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NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION

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HIGHLIGHTS

New Volume 12 on Insurance Litigation, Arbitration and Settlement

New Chapter 95 on Insurable Interest

New Chapter 120 on Commercial Crime Policy Insuring Agreement 1: Employee Dishonesty and Employee Theft Coverage

Miscellaneous Updates to pre-existing chapters, especially those in Volumes 5 through 9, including an analysis of a U.S. Supreme Court decision in Chapter 107

New Chapter 95, INSURABLE INTEREST, Chapter 95 examines the insurable interest doctrine in the context of life insurance policies and provides an in-depth review of the key issues concerning insurable interest, including the historical development of the doctrine, who is deemed to have an insurable interest in another's life, the basis for challenging violations of the insurable interest rule, potential defenses to insurable interest challenges, and the remedies and relief available after a successful challenge.

New Chapter 120, COMMERCIAL CRIME POLICY INSURING AGREEMENT 1: EMPLOYEE DISHONESTY AND EMPLOYEE THEFT COVERAGE, analyzes the coverage provided by commercial crime policies. Commercial crime policies are insurance fidelity policies designed to protect commercial enterprises other than financial institutions or other participants in the financial services industry. Standard forms of these policies are in use, and in general, they include coverage for loss resulting directly from either employee dishonesty or employee theft. This chapter examines the coverage issues that arise in those contexts.

New Chapter 150, INITIATION OF LITIGATION, provides information, analyzes pertinent issues and includes a check-

list for the measures that need to be taken for the initiation of lawsuits in insurance disputes. The chapter provides the framework for the thought-process that should be part of filing a lawsuit. It addresses the parties to the lawsuit, timing of filing a lawsuit, jurisdiction / forum / venue, causes of action, some specific types of lawsuits (intervention, interpleader, class action), and service of the complaint. Particular parties to insurance disputes are identified and discussed, including admitted and non-admitted insurers, claims organizations and representatives, insurance intermediaries, policyholder, claimant, assignees, intervenors, and reinsurers. The chapter addresses difficult situations that can arise in the filing of a lawsuit, such as when the party suing or being sued is insolvent, deceased, dissolved, suspended, or bankrupt and—when suing London insurers—any missing markets. It features analyses of the content of the initial pleading, including addressing many types of causes of action that the insurance company, policyholder, or other party initiating a complaint involving an insurance dispute may want to include. It considers the types of remedies that the party initiating the lawsuit may want to seek including a declaration of the parties' rights, damages, restitution or other equitable remedies, interest, and attorney's fees and it also covers the right to jury trial in the context of an insurance dispute.

New Chapter 151, RESPONDING TO LITIGATION, focuses on the procedural and strategic considerations of the party that has been sued as it responds to litigation. These considerations that are not necessarily driven by the procedural law of what a party *can* do in responding to litigation. Rather, these considerations may be based on prudential, financial, or other strategic concerns. The chapter analyzes what can be the most important procedural battle in insurance coverage litigation—the battle over the forum where the litigation will occur. It addresses the procedural pleading rules for answers, including the consequences to the defendant of admitting the plaintiff's allegations. More specific to insurance coverage litigation, this section also addresses how a defendant should address insurance policy language when drafting its answer. It surveys the specific affirmative defenses that may be available to an insurance coverage litigant when drafting its answer, which leads to an analysis of certain substantive points of insurance law. The chapter considers the the various substantive and procedural motions available to the parties in the early stages of litigation. It further addresses the assertion of counterclaims and cross-claims by the defendant responding to litigation. It covers issues surrounding both the permissive and necessary joinder of additional parties. The chapter further considers the crucial, yet often overlooked, steps a defendant must take to preserve its right to a jury trial. The remainder of the chapter covers other thorny issues that arise when there are concurrent underlying and coverage actions.

New Chapter 152, DISCOVERY, begins with an overview of the scope of discovery permitted in civil litigation. Although this chapter focuses primarily on the Federal Rules of Civil Procedure, it notes that both the federal rules and corresponding state rules permit insurers and insureds to engage in broad pretrial discovery that extends to facts and information that are relevant to the claims and defenses of either party. It describes the various discovery mechanisms that are authorized by the federal rules. The chapter discusses the steps that litigants must take to protect their rights in discovery. It addresses the various contexts in which the attorney-

client privilege, as well as the attorney work-product doctrine, may arise in coverage litigation. It also explores issues as to the discovery of extra-contractual information in coverage litigation. The chapter analyzes additional controversial areas of discovery in coverage litigation, including disputes that may arise in connection with efforts to discover insurance claim files, insurance reserves, claim files of insureds that are not parties to the coverage litigation, the personnel file and compensation records of a claims adjuster, communications between an insurer and a reinsurer, and internal insurer claim handling manuals. The chapter identifies disputes that may arise regarding the format in which electronic discovery must be produced and the approaches taken by the courts in balancing the burden and cost of electronic discovery against the parties' rights to discover relevant information. Lastly, it explores the role that protective orders play in coverage litigation.

New Chapter 153, EXPERT WITNESSES, analyzes legal standards and factual criteria considered by federal and state courts in the insurance context to determine what constitutes expertise, and standards that various courts apply to determine admissibility of expert testimony. This chapter also explores purposes and roles—typical and novel—of testifying and non-testifying experts in insurance and reinsurance coverage disputes. It discusses the appropriate roles of expert testimony in assisting triers of fact render determinations with which they are tasked. It then analyzes the criteria courts use to determine what constitutes qualified expertise. Examples of strategic concerns are considered including, for example, publicly available information about the potential expert that may not be disclosed on or relevant to his or her resume. The chapter also analyzes examples of topics about which insurance experts frequently testify, and the limitations on experts' ability to testify about those topics. For instance, it discusses the potential usefulness of expert testimony surrounding causation, as well as insurance industry custom and practice. It examines an exception to the general rule against allowing expert testimony regarding matters of law. of impermissible uses of expert testimony are also addressed. The chapter explores ddifferent tactics parties use to preclude expert testimony that is arguably impermissible for any reason. The chapter further discusses expert discovery, an area of practice complicated by strategy and procedure. It concludes with consideration of the uses of expert testimony in arbitration proceedings.

New Chapter 154, SUMMARY JUDGMENT, analyzes procedural requirements for summary judgment motions including timing, the length of summary judgment motions and memoranda as to the proposed judgment, and cross-motions for summary judgment. It describes the prevalence and usefulness of summary judgment in resolving issues of insurance policy interpretation. In insurance coverage litigation, parties frequently file multiple motions for summary judgment or cross-motions in a process of narrowing the issues in dispute, and these issues are also addressed. The chapter provides specific examples for how the general standard for awarding summary judgment has been applied in insurance cases. Special emphasis is placed on how the burdens on a motion for summary judgment apply in light of the general burdens of proof in insurance coverage disputes. It also addresses state law, where the burdens on a motion for summary judgment sometimes follow federal rules and sometimes diverge. The chapter features analyzes of how summary judgment

has been used in the context of specific insurance coverage disputes including the duty to defend, exclusions and other coverage limiting provisions, as well as allegations of bad faith.

New Chapter 155, TRIAL, analyzes the insurance coverage and bad faith trial. The chapter addresses the threshold issue of whether the case will be tried to a jury or to the court. It also addresses also addresses the theory of the case and the narrative each party wants to present at trial. It examines a range of pretrial motions. The chapter further explores the right to a jury trial and the process and issues surrounding jury selection in the insurance coverage and bad faith case. It considers evidentiary issues in the insurance coverage case. The chapter discusses the availability of attorney's fees in insurance coverage and bad faith trials. It addresses considerations for protecting the record for appeal and for putting offers of proof on the record for evidence that was proffered but excluded.

New Chapter 156, POST-TRIAL ISSUES, observes that post-trial proceedings take place at both the trial court and appellate levels. Although the first source of information that should always be consulted is the local rules of civil and appellate procedure, the chapter explores the substantial areas of conformity among the various state and federal jurisdictions. It surveys issues surrounding various categories of motions such as motions for directed verdicts made during trial, and motions for judgment notwithstanding the verdict made post-trial, as well as motions for a new trial. The chapter examines the doctrines of *additur* and *remittitur*. It analyzes issues surrounding motions for relief from a judgment, motions to alter or amend a judgment, motions to seek adjustments to jury verdicts, and motions for judgment interest and attorney's fees. The chapter considers timing requirements for post-trial motions and the time to appeal. It examines the various grounds for obtaining appellate jurisdiction, including for interlocutory appeals. The chapter also covers the requirements for filing a formal notice of appeal and the posting of a bond with the trial court. It further addresses issues arising in the context of the calculation and taxation of costs, awards of attorney's fees, and pre-judgment and post-judgement interest. It addresses issues arising out of a claim of preclusion—either preclusion of an entire matter through the doctrine of *res judicata*, or preclusion of an issue of fact through the doctrine of collateral estoppel. It lastly considers other important limitations on the scope of post-trial litigation and appeals including the doctrines of law-of-the-case, judicial estoppel, and "invited error."

New Chapter 157, INSURANCE SETTLEMENT, first notes that most coverage disputes settle and explains why. considers settlement before any litigation has occurred and those circumstances in which pre-litigation settlement may be preferable for one or more parties to the dispute. The chapter discusses particular procedural issues arising after suit is filed. It surveys the different forms of settlement agreements that can occur, including oral and written settlement agreements and settlement inferred from conduct like the negotiation of a check in payment of a disputed claim. It addresses settlement concerns for liability and property claims. The complexities of environmental and mass tort claims are also explored where the more complex forms of agreement may be necessary, such as interim defense, pay-as-you-go, and site release agreements. Also discussed are policy buybacks, percentage settlements and claim funds commonly used in settling complex claims. The chapter considers the settlement of workers'

compensation claims and the issues created by the unique statutory framework for such coverage. It walks through issues that arise where there is insufficient coverage for multiple claims or insureds. The chapter further addresses claim aggregation issues that can arise in the settlement of coverage disputes and settlement with insurers providing different layers of coverage. The chapter concludes in Section 157.09 with a discussion of enforcement, including jurisdiction, evidence, and waiver and estoppel issues.

In addition, several chapters in the existing volumes of the publication have been updated. Here are some of the highlights:

Chapter 18, DUTY TO INDEMNIFY—BODILY INJURY AND PROPERTY DAMAGE, features an analysis of the broadening of Exclusion "p" in 2014 to include liability arising out of data breaches or other data related activity. (*See* § 18.03[15].)

Chapter 41, INTRODUCTORY MATTERS IN PROPERTY INSURANCE—In *Millennium Inorganic Chemicals, Ltd. v. National Union Fire Ins.* Co., 744 F.3d 279 (4th Cir. 2014) (applying Maryland law), an action for coverage under contingent business interruption provisions of commercial liability insurance policies, endorsements provided coverage only with respect to "direct contributing properties." Gas producing facilities, which exploded, were not a "direct contributing property" of the insured, a titanium dioxide processor; the relationship between the gas producer and the insured was clearly interrupted by an intermediary, who took full physical control of the gas before delivering indistinguishable commingled gas to the insured. (*See* § 41.01[2][1][ii].)

In *W.W. Rowland Trucking Co. v. Max American Insurance Co.*, 2014 U.S. App. LEXIS 3378 (5th Cir.) (applying Texas law), the Anti-Technicality Statute, Tex. Ins. Code Ann. § 862.054 applied to the insured's claim resulting from the theft of video game consoles the insured was transporting, because the insured, as bailee, had an insured interest in the stolen game consoles, and, thus, relevant portions of the policy covering those consoles amounted to property insurance, not liability insurance. (*See* § 41.05[4][d].)

In *200 Leslie Condominium Ass'n v. QBE Insurance Corp.*, 965 F. Supp. 2d 1386 (S.D. Fla. 2013) (applying Florida law), a property owner failed to provide the insurer with a sworn proof of loss on the form provided by the insurer containing the information requested, as required by the policy. The property owner also breached the Inventory of Damaged and Undamaged Property post-loss condition because it did not give a specific count as to the number of units that actually had damage, and the policy required that the owner provide inventories of all property covered by the policy and was not limited to building contents or personal property. (*See* § 41.06[2][a].)

In *Biscayne Cove Condominium Ass'n v. QBE Insurance Corp.*, 971 F. Supp. 2d 1121 (S.D. Fla. 2013) (applying Florida law), a case involving a property damage claim, the insurer was entitled to judgment because the insured materially breached the policy by failing to comply with the post-loss obligations to provide a proof of loss, to provide inventories of damaged and undamaged property, and to submit to an examination under oath. (*See* § 41.06[2][b].)

Chapter 42, DETERMINING COVERAGE IN PROPERTY INSURANCE POLICIES—In *Georgitsi Realty, LLC v*

Penn-Star Insurance Co., 999 N.E.2d 520 (N.Y. 2013), the New York Court of Appeals, in response to two certified questions from the Second Circuit relating to a property insurance policy covering acts of "vandalism," answered that: (1) malicious damage within the coverage of such a policy may be found to result from acts not directed specifically at the covered property and (2) to obtain coverage under such a policy, the insured must show malice, defined as such a conscious and deliberate disregard of the interests of others that the conduct in question may be called willful or wanton. (*See* § 42.01[6].)

Chapter 43, EXCLUSIONS IN PROPERTY INSURANCE POLICIES—In *Magnus, Inc. v. Diamond State Ins. Co.*, 2013 U.S. App. LEXIS 22266 (10th Cir.), an action for coverage brought by the assignee of a CGL insurance policy, remand was required because, in granting summary judgment for the insurer, the district court did not address whether the record demonstrated that the insured's intentional acts in manufacturing aluminum adaptors, which permitted a consumer to attach a broadhead to an arrow shaft, led to intended or unintended injuries under either the natural and probable consequences test or the substantial certainty test. (*See* § 43.02[1][a]).

In *Doe Run Resources Corp. v. Lexington Ins. Co.*, 719 F.3d 876 (8th Cir. 2013) (applying Missouri law), the pollution exclusion precluded duty to defend claims premised on the release of hazardous substances from a 500-acre waste pile. However, allegations that the insured distributed and left "open and available" chat and other toxic substances for use as fill material and use in children's sandboxes, did not necessarily entail a "release" that would trigger the pollution exclusion. (*See* § 43.03[5][b].)

In *Lapolla Industries, Inc. v. Aspen Specialty Ins. Co.*, 2014 U.S. App. LEXIS 9199 (5th Cir.), the insurer had no duty to defend the insured in a products liability action concerning a spray polyurethane foam that allegedly released toxins because the CGL policy's total pollution exclusion applied to property damage that "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." (*See* § 43.03[5][c].)

In *United Fire & Cas. Co. v. Titan Contractors Service, Inc.*, 2014 U.S. App. LEXIS 8879 (8th Cir.) (applying MO law), a particular acrylic concrete sealant fell unambiguously within the CGL policy's definition of "pollutant," and an ordinary insurance purchaser would have concluded that the sealant constituted an irritant and, in turn, a pollutant under policy's absolute pollution exclusion; that conclusion was buttressed by fact that federal Clean Air Act classified xylene, one of the sealant's constituent chemicals, as a "pollutant." (*See* § 43.03[5][d].)

Chapter 44, THE CAUSATION QUESTION IN PROPERTY INSURANCE—In *American Home Assurance Co. v. Sebo*, 2013 Fla. App. LEXIS 14799 (2013), involving a coverage dispute, the insurer that issued a homeowner's policy was entitled to a new trial because the concurrent causation doctrine involving multiple perils was inapplicable in the insured's first-party property loss case and, instead, the insured's loss had to be examined under the efficient proximate cause theory. (*See* § 44.03[6].)

In *Selective Way Ins. Co. v. National Fire Ins. Co.*, 2013 U.S. Dist. LEXIS 178665 (D. Md.) (applying Maryland law), the plaintiff-insured was granted summary

judgment because damage to the building from water intrusion resulting from a subcontractor's faulty installation of a fitting on a water line was a covered loss due to applicability of the ensuing loss clause of policy. (*See* § 44.05[3][b].)

Chapter 45, ADDITIONAL AND SUPPLEMENTAL PROPERTY INSURANCE COVERAGES—In *Chafin v. Farmers & Mechanics Mut. Ins. Co.*, 751 S.E.2d 765 (W. Va. 2013), a case involving a named perils homeowner's policy, which provided coverage for "collapse" caused by hidden decay, the lower court erred in finding as a matter of law that the term "collapse," which was not defined in the policy, was not ambiguous and that the insured's kitchen floor did not collapse, because the term "collapse" had to be construed to mean something less than the complete falling in of the kitchen floor and to include substantial impairment of the structural integrity of the floor. Whether the insured should have known that decay was causing her kitchen floor to sink was a genuine issue of material fact that had to be decided by a jury. (*See* § 45.06[3][b].)

Chapter 46, TIME ELEMENT (BUSINESS INTERRUPTION) INSURANCE—In *Manpower, Inc. v. Ins. Co. of Pa.*, 732 F.3d 796 (7th Cir. 2013), an insurance coverage dispute in which the insured claimed various losses stemming from a building collapse that left its French subsidiary unable to access its office space for more than a year, the district court abused its discretion under Fed. R. Evid. 702 in excluding the insured's accounting expert, without whom the insured could not establish its business interruption damages, because the expert used an accepted and reliable methodology, and whether the expert selected the best data set to use was a question for the jury, not the judge. (*See* § 46.08[3][c][iii][E].)

In *UrbCamCom/WSU I, LLC v. Lexington Ins. Co.*, 2014 U.S. Dist. LEXIS 56228 (E.D. Mich.) (applying MI law), the amount of business interruption losses owed to an insured was not an appropriate issue for the court to decide because the "period of restoration" valuation did not involve a legal dispute over coverage but, instead, was a fact question for an appraisal panel to decide; the parties agreed to an appraisal, and the policy and Michigan law provided for an appraisal, Mich. Comp. Laws § 500.2833(1)(m). (*See* § 46.09.)

Chapter 47, CALCULATING THE AMOUNT OF PROPERTY INSURANCE COVERAGE—In *Alexander v. Farmers Ins. Co., Inc.*, 162 Cal. Rptr. 3d 455 (Cal. App. Ct. 2013), the trial court properly deferred an insurance appraisal of the actual value of the insured property because the appraisal could be rendered unnecessary by resolution of whether the insurer engaged in illegal adjusting practices by failing to comply with the method set forth in Ins. Code § 2051 for determining the actual cash value for a partial loss in a fire. (*See* § 47.06[4].)

In *Citizens Property Ins. Corp. v. Demetrescu*, 2014 Fla. App. LEXIS 4377, because the insurer wholly denied that there was a covered loss, and because the trial court never decided the applicability of any of the policy exclusions set forth in the insurer's affirmative defenses or resolved the issues surrounding the insureds' post-loss duties, the trial court erred in ordering an appraisal. (*See* § 47.06[4].)

Chapter 50, BUILDERS RISK INSURANCE—In *City of South Pittsburg v. James C. Hailey & Co.*, 2013 Tenn. App. LEXIS 430, an insurer was not entitled to summary judgment in a coverage dispute with a city regarding a builder's risk policy issued to an insured, naming the city as an

additional insured, because evidence submitted by the city raised a disputed issue of material fact as to whether the construction project was "put to its intended use" when the damage occurred. (*See* § 50.01[4][a].)

Chapter 51, BOILER AND MACHINERY INSURANCE—In *Fisher Communications, Inc. v. Travelers Prop. Cas. Co.*, 2013 U.S. Dist. LEXIS 159294 (W.D. Wash.) (applying WA law), involving a dispute between two insurers concerning the extra expense provision of two policies, the extra expense provision of the boiler and machinery policy extended coverage for reasonable extra expenses the insured incurred to operate its business during the "period of restoration." This was defined as the period of time beginning at "breakdown" and ending 30 days after the date when the damaged property "could have been repaired or replaced with reasonable speed and similar quality." The insurer allowed coverage for five days and paid all of the extra expense associated for those five days. The second policy was an all-risk policy with a similar provision, but that insurer paid extra expenses for almost four months. The court denied the second insurer's motion for contribution, based on the undisputed testimony of the first insurer's expert, an electrical engineer, that the property could have been repaired with reasonable speed in eight days. However, the court found that the first insurer owed in total 38 days of extra expense coverage (eight days of repair, not five, plus the 30 additional days included in the period of restoration). (*See* § 51.04[2].)

Chapter 53, HOMEOWNER'S INSURANCE—In *Johnson v. Safeco Ins. Co.*, 316 P.3d 1054 (Wash. Ct. App. 2013), in which a homeowner's home and personal property were destroyed in a fire, the unrebutted evidence established that the homeowner was provided sufficient notice of cancellation for failure to pay the renewal premium for the insurer to cancel its policy. The insurer mailed the December 2 notice to the insured and a separate notice to the mortgage company, and, under the policy and Wash. Rev. Code § 48.18.293(2), proof of mailing was proof of notice. (*See* § 53.01[13].)

In *Schuchman v. State Auto Prop. & Cas. Ins. Co.*, 733 F.3d 231 (7th Cir. 2013) (applying IL law), an action by insureds for a declaratory judgment that the insureds were entitled to coverage under a homeowner's insurance policy for the repair and replacement of a house that was damaged by a fire, the district court improperly granted summary judgment to the insurer on the basis that the insureds were not residing on the "residence premises" as defined in the policy at the time of the fire because the term "residence premises" was ambiguous and, therefore, should be liberally construed in favor of coverage. (*See* § 53.02[1][a].)

In *Adams v. Cameron Mut. Ins. Co.*, 2013 Ark. 475, a breach of contract case involving the interpretation of a homeowners' insurance policy, the term "actual cash value" was ambiguous because it was fairly susceptible to more than one reasonable interpretation; as such, the policy was construed liberally in favor of the insureds and strictly against the insurer. The costs of labor could not have been depreciated when determining the actual cash value under an indemnity insurance policy; allowing an insurer to depreciate the cost of labor would have left the insureds with a significant out-of-pocket loss, which was inconsistent with the principal of indemnity. (*See* § 53.05[3][b].)

In *Trinidad v. Florida Peninsula Insurance Co.*, 121 So. 3d 433 (Fla. 2013), the insured sought coverage for fire damage to

his home, and the insurer admitted coverage and paid for completion of the repairs, which were not actually undertaken, but excluded an amount for a general contractor's overhead and profit pending the insured's actual incurring of those expenses. The high court held that the insurer's required payment under the replacement cost homeowner's policy (RCHP) was to include overhead and profit when the insured was reasonably likely to need a GC for the repairs. As the policy and Fla. Stat § 627.7011(3) and (6) did not require the insured actually to repair the property as a condition precedent to the insurer's payment, the insurer was not authorized to withhold payment pending actual repair. (*See* § 53.05[4][c][iii].)

Chapter 61, GENERAL PRINCIPLES AND INTRODUCTORY MATTERS IN MOTOR VEHICLE INSURANCE LAW—In *Progressive Gulf Ins. Co. v. Faehnrich*, 2014 U.S. App. LEXIS 8578 (9th Cir. May 7, 2014), involving a choice of law question, Nevada public policy did not preclude application of a household exclusion clause in an automobile liability insurance policy delivered in Mississippi to Mississippi residents. The policy selected Mississippi law as controlling. Mississippi law permits household exclusions but Nevada does not. (*See* § 61.02[3][c][iii].)

In *Fisher v. State Farm Mut. Auto. Ins. Co.*, 305 P.3d 861 (Mont. 2013), the court enforced a family member exclusion in an umbrella policy. The premiums for $2 million in umbrella coverage were more economical than the premiums for $500,000 in automobile liability coverage. Therefore, permitting frequent family passengers to turn economical excess coverage into expensive liability coverage would be contrary to the umbrella policy's purpose and undermine its viability. (*See* § 61.02[3][c][iii].)

In *Am. Access Cas. Co. v. Reyes*, 1 N.E.3d 524 (Ill. 2013), the court refused to enforce an automobile liability policy that excluded from coverage the only named insured and owner of the insured vehicle because it violated public policy. (*See* § 61.02[3][c][iv].)

According to the court in *Montgomery County v. Distel*, 436 Md. 226 (2013), Maryland's compulsory motor vehicle insurance scheme did not permit the county, a self-insurer, to disclaim or exclude insurance coverage, in a self-insurance guarantee, on the basis that the officer operated his personal patrol vehicle under the influence of alcohol. The disclaimer was invalid because it violated Maryland's compulsory motor vehicle insurance scheme by reducing benefits below minimum levels set by statute. (*See* § 61.02[3][c][v].)

Under *Ala. Code § 32-7-23*, the recovery by an injured person under the uninsured motorist provisions of any one policy is limited to the primary coverage plus such additional coverage as may be provided for additional vehicles. However, the insured can stack an unlimited number of insurance policies. (*See* § 61.03[3][c][ii][A].)

Missouri does not require underinsured motorist (UIM) coverage and thus stacking is determined by policy provisions. In *Daughhetee v. State Farm Mut. Auto. Ins. Co.*, 743 F.3d 1128 (8th Cir. 2014), the anti-stacking provision stated that UIM coverage in different policies will "not be added together" to determine the most an insured is paid. The maximum amount that may be paid from all such policies combined is the single highest applicable limit provided by any one of the policies. Because Missouri does not require UIM coverage the existence of the coverage and its ability to be stacked are determined by the contract entered between the insured and

the insurer. The parties agreed that the policy unambiguously precluded stacking and an ordinary reader would understand this prohibition. (*See* § 61.03[3][c][ii][A].)

In *AAA Mid-Atlantic Ins. Co. v. Ryan*, 84 A.3d 626 (Pa. 2014), a limit of liability clause in an insureds' policy did not conflict with the clearly expressed public policy of the Pennsylvania Motor Vehicle Financial Responsibility Law to protect those injured by a negligent driver who lacked adequate coverage because the clause allowed the insureds to be fully compensated for their injuries and to receive the entire amount of damages to which they were entitled. (*See* § 61.03[3][c][ii][A].)

Some states, such as Rhode Island, have established an uninsured motorist identification database to verify compliance with motor vehicle owner's or operator's security requirements with current motor vehicle registrations. Rental vehicles and commercial autos are exempted. *R.I. Gen. Laws §§ 31-47.4-2*, 31-47.4-10. (*See* § 61.04[7][a].)

In *Vanderhoff v. Harleysville Ins. Co.*, 78 A.3d 1060 (Pa. 2013), the court held that a showing of prejudice does not require proof of what the insurer would have found had timely notice been provided. Prompt notice to both law enforcement and the insurer allows them to investigate the accident. In *Vanderhoff*, the insurer did not suffer prejudice because of an insured's failure to report a phantom vehicle within the 30-day time period. (*See* § 61.07[2][b][ii].)

In *Osmic v. Nationwide Agribusiness Ins. Co.*, 841 N.W.2d 853 (Iowa 2014), the policy statute of limitations applied to all insureds, including a passenger. The passenger, as an insured and a third-party beneficiary of the policy, did not have greater rights than the named insured. The insurer did not have an affirmative duty to disclose the contractual deadline for filing suit to the passenger's attorney. In the absence of a duty to disclose the limitations period or conduct amounting to an estoppel, the insurer may enforce the limitations clause in its policy. (*See* § 61.10[2][b].)

Chapter 62, PHYSICAL DAMAGE COVERAGE FOR MOTOR VEHICLES (COLLISION, COMPREHENSIVE AND NAMED-PERILS COVERAGES)—Effective January 1, 2014, in South Carolina, the uninsured motorist (UM) provision must also provide for no less than $25,000 coverage for injury to or destruction of the property of the insured in any one accident but may provide an exclusion of the first $200 of the loss or damage. *S.C. Code Ann. § 38-77-150*. (*See* § 62.01[2][a].)

Effective January 1, 2014, in Illinois, an insurer providing property damage liability insurance is required to advise applicants of the availability of UM vehicle property damage coverage, the premium for that coverage, and a brief description of the coverage. That information need be given only once and is not be required in any subsequent renewal, reinstatement or reissuance, substitute, amended, replacement or supplementary policy. *215 Ill. Comp. Stat. 5/143a*. (*See* § 62.01[2][a].)

Following Super Storm Sandy, New York adopted new regulations defining certain minimum standards for insurers which, if violated without just cause and with such frequency as to indicate a general business practice, would constitute unfair claims settlement practices. *11 N.Y. Comp. Codes R. & Regs. § 216.0* (Unfair Claims Settlement Practices and Claim Cost Control Measures). (*See* § 62.12.)

Although property damage is generally not coFvered under an

uninsured/underinsured motorist (UM/UIM) policy, some states include provisions allowing property damage coverage. These states include Illinois, *215 Ill. Comp. Stat. 5/143a* (an insurer providing property damage liability insurance is required to advise applicants of the availability of UM vehicle property damage coverage, the premium for that coverage, and a brief description of the coverage), South Carolina, *S. C. Code Ann. § 38-77-150* (the UM must also provide for no less than $25,000 coverage for injury to or destruction of the property of the insured in any one accident but may provide an exclusion of the first $200 of the loss or damage), and Texas, *Tex. Ins. Code § 1952.107* (an insured who has collision coverage and UM/UIM property damage liability coverage may recover under the coverage the insured chooses). (*See* § 62.01[2][a].)

In *Noteboom v. Farmers Tex. County Mut. Ins. Co.,* 406 S.W.3d 381, 385 (Tex. App. 2013), the insurer provided both collision and UM coverage. After it was determined that the driver of the other car was uninsured, the insurer proceeded on the claim as if it was under the UM coverage. The insureds had not elected to proceed under the collision coverage under the terms of the policy. The UM coverage obligated the insurer to pay for the damages for the cost of repairs, loss of use, and diminished value as calculated based on a comparison of the car's value before the accident and after the repairs. (*See* § 62.01[2][b].)

In *Geico Indem. Co. v. Portillo,* 2014 U.S. Dist. LEXIS 33152 (D. Alaska March 14, 2014), applying Arkansas law, the police department's investigation concluded that the parties were racing at the time of the accident. The parties did not have a reasonable expectation of coverage while racing. (*See* § 62.07[1][f].)

The Illinois statute, *215 Ill. Comp. Stat. 5/143.24d,* mandating arbitration of physical damage subrogation claims between insurers in certain cases, was ruled unconstitutional in *Interstate Bankers Cas. Co. v. Hernandez,* 3 N.E.3d 353 (Ill. App. Ct. 2013). The statute eliminated the right to trial by jury in actions to which that right has historically attached. The legislature not only mandated binding arbitration, but it mandated binding arbitration in accordance with a particular industry agreement, removing the right to a jury trial, even for nonsignatories to that agreement. (*See* § 62.10.)

Chapter 63, AUTOMOBILE LIABILITY INSURANCE—Nevada excludes commercial fleet vehicles from the Department of Motor Vehicles vehicle insurance verification system. *Nev. Rev. Stat. § 482.215.* (*See* § 63.03[2].)

In *Nodak Mut. Ins. Co. v. Bahr-Renner,* 842 N.W.2d 912 (N.D. 2014), the driver was not a resident of her mother's household for purposes of the insurance policy because she had a Swiss residence permit, did not live in her mother's home, was 60 years old and had been living on her own independently for decades. The court enforced a step-down provision, which was contained in a restrictive endorsement to the policy. (*See* § 63.04[3].)

In *Jackson v. Wis. County Mut. Ins. Corp.,* 832 N.W.2d 163 (Wis. Ct. App. 2013), a deputy sheriff who helped a motorist safely re-enter traffic in an area she was patrolling was "using" her employer's car to avoid injury to the motorist when she was struck by the motorist's vehicle. The employer's policy provided UIM coverage to an insured while using an automobile within the scope of his or her employment or authority. An insured does not have to be in direct physical contact with the vehicle

to be using it. (*See* § 63.04[3].)

Two Maryland cases addressed set-offs for workers compensation benefits. In *Ross v. Agurs,* 75 A.3d 1022 (Md. Ct. Spec. App. 2013), the UIM insurer was entitled to reduce benefits payable to the employee under its UIM coverage to the extent of the unreimbursed workers' compensation benefits. The amount of the lien was not reduced by a proportional amount of attorney's fees and costs. In *Brethren Mut. Ins. Co. v. Suchoza*, 66 A.3d 1073 (Md. Ct. Spec. App. 2013), the insurer breached its policy with the employer by failing to pay UM benefits due to the employee. The trial court properly entered judgment on the jury verdict less the workers' compensation benefits actually received by the employee as of the date of trial. Under *Md. Code Ann., Ins. Law § 19-513*, the insurer was not entitled to have the judgment reduced by any future workers' compensation benefits that would be received by the employee. (*See* § 63.06[3].)

Pennsylvania law governed a choice of law dispute involving a Pennsylvania claimant who was injured in Kentucky. In *State Farm Mut. Auto. Ins. Co. v. Hodgkiss-Warrick*, 413 S.W.3d 875 (Ky. 2013), a Pennsylvania claimant was not entitled to UIM coverage because her policy disallowed coverage when she was injured in an underinsured vehicle owned or regularly used by a "resident relative." Although Kentucky did not prohibit the regular use exclusion, Kentucky law did not override Pennsylvania law. Pennsylvania law governed the dispute because the insured was a Pennsylvania resident, the policy was entered into in Pennsylvania, and the vehicle was registered, garaged, and used exclusively in Pennsylvania. The fortuitous fact that the accident occurred in Kentucky was far outweighed by the significant relationship Pennsylvania had with the parties and the insurance transaction. (*See* § 63.06[12][d].)

In Maine, if an underinsured vehicle policy applicable to multiple claimants contains a single per accident limit, the amount of UIM coverage available to each claimant must be calculated by deducting any payment received from the owner or operator of the underinsured motor vehicle from that single limit. In no event may the maximum amount payable by the insurer to all claimants exceed that limit. *24-A Me. Rev. Stat. Ann. § 2902*. (*See* § 63.16[2].)

In West Virginia, an implied private cause of action may exist for a violation by an insurer of the unfair settlement practice provisions of the West Virginia Unfair Trade Practices Act. *W. Va. Code § 33-11-4. Lemasters v. Nationwide Mut. Ins. Co.*, 751 S.E.2d 735, 740 (W. Va. 2013). (*See* § 63.18[1].)

Chapter 64, MEDICAL PAYMENTS COVERAGE—In Nevada, insurers must offer insureds the option of purchasing medical payment or "medpay" coverage. *Nev. Rev. Stat. § 687B.145*. In *Wingco v. Gov't Employees Ins. Co.,* 321 P.3d 855 (Nev. 2014), the court determined that the statute requires insurers to offer insureds the option of purchasing medical payment or "medpay" coverage in the amount of at least $1,000 but does not state that the insurer must obtain a written rejection of that coverage. (*See* § 64.04[1].)

Golchin v. Liberty Mut. Ins. Co., 466 Mass. 156 (2013) held that an insured could seek medical expense benefits under the medical payments coverage offered in the automobile insurance policy even though the medical expenses were covered by and paid under a separate policy of health insurance. (*See* § 64.04[2].)

The Colorado med-pay statute does not state whether an insurer may place time

limits on med- pay coverage. *Colo. Rev. Stat. § 10-4-635*. In *Countryman v. Farmers Ins. Exch.*, 2013 U.S. App. LEXIS 23187 (10th Cir. Nov. 18, 2013) (unpublished), the court upheld a policy provision limiting med-pay coverage to two years because it did not violate the statute. (*See* § 64.02[7][a].)

Chapter 65, UNINSURED AND UNDERINSURED MOTORIST INSURANCE—In *Wehrle v. Cincinnati Ins. Co.*, 719 F.3d 840 (7th Cir. 2013), applying IL law, the insureds were severely injured in an auto accident with a drunk-driver who had minimal insurance. They received $200,000 from the at-fault driver and $800,000 from their insurer, with whom they had a policy limit of $1 million. A provision designed to offer insurance to 'fill the gap' between the claim and the tortfeasor's insurance was obviously not intended to allow the insured to recover amounts from the insurer over and above the coverage provided by the UIM policy. (*See* § 65.01[1][a].)

The Montana Supreme Court in *Fisher v. State Farm Mut. Auto. Ins. Co.*, 305 P.3d 861 (Mont. 2013), held that a family member exclusion in an umbrella policy did not violate public policy. Permitting frequent family passengers to turn economical excess coverage into expensive liability coverage would be contrary to the umbrella policy's purpose and undermine its viability. (*See* § 65.04[1][a].)

In *Carter v. Std. Fire Ins. Co.*, 406 S.C. 609 (2013), the insured purchased UIM coverage on the vehicle involved in the accident. The South Carolina statute does not permit an insurer to exclude UIM coverage to a Class 1 insured when he was occupying a vehicle he owned but did not insure under the same policy. The exclusion in the insurer's policy purporting to limit a Class 1 insured's ability to stack UIM coverage when the vehicles insured under the policy were not involved in the accident was void. (*See* § 65.02[1].)

Mandatory arbitration is the sole available remedy to determine issues of coverage between insurers and the New York Motor Vehicle Accident Indemnification Corporation (MVAIC). In a framed hearing in *Mendoza v. Farmers Ins. Co.*, 979 N.Y.S.2d 570 (App. Div. 2014), the insurer included the affirmative defense of no coverage due to cancellation of the policy and yet did not appear, seek an adjournment to present the necessary documentation regarding the cancellation, or file a petition to vacate the arbitration award. The arbitrator decided the issue of the alleged cancellation of the insurance policy. The insurer, not MVAIC, was obligated to provide the plaintiff with coverage for the accident. (*See* § 65.01[7].)

In *Progressive Choice Ins. Co. v. California State Automobile Ass'n Inter-Insurance Bureau*, 160 Cal. Rptr. 3d 662 (Cal. App. Ct. 2013), although the passenger's policy's "other insurance" clause contained an excess coverage provision, the insurer could not rely on that provision because the policy covering the vehicle had a pro rata provision. The pro rata provision in the vehicle's policy took precedence over the excess coverage provision in the passenger's policy. Therefore, the UIM loss must be allocated on a pro rata basis between the passenger and vehicle's insurer. (*See* § 65.01[2][a].)

In *Countryway Ins. Co. v. United Fin. Cas. Co.*, 2014 Ky. App. LEXIS 12 (Ky. Ct. App. Jan. 24, 2014), the court noted that adopting a rule to place primary liability on the insurer of the vehicle would fundamentally change the dynamic of UM coverage. In the case of a passenger, UM coverage

would cease to be personal. The coverage selected, or not, by a third party would take precedence over that selected by the individual for his or her own benefit and protection. If two excess/other insurance UM provisions clash, the UM policy covering the injured person was deemed primary as a matter of public policy and judicial economy. In this case, the vehicle's policy provided coverage up to $50,000 per person and $100,000 per accident and the passenger's policy provided coverage up to $100,000 per person and $300,000 per accident. (*See* § 65.07[2].)

In *Tweten v. Country Preferred Ins. Co.*, 833 N.W.2d 435 (N.D. 2013), the term 'insured' was restricted solely to the minor son, who was killed in an underinsured motor vehicle accident, in which his divorced parents, each of whom had separate policies insuring the deceased son, were uninvolved and unharmed in the underlying automobile accident. The court prohibited stacking policies to determine the amount of coverage available where the term "insured" referred solely to the insureds' son. (*See* § 65.02[4].)

The court in *Belding v. Demoulin*, 843 N.W.2d 373 (Wis. 2014) applied the test set forth in Wis. Stat. § 632.32(5) that harmonized the drive other vehicle exclusion with the prohibition on anti-stacking clauses in Wis. Stat. § 632.32(6). The insurer could not use the drive-other-car exclusion in the insureds' policy to prevent them from stacking the UM coverage of up to three vehicles owned and insured by them. The insured had two separate policies with the defendant insurer for which they paid separate premiums and had separate UM/UIM coverage. The insured sought to collect UM coverage under both policies, one of which had a drive other vehicle exclusion. Thus, the anti-stacking provisions barred the drive-other-vehicle exclusion. (*See* § 65.07[2].)

Chapter 66, NO-FAULT INSURANCE—To satisfy the serious injury threshold in New York, a gap in treatment may be explained by termination of health or no-fault benefits. In *Ramkumar v. Grand Style Transp. Enters. Inc.,* 22 N.Y.3d 905 (2013), the plaintiff came forward with the bare minimum required to raise an issue regarding "some reasonable explanation" for the cessation of physical therapy based on evidence that the plaintiff's no-fault insurer terminated his benefits and that he did not have medical insurance to pay for further treatment. The plaintiff claimed he sustained knee and back injuries in a livery car accident. The plaintiff explained the gap in treatment by testifying that his no-fault insurer cut him off, and that he did not have medical insurance at the time of the accident. In *Trezza v. Metropolitan Transp. Auth.*, 978 N.Y.S.2d 40 (App. Div. 2014), the plaintiff sufficiently explained the gap in treatment for her spine by testifying that her medical insurance did not cover physical therapy and that she could not afford to pay for it out of pocket. (*See* § 66.03[3][c][v].)

Challenges to the 2012 amendment to the Florida no-fault statute excluding massage and acupuncture services have been unsuccessful. In *McCarty v. Myers*, 125 So. 3d 333 (Fla. Dist. Ct. App. 2013), the appellate court reversed a non-final order temporarily enjoining the Insurance Commissioner from enforcing certain portions 2012 of the no-fault statute limiting medical benefits for non-emergency injuries and excluding acupuncture and massage benefits. The health care providers, including acupuncturists, lacked standing to assert this claim. The real parties in interest—injured motorists whose ability to sue tortfeasors has been impermissibly limited—were absent from this case. (*See* § 66.04[1][b][v].)

A 2013 amendment to the Florida statute, *Fla. Stat. Ann. § 627.736(6)(g)*, requires that insureds seeking no-fault benefits submit to an examination under oath. In *Nunez v. Geico Gen. Ins. Co.*, 117 So. 3d 388 (Fla. 2013), involving an accident that occurred before the amendment of the 2013 Florida statute, the court decided that the insurer could not require an insured to attend an examination under oath as a condition precedent to recovery of personal injury protection benefits. (*See* § 66.07[2][c].)

In response to the decision in an earlier court decision, *Fair Price Med. Supply Corp. v. Travelers Indem. Co.*, 837 N.Y.S.2d 350, 355 (App. Div. 2007), the 2013 amendment to the New York insurance regulations closed the apparent loophole that requires insurers to pay for non-rendered medical services simply because of technical errors made by those insurers during the claims process. *11 N.Y. Comp. Codes R. & Regs. § 65-3.8(h)* provides that "an insurer's non-substantive technical or immaterial defect or omission shall not affect the validity of a denial of claim." The 2013 amendment also prevents health care providers from ignoring requests for verification concerning the medical necessity of treatment by setting a 120-day deadline to provide such requested information. *11 N.Y. Comp. Codes R. & Regs. § 65-3.5.* (*See* § 66.08[1].)

Chapter 67, BUSINESS-OWNED VEHICLES INSURANCE—The test for determining whether the business owned policy provided coverage is whether there is a causal connection between the use of the automobile and the accident. In *Integon Nat'l Ins. Co. v. Helping Hands Specialized Transport*, 2014 N.C. App. LEXIS 408, use of the the insured handicapped accessible van included moving the claimant into her residence as a part of the transport service. (*See* § 67.01[3][a].)

N.J. Stat. Ann. § 17:28-1.1(f) prohibits the use of step-down provisions in an employer's commercial motor vehicle liability policy to provide less UM/UIM coverage for employees than that which is provided to the "named insureds" on the policy. In *James v. New Jersey Mfrs. Ins. Co.*, 216 N.J. 552 (2014), because the claimant's accident preceded the effective date of the statute, his claims were governed by the provisions of the policy that were in existence as of the date of his accident. (*See* § 67.03[8].)

In *Luizzi v. Pro Transp., Inc.*, 2013 U.S. Dist. LEXIS 107566 (E.D.N.Y.), for purposes of Symbol 8 coverage, the claimant was an independent contractor, rather than an "employee" of the trucking company. The lease agreement alone, which gave the trucking company the right to exercise exclusive control, was sufficient to bring the vehicle within the "hired auto" provision of the policy, even though the parties to the lease agreement never chose to enforce that right. (*See* § 67.02[4][i].)

Chapter 68, GARAGE OWNERS' INSURANCE—In *Safeco Ins. Co. v. Federated Mut. Ins. Co.*, 2014 U.S. Dist. LEXIS 51828 (D. Or.), the dealer and the customer entered into a contract for the sale of the vehicle. The customer took possession of the vehicle and performed all then-due obligations under the contract. The dealer's bid to repossess the vehicle in the event of the customer's inability to obtain financing did not override all other considerations in interpreting what the parties to the garage policy intended. (*See* § 68.03[1][c][i].)

In *Automax Hyundai South, L.L.C. v. Zurich Am. Ins. Co.*, 720 F.3d 798, 802 (10th Cir. 2013), applying OK law, the court ruled that negligent failure to detect damage in a car constituted an accident.

Thus, the allegation of undisclosed damage triggered the insurers' duty to defend. (*See* § 68.03[1][a][ii][B].)

In *Pietrangelo v S & E Customize it Auto Corp.*, 972 N.Y.S.2d 146 (Civ. Ct. 2013) (unpublished), the plaintiff brought her vehicle to the defendant auto repair shop before Super Storm Sandy. The plaintiff alleged that the defendant indicated that if any damage claim was not covered by plaintiff's insurer, he would make good on it. The plaintiff's insurer declared the vehicle a total loss at $22,156.12 but paid the claimant $1,000 less because of the plaintiff's deductible. The defendant repair shop's failure to have casualty or flood insurance was not negligence. (*See* § 68.03[3][a][iii][C].)

Chapter 69, TRUCKERS' AND MOTOR CARRIERS' COMMERCIAL VEHICLE INSURANCE—In 2005, Congress enacted the Unified Carrier Registration Act, *49 U.S.C. § 13908*. It established an online federal registration system and replaced the single state registration system. Many jurisdictions, including Colorado, *Colo. Rev. Stat. § 40-10.5-102*, Georgia, *Ga. Code § 40-1-8*, Nebraska, *Neb. Rev. Stat. § 75-393*, and Wisconsin, *Wis. Stat. § 194.41*, have adopted the unified carrier registration system. (*See* § 69.01[7][a].)

In *Casey v. Smith*, 2014 WI 20, the court noted that not all repairs and maintenance to a leased semi-tractor furthered the commercial interest of the lessee. Repairs are in furtherance of a lessee's commercial interests when they are necessary to allow the semi-tractor to continue to accept and complete hauls for the lessee. Repairs to the grille and oil filler tube were not required to comply with the federal regulations. There was no evidence in the record that indicated that the repairs were necessary to comply with federal regulations. There was also no support for the argument that the repairs were necessary to fulfill contractual duties because the repairs were not required by the lease agreement, were not done pursuant to orders by Taylor Truck Line, and were not necessary for the semi-tractor to continue its service. The court concluded that the defendant driver was not acting in furtherance of Taylor Truck Line's commercial interest at the time of the accident. (*See* § 69.02[1][d][ii].)

In Kentucky, a motor carrier transportation contract that purports to indemnify, defend, or hold the promisee harmless for acts or resulting intentional acts or omissions of the promisee violates public policy and is void and unenforceable. *2014 Ky. Acts 43; 2014 Ky. Ch. 43; 2014 Ky. SB 59.* (*See* § 69.02[8][a].)

In *Smith v. Shelter Mut. Ins. Co.*, 2013 Okla. Civ. App. LEXIS 139 (Okla. Civ. App. 2013), a case in which the decedent's vehicle collided with a dump truck, the court rejected the argument that the truck was subject to the Motor Carrier Act (MCA) 47 Okla. Stat. § 230.21. Thus, the minimum limit of liability insurance coverage of the financial responsibility law, 47 Okla. Stat. § 7-324, rather than the higher amount set forth in the MCA applied. (*See* § 69.01[2][d].)

Chapter 71, INTRODUCTION AND GENERAL PRINCIPLES OF REINSURANCE LAW—In *DeMarco v. Keefe Real Estate, Inc.*, 842 N.W.2d 536 (Wis. Ct. App. 2013), where one carrier assumed 100% of in-force, new and renewal policies of an insolvent company, the agreement between those companies was not a reinsurance agreement, but an assumption agreement involving assumption of direct liability. (*See* new § 71.02[5][d].)

Chapter 72, THE REINSURANCE

CONTRACT—In *NationMotor Club, Inc. v. Stonebridge Cas. Ins. Co.*, 2013 U.S. Dist. LEXIS 180496 (S.D. Fla. Oct. 29, 2013), a cover note was a contract between a broker and an insured made as assurance that insurance has been placed on behalf of the insured. Where a Lloyd's underwriting syndicate did not sign the [note, agree to commit coverage, or issue a reinsurance policy, the court refused to hold it liable for reinsurance proceeds under a "novel theory of agency law." (*See* § 72.01[3][c].)

Chapter 73, DUTIES OF THE CEDENT—In *Ins. Co. of the Pa. v. Argonaut Ins. Co.*, 2013 U.S. Dist. LEXIS 110597 (S.D.N.Y. Aug. 6, 2013), a carrier issued a comprehensive general liability policy,the appellant issued an excess policy and obtained reinsurance from the appellee. The primary carrier brought a declaratory judgment action against its insured and the insured filed a cross-claim against the appellant. The appellant's obligation to notify the reinsurer arose, at the latest, when the insured asserted that cross-claim. Because the appellant did not provide the reinsurer with notice until just over seven years later, it breached its contractual notice obligation. (*See* § 73.02[1].)

Chapter 77, REINSURANCE DISPUTE RESOLUTION—In *Republic Ins. Co. v. Banco De Seguros Del Estado*, 2013 U.S. Dist. LEXIS 110842 (N.D. Ill. July 26, 2013), the court noted the location of the risks being insured is not particularly relevant to the choice-of-law determination for a reinsurance contract, and even less so for a retrocession. (*See* § 77.03[4][c].)

In *Savers Prop. & Cas. Ins. Co. v. Nat'l Union Fire Ins. Co.*, 748 F.3d 708 (6th Cir. 2014), a general choice-of-law provision and arbitration clause of a reinsurance agreement provided any arbitration would be subject to the laws of Michigan. The court agreed that Michigan law governed its review of a preliminary injunction that halted an ongoing arbitration proceeding, but noted that the Michigan Arbitration Act and a related court rule were almost identical to the FAA and, therefore, the choice-of-law determination bore little impact on the analysis or disposition of the case. The court said that, given the similarities between federal and state law, it would generally apply cases interpreting the FAA, but would consider specific application of Michigan law where the relevant provisions differed in substance. (*See* § 77.04[3][f][i].)

Chapter 82, STATE OR FEDERAL REGULATION--ERISA AND PREEMPTION—In *Liberty Mut. Ins. Co. v. Donegan*, 746 F.3d 497 (2d Cir. 2014), the reporting requirements of Vt. Stat. Ann. tit. 18, § 9410 and its implementing regulations had a connection with ERISA plans and thus were preempted as applied because reporting was a core ERISA function that was shielded from potentially inconsistent and burdensome state regulation. (*See* § 82.02[2][a][ii].)

In *America's Health Insurance Plans v. Hudgens*, 742 F.3d 1319 (11th Cir. 2014) (applying federal and Georgia law), state prompt-pay legislation related to benefit plans and was preempted under 29 U.S.C. § 1144(a) because self-funded plans would have different timeliness obligations in different states; it did not matter whether risk pooling was affected for purposes of ERISA's saving clause, § 1144(b)(2)(A), because the § 1144(b)(2)(B) deemer clause applied. (*See* § 82.02[2][a][iii].)

Chapter 83, OBTAINING LIFE INSURANCE COVERAGE: APPLICATION, REPRESENTATIONS AND WARRANTIES—In *Alfa Life Insurance Corp. v. Colza*, 2014 Ala. LEXIS 64, an

action arising when a decedent died after completing an application for a life insurance policy but before that policy was issued, a decision in favor of his widow was reversed, as the record unequivocally established that the decedent had not satisfied the terms and conditions set forth in a "conditional receipt" document. (*See* § 83.02[2].)

In *Cardenas v. United of Omaha Life Insurance Co.*, 731 F.3d 496 (5th Cir. 2013) (applying TX law), in which the plaintiff sought benefits from a life insurance policy taken out by her daughter, the policy had lapsed and was subsequently reinstated, and the daughter died 13 months after the reinstatement. As required by the Texas Insurance Code, the policy contained a provision that it would become incontestable if it remained in force "for two years from its date of issue during the lifetime of the insured." The appellate court affirmed the district court's finding that the reinstated policy never became incontestable because the insured died before the two-year period ran. (*See* § 83.09[10].)

Chapter 85, CAUSES OF LOSS—In *Farmers New World Life Insurance Co. v. Rees*, 161 Cal. Rptr. 3d 678 (Cal. Ct. App. 2013), when a life insurance beneficiary was being investigated for killing the insured, an interpleader action was an authorized method to determine to whom the proceeds were payable, and attorney fees were properly awarded under Code Civ. Proc. § 386. There was a reasonable probability of double vexation at the time the action was filed.(*See* § 85.03[1].)

In *Thomas v. United of Omaha Life Insurance Co.*, 2013 U.S. App. LEXIS 15465 (4th Cir. 2013), when the decedent died after his colon was unintentionally perforated during partial colonoscopy, the widow's claim for accidental death benefits under the insurance policy was properly denied under ERISA because the evidence supported the reasonable conclusion that he died as result of medical or surgical treatment for liver disease. (*See* § 85.04[2][c].)

Chapter 89, CHOICE OF LAW AFFECTING LIFE INSURANCE POLICIES—In *Karpenski v. American General Life Cos.*, LLC, 2014 U.S. Dist. LEXIS 46326 (W.D. Wash.) (applying Washington and Virginia law), the choice-of-law provision in the master policy, selecting Virginia law as the governing law, was valid and enforceable, and the insurers' prior failure to assert Virginia law was not an unequivocal act evidencing their intent to waive the contractual choice of Virginia law. (*See* § 89.01[2].)

Chapter 90, BAD FAITH IN THE CONTEXT OF LIFE INSURANCE—In *McNair v. State Farm Fire & Casualty Co.*, 2013 Ohio 5625 (Ct. App. 2013), it was error to grant summary judgment to an insurer on an insured's bad faith claim because genuine issues of material fact existed due to the insurer's failure to investigate adequately the claim for death benefits under a life insurance policy and its failure to follow its own procedures in such a situation. (*See* § 90.02[2][a][iii].)

In *Hood v. Jenkins*, 2013 Tenn. LEXIS 1009, an insurer did not breach its contractual duties by entrusting life insurance proceeds to the minor beneficiary's financial guardian because the insurer was entitled to rely on a juvenile court's facially valid order authorizing disbursement of proceeds and, prior to payment, the insurer acted in good faith by conducting an investigation into the adequacy of documentation of the order. (*See* § 90.02[2][c][ii][P].)

Chapter 91, ANNUITIES—In *Western Reserve Life Assurance Co. v. ADM Assocs.*, LLC, 737 F.3d 135 (1st Cir. 2013)

(applying RI law), because state law was so uncertain, the court certified two questions for the Rhode Island Supreme Court, including whether an annuity with a death benefit was infirm for want of an insurable interest and whether an incontestability provision precluded the maintenance of an action based on the lack of an insurable interest. (*See* § 91.01[2][b].)

Chapter 93, SERVICE LIFE INSURANCE—In *Hillman v. Maretta*, 133 S. Ct. 1943 (2013), the insured's widow was denied payment of the proceeds of a policy that was issued under the Federal Employees' Group Life Insurance Act (FEGLIA) because the insured did not change the form designing his beneficiary from his former spouse to the widow before he died. The widow was denied relief under Va. Code Ann. § 20-111.1(D) because that statute was preempted by FEGLIA. The Court stressed that, as with the Servicemen's Group Life Insurance Act of 1965 (SGLIA), FEGLIA created a scheme that gives highest priority to an insured's designated beneficiary and includes an "order of precedence" that is nearly identical to the one in the SGLIA. (*See* § 93.02[5][c].)

Chapter 94, DISABILITY INSURANCE—In *Heimeshoff v. Hartford Life & Accident Insurance Co.*, 134 S. Ct. 604 (2013), in which a plan participant sued her employer and a plan administrator, seeking review of a denied claim for disability benefits pursuant to 29 U.S.C. § 1132(a)(1)(B), the Court held that a limitations provision was enforceable when a participant and a plan were allowed to agree by contract to a particular limitations period, even one that started to run before the cause of action accrued, the three-year limitations period was not unreasonably short, and ERISA was not a controlling statute to the contrary. (*See* § 94.08[2][b].)

In *Gross v. Sun Life Assurance Co.*, 734 F.3d 1 (1st Cir. 2013), a plan administrator's rejection of an employee's claim for long-term disability benefits was subject to de novo review under ERISA as the language requiring proof of disability "satisfactory to us" did not confer the discretionary authority that triggered deferential review. (*See* § 94.08[3].)

Chapter 107, Bankruptcy and Insurance—The U.S. Supreme Court held that while Article III of the Constitution prohibits a bankruptcy court from entering final judgment on a bankruptcy-related claim, the relevant statute nevertheless permits a bankruptcy court to issue proposed findings of fact and conclusions of law to the district court for *de novo* review. The Court held that when a bankruptcy court is presented with a "*Stern*" claim—*i.e.* a claim designated for final adjudication in the bankruptcy court as a statutory matter, but not as a constitutional matter—the proper course is to issue proposed findings of fact and conclusions of law for *de novo* review and entry of judgment by a district court. Exec. Benefits Ins. Agency v. Arkison, 134 S. Ct. 2165, 189 L. Ed. 2d 83 (2014). (*See* § 107.01[6][c][i].)

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☐	53-107	53-107 thru 53-108.1
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