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I. DENIAL OF COVERAGE

A. Introduction

A denial of insurance coverage may have serious repercussions. The insured, left without defense or indemnity, may settle a claim or suit, or remedy a loss, as the insured deems appropriate. The insurer, by denying the claim, foregoes any right to object to the insured's resolution of the claim or loss (absent fraud or collusion). *Sanderson v. Ohio Edison Co.* (1994), 69 Ohio St.3d 582, 586. The insurer may be sued for compensatory and punitive damages. Therefore, striving to ensure that denials are appropriate is important.

This article proposes rules to follow in issuing denials of coverage and suggests how to structure a denial letter.

B. Rules For Denials Of Coverage

1. Construe Your Policy As A Court Would

When confronted with issues of contract interpretation, the insurer should seek to give effect to the intent of the parties to the agreement because a court will do so. *Hamilton Ins. Servs., Inc. v. Nationwide Ins. Cos.*, 86 Ohio St.3d 270, 273, 1999-Ohio-162; *Employers' Liab. Assur. Corp. v. Roehm* (1919), 99 Ohio St. 343, syllabus. The insurer should examine the insurance contract as a whole and presume that the intent of the parties is reflected in the language used in the policy. *Kelly v. Med. Life Ins. Co.* (1987), 31 Ohio St.3d 130, paragraph one of the syllabus. The insurer should look to the plain and ordinary meaning of the language used in the policy unless another meaning is clearly apparent from the policy. *Alexander v. Buckeye Pipeline Co.* (1978), 53 Ohio St.2d 241, paragraph two of the syllabus. Any ambiguity in an insurance contract is construed against the insurer and in favor of the insured. *King v. Nationwide Ins. Co.* (1988), 35 Ohio St.3d 208, syllabus. However, this rule should not be applied so as to provide an unreasonable interpretation of the words in the policy. *Morfoot v. Stake* (1963), 174 Ohio St. 506, paragraph one of the syllabus. Also, a claimant who is not a party to the contract of insurance is not in a position to urge that the contract be construed strictly against the insurer. *Cook v. Kozell* (1964), 176 Ohio St. 332, 336. This rings especially true where expanding coverage beyond a policyholder's needs will increase the policyholder's premiums. *Id.*

2. Be Cognizant That A Duty To Defend Arises When The Complaint Alleges A Claim That Could Be Covered By The Insurance Policy

When a complaint against an insured states both covered and non-covered claims, the insurance company is contractually obligated to defend both the covered and non-covered claims against the insured, regardless of the ultimate outcome of the action or the insurance company's ultimate liability to its insured. *Preferred Mut. Ins. Co. v. Thompson* (1986), 23 Ohio St.3d 78. The

duty to defend arises when the complaint alleges a claim that could be covered by the insurance policy. *Sharonville v. American Employers Ins. Co.*, 109 Ohio St.3d 186, 2006-Ohio-2180, at ¶13. "Where the insurer's duty to defend is not apparent from the pleadings in the action against the insured, but the allegations do state a claim which is potentially or arguably within the policy coverage, or there is some doubt as to whether a theory of recovery within the policy coverage has been pleaded, the insurer must accept defense of the claim." *Willoughby Hills v. Cincinnati Ins. Co.* (1984), 9 Ohio St.3d 177, 180. In reaching this holding, the Supreme Court of Ohio noted that the duty to defend could attach at some later stage in the litigation despite the fact that the pleadings did not conclusively establish the duty, and that "the 'scope of the allegations' may encompass matters well outside the four corners of the pleadings." *Id.* In *Motorists Mut. Ins. Co. v. Natl. Dairy Herd Improvement Assoc., Inc.* (2001), 141 Ohio App.3d 269, though, it is explained that "[t]he inquiry into the insurer's duty to defend must naturally begin with a close scrutinization of the allegations of the disputed complaint," and "where a court reviews a complaint and concludes beyond a doubt that there are not arguably covered claims encompassed therein it need not stretch the allegations beyond reason to impose an absolute duty upon the insurer * * * to provide a defense to the insured regardless of the cause of action stated in the complaint." *Id.* at 278-79, quoting *Leland Electrosystems, Inc. v. The Travelers Ins. Co.* (July 10, 1984), Montgomery App. No. 8580. "Even under the liberal notions of notice pleading it would be inherently unfair to require the insurer to provide a defense where the pleadings failed to notify, even arguably, that the insured is being sued on a claim covered by the policy." *Leland* at *5.

3. Conduct An Appropriate Investigation

"[I]t is the duty of an insurance company to assess claims after an appropriate and careful investigation, and its conclusions should be the result of the weighing of probabilities in a fair and honest way." *Pizzino v. Lightning Rod Mut. Ins. Co.* (1994), 93 Ohio App. 3d 246, 253-54. Only with a complete understanding of the facts of each claim can an insurance carrier make an accurate determination regarding coverage. A fair, thorough, and careful investigation will ensure that the insurance carrier has met its obligation of good faith,[1] satisfied Department of Insurance regulations, and not waived any potential legal rights.[2] Also, a good investigation may persuade even the insured or claimant that the claim has been fairly and correctly handled.

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[1] "An insurer fails to exercise good faith in the processing of a claim of its insured where its refusal to pay the claim is not predicated upon circumstances that furnish reasonable justification therefor." *Zoppo v. Homestead Ins. Co.* (1994), 71 Ohio St.3d 552, paragraph one of the syllabus.

[2] "[A]s a general proposition, the doctrine of waiver cannot be employed to expand the coverage of a policy." *Hybud Equip. Corp. v. Sphere Drake Ins. Co.*, 64 Ohio St.3d 657, 668; *16B Appleman, Insurance Law and Practice* (1981) 579, Section 9090. "This rule has been applied when coverage is expressly excluded under the terms of the policy." *Id.*, citing *Hartory v. State Auto. Mut. Ins. Co.* (1988), 50 Ohio App.3d 1." *Id.* Even so, the doctrines of waiver and estoppel have been invoked against insurers, especially with respect to policy conditions (*e.g.* notice or arbitration).

Although a violation of the Ohio Administrative Code ("OAC") does not create or imply a private cause of action,[3] insurers as a condition of doing business in the state of Ohio are expected to comply with the OAC, and a violation of the OAC may prompt an insured to file a complaint with the Department of Insurance or institute a civil suit alleging a breach of the insurer's duty of good faith. An insurer, therefore, always should seek to comply with OAC 3901-1-07, which defines certain unfair trade practices, and OAC 3901-1-54 which, "set[s] forth uniform minimum standards for the investigation and disposition of property and casualty claims," and "define[s] procedures and practices which constitute unfair claim practices." For example, the insurer should not knowingly misrepresent to an insured or claimant pertinent facts or policy provisions, or deny a claim on the grounds of a specific policy provision, condition, or exclusion without reference to such provision, condition, or exclusion. See OAC 3901-1-07(C)(1); OAC 3901-1-54(E)(2), (G)(2). The insurer should acknowledge pertinent communications from an insured or claimant within the time frames set forth in the OAC (generally fifteen days), and provide an unrepresented insured or claimant with advance notice of the expiration of any statute of limitation or contractual limit (sixty days before the expiration). See OAC 3901-1-07(C)(2), (12); OAC 3901-1-54(G)(1), (5).

C. Structure Of A Denial Of Coverage Letter

Of course, there is no one way to structure a denial letter. In general, however, most denial letters should include the following:

-- **The Pertinent Facts Or Allegations Of The Claim.** A statement of the most pertinent facts of the loss or allegations against the insured will place a denial of coverage in its proper context. The delineated facts or allegations should include those provided by the insured or claimant and any other pertinent facts or allegations that the insurer considers in reaching its coverage decision.

-- **The Most Relevant Policy Terms And, If The Insured Or Claimant Is Not Represented By Counsel, Advance Notice Of Any Statute Of Limitation Or Contractual Limitation Of Action.** The letter should confirm whether the policy at issue or any other insurance was in force when the loss or claim occurred, and state whether the company's policy or other insurance was in effect and applicable. The relevant language of any policies alleged to apply should be cited, typically beginning with the insuring agreements of any pertinent coverage parts and concluding with related parts of the policy in the same policy form or a separate form or endorsement, *e.g.*, "Covered Causes of Loss," "Limitations," "Who Is An Insured," "Exclusions," and "Conditions." If the recipient of the letter is not represented, the insurer should be given notice of any statute of limitation or contractual limitation of action.

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[3] See *Strack v. Westfield Cos.* (1986), 33 Ohio App.3d 336; OAC 3901-1-54(B)("Nothing in this rule shall be construed to create or imply a private cause of action for violation of this rule.")

-- **A Clear Explanation Of The Insurer's Coverage Position.** The letter should contain a section applying the relevant policy language to the pertinent facts or allegations. To the extent that any investigation forms the basis for the denial, the results of the investigation should be set forth. The insurer should explain the basis for denying coverage in as much detail as is necessary, the goal being clarity, not brevity.

-- **A Reservation Of The Right To Assert Other Policy Provisions And Coverage Defenses**. The letter should state that the denial of coverage is premised on the terms and conditions of the insurance policy and the facts currently known. The insurer should reserve its rights under the insurance policy and applicable law to rely upon or enforce additional applicable policy provisions as may be appropriate. The insurer may even wish to incorporate into the denial letter the entirety of the policy as if fully rewritten; doing so may facilitate advancing coverage defenses in the future.

-- **An Invitation To Respond.** It is important to solicit in the denial letter a response from the party seeking coverage. By asking for a response, the insurer demonstrates its willingness to consider pertinent information and even change its position, if warranted. Moreover, if the party claiming coverage fails to respond, he or she may have difficulty explaining in any later suit the failure to provide any additional information. Indeed, the lack of such a response may help the insurer defeat any claim that it acted inappropriately.

-- **Carefully Review The Final Work Product.** A denial letter may be attached to a lawsuit filed against the insurer or blown up as an exhibit at trial. Thus, the letter should be well written and, to the extent possible, error free. Many insurers require one or more supervisory personnel to review a denial letter before it is issued. Even in the absence of such a policy or procedure, it is helpful to have more than one set of eyes scrutinize the letter.

Of course, an insurer cannot prevent someone from filing suit following a denial of coverage. If the insurer follows the foregoing proposals and suggestions, however, the insurer should improve its prospects of prevailing in any suit.

II. SUPREME COURT OF OHIO

A. Intentional Act Exclusions Are Declared Inapplicable To A Judgment Against Insureds Whose Negligence Is Found To Have Caused A Separate Injury To Persons Injured As A Result Of Another Insured's Intentional Or Illegal Act.

Safeco Ins. Co. of Am. v. White, 2009-Ohio-3718. The Whites' minor son attacked and stabbed a thirteen-year-old female jogger. The son pled guilty to attempted murder and felonious

assault. The jogger and her parents then brought a civil suit against the son and his parents. The son was sued for an intentional tort and his parents for negligent supervision, negligent entrustment, and negligent infliction of emotional distress. A jury verdict was returned against both him and his parents; he was found 30% responsible and his parents were found 70% responsible. The Whites were insured by Federal under a homeowners policy, by Pacific under an umbrella policy, and by Safeco under a homeowners policy and umbrella policy. Federal and Pacific paid the judgment against the parents and sought reimbursement from Safeco for its share of the judgment against the parents. Both Safeco polices required an "occurrence" and contained exclusions for an intentional or illegal act of "an insured" or "any insured." Safeco argued that there was no "occurrence" and that the exclusions precluded any coverage for any damages arising from the son's intentional or illegal act. Federal and Pacific maintained that coverage was not excluded for the negligence claims made against the parents, particularly in light of the policies' separation of insureds clause. The Supreme Court held that because the parents were only negligent, there was an "occurrence." The court declined to consider whether the exclusions were ambiguous. The court simply found that the exclusions were not applicable because the jury found that the parents' negligent acts caused a separate injury -- the Whites and their son were found to be separately liable.

B. An Order That Declares That A Person Is Entitled To Uninsured Motorists Coverage But Does Not Decide Damages Is Not A Final And Appealable Order.

Walburn v. Dunlap, 121 Ohio St.3d 373, 2009-Ohio-1221. The plaintiff, Stryk Walburn, was involved in a motor vehicle accident while in the course of employment. He sued the uninsured motorist whose negligence allegedly caused the accident, as well as his own automobile liability insurer and his employer's automobile liability insurer. He sought uninsured motorists coverage from his own insurer and his employer's liability insurer. The trial court rendered a partial summary judgment in favor of the plaintiff, finding that the employer's insurer owed him uninsured motorists coverage. Damages were not determined, but the trial court's judgment entry stated that the order was final and appealable, and that there was no just cause for delay.

An appellate court must engage in a two-step analysis in determining whether a judgment is final: first, it must determine if the order is final within the requirements of R.C. 2505.02. If the court finds that the order complies with R.C. 2505.02 and is in fact final, then the court must take the second step to decide if Civ.R. 54(B) language is required. In *Walburn*, the court of appeals found that the trial court's order was final under R.C. 2505.02(B)(2) because it was a declaratory judgment that decided insurance coverage. The appellate court further decided that the order became final and appealable because the trial court had added a Civ.R. 54(B) certification. R.C. 2505.02(B)(2) provides, "An order is a final order * * * when it is * * * [a]n order that affects a substantial right made in a special proceeding."

The Supreme Court reversed the court of appeals decision. The court agreed that a declaratory judgment is a special proceeding for purposes of R.C. 2505.02(B)(2), but found that a declaratory judgment that declares the insured is entitled to uninsured motorists coverage, but does

not determine whether the insured is entitled to damages, does not affect a substantial right. The court distinguished a declaration that an insured is entitled to uninsured motorists coverage from a declaration that an insured is entitled to liability coverage (defense and indemnity). The court explained that a decision regarding the duty to defend immediately affects a substantial right of the insurer or insured: the insurer may incur substantial costs if wrongfully required to defend an insured in a case that a court of appeals may later hold was not within the terms of the policy; or an insured, when not provided a defense, may have to choose a quick settlement over costly litigation, file a separate declaratory judgment action against the insurer, or incur great expense defending without insurance. However, a decision that an insured is entitled to uninsured motorists coverage, without a determination of damages, does not affect a substantial right of the insurer or insured.

III. OHIO COURTS OF APPEAL

A. Policy Language, Endorsements, And Exclusions

1. A Multi-Car Chain Reaction Automobile Accident Is A Single "Accident" For Purposes Of Auto Liability Coverage.

Dutch Maid Logistics, Inc. v. Acuity, Cuyahoga App. Nos. 91932, 92002, 2009-Ohio-1783. Dutch Maid was insured for auto liability coverage by Acuity. One of Dutch Maid's employees caused a multi-car accident which resulted in five claims. The issue presented was whether there was a single "accident" or multiple "accidents" so as to trigger the Acuity policy limits more than once. The court found that "the term 'accident' includes the unambiguous phrase 'continuous or repeated exposure to the same conditions' when referring to multiple parties involved in the same continuous course of events." The court therefore found that Acuity's coverage limits were triggered only once, because "there was but one continuous accident that caused all the bodily injury claims that flowed from it."

2. Attorney Fees Awarded As A Result Of A Punitive Damage Award Are Covered Under An Insurance Policy That Excludes Coverage For Punitive Damages.

Neal-Pettit v. Lahman, Cuyahoga App. No. 91551, 2008-Ohio-6653, appeal granted, 2009-Ohio-2511. Allstate's insured was found liable and punitive damages and attorney fees were awarded. The plaintiff filed a supplemental complaint against Allstate seeking both the compensatory damage award and the attorney fee award. The Allstate policy excluded coverage for "any punitive or exemplary damages, fines or penalties." The court found that attorney fees awarded with punitive damages are undeniably punitive in nature. It further concluded that attorney fees are conceptually distinct from punitive damages and "may be awarded as an element of compensatory damages where the jury finds that punitive damages are warranted." Because the Allstate policy did not "exclude the payment of attorney fees awarded in conjunction with the punitive damage award," the court

found coverage. The court further ruled that such coverage did not violate Ohio public policy or statutory language prohibiting insurance for punitive damages. This case is on appeal to the Supreme Court of Ohio.

3. Unsolicited Facsimile Transmissions May Be Covered Under The Advertising Injury Coverage Of A Comprehensive General Liability Policy.

Motorists Mut. Ins. Co. v. Dandy Jim, Cuyahoga App. No. 92023, 2009-Ohio-2270. Dandy Jim was insured under a CGL Policy issued by Motorists Mutual Insurance Company and sought defense and indemnity for a suit alleging violations of the Federal Telephone Consumer Protection Act due to the transmission of unsolicited facsimile advertisements. Motorists provided a defense to Dandy Jim subject to a reservation of rights, but simultaneously filed a declaratory judgment action on the issue of coverage.

Motorists first argued that the unsolicited facsimiles were not covered as an advertising injury because such coverage was limited to publication which violates a third party's right to "privacy," *i.e.*, secrecy of personal information, rather than a right to "seclusion" for unwanted disturbances. The court disagreed, because "the plain and ordinary meaning of 'privacy' also refers to 'freedom from unauthorized intrusion.'" Motorists next argued that in order to trigger "advertising injury" liability coverage, the content of the facsimile itself must be offensive. The court disagreed, finding that "all advertising, so long as it is unsolicited, is an offensive intrusion into the recipient's solitude." Motorists further argued that coverage was not afforded because there was no "publication" of defamatory information to third parties. The court again disagreed, holding that "there is nothing in the Motorists policy that suggests that 'publication' means communicating the offending material to a third party." Rather, the ordinary meaning of "publication" included Dandy Jim "publishing" the advertisements by communicating information to the public and distributing copies of the advertisements. The court accordingly found coverage. Finally, the court found that the statutorily imposed treble damages are not intended to be "punitive" and therefore also may be covered.

B. UM/UIM

1. Trial Court Erred In Denying Prejudgment Interest On An Underinsured Motorist Claim.

Burke v. Auto-Owners Ins. Co., Stark App. No. 2008-CA-00258, 2009-Ohio-429. The plaintiff appealed the trial court's denial of prejudgment interest ("PJI") after the plaintiff prevailed on an underinsured motorist claim. The appellate court reversed, finding that the trial court erroneously applied R.C. 1343.03(C), the good faith effort to settle test, in determining whether plaintiff was entitled to PJI. The court found that the trial court was required to award PJI as a matter of law pursuant to R.C. 1343.03(A), although it had discretion to determine the date from which PJI should be calculated.

2. Insured Provides Corroborative Evidence To Support Uninsured Motorist Claim Under Policy.

Mosley v. Personal Serv. Ins. Co., Pike App. No. 08CA779, 2009-Ohio-419. Mosley sought uninsured motorist coverage under her Personal Service policy. She alleged that as she entered a sharp curve, she encountered a van traveling in the opposite direction on her side of the roadway. She drove off the road to avoid a collision. Mosley was unable to identify the driver of the other vehicle. In addition to her testimony regarding the incident, Mosley offered testimony from two firefighters who said that sometime after the accident, a van drove through the accident scene at a high rate of speed and nearly struck several firefighters who were directing traffic. The description of the van was similar to Mosley's. The court held that the firefighters' testimony was not speculative – it was evidence and, if believed, established that a van closely resembling the one that Mosley described was driving erratically in the area of the accident within a reasonable time afterward. The court held this evidence was enough to preclude summary judgment to Personal Service under the corroborative evidence rule.

3. An Excess/Umbrella Policy Does Not Provide UM/UIM Coverage By Providing Follow-Form Coverage.

Blake v. Thornton, Cuyahoga App. No. 91938, 2009-Ohio-2487. A vehicle operated by the assisted living facility in which the plaintiffs resided was involved in an accident caused by third-party tortfeasor Thornton. Several plaintiffs were injured, and several subsequently died. The claims against Thornton were resolved by payment of his insurance policy limits.

The assisted care facility had a primary business auto policy issued by Progressive and an excess auto liability policy issued by National Union. There was no dispute that the primary Progressive business auto policy provided UM/UIM coverage and that the plaintiffs qualified as insureds under that coverage. Accordingly, Progressive tendered its UM/UIM limits to the plaintiffs. The plaintiffs then sought additional coverage under the excess policy issued by National Union. The plaintiffs claimed that UM/UIM coverage was afforded by the terms of the "Automobile Liability Follow-Form Endorsement" in the National Union excess policy because it incorporated the coverages afforded by the underlying Progressive auto policy, including the UM/UIM coverage. The court disagreed, holding that: 1) the endorsement was a policy exclusion that could not create coverage which was not afforded by the general insuring language (which was limited to third-party liability coverage); and 2) the exception to that exclusion providing follow-form auto liability coverage did not apply to UM/UIM coverage.

C. Bad Faith

1. *Res Judicata* Does Not Bar A Bad Faith Claim After The Insured Litigates A UIM Claim With That Insurer.

Geiger v. Westfield Natl. Ins. Co., Hamilton App. No. C-080355, 2008-Ohio-6904. Geiger sued Westfield National Insurance for UIM coverage. The suit was resolved in binding arbitration; the parties signed a satisfaction of arbitration award and dismissed the case with prejudice. Geiger then filed a bad faith claim against Westfield related to the processing of Geiger's claims. The court held that *res judicata* did not bar this subsequent action against Westfield because the lawsuits did not involve the same facts. The first suit involved existence of a policy, the extent of the tortfeasor's liability, the amount of damage to Geiger, and the amount of damage in excess of the tortfeasor's policy. In contrast, the second lawsuit involved Westfield's actions in processing the claim, which is distinguishable from Westfield's contractual liability and the tortfeasor's negligence. Thus, *res judicata* does not bar the bad faith claim.

2. No Third Party Bad Faith Claim Exists Against Tortfeasor Insurer.

Schneider v. Eady, Lorain App. Nos. 07CA009273, 07CA009305, 2008-Ohio-6747. Eady negligently drove her car into Schneider's car, injuring Schneider. Eady was insured by Allstate, which refused to negotiate with Schneider. Schneider obtained a judgment against Eady, and sued Allstate for bad faith. Schneider argued that she was an intended beneficiary of the insurance policy and had standing to sue Allstate for breaching its duty of good faith, because Ohio's financial responsibility law mandated that Eady maintain insurance coverage to protect injured third parties. The court disagreed, and held that Allstate's duty of good faith runs only from the insurer to the insured, not to third parties, because the policy of insurance was intended to benefit Eady by protecting her from liability, not to protect injured third parties. Accordingly, Schneider had no cause of action for bad faith against Allstate, because Allstate had no duty to her.

D. Subrogation, Liens, And Med Pay Coverage

1. Auto Insurers May Permissibly Prohibit Duplication Of Benefits Between Medical Payments Coverage And UM/UIM Coverage.

Shenyey v. Glasgow, Cuyahoga App. No. 91713, 2009-Ohio-1366. Shenyey was insured by State Farm and was in an auto accident caused by an uninsured motorist. He submitted $14,000 in medical expenses for payment under the medical payment coverage portion of his policy, and then submitted the same $14,000 in medical expenses under the UM coverage of the policy. State Farm refused to pay the second sum based on the non-duplication clause in its policy. The court found the non-duplication clause to be unambiguous and permissible under R.C. 3937.18, as amended by S.B.

97 (effective 10/31/01). The court distinguished prior case law holding to the contrary, because that case law was decided prior to the S.B. 97 amendments to R.C. 3937.18.

2. An Insurer Is Entitled To Reimbursement Of Medical Payments Made After Plaintiff Settles With Tortfeasor.

Allen v. Binckett, Muskingum App. No. CT2008-0027, 2009-Ohio-2969. The plaintiffs filed suit against the tortfeasor and the personal UIM carrier, State Farm, for injuries arising out of an automobile accident. State Farm filed a cross-claim against the tortfeasor to recover the amounts paid under the med pay coverage of the plaintiffs' policy. State Farm also insured the tortfeasor under a separate policy. The plaintiffs settled with the tortfeasor for less than the tortfeasor's liability limits. The trial court determined that State Farm had a valid subrogation/reimbursement claim. The court determined that there was no conflict of interest because State Farm did not represent the plaintiffs and was made a party when they were named as a defendant in the lawsuit, and to hold otherwise "would give Appellants [the plaintiffs] the power to disregard the terms of the insurance contract without any action on the part of State Farm." Therefore, the plaintiffs had a duty to reimburse State Farm for medical payments made under the policy. The court also rejected the plaintiffs' argument that State Farm was not entitled to reimbursement under the "make whole" doctrine, ruling that "[b]y settling their case for less than [the policy] limits, there was some evidence tending to provide that [the plaintiffs] were fully compensated for their injuries."

3. An Insurer Does Not Owe Medical Payments Coverage When The Insured Has Already Settled With And Been Fully Compensated By The Tortfeasor.

Snider v. Nationwide Assur. Co., Belmont App. No. 07-BE-35, 2009-Ohio-1026. Nationwide Assurance Company insured Snider, who was injured in an auto accident. Snider sought medical payments coverage from Nationwide. Without Nationwide's consent, Snider settled with the tortfeasor. Snider then sued Nationwide for medical payments coverage. The court held that Snider could not recover medical payments coverage under the Nationwide auto policy because Snider already received full compensation in the settlement with the tortfeasor. Further, under the Nationwide policy Snider would have to repay the medical payment coverage amount back to Nationwide in any event, because Snider's damages were already compensated by the tortfeasor.

4. The BWC Is Entitled To Recover The Full Amount Of Subrogated Lien Where There Was No Notice Of A Settlement With The Tortfeasor.

Ohio v. Williams, 180 Ohio App.3d 239, 2008-Ohio-6685. Without notice to the Ohio Bureau of Workers Compensation, an injured worker settled with the tortfeasor's insurer, Motorists Mutual. The BWC filed suit against the injured worker and Motorists to recover the amounts paid to the worker. The tenth appellate district affirmed the trial court's granting of summary judgment in favor of the BWC. Pursuant to R.C. 4123.931, Motorists and the worker were jointly and severally liable for the BWC's full subrogated lien (including prior medical expenses and wages, as well as future payments) because notice was not given to the BWC prior to settlement.

5. A Subrogated Insurer Is Not A Necessary Party To An Action Against The Tortfeasor Where The Insurer Has Agreed To Mandatory Intercompany Arbitration With The Tortfeasor's Insurer.

Campana v. Alexander, Mahoning App. No. 07-MA-208, 2009-Ohio-3351. The tortfeasor was insured by Nationwide. The injured party sued the tortfeasor and his own insurer, Grange, "so that Grange could assert subrogation claims related to the medical payments it had made." Grange moved to be dismissed because it was already pursuing its subrogation claim through arbitration with Nationwide, based on an intercompany arbitration agreement. The court held that while an insurance company should generally be joined as a party to litigation when that insurance company has a subrogation claim, an insurance company may waive or forfeit its subrogation rights. The court found that Grange had done so by agreeing to intercompany arbitration, and therefore dismissal of Grange was proper.

E. <u>Reservation Of Rights</u>

1. An Insurer Defending Under A Reservation Of Rights Preserves Its Coverage Defenses.

Efficient Lighting Sales Co. v. Neverman, Cuyahoga App. Nos. 91093, 91122, 2009-Ohio-627. Efficient Lighting Sales acquired two subsidiaries: URI and ITT. Efficient was insured by Motorists. Motorists issued an endorsement adding URI and ITT as additional insureds, "but only with respect to liability arising out of your operations or premises owned by or rented to you." Numerous suits were filed against URI, and Motorists defended the suits under a reservation of rights. After investigating the suits, Motorists denied coverage because the endorsement only covered URI for liability stemming from Efficient's operations, operations not at issue in the suits. Efficient and URI sued Motorists for coverage. They did not claim that URI was covered, but rather asserted that Motorists had waived its right to deny coverage by providing URI with a defense. The court disagreed, holding that Motorists' reservation of right letters preserved Motorists' right to deny

coverage, even while providing a defense. The court further held that identifying Efficient as the named insured under the Motorists policy did not expand coverage to its subsidiaries.

F. Insurance Fraud

1. Convictions For Arson And Insurance Fraud Based On A Plea Of No Contest Are Inadmissible In A Subsequent Action For Insurance Coverage.

Elevators Mut. Ins. Co. v. J. Patrick O'Flaherty's, Inc., 180 Ohio App.3d 315, 2008-Ohio-6946, appeal granted, 2009-Ohio-2045. Heyman owned J. Patrick O'Flaherty's, which had fire insurance issued by Elevators Mutual Insurance. Heyman was found guilty of arson and insurance fraud in connection with a fire at the property. Elevators then sought a declaratory judgment that there could be no coverage for damage caused by the fire. Heyman and J. Patrick O'Flaherty's counterclaimed, seeking coverage. The trial court found Heyman's convictions admissible even though his pleas of no contest were not admissible, and entered summary judgment in favor of Elevators based on the intentional and criminal acts exclusions in its policy. The sixth appellate district reversed, holding that a conviction on a plea of no contest is admissible only where made expressly relevant by statute. Here, because no statute made Heyman's convictions admissible, the court reversed the entry of summary judgment in favor of Elevators. This case has been accepted for further review by the Supreme Court of Ohio. (Gallagher Sharp represents one of the appellants seeking reversal.)

G. Insurance Agent Liability

1. In An Action Against The Agent, The Insureds' Failure To Read The Insurance Policy May Constitute Comparative Negligence.

Britton v. Gibbs & Assoc., Highland App. No. 08CA9, 2009-Ohio-3943. Britton and her sister purchased insurance from Gibbs & Associates to cover a mobile home that was to be moved and then installed on property that they owned. Gibbs advised Britton that she did not need additional coverage related to the move. Britton moved but had not completed installation of the mobile home when it was destroyed in a fire caused by a lighting strike. Progressive denied the claim, citing the policy's "in transit" exclusion. Britton sued the agent and Progressive for negligent misrepresentation. Progressive was dismissed on a directed verdict, and the jury awarded damages against Gibbs.

The insureds testified that they did not read the policy. Gibbs argued that they were unable to establish justifiable reliance upon Gibbs' representations because "Ohio law imposes a duty on the customer to examine the coverage provided by their insurance policy." The court held that an insured's failure to read his or her policy is a matter of comparative negligence to be decided by the jury.