Gallagher Sharp LLP

Insurance Newsletter

June 2017

Special Interest Areas:

Individual Highlights:

Anatomy of a Claim – Notice to Suit

This article is the first of a Gallagher Sharp's "Anatomy of a Claim" series, and will provide an overview of the initial steps in claim handling, from first notice to suit. This article will focus on coverage as well as applicable Ohio case law and code provisions. Subsequent articles will take us from suit through any appeal.

Typically, the first notice of an accident or occurrence is provided to an insurance broker, but may also come straight from an insured through a company hotline, web portal, or more recently, Smartphone app. In Ohio, the broker may be deemed an agent of the insurance company for receipt of the insured's notice. *Damon's Missouri, Inc. v. Davis*, 63 Ohio St. 3d 605, 609, 590 N.E.2d 254 (1992) ("An insurance broker (or independent insurance agent) becomes an agent for a particular insurer when: (1) the broker notifies its customer, the potential insured, that he or she intends to place the customer's insurance coverage with a particular insurer; or (2) the broker accepts an application for insurance on behalf of the customer. (R.C. 3929.27, construed.)"). Initially, the insurance company may have very little information available to determine whether coverage is triggered, who may be liable, and the extent of damages. For example, at this time you may know only that there was a loss and who was involved. Still you may have enough to make an early coverage assessment, and in particular to confirm (1) whether there was a policy in place that may be implicated, (2) whether that policy was in effect on the date of loss, and (3) whether the person or property involved qualifies as an "insured" or covered property under the policy.

If there are any coverage issues, a reservation of rights letter should be sent to the insured citing the policy provisions that may be potentially relevant, stating that the company's analysis may change as more information becomes available, and inviting the insured to provide pertinent information. Incorporating the policy as if fully rewritten is also a good idea.

Bear in mind Ohio's unfair practices provisions, which can be found in Ohio Administrative Code Sections 3901-1-07 (Unfair Trade Practices) and 3901-1-54 (Unfair Property & Casualty Claims Settlement Practices).[1] The Ohio Administrative Code provides a list of generally applicable time periods for claims acknowledgements and updates, including requiring an acknowledgement of the claim and providing all necessary claim forms and instructions 15 days after notice of a claim. Notices should be provided to potential first and third party claimants, and ideally include when the statute of limitations may expire for a suit.

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[1]A more comprehensive summary was provided in our June, 2015 newsletter, provided here: *Gallagher Sharp June 2015 Newsletter*.

Ohio State Appellate Decisions

Potential injury and purely economic damages are not covered under a CGL Policy.

The Orianis sued various entities insured by Century Surety Company for damages due to those insured entities' operation of a "garbage hauling/recycling business" on property the Orianis owned. They also sued Century seeking insurance coverage for the claimed damages. The court of appeals rule in favor of Century because "'[p]otential' bodily injury is not covered by the policy," therefore "'a threat of potential bodily injury' because the rats were attracted to the garbage" and "cleanup of the nuisance" "required to prevent any bodily harm" was not covered. The court noted that "[t]he Orianis offered no evidence that anyone was actually physically injured or got sick as a result of [the insured's] actions." Further, the court found that "purely economic damages" "do not qualify as either bodily injury or property damage under policy." *Oriani v. Reach Out Disposal, L.L.C.*, 8th Dist. No. 103128, 2016-Ohio-7392.

A mortgage holder is bound by the prompt notice provisions of the homeowner's policy issued to mortgagor/homeowner.

American Family Mutual Insurance Company insured a vacant home which was damaged by fire. Wells Fargo held the mortgage and filed a claim with American Family four months after the fire; the home had already been demolished. American Family denied coverage based on late notice, and Wells Fargo filed suit arguing that the prompt notice provisions did not apply to it as the mortgage holder. Both the trial court and the court of appeals disagreed because the prompt notice provisions applied not only to the named insured but also to "any person claiming Coverage under this policy," including Wells Fargo. The court also found that, although "person" was not a defined term in the American Family policy, Wells Fargo qualified as a "person" as that term is defined in the Ohio Revised Code. The court concluded that no coverage existed because American Family showed actual prejudice due to the four month delay. In particular, the demolition of the house made it impossible for American Family to determine "whether it would have subrogation rights against third persons who may have caused the fire" and "to determine the actual value of the property prior to the fire for purposes of indemnification." *Wells Fargo Bank, N.A. v. Am. Family Mut. Ins. Co.*, 8th Dist. No. 104125, 2016-Ohio-7892.

Policy voided based on intentional misrepresentations of fireworks manufacture.

An explosion and fire leveled a garage owned by Cotten. The home was insured by Erie Insurance. Subsequent investigation found chemicals, tubing, and other items used to manufacture explosives. A neighbor testified that after the initial explosion she heard firecrackers. The Erie policy provided that it "is void if before or after a loss you or anyone we protect is intentionally concealing or misrepresenting any material fact or circumstance concerning this insurance." Although Cotten would not admit to manufacturing fireworks, Erie was awarded summary judgment based on the affidavit of an expert investigator. The court of appeals affirmed, citing case law holding that a misrepresentation is material when it pertains to a fact that significantly affects the rights or obligations of the insurer. *Erie Ins. Exchange v. Cotten*, 5th Dist. No. 2016CA00132, 2017-Ohio-9.

An insurer's reliance on non-physician opinions in making claim decisions may not constitute reasonable justification.

Marshall made a UM/UIM claim under his insurance policy with Colonial Insurance Company of California. He recovered $50,000 in UM/UIM coverage after filing suit and proceeding to arbitration. He then filed a second suit, this time alleging bad faith. The trial court granted summary judgment in favor of Colonial, but the court of appeals reversed, holding that there was a genuine issue of material fact as to whether Colonial acted in bad faith. The factual focus was on Marshall's prior accidents and preexisting injuries similar to those he claimed in the accident at issue. His physicians opined that the most recent accident exacerbated those conditions. Colonial did not have an opinion of a physician to the contrary. Rather, Colonial relied on analyses performed by nurses and claims adjusters. Specifically, the court found an issue of fact created because "one could find Colonial lacked reasonable justification when relying on a nurse's or claims adjuster's construction of the medical records to justify a delay in authorizing a settlement offer, deciding on a settlement offer, and then waiting [several years] to obtain a medical review by a surgeon." *Marshall v. Colonial Ins. Co.*, 7th Dist. Mahoning No. 15 MA 0169, 2016-Ohio-8155.

Certain policy provisions may apply to restore coverage for property damage caused by subcontractor's faulty workmanship in a completed project despite Custom Agri decision.

The court of appeals reversed and remanded a trial court decision granting summary judgment in favor of Cincinnati Insurance Company in a construction defect case. The court concluded that certain provisions in the Cincinnati policy, together with supplemental classifications set forth in the policy declarations, all of which contemplate coverage, created an ambiguity as to whether the parties intended and contracted for coverage for "property damage" caused by a subcontractor's faulty workmanship in a completed project. Specifically, the court found that an exception to the j(6) exclusion could be applied to restore coverage where the "property damage" was included in the "products-completed operations hazard." In doing so, the court noted that the products-completed operations coverage applied because the declarations indicated that premiums were made for this coverage and there was no dispute that construction had been completed when the underlying claims arose. The court also found that the exception to exclusion [L] Damage to Your Work may similarly restore coverage under the products-completed operations hazard for work that was done by a subcontractor or if the subcontractor's work itself was damaged. Thus, the court concluded that "according to the specific exceptions to exclusion j(6) and exclusion [L], the products-completed operations coverage applies when: (1) the project was completed at the time the claim arose; and (2) the claim involved "property damage" caused by work performed on the insured's behalf by a subcontractor—which are the precise allegations underlying [the] claims against [Cincinnati's insured]."

The court specifically rejected Cincinnati's argument that *Westfield Ins. Co. v. Custom Agri Sys., Inc.*, 133 Ohio St.3d 476, 2012-Ohio-4712, stands for the proposition that all "property damages" arising from defective workmanship can, as a matter of law, never constitute an "occurrence." *Ohio N. Univ. v. Charles Constr. Servs.*, 3d Dist. No. 5-16-01, 2017-Ohio-258.

An anti-concurrent causation clause applies to policy endorsements, unless the endorsement states otherwise.

A homeowner had basement damage caused by both surface water intruding through the windows and a backup of the sump-pump system. The policy had an anti-concurrent causation clause, which stated that it will not pay for loss from any of the following, "even if other events or happenings contributed concurrently, or in sequence, to the loss," and listed exclusions for surface water and water or sewer backup including from a sump-pump. However, the insured purchased a separate "backup coverage endorsement" that did provide for coverage for loss caused by water backup. The insurer denied coverage, citing the anti-concurrent causation clause, and the trial court granted summary judgment. On appeal the homeowner argued that the endorsement did not contain an anti-concurrent causation clause, so there was coverage for the sewer backup even if there was concurrent surface water. The court of appeals affirmed, finding that the contract must be read as a whole. The general exclusions still applied to endorsements unless the endorsement stated otherwise, and it did not in this case. *Hartman v. Erie Ins. Co.*, 6th Dist. No. 2015CV0434, 2017-Ohio-668.

Where there is coverage for loss due to trick, scheme, of false pretenses, circumstantial evidence is sufficient to prove the cause of the loss.

Motorist Mutual Insurance Company insured Canfield Motor Sports under a CGL policy which, under "False Pretense Coverage," insured "loss" to a covered "auto" caused by "[s]omeone causing you to voluntarily part with the covered 'auto' by trick, scheme or under false pretenses." Canfield was induced to sell 10 motorbikes through an auction house. The motorbikes were picked up and, supposedly auctioned, but the auction proceeds were never forwarded and the auction house declared bankruptcy immediately following the supposed auction. Motorists claimed that no coverage applied because Canfield failed to show that the auction house had intentionally tricked Canfield. The court found, however, that such intent could be inferred based on "the chain of events [that] occurred over approximately a 45-day period, starting with [the auction house's] relentless sales pitch during the month of August through the September 5th auction, the multiple unreturned phone calls, culminating in [the auction house's] Bankruptcy petition filed on September 25th." Therefore, the existence of coverage was affirmed. *Canfield Motor Sports, Inc. v. Motorist Mut. Ins. Co.*, 7th Dist. No. 16 MA 0001, 2017-Ohio-735.

When several layers of insurance agents are interposed between the insurer and insured, notice to the sub-agent may be imputed to the insurer.

Kaplan Trucking Company contracted with another trucking company named Grizzly to haul cargo. Under that agreement, Grizzly was required to insure the cargo and include Kaplan as an additional insured under that policy. Grizzly complied by purchasing an insurance policy from Westchester Fire Insurance Company through its insurance broker, K&A. K&A, in turn, purchased a Westchester policy through W&A, a broker for Westchester. An accident occurred involving a newly acquired Grizzly truck. Grizzly had informed K&A of the new truck but did not notify Westchester. Westchester denied coverage because the new truck had not been added to the policy at the time of the accident. Kaplan, who was

ultimately liable for the loss of cargo carried by Grizzly, sued Grizzly for indemnity, and ultimately, Westchester, for coverage. The trial court found Westchester not to be bound by notice to K&A but the court of appeals reversed, concluding that a sub-agency relationship could exist between W&A and K&A which would result in notice to K&A being imputed to Westchester. The court found an issue of fact because K&A was listed as the producer, K&A received premium invoices, and K&A received commissions. The court observed that although the Westchester policy expressly states that, for changes to the policy, "contact us" could have meant the agent, W&A, or sub-agent, K&A, because "[t]here is no accompanying contact information." The court further found that Westchester could be estopped from denying coverage because "[w]hen one of two innocent persons must suffer loss, the loss must fall on him whose conduct brought about the situation or placed it within the power of a third person to cause the loss," and Westchester potentially did so as to K&A. *Kaplan Trucking Co. v. Grizzly Falls Inc.*, 8th Dist. No. 104148, 2017-Ohio-926.

UM/UIM coverage limited to bodily injury to an insured does not provide coverage for an insured's loss of services claim based on a family member's death.

Lisa Frank's mother was a passenger in a vehicle being driven by her aunt, i.e. her mother's sister. The aunt's negligence resulted in the death of Frank's mother. Frank was not present or otherwise involved in the accident. The aunt's insurer offered its $250,000 policy limits to the estate. Frank then sought UIM coverage from her own insurer, Westfield National Insurance Company. Westfield denied coverage because Frank had not sustained a bodily injury caused by the accident and arising out of the ownership, maintenance, or use of an underinsured motor vehicle. Frank filed suit claiming that under Ohio's wrongful death statute she was presumed to be damaged "by the wrongful death of her mother and that those compensatory damages included the loss of services of her mother. See R.C. 2125.02(B)(2)." Frank claimed that because the Westfield policy provided coverage for "bodily injury includ[ing] loss of services," "she was entitled to recover from Westfield." The court disagreed because UIM coverage was afforded for "bodily injury" "[s]ustained by an insured." The court reasoned that Frank's mother, who did sustain bodily injury, was not an insured under the policy, while Frank, who was an insured, did not sustain bodily injury. The court concluded that Frank's loss of services did not result from any bodily harm, sickness or disease she suffered. The court held that "[t]he policy as a whole denotes an intent to limit recovery under the UIM provision to 'bodily injury' sustained by an insured." *Frank v. Westfield Nat'l Ins. Co.*, 9th Dist. No. 27925, 2017-Ohio-1026.

Where an insurer defends while also outright denying indemnity coverage, the insured may settle without notice to, or consent of, the insurer without violating the policy provisions requiring notice and consent.

Patterson was killed while within the course and scope of his employment for Fabrizi Trucking and Paving Co., Inc. ("T&P"). He was crushed when the bucket of an excavator unexpectedly disconnected and fell on him. His estate sued T&P for employer intentional tort. His estate also sued Fabrizi Recycling, Inc. ("Recycling")

for negligence and product liability because it purchased the excavator and transferred it to T&P, a related entity. Both T&P and Recycling were insured under separate insurance policies issued by Cincinnati Insurance, which did not issue a reservation of rights letter. Rather, it denied indemnity coverage outright. It did, however, provide a defense to both T&P and Recycling, allowing the entities to select their own defense counsel. This was, apparently, an attempt to avoid the holding of *Sanderson v. Ohio Edison Co.*, 69 Ohio St.3d 582, 1994-Ohio-379, which states that "where an insurer unjustifiably refuses to defend an action, leaving the insureds to fend for themselves, the insureds are at liberty to make a reasonable settlement without prejudice to their rights under the contract." By paying for defense counsel, Cincinnati apparently wished to simultaneously: (1) exercise control under the consent to settlement provisions of the policies; and (2) deny indemnity coverage.

Patterson's estate settled with T&P and Recycling for $3,119,000 pursuant to a covenant not to collect without notice to, or the consent of, Cincinnati. His estate also received an assignment of any rights of recovery T&P and Recycling may have against Cincinnati, including any bad faith claim. Patterson's Estate then sued Cincinnati for coverage under a supplemental complaint. The court found no coverage for the employer intentional tort claim against T&P reasoning as follows: "an insurance provision that excludes coverage for acts committed with the deliberate intent to injure an employee precludes coverage for employer intentional torts, which require a finding that the employer intended to injure the employee."

Cincinnati asserted that, as to Recycling, the settlement barred coverage because it was entered into without notice to, or the consent of, Cincinnati. The trial court entered summary judgment in favor of Cincinnati on that basis. The court of appeals disagreed, holding that "[w]hen an insurance company refuses to provide coverage and at the same time seeks to maintain control of the same litigation, it disclaims liability to indemnify, it creates a frustration of purpose. Such conduct would compel a person of reasonable faculty to cut its costs and settle a lawsuit to avoid the possibility of a higher judgment." The court analyzed the issue as follows: the insurer's attempt to "'have its cake and eat it created a mouthful' and put the [insured] in an 'untenable position' . . . [because] . . . the insurance company controlled the case, and if it won, the employer was vindicated and neither it nor the employer had any liability. But if it lost, it would [disclaim indemnity coverage] . . . while the [insured's] liability 'might be more than what [it] would have paid had it settled out of court.'" The court therefore found that the settlement and assignment did not violate "the anti-assignment, voluntary payment, cooperation, and no action clauses, which all involve consent on the insurance company's part to settle a claim." The court noted that the insurer could have filed a declaratory judgment action to avoid this result, and also observed that the parties to the underlying suits did engage in good faith discovery and motion practice before settling. The matter was remanded to the trial court to determine the sole remaining issue -- whether coverage exits for the negligence claim against Recycling. *Patterson v. Cincinnati Ins. Cos.*, 8th Dist. Cuyahoga No. 104371, 2017-Ohio-2981.

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It is also essential to investigate what actually happened. For a car accident, this could include obtaining a copy of the police report, securing photographs of the vehicles, and interviewing witnesses. During the investigation make sure to document the file. We have heard it said "if it isn't in your file it never happened," the point being that it is important to memorialize what occurs.

A word of caution, though – be judicious about what you put in the claim file. All relevant facts should be included, but without personal opinions and unfounded conclusions or hunches.[2] When in doubt think how it will sound out loud or look when blown up on a poster board.

Once you set up the claim and start the investigation, it is important to keep the insured apprised as to what is going on. The Ohio Administrative Code suggests providing updates every 45 days. It may be helpful to set up calendar reminders to send some communication to the insured every 45 days, even if you only report to the insured that you are awaiting more information.

If the insured is sued, reexamine coverage. A short synopsis of Ohio law regarding an insurance company's duty to defend is set forth in *City of Sharonville v. American Employers Ins. Co.*, 109 Ohio St. 3d 186, 846 N.E.2d 833, 2006-Ohio-2180:

> An insurer's duty to defend is broader than and distinct from its duty to indemnify. *Socony-Vacuum Oil Co. v. Continental Cas. Co.*, 144 Ohio St. 382, 59 N.E.2d 199 (1945), paragraph one of the syllabus; *W. Lyman Case & Co. v. Natl. City Corp.*, 76 Ohio St.3d 345, 347, 667 N.E.2d 978, 1996-Ohio-392. An insurer has an absolute duty to defend an action when the complaint contains an allegation in any one of its claims that could arguably be covered by the insurance policy, even in part and even if the allegations are groundless, false, or fraudulent. *Sanderson v. Ohio Edison Co.*, 69 Ohio St.3d 582, 635 N.E.2d 19, 1994-Ohio-379, at paragraph one of the syllabus. Once an insurer must defend one claim within a complaint, it must defend the insured on all the other claims within the complaint, even if they bear no relation to the insurance-policy coverage. *Preferred Mut. Ins. Co. v. Thompson*, 23 Ohio St.3d 78, 491 N.E.2d 688 (1986). An insurer need not defend any action or any claims within the complaint when all the claims are clearly and indisputably outside of the contracted policy coverage. *Preferred Risk Ins. Co. v. Gill*, 30 Ohio St.3d 108, 113, 507 N.E.2d 1118 (1987). The duty to defend is further heightened when the insurer expressly states that it will defend claims that are groundless, false, or fraudulent. *See Wedge Products, Inc. v. Hartford Equity Sales Co.*, 31 Ohio St.3d 65, 67-68, 509 N.E.2d 74 (1987); *Preferred Risk*, *supra*, at paragraph two of the syllabus. The duty to defend an action is

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[2]For instance, "I think the insured is a liar" may be problematic in that it makes the author appear biased. Stating "the insured's account may not be credible because it is contradicted by an independent witness" is more appropriate because it is based on specific information. Also, if a case is in suit avoid disparaging the judge, who later may review the claim file.

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> not determined by the action's ultimate outcome or the insurer's ultimate liability. *Motorists Mut. Ins. Co. v. Trainor*, 33 Ohio St.2d 41, 294 N.E.2d 874 (1973), at paragraph two of the syllabus.

If there are coverage issues, a reservation of rights letter should be sent. You will have then the benefit of seeing in writing what is alleged, and whether any allegation in the complaint triggers coverage. For example, in a suit alleging a construction claim, does the complaint assert both faulty workmanship and consequential damages? Does the complaint allege only breach of contract or negligence? Remember, though, that an insurer's duty to defend is not confined to what is alleged in the complaint. In *City of Willoughby Hills v. Cincinnati Insurance Co.*, 9 Ohio St. 3d 177, 459 N.E.2d 555 (1984), the Supreme Court of Ohio stated that:

> The pleadings alone may not provide sufficient factual information to determine whether the insurer has an obligation to defend the insured. It remains true that where the pleadings unequivocally bring the action within the coverage afforded by the policy, the duty to defend will attach. However, where the insurer's duty to defend is not apparent from the pleadings in the case 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 had been pleaded, the insurer must accept the defense of the claim. Thus, the "scope of the allegations" may encompass matters well outside the four corners of the pleadings.

Id. at 180 (internal citations omitted)(emphasis added).

Finally, if there is a duty to defend, forward the summons and complaint to counsel with any pertinent investigation and information. After confirming that there are no conflicts, counsel will protect the interests of your insured.

About Gallagher Sharp

For over 100 years Gallagher Sharp LLP has provided aggressive and cost-efficient representation in a wide variety of civil litigation. Our registered service mark -- "Solutions, Not Surprises" -- embodies Gallagher Sharp's core philosophies and illustrates our commitment to partnering with clients by providing prompt and accurate reporting, case evaluations focused on early resolution strategies, thorough knowledge of your industry, client-oriented seminars, publications, and news advisories, rapid and on-site response to accidents, and nurse paralegals to assist in injury and wrongful death issues. We believe our client team structure gives clients the benefits of small firm responsiveness and accountability as well as large firm stability, experience, and resources.

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