

Insurance Coverage Update

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Business to Business Markets, Inc. vs. Zurich Specialties, et al.

Third Party Claimant Is Entitled to Maintain a Professional Negligence Action Against Surplus Lines Broker Notwithstanding Absence of Contractual Privity

In *Business to Business Markets, Inc. v. Zurich Specialties, et al.*, __ Cal.App.4th __ (December 27, 2005), the California Second District Court of Appeal held that Business to Business Markets, Inc. ("B2B") was entitled to maintain a lawsuit for professional negligence against surplus lines broker, Professional Liability Insurance Services, Inc. ("PLIS"), despite the absence of contractual privity between the two companies. The parties' dispute arose out of a failed business deal between B2B and Tricon Infotec, an Indian software company.

B2B hired Tricon Infotec to write a custom main computer program for B2B's business. The parties' agreement required Tricon to carry an errors and omissions insurance policy to compensate B2B if Tricon failed to deliver the promised software. B2B contacted Hoyla, a retail insurance broker. B2B informed Hoyla of Tricon's insurance needs and told Hoyla that Tricon was based in India. Hoyla contacted PLIS, a surplus lines insurance broker, to place the insurance policy and gave PLIS the information it had received from B2B. PLIS contacted Zurich Specialties London Limited which issued a policy to Tricon. Although Tricon was an Indian company doing business in India, the policy excluded coverage for any claims arising from or related to work performed in India.

Subsequently, Tricon failed to deliver usable software to B2B, so B2B sued Tricon for breach of contract. Based on the insurance policy's exclusion for work done in India, Zurich Specialties refused to pay for Tricon's defense or to indemnify Tricon against B2B's claim. Subsequently, B2B obtained a default judgment from Tricon in the amount of \$922,480. Thereafter, B2B filed a direct action and professional negligence lawsuit against PLIS and Zurich Specialties. PLIS filed a demurrer to B2B's lawsuit based on the argument that it owed no duty of care to B2B. The trial court agreed and issued an order dismissing B2B's lawsuit against PLIS.

In reversing the trial court's decision, the Court of Appeal followed the California Supreme Court's decision in *Biakanja v. Irving* (1958) 49 Cal.2d 647 (*Biakanja* case). The Court of Appeal applied factors listed in the *Biakanja* case in reaching its decision that B2B may maintain a claim for professional negligence against PLIS. The Court of Appeal considered the following the factors:

1. The extent to which the transaction was intended to affect the plaintiff;
2. The foreseeability of harm to the plaintiff;
3. The degree of certainty that the plaintiff suffered injury;
4. The closeness of the connection between the defendant's conduct and the injury suffered;
5. The moral blame attached to the defendant's conduct; and
6. The policy of preventing future harm.

After considering each of the above factors, the Court of Appeal held that B2B could maintain a cause of action for professional negligence against PLIS. In so finding, the Court noted that the most problematic factor involved whether B2B constituted an incidental or intended third party beneficiary with respect PLIS' agreement to place insurance on behalf of Tricon. The Court of Appeal stated as follows:

An intended beneficiary of insurance, in contrast, is one who intentionally receives the benefit of the insurance. However, this person does not need to be specifically named, as long as he is in the class of members that the insurance is intended to benefit.

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Although B2B is, strictly speaking, not quite an intended beneficiary, it comes close enough to being one that imposing duty on PLIS is within the spirit of *Biakanja*. Just because other parties, such as retail insurance broker Hoyla, may have closer connections to B2B does not mean PLIS' connection was legally inadequate. B2B is more than an incidental beneficiary—it made the initial phone and contact with Hoyla (who then contacted PLIS) because it considered itself the intended beneficiary of the policy. Moreover, and more importantly, the software contract between B2B and Tricon called for such a policy, a contractual obligation that, upon demurrer, we infer retail broker Hoyla told PLIS about when Hoyla gave PLIS the information Hoyla had received from B2B about Tricon's being an Indian company.

Progressive West Insurance Company vs. Superior Court (Preciado)

Insurer's Complaint for Reimbursement of First Party Med Pay Benefits Against Policyholder Does Not Constitute Bad Faith. However, Such Claim for Reimbursement Maybe Barred or Reduced By the "Made-Whole Doctrine" and "Common-Fund Doctrine"

In *Progressive West Ins. Co. v. Yolo County Superior Court (Preciado Real Party In Interest)*, ___ Cal.App.4th ___ (December 28, 2005), the California Third District Court of Appeal reversed in part, and affirmed in part, the trial court's order sustaining a demurrer in its entirety filed by Progressive West Insurance Company ("Progressive") with respect to a cross-complaint for bad faith filed by policyholder, Simon H. Preciado. Progressive West filed a lawsuit seeking reimbursement of "Med Pay" benefits paid to Preciado in connection with an automobile accident. Preciado had filed a personal injury lawsuit against a third party which was ultimately settled in his favor. Progressive's lawsuit relied on a provision in the policy entitling Progressive to reimbursement of Med Pay benefits should the policyholder recover in a settlement or judgment from a third party.

In response to Progressive's reimbursement lawsuit, Preciado filed a cross-complaint for bad faith arguing that Progressive had failed to take into account the "made whole doctrine" and "common-fund doctrine". Specifically, Preciado argued that Progressive West failed to evaluate whether the recovery made by Preciado in his third party personal injury lawsuit was sufficient to make him whole with respect to his injuries. He also argued that Progressive had failed to pay a prorata share of his attorneys' fees spent in recovering a judgment from the third party tortfeasor.

In reversing the trial court, the Court of Appeal noted that there are two separate requirements needed to establish a breach of the implied covenant of good faith and fair dealing:

- (1) Benefits due under the policy must have been withheld; and
- (2) The reason for withholding benefits must have been unreasonable or without proper cause.

In this case, the Court of Appeal noted that Progressive West had immediately paid out the Med Pay benefits. Hence, Preciado could not maintain a lawsuit for bad faith because Progressive West had immediately paid out the Med Pay benefits owed under the policy. The Court of Appeal stated as follows:

Here, these rules dictate that Preciado has not stated a cause of action against Progressive for the breach of the covenant of good faith and fair dealing. By pleading that Progressive

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is seeking *reimbursement* under the policy, Preciado acknowledges Progressive paid him what was due under that policy. No factual allegations in the cross-complaint suggest that Progressive unduly delayed in paying these benefits, or that it failed to properly investigate the claim in a manner that delayed the payment of those benefits to the detriment of its insured. Because the essence of the tort of the implied covenant of good faith and fair dealing is focused on the prompt payment of benefits due under the insurance policy, there is no cause of action for breach of the covenant of good faith and fair dealing when no benefits are due.

While the Court of Appeal ruled in favor of Progressive West relative to Preciado's cross-complaint for bad faith, it also held that Preciado may maintain a cause of action against Progressive West for fraudulent business practices pursuant to Business and Professions Code §17200. The Court of Appeal also explained in detail the "made whole" and "common-fund doctrines." The Court of Appeal stated as follows:

Made-Whole Rule

When an insurance company pays out a claim on a first-party insurance policy to its insured, the insurance company is subrogated to the rights of its insured against any tortfeasor who is liable to the insured for the insured's damages. (See, e.g., *Plut v. Fireman's Fund Ins. Co.* (2000) 85 Cal.App.4th 98, 104 ["Subrogation is the insurer's right to be put in the position of the insured, in order to recover from third parties who are legally responsible to the insured for a loss paid by the insurer. [Citation.] [Citation.]"'] *Hodge v. Kirkpatrick Dev., Inc.* (2005) 130 Cal.App.4th 540, 548.) Subrogation has its source in equity and arises by operation (legal or equitable subrogation). (*Sapiano v. Williamsburg Nat. Ins. Co.* (1994) 28 Cal.App.4th 533, 537, fn. 1.) It can also arise out of the contractual language of the insurance policy (conventional subrogation). (*Ibid.*) The subrogation provisions of most insurance contracts typically are general provisions and add nothing to the rights of subrogation that arise as a matter of law. (*Id.* at p. 538.)

Subrogation places the insurer in the shoes of its insured to the extent of its payment. (*Hodge v. Kirkpatrick Dev., Inc., supra*, 130 Cal.App.4th at p. 548.) In personal injury actions, however, the insurance company may not assert its subrogation claim directly against the third party tortfeasor on its own behalf. (*Fifield Manor v. Finston* (1960) 54 Cal.2d 632, 639-640, 643.) Moreover, the insurance company may not seek to "gang-press" a policyholder's personal injury attorney into service as a collection agent by suing the attorney to pay it any judgment or settlement proceeds from the third party that passes through that attorney's hands. (*Farmers Ins. Exchange v. Smith* (1999) 71 Cal.App.4th 660, 662.) Thus, to preserve its right of subrogation, the insurance company must either interplead itself into any action brought by the insured against the third party tortfeasor, or wait to seek reimbursement under the language of its policy from its insured to the extent that the insured recovers money from the third party. (*Plut v. Fireman's Fund Ins. Co., supra*, 85 Cal.App.4th at p. 104; *Hodge v. Kirkpatrick Dev., Inc., supra*, 130 Cal.App.4th at p. 548.)

Where the insurance company does not interplead itself into the underlying action, the insurance company's rights to recover any payments received by its insured are limited. Under the made-whole rule, "[w]hen an insurer does not participate in the insured's action against a tortfeasor, despite knowledge of that action, the insurer cannot recover any funds obtained through settlement of the action unless the full amount received exceeds the insured's actual loss.

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[Citation.] Furthermore, the insured need not account to the nonparticipating insurer 'for more than the surplus remaining in his hands, after satisfying his loss in full and his reasonable expenses incurred in the recovery.' [Citation.] Thus, when an insurer elects not to participate in the insured's action against a tortfeasor, the insurer is entitled to subrogation only after the insured has recouped his loss *and* some or all of his litigation expenses incurred in the action against the tortfeasor." (*Plut v. Fireman's Fund Ins. Co.*, *supra*, 85 Cal.App.4th at p. 104-104; see also *Hodge v. Kirkpatrick Dev., Inc.*, *supra*, 130 Cal.App.4th at p. 552-553.)

Progressive argues the made-whole rule does not apply here because it is seeking "reimbursement" from its insured, not "subrogation" from the party who injured Preciado. As explained by a leading commentator on insurance law, there is a technical difference between subrogation and reimbursement. (16 Couch, Insurance (3d ed. 2000) § 222.2, pp. 222-10 through 222-14.) Subrogation refers to the right of the insurance company to step into the shoes of the insured and assert the insured's rights against the third party. (*Id.* at p. 222-11.) Reimbursement refers to the right to receive payment back of what has been expended by the insurance company. (*Ibid.*) That same commentator, however, acknowledges that those terms are often used interchangeably in the cases (*Ibid.*) In California, both the subrogation rights and reimbursement rights of the insurance company fall within the rubric of subrogation. (See *Plut v. Fireman's Fund Ins. Co.*, *supra*, 85 Cal.App.4th at p. 104-105; *Textron Financial Corp. v. National Union Fire Ins. Co.* (2004) 118 Cal.App.4th 1061, 1077; *Hodge v. Kirkpatrick Development, Inc.*, *supra*, 130 Cal. App.4th at p. 553.) Thus, both of those rights are limited by the made-whole rule.

Common Fund

Progressive does not argue the common-fund doctrine does not apply here and thus, we provide a brief summary of that rule here. The common-fund doctrine is a second limitation on an insurance company's ability to recover funds from its insured where the insured obtains a judgment or settlement from the third party tortfeasor. Under the common-fund rule, "[W]hen a number of persons are entitled in common to a specific fund, and an action brought by a plaintiff or plaintiffs for the benefit of all results in the creation or preservation of that fund, such plaintiff or plaintiffs may be awarded attorney's fees out of the fund." (*Lee v. State Farm Mut. Auto. Ins. Co.* (1976) 57 Cal.App.3d 458, 567. "The bases of the equitable rule which permits surcharging a common fund with the expenses of its protection or recovery, including counsel fees, appear to be these: fairness to the successful litigant, who might otherwise receive no benefit because his recovery might be consumed by the expenses; correlative prevention of an unfair advantage to the others who are entitled to share in the fund and who should bear their share of the burden of its recovery; encouragement of the attorney for the successful litigant, who will be more willing to undertake and diligently prosecute proper litigation for the protection or recovery of the fund if he is assured that he will be promptly and directly compensated should his efforts be successful.' [Citation.]" (*Id.* at pp. 467-468.) Under this rule, an insurance company that does not participate in the underlying action must pay a pro rata share of the insured's attorney fees and costs when it seeks reimbursement from its insured out of funds obtained by the insured from the responsible third party. (*Id.* at p. 469.) That is, the insurance company's reimbursement must be reduced proportionately to reflect the attorney fees paid by the insured. (*Hartford Accident & Indemnity Co. v. Propman* (1984) 163 Cal.App.3d Supp. 33, 39-40.)

Wayne vs. Staples, Inc.

Staples' Offer of Declared Value Shipping Coverage and Charge of Premium Constituted the Business of Insurance and Therefore Was Subject to Regulation Under the Insurance Code

In *Wayne v. Staples, Inc.*, __ Cal.App.4th __ (January 4, 2006), California Second District Court of Appeal reversed the trial court's entry of judgment in favor of Staples relative to the class action filed in connection with Staples' offer to allow customers to purchase "declared value coverage" intended to cover parcels shipped from Staples stores. Staples contracted with UPS for parcel shipping services. UPS charged Staples \$.35 per \$100 of declared value for parcel coverage. In turn, Staples charged customers \$.70 per \$100 of declared value over \$100 for "excess value coverage." The coverage was provided by an inland marine basic policy from National Union Fire Insurance Company of Pittsburgh, PA ("National Union"). Staples' customers who purchased the coverage at Staples or at other UPS shipping sites are additional insureds under the policy.

In reversing the trial court's decision, the Court of Appeal noted that "offering insurance coverage is an activity requiring a license and regulated by the Insurance code."

Staples argued that the primary focus of its business was the sale and shipment of customers' packages. The offer of excess value coverage was merely "incidental" to Staples' main service transaction, i.e., the shipping of customers' packages. In rejecting Staples' argument and holding that Staples was subject to regulation under the Insurance code, the Court of Appeal stated as follows:

. . . . [T]he declared value coverage offered by Staples to its shipping customers is, without question, insurance; and the fact it is offered only as an "incidental aspect" of a transaction focused on shipping packages does not exempt Staples from insurance licensing requirements. Although Staples' current marketing practices (charging its customers only what it is actually charged by UPS for excess value insurance) may well fall within the exemption provided by Insurance Code §1635, subd. (h), the transactions challenged by Wayne's lawsuit do not qualify for that exemption. Accordingly, it was error to grant summary judgment with respect to Wayne's cause action asserting Staples' violation of the Insurance Code constitutes unfair business practices.

The Court of Appeal went on to hold that Staples' charge of double the UPS premium did not constitute unconscionable pricing of the declared value coverage offered by Staples.

Fuller-Austin Insulation Company vs. Highlands Insurance Company

Determination of Value of Past, Present and Future Asbestos Claims Under Provision in United States Bankruptcy Code Does not Constitute an Adjudication of Liability Triggering an Indemnity Obligation Under Excess Policies. However, Confirmation of Evaluation Plan Did Constitute a Settlement Subject to the Excess Insurers' Defense of Unreasonableness. Further, the Obligation to Indemnify the Policyholder Does Not Extend to an Estimation of Future Claims Against the Policyholder.

In *Fuller-Austin Insulation Co. v. Highlands Ins. Co., et al.*, __ Cal.App.4th __ (January 19, 2006), the Second District Court of Appeal reversed a judgment rendered against excess insurers which had issued policies to Fuller-Austin Insulation Company ("Fuller"). The Court of Appeal held that filing a "prepackaged" bankruptcy plan which provided for the implementation of a trust assuming Fuller's liability for all present and future asbestos claims, and providing for the payment of a percentage of the trust assets to resolve all such claims, did not constitute an "actual trial" establishing the excess insurers' indemnity obligations under their policies. On the other hand, the Court of Appeal held that the confirmation of the bankruptcy plan could constitute a settlement wherein, the excess carriers could not withhold consent of such settlement absent the assumption of defense of the underlying asbestos claims against Fuller, or challenging such settlement based on unreasonableness.

In addition, the Court of Appeal held that the jury's determination of Fuller's future asbestos liability did not constitute an actual adjudication of a fixed amount of damages triggering the duty to defend under Fuller's excess policies. The Court of Appeal stated as follows with respect to each of its findings:

Confirmation of the Bankruptcy Plan did not constitute an actual trial

An actual trial is defined as follows:

"(1) An independent adjudication of facts based on an evidentiary showing; and (2) a process that does not create the potential for fraud and abuse."

In rejecting the trial court's determination that the confirmation of the bankruptcy plan constituted an actual trial, the Court of Appeal stated as follows:

Like the claim allowance hearing in *Wolkowitz*, the bankruptcy confirmation proceedings here contained none of the attributes of an actual trial. The confirmation hearing was not a contested evidentiary hearing. Indeed, the bankruptcy court expressly limited the scope of the hearing to Fuller-Austin's one-hour presentation of evidence in support of disclosure in the proposed plan, without any cross-examination. Moreover, the "evidence" offered during the hearing did not address Fuller-Austin's liability; rather, the testimony focused on the plan's fairness to the claimants. Further, the plan was the result of negotiation—not factfinding. As indicated in the disclosure statement and repeated in the bankruptcy court findings, the plan developed during four months of intense negotiations between Dyncorp, Fuller-Austin and representatives of present and future asbestos claims. Additionally, the key purpose of the bankruptcy court's findings were to ascertain the Plan's good faith and reasonableness as to the asbestos claimants.

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Accordingly, the bankruptcy court confirmation proceedings were not an "actual trial" within the meaning of the insurance policies.

Plan Confirmation Was a Settlement, the Effect of Which the Insurers May Challenge on Retrial

The Court of Appeal held that the confirmation of the plan did constitute a settlement. In addition, the Court of Appeal found that an excess insurer may not refuse to consent to a settlement and then simultaneously refuse to undertake the defense of the underlying lawsuit, wherein, a settlement exceeding primary limits had been reached. The Court of Appeal noted that when an excess insurer is presented with a settlement in excess of primary limits, it may either assume the defense of the underlying action or contest the settlement as being unreasonable and a product of collusion and fraud.

Future Claims

The Court of Appeal also rejected the jury's findings of the future value of asbestos claims in determining whether a duty to indemnify had been triggered under Fuller's excess policies. In the trial of the underlying insurance action, Fuller was allowed to present evidence to a jury regarding its aggregate asbestos liability, i.e., the present liability of Fuller to pay pending and future asbestos claims and that the adjudication by the jury would be binding on Fuller's excess insurers. The excess insurers challenged the trial court's determination and jury findings as to the value of future claims as constituting an unlawful acceleration of their contractual obligations. The excess carriers contended on appeal that their duty to indemnify Fuller arose only after damages had been fixed in their amount, and that a jury's estimation of the present and potential future claims against Fuller-Austin is not the equivalent of a fixed amount of damages.

In rejecting the trial court's findings and jury's estimate of present and future claims, the Court of Appeal confirmed California law holding that the duty to indemnify entails the payment of money and has as its purpose to resolve liability, after liability is established and can only arise after damages are fixed in their amount.

Similarly, the excess carriers are only obligated to pay for the amount the plan obligates Fuller to pay for each allowed claim, rather than the estimated allowed liquidated value placed on the total amount of claims expected to be tendered to the Trust.

Miscellaneous Matters

The Court of Appeal also held that Fuller is required to prove that each asbestos claimant sustained injury during the excess carriers' policy periods and that the presumption of harm sustained by the claimants did not amount to proof of injury during excess insurers' policy periods.

In addition, the Court of Appeal found that excess insurer, Stonewall Insurance Company's policy on the risk for a period of two years afforded a total "aggregate limit" of \$50.0 million, wherein, such policy included language affording annual aggregate of \$25.0 million. The Court reasoned that since there were two annual periods, Stonewall policy afforded a total aggregate limit of \$50.0 million, rather than \$25.0 million for the two year period.

Lastly, the Court of Appeal held that the "prior insurance clause" limiting a carrier's obligation to indemnify to a total amount reduced by amounts paid by prior excess insurers on the risk was unambiguous. However, the Court of Appeal held that since there had been no finding of the prior excess insurers' payment obligations under their policies, a question of fact existed as to the application of such clause to the claims pending against Fuller.

1231 Euclid Homeowners Association vs. State Farm Fire & Casualty Company

Withdrawal of First Party Property Damage Claim Immediately After Northridge Earthquake Bars Subsequent Complaint for Bad Faith Against Insurer Filed Eight Years Later Under an Extended Statute of Limitations for Northridge Earthquake Claims

In *1231 Euclid Homeowners Association v. State Farm Fire & Cas. Co.*, __ Cal.App.4th __ (January 20, 2006), the California Second District Court of Appeal affirmed the trial court's entry of summary judgment in favor of State Farm with respect to a claim for breach of contract and bad faith alleged by the 1231 Euclid Homeowners Association ("HOA") with respect to failure to pay for the repair of damages sustained by a ten-unit residential condominium complex.

The complex sustained cosmetic damage as a result of the January 17, 1994 Northridge earthquake. State Farm insured the complex and afforded property coverage of \$1,191,600 for earthquake damage, subject to a 10 percent deductible (\$119,160). The HOA inspected the complex after the earthquake and determined that the total amount of damages sustained by the complex was well within the deductible afforded by the State Farm policy. In turn, State Farm's own adjuster also inspected the complex and came to the same conclusion. Although the HOA had submitted a claim immediately after the earthquake, as a result of its inspection as well as that of State Farm's, it withdrew its claim on February 18, 1994.

Subsequently, after the passage of legislation allowing for the extension of the statute of limitations for Northridge earthquake claims, as codified in Code of Civil Procedure, §340.9, the HOA filed a complaint for breach of contract and bad faith against State Farm in December, 2001, nearly eight years after the withdrawal of its original claim to State Farm for damages sustained by the complex.

Because the HOA had withdrawn its claim for damage under the State Farm policy, the Court of Appeal held that State Farm had not breached obligations owed under its policy to the HOA. The Court of Appeal found that the HOA's voluntary withdrawal effectively resolved its original claim. The Court of Appeal noted that Section 340.9 did not give or create any rights for the HOA beyond a one year window to file any claim it might otherwise have. Such code section did not bar an insurer's defenses to such claim.

Further, the Court of Appeal noted that State Farm had been substantially prejudiced by the HOA's delay of eight years before "resurrecting its claim" and filing its lawsuit for breach of contract and bad faith. The Court of Appeal noted that the HOA's voluntary claim withdrawal terminated both State Farm's obligation and reason to conduct an appropriate investigation. The resurrection of such claim nearly eight years later made it impossible for State Farm to properly investigate the claim. Hence, it had been substantially prejudiced by the HOA's delay.

MISCELLANEOUS MATTERS

*Although not an insurance case, we note that the California Fourth District Court of Appeal issued a decision commenting on indemnity obligations between general contractors and subcontractors entitled *Crawford v. Weather Shield Mfg., Inc.*, __ Cal.App.4th __ (January 31, 2006). The *Crawford* case includes an excellent overview of the law on indemnity provisions and defense obligations under such provisions.*

American Alternative Insurance Corporation vs. Superior Court (Aero Falcons, LLC)

Insurer is Required to Reimburse Policyholder for Attorneys' Fees Incurred in Recovering Aircraft Seized in Connection With Criminal Proceeding

In *American Alternative Ins. Corp. v. The Superior Court of Los Angeles County (Real Parties in Interest – Aero Falcons, LLC)*, ___ Cal.App.4th ___ (January 25, 2006), the California Second District Court of Appeal denied a petition for writ of mandate filed by American Alternative Insurance Corporation ("American") and Amicus Curiae, United States Aviation Underwriters, Inc. ("USAU") requesting the Court of Appeal to overturn an order granting summary adjudication in favor of insureds, Aero Falcons, LLC ("Aero Falcons") and Sands Media, Inc., ("Sands Media") (unless otherwise stated, Aero Falcons and Sands Media collectively referred to as the "insureds"). The parties' dispute arose out of the seizure of an aircraft owned by Aero Falcons by the Bay County Sheriff in Florida on April 2, 2003.

The Sheriff commenced a civil forfeiture proceeding by filing a petition for final order of forfeiture alleging that the airplane owned by Aero Falcons as well as a Ferrari automobile were used in the commission of a felony and were subject to forfeiture under the Florida Contraband Forfeiture Act. The felonies allegedly committed by the owner of Sands Media, Joseph Francis, and other individuals, included procuring persons under the age of 18 for prostitution, sexual exploitation of children, and possession of and trafficking controlled substances. Aero Falcons contested the Sheriff's forfeiture claim.

The Florida Circuit Court found probable cause to seize the automobile, but found no probable cause to seize the airplane. The Sheriff released the airplane on May 22, 2003. The airplane had suffered minor damage.

Aero Falcons submitted a claim for reimbursement of attorneys' fees expended in recovering the aircraft from the Bay County Sheriff. In addition, Aero Falcons requested reimbursement for the damage sustained by the aircraft during the time that it was in the Sheriff's possession. American denied coverage for the claim. American had issued a "Broad Horizon Aviation Insurance Policy" to Aero Falcons and Sands Media. The policy commenced on March 17, 2003. The policy included coverage parts for liability, medical expenses, and physical damage to the subject aircraft. The physical damage part included Coverage L, which states:

The Company shall pay for physical damage to the scheduled aircraft including disappearance of the scheduled aircraft.

The policy defines "physical damage" as follows:

Physical damages means direct and accidental physical loss of or damage to the scheduled aircraft, . . . but does not include loss of use or any residual decrease in value after repairs have been made.

The "Conditions" section of the policy stated as follows:

The Named Insured shall: (a) protect the damaged property whether or not Covered L . . . of this policy applies and if the Named Insured does not, the Company shall have no obligation to pay for any further physical damage due to the Named Insured's failure to protect the damaged property;

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reasonable expenses incurred in affording such protection shall be deemed to be incurred at the Company's request.

By endorsement, an exclusion barring claims for confiscation, seizure or detention of aircraft under the order of any government, public or local authority was deleted from the policy.

As a result of American's denial of Aero Falcons' claim, Sands Media and Aero Falcons filed a complaint in February, 2004 and filed a second amended complaint against American in August, 2004 alleging causes of action for breach of contract, bad faith and declaratory relief. The parties moved for summary adjudication of issues seeking to establish that: (1) American had a duty under the policy to pay attorneys' fees incurred to protect the aircraft after it was seized by the Bay County Sheriff; (2) American had a duty under the policy to pay all amounts necessary to repair damage sustained by the aircraft as a result of the seizure; and (3) that the insureds are entitled to a declaration that American had a duty under the policy to pay all expenses, including attorneys' fees, incurred to repair or protect the aircraft. The parties stipulated to adjudication of American's obligation to reimburse the insureds for costs incurred to repair damage sustained by the aircraft as a result of the seizure. As respects issues one and three, the trial court found in favor of Aero Falcons and Sands Media.

In petitioning the Court of Appeal to overturn the trial court's order granting summary adjudication of issues in favor of Sands Media and Aero Falcons, the Court of Appeal held that the term "physical damage" extended to cover seizure or confiscation of the aircraft. Hence, the Court of Appeal found that the seizure of the aircraft came within the insuring agreement afforded by Coverage L in the American policy.

In addition, American argued that the insureds' attorneys' fees did not constitute expenses incurred to protect "damaged property". American argued that the term "damaged property" meant "property that has been 'physically damaged.'" In response, the insureds argued that the term "damaged property" could encompass the "physical loss" of the aircraft. Hence, the term "damaged property" was ambiguous. As such, the Court was required to interpret the policy consistent with the objectively reasonable expectations of the insureds such that the reimbursement of the attorneys' fees and expenses incurred in recovering the seized aircraft were covered by the policy. The Court of Appeal agreed with the insureds and held as follows:

We conclude that the latter interpretation is consistent with the insureds' objectively reasonable expectations. The apparent purpose of the insured's obligation to "protect the damaged property whether or not Coverage L . . . of this policy applies" is to prevent further avoidable "*physical damage*" that otherwise potentially would be covered under the policy. Accordingly, the policy condition states that the insurer has no obligation to pay for "any further *physical damage*" that could have been avoided. The purpose of avoiding further potentially covered "*physical damage*" is equally served whether the insured acts to prevent further "physical loss of," or "damage to," the aircraft, as those terms are used in the policy definition of "*physical damage*." The expectation that the policy provided for reimbursement of expenses reasonably incurred to prevent further "physical loss of" the airplane caused by the seizure and detention therefore was objectively reasonable.

The Court of Appeal also rejected American's and USAU's argument that forfeiture of aircraft based on "serious criminal charges" was not "accidental" within the meaning of the policy. The Court noted that the policy contained no exclusion or limitation applicable to claims that arise from serious, and unproved, criminal charges against an insured. The Court interpreted the term "accidental" to mean "unintended and unexpected by the insured". Because a Florida court found that there was no probable cause to seize the airplane and did not find that the insureds had committed any crime, the Court noted that the record did not establish that the loss of the aircraft involved intentional conduct. However, the Sheriff's action resulted in a "direct and accidental physical loss" of the aircraft.

Wilson vs. 21ST Century Insurance Company

Summary Judgment in Favor of Insurer on Complaint for Breach of Contract and Bad Faith With Respect to an Underinsured Motorist Claim Must Be Reversed Based on Questions of Fact Relative to the Insurer's Initial Investigation of the Claim

In *Wilson v. Century Ins. Co.*, __ Cal.App.4th __ (January 30, 2006), the California Second District Court of Appeal reversed the trial court's entry of summary judgment in favor of 21st Century Insurance Company in connection with a lawsuit for breach of contract and bad faith brought by the insured, Reagan Wilson. The parties' dispute arose out of an underlying underinsured motorist claim made by Wilson arising out of an automobile accident. Wilson sustained injuries after her vehicle was struck by a drunk driver. The insurer of the drunk driver's vehicle paid Wilson the driver's policy limits of \$15,000. Thereafter, Wilson made a claim under her own policy issued by 21st Century for her underinsured motorist limit of \$100,000. 21st Century rejected Wilson's policy limit demand and determined that the value of her claim was \$20,000, which consisted of the \$15,000 received from the carrier for the underinsured vehicle and a \$5,000 medical payment made under the 21st Century policy. According to Wilson's attorney her claim against the underinsured motorist was in the range of \$500,000 to \$1.5 million if a lawsuit had been filed against driver who caused the accident.

For the next two years, doctors retained by Wilson examined and evaluated her and arrived at different conclusions. All the doctors agreed Wilson had undergone cervical disk changes which they variously described as "atypical," "slight," "very slight," and "minimal." The doctors disagreed, however as to the appropriate course of treatment. One recommended physical therapy, one recommended surgery, one recommended against surgery. The matter was resolved in June 2003 when a neurosurgeon retained by 21st Century examined Wilson and reviewed her medical records. This doctor concluded "surgical intervention would be indicated" and Wilson had a 80% likelihood of obtaining benefit from surgical intervention. Less than a month later, 21st Century paid Wilson the remaining amount of her UIM coverage, \$85,000. Hence, it took approximately two years for 21st Century to pay out the remaining amount of her UIM coverage in the amount of \$85,000.

Subsequently, Wilson filed an action for breach of contract and bad faith against 21st Century. She alleged that 21st Century had unreasonably delayed in paying out the policy limits under her UIM coverage. She contended that this delay was due to 21st Century's failure to conduct a prompt, fair, reasonable and adequate investigation of her claim. She also contended that 21st Century acted in bad faith and violated the terms of her policy by initially offsetting the \$5,000 it paid under her medical payments coverage against her UIM coverage. In addition, she contended that 21st Century may have breached its duty of good faith and fair dealing by failing to use a software program known as "Colossus" in evaluating her claim. 21st Century used such program in adjusting other claims. However, because it was not used in connection with Wilson's claim, the adjuster initially assigned to handle her claim was instructed at his deposition not answer questions regarding the Colossus program.

21st Century moved for summary judgment contended that there were no disputed issues of material fact and that it was entitled to judgment on both causes of action alleged by Wilson as a matter of law. The trial court agreed and entered summary judgment in favor of 21st Century.

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In reversing the court's entry of summary judgment, the Court of Appeal found as follows:

- 21st Century should have retained a doctor of its choice to examine Wilson or at least consult with Wilson's treating physician. Based on its failure to do so, a question of fact existed as to whether it had thoroughly investigated Wilson's claim in good faith.
- 21st Century's willingness to reconsider its decision does not eliminate plaintiff's claim for bad faith. 21st Century's requests for information from Wilson did not eliminate its obligation to affirmatively and independently seek information relative to Wilson's claim. 21st Century was not entitled to simply rely on evidence supplied by Wilson and its willingness to reconsider its decision.
- Wilson's bad faith claim is not barred by 21st Century's argument that a "genuine dispute" existed relative to the value of her claim. The genuine dispute doctrine as outlined in *Chateau Chamberay Homeowners Assn. v. Associated International Ins. Co.*, 2001, 90 Cal.App.4th 335, 347-349 does not apply when the dispute arises because the insurer failed to conduct a thorough investigation.
- An issue of fact exists as to whether 21st Century acted in bad faith by failing to retain an experienced trial attorney to evaluate the value of Wilson's claim.
- Issues of fact exist as to whether 21st Century failed to objectively evaluate Wilson's pain and suffering.
- An issue of fact also exists as to 21st Century's failure to use Colossus to assist in evaluating Wilson's damages constituted unreasonable conduct.
- 21st Century did not act in bad faith by offsetting Wilson's medical payments coverage against her uninsured motorist coverage. The court noted that the adjuster correctly offset the \$5,000 med pay payment against the estimated total value of plaintiff's claim. Initially, 21st Century evaluated Wilson's uninsured motorist claim in the amount of \$20,000. It then offset the \$5,000 against such evaluation and paid her \$15,000. Hence, the offset was proper.
- The Court of Appeal found that based on the record before it that Wilson was not entitled to punitive damages. However, the Court of Appeal found that Wilson should be entitled to propound additional discovery before the trial court makes a final determination barring a claim for punitive damages.

Kaufman & Broad Communities, Inc. vs. Performance Plastering, Inc.

An Insurer Must Intervene in Order to Defend an Action Against a Suspended Corporation

In *Kaufman & Broad Communities, Inc. v. Performance Plastering, Inc.*, ___ Cal.App.4th ___ (January 31, 2006), the California Third District Court of Appeal affirmed the trial court's denial of Calfarm Insurance Company's ("Calfarm") motion for an award of attorneys' fees after Kaufman & Broad Communities, Inc. ("K&B") had dismissed its cross-complaint for indemnity against Calfarm's named insured, Performance Plastering, Inc. At the time of the filing of the cross-complaint by K&B, Performance Plastering had been deemed a suspended corporation based on its failure to pay taxes, pursuant to Tax Code §23301.

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The trial court reasoned that since Calfarm was not a party to the underlying lawsuit, and Performance Plastering was a suspended corporation, pursuant to Tax Code §23301, Calfarm is not entitled to recover fees or costs from K&B.

On appeal, Calfarm argued that under Tax Code §19719, Performance Plastering was entitled to have Calfarm provide it with defense counsel and that it could defend the K&B cross-complaint in the underlying lawsuit in Performance Plastering's name without Calfarm's intervention in such lawsuit.

Section 23301 of the Tax Code states in relevant part as follows:

The corporate powers, rights and privileges of a domestic taxpayer may be suspended if it does not pay its taxes.

The suspension of the corporate powers, rights and privileges means a suspended corporation cannot sue or defend the lawsuit while its taxes remained unpaid. Once a suspended corporation pays its taxes and obtains a "certificate of revivor", however, the corporation may be allowed to carry on the litigation. Its revivor will validate most otherwise invalid prior proceedings in the case. The underlying purpose of this statute is to induce the corporation to pay its taxes. See, *Gar-lo, Inc. v. Prudential Sav. & Loan Assn.* (1974) 41 Cal.App.3d 242, 244.

Prior to 1998, Section 19719 of the tax code provided:

Any person who attempts or purports to exercise powers, rights and privileges of a . . . corporation which has been suspended pursuant to Section 23301 . . . is punishable by a fine of not less than \$250 and not exceeding \$1,000, or by imprisonment not exceeding one year or both by fine and imprisonment.

Subsequently, in January, 1999, the Legislature amended Section 19719 as follows:

(b) "This section shall not apply to any insurer, or to counsel retained by an insurer on behalf of the suspended corporation, who provides a defense for a suspended corporation in a civil action based upon a claim for personal injury, property damage, or economic losses against the suspended corporation, and, in conjunction with this defense, prosecutes subrogation, contribution, or indemnity rights against persons or entities in the name of the suspended corporation.

Based on the amendment to Section 19719, Calfarm argued on appeal that it was entitled to defend the K&B cross-complaint in the name of the suspended corporation, Performance Plastering, and to recover attorneys' fees expended in such defense. The Court of Appeal rejected Calfarm's argument. Rather, the Court of Appeal noted that the amendment to Section 19719 does not eliminate the requirement of Calfarm filing a motion to intervene in the K&B cross-action and to defend such action in its own name. According to the Court of Appeal, the amendment of Section 19719 merely eliminated Calfarm's criminal liability for defending Performance Plastering without intervening. The Court of Appeal noted that the amendment of Section 19719 is silent as to the mechanism for defending a suspended corporation.

The Court of Appeal also found that Calfarm's intervention in the underlying lawsuit would not waive its ability to assert coverage defenses in any subsequent direct action brought by a judgment creditor to recover on a judgment under the Calfarm policy. The Court held that so long as Calfarm properly reserved its rights regarding coverage, there would be no waiver of coverage defenses. However, the Court did acknowledge that Calfarm ran the risk of being collaterally estopped as to those issues which may be determinative of coverage in the underlying action if it failed to intervene in such action.



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