

Insurance Coverage Update

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STATE OF CALIFORNIA vs. UNUMPROVIDENT CORPORATION

*(State is Barred From Prosecuting Lawsuit For Fraudulent Claims
Under Insurance Code §1871.7 Against Insurance Carrier)*

In *State of California v. UnumProvident Corporation*, 140 Cal.App.4th 442 (June 15, 2006), the California Second District Court of Appeal affirmed the trial's court's order dismissing the State of California's lawsuit against UnumProvident Corporation ("UnumProvident") based on Insurance Code §1871.7. This code section allows the State to prosecute actions against any person making false or fraudulent claims to insurers as defined in California Penal Code §§549 and 550. The Court of Appeal held that Section 1871 *et. seq.* is specifically tailored toward preventing and punishing the making of fraudulent claims to insurance companies. In this instance, the State's complaint did not allege that UnumProvident had made fraudulent claims to other insurers. Hence, the State could not proceed based on Section 1871.7. The Court of Appeal summarized its decision as follows:

The wording of these provisions reveals that they simply do not apply to the conduct plaintiff complains of in the complaint. Insurers do not "support" or "oppose" claims, they "approve" or "deny" them. Nor do insurers submit "statements as part of a claim for payment." We believe the clear import of these sections is to extend liability to persons other than those who actually file the suspect claim. These provisions might apply, for example, to a doctor who submits false documentation in support of an employee's claim for benefits under a workers' compensation policy, or an employer who makes a false statement in opposition to such a claim, or to a person who files a false statement in support of an insured's claim under a disability policy, and extends as well to anyone who knowingly assists or conspires to do any of these things. They do not apply to the insurance company to whom the claim is presented, which cannot conspire with itself to create civil liability. (See, e.g., *Applied Equipment Corp. v. Litton Saudi Arabia Ltd.* (1994) 7 Cal.4th 503.)

SAFECO INSURANCE COMPANY OF AMERICA
vs.
THE SUPERIOR COURT (CENTURY SURETY COMPANY)

(Prima Facie Showing of Duty to Defend Under Non-Participating Insurer's Policy By Defending Insurer Entitled Defending Insurer to Contribution for Settlement of Underlying Claims Unless Non-Participating Insurer Can Establish The Absence of Actual Coverage. The Burden of Proof Is On the Non-Participating Co-Insurer to Establish The Absence of Coverage In Order to Bar a Claim for Contribution.)

In *Safeco Ins. Co. of America v. The Superior Court of Los Angeles County (Century Surety Company-Real Party In Interest)*, 140 Cal.App.4th 874 (June 22, 2006), the California Court of Appeal granted a Petition for Writ of Mandate filed by Safeco challenging the trial court's ruling in an underlying contribution action filed by Safeco and America States against Century Surety Company ("Century"). The parties' dispute arose out of 17 underlying construction defect lawsuits brought against 13 insureds. The lawsuits alleged property damage which occurred during the Safeco, America States and Century policy periods.

In each of the lawsuits, Safeco and/or American States agreed to defend the insureds, while Century refused to participate in the defense, based on an "excess clause" in the insuring agreement in its policies.

Subsequently, Safeco and America States sued Century for equitable contribution and declaratory relief alleging that Century had breached its duty to defend the carriers' mutual insureds, thus obligating Century to reimburse Safeco and America States for their equitable share of the costs of defense and settlements of the underlying lawsuits.

Initially, the trial court held that the excess clause in the Century policy insuring agreement did not relieve Century of participating in the defense of the underlying lawsuits. Hence, Century was obligated to contribute to the defense of such lawsuits.

Subsequently, Safeco moved for summary judgment and/or summary adjudication of issues arguing that since a duty to defend was triggered under the Century policy for each of the lawsuits, Century was also obligated to reimburse Safeco for the costs of settling such lawsuits. In response, Century argued that Safeco had the burden of proving "actual coverage" under its policies in order to recover for the costs of settling the underlying lawsuits. In response, Safeco argued that it need only establish that potential coverage was triggered under the Century policies in order obtain contribution from Century. The trial court disagreed and held that Safeco had the burden of proving actual coverage under the Century policies in order to obtain contribution from Century for the settlements of the underlying lawsuits. Safeco filed a Petition for Writ of Mandate challenging the trial court's ruling in its entirety. The Court of Appeal granted Safeco's Petition.

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The Court of Appeal framed the issue of a settling insurer seeking equitable contribution from a non-participating co-insurer for settlement costs as follows:

The parties agree that a settling insurer seeking equitable contribution from a nonparticipating coinsurer need only establish a *potential for coverage* under the recalcitrant coinsurer's policy in order to obtain contribution for the costs of defense, but they disagree about the showing necessary to obtain contribution for a settlement – with Safeco contending the showing is the same for settlements as it is for costs of defense, while Century insists that *actual coverage* must be shown. For the equitable and public policy reasons explained below, we agree with Safeco that, once it has made a prima facie showing of coverage (that is, of potential liability triggering a duty to defend), it has met its burden of proof – and the alleged absence of *actual* coverage under the nonparticipating coinsurer's policy is a defense which the coinsurer must raise and prove.

The Court of Appeal went on to explain the consequences of the non-participating insurer's refusal to defend an insured in an underlying lawsuit. The Court of Appeal stated as follows:

Instead, we hold that in an action for equitable contribution by a settling insurer against a nonparticipating insurer, the settling insurer has met its burden of proof when it makes a prima facie showing of coverage under the nonparticipating insurer's policy – the same showing necessary to trigger the recalcitrant insurer's duty to defend – and that the burden of proof then shifts to the nonparticipating insurer to prove the absence of actual coverage.

KACHA vs. ALLSTATE INSURANCE COMPANY

(Appraisal Under Property Policy Is Limited to the Value of a Loss and Not Coverage Issues. Hence, Appraisal Award Making Determinations of the Nature and Scope of Coverage is Invalid.)

In *Kacha vs. Allstate Ins. Co.*, 140 Cal.App.4th 1023 (June 28, 2006), the California Fourth District Court of Appeal granted the insured, Jeffrey Kacha's, Petition requesting the Court to vacate an appraisal award which addressed coverage under his property policy. The parties' dispute arose out of smoke and heat damage sustained by Kacha's home as a result of a wild fire in San Diego County, California. Allstate provided Kacha's homeowner's insurance. Allstate valued the cost to clean the home and contents at \$25,799.77 and paid that amount to Kacha. In response, Kacha retained a public adjuster who determined that Kacha had sustained \$639,688.82 in covered losses under the Allstate policy.

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Kacha also petitioned the Superior Court to compel an appraisal and appoint an umpire. The Court granted Kacha's motion to compel an appraisal. It then appointed two retired judges to act as appraisers and a third to act as an umpire.

Allstate submitted a form for the appraisal award which included findings relative to the nature and scope of the damages claimed by Kacha. In response, Kacha objected to the form of award and took the position that the appraisal was limited to the value of the loss only. Subsequently, the panel delivered an appraisal award of \$163,792.00 in replacement cost value and \$155,993.00 in actual cash value. The award included amounts of zero for numerous items, such as marble and stone work in a bathroom and a shower, an interior brass and stainless steel banister, the front entry door, baseboard, concrete pool and decking, block fencing, a retaining wall cap, the driveway, entry wall, speakers, amplifiers and video games. Allstate sent Kacha two checks totaling \$138,010.07 representing the \$163,079.00 sum, less the amount it already paid on the claim. Kacha did not endorse or negotiate the checks. Rather, Kacha requested the appraisal panel to correct the award, arguing the panel exceeded its authority by making coverage determinations reserved to Allstate. Kacha noted that the panel did not have authority to determine or decide if a loss occurred or if the loss claimed caused the damage. Allstate opposed the application and the panel denied it.

Subsequently, Kacha filed a petition in Superior Court to vacate the appraisal award. The trial court denied Kacha's petition. Subsequently, a judgment was entered in conformance with the Court's order denying Kacha's petition and confirming the appraisal award. Kacha then filed an appeal of the trial court's judgment.

In reversing the judgment and directing the trial court to vacate the appraisal award, the Court of Appeal held that an appraisal is limited to determining the actual value of the loss. Appraisers are not empowered with the authority to determine coverage for such loss. The Court of Appeal relied on its decision in *Safeco Insurance Company v. Sharma* (1984) 160 Cal.App.3d 1060, 1063 and Insurance Code § 2071. In addition, the Court of Appeal held that Kacha did not waive his right to rely on the *Sharma* decision relative to the scope of authority extended to the appraisal panel.

The Court of Appeal explained its decision as follows:

As our high court held in *Jefferson Ins. Co. v. Superior Court* (1970) 3 Cal.3d 398, 402 (*Jefferson*): "Although *arbitrators* are frequently, by the terms of the agreement providing for arbitration, . . . given broad powers [citation], *appraisers* generally have more limited powers. As stated in *Hughes v. Potomac Ins. Co.* [(1962)] 199 Cal.App.2d 239, 253 [(*Hughes*): 'The function of appraisers is to determine *the amount of damage resulting to various items submitted for their consideration. It is certainly not their function to resolve questions of coverage and interpret provisions of the policy.*'" (Third italics added; see also *Figi v. New Hampshire Ins. Co.* (1980) 108 Cal.App.3d 772, 777 [an appraiser "only evaluates the loss and does not consider questions of policy, interpretation or scope of coverage"].)

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The *Sharma* court repeated this rule, citing the language of section 2071 and the *Jefferson* and *Hughes* opinions. (*Sharma, supra*, 160 Cal.App.3d at p. 1065.) The *Sharma* court elaborated as follows: “In no authority is it suggested that an appraisal panel is empowered to determine whether an insured lost what he [or she] claimed to have lost or something different.

[¶] When an insurer disputes an insured’s description . . . of the lost or destroyed property, it necessarily claims the insured *misrepresented* – whether innocently or intentionally – the character of the loss in filing a proof of loss. In turn, this claim opens the door to allegations of *fraud*. Were an insurer permitted to include the former issue within the scope of an appraisal, a determination in the insurer’s favor would foreclose a court from determining one essential element of fraud in any subsequent litigation. Certainly, an insurer is free to litigate whether the insured has misrepresented what he [or she] lost; but it is beyond the scope of an appraisal. When an appraisal panel exceeds its powers by deciding coverage issues, and the award cannot be corrected without affecting the merits of the decision, the decision must be vacated. (*Id.* at p. 1066.)

ESSEX INSURANCE COMPANY vs. FIVE STAR DYE HOUSE, INC.

(Policyholder May Assign Right to Recover Attorneys’ Fees From Insurer (i.e., Brandt Fees) to Judgment Creditor Along With Cause of Action for Bad Faith Breach of the Duty to Defend and Indemnify the Policyholder)

In *Essex Ins. Co. vs. Five Star Dye House, Inc.*, 38 Cal.4th 1252 (July 6, 2006), the California Supreme Court held that a policyholder may assign its right to recover attorneys’ fees from an insurer for the wrongful denial of policy benefits pursuant to the California Supreme Court’s holding in *Brandt v. Superior Court* (1985) 37 Cal.3d 813. The parties’ dispute arose out of Essex Insurance Company’s denial of the duty to defend and indemnify its insured, Luis Sanchez, in an underlying lawsuit brought by Five Star Dye House, Inc. (“Five Star”). The underlying lawsuit arose out of a commercial dryer damaged while being transported by Sanchez. Essex denied coverage and forced Sanchez to undertake the defense of the *Five Star* lawsuit with his own funds. The trial of such lawsuit resulted in a judgment for \$1,350,000, plus costs. Subsequently, Sanchez assigned his rights under the Essex policy to Five Star in exchange for Five Star’s promise to defer satisfaction of the judgment against Sanchez until such time as all efforts to collect the judgment against Essex had been exhausted.

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Subsequently, Essex filed a declaratory relief action seeking an adjudication that coverage was not afforded under its policy for the Five Star judgment. The trial court ruled against Essex and held that it was obligated to defend and indemnify Sanchez in the underlying *Five Star* lawsuit. The court awarded Five Star \$1.6 million in damages against Essex. However, the Court denied Five Star's request for *Brandt* fees.

The Court of Appeal affirmed the trial court's decision in favor of Five Star but reversed the decision relative to the denial of *Brandt* fees. Rather, the Court of Appeal held that Five Star was also entitled to an award of *Brandt* fees pursuant to the assignment provided by Sanchez to Five Star.

In affirming the Court of Appeal's decision, the California Supreme Court noted the general rule of assignability which allows the assignment of all types of causes of action except for those which are purely personal in nature. Hence, a policyholder could not assign claims for emotional distress and punitive damages to a third party judgment creditor.

In affirming the Court of Appeal's decision, the Supreme Court held as follows:

We start from the proposition that assignability is the rule. (§954.) From that general rule we except those tort causes of actions “ “founded upon wrongs of a purely personal nature.”” (*Reichert, supra*, 68 Cal.2d at p. 834.) Actions for bad faith against an insurer have generally been held to be assignable (*Communal v. Traders & General Ins. Co.* (1958) 50 Cal.2d 654, 661-662), including claims for breach of the duty to defend) *Hamilton v. Maryland Casualty Co.* (2002) 27 Cal.4th 718, 728). Although some damages potentially recoverable in a bad faith action, including damages for emotional distress and punitive damages, are not assignable (*Murphy, supra*, 17 Cal.3d at p. 942), the cause of action itself remains freely assignable as to all other damages (*id.* at p. 946).

Here, the claim that Sanchez assigned to Five Star is based on Essex's tortious breach of its contract obligation under the policy to defend its insured, Sanchez, in the lawsuit brought against him by Five Star. In suing on this assigned claim, Five Star has not sought damages for emotional distress or punitive damages, or damages for injury to reputation or other personal interests. What Five Star has sought to recover as tort damages is the monetary value of the policy benefits wrongfully withheld by Essex.

As this court has explained, “[w]hen an insurer's tortious conduct reasonably compels the insured to retain an attorney to obtain the benefits due under the policy,” the fees incurred for those attorney services “are an economic loss—damages—proximately caused by the tort.” *Brandt, supra*, 37 Cal.3d at p. 817.) Those

attorney fees do not possess any of the personal aspects that preclude assignment of other tort damages, such as damages for emotional distress. They are not damages arising “from the personal tort aspect of the bad faith cause of action.” (*Murphy, supra*, 17 Cal.3d at p. 942.)

We reject Essex’s argument that because *Brandt* fees are tort damages, they are recoverable only if incurred by the insured personally, rather than by the assignee. “As a general rule, the assignee of a chose in action stands in the shoes of his assignor, taking his rights and remedies . . .” (*Salman v. Bolt* (1977) 74 Cal.App.3d 907, 919.) Had Sanchez brought the bad faith action against Essex, his right to recover *Brandt* fees would be unquestioned. As the assignee of Sanchez’s claim against Essex, Five Star stands in his shoes, and so may assert his right to recover any *Brandt* fees incurred in prosecuting the assigned claim. We agree with the Court of Appeal here that the right that Sanchez assigned to Five Star was the “right to recover the policy benefits in full, undiminished by the attorney fees incurred in bringing the action to recover those benefits.” Were we to accept Essex’s argument, Sanchez would no longer be assigning the right to recover the policy benefits in *full*.

RLI INSURANCE COMPANY vs. CNA CASUALTY OF CALIFORNIA

(Absent A Judgment, An Excess Insurer May Not Prosecute An Action For Equitable Subrogation Against Primary Insurer Based On The Failure To Settle Within Primary Limits)

In *RLI Ins. Co. v. CNA Casualty of California*, 141 Cal.App.4th 75 (July 7, 2006), the California Second District Court of Appeal affirmed the trial court’s entry of judgment in favor of primary carrier CNA Casualty of California (“CNA”) in connection with the settlement of an underlying wrongful death lawsuit arising out of a traffic accident. CNA paid its primary limits of \$1.0 million and RLI paid its excess limits of \$1.0 million to settle the underlying accident against their mutual insured, Jim Aartman, Inc. (“Aartman”). CNA failed to accept a settlement demand received in the underlying lawsuit against Aartman to settle such lawsuit in exchange for a payment of its primary limits of \$1.0 million. As a result, a subsequent settlement was reached for a total of \$2.0 million. The lawsuit never proceeded to trial and a judgment was not rendered against Aartman.

Subsequently, RLI filed an action for equitable subrogation against CNA arguing that it was entitled to reimbursement of the \$1.0 million that it contributed to the settlement of the lawsuit against Aartman based on CNA's failure to settle such lawsuit within its primary policy limits. In response, CNA filed a motion for judgment on the pleadings arguing that since a judgment was never reached in the underlying lawsuit against Aartman, RLI was barred from seeking equitable subrogation against CNA. The trial court agreed with CNA and entered judgment in its favor.

In affirming the trial court's decision, the Court of Appeal noted that an excess carrier stands in the shoes of an insured when pursuing a claim for equitable subrogation. Hence, under the California Supreme Court's decision in *Hamilton v. Maryland Cas. Co.* (2002) 27 Cal.4th 718, Aartman would have been barred from filing a claim for bad faith against CNA absent a judgment resulting in an award of damages in excess of Aartman's primary limits. Because a judgment was never rendered in excess of CNA's primary limits in the underlying lawsuit against Aartman, RLI standing in the shoes of Aartman, was barred from prosecuting a claim for equitable subrogation against CNA. The Court of Appeal explained its decision as follows:

The subrogation complaint in this case alleges that the Bodirsky lawsuit settled. Missing from the complaint is the critical allegation that an excess judgment was entered against Aartman in the Bodirsky lawsuit. Because there is not an excess judgment, Aartman suffered no harm, and has no claim to assert against the primary insurer. As a result, the excess insurer has no claim to assert against the primary insurer because the subrogation rights of the excess insurer are co-equal to and derivative of the rights of the insured. (*United Services Automobile Assn. v. Alaska Ins. Co.*, *supra*, 94 Cal.App.4th at p. 645.) The excess insurer cannot sue the primary insurer for failure to settle within the limits of the primary insurer's policy, absent an excess judgment against the insured.

PILIMAI
vs. FARMERS INSURANCE EXCHANGE COMPANY

(Offer To Compromise Made Pursuant To Code of Civil Procedure §998 Applies To Uninsured Motorists Arbitration And Entitles Prevailing Party To An Award of Costs In Excess Of Limits. Such Costs May Include Deposition And Expert Preparation Costs.)

In *Pilimai v. Farmers Ins. Exch. Co.*, 39 Cal.4th 133 (July 13, 2006), the California Supreme Court affirmed, in part, and reversed in part, the Court of Appeal's decision finding that the cost shifting provisions in California Code of Civil Procedure §998 applies to an uninsured motorist arbitration. The underlying dispute arose out of a demand for arbitration made by Farmers' insured, Isofea Pilimai, after he was injured in an automobile accident. The Farmers' policy afforded \$250,000 in uninsured motorist limits. Subsequently, prior to the arbitration, Pilimai served a settlement demand pursuant to Code of Civil Procedure §988 on Farmers offering to settle his claim for \$85,000. Farmers rejected this settlement demand. Thereafter, the matter proceeded to arbitration and the arbitrator awarded Pilimai \$556,972. Farmers moved to affirm the award in the amount of \$250,000 less the \$15,000.00 credit to which it was entitled under the policy. Pilimai also filed a petition to confirm the award and requested costs and prejudgment interest. Pilimai claimed he was entitled to recover his costs of suit and prejudgment interest based on California Civil Code §998 and Civil Code §3291. He claimed reimbursement of \$266.80 in filing fees, \$2,683.07 in deposition costs, \$195.51 in exhibit costs and \$14,975.85 in expert fees. Pilimai also requested prejudgment interest in the amount of \$36,470.22.

The trial court entered judgment in the amount of \$235,000. The trial court disallowed Pilimai's request for costs and prejudgment interest.

Subsequently, the Court of Appeal reversed the trial court's judgment with respect to costs and prejudgment interest. Thereafter, Farmers filed a petition for review in the California Supreme Court.

The California Supreme Court found that Civil Code §998 applied to uninsured motorist arbitrations pursuant to Insurance Code §11580.2. In so finding, the Supreme Court noted that Section 998 applied to trials and arbitrations. Hence, the Court found that arbitration pursuant to Insurance Code §1158.2 is a form of contractual arbitration governed by the California Arbitration Act. Hence, the cost shifting provisions in Section 998 applied to uninsured motorist arbitrations.

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The Supreme Court also found that costs awarded in connection with Section 998 were in addition to the uninsured motorist limits afforded by the Farmers' policy. The Court found that Insurance Code §11580.2(p)(4) does not explicitly or directly bar an insured from recovering costs above such liability when the conditions of Code of Civil Procedure §998 are met.

The Supreme Court rejected Pilimai's request for prejudgment interest. The Supreme Court noted that an uninsured motorist arbitration is not an action brought to recover damages for personal injury. Rather, it relates to a claim for damages premised upon breach of contract.

Lastly, the Supreme Court found that an award of costs under Section 998 included deposition and expert preparation costs.

EMPLOYERS INSURANCE COMPANY OF WAUSAU vs. TRAVELERS INDEMNITY COMPANY

*(Insurer Was Entitled To Equitable Contribution From Other Insurers
Which Settled With Their Policyholder For A Release Of All Claims Arising
Out of the Defense And Indemnity Of Environmental Lawsuits)*

In *Employers Ins. Co. of Wausau v. The Travelers Indem. Co., et al.*, 141 Cal.App.4th 398 (July 14, 2006), the California First District Court of Appeal affirmed the trial court's entry of judgment in favor of Employers Insurance Company of Wausau ("Wausau") in connection with a lawsuit for declaratory relief seeking equitable contribution for defense costs incurred in defending two pollution lawsuits. Wausau filed its complaint for declaratory relief against Travelers Indemnity Company, the Continental Insurance Company of Milwaukee, and National Union Fire Insurance Company of Pittsburgh (collectively, the "defendant insurers"). Wausau and the defendant insurers issued general liability policies to a succession of companies that allegedly released hazardous contaminants from a manufacturing plant in Willits, California. The Willits site was owned and operated by Remco Hydraulics, Inc. from approximately 1948 until 1968, when it was acquired by Sanray Corporation. Sanray was later acquired by Illinois Central Industries, Inc., which later changed its name to Whitman Corporation; Whitman, in turn, subsequently merged with PepsiAmericas, Inc.

In 1997 and 1998, Whitman settled with a number of insurers, including the defendant insurers to resolve disputed coverage of environmental claims raised in an environmental declaratory relief action entitled *Jensen-Kelly Corp., et al. v. Allianz Underwriters Ins. Co., et al.*, ("*Jensen-Kelly* lawsuit"). As part of the *Jensen-Kelly* settlements, Whitman released the defendant insurers from any obligation to defend or indemnify it against past, present and future environmental actions and agreed to indemnify the settling carriers against any claims under their policies, including other insurers' claims for contribution. In exchange, the defendant insurers paid Whitman an aggregate of approximately \$24.0 million.

Subsequently, two cases were filed involving the Willits site alleging damages for bodily injury and property damage. These cases were entitled *Avila, et al. v. Willits Environmental*

Remediation Trust and Arlich, et al. v. Willits Environmental Remediation Trust. The cases were filed in August, 1999 and January, 2000, respectively. Several hundred plaintiffs sued Whitman and others for bodily injury and property damage due to chromium contamination that emanated from the Willits site between 1958 and the present. Wausau was a primary general liability insurer of Whitman (then Sanray) for three years between January 1969 and January 1972. Each of the defendant insurers also provided Whitman with primary coverage during the years contamination allegedly occurred.

Wausau agreed to defend Whitman in the *Arlich* and *Avila* lawsuits. Subsequently, Wausau filed a complaint for declaratory relief and equitable contribution against the defendant insurers. In response, the defendant insurers argued that their settlement with Whitman barred any claims for contribution from Wausau. Subsequently, the trial court entered judgment in favor of Wausau finding that its claim for equitable contribution was not barred by the settlement reached with the policyholder by the defendant insurers. The trial court relied on the California Court of Appeal's decision in *Fireman's Fund Ins. Co. v. Maryland Cas. Co.* (1998) 65 Cal.App.4th 1279 (*Fireman's Fund* decision).

In affirming the trial court's decision, the Court of Appeal also relied on the *Fireman's Fund* decision. The Court of Appeal noted that equitable contribution rights exist independently of the rights afforded a policyholder under an insurance policy. Rather, the right of equitable contribution is predicated on the common sense principle that where multiple insurers or indemnitors share equal contractual liability for the primary indemnification of a loss or the discharge of an obligation, the selection of which indemnitor is to bear the loss should not be left to the often arbitrary choice of the loss claimant, and no indemnitor should have any incentive to avoid paying a just claim in the hope that the claimant will obtain full payment from another co-indemnitor. Thus, the Court of Appeal held that "The well settled rule is that an insurer's obligation to contribute to another insurer's defense or indemnification of a common insured arises independently and is separate from any contractual obligation owed to their insured."

The Court of Appeal also found that the cost of defending the *Arlich* and *Avila* lawsuits should be allocated using a "time on the risk" formula. Hence, the Court added up the total number of months of coverage afforded by all of the insurers and determined each insurer's share based on each insurer's time on the risk as it bears to the total number of months for time on the risk.

**KLEVELAND
vs. CHICAGO TITLE INSURANCE COMPANY**

(Arbitration Clause in Title Insurance Policy Held Unenforceable Where Preliminary Title Report Does Not Reference Such Clause and Different Policy Was Issued Than the Type of Policy Referred to in the Preliminary Title Report)

In *Kleveland Vs. Chicago Title Ins. Co.*, 141 Cal.App.4th 761 (July 24, 2006), the California Second District Court of Appeal affirmed the trial court's order refusing to compel arbitration of a bad faith lawsuit filed by Chris Kleveland and AOK Land Company LLC against Chicago Title. The parties' dispute arose out of the discovery of an easement on the insured property that plaintiffs claimed was not mentioned in the preliminary title report. As a result of the lawsuit, Chicago Title filed a motion to compel arbitration based on the clause in the California Land Title Association's standard coverage policy ("CLTA") it had issued in connection with the property. Plaintiff's opposed Chicago Title's motion based on the fact that the preliminary title report did not include an arbitration clause, nor did it incorporate by reference the CLTA issued by Chicago Title. Rather, it incorporated by reference another policy which had not been issued by Chicago Title to insure the subject property.

In affirming the trial court's order denying Chicago Title's motion to compel arbitration, the Court of Appeal focused on the fact that the preliminary title report did not include an arbitration clause. Further, the Court of Appeal noted that the actual policy issued by Chicago Title was not the policy identified in the preliminary title report and incorporated by reference by such report.

**ORTEGA ROCK QUARRY
vs. GOLDEN EAGLE INSURANCE CORP.**

(Total Pollution Exclusion Applied to Bar Coverage of Creek Damaged As a Result of Fill Deposits in Creek Due to the Policyholder's Activities)

In *Ortega Rock Quarry v. Golden Eagle Ins. Corp.*, 141 Cal.App.4th 969 (July 27, 2006), the California Fourth District Court of Appeal affirmed a summary judgment entered by the trial court in favor of Golden Eagle Insurance Corporation, Liberty Mutual Insurance Company, Continental Casualty Company and Valley Forge Insurance Company ("Insurers") based on "total pollution exclusions" included in the Insurers' policies. The parties' dispute arose out of an EPA order and corresponding civil lawsuit requiring Ortega Rock Quarry to clean up a creek which had been contaminated by soil located on the property leased by Ortega Rock Quarry ("Ortega"). In 1999, the EPA issued an order which stated that on "numerous dates in 1999, Ortega had, without a permit, discharged fill material, consisting of dirt and rocks, along the northern embankment of Lucas Canyon Creek, causing substantial portions of the creek to fill. The order stated that the fill materials consisting of dirt and rocks, that Ortega placed into the creek bed "are dredged and fill material, hence pollutants, within the meaning of the Clean Water Act."

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In response to the EPA's order, Ortega assisted in the development of a removal/restoration plan for the creek. In October, 2000, the EPA issued a second order directing Ortega to implement and complete by December 15, 2000 the remediation and clean-up of the creek.

In June, 2001, the owner of the property which was leased by Ortega, Santa Margarita Company, filed a civil lawsuit against Ortega alleging that Ortega had damaged the creek and surrounding property.

Ortega tendered the EPA orders and Santa Margarita lawsuit to its Insurers. The Insurers declined to defend Ortega in connection with the subject claims based on the absence of a "suit" as required by their policies and the total pollution exclusions included in the Insurers' policies. The exclusions stated as follows:

- "1) "Bodily injury,' 'property damage,' or 'personal injury' which would not have occurred in whole or part but for the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of pollutants at any time.
- "2) Any loss, cost or expense arising out of any:
 - "a. Request, demand or order that any insured or others test for, monitor, clean up, remove contain, treat, detoxify, or neutralize, or in any way respond to, or assess the effects of pollutants; or
 - "b. Claim or suit by or on behalf of any authority for damages because of testing for, monitoring, cleaning up, removing, containing, treating, detoxifying or neutralizing, or in any way responding to, or assessing the effects of pollutants; or
 - "c. Payment related to the investigation or defense for any loss, injury or damage, or any cost, fine or penalty, or for any expense or claim or suit related to 1) and 2) a. and b. above." The CNA policy included a substantially similar pollution exclusion endorsement.

Under both the GEIC and CNA policies, "pollutants" were defined as "any solid, liquid, gaseous, or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes materials to be recycled, reconditioned or reclaimed."

As a result of the Insurers' denials of coverage, Ortega filed a lawsuit against the Insurers for breach of contract and bad faith. In response, the Insurers' filed motions for summary judgment arguing the claims did not involve a "suit" and/or that the pollution exclusions in their policies applied to bar coverage of the claims. The trial court entered

In affirming the trial court's entry of summary judgment in favor of the Insurers, the Court of Appeal noted that EPA's orders did not constitute "suits" based on the California Supreme Court's holding in *Foster-Gardner, Inc. v. National Union Fire Ins. Co.*(1998) 18 Cal.4th 857. In addition, the Court of Appeal found that the total pollution exclusions included in the Insurers' policies applied to bar coverage of the underlying claims. The Court of Appeal noted that the Clean Water Act defines pollutants to include dredged soil. Hence, natural dirt and rock constituted pollutants within the meaning of the pollution exclusions and as referred to in the Clean Water Act.

The Court of Appeal rejected Ortega's argument that under the California Supreme Court's holding in *MacKinnon v. Truck Ins. Exch.* (2003) 31 Cal.4th 635, the pollution exclusions only applied to bar claims involving industrial pollution. The Court of Appeal also relied on a decision entitled "*Garamendi v. Golden Eagle Ins. Co.* (2005) 127 Cal.App.4th 480 wherein, the Court of Appeal found that silica dust constituted a pollutant excluded by the absolute pollution exclusion.

THE STANDARD FIRE INS. CO. vs. THE SPECTRUM COMMUNITY ASSOCIATION

(Defense Owed Under a General Liability Policy in Connection With a Construction Defect Property Damage Lawsuit, Notwithstanding That the Claimant Homeowners Association Was Not In Existence During the Policy Period)

In *The Standard Fire Ins. Co. v. The Spectrum Community Association*, 141 Cal.App.4th 1117 (July 31, 2006), the California Fourth District Court of Appeal reversed the trial court's entry of summary judgment in favor of Standard Fire relative to the absence of property damage occurring during its policy period. Standard Fire afforded coverage to the developer of the Spectrum Condominium Project for the period of August 6, 1991 to August 6, 1992. The policy was cancelled effective June 26, 1992. The homeowners association for the Spectrum project was not formed until nearly a year after the expiration of the Standard Fire policy. The parties' dispute arose out of the tenders of defense of 67 separate construction defect lawsuits against the developers of the Spectrum project. In addition, the Spectrum Homeowners Association ("HOA") filed a construction defect suit. Standard Fire agreed to defend the developer in connection with the HOA's lawsuit pursuant to a reservation of rights. Subsequently, Standard Fire filed a complaint for declaratory relief arguing that potential coverage was not afforded under its policy in connection with the HOA lawsuit. Standard Fire essentially argued that because the HOA was not formed until approximately one year after the expiration of the Standard Fire policy, it could not have sustained property damage during the policy period. The trial court agreed with Standard Fire and entered summary judgment in its favor.

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In reversing the trial court's decision, the Court of Appeal relied on two Court of Appeal decisions: *Garriott Crop Dusting Co. v. Superior Court* (1992) 221 Cal.App.3d 783 and *Century Indemnity Co. v. Hearrean* (2002) 98 Cal.App.4th 734. The Court of Appeal reasoned that the Standard Fire policy afforded coverage for property damage which occurred during the policy period. In this case, the parties acknowledged that property damage took place during the Standard Fire policy period. However, Standard Fire insisted that since the HOA was not in existence, it could not have sustained any damage until after being formed nearly a year after the expiration of the Standard Fire policy.

In rejecting Standard Fire's reasoning, the Court of Appeal relied on the *Garriott* and *Hearrean* decisions which emphasized that potential coverage is triggered under general liability policies at the time that property damage takes place, rather than when a claimant purchases the property which sustained property damage.

The Court of Appeal also held that the HOA had standing pursuant to Code of Civil Procedure §383 and subsequently enacted Civil Code §1368.3 which allows an association to sue for damages sustained by the common areas and the separate interests which the association is obligated to maintain or repair.

PARKWOODS COMMUNITY ASSOCIATION vs. CALIFORNIA INSURANCE GUARANTEE ASSOCIATION

(Claimant Is Not Entitled to Recover From CIGA Amounts Owed in Connection With the Settlement of a Construction Defect Lawsuit As Excess Policy Issued to Developer Constituted "Other Insurance" Barring Recovery From CIGA)

In *Parkwoods Community Association v. California Ins. Guarantee Association*, 141 Cal.App.4th 1362 (August 7, 2006), the California First District Court of Appeal reversed the trial court's entry of judgment in favor of Parkwoods Community Association ("Parkwoods") in connection with the declaratory relief action filed by Parkwoods against the California Insurance Guarantee Association ("CIGA") for recovery of that portion of a settlement reached in resolving a construction defect lawsuit. The parties' dispute arose out of a settlement between Parkwoods and the developer and general contractor for the Parkwoods condominium development in Oakland, California. Five of the subcontractor defendants in the lawsuit were insured by Reliance Insurance Company. Reliance was placed into liquidation causing CIGA to assume the defense of the subcontractors. Parkwoods entered to a settlement with the general contractor and developer of the project, wherein, all of their primary insurance was exhausted. In addition, the developer's and general contractor's excess insurer agreed to contribute a portion of its policy limits to the settlement. However, the parties agreed that the excess policy was not exhausted by the settlement and that approximately \$925,000 in limits remained under such excess policy. Thereafter, Parkwoods demanded that CIGA contribute to the settlement of its lawsuit in an amount equaling the remaining amount in the developer's and general contractor's excess policy (*i.e.*, \$925,000). CIGA refused and contended that the excess policy "constituted other insurance" barring any claim against it for contribution.

Subsequently, Parkwoods filed a complaint for declaratory relief against CIGA arguing that since the excess insurer did not afford coverage to any of CIGA's insureds, it did not constitute "other insurance" under the Insurance Code. Hence, Parkwoods was entitled to pursue a claim for contribution from CIGA. In response, CIGA relied on Insurance Code §1063.1, subd. (c)(9) which provides that "'covered claims' do not include any claim to the extent that it is covered by any other insurance of a class covered by this article available to the **claimant** or insured." CIGA argued that since the excess policy was "available" to Parkwoods, the claimant, §1063.1, subd. (c)(9) barred Parkwoods' claim. The Court of Appeal agreed. In particular, the Court of Appeal noted that the Code section was not limited to other insurance available to the policyholders of the liquidated insurer for which CIGA had replaced for purposes of affording a defense. Rather, the term "available insurance" also applied to a claimant. In short, pursuant Section 1063.1 subd. (c)(9)(i), Parkwoods' claim did not constitute a "covered claim" as required by such code section.

**UNIFIED WESTERN GROCERS, INC.
vs. TWIN CITY FIRE INSURANCE COMPANY**

*(Insurance Code §533 Excluding Coverage of Wilful Acts Did Not Preclude
Reimbursement of Defense Costs Incurred On Behalf of Individual
Corporate Officers Sued for Wilful Conduct and Breach of Fiduciary Duty)*

In *Unified Western Grocers, Inc., et al. v. Twin City Fire Ins. Co.*, 457 F.3d 1106 (9th Cir. August 15, 2006), the United States Court of Appeals for the Ninth Circuit reversed the United States District Court's entry of summary judgment in favor of Twin City Fire Insurance Company ("Twin City") relative to its obligation to reimburse six corporate officers for defense costs incurred in defending the lawsuit brought by a bankruptcy trustee of a subsidiary in which the officers approved a leveraged buyout transaction relative to the sale of such subsidiary. The individual officers were insured by Twin City under a directors and officers liability policy. The directors tendered a request for reimbursement of defense costs to Twin City. Twin City refused to indemnify the officers, arguing that the underlying complaint solely alleged wilful conduct barred by Insurance Code §533. As a result, the officers filed a complaint for declaratory relief seeking a judgment that Twin City was obligated to pay defense costs and reimburse appellants for losses resulting from the underlying bankruptcy trustee complaint. In response, Twin City filed a motion for summary judgment arguing that Insurance Code 533 barred coverage of the officers. The District Court agreed and entered summary judgment in favor of Twin City.

The Court of Appeals referred to the following law in connection with interpreting Insurance Code §533:

The district court held that section 533 of the California Insurance Code would preclude coverage for the claims asserted against the directors and officers in the Underlying Complaint. Section 533 states: "An insurer is not liable for a loss caused by the wilful act of the insured; but he is not exonerated by the negligence of the insured, or of the insured's agents or others."

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The California Supreme Court has made clear: “Section 533 reflects a fundamental public policy of denying coverage for willful wrongs.” *J.C. Penney Cas. Ins. Co. v. M.K.*, 804 P.2d 689, 694 n.8 (Cal. 1991). “It is an implied exclusionary clause which, by statute, must be read into all insurance policies.” *Downey Venture v. LMI Ins. Co.*, 78 Cal. Rptr. 2d 142, 154 (Ct. App. 1998). Because section 533 is considered under California to be an exclusionary clause, the insurer has the “burden of proving that the requested claims are matters ‘uninsurable under the law.’” *Raychem Corp. v. Fed. Ins. Co.*, 853 F.Supp. 1170, 1175 (N.D. Cal. 1994).

“Section 533 does not bar coverage for conduct which may be wrongful, but which is not intentional or willful from the standpoint of the insured.” *Melugin v. Zurich Ca.*, 57 Cal.Rptr.2d 781, 785 (Ct. App. 1996). Preclusion under this statute requires more than negligence, recklessness or even the “intentional doing of an act constituting ordinary negligence or the violation of a statute.” *Downey*, 78 Cal.Rptr. 2d at 155. The statutory exclusion is intended to preclude indemnification for conduct that is “clearly wrongful and necessarily harmful.” *Mez Indus., Inc. v. Pac. Nat’l Ins. Co.*, 90 Cal.Rptr. 2d 721, 736 (Ct. App. 1999) (footnote omitted).

Although previous case law had required a specific intent to inflict harm, see *Clemmer v. Hartford Inc. Co.*, 587 P.2d 1098, 1110 (Cal. 1978), the California Supreme Court held in 1991 that section 533 can preclude indemnification without “a showing by the insurer of its insured’s ‘preconceived design to inflict harm’ when the insured seeks coverage for an intentional and wrongful act if the harm is inherent in the act itself.” *J.C. Penney*, 804 P.2d at 698. A “willful act” has been further defined by California’s intermediate appellate courts as “an act deliberately done for the express purpose of causing damage or intentionally performed with knowledge that damage is highly probable or substantially certain to result.” *Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 15 Cal.Rptr.2d 815, 832 (Ct. App. 1993). “Therefore, section 533 precludes indemnification for liability arising from deliberate conduct that the insured expected or intended to cause damage.” *Id.* at 833.

The Court of Appeals then noted that since the complaint could encompass negligent conduct as well as willful conduct, the District Court’s entry of summary judgment should be reversed. In particular, the Court of Appeals noted that the complaint alleged breach of fiduciary duty. Recovery on this theory did not require the plaintiff trustee to establish that the defendants had acted willfully as required by Insurance Code §533.

In addition, the Court of Appeals rejected Twin City’s argument that trustee’s complaint did not seek damages, but rather, sought only restitution of ill-gotten gains. The Court of Appeals noted that the trustee’s complaint included claims which were not necessarily limited to restitution of ill-gotten gains. Rather, such complaint included allegations supporting a claim for damages. In particular, the Court focused on the allegations seeking recovery of damages in excess of the amount actually alleged to have been taken by the defendants.

PRINCE **vs. UNITED NATIONAL INSURANCE COMPANY**

(Automobile Exclusion in Liability Policy Applied to Bar Coverage of Wrongful Death Claim Involving Children Who Died in A Locked Car Due to Heat Exposure)

In *Prince, et al. v. United National Ins. Co.*, 142 Cal.App.4th 233 (August 24, 2006), the California Second District Court of Appeal affirmed the trial court's order sustaining United National Insurance Company's, Fire Insurance Exchange's and Mercury Casualty Company's (collectively "insurers") demurrers to a complaint for contribution filed by the parents of two children which died as a result of heat exposure while locked in a car in front of a preschool. The children were dependants of the Los Angeles County Foster Care System. The plaintiffs were the natural parents of the children. In July 2003, the children were left in the car of their foster mother for six hours outside a preschool operated by the foster mother and her husband. As a result, the children died to due to exposure to heat inside the car. As part of settlements reached with the insurers of the foster parents, assignments were provided to the plaintiffs who then prosecuted contribution claims against the liability carriers of the foster parents. Such carriers had declined coverage of the claim based on the automobile exclusion in their policies. This exclusion states:

"This insurance does not apply to bodily injury or property damage arising out of the ownership, maintenance use or entrustment to others of any aircraft, auto, or watercraft owned or operated by or rented or loaned to any insured."

In affirming the trial court's order dismissing the plaintiffs' lawsuit, the Court of Appeal reaffirmed the rule in California that the automobile exclusion applies to claims, wherein, the use of an automobile was a "predominating cause/substantial factor in causing the claimed injury." And in this case, the car, itself, was the instrumentality which caused the death of the children. The negligence of the foster mother in leaving the children in the car for six hours could not be "disassociated" from the use of the vehicle. Rather, it was the heat generated inside the locked car which caused the death of the children. If the children had been left on a park bench by the negligent foster mother, they would not have expired due to exposure to heat. Such heat could only be created by the car itself. Hence, the Court of Appeal found that the claim arose out of the use of the vehicle and was barred by the automobile liability exclusion in the insurers' policies.

ELNEKAVE
vs. VIA DOLCE HOMEOWNERS ASSOCIATION

(Settlement of Lawsuit Brought Against HOA and Individual Condominium Unit Owner Could Not Be Enforced, Wherein, HOA Board Member Did Not Approve Such Settlement On the Record)

In *Elnekave v. Via Dolce Homeowners Association*, 142 Cal.App.4th 1193 (September 12, 2006), the California Second District Court of Appeal reversed the Court's order enforcing a settlement placed on the record pursuant to California Code of Civil Procedure §664.6 between a plaintiff condominium owner, the insurer for a condominium homeowner association ("HOA") and an adjoining individual condominium unit owner. The parties' dispute arose out of mold and property damage sustained by plaintiff's condominium due to the leaks in plumbing in the adjacent condominium unit. The plaintiff alleged that the HOA and adjoining condominium unit owner were liable for the damages sustained by her condominium unit.

A settlement of plaintiff's claim was reached at a mandatory settlement conference on September 8, 2004. The settlement agreement was placed on the record and approved by plaintiff, a representative of the HOA insurer, State Farm and an employee of the property management company hired by the HOA to manage the condominium complex. Subsequently, the parties could not agree as to the scope of the settlement agreement. Essentially, the HOA contended that such agreement did not extend to bar its efforts to enforce the CC&Rs with respect to the repair of plaintiff's condominium unit. Subsequently, the plaintiff filed a motion to enforce the parties' settlement pursuant to Code of Civil Procedure §664.6. The trial court granted such motion.

In reversing the trial court's order enforcing the parties' settlement, the Court of Appeal noted that a member of the HOA board did not approve the settlement on the record. Further, the property management representative did not comply with the strict guidelines set forth in Section 664.6 which specifically requires that the parties, and not their attorneys or other agents, must approve a settlement placed on the record.

**AMERICAN INTERNATIONAL SPECIALTY LINES
INSURANCE COMPANY
vs. CONTINENTAL CASUALTY INSURANCE COMPANY**

*(Insurer Is Barred From Seeking Equitable Contribution From Another
Insurer Wherein Settlement Was Reached Prior to
Providing Notice to Insurer)*

In *American International Specialty Lines Ins. Co. v. Continental Cas. Ins. Co.*, 142 Cal.App.4th 1342 (September 14, 2006), the California Second District Court of Appeal affirmed the trial court's entry of summary judgment in favor of Continental Casualty Company ("Continental"), Gulf Underwriters Insurance Company ("Gulf") and Admiral Insurance Company ("Admiral") relative to a claim for contribution by American International Specialty Lines Insurance Company ("American") and Lexington Insurance Company ("Lexington") arising out of the settlement of an underlying intellectual property lawsuit. American and Lexington paid \$21.5 million to a fund settlement on behalf of Walt Disney Company with respect to a trademark infringement lawsuit brought by GoTo.com, Inc. against Disney and Info Seek Corporation ("Info Seek") (the insured of Gulf and Admiral). American's/Lexington's claim for contribution arose out of a lawsuit filed by GoTo.com on February 18, 1999 against Disney alleging claims for false designation of origin, statutory unfair competition under California Business and Professions Code §17200 *et. seq.* and common law unfair competition. On May 25, 2000, Disney, Go To and Info Seek settled the Go To lawsuit for \$21.5 million. Subsequent to the settlement, counsel for American sent a letter to Continental advising that the American policy schedule of underlying insurance listed the Continental policy and that the American policy was excess. American took the position that Continental was obligated to indemnify Disney. Continental never responded to American's letter.

Thereafter, American contested Disney's proposed settlement of \$21.5 million. Notwithstanding American's position, Disney settled its lawsuit with Go To for \$21.5 million. Subsequently, on February 20, 2001, Lexington and American reimbursed Disney for the settlement amount and defense costs in the amount of \$3,214,612. Lexington and American failed to advise Continental of the settlement of the Go To lawsuit and their reimbursement of Disney for defense and indemnity costs.

Continental refused to reimburse American and Lexington for any portion of the settlement. In addition, Gulf declined coverage of Info Seek's involvement in the settlement based on the fact that Info Seek knew prior to the inception of the policy that Go To had asserted a claim for trademark infringement against Disney and Info Seek.

In affirming the trial court's entry of judgment in favor of Continental and Info Seek, the Court of Appeal relied on the decision entitled *Truck Ins. Exch. v. Uniguard Ins. Co.* (2000) 79 Cal.App.4th 966.

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The Court of Appeal noted that the Continental policy included three conditions before coverage was triggered under such policy: (1) a requirement of prompt notice, (2) the right, but not the obligation to defend claims or suits, and (3) a bar against voluntary payments.

Based on these provisions, in particular, the notice and voluntary payments provisions, the Court of Appeal held that settling insurers could not recover from Continental because they did not notify Continental of its potential liability for contribution prior to the Disney settlement. The Court of Appeal followed the reasoning in the *Uniguard* case. The Court of Appeal also noted that its decision was based on equity as reflected in the particular facts peculiar to the settling insurers' lawsuit.

As respects American/Lexington's claims for contribution against Gulf and Admiral, the Court of Appeal affirmed the trial court's holding that Info Seek knew about the GoTo trademark claim prior to the inception of their policies on February 12, 1999.

BERNSTEIN vs. THE TRAVELERS INSURANCE COMPANY

(Insurer is Required to Disclose Information Regarding Insurance Reserves in Connection With a First Party Bad Faith Lawsuit)

In *Bernstein, et al. v. The Travelers Ins. Co.*, 447 F.Supp.2d 1100 (September 28, 2006), the United States District for the Northern District of California ordered Travelers to disclose information regarding its policy reserves in connection with a first party bad faith lawsuit filed with respect to the adjustment of property claims asserted by the plaintiffs. The District Court followed the holding in the California Court of Appeal's decision entitled *Lipton v. Superior Court*, (1996) 48 Cal.App.4th 1599. The District Court also granted Travelers' request for a protective order prohibiting the plaintiffs or their counsel from using information for any purpose other than the instant litigation, and from disclosing it to anyone who is not an officer or an agent of the Court or party to the lawsuit.

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