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How to Pay D&O Premiums and Still Lose Coverage – Part 1 of 2

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Recently we have seen some cases in which carriers denied coverage under directors and officers (D&O) liability policies on what normally should have been covered claims. The carrier's denials arise out of a "Catch-22" that few people recognize. The nature of D&O insurance is such that associations actually can have D&O coverage in effect continuously from one carrier to the next and yet not have coverage when a claim arises. To avoid this outcome, it is essential (1) to tender a claim to the carrier whenever there is even a potential risk of a lawsuit and (2) to be extremely careful when completing an application for new insurance.

D&O insurance is almost always a "claims-made" policy. These policies, theoretically, cover any claim made during the policy period, sometimes even if the incident on which the claim is based occurred before the policy began. However, most D&O policies will not cover a claim, if the association knew of ANY facts or circumstances before the policy began that might give rise to that claim.

D&O insurance provides different coverage from the typical comprehensive general liability (or "CGL") policy. CGL policies typically cover only those claims that result in bodily injury or property damage and sometimes non-bodily "personal injuries." CGL policies are typically "occurrence" policies, so named because they protect the insured against claims arising from an "occurrence" during the policy period. They provide coverage even if a claim does not arise until after the policy period ends. It is fairly easy to identify an occurrence and when it occurred, because it usually produces bodily injury or property damage at that time. D&O insurance, on the other hand, usually covers only those claims made during the policy period. With a D&O incident, it is often easier to identify when the claim is made than when the occurrence happened that gave rise to the claim.

Some claims-made policies will cover claims that are made during the policy period even if the occurrence giving rise to the claim occurred prior to the start of the policy period. The catch is that a new carrier will accept such claims only if the insured party had no prior knowledge, when the policy period began, of any facts or circumstances giving rise to that particular claim.

What exactly is a "claim?" Certainly a lawsuit is a claim under any policy, but some policies define a claim as any written threat or demand or even a verbal threat or demand. Whatever the definition, it is easy to understand that no carrier wants to cover a lawsuit that arises out of any facts or circumstances about which the association was aware before the policy began. Many carriers will cover it, if neither the carrier nor the association knew it existed at policy inception, but no carrier will cover what amounts to a known pre-existing liability.

What if facts or circumstances have occurred, but they don't yet meet the policy definition of a "claim?" Maybe there was a verbal threat, but the policy defines a claim as a written threat. Some claims-made policies consider that a claim was made, if the insured party notifies the carrier during the policy period of the facts that may become a claim. Even if the policy does not provide for notifying the carrier of a potential claim, it is still wise to do so before the policy period ends. If the incident becomes a real claim after the policy period ends, the earlier notice may be enough to trigger coverage, but it will be impossible, if the former carrier's first notice occurs after the policy ended, because the claim wasn't made during the policy period, and the carrier will deny coverage.

This is how an association can lose coverage. Assume one owner objects verbally when the association approves a neighbor's architectural modification. The complaining owner sends no written complaint or anything that the policy defines as a "claim." Then, things calm down for a period of months, and the association either concludes that the complaint is minor or believes it resolved the problem. The association doesn't notify the current D&O carrier of the owner's complaint.

Three months later the association selects a new D&O carrier. The carrier sends an application to the manager to complete, or maybe the broker asks the association board or manager if there are any pending claims, completes the application, and the board or manager signs it. The signed application states that the association has no pending claims nor any knowledge of any facts or circumstances that may give rise to a claim. The board may have forgotten the prior threat, or the board may have changed, and the new board doesn't know of the prior complaint. Either way, the old D&O carrier got no notice of the potential claim, and the new carrier is told that there are no potential claims.

The new D&O policy takes effect, and the complaining owner surfaces with written threats or litigation. The association tenders the claim to both the old and the new D&O carrier. The prior D&O carrier denies the claim, because it wasn't made during the policy period. The new D&O carrier denies coverage, either because the association failed to disclose the potential claim on the application, or because the new policy states it will not cover a claim, if the association knew of any prior facts or circumstances that might give rise to a claim.

Part 2 will address what associations should do to avoid having both the old and new carrier deny coverage. Part 2 will also discuss being alert to "burning balance" policies, in which the coverage limit available to pay claims is reduced by the amounts expended in defense costs.