Survey of Insurance Law Cases

Declaratory Judgment Action Against Insurer By Injured Party Barred Where Insurer Defending Under Reservation of Rights Because There Was No Controversy

In the underlying class action in *Byer Clinic and Chiropractic, Ltd. v. State Farm Fire and Casualty Company*, the class sued the insured under the Telephone Consumer Protection Act, 47 U.S.C. § 227, claiming the right to damages for so-called "junk faxes." State Farm Fire and Casualty Company issued commercial general liability policies naming Kapraun, P.C. as an insured. Kapruan was a defendant in the underlying action along with Eniva USA, Inc., Eniva International, Inc., and Eniva I-Disc.

Class action plaintiff Byer Clinic and Chiropractic, Ltd. sought a declaration regarding State Farm's "rights and obligations under the commercial general liability policy" as to the Eniva companies. In response, the insurer moved to dismiss pursuant to 735 ILCS 5/2-619 because it did not insure Eniva. In its reply, the insurer raised the argument that there was no justiciable controversy because the insured Kapraun, P.C., was being defended under a reservation of rights. The trial court dismissed the case. The appellate court affirmed, finding that no case supported the plaintiff's argument that it was entitled to a declaration of coverage when the insurer was presently defending its insured. In clarifying the apparent confusion in the case regarding standing to sue and the need for a justiciable controversy, the appellate court noted there must be a justiciable controversy before the issue of standing is addressed. Here the case failed on the threshold issue of controversy despite the fact that the insurer had filed and was prosecuting a declaratory judgment action in Michigan state court. The court in *Beyer Clinic* distinguished the present case from those where the insurer refuses to defend its insured and does not file a declaratory judgment action. In the latter case, the tort plaintiff has standing to bring an action against the insurer for declaration of coverage. The court cited *Pratt v. Protective Insurance Co.*, 250 Ill. App. 3d 612 (1993) and *Record-A-Hit, Inc. v. National Fire Insurance Company of Hartford*, 377 Ill. App. 3d 632 (1993), in which the courts held a tort plaintiff had standing to sue where the insurer refused to defend the tort defendant-insured.

Byer Clinic and Chiropractic, Ltd. v. State Farm Fire and Casualty Company, 2013 IL App (1st) 113038.

Car Owners Not Covered Where Autos Seized by Law Enforcement as Stolen and Policy Required "Damage To" Autos

In *State Farm Mutual Auto Insurance Co. v. Rodriguez*, the insured's listed auto on a personal auto policy was seized by law enforcement officials as a stolen automobile. There was no argument that the insured was complicit in the theft, but instead was an innocent purchaser of the auto. Three actions by different insureds under separate personal auto policies were consolidated for appeal from the Circuit Court of Cook County, where the underlying facts were similar. The trial courts found no coverage. The appellate court agreed. The personal auto policies contained identical policy language. The insuring agreement for the physical damage coverage provided that the insurer will pay "for ***loss*** except ***loss caused by collision***, to a ***covered vehicle***[.]" *State Farm*, 2013 IL App (1st) 121388 ¶ 9 (emphasis in original). The policy term "loss" was defined as follows:

> "***Loss*** means:
> 1. direct, sudden, and accidental damage to; or
> 2. total or partial theft of
>
> a ***covered vehicle***."

Id. (emphasis in original). The parties agreed that seizure by law enforcement is not "theft," so the sole issue was the construction of the first paragraph of the definition of "loss." The insureds argued that they had insurable interests in the covered vehicles, that the term "damage" was undefined. The insureds then pointed to Black's Law Dictionary, 445 (9th ed. 2009), which defines "damage" as "[l]oss or injury to person or property." *Id.* at ¶ 20. Because Black's does not define "loss" within the term "damage," the insureds resorted to Black's definition of "loss," which defines "loss" as, in part, the "disappearance or diminution of value." *Id.*

The appellate court rejected those arguments, finding whether the insured had an insurable interest in the policy to be irrelevant because the policy required "direct, sudden and accidental damage to" the covered auto. *Id.* at ¶ 21. As the court explained, "[a]lthough we acknowledge the harsh result of the seizures on the innocent purchaser defendants herein, we cannot ignore or modify the preposition 'to' in the 'loss' definition, and transfer their burdens to parties that did not contract to insure this risk." *Id.* at ¶19.

State Farm Mutual Auto Insurance Co. v. Rodriguez, 2013 IL App (1st) 121388.

Truck Borrowed from Corporation Owner Did Not Qualify as "Non-Owned Vehicle" within Business Auto Policy Coverage

In *Metzger v. Country Mutual Ins. Co.*, suit was brought against an insurer by a party injured in a motor vehicle accident, seeking a declaration of coverage for the vehicle driven by a deceased motorist that allegedly caused the accident. Country Mutual issued a business auto policy to McKee Masonry, which covered only "non-owned" vehicles operated in the business. *Id.* at ¶ 5. Jeffrey Metzger was injured when a Ford F-250 titled and registered to Brian McKee collided with the Metzger vehicle. Another insurer on whose policy the F-250 was a covered auto was defending the estate of Brian McKee, who died as a result of the accident. It was undisputed that Brian McKee was the co-owner of McKee Masonry, along with his wife. It was also undisputed that McKee Masonry was an "S" corporation. Metzger sought a declaration that Country Mutual defend the estate of Brian McKee in the underlying case and that the limits of the business auto policy be applied to any settlement or judgment. *Id.* After discovery, the trial court granted Metzger's motion for summary judgment and denied the insurer's motion for summary judgment. The insurer appealed. The appellate court reversed. The policy term "non-owned auto" was defined as: "any 'auto' you do not own, lease, hire or borrow which is used in connection with your business." *Id.* at ¶ 27. The trial court granted summary judgment because it found the corporation did not own the F-250, but the appellate court held that the vehicle was "borrowed" by the corporation. The evidence showed the corporation owners bought the vehicle solely for business purposes, and it was used almost exclusively in the business. While the policy did not define "borrow," the *Metzger* Court relied on the common dictionary meaning of "borrow" as "temporary use," the frequency of which is not pertinent." *Id.* at ¶ 37-38.

Metzger v. Country Mutual Ins. Co., 2013 IL App (2d) 120133.

Excess Premium Precludes Cancellation of Auto Policy for Non-Payment

The court held in *Auto-Owners Ins. Co. v. Yocum* that where a business auto policy was changed by dropping and adding vehicles, which resulted in excess premium paid by the insured, the insurer could not effectively cancel the policy. Yocum Trucking had a history of non-payment of monthly premiums, which were paid before cancellations by the insurer. In the policy period of June 23, 2005 to June 23, 2006, two of three vehicles on the policy were damaged in an accident and taken out of use. The insured requested the insurer remove these two vehicles from the policy. The endorsement removing the vehicles was not issued until August 30, 2005, but was effective as of June 30, 2005. Removing the two vehicles reduced premium from $257.25 per month to $104 per month. *Id.* at ¶ 5. When Yocum did not pay the premium in July, the insurer issued a notice of cancellation, requiring the insured to pay $539.50 by August 25, 2005. When the insured did not make any payments, the insurer issued a notice of cancellation to the insured. However, on September 7, 2005, the insurer issued a check to Yocum for $238.66, which represented unearned premium. An accident on September 22, 2005, involved the vehicle on the policy. The insurer denied coverage for the September 22, 2005 accident, based on the cancellation of the policy effective August 25. The trial court and appellate court held that, pursuant to *Leach v. Federal Life Insurance Co.*, 296 Ill. App. 88, 15 N.E.2d 1006 (1938), the insurer was required to apply the premium credit to any premium amount due. If the insurer had done so, the policy would not have been cancelled. The insurer's argument that it had no liability because it had followed all statutory requirements for policy cancellation for non-payment of premium was rejected.

Auto-Owners Ins. Co. v. Yocum, 2013 IL App (2d) 111267.

Adulteration of Drinking Water with PCE is Traditional Pollution Barred by the Absolute Pollution Exclusion

The underlying dispute in *Village of Crestwood v. Ironshore Specialty Insurance Company* arose when the Village of Crestwood was sued by a number of its residents for using municipal well water containing PCE's and other contaminants mixed with Lake Michigan water for its municipal water supply, and delivering the tainted water to residents and businesses. Specifically, the underlying complaints in 25 individual and class actions asserted that the Village had "knowingly and routinely mixed cheap, polluted water into the municipal tap water supply in order to cut municipal expenses." *Id.* at ¶ 1. Summary judgment was granted to various insurers by the trial court in the declaratory judgment action filed by the Village and its former mayor. Each insurer issued policies to the Village containing "absolute pollution exclusions," which were substantively the same. The Ironshore policy's absolute pollution exclusion, for example, excluded coverage for "'bodily injury or property damage which would not have occurred in whole or part but for the actual or alleged or threatened discharge, dispersal, seepage, migration, release or escape of pollutants at any time.'" *Id.* at ¶ 9. Neither the trial court, previous federal court, nor the appellate court was receptive to the Village's attempt to cast the Village as the negligent supplier of a defective product polluted by others. The federal decision, *Scottsdale Indemnity Co. v. Village of Crestwood*, 673 F.3d 715 (7th Cir. 2012),

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involved a declaratory judgment action filed by two insurers. In that case, the insurers prevailed on the absolute pollution exclusion contained within their respective policies. In the Illinois Appellate Court decision, the court also rejected the Village's argument that the absolute pollution exclusion, if applied, would render the policy meaningless. This argument was rejected because it was never the Village's central business activity to work with the chemicals that contaminated its well.

Village of Crestwood v. Ironshore Specialty Insurance Company, 2013 IL App (1st) 120112.

"Each Occurrence" and "General Aggregate" Limits Unambiguous

The dispute in *Bituminous Cas. Corp. v. Iles* arose following an explosion at an oil and gas well that resulted in several injuries and deaths to oil well workers. At issue were two commercial general liability policies that provided "each occurrence" liability limits and higher "general aggregate" liability limits. The company that issued the two policies filed a complaint for interpleader against the injured parties seeking to deposit with the court the total "each occurrence" limit for each policy so that the injured parties could assert their respective claims to the funds. Some of the injured parties counterclaimed that the policy limits available under the two policies were the higher "general aggregate" limits, and not the "each occurrence" limits. The policy language in the Limits of Insurance section provided that the limits of insurance in the Declarations are the most the insurer will pay regardless of the number of insureds or claims. That section of the policy also provided that the "the general aggregate limit is the most we will pay for the sum of… damages under Coverage A… because of all bodily injury and property damage arising out of any one occurrence." *Id.* at ¶ 10. Under Coverage A, the insurer agreed to pay all sums the insured becomes legally obligated to pay as damages because of bodily injury caused by an occurrence. The injured parties argued that, when read together, this policy language was ambiguous and appeared to apply the higher "general aggregate" limit to claims that arise from a single occurrence. The insurer argued that the unambiguous language provides that the limit of coverage for a single occurrence is the "each occurrence" limit. The trial court agreed with the injured parties that the policies were ambiguous and, therefore, should be construed in favor of the insureds with the higher "general aggregate" limit applying. The trial court focused its analysis on the fact that the Limits of Insurance language referred the reader to Coverage A and the Declarations, neither of which explained what is meant by "general aggregate." The appellate court reversed, finding no ambiguity. Noting that there was no dispute that injuries resulting from the well explosion were caused by one occurrence, the appellate court found that the policy language clearly limited the amount to be paid for any one occurrence. Therefore, the "each occurrence" limit properly applied. The appellate court also found that the language of the "general aggregate" read in conjunction with the "each occurrence" limit made apparent that the "general aggregate" applies for multiple occurrences during the policy period.

Bituminous Cas. Corp. v. Iles, 2013 IL App (5th) 120485.

Store Found to be Additional Insured Entitled to Defense for Injury to Customer Suffered While Loading Vehicle

The underlying dispute in *Menard, Inc. v. Country Preferred Ins. Co.* arose when a hardware store customer tripped and fell on some debris on the ground near her vehicle while an employee of the store was loading a customer's car with bricks the customer had purchased. The customer filed a premises liability case against the hardware store alleging that the hardware store failed to maintain the property in a safe condition by allowing debris to accumulate on premises. The hardware store requested that the customer's personal auto liability insurer defend and indemnify it for the lawsuit. When that auto liability insurer refused, the hardware store filed a declaratory judgment action against it. The hardware store argued that it was an "insured" under the customer's personal auto liability insurance policy because it was an authorized user of the customer's vehicle and the alleged injury was caused in connection with the use of her vehicle. The trial court agreed and the Illinois appellate court affirmed. The appellate court found that the hardware store employee's act of loading the customer's vehicle squarely falls within the authorized "use" of the customer's vehicle because the policy itself stated that "use" includes loading and unloading. In holding that the hardware store was an authorized user of the customer's vehicle, the court rejected the insurer's argument that loading bricks into a vehicle was not using a vehicle in an operation or driving sense. The court then applied the "complete operations" doctrine, in which loading includes the entire process of moving an article, to find that the customer was injured while the hardware store employee was loading bricks into the vehicle. Lastly, the court found that the alleged injury was at least potentially the result of an activity that was reasonably contemplated by the parties because the complaint contained allegations that made it possible that the debris on which the customer fell could have been placed there in the course of loading the vehicle or disturbed in the loading process. As there were no allegations specifically stating that the debris did not originate from the loading process, the injury

potentially could have resulted from the hardware store's use of the vehicle and a duty to defend existed.

Menard, Inc. v. Country Preferred Ins. Co., 2013 IL App (3d) 120340

Appellate Court Allows Consideration of Third Party Pleadings Filed by Parties Not Seeking Coverage in Determining Defense Obligation

Following a line of Illinois decisions refusing to limit a trial court to solely the allegations in a complaint in determining whether an insurer has a duty to defend, the court in *Illinois Emcasco Ins. Co. v. Waukegan Steel Sales Inc.* allowed consideration of third party pleadings in finding that an insurer had a duty to defend a general contractor for a lawsuit involving alleged injuries to an employee of the general contactor's subcontractor. In this case, the insurer claimed that it had no duty to defend the general contractor because the general contractor only qualified as an additional insured for its vicarious liability for the subcontractor's actions and the complaint did not contain any allegations of vicarious liability against the general contractor. Two other defendants in the lawsuit, not the general contractor, filed third party complaints against the subcontractor alleging that the subcontractor's acts or omissions were the direct and proximate cause of the employee's injuries or a contributing factor. Relying on the third party pleadings, the trial court held that a duty to defend existed. After determining that the allegations in the complaint alone did not trigger any duty to defend as they alleged only direct negligence against the general contractor, the appellate court focused on whether the third party pleadings were properly considered by the trial court in evaluating the duty to defend. The insurer first argued that consideration of the third party pleadings was improper because such pleadings are self-serving. This argument was rejected on the grounds that the general contractor was not relying upon third party pleadings that it brought, but rather on third party pleadings brought by others. Thus, the court distinguished Illinois decisions that refuse to consider third party pleadings brought by the party seeking coverage and consideration of the third party pleadings was allowed. The insurer next argued that because the third party complaints alleged, in the alternative, that the subcontractor's acts or omissions were only a contributing factor, as opposed to a proximate cause, there was a possibility that the subcontractor may only be partially liable for the alleged injuries, and no duty to defend existed. However, as the allegations need only raise the potential to trigger a defense, the fact that the third party complaints alleged both proximate cause and contribution was of no significance. Lastly, the insurer argued that the general contractor lacked sufficient control over the subcontractor's performance and the worksite under Section 414 of the Restatement (Second) of Torts (1965) to support a claim for vicarious liability. This argument was also rebuffed by the court, which stated that the question is not whether the general contractor is vicariously liable, but whether it could potentially be found vicariously liable. Allegations in the third party pleadings raised the potential for vicarious liability on the part of the general contractor. The appellate court, relying on allegations in third party pleadings, held that there was at least the potential the general contractor could be held vicariously liable for the subcontractor's actions and, therefore, a duty to defend existed.

Illinois Emcasco Ins. Co. v. Waukegan Steel Sales Inc., 2013 IL App (1st) 120735.

In Deciding Duty to Defend, Court Refuses to Consider Allegations in Third Party Pleading Filed by Party Seeking Coverage

In *Pekin Ins. Co. v. United Contractor Midwest*, the employee of a subcontractor on a construction project was injured when the tree removal equipment he was operating struck a power line. The employee filed suit against the general contractor alleging negligence. The complaint did not contain any allegations of the subcontractor's negligence. The general contractor filed a third party complaint against the subcontractor alleging that the subcontractor was solely negligent for the employee's injuries. The general contractor sought a defense for the lawsuit from the subcontractor's insurer. The insurer refused and filed a declaratory judgment action claiming that its policy did not cover the general contractor when it was alleged to be directly liable, and not vicariously liable for the subcontractor's actions. The trial court found in favor of the general contractor. It held that the allegations in the underlying complaint raised the potential that the general contractor's liability arose from the subcontractor's actions. Further, the trial court held that a third party complaint filed by the general contractor against the subcontractor also established a potential that the general contractor was liable for the subcontractor's actions. The appellate court reversed. It found, first, that the complaint alleged only that the general contractor's negligence caused the alleged injuries and a general contractor could not be vicariously liable for its own acts. The appellate court then examined whether the trial court properly considered the third party complaint filed by the general contractor against the subcontractor. Noting that consideration of third party complaints is proper in some circumstances, the court held consideration of that pleading in this case was improper. The court reasoned that the third party complaint was prepared by the general contractor seeking coverage and filed after the declaratory judgment action was initiated. It, therefore,

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could have been filed solely to get insurance coverage and should not have been considered by the trial court. As such, there was no duty to defend the general contractor.

Pekin Ins. Co. v. United Contractor Midwest, 2013 IL App (3d) 120803.

Misrepresentations in Application for Insurance Were Not Material and Did Not Entitled Insurer to Rescission

In *Direct Auto Ins. Co. v. Beltran*, an insurer brought a declaratory judgment action claiming that an insured made material misrepresentations in her application for insurance, which precluded coverage for a subrogation action brought against the insured and her brother, an authorized driver of the vehicle. The insurer sought rescission of the policy. On the application, the insured, a Spanish speaking female, was listed as a male. The application also stated that the insured possessed an international driver's license, which was not true. Further, the application requested a list of known drivers of the insured's vehicle. The application listed only the insured, but the insured testified that she did not drive and bought the car so that her brother could drive her to and from work. The application was not signed by the insured and included a notation that it was taken over the phone by an independent insurance broker. The insurer alleged that the insured intentionally misled it as to the other drivers and that, had it known the vehicle was being operated by other drivers, that information would have materially affected its decision to issue the policy and it would not have issued the policy as written. Both the trial and appellate court held that any misrepresentations were immaterial and did not support rescission. As the insured did not drive and did not operate the insured vehicle, there was only one known driver—her brother. According to the appellate court, the number of drivers was, therefore, the same as indicated on the application: one. The only discrepancy was the name of the driver as the application was for a male, which the brother was. This discrepancy was found to not be material as the insurer would have still issued the policy. While the insurer claimed that it would have charged a different premium if the insured disclosed her brother as an additional driver, the number of drivers was accurate because the insured herself did not drive. Finding that there was no misrepresentation that substantially increased the risk, rescission was not appropriate and coverage applied.

Direct Auto Ins. Co. v. Beltran, 2013 IL App (1st) 121128.

Insurer's Proof of Mailing Sufficient under Section 143.13(a)

In *Hunt v. State Farm Mutual Automobile Insurance Co.*, when an insured failed to pay the premium on her automobile liability policy, her insurer mailed her a cancellation notice, stating that her policy was cancelled effective on April 29, 2005. The insured was subsequently sued after being involved in an automobile accident in October 2005. Her insurer did not provide a defense to the suit or file a complaint for declaratory judgment. After the personal injury plaintiff took assignment of the insured's rights against the insurer, he sued the insurer. In his suit, he asserted that the insurer was estopped from raising cancellation as a coverage defense because it failed to defend the insured or file a declaratory judgment action. The plaintiff also asserted the cancellation was ineffective because the insurer did not comply with statutory proof of mailing requirements. On cross-motions for summary judgment, the trial court entered judgment in the insurer's favor, and the Illinois appellate court affirmed.First, the appellate court ruled that the insurer was not estopped from raising the policy's cancellation as a defense because the estoppel doctrine did not apply. The court reasoned that the estoppel doctrine only applies when the insurer has breached its duty to defend. *Id.* at ¶ 18. If, however, the insurer has no duty to defend because there was no insurance policy in existence, the estoppel doctrine does not apply. *Id.* As such, the court needed to determine whether the insured's policy was in existence before applying the estoppel doctrine. *Id.*The appellate court held that the insured's policy was not in existence at the time of the accident because the insurer met the requirements of the Illinois Insurance Code for an effective cancellation in April 2005. At issue was whether the insurer maintained proof of mailing of the cancellation "on a recognized U.S. Post Office form or a form acceptable to the U.S. Post Office or other commercial mail delivery service," as required by 215 ILCS 5/143.14(a). According to the personal injury plaintiff, when, as here, the insurer was requesting a certificate of mailing for three or more pieces of mail presented at one time, federal law required the use of U.S. Post Office Form 3877 or a facsimile of Form 3877. *Id.* at ¶ 32. Therefore, because the insurer did not use Form 3877 (or an exact copy thereof), its cancellation of the insured's policy was ineffective.

The appellate court disagreed holding that the form used by the insurer met the "very low threshold of proof" of mailing required by Section 143.14(a) because it contained the same information as Form 3877. The court also found significant that the insurer submitted a letter from the manager of business entry for the U.S. Postal Service stating that the form used by the insurer was approved by the U.S. Postal Service and acceptable to it. *Id.* at ¶¶ 39-40.

Hunt v. State Farm Mutual Automobile Insurance Co, 2013 IL App (1st) 120561.

An Insurer's Liability for Converted Policy Proceeds

In *Parkway Bank & Trust Co. v. State Farm Fire & Casualty Co.*, an insurer issued a policy covering accidental direct physical loss to an apartment building in Chicago, Illinois. The policy contained a "Mortgage Holders" provision, which stated that mortgage holders on the property have the right to receive payment for covered losses. *Id.* at ¶ 3. Parkway Bank & Trust Company was listed as a mortgage holder under the policy.After a fire occurred at the apartment building, the owners of the building entered into a "Repair Agreement" with a contractor to fix the fire damage, and the insurer issued two checks, totaling $252,830.94, which listed as payees the owners of the apartment building, the contractor, and Parkway Bank & Trust Company. *Id.* at ¶¶ 4-5. The insurer delivered these checks to the contractor, who forged the bank's and owners' signature on the checks and cashed them. *Id.* at ¶ 6. Parkway Bank & Trust Company then sued the insurer, demanding that the insurer pay it the full amount of the loss pursuant to the Mortgage Holders provision of the policy. The trial court granted summary judgment for the insurer, holding that it was not required to pay the claim again. The appellate court affirmed.The court held that the insurer was not liable because, pursuant to Section 3-110 of the Uniform Commercial Code, where a drawer writes a check for an obligation which is taken by the obligee, the obligation is suspended until the check is paid or dishonored. *Id.* at ¶ 10. Additionally, if "a payor bank pays a person not entitled to enforce the check, such as a joint payee who has stolen the check from his co-payee and forged the co-payee's signature, the suspension of the obligation continues because the check is not considered properly 'paid.'" *Id.* In this case, because the contractor had forged Parkway Bank's signature on the checks, the insurer's obligation to pay pursuant to the insurance policy was still suspended, and it had no obligation to pay Parkway Bank. *Id.* at ¶¶ 11-12. The appellate court also determined that Parkway Bank & Trust Company did not satisfy the requirements of Section 3-309 of the Uniform Commercial Code for the enforcement of a lost, destroyed, or stolen instrument. *Id.* at ¶¶ 12-13.

Parkway Bank & Trust Co. v. State Farm Fire & Casualty Co., 2013 IL App (1st) 122387.

When Must a Court Engage in a Choice of Law Analysis?

In *Bridgeview Health Care Center v. State Farm Fire & Casualty Co.*, an insured operated an unincorporated business in Terre Haute, Indiana, selling and repairing hearing aids. *Id.* at ¶ 4. The insured purchased a commercial general liability policy from an insurer to cover his business activities in Indiana. The policy was purchased through an Indiana insurance agency and issued by one of the insurer's offices in Indiana. *Id.* In 2009, the insured was sued in a class action complaint filed in the U.S. District Court for the Northern District of Illinois, alleging that the insured violated the Telephone Consumer Protection Act of 1991 (TCPA) through the insured's business solicitation practices. *Id.* at ¶ 5. The insured had hired Business to Business Solutions to fax ads to approximately 100 businesses within 20 miles of Terre Haute. The insured, however, did not authorize Business to Business Solutions to fax ads to businesses or individuals in Illinois, did not solicit individuals who resided in Illinois, and he did not conduct his business in Illinois. *Id.* at ¶ 8. After the TCPA suit was filed, a declaratory judgment was initiated to determine the obligations of the insurer. *Id.* at ¶¶ 7-8. During this case, a dispute arose over choice of law. While Illinois decisions suggested that the insurer had a duty to defend the TCPA complaint, no Indiana court had addressed the issue—although two federal courts interpreting Indiana law predicted that an Indiana court would find no duty to defend. *Id.* at ¶¶ 11, 18. Observing that no Indiana state court had addressed the issue, the trial court granted the class action plaintiff's motion for summary judgment under Illinois law and found a duty to defend. The trial court believed that a choice of law analysis was unnecessary because without an Indiana state court opinion, there was no "conflict of law" between Illinois and Indiana law. *Id.* at ¶ 13.The appellate court reversed and instructed the trial court to engage in a choice of law analysis. According to the appellate court, because Indiana law could possibly lead to a different result than the one reached under Illinois law, the trial court must engage in a choice of law analysis to determine whether Indiana or Illinois has the most significant contacts to the dispute. *Id.* at ¶ 22. If the trial court finds that Indiana has the most significant contacts to the litigation, then it "must attempt to determine what Indiana courts would do in this case" relying on "decisions from the federal courts and the courts of other states, as well as law reviews, treatises, and other sources." *Id.*

Bridgeview Health Care Center v. State Farm Fire & Casualty Co., 2013 IL App (1st) 121920.

Deriving the Identity of the Named Insured

In *Ryding v. Cincinnati Special Underwriters Insurance Co.*, Fairchild was a ward of the public guardian of Du Page County prior to her death in March 2009. *Id.* at ¶ 2. On December 23, 2008, an insurer issued a commercial property policy insuring certain sched-

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uled properties owned by Fairchild. The declarations of the Policy identified the named insured as "Office of the Public Guardian for Du Page Co. Refer to Named Insured Schedule CSIA 409 01 08," but no "Named Insured Schedule" was attached to the policy. *Id.* at ¶¶ 2-3. In September 2009, one of the scheduled properties on the policy burned. When the administrator of the Fairchild estate made a claim under the commercial property policy, the insurer denied coverage, arguing that the named insured under the policy was the Public Guardian for Du Page County and its insurable interest ceased in the property when its duties were discharged in March 2009. *Id.* at ¶ 5.On appeal, the appellate court found that the policy provided coverage because Fairchild and her estate were intended insureds. *Id.* at ¶ 13. The court found significant that the "portion of the declarations page specifying the insured under the policy not only named the Public Guardian, but also made reference to an apparently nonexistent 'Named Insured Schedule.'" *Id.* This discrepancy was "reason enough for an inquiry into the intention of the parties as to the identity of the insured." *Id.* After doing so, the court found that it was "clear from the face of the policy that the Public Guardian obtained coverage not to protect his own property interests, but to protect the property interests of his wards, including Fairchild." *Id.* Therefore, Fairchild's estate was an insured under the policy.

Ryding v. Cincinnati Special Underwriters Insurance Co., 2013 IL App (2d) 120833.

Which Policy Applies to an Owner/Operator

In *Progressive Premier Insurance Co. of Illinois v. Emiljanowicz*, an independent owner/operator executed a contractor operating agreement with a trucking company, in which the trucking company agreed to lease the owner/operator's truck. *Id.* at ¶ 2. According to the agreement, the owner/operator would furnish his truck "for the exclusive possession, Control (sic) and use of" the trucking company and would only transport the freight of the trucking company. *Id.* After signing the contractor operating agreement, the trucking company gave the owner/operator decals for his truck authorizing the operation of the truck under DOT regulations and instructed the owner/operator to take his truck to a mechanic for an inspection required by the trucking company. On the same day, after signing the agreement, the owner/operator was involved an accident that injured another driver. *Id.* at ¶ 8. At the time of the accident, the owner/operator was driving to meet a friend who would drive him home when he left his truck for the mechanic's inspection. *Id.*The owner/operator had his own policy providing bodily injury liability coverage, but the policy did not apply when the owner/operator was "operating, maintaining, or using the **insured auto** or any other **auto** for or on behalf of anyone else or any organization whether or not the **insured** is being compensated for such use." *Id.* at ¶ 10.The trucking company also had a policy, which defined "insured" as an "owner ... from whom you hire or borrow a covered 'auto' … while the covered 'auto' (1) Is being used exclusively in your business as a 'trucker'; and (2) Is being used pursuant to operating rights granted to you by a public authority." *Id.* at ¶ 11. The owner/operator's truck was listed as a covered auto.After the owner/operator was sued, a dispute arose between the carriers concerning who provided coverage for the accident. Eventually, the owner/operator's insurer settled the personal injury claim and filed a declaratory judgment action against the trucking company's insurer seeking recovery of the money that it had paid. During the declaratory judgment action, the trial court ruled that only the truck company's policy provided coverage, and the appellate court affirmed. According to the appellate court, "[w]here the contractor agreement provides that the insured corporation has exclusive possession, control and use of a leased vehicle, and at the time of the accident the vehicle was operated on directions from the corporation, the vehicle is being used in the business of the corporation." *Id.* at ¶ 21. Thus, even though the owner/operator was not hauling freight, because the trucking company directed the owner/operator to take his vehicle to the mechanic (which prompted the owner/operator to pick up his friend), he was engaged in the truck company's business at the time of the accident. *Id.* at ¶¶ 22-24. The appellate court also noted that the trucking company had already given the owner/operator his decals for the operation of the truck. *Id.* at ¶ 23. Conversely, the appellate court found that the owner/operator's policy did not apply because he was using the truck on behalf of the trucking company at the time of the accident—which precluded coverage under the owner/operator's policy. *Id.* at ¶¶ 28-30.

Progressive Premier Insurance Co. of Illinois v. Emiljanowicz, 2013 IL App (1st) 113664.

Coverage for Claim Alleging Bad Odor Not Eliminated By Pollution Exclusion

In *Country Mutual Insurance Co. v. Hilltop View, LLC*, the insurer sought a declaratory judgment finding that it had no duty to defend or indemnify the insureds under an umbrella policy for a lawsuit filed by the insureds' neighbors alleging nuisance and negligence due to odors associated with the insureds' operation of a hog farm. The insurer argued that the pollution exclusion barred coverage under its umbrella policy. The insureds argued that the pollution exclusion did not apply to the emission of odors from a hog farm and also argued that the insurer was estopped from asserting policy defenses under the umbrella policy because it breached the duty to

defend. The pollution exclusion stated that the umbrella policy did not apply "to personal injury or property damage arising out of the actual, alleged or threatened discharge, dispersal, release or escape of pollutants." "Pollutants" was defined as "any solid, liquid, gaseous or thermal irritant or contaminant…" The court cited *American States Insurance Co. v. Koloms*, 177 Ill. 2d 473 (1997), which held that a similar pollution exclusion applied only to injuries caused by "traditional environmental pollution" and thus did not exclude coverage for carbon dioxide fumes from a faulty furnace. The court considered the definition of "traditional environmental pollution" adopted by the court in *Kim v. State Farm Fire & Casualty Co.*, 312 Ill. App. 3d 770 (1st Dist. 2000), which defined it as "hazardous material discharged into the land, atmosphere, or any watercourse or body of water." However, the court found this definition misleading because some materials, such as manure, can be hazardous to a body of water but beneficial to the land. The insurer argued that, under this definition, the odors at issue constituted traditional environmental pollution. The court disagreed, finding that the cases cited by the insurer all involved non-naturally occurring chemicals. Thus, the court concluded that the odors were not traditional environmental pollution so the pollution exclusion did not bar coverage. However, the court rejected the insureds' estoppel argument, because the insureds had not demonstrated that all of the insurer's coverage defenses were invalid. As the insurer still had policy defenses remaining under the umbrella policy, it did not breach its duty to defend.

Country Mutual Insurance Co. v. Hilltop View, LLC, 2013 IL App (4th) 130124.

Lawsuit Not Required to Trigger Duty to Indemnify

In *Selective Insurance Co. of South Carolina v. Cherrytree Companies, Inc.*, the insurer sought a declaratory judgment that there was no coverage under the insured's policy for construction defects in a grain storage facility the insured had built for another company. The insurer initially denied coverage because 1) there was no "occurrence" under the policy; 2) the "your work" and "your product" exclusions barred coverage; and 3) the problem with the facility did not constitute "property damage" under the policy. The insured counterclaimed, alleging breach of contract and bad faith under Section 155 of the Illinois Insurance Code, 215 ILCS 5/155. The insurer moved to dismiss the counterclaims, arguing that the policy required a "suit" to be filed before coverage would apply and no "suit" had been filed against the insured. The insurer further argued that because there was a *bona fide* coverage dispute, there could be no bad faith. The trial court dismissed both counterclaims with prejudice and the insured appealed. On appeal, the court only addressed the issue of whether the policy required the filing of a "suit" before the insured could seek indemnification for damages it had agreed to pay. The policy stated that the insurer would "pay those sums that the insured becomes legally obligated to pay as damages…. to which this insurance applies. We will have the right and duty to defend the insured against any 'suit' seeking those damages." *Id.* at ¶ 4. Citing *Sokol and Co. v. Atlantic Mutual. Ins. Co.*, 430 F.3d 417 (7th Cir. 2005) and *Keystone Consolidated Industries, Inc. v. Employers Insurance Co. of Wausau*, 456 F.3d 758 (7th Cir. 2006), the court found that without language limiting indemnification to circumstances where a suit has been filed, like the language for the duty to defend, there is no requirement for filing of a suit before the insured may seek indemnification for damages it agreed to pay.

Selective Insurance Co. of South Carolina v. Cherrytree Companies, Inc., 2013 IL App (3d) 120959.

Severability Clause Precludes Rescission as to Innocent Insureds

In *Illinois State Bar Association Mutual Ins. Co. v. Law Office of Tuzzolino & Terpinas*, a legal malpractice insurer sought rescission of a law firm's malpractice insurance policy due to one partner's failure to disclose a malpractice claim against Tuzzolino, one of the firm's attorneys, on the firm's renewal application. From 2002 to 2008, Tuzzolino represented a client in several matters. The client believed Tuzzolino mishandled one of the matters and filed a malpractice claim against him. Tuzzolino offered to settle with the client, and while his settlement offer was pending, submitted a renewal application to his malpractice insurer without disclosing the client's claim. Tuzzolino signed the form but Terpinas, another of the firm's attorneys, did not. When Terpinas became aware of the pending malpractice claim, he reported it to the insurer. The malpractice insurance policy contained both an innocent insured clause and a severability clause. The innocent insured clause stated: "whenever coverage … will be excluded because of the insured's failure to provide notice, the company agrees that [coverage] should be applicable with respect to any insured who do not personally fail to give timely notice after having knowledge of the conduct that forms the basis of the claim." Regarding the innocent insured clause, the court addressed the issue of whether the common law innocent insured doctrine allowed the policy to remain in force as to Terpinas. The common law innocent insured doctrine preserves coverage for innocent insureds "where a reasonable person would not understand that the wrongdoing of a co-insured would prevent recovery under the policy." *State Farm Fire & Cas. Ins. Co. v. Miceli*, 164 Ill. App.

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3d 874, 881 (1st Dist. 1987). The court found the situation faced by Terpinas analogous to a situation in which one insured property owner sets fire to mutually owned property without the co-owner's knowledge; in that circumstance, the innocent property owner may still be covered under the relevant insurance policy. *Economy Fire & Casualty Co. v. Warren*, 71 Ill. App. 3d 625, 629 (1st Dist. 1979). The court further noted that a misrepresentation on a renewal application renders the policy *voidable*, not *void ab initio*. Finally, the court stated that under Section 154 of the Insurance Code, 215 ILCS 5/154, it is Illinois policy to "favor coverage under an insurance policy whenever the facts justify such coverage." *Inter-Insurance Exchange of Chicago Motor Club v. Milwaukee Mutual Insurance Co.*, 61 Ill. App. 3d 928, 931 (3rd Dist. 1978). Therefore, the court found that the innocent insured doctrine preserved coverage for Terpinas.The court also addressed whether the severability clause operated to form separate insurance contracts as to Tuzzolino and Terpinas. The severability clause stated that the "particulars and statements contained in the application will be construed as a separate agreement with and binding on each insured." Because the misrepresentation did not void the policy *ab initio*, the court found that the severability clause operated to create separate contracts as to the two insureds until such time as the contract is fully rescinded.

Illinois State Bar Association Mutual Ins. Co. v. Law Office of Tuzzolino & Terpinas, 2013 IL App (1st) 122660.

Notice By Additional Insured Triggered Insurer's Coverage Obligations

In *Mt. Hawley Insurance Co. v. Robinette Demolition, Inc.*, the appellate court considered whether coverage for an additional insured was contingent on the named insured's compliance with notice provisions under the policy. It also considered whether a sub-subcontractor qualified as an additional insured under the relevant insurance policy. The named insured and the subcontractor were parties to an ongoing subcontract agreement under which the named insured was required to provide insurance for the subcontractor and any other parties reasonably required by the subcontractor to be added as additional insureds. Pursuant to that agreement, the insurer issued certificates of insurance to the subcontractor and the sub-subcontractor. An employee of the insured was injured in 2009 while working on a project where the subcontractor and sub-subcontractor were involved. The employee filed suit in 2010 against the subcontractor and sub-subcontractor, both of which tendered their defense to the insurer. The insurer denied the tender, stating that notice requirements were breached and that the sub-subcontractor did not qualify as an additional insured under the policy.The notice provision of the policy required only the named insured to notify the insurer of an occurrence or an offense which may result in a claim. It required the named insured and any other involved insureds to immediately send copies of papers received in connection with claims or suits. There was no dispute that the named insured failed to notify the insurer of the occurrence in 2009. There was also no dispute that the subcontractor complied with the requirement that it send copies of the suit immediately to the insurer. The issue was whether the named insured's breach of its duty to notify precluded coverage for the additional insureds who complied with their duty to notify. Citing *American National Fire Ins. Co. v. National Union Fire Insurance Co. of Pittsburg, P.A.*, 343 Ill. App. 3d 93 (1st Dist. 2003), the court found that there was nothing in the notice provision of the policy rendering coverage contingent on the named insured's compliance with the policy's notice provisions. Because the subcontractor complied with its notice requirement, coverage was not precluded. Regarding whether the sub-subcontractor qualified as an additional insured, the policy included as an insured any person or organization listed in the schedule or "where required by written contract." The insurer argued that the named insured had no contract with the sub-subcontractor, and, therefore, it could not be an additional insured under the policy. However, the named insured was required by contract to defend and indemnify the subcontractor as well as procure insurance for the subcontractor as well as any other parties as reasonably required by the subcontractor. The subcontractor had requested that the sub-subcontractor be added as an additional insured, and the insurer issued a certificate of insurance for the sub-subcontractor. The appellate court found that these documents construed together demonstrated a requirement that the insurer name the sub-subcontractor as an additional insured and that the sub-subcontractor qualified as an additional insured under the policy.

Mt. Hawley Insurance Co. v. Robinette Demolition, Inc., 2013 IL App (1st) 112847

Duty to Defend Requires More Than Retention of Defense Counsel

The plaintiff in *Delatorre v. Safeway Insurance Co.* was injured in a two-automobile accident while riding as a passenger in the named insured's vehicle. The other driver and his passenger were also injured. All three parties sued the insured, whose policy had limits of $20,000 per person and $40,000 per accident. The plaintiff made a settlement demand for policy limits in the underlying suit, which the insurer rejected. The insurer agreed to defend the insured under a reservation of rights and appointed an attorney. That attorney filed an appearance and answer, but took no further action. Default in the amount of $250,000 was entered against the insured in the underlying action as a sanction for failure to respond to outstanding discovery. The insurer admitted that it never received any bills

from the attorney, nor did it pay any fees. The insured assigned his rights under the insurance policy to the plaintiff. Meanwhile, the insurer paid policy limits in connection with the lawsuit initiated by the other driver and his passenger. Plaintiff then sued the insurer for the amount of the default judgment, alleging breach of the duty to defend. The insurer argued that since it had retained counsel to defend its insured it could not have breached its duty to defend. The court noted that another district of the appellate court had previously considered this issue in *Brocato v. Prairie State Farmers Insurance Association*, 166 Ill. App. 3d 986 (4th Dist. 1988), and ruled that an insurer's obligation to its insured regarding defense is fulfilled when the insurer retains counsel for the insured. However, the court distinguished *Brocato* on the grounds that the attorney in *Brocato* "actually defended" the insured throughout trial whereas the attorney here did nothing besides file an appearance and an answer and the insurer admitted it received no statements of legal work performed by the attorney. *Id.* at ¶ 22. Thus, the court determined that the insurer had breached its duty to defend. Because the insurer's breach of its duty to defend caused the excess judgment, the plaintiff could recover the entire $250,000 judgment from the insurer.

Delatorre v. Safeway Insurance Co., 2013 IL App (1st) 120852.

Allegations of Negligence Insufficient to Create Duty to Defend in Sexual Abuse Case

In *Empire Indemnity Ins. Co. v. Chicago Province of the Society of Jesus*, the court considered whether a Catholic religious order was insured against a lawsuit involving alleged molestation of minors by one of its priests.

Various John Doe plaintiffs sued the Chicago Province of the Society of Jesus (Jesuits) alleging that they had been sexually abused by a Jesuit priest. The complaint alleged that the priest had been a teacher at Loyola Academy, a high school operated by the Jesuits, and that the Jesuits either knew or should have known of the priest's abuse of minors because a prior abuse victim previously had informed a Chicago Archdiocesan priest that the priest had abused him. The Archdiocesan priest allegedly reported that abuse to the Jesuits and officials at Loyola Academy, including its president, principal, and headmaster. The plaintiffs alleged that the Jesuits did not report these allegations to law enforcement, but instead transferred the abuser and allowed him to "remain in ministry and travel around the world" to avoid scandal. The plaintiffs alleged that Fr. McGuire abused them in the following years.

First Nonprofit Insurance Company (FNIC) issued one-year multiple-peril insurance policies to the Jesuits. The policies contained provisions covering "Bodily Injury and Property Damage Liability" as well as "Sexual Abuse or Sexual Molestation Liability." The bodily injury coverage provided in that FNIC would pay sums that the Jesuits became legally obligated to pay as damages due to "bodily injury or property damage to which this coverage applies." It specifically excluded damages "expected or intended from the standpoint of the insured."

The sexual abuse or molestation coverage stated that FNIC would pay damages that the Jesuits became legally obligated to pay "arising out of any actual, threatened, intentional or unintentional sexual molestation of any person to which this coverage applies." This coverage had a provision that stated that the coverage would not apply "if any executive officer, supervisory employee, director or trustee [had] actual knowledge of any act, incident or alleged act of sexual abuse or sexual molestation."

The Jesuits argued that the "expected or intended" exclusion in the bodily injury coverage did not apply, at least for purposes of the duty to defend, because the complaints in the underlying litigation were "littered" with negligence-based allegations that the Jesuits either should have known, should have been aware, or had constructive notice of McGuire's prior sexual abuse of minors. The court disagreed. It held that for the purposes of the exclusion, an "expected" injury is merely one that should have been "reasonably anticipated" by the insured. The appellate court noted that the underlying complaints alleged that the Jesuits were aware of the priest's abuse of minors on multiple prior occasions and reasonably should have anticipated or expected the injuries that McGuire subsequently inflicted on the John Doe plaintiffs. Indeed, it held that "[p]rior knowledge of McGuire's predilections is the cornerstone of each John Doe claim against the Jesuits." Accordingly, the court concluded that the expected or intended exclusion applied.

With respect to the sexual abuse or molestation coverage, the court noted that the John Doe plaintiffs had alleged that the priest had discussed prior abuse claims with representatives of the Jesuits and Loyola Academy, including the president, the headmaster, and the principal of the academy. As a result, the complaints alleged that supervisory employees had actual knowledge of the priest's alleged acts of sexual abuse. Accordingly, the court held that this coverage did not apply under the "actual knowledge" provision.

Empire Indemnity Ins. Co. v. Chicago Province of the Society of Jesus, 2013 IL App (1st) 112346.

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Drainage Exclusion Held Unambiguous

In *Grinnell Mut. Reinsurance Co. v. Hubbs* the court reviewed whether a series of farm insurance policies provided coverage for claims of cropland damage caused by the insured's alteration of the flow and level of surface and groundwater following the insured's construction of a holding pond.

The underlying plaintiff brought an action against the insureds after they constructed a holding pond on their own property, alleging that the insureds dredged the pond by constructing a weir to hold back the water. The complaint alleged that the weir was constructed by dredging land on the northern border between the plaintiff's property and the insured's property. It further alleged that the dredging caused the retention of ground and surface water on the insured's property which caused a substantial elevation of the groundwater table on the plaintiff's property, which flooded the plaintiff's farmland.

Grinnell had issued farm insurance policies to the insureds that excluded "property damage resulting from diversion or obstruction of streams or surface water, or from interference with the natural drainage to or from the land of others." The insureds argued that the term "drainage" in the exclusion was ambiguous because it could be read to apply to only "surface" drainage and not "subsurface" drainage.

The court disagreed. It held that Illinois law long has held that the term "drainage" applies to both surface and subsurface drainage patterns. The pleadings and supporting attachments all showed that the construction of the weir and retention pond caused a substantial elevation of the groundwater table on the plaintiff's property which impeded the subsurface flow of water and caused his farmland to flood. Accordingly, the court held that the insurer did not have a duty to defend the insureds.

Interestingly, the insureds objected to the court's consideration of any evidence outside of the pleadings in determining the duty to defend. The court noted that the extrinsic evidence "added little beyond the unrebutted facts alleged in the verified complaint," but ultimately concluded that "all evidence properly before the court may be considered when determining whether an insurance company has a duty to defend the insured under the policy."

Grinnell Mut. Reinsurance Co. v. Hubbs, 2013 IL App (3d) 110861.

Allegations of a Kickback Scheme Not an "Occurrence"

At issue in *West American Insurance Co. v. Midwest Open MRI, Inc.* was whether a commercial general liability carrier had a duty to defend or indemnify its insured against a Consumer Fraud Act lawsuit filed by one of its insured's competitors.

The insured, Midwest Open MRI, Inc., provided magnetic resonance imaging (MRI) services to patients. One of Midwest's competitors, Advanced Physicians, alleged that Midwest violated the Illinois Consumer Fraud and Deceptive Business Practices Act by engaging in various kickback schemes with physicians and clinics. The complaint alleged that Midwest contracted with certain physicians who referred patients to it for MRI scans. In return, these referring physicians allegedly shared in Midwest's medical billing revenues. Advanced Physicians contended that Midwest's conduct wrongfully interfered with market competition and unfairly prevented Advanced Physicians with access to these referral sources.

The policy defined an "occurrence" as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." The policy did not define the term "accident," but the court held that "an accident is 'an unforeseen occurrence, usually an undesigned sudden or unexpected event of an inflictive or unfortunate character.'"

West American's CGL policy applied to claims for property damage only if the property damage was caused by an "occurrence." The policy defined an "occurrence" as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions." The policy did not define the term "accident," but the court held that "an accident is 'an unforeseen occurrence, usually an undesigned sudden or unexpected event of an inflictive or unfortunate character.'"

The court noted that the underlying complaint alleged that Midwest engaged in these schemes "with the express purpose of 'driv[ing] entities like [Advanced Physicians] out of business;'" that Midwest's fraudulent and deceptive scheme was designed to price other MRI facilities out of the market; and that Midwest intended to put its competitors out of business so that it could dominate the diagnostic testing market in the region. The court concluded that these allegations did not present an "accident" or "occurrence."

West American Insurance Co. v. Midwest Open MRI, Inc., 2013 IL App (1st) 121034

Assignment of Personal Injury Claim Invalid in Liquidation of Insolvent Insurer

The court in *In re Liquidation of Legion Indemnity Co.* addressed whether an assignment of a personal injury claim was valid against an insolvent insurance carrier in liquidation under the Illinois Insurance Code.

The underlying case involved a ten year old girl named Kristie Talley who died as a result of injuries sustained when the bicycle she was riding was caught between a curb and a school bus owned and operated by Barrington Transportation Co., Inc. Her parents filed suit against Barrington and other several defendants. Before trial, Legion Indemnity Company, Barrington's primary and excess insurer, was declared insolvent and placed into liquidation. Without insurance, Barrington filed for bankruptcy on the eve of trial. The Talleys then filed a proof of claim with the bankruptcy court.

After mediating the matter, the Talleys and Barrington entered into a settlement agreement in which the Talleys received $1.2 million from Barrington; $250,000 from the Illinois Insurance Guaranty Fund; and $50,000 from uninsured motorist coverage. In return, the Talleys assigned to Barrington their rights to any payment from Legion. As part of the settlement, the parties stipulated, and the Talleys submitted a proof of claim, in the bankruptcy proceeding that the claims against Barrington were valued at $7.5 million. After the bankruptcy court approved the settlement and entered judgment for $7.5 million, the former principals of Barrington submitted a claim in the liquidation of Legion seeking the remaining $5,750,000 limits in Barrington's two policies with Legion. The liquidator, however, recommended the claim be approved for only $1.2 million, the amount Barrington paid to the Talleys. The trial court approved that amount.

On appeal, the appellate court reviewed whether the assignment that the Talleys provided to Barrington would escape the judgment prohibition set forth in section 209(8) of the Illinois Insurance Code. That section provides: "No judgment against such an insured or an insurer taken after the date of the entry of the liquidation, rehabilitation, or conservation order shall be considered in the proceedings as evidence of liability, or of the amount of damages." 215 ILCS § 5/209(8). The Barrington principals argued that this section did not apply because it failed to mention agreements or settlements.

The appellate court agreed that section 209(8) did not mention settlements or agreements in particular, but the court concluded that the settlement between the Talleys and Barrington "is specifically based on the judgment entered in the bankruptcy court." The appellate court held that it could not allow the Barrington principals to "circumvent parts of the Code through contractual negotiation." The appellate court also noted that Illinois has a long-standing prohibition against the assignment of personal injury claims as being against public policy.

As a result, the appellate court affirmed the trial court's decision to approve the Barrington principals' claim for only $1.2 million, the amount Barrington paid to the Talleys.

In re Liquidation of Legion Indemnity Co., 2013 IL App (1st) 120980.

"Other Insurance" Reduction for Guaranty Fund Applies to Maximum Dram Shop Recovery

The court in *Guzman v. 7513 W. Madison St., Inc.* considered the obligations of the Illinois Insurance Guaranty Fund when the Fund assumes the defense of a dramshop case due to the insolvency of the defendant's insurer. Specifically, the court considered whether the reduction for "other insurance" recoveries set forth in Section 546(a) of the Illinois Insurance Guaranty Fund Act, 215 ILCS 5/546(a), applied against each defendant's maximum liability under the dram shop statute.

The plaintiff was driving a motor vehicle with his wife in the passenger seat when they were struck by a vehicle driven by Nikki Klassert. A third plaintiff was a pedestrian who was injured as a result of the collision of the two automobiles. The plaintiffs alleged that at the time of the accident, Klassert was intoxicated and that she had been served alcohol by Duffy's Tavern. Some of the plaintiffs later obtained payments or settlement monies from Ms. Klassert's auto liability carrier, or from their own auto liability carriers, underinsured motorist carriers, or health insurers.

The plaintiffs then sued against Duffy's Tavern. At the time of the accident, Duffy's Tavern was insured under a liquor liability policy issued by Constitutional Casualty Company. That carrier, however, later was declared insolvent and placed into liquidation by the Illinois Department of Insurance. In accordance with the Guaranty Fund Act (215 ILCS 5/532 et seq.), the Illinois Insurance Guaranty Fund (Fund) assumed responsibility for the obligations of Constitutional and assumed Duffy's Tavern's defense.

Under section 546(a), however, any obligation of the Fund for a "covered claim" under the Act is reduced by any amounts a claimant receives from other insurance companies. The Act defines a "covered claim" to mean "an unpaid claim for a loss arising out of and within the coverage of an insurance policy to which this Article applies and which is in force at the time of the occurrence giving rise to the unpaid claim made by a person insured under such policy or by a person suffering injury or damage for which a person insured under such policy is legally liable." Based on this statutory

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language, the court held that a "covered claim" is an "unpaid claim made by a person suffering injury or damage under a policy issued by a company that has been declared insolvent for which a person insured under such policy is legally liable."

Applying that definition, the court noted that the maximum amount recoverable under the Dramshop Act was set annually by a formula provided by the Act. The parties in *Guzman* agreed the maximum amount of damages recoverable by the plaintiffs for their injuries under the Dramshop Act was $58,652.33 per plaintiff. Reading the relevant provisions of the Guaranty Fund Act together with the Dramshop Act, the appellate court held that because the legal liability of Duffy's Tavern was limited to $58,652.33 per person, the Fund's "covered claim" liability likewise was limited to $58,652.33 per person. Accordingly, the appellate court held that the reduction required for recoveries from other insurance in section 546(a) should be made from the $54,652.33 covered claim obligation in this case.

Notably, the court in *Guzman* rejected the court's finding on the exact same issue in *Rogers v. Imeri*, 2013 IL App (5th) 110546, which provided that the deduction for other insurance recoveries in a dramshop case should be made from the jury damage award.

Guzman v. 7513 W. Madison St., Inc., 2013 IL App (1st) 122161.

Statutory Cap on Illinois Guaranty Fund's Workers' Compensation Liability Applies to Primary and Excess Policies

In *Skokie Castings, Inc. v. Illinois Insurance Guaranty Fund*, the court held that the exemption to the statutory cap on the Illinois Insurance Guaranty Funds' liability for "any workers' compensation claims" applies to both primary and excess policies.The Guaranty Fund had argued that the claim submitted did not qualify as a "workers' compensation" claim because the excess policy at issue only provided indemnity to the insured, not direct payment to the injured employee. The majority characterized this difference as one of mechanics and not substance because the insurance company still makes payments on the claim. The majority held that to rule otherwise would produce an unjust result. To illustrate this point, the court explained that it would be unjust if, for example, a claim made under a primary workers' compensation policy with a high deductible was classified as a workers' compensation claim but a claim made under an excess workers' compensation policy with a self-insured retention of the same amount as the deductible was not classified as a workers' compensation claim. Justice Kilbride and Justice Thomas dissented based on the differences between primary liability workers' compensation coverage and excess indemnity workers' compensation coverage. They pointed out that with primary liability coverage, the insurance company actually assumes the responsibility for paying the injured employee directly, whereas in an excess indemnity policy, the insurer only obligates itself to indemnify the employer for amounts the employer actually pays to the injured employee. Justice Thomas characterized the issue as not so much a distinction between primary and excess insurance, but between liability and indemnification insurance. Both dissenting Justices reasoned that a claim under an excess indemnification policy did not constitute a workers' compensation claim under a strict interpretation of the statutes and policy.

Skokie Castings, Inc. v. Illinois Insurance Guaranty Fund, 2013 IL 113873.

Insurance Broker's Duty to Client Does Not Extend to Renewal Policy Procured by Subsequent Broker

In *Garrick v. Mesirow Financial Holdings, Inc.*, an insured sued its insurance broker for professional negligence. The broker had procured personal property insurance for the plaintiffs, which included a pair of earrings in the schedule of covered items and expenses. During the initial period of coverage, one of the earrings was lost and replaced. The insurer, AIG, paid the claim. The plaintiffs later renewed their coverage with AIG, but through a different producer. During the period of subsequent coverage, both of the earrings were lost. AIG denied the claim, claiming that the earrings were not covered under the subsequent policy because they were not separately listed on the new policy. The plaintiffs alleged in their complaint that the defendant had failed to advise them that when the one earring was lost and replaced under the previous policy, the set of earrings then was considered a new item, and had to be separately listed on the new policy. The court affirmed dismissal of the plaintiffs' complaint, holding that the defendant's fiduciary duty did not extend past the end of the previous policy which it had procured. The court further held that any negligence by the defendant during the previous policy could not have been the proximate cause of the plaintiffs' damages under a subsequent policy because it was too remote. The court found that it was the plaintiffs' responsibility to advise the subsequent insurance producer if the renewed policy did not contain any specific items they wanted covered.

Garrick v. Mesirow Financial Holdings, Inc., 2013 IL App (1st) 122228.

Allocation of Losses and Horizontal Exhaustion

The coverage dispute in *John Crane, Inc. v. Admiral Insurance Company* involved the interpretation of umbrella and excess insurance policies issued to the manufacturer of asbestos containing gaskets at various times by different insurers. During the entire period, John Crane had its primary coverage with Kemper. It also had excess and umbrella coverage with various insurers before January 1,

1987. As part of an agreement concerning coverage (ACC) between Crane and Kemper regarding a "no settlement" policy, Crane and Kemper agreed, among other things, that the policy limits for post 1986 policies would be eroded by both defense costs and damage expenses. Crane did not have excess or umbrella coverage with any of the defendants after 1986.

The excess and umbrella carriers challenged Crane and Kemper's right to alter triggering of their policies through the ACC. The court also considered triggers of coverage and allocation of excess and umbrella liability.

Although the court held that the ACC did not violate any duty of good faith which Crane owed to the excess and umbrella carriers, it held that those carriers did have standing to challenge the ACC. The court found, that under the doctrine of horizontal exhaustion, Crane could not choose, through the ACC, to make portions of the primary policies unavailable in an exhaustion analysis. The court held that all of the primary policies to which the ACC applied (the post 1986 policies) had to be exhausted under the language of the policies as they existed prior to the ACC, before the excess umbrella coverage could be triggered. The court applied a triple trigger, not a continuous trigger. It held the triple trigger analysis triggered coverage under policies when either bodily injury, sickness or disease occurred. In other words, it did not require the happening of all three of those events to trigger coverage. Bodily injury was said to occur simply upon a claimant's exposure to asbestos. The court rejected CNA's claim that an equitable continuous trigger should occur. Finally, the court rejected application of a pro-rata distribution of liability and applied the "all sums" approach in which each triggered insurance policy would be jointly and severally liable up to each policy's liability limit.

John Crane, Inc. v. Admiral Insurance Company, 2013 IL App (1st) 1093240-B.

Settlement of TCPA Class Action Covered Under CGL Policy

The court in *Standard Mutual Insurance Company v. Lay* considered whether a statutorily prescribed damage limit of $500 per violation under the federal Telephone Consumer Protection Act (TCPA) constituted uninsurable punitive damages. The Illinois Supreme Court held that because the primary purpose of the TCPA was remedial, not penal, a settlement of a TCPA class action constituted covered compensatory damages under a commercial general liability insurance policy. Finding that the settlement was covered, the court declined to address the following arguments raised by the insured: (1) that the $500 per violation damage amount should be an exception to the general rule that punitive damages are not insurable or in the alternative; or (2) that all punitive damages should be insurable.

Standard Mutual Insurance Company v. Lay, 2013 IL 114617.

Late Notice Bars State Guaranty Fund From Pursuing Equitable Subrogation Claim

The decision in *Illinois Insurance Guaranty Fund v. Liberty Mutual Insurance Company* involved a claim by the Illinois Insurance Guaranty Fund against Zurich American Insurance Company under a theory of equitable subrogation. The Guaranty Fund attempted to obtain reimbursement from Zurich for workers' compensation payments it had made on behalf of an insolvent insurance company which had provided coverage to a loaning employer under the Workers' Compensation Act. Zurich insured the borrowing employer. The Fund alleged that Zurich, as the insurer for the borrowing employer, was jointly and severally liable with the insurer for the lending employer. The court held that the Guaranty Fund's complaint failed to allege a cause of action for equitable subrogation because it did not allege that the insolvent insurance company ever triggered Zurich's coverage by notifying Zurich within the statute of limitations period that Zurich should either provide primary coverage or share coverage for the workers' compensation claim. The court also held that the Fund did not file its claim against Zurich until after any statute of limitations governing such a claim had expired.

Illinois Insurance Guaranty Fund v. Liberty Mutual Insurance Company, 2013 IL App (1st) 123345.

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Terry A. Fox, co-chair of the Insurance Committee, is a Partner at *SmithAmundsen's* Chicago and St. Charles offices concentrating his practice in tort and employment-related litigation, and related insurance coverage matters. In the area of coverage, Mr. Fox is involved in providing coverage analysis, policy drafting, and other risk-transfer strategies. He is admitted to practice before all Illinois state courts and administrative agencies, the United States District Court for the Northern District of Illinois (Chicago and Rockford), the Northern District of Indiana, the Seventh Circuit Court of Appeals, and is a member of the trial bar. He obtained his B.A. with honors and distinction from Iowa State University, and his J.D. with distinction from the University of Iowa.

Seth D. Lamden is a litigation partner at *Neal, Gerber & Eisenberg, LLP* in Chicago. He concentrates his practice on representing corporate and individual policyholders in coverage disputes with their insurers. In addition to dispute resolution, Mr. Lamden counsels clients on matters relating to insurance and risk management, including maximizing insurance recovery for lawsuits and property damage, policy audits and procurement, and drafting contractual insurance specifications and indemnity agreements. He obtained his B.A. from Brandeis University, and his J.D., *magna cum laude*, from The John Marshall Law School.

Camilla Pollock-Flynn is an associate at *LaBarge, Campbell & Lyon* in Chicago. Prior to joining the firm, Ms. Pollock-Flynn received her undergraduate degree, *cum laude*, from Notre Dame in 2004 and graduated from DePaul University College of Law, *cum laude*, in 2007. While at DePaul, Ms. Pollock-Flynn received the CALI Award for Excellence in Trial Advocacy. Ms. Pollock-Flynn concentrates her practice in construction litigation, medical malpractice, professional liability, personal injury defense, premises liability, product liability, ERISA litigation, insurance coverage and general insurance defense. She has been admitted to practice in the state of Illinois and in the United States District Court for the Northern District of Illinois, and is an active member of the Chicago Bar Association, the Illinois State Bar Association, the Women's Bar Association of Illinois, and the Illinois Association of Defense Trial Counsel.

Paul P. Waller, III is a shareholder with the law firm of *Walker & Williams, P.C.*, in Belleville, Illinois. He is a graduate of the University of Notre Dame and St. Louis University Law School. He is a former a law clerk to Judge William Beatty in the U.S. District Court for the Southern District of Illinois and has concentrated his practice in insurance defense and insurance coverage for over thirty years.

Michael L. Young is a partner with the St. Louis office of *HeplerBroom LLC*, with a primary emphasis in the practice of insurance law. He represents both insureds and insurers in complex insurance coverage matters at all stages of the claims process. Mr. Young's litigation practice also includes the defense of personal injury, products liability, and white collar criminal defense matters. Mr. Young obtained his law degree from Saint Louis University, *summa cum laude*, in 2002, where he was the Valedictorian of his class. While in law school, Mr. Young served as a Staff Member for the *Saint Louis University Law Journal* in 2000–2001. He received his Bachelor of Arts degree in 1999 from Washington University in St. Louis, Missouri, *summa cum laude*, majoring in History.

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