there was no theft of Money because the dishonest employees did not steal anything within the definition of that term. Rather, the real claims against them were for breach of fiduciary duty, fraudulent misrepresentation or deceit. Next, the court similarly concluded that there was no theft of “Securities” which was also a defined term under the policy, meaning “all negotiable and non-negotiable instruments or contracts representing either Money or other property, including revenue and other stamps in current use, tokens and tickets, but not including Money.” Finally, the court focused on the term “other property” which was not defined in the policy. In this respect, the court found that there was nothing in the policy that would restrict its meaning to tangible objects, and accordingly found that the actions of the dishonest employees could well fall within the term of “other property.”

### 1. Was There “Theft” Within the Meaning of the Policy?

The parties next contended whether there was a “Theft” within the meaning of the policy, which defined it as the “unlawful taking of Money, Securities, or other property ...” The court after analyzing the entire policy concluded that the actions of the dishonest employees in relation to the negotiation of the amendments to the supply agreement come within the meaning of the term “Theft.”

### 2. Direct Loss.

The parties also argued over the issue of whether a “direct loss” had occurred under the policy. The employer argued that “direct loss, equates to ‘proximate’ loss and does not therefore require that theft be the exclusive cause of the loss.” The court sided with the employer on this issue finding that the requirement of a “direct loss” is satisfied where the peril insured against is a “proximate cause” of the loss, relying on cases cited by the employer, including United States cases such as *Scirex Corp. v. Federal Insurance Company*, 313 F. 3d 841 (3d Cir. 2002); *Resolution Trust Corp. v. Fidelity Deposit Co. of Maryland*, 205 F. 3d 615 (3d Cir. 2000); and *Auto Lenders Acceptance Corporation v. Gentilini Ford, Inc.*, 854 A. 2d 378 (N.J. Sup. Ct. 2004).

### 3. Did the Conduct of the Dishonest Employees Cause the Employer a Loss?

The court next addressed whether the conduct of the dishonest employees caused any loss to the employer. It should first be noted that Chubb

paid a portion of the loss, relating to the \$1 million bribe received by the dishonest employees. It contested the coverage for the greater portion of the loss, consisting of alleged increases in prices which the employer had to pay for phosphate under the amended agreements.

The court first noted that there was no evidence presented that the dishonest employees' conduct led to the increase in pricing. The evidence at trial showed that the higher prices agreed to in amendments to the supply agreement were approved by upper level management, and were consistent with pricing trends in the industry over the period in question. Second, with respect to the lost opportunity to secure more favorable pricing, the Court found this to be a result of the employer's preoccupation with its pending merger, and not because of any dishonest conduct of the employees. Finally, with respect to the disclosure of confidential information by one of the employees to the former employee, the court found that these acts did not provide the supplier with any advantage in its negotiations with the employer. There was no evidence that the remaining employee had any influence over the decision to accept the amendments to the contract, nor that he gave any information to his former fellow employee that gave the supplier a competitive advantage in its negotiation with the employer.

#### 4. Statute of Limitations.

Although it was not necessary for the court to address this, Chubb had asserted that the two year statute of limitations, triggered from the date of discovery, had lapsed. This was obviously a fact intensive issue. After reviewing the evidence, the court concluded that the suit was timely brought with the limitations period because the employer had nothing more than a "mere suspicion" of wrongdoing at the point that Chubb argued that the statute began running.

### **C. NOTICE OF LOSS**

1. *Union Planters Bank v. Continental Casualty Company*, 478 F. 3d 759 (6th Cir. 2007).

After several years of doing business with one another, the mortgage lender stopped making payments to the bank and defaulted on the loans. It was soon discovered that the mortgage lender had been involved in an elaborate bank fraud. While many of its mortgages were legitimate, toward the end of the relationship with the bank, most were not. The mortgage lender generated fraudulent mortgages by forging borrowers' signature on new loan forms, etc. Thus, when the mortgage lender defaulted, the bank was left with worthless collateral in the form of forged promissory notes, mortgages and assignments of security interests. All tolled, the bank suffered losses in excess of \$25 million.

The bank then looked to its insurance carriers for indemnity. It had an initial layer of coverage with one bank, and three successive layers of coverage, up to \$100 million, with three “excess” insurers. The policies of the three excess insurers required that they be given notice of loss “simultaneously” with any notice to the primary carrier.

With respect to the excess insurers, the District Court was found to have properly granted motions for summary judgment based upon the notice provisions in the insuring agreements. The court found that the bank provided notice to the primary insurer on February 15, 2002, but did not provide notice to the excess carriers until March 12, 2002 -- 25 days later. The Sixth Circuit Court of Appeal stated, “We agree with the District Court that, whatever simultaneous notice means, it does not mean a 25-day delay.” The bank tried to counter this by arguing that there had been no prejudice by the delay. The appellate court rejected this argument finding that the only law in Tennessee that permitted a “no prejudice” exception to strict compliance with a notice provision related to occurrence-based policies. The court noted that these types of policies frequently amount to “contracts of adhesion” and the enforcement of the strict notice provisions would frequently produce an “undeserved windfall” for insurers. The court found that the policies in question in this case, however, were “claims made” policies, and the court further observed that this was a contract entered into by very sophisticated parties and that there was nothing to have prevented the bank from negotiating the notice provision. Accordingly, it affirmed the summary judgment in favor of the excess carriers.

2. *St. Paul Fire & Marine Insurance Co. v. Whitaker Construction, Inc.*, 2007 W.L. 196903 (W.D. La. 2007).

In this action, a construction company went into bankruptcy. During the bankruptcy, it was discovered that the company’s treasurer had embezzled more than \$500,000.00 between 1993 and 2002 by forging checks on the company’s account made payable to a company he had created. The payments were made to appear to be for construction materials or services that were never actually provided.

Upon discovery of this embezzlement in November 2003, the company made demand upon its fidelity insurer, who had provided the company with policies for a five-year period between 1998 and 2002. The policies from 1998 through 2001 contained language providing:

*“We’ll apply this agreement to covered losses that happen while this agreement is in effect. And you have up to one year after this agreement ends to discover the loss.”*

The 2002 policy was similar, but provided for a shorter discovery period:

*“We’ll pay for covered losses that you sustain from events occurring at any time and discovered by you while this agreement is in effect. You’ll have up to 60 days after this agreement ends to discover the loss.”*

While the bankruptcy court refused to enforce these notice provisions, on appeal to the district court the fidelity insurer found a more sympathetic ear. The district court first had no difficulty finding that the discovery of the embezzlement scheme had occurred well after the last of the five policies had elapsed, together with the discovery periods inserted in each.

The principal issue raised was the enforceability of these notice provisions. Under Louisiana law, it provides that no insurance contract shall contain any condition limiting the “right of action against the insurer to a period of less than 12 months” after the inception of the loss or from the time when the cause of action accrues. The insured argued that this provision voided the notice provisions in the fidelity bond.

The court disagreed, finding that the notice provisions did not contravene Louisiana law because they did not constitute a limitation on the right of the insured to sue the insurer -- i.e. a statute of limitations period of less than one year. Rather, they are intended to “define a covered loss as one that occurs during the policy year and is discovered by the insured within” the prescribed period in the policy.

3. *Hewlett Packard Company v. Factory Mutual Insurance Company*, 2007 W.L. 983990 (S.D. NY 2007).

In this case, Hewlett Packard was developing a new server known as the “Superdome.” Before this program could be marketed, it was necessary to build a large database to run benchmark tests for the Superdome. In August 2002, shortly before the marketing launch of the Superdome, one of the Hewlett Packard employees began sabotaging the efforts to build the necessary database to run the benchmark tests. In January 2001, the database was destroyed, and it is now known that the HP employee was responsible.

As efforts were thereafter made to rebuild the database, the employee disguised his sabotage activities to make the problems HP was encountering appear to be the type of problems which might be encountered because of the nature of the project. Then, in September 2001, the employee was caught accessing files on a coworker’s computer. This promptly led to the discovery that he had been committing sabotage, although the details only emerged gradually. On October 4, 2001, HP presented its claim to its fidelity insurer.

The policy in question provided that in the event of a loss, the insured will “give immediate written notice to” the insurance carrier. The carrier argued that

notice should have been given in January 2001 when the database was destroyed. To the contrary, HP contended that it did not have sufficient grounds for believing that it had a loss for which coverage was available until it discovered the sabotage approximately nine months later.

The court agreed with HP. In reading the policy in context with other provisions, the court noted that there were exclusions for such things as programming errors, faulty workmanship, material, construction or design flaws. Any of these were possible causes of the destruction of the database, and until such time as HP was able to determine that there was a recoverable loss, it was not obligated to give notice. As the court noted:

*“Reasonable notice is the standard.”*

#### **D. FALSE PRETENSES**

1. *Hal-mark Rental Center, Inc. v. Sentry Select Insurance Co.*, 862 N.E. 2d, 1292 (App. Ct. Ind. 2007).

In this case, the insured was a company in the business of renting commercial equipment, including Bobcat excavators. It had obtained an insurance policy, which, among other things, covered it for losses resulting from false pretenses. There was an exclusion to this coverage, however, which provided:

*“If you fail to obtain, verify and document, prior to the transaction, the other parties’ business address, telephone number and driver’s license number”*

the coverage does not apply. After obtaining the policy, the company received a telephone call from an individual who wanted to rent a Bobcat excavator. The transaction was handled over the telephone and the company’s employee obtained the name, address and phone number of the customer, and then read back the information to him to verify its accuracy. He did not, however, obtain the driver’s license number or a copy of the driver’s license from the renter.

Thereafter, the predictable happened. The Bobcat excavator was delivered to the jobsite, and when the rental company went to pick it up at the end of the day, it was gone, never to be found again. The company then made a claim against its insurance carrier for a loss under the false pretenses coverage of the policy. It was undisputed that the company had failed to obtain the driver’s license of the renter before the transaction, and on this basis the insurance company moved for summary judgment. In response, the company made an argument that the false pretenses provision of the insurance policy created illusory coverage, although the details of that argument are omitted from the

opinion. The trial court had little trouble in granting the insurance company's motion for summary judgment.

On appeal, the company conceded that it did not obtain the renter's driver's license number prior to the transaction or obtain any physical documentation from the renter. It instead, relied upon its illusory coverage defense, arguing that "even had a driver's license been provided, the insurance company would have still denied coverage under the false pretenses provision of the policy, thereby creating illusory coverage." Again, this argument is not developed in the opinion. The court rejected this argument finding that illusory coverage is only present in situations "for which the insured paid a premium but from which he would not be paid benefits under any reasonable expected circumstances." The court found that set of circumstances not to exist in this case.

#### **E. IN TRANSIT COVERAGE**

1. *Palm Desert National Bank v. Federal Insurance Company*, 473 F. Supp. 2d 1044 (C.D. Cal. 2007).

In this case, a bank located in California engaged in the business of supplying "bulk cash" for ATM machines throughout the country. When, for example, an ATM machine located in Pennsylvania needed funds, the bank would wire funds to its correspondent bank in the area. The bank then contracted with an armored services company to pick up the funds from the correspondent bank and retrieve the bulk cash. It would then, through a series of steps, place the money in the ATM machine, which was loaded in a "cassette." In placing the new cassette of cash in the ATM machine, it would retrieve the "old" cassette, take it back to its offices and, deposit what residual cash remained in the old cassette into the bank's account.

On the issue of whether the loss occurred while the funds were "in transit," the court observed that the central issue is whether the loss of property occurred "in transit" under California law. The bank argued that the funds were "in transit" from the time they left its corresponding bank until they reached their destination at the ATM machines or returned the residual cash to the corresponding bank. On the other hand, the insurance carrier claimed that because the thefts occurred inside the armored car company's offices, where the funds were sorted, they did not occur "in transit."

In analyzing the issue, the court considered a number of cases, on both sides of the issue, which address the question of when a series of steps were involved in the transport of funds, and in which there was some "break" in the process, when would coverage be available.

Based on the facts of this case, which the court found to be novel, the court concluded that the goods were not in transit when they were at the armored car company's offices, where the losses occurred. The stop at those offices took the goods out of "transit."

#### **F. ON PREMISES**

1. *Citizens Bank v. Kansas Bankers Surety Co.*, 149 P. 3d, 25 (App. Ct. Kansas 2007).

In this case, a bank customer, who maintained his business loans and personal accounts at the bank, also was given a Power of Attorney for a money market savings account at the bank opened on behalf of his aunt. The customer, who was in the used car business, met with the bank president on the bank premises and advised that he was having cash flow problems with his business. He told the president that his aunt had agreed to loan him money from her trust funds until the financial problems were resolved. Thereafter, the customer drew 26 checks on the aunt's trust account, in an amount in excess of \$1,000,000.00. Thereafter, once the losses were discovered by a co-trustee, the customer's trustee powers were revoked, and the remaining trustee filed suit against the bank. The basis of this suit was a Kansas statute preventing a customer from depositing fiduciary funds into his personal and business accounts.

With respect to the "on premises" coverage, the bank argued that it sustained a loss when the question of whether there were trust funds deposited into the bank, and those deposits were made by a person on the bank's premises. Conversely, the bonding company argues that even if the loss occurred at the time the proceeds were deposited into the bank, most of the deposits were made by an employee of the customer, and not by the customer who committed the theft.

The appellate court agreed with the insurance company's argument, finding that the policy language required that the person committing the theft be physically present on the premises of the bank, and that this requirement was not satisfied by the fact that the customer's employee made deposits from the trust account into the customer's account.

#### **G. FORGERY COVERAGE**

1. *Union Planters Bank v. Continental Casualty Co.*, 478 F. 3d, 759 (6th Cir. 2007).

In this case, a bank entered into a warehouse line of credit with a mortgage lender. Under this arrangement, the mortgage lender would generate residential mortgages, which were frequently thereafter resold in the secondary market. When this mortgage banker lacked sufficient capital to originate a

residential mortgage, it would use a warehouse line of credit with the bank, pursuant to which it would obtain funding necessary to make the mortgage loan, and would offer as collateral, the underlying mortgage documents. Once the mortgage lender sold the mortgages on the secondary market, the bank would be repaid, such that the commercial bank's collateral would rotate continuously. Apparently there are two types of warehouse lending procedures. One is called "wet," when the lender advances funds before it has in hand the original mortgage documents. By contrast, a "dry" transaction is one in which the bank only advances funds after it possesses these documents. In this particular case, the advances by the bank to the mortgage lender were made in "wet" transactions.

On the question of whether forgery coverage existed under the policy, the court found that in order for the bank to establish coverage, it must show that: i) it acted in good faith, ii) it acted on original financial documents that iii) contained a forgery upon which (iv) the bank relied, and (v) that the losses "resulted directly" from the bank's reliance on the forgeries. With respect to this provision, the bank also challenged the reliance upon the forged documents, arguing that in the case of a "wet" warehouse line of credit, the money was obtained before the forged documents were received. The court, however, rejected this argument stating:

*"Nor does the policy by its terms preclude coverage under these circumstances. The policy says only that the bank must rely on the forged documents in advancing funds. It does not say that the bank's reliance has to relate only to funds connected to a particular piece of collateral; it thus does not exclude from coverage an entire category of revolving lines of credit -- namely a 'wet' warehouse line of credit."*

2. *First National Bank of Manitowoc v. Cincinnati Insurance Co.*, 485 F. 3d 971 (7<sup>th</sup> Cir. 2007).

In this case, a bank extended credit to a used car dealership based upon presentations of leases signed by customers of the dealership. Unbeknownst to the bank, in many cases the dealership's president forged customers' signatures on leases that were fabricated or altered. The scam worked in one of two ways: the dealership either fabricated a lease agreement for a non-existent vehicle and transaction, or altered the terms of a valid lease agreement and submitted the altered version to the bank.

After the president of the dealership mysteriously left town, the bank learned that it had a problem. It submitted a claim to its financial institution carrier, which was rejected. The relevant policy provisions were Insuring Agreement E which provided coverage for a loss "by reason of the Insured (a) having in good faith and in the usual course of business ... extended any credit

... upon any ... Document ... which proves to have been a forgery or to have been altered ...” The other relevant provision is Exclusion H, which excludes coverage for “loss caused by an Employee ...”

The lower court ruled against the insurance carrier, and an appeal was taken to the Seventh Circuit Court of Appeals. The appellate opinion started on a high note, in which the court affirmed the principle that bankers blanket bond policies, which were jointly drafted by representatives of both the banking and insurance industries, will not be construed against the insurers. Everything after this went downhill for the insurer. The court first addressed the insurer’s two arguments that no coverage was provided under Insuring Agreement E because the policy provisions that the bank act “in good faith” and “in the usual course of business” imposes a duty on the bank to “follow sound banking practices.” The bank argued that there were various “red flags” that the bank employees overlooked which should have been further investigated, and which would then have lead to an earlier discovery of the fraudulent activity. The court first broke this phrase down, and found that “in good faith” does not impose a “sound business practices” prerequisite to coverage. In this regard, the court noted that there was case law, which it endorsed, supporting the proposition that mere negligence on the part of the bank would not bar it from obtaining coverage unless the negligence was “such that it amounts to fraud or bad faith.”

The court next addressed the phrase “in the usual course of business” and found that on its face, this phrase does not suggest a duty of care but rather a certain category of acts – i.e., those conducted in the banking business.

Next the court addressed the insurer’s argument that there was no coverage because there was no “direct loss.” Here, the insurer argued that it was not the forgery that caused the loss but the non-existent assets or transactions. Thus, it argued that the leases did not directly cause the bank’s loss, but it was the absence of collateral that did. The court likewise rejected this argument. In so ruling, the court specifically rejected the cases cited by the insurer.

Finally, the court addressed the bank’s argument that Exclusion H applies because the bank’s employees caused the loss by failing to properly investigate the collateral presented by the used car dealership. Again, the insurer argues that had this been done, the bank would have quickly learned of the fraudulent activity. Once more, the court rejected this contention, finding that to accept the bank’s contention would effectively eliminate coverage under Insuring Agreement E because all bank employees are intermediaries in every forgery-related bank loss, and therefore, it could be argued that their failure to be more vigilant in detecting fraud defeats coverage.

## H. DEFINITION OF EMPLOYEE

1. *Carytown Jewelers, Inc. v. St. Paul Travelers Companies, Inc.*, 2007 W.L. 174020 (E.D. Va. 2007). In this case, a jewelry company filed a claim under the employee dishonesty portion of its coverage for the alleged theft by one of its “employees.” The issue came down to a question of whether indeed the alleged thief was an employee of the jewelry company. The arrangement between the jewelry company and the alleged employee was anything but simple. The employee had his own jewelry company which specialized in sales of jewelry over the internet, and he hired and paid his own employees separate and apart from those of the jewelry company. The “employee” took consignment of jewelry from the jewelry company, sold it on the internet, and the jewelry company “employee” would share in the profits.

There were occasions, however, where the “employee” opened the jewelry store, worked in the store all day, and closed the store in the evening. When the court analyzed this aspect of the relationship, it looked principally to whether the jewelry company exercised a right to direct and control the activities of the alleged employee while he performed services for the jewelry company. The court found there to be evidence on both sides of this point, precluding summary judgment. Next, the court considered the definition of employee in the crime policy. That definition provides in part that an employee is one “whom the jewelry company compensates directly by salary, wages or commissions.” On this issue, the court found the jewelry company’s accountant testimony to be particularly persuasive. He testified that he had been doing the accounting for the company’s books and records, and filing appropriate federal returns, for approximately 11 years. During that period, he never calculated wages, tips or commissions for the alleged employee; never calculated or withheld federal or state income taxes, FICA taxes, or unemployment taxes for the alleged employee; he never completed a W-2 wage reporting form for the alleged employee; and he never filed the required IRS Form 941 (an Employer’s quarterly federal income tax return) which is used to confirm the number of employees who receive wages, tips or other commissions that included the alleged employee with an account.

The court also found persuasive that prior to instituting the suit against the bonding company, the jeweler had first sued its alarm company, and in deposition testimony in that case, had referred to the alleged employee as a “business friend” and that he was “not basically an employee.” Finally, the alleged employee testified that he was never an employee of the jewelry company and never received any compensation for any services rendered on its behalf.

Based upon these facts, the court concluded as a matter of law that the alleged thief was not an employee, and therefore, the employee dishonesty coverage was not available to the jewelry company.

## **I. MISCELLANEOUS FIDELITY POLICY INTERPRETATIONS**

1. *MDB Communications, Inc. v. Hartford Casualty Insurance Co.*, 479 F. Supp. 2d 136 (D. D.C. 2007). In this case, a company was the victim of a series of forged checks by one of its employees. Upon discovery of the dishonest employee's embezzlement, the company caused the dishonest employee to execute a promissory note payable to her employer. Thereafter, over a period of nine months she repaid approximately \$280,000 of the \$650,000 she had embezzled.

At the same time, the company filed a proof of loss with its bonding company. The bonding company initially rejected the proof of loss because they failed to address the total loss incurred by the insured. Specifically, requests were made by the bonding company that required details and documentation be provided concerning the amount of restitution that has been received from the dishonest employee. In response, the company only provided summaries and did not clearly document the amounts received and provide documentation thereof. As a consequence, the proof of loss was ultimately rejected.

The relevant policy provisions provided that proof of loss must be filed and that the bonding company must be permitted to inspect the records proving loss or damage. The policy further provided that no one may bring legal action against the bonding company unless there has been full compliance with the terms of the insuring agreement.

In spite of this provision, and in spite of its failure to provide the information requested by the bonding company, the insured filed suit. The bonding company moved for summary judgment because of the insured's failure to submit documentation in support of its claim.

The court granted the bonding company's motion for summary judgment, finding that the "Plaintiff in effect asked Hartford to trust" it that it had properly deducted the amount of restitution. The court concluded that:

*[The insured] breached the provision of the insurance policy requiring it to submit the information requested by the insurance company, and it therefore may not bring suit under the policies at issue ...."*

## **J. STATUTE OF LIMITATIONS**

1. *Indiana Regional Council of Carpenters Pension Trust Fund v. Fidelity & Deposit Company of Maryland*, 207 WL 683795 (N.D. Ind. 2007). In this case, a trustee for a pension fund received a large kickback from a real estate agent to vote in favor of using trust funds to buy a parcel property for a wildly inflated amount. The trustee and real estate agent profited handsomely in the short term, but ended up in jail in the long term. The trust had a bond to protect it against criminal conduct, and that coverage extended to acts by fiduciaries of the trust, such as the trustee in this case.

The issue framed in the case was whether the lawsuit against the bonding company was brought within the applicable statute of limitations. With respect to this issue, the bond provided for a two-year statute of limitations. The relevant facts show that discovery of the trustee's fraud was made in either November or December of 2003. Notice to the bonding company of a claim under the bond was first given in October, 2004. A proof of loss was submitted in January, 2005. Thereafter, a series of correspondence and telephone messages were exchanged between the trust's attorney and F&D. On one of these messages, the trust's attorney requested that F&D respond to its proof of claim at a point which would have put it within the two-year statute of limitations. F&D, however, asked for additional time to respond, and on one occasion cited an illness in the family of the F&D claims person as a reason for further delaying their response. Ultimately F&D denied the claim, and suit was filed in January, 2006.

F&D then moved for summary judgment, arguing that since more than two years had lapsed from the time of discovery of the loss to the time suit was filed, the applicable contractual statute of limitations had expired. In response, the insured set up several defenses, including one that the bond provided by F&D was an "official bond" and that therefore, under any Indiana law, the shortened statute of limitations was void. The court then analyzed Indiana law and concluded that although there was not a specific statutory provision which voided the statute of limitations period that based on case law it was the public policy of Indiana "that any provision tending to limit the surety's liability is void." Accordingly, the court refused to enforce the contractual two-year statute of limitations, and instead looked at the general statute of limitations involving contract claims. It found that the lawsuit was filed well within that statutory period and accordingly granted the motion for summary judgment of the insured on this defense.

## **K. RESCISSION OF FIDELTY POLICY**

1. *Great American Insurance Companies v. Subranni*, 366 B.R. 326 (D. NJ. 2007).

In this case, an armored car company was in the business of servicing ATM machines owned by financial institutions. It was incorporated in September, 1997, and within a month of its formation, its principal owners and officers began making unauthorized "borrowings" from funds received from its customers in order to pay operating expenses. As time passed, some of the customer funds were also converted by the officers of the company as well. By 2001, the armored car company filed for bankruptcy protection, listing its losses at over \$32,000,000.

During its period of operation, the armored car company's customers required it to obtain comprehensive employee dishonesty, crime and disappearance coverage. An application was made to Great American for this coverage. During the review of the application, the insurer became aware that Lloyds of London had declined to offer coverage because of a loss it was investigating with a predecessor company. Nonetheless, the application was granted and insurance coverage was issued. Within a few months the armored car company asked for additional vault coverage, and by that time the insured was well aware that over \$80,000 had been removed from the vault by the company for its operating account. Again, approximately a year after initial coverage was issued, the policy was renewed. There was an application submitted that asked, among other things, for information respecting "all claims or occurrences which may give rise to claims for the prior five years." The president of the company responded "N/A." In addition, a question on the application read "Please provide descriptions of all losses in excess of \$5,000.00, including corrective action." In response to this, the armored car company gave no response.

Several months later, the insurer became aware of an article in the newspaper regarding a law enforcement raid on a former principal of the armored car company in which the article reported that the former principal was under investigation by the FBI and the IRS for "pilfering millions of dollars meant for automatic teller machines" and "for allegedly stealing money from the company starting in 1996." When the insurer got this article, it asked the armored car company's president about the investigation and was assured that it did not involve the armored car company or its customers.

Following that, yet another application for renewal of the policy was made, and issued. No claims or losses were reported in the application.

Following the filing of bankruptcy, the insurer filed an adversary proceeding seeking a declaratory judgment that the policies should be rescinded based upon misrepresentations contained in the applications. The bankruptcy trustee filed counterclaims, and various customers of the armored car company, which were also designated as loss payees under the policy, intervened in the bankruptcy action and filed claims against the insurer as well.

Following a 17 day trial, the bankruptcy court concluded that the insurer was entitled to rescission based upon untruthful answers in the application and also dismissed all counterclaims and third party claims against the insurer.

An appeal was then taken to the federal district court, which first dealt with the issue of misrepresentation. The court observed that under controlling New Jersey law, “a representation by the insured, whether contained in the policy itself or in the application for insurance, will support the forfeiture of the insured’s rights under the policy if it is untruthful, material to the particular risk assumed by the insurer, and the insurer actually and reasonably relied upon it in issuance of the policy.” In arguing that the insurer had not met its burden, the trustee attacked the latter point, arguing that there was no actual or reasonable reliance. Its argument was centered principally upon the fact that the insured knew that the armored car company was being investigated because of the newspaper article it received, and further that Lloyd of London had declined to sell a policy to the insured at the time of its formation. The court rejected these arguments finding that an investigation was done into the statements in the newspaper article, and the president of the insured affirmatively assured the insurer that the allegations did not involve his company. Further, the fact that one insurer fails to issue coverage to an insured does not raise any inference of knowledge by the insurer of improper activity, since an insurer can decline coverage on many grounds. The court noted that simply because there are some “red flags” regarding the truthfulness of representations by an insured, does not, standing alone, impute knowledge of falsity to the insurer.

The loss payee raised additional grounds. Among these was the doctrine of partial rescission, with respect to the loss payees in which they argued that “innocent parties” such as themselves should not be punished for the misrepresentations of the insured. The court rejected this argument, finding that regardless of “their innocence and reliance on the existence of insurance coverage, the customers ... may only receive the benefit of coverage if [the insured] has coverage in place.”

Another issue raised by the loss payees concerned spoliation by the insurer. The facts on which this claim is based were that one of those investigating the claim on behalf of the insurer had sent and received various email messages which, long after the claims had been filed, lost them because he had discarded his computer and there were no backup tapes available. While the court found that most of the elements of a spoliation claim were proved by these facts, one critical element was missing. The loss payees had failed to prove that they were “damaged.” The court based this reasoning upon the fact that all of the relevant facts which lead to the rescission of the insurance policy were completed before any claims were filed. Since the emails in question post-dated the filing of these claims, the court concluded that they could not have provided any relevant information on the issue of rescission.

## L. **BAD FAITH**

1. *Retail Ventures, Inc. v. National Union Fire Insurance Co. of Pittsburgh*, 2007 WL 943011 (S.D. Ohio 2007).

In this action an insured company was the subject of a commercial “hacking incident,” in which someone gained unauthorized access and theft of customer data on the company’s retail stores and corporate computer systems. Among other things, the company was required to pay the cost of the re-issuance of credit cards for its customers, whose account information was fraudulently used.

The insured brought suit against its fidelity insurer for, among other things, bad faith. The key allegation in the complaint relating to bad faith was that “[the fidelity insurer] failed to meet the minimum standard set forth in Ohio Revised Code, Section 39.01.21 and Ohio Administrative Code, Section 3901-1-07 by its breach of the duty of good faith and fair dealing.”

The fidelity insurer moved to dismiss the claim for bad faith arguing that violations of insurance statutes and regulations do not establish bad faith. The fidelity insurer cited to Ohio case law that stood for the proposition that violations of Ohio’s insurance statutes and corresponding administrative code provisions are not relevant to establishing an insurer’s bad faith. The court agreed with this argument finding that the Ohio Department of Insurance rules do not create a private right of action, but are regulatory in nature. As such, the rules cannot be considered evidence of the applicable standard of bad faith.

2. *Federal Insurance Co. v. HPSC, Inc.*, 480 F. 3d 26 (1<sup>st</sup> Cir. 2007).

In this action, an officer of the insured embezzled almost \$5 million over a 5 year period. The insured made a claim under its executive protection policy which had a \$1 million limit, and a \$25,000 deductible. The insured had its outside accountants conduct an investigation of the loss, and prepare a report. Among other things, the report found that the dishonest executive “exercised sole control over” a number of bank accounts relating to his work, and that there had been an “insufficient segregation of duties” in that business segment. Based upon this report, the insurance company concluded that the dishonest employee had both reconciled bank statements and signed checks on the same accounts, which contradicted information supplied on a renewal application. In particular, there was a question on the application – “do the employees who reconcile the monthly bank statements also either: (a) sign checks? ...” To this question, the insured answered “no.”

The insurance company filed a declaratory judgment action and the insured counterclaimed for, among other things, bad faith based upon a violation

of the Massachusetts law against unfair and deceptive trade practices in investigating and paying the claim.

In the early stages of the case, the insured informed the insurance company that it had misread the accountant's report. In fact, the dishonest employee did not reconcile bank statements for 15 of the 16 bank accounts under his control. Rather, one of his subordinates reconciled those 15 accounts. The one account which the dishonest employee both reconciled and wrote checks was a petty cash fund account which was capped at \$10,000, and could only be replenished each month after a review of disbursements by other officials in the company.

Upon learning this, the insurance company shifted its theory of the case, relying on the dishonest employee's general authority over all 16 of the accounts.

The lower court found that the insured had honestly answered the question on the renewal application as to the 15 accounts for which there was a division of responsibility on reconciling and check writing, but found that there was an issue of "materiality" with respect to the remaining account on which the dishonest employee had both check writing and reconciliations responsibilities for the petty cash fund account.

After a jury trial, the jury ruled in favor of the insured, finding that there was no "material" misrepresentation in the renewal application. Following the jury verdict, the court conducted a bench trial with respect to the bad faith claim. The lower court found that the insurance company had violated two sections of the unfair and deceptive trade practices act: (1) that its decision to not pay the claim violated the section of the act requiring it to conduct a reasonable investigation before rejecting a claim, and this section was violated because of its failure to inquire about the facts sufficiently to learn of its mistaken impression; and (2) it violated the section requiring that it make a reasonable settlement offer, and this was triggered by the fact that it did nothing to make a reasonable settlement offer upon learning of its mistaken conclusion regarding the dishonest employee's reconciliation and check writing duties on the 15 operating accounts. The lower court further found that the conduct of the insurance company, after learning of its mistaken conclusion was woeful and therefore doubled the damages recoverable.

On appeal to the First Circuit Court of Appeals, the Court initially upheld the judge's finding that the insurance company had failed to do an adequate investigation. The Court found from the record that the insurance company did nothing to confirm their tentative conclusion regarding the dishonest employee's check writing and reconciliation functions. In fact, it did no investigation at all apart from reviewing materials submitted to it by the insured's accountant. Second, the Court also found that the lower court's decision regarding failure to make a reasonable offer was also supported by the record. In this regard, under

Massachusetts law, the duty to make a settlement offer arises when “liability has become reasonably clear.” This determination depends on whether “a reasonable person, with knowledge of the relevant facts in law, would probably have concluded, for good reason, that the insurer was liable to the plaintiff.” While the district court did have some difficulty in affirming this determination, and probably would not have done so had it been reviewing under a *de novo* standard, this portion of the lower court’s ruling was reviewed under a “clearly erroneous standard” which the court refused to overturn.