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California and Nevada

Insurance Coverage UPDATE

MESSAGE FROM THE EDITOR

Did you know that Morris Polich & Purdy LLP has over 100 published appellate decisions to its name, including some of the leading California cases on insurance law? As a member of both the firm's Appellate Practice and Insurance Litigation groups, I hope you will consider our firm not only for insurance litigation but also for any appellate needs you may have in California, Nevada or elsewhere. We hope you find this quarter's coverage case summaries informative and welcome your comments or questions.

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Multiple "Per Claim" SIRs Do Not Apply to a Single Lawsuit Involving Numerous Homes

Clarendon America Ins. Co. v.
North American Capacity Ins. Co.
(Fourth District Court of Appeal, June 15, 2010)
186 Cal.App.4th 556, 112 Cal.Rptr.3d 339

After settling an underlying action against its insured, a residential developer, for alleged construction defects in forty-three homes, Clarendon brought suit against North American Capacity (NAC) for its failure to participate in the defense and indemnity of their mutual insured. NAC denied coverage, and subsequently prevailed on summary judgment, on the basis that the insured failed to pay a $25,000 "per claim" SIR for each home involved in the underlying litigation. In reversing the trial court, the Court of Appeal found that the insured may have had an objectively reasonable expectation that the "per claim" SIR meant it would apply only once to the entire construction defect lawsuit rather than to each home. The policy did not define "claim" and the term was used in many different contexts in the policy that did not shed light on whether a "claim" could refer to a single suit involving multiple homes or plaintiffs. Because the SIR provision could be susceptible to two interpretations, the Court found that NAC failed to meet its burden that there was no possibility of coverage and therefore no duty to defend the insured. ■

As Matter of First Impression, Duty To Defend "Suit" Includes Calderon Proceedings

Clarendon America Insurance Company v.
Starnet Insurance Company
(Fourth District Court of Appeal, July 27, 2010)
186 Cal.App.4th 1397, 113 Cal.Rptr.3d 585

Clarendon and StarNet issued CGL policies to two respective subcontractors that had performed work for Centex Homes on a residential development. Centex was named as an additional insured on both policies. The HOA initiated proceedings against Centex under Civil Code § 1375 et. seq., commonly known as the Calderon Act, which requires a common interest development association to satisfy certain dispute resolution requirements against builders before filing a complaint in court for construction or design defects. Centex filed suit against Clarendon seeking payment of defense costs incurred defending against the Calderon Notice. Clarendon cross-complained against StarNet. StarNet contended the Calderon process did not constitute a "suit." The trial court disagreed, as did the Fourth District Court of Appeal, which concluded, as a matter of first impression, that Calderon proceedings trigger the duty to defend under standard CGL policy language. ■

Insurer Waives Claim for Equitable Subrogation By Entering Into Settlement Without Apportioning Payment

Essex Insurance Company v. Richard Heck, M.D.
(Fifth District Court of Appeal, July 29, 2010)
186 Cal.App.4th 1513, 112 Cal.Rptr.3d 915

Essex provided a defense to a defendant in a personal injury action. After a substantial verdict against the defendant, Essex concluded that the defendant was not its named insured. Litigation regarding Essex' obligation to pay the judgment followed. Essex later entered into a global settlement with the plaintiff that resulted in the dismissal of three lawsuits including the personal injury action and a bad faith action against Essex. The settlement agreement did not allocate the payment among the three lawsuits. Essex later pursued equitable subrogation against the doctor that had treated the plaintiff after the initial incident that caused the plaintiff's injury, seeking indemnity for the amounts Essex had paid in settlement. The trial court granted the doctor's summary judgment motion and the court of appeal affirmed. It held that Essex had waived its right to equitable subrogation by not allocating an amount for payment of the personal injury claim in the settlement agreement. ■

Storms Were Not Efficient Proximate Cause of Failure of MRI Machine to "Ramp Up" Nor Was Failure to "Ramp Up" "Direct Physical Loss"

MRI Healthcare Center of Glendale, Inc. v. State Farm Insurance Company
(Second District Court of Appeal, August 4, 2010)
187 Cal. App.4th 766, 115 Cal. Rptr.3d 27

An MRI provider sued for breach of contract and breach of the covenant of good faith and fair dealing after State Farm denied coverage for the provider's claim that its MRI machines failed to "ramp up" after being "ramped down" so that plaintiff's landlord could replace the roof on plaintiff's business premises due to prior rain storms. The Court of Appeal affirmed the trial court's finding that the storms were not the efficient proximate cause of the damage to the MRI machines. The Court further concluded that the failure of the MRI machines to "ramp up" after being "ramped down" did not constitute "direct physical loss" to the insured property (i.e., there was no actual change in the insured property), and that the act of ramping down the MRI machines was not "accidental." ■

Under Nevada Law, Insurance Agent Owes No Duty to Indemnify Insurer Where Indemnity Provision Between Them Did Not Specifically Refer to the Insurer/Indemnitee's Own Negligence

George L. Brown Ins. v. Star Insurance Company
(Nevada Supreme Court, August 12, 2010)
126 Nev. Adv. Op. 31, 237 P.3d 92

Brown, an independent insurance agency, sold insurance policies for various insurers, including Star Insurance Company. A provision in a contract between Brown and Star required Brown to defend and indemnify Star for losses arising from Brown's performance under the contract. The indemnity provision did not expressly refer to Star's negligence. Deciding an issue of first impression, the Supreme Court held that when a contractual provision provides for a party to be indemnified for its own negligence, the provision is enforceable only if it expressly refers to the party's own negligence. A clause providing for indemnification "for any and all liability," it stated, does not entitle a party to indemnification for its own negligence. ■

"Evidence of Property Insurance" Form Upheld As Legal Binder of Coverage

Chicago Title Insurance Company v. AMZ Insurance Services, Inc.
(Fourth District Court of Appeal, September 9, 2010)
188 Cal.App.4th 401, 115 Cal.Rptr.3d 707

The Mustains sought to refinance their home mortgage. Their broker obtained a homeowners' policy through AMZ, which issued a form entitled Evidence of Property Insurance ("EOI"), naming Pacific Specialty Insurance Company ("PSIC") as the insurer, the Mustains as the insureds, and listing the effective dates, the nature and limits of coverage, and the deductible amount. After the Mustains' home was destroyed in a fire, PSIC denied coverage, asserting that the policy was void and that it did not authorize AMZ to issue the EOI. The title company, Chicago Title, paid for the loss in exchange for an assignment of rights against PSIC. The trial court determined that the EOI was a legal binder under Insurance Code Section 382.5 regardless of a non-payment of the premium and the fact that the Mustains did not fill out an application, and entered a judgment for Chicago Title. The Fourth District affirmed, reasoning that the EOI was a legal binder and that evidence of prior dealings between AMZ and PSIC in other escrow transactions established AMZ's authority to bind coverage prior to receiving a signed application and policy premiums. ■

No Rescission Without Restoration of Benefits

Village Northridge v. State Farm Fire & Casualty Co.
(California Supreme Court, August 30, 2010)
50 Cal.4th 913, 114 Cal. Rptr. 280

State Farm paid the Village Northridge HOA for damages suffered in the Northridge Earthquake. Subsequently, State Farm paid an additional amount to the HOA to settle its claim for additional disputed benefits, after which the HOA signed a release of present and future claims. After the legislature revived the HOA's claims previously barred by the statute of limitations, the HOA sued State Farm for damages based on the allegation that State Farm had procured the release through misrepresentations as to the amount of the HOA's damages and the amount of coverage available. However, the HOA did not return the funds previously paid by State Farm in order to obtain the release in question. The California Supreme Court held that the HOA could not circumvent the common law requirement that the consideration for the release be restored to State Farm, and that the release be rescinded, before it could seek additional damages from State Farm. ■

Reasonable Expectation of Coverage Revisited – "Metes and Bounds" Description in Title Policy Held Ambiguous due to Erroneous Preliminary Title Report

Lee v. Fidelity National Title Insurance Company
(First District Court of Appeal, September 16, 2010)
188 Cal.App.4th 583, 115 Cal.Rptr.3d 748

The Lees purchased two neighboring parcels of land. Fidelity issued a preliminary title report referring to the two parcels by their assessor numbers and by "metes and bounds" description for the first parcel. After the Lees learned that they in fact did not own the second parcel, Fidelity denied coverage because the property description in the policy only included the first parcel. The Lees sued and the trial court granted Fidelity's motion for summary judgment. The Court of Appeal reversed, holding that because the preliminary report included the second parcel, listed exclusions from coverage specific to the second parcel, and included a map with an arrow pointing to the second parcel, the Lees had the right to assume that it correctly reflected the scope of the coverage offered by Fidelity. ■

Insurer's Alleged Failure to Follow Internal Underwriting Guidelines Did Not Equitably Estop It from Declining a Defense

Colony Ins. Co. v. Crusader Ins. Co.
(Second District Court of Appeal, August 27, 2010)
188 Cal.App.4th 743, 115 Cal.Rptr.3d 611

Colony, a landlord's current liability insurer, brought suit against the landlord's former liability insurer, Crusader, for declaratory relief and equitable contribution. Crusader had previously refused to defend a lawsuit brought against the landlord on the basis of misrepresentation in the insurance application - the landlord failed to disclose that it had been issued several citations by the City of Los Angeles's Housing Department. Colony argued that because Crusader had failed to investigate public records (which would have revealed the citations), as required by its own internal underwriting guidelines, it was estopped from denying coverage and waived the right to rely on the misrepresentation. The Court of Appeal disagreed. It held that Crusader's underwriting guidelines did not create rights that Colony could enforce and that there was no waiver because the California Insurance Code expressly permits an insurer to rely on an insured's representations. ■

Insured Employee is Subject to Automobile Exclusion in Employer's Commercial General Liability Policy

Rose Sprinkles, et al. v.
Associated Indemnity Corporation, et al.
(Second District Court of Appeal, September 1, 2010)
188 Cal.App.4th 69, 114 Cal.Rptr.3d 887

In an underlying personal injury action arising from an accident caused by an employee of Sinco Co. Inc. ("Sinco") while driving to work in a vehicle used in the course of his job duties, the injured plaintiff Sprinkles was assigned Sinco's and its employee's rights against Sinco's liability insurer, Fireman's Fund. Fireman's Fund had declined to defend or indemnify Sinco and the employee on the grounds that an exclusion for injury or damage arising from an insured's use of an automobile applied. Sprinkles brought an action against Fireman's Fund, asserting that the exclusion did not apply because Sinco's employee was not an "insured" because he was not in the scope of employment when the accident occurred. The trial court sustained Firemen's Fund's demurrer. The Court of Appeal affirmed, holding that the exclusion applied because the policy defined "insured" to include employees for purposes of acts within the scope of their employment while performing duties related to the conduct of the business, the complaint against Sinco alleged that the employee was the employer's agent acting within the course and scope of his authority, and an arbitration award against Sinco confirmed that the employee was acting in a manner that made him an insured. ■

Mandatory Arbitration of UM Claim Protected Under Anti-SLAPP Statute

Winly Mallard v.
Progressive Choice Insurance Company
(Fourth District Court of Appeal, September 15, 2010)
188 Cal.App.4th 531, 115 Cal.Rptr.3d 487

In the course of Mallard's UM Claim, Progressive's attorney, Morell, subpoenaed Mallard's mental health records. Mallard thereafter filed suit against Progressive and Morell for invasion of privacy and abuse of process. Morell filed an anti-SLAPP motion pursuant to Code of Civil Procedure, Section 425.16 to strike Mallard's complaint, alleging that it was a strategic lawsuit against public participation. The trial court granted Morell's motion and ordered the complaint dismissed against both Progressive and Morell. On appeal, Mallard contended that Morell's conduct was not within the protection of the anti-SLAPP statute because the UM arbitration was a private contractual arbitration and not an official proceeding authorized by law. The Court of Appeal affirmed the trial court's ruling as to Morell, finding that the use of subpoenas in the contractual arbitration of Mallard's UM claim was a writing in connection with "any other official proceeding authorized by law" within the meaning of Code of Civil Procedure, Section 425.16. ■

Minor Status of Claimant Does Not Toll Two-Year Statute Of Limitations To Demand UM Arbitration

Blankenship v. Allstate Ins. Co.
(Third District Court of Appeal, June 29, 2010)
186 Cal.App.4th 87, 111 Cal.Rptr.3d 528

A 13-year old was involved in an auto accident. The at-fault driver was uninsured and his auto's insurer denied coverage. The child's stepfather initiated a UM claim with his own insurer,

Allstate. Allstate made a settlement offer, but received no response. More than two years after the accident, an attorney for the child made a demand for arbitration, which Allstate denied, and then filed a Petition to Compel UM Arbitration. The trial court held that the minority status of the claimant did not excuse his failure to make a demand for arbitration within two years of the accident. The Court of Appeal upheld the trial court's ruling, finding that Insurance Code § 11580.2(i) does not list minority as one of the grounds for excusing noncompliance with the limitations period and that minority is not a disability that renders performance under Insurance Code § 11580.2(i) impossible or impractical. ■

CIGA Cannot Make Payments on Claims Made After the Deadline Imposed By A Domiciliary Liquidation Proceeding

HCM Healthcare, Inc. v. CIGA
(Second District Court of Appeal, August 30, 2010)
187 Cal.App.4th 1317, 115 Cal.Rptr.3d 185

HCM Healthcare operated nursing homes. Legion was its liability insurer. In July 2003, Pennsylvania declared Legion insolvent. The Pennsylvania Liquidation Order imposed a June 30, 2005 deadline for policyholders to file claims against Legion, and HCM was notified of the deadline. In April 2005 and November 2005, two lawsuits were filed against HCM for elder abuse. HCM notified the Pennsylvania liquidator and CIGA of the two lawsuits after the June 30, 2005 deadline. CIGA refused to cover the claims. The Second District Court of Appeal held that CIGA had no responsibility to cover the two lawsuits because notice of them was not given by the deadline imposed by the Pennsylvania liquidator. ■

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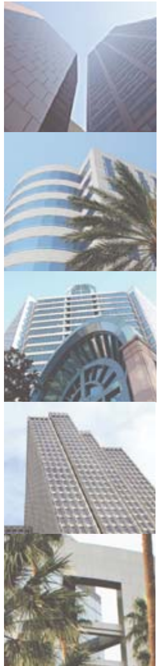

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