



Complex Insurance Litigation and Liability Defense

COURT DECISIONS

Georgia Decisions

When a denial letter does not constitute a denial of coverage and other interesting holdings.

Court of Appeals reviews a declination of coverage under the unique terms of a crop insurance policy and addresses many interesting coverage questions that rarely get addressed under Georgia law such as when an insurer issues a denial letter does it constitute a denial of coverage.

Insurer's inaccurate statement for its basis for denial is found to be a misrepresentation of policy permitting a jury to determine bad faith.

Insurer was found to have added requirements into its exclusion when representing the exclusion to insured and the court.

Recent Cases Of Interest Around the Country

Oregon Court of Appeals addresses multiple questions related to burden of proof between insured and insurer under a variety of primary and umbrella liability policies.

Appellate Court reverses trial court on the evidentiary burdens of insurer and insured for the fundamental requirement of "fortuity" and whether the damage was "unexpected and unintended" per the definition of "occurrence."

Kansas Supreme Court applies two-prong test to misrepresentation in application defense.

Based on the application and the policy, a two prong test, considering subjective and objective intent should be applied when insurer seeks to exclude coverage for insured's failure to report possible claim on an E & O application.

Georgia Insurance Coverage Decisions

Bullington v. Blakely Crop Hail, Inc., 2008 Ga. App. LEXIS 1050 (Ga. App. Sept. 24, 2008): The insured, Bullington, was a peanut farmer insured under a multiple peril crop insurance policy issued by Blakely and reinsured by the Federal Crop Insurance Corporation (FCIC). Bullington claimed a loss to his peanut crop in 2001, promptly notified the carrier and submitted a written claim for indemnity. Blakely determined the reduced crop was based upon the farmer's failure to plant sufficient seed. On January 4, 2002, Blakely wrote a declination letter to Bullington denying the claim because the amount of seed per acre planted was not consistent with his prior farming practices. As is generally considered good practice, the declination letter concluded providing Bullington the opportunity to submit additional information if it disagreed with the insurance company's position. Bullington on January 22, 2002 submitted additional information claiming Blakely's calculations on the amount of seed had been in error. Blakely then recalculated the numbers and on January 31, 2002 wrote a letter stating it agreed it had made an error on the seed calculation, that the seed planted had been *even less*, so it again denied coverage stating its January 4, 2002 denial of the claim still applied. The crop policy contained an arbitration clause pursuant to FCIC regulations. Bullington then on January 29, 2003 filed a demand for arbitration. Finally, the crop policy provided that the insured must bring any *legal action* against the insurer within 12 months from the *date of denial of coverage*.

Five years later it was reported the arbitration was still pending. Bullington therefore initiated suit against Blakely on January 3, 2008. Blakely moved for summary judgment claiming that Bullington had not complied with the policy condition that a legal action be filed within 12 months after denial of the claim which first occurred on January 4, 2002. The trial court granted summary judgment to Blakely. Bullington appealed claiming the policy 12 month period to file a legal action was not applicable; instead, it claimed the standard six-year statute of limitations on breach of written contract applied. The appellate court rejected that contention finding Georgia clearly respects a policy's 12 month time period to bring a legal action against a policy. Bullington argued that the trial court erred in finding that Blakely denied the claim on January 4, 2002 and that it failed to bring its legal action within 12 months of the denial of coverage. On this point the Court of Appeals agreed finding that in the first denial letter the insurer offered to con-

sider additional information if submitted by the insured. The appellate court found that when the insured submitted additional information the insurer did in fact review it. Although this additional information did not alter the original basis for declination, rather it affirmed it, the appellate court nevertheless found that “a Jury could find from the evidence that Blakely did not deny Bullington’s claim until January 31, 2002.” (We question whether the Court is not more properly charged with determining the legal consequence of the declination letters than the jury as they are both undisputed written communications.) The appellate court then decided when Blakely first instituted a “legal action.” It found that per the policy an arbitration constituted “a legal action” and since the arbitration demand was made by January 29, 2003, the insured would be deemed to have fulfilled the condition of instituting a legal action within 12 months from date of declination if the jury found the actual declination occurred as of the second letter affirming the declination dated January 31, 2002.

We note clear points of distinction in this case compared to many other Georgia cases on these issues in that (1) usually there is no binding arbitration clause in the policy and (2) the suit or legal action must be brought within 12 months from “date of loss” not “date of denial of claim.” Another issue that disturbs us in this decision is the appellate court’s failure to address that part of the conditions which required that “suit” must be brought in accordance with 7 USC § 1508 thereby incorporating by reference a federal statute requiring *suit* within 1 year after final denial of coverage. The appellate court did not address whether this condition, when giving all parts of the policy meaning, more precisely restricted the insured’s time to file an actual “suit” against the insurer after final denial (which clearly was not complied with) as contrasted to only determining if the insured initiated a “legal action” within 12 months of denial.

Rentrite, Inc. v. Sentry Select Ins. Co., 2008 Ga. App. LEXIS 1042 (Ga. App. Sept. 23, 2008): Rentrite owns a construction equipment rental business and had a Commercial Inland Marine Policy with Sentry. The insured rented an excavator in exchange for a signed rental agreement and a deposit check from a new customer, Pettiford, who represented himself as owning a construction company. A credit application was left with Pettiford when renting the excavator but he never completed it. The check then bounced. Pettiford explained cash from a job was late in being deposited resulting in the check bouncing and he promised another check. After running a background check on Pettiford and obtaining his driver’s license number Rentrite rented Pettiford a bulldozer in exchange for another signed rental agreement and a promise of a wire transfer payment that would cover the rental of both pieces of equipment. Pettiford did not wire any monies but instead sent over a larger check, which was again later rejected for insufficient funds. The Vice President of Rentrite that had been dealing with Pettiford demanded payment and Pettiford sent another check and it bounced. The VP of Rentrite then left the country on vacation and while he was gone, to his later dismay, his company rented another backhoe to Pettiford. Returning from vacation, Rentrite’s VP sought to recover Rentrite’s property and money and ultimately learned the new customer had been arrested as a member of a professional ring which “engaged in the criminal conversion of leased construction equipment.”

Upon learning of the criminal charges filed against its customer, Rentrite sought coverage under its policy for a “false pretense loss”. The false pretense loss coverage was subject to multiple exclusions but distilled down, coverage would be excluded if the insured failed to obtain the “other party’s business address, phone number and driver’s license number.” However, and this is the critical point to the court, it appears Sentry represented that it had a right to deny coverage because its policy provided that Rentrite was required to obtain “a copy of Mr. Pettiford’s driver’s license, driver’s license number or credit application”. The trial court, purportedly relying on these representations, ruled in favor of Sentry’s denial. Rentrite appealed claiming the Sentry policy did not require either Pettiford’s “driver’s license” or a “credit application”. The Court of Appeals restated Georgia’s longstanding rule requiring that exclusions be interpreted narrowly. The Court of Appeals found that the trial court’s ruling misstated the policy exclusion and read into the policy language that did not exist in the policy as all that was required beyond an address and phone number was a driver’s license number. The appellate court then

held that because Rentrite at least got Pettiford's driver's license number *after* the first transaction, only the first conveyance of the excavator was excluded. The Court of Appeals then reversed the summary judgment on bad faith and stated, in rather stern language, that a jury may consider a bad faith claim because Sentry misrepresented to its insured, the trial court and the appellate court the terms of its exclusion by injecting requirements on the insured that were not contained in the exclusion.

Recent Cases Of Interest Around The Country

ZRZ Realty Co. v. Beneficial Fire & Cas. Ins. Co., 2008 Ore. App. LEXIS 1337 (Or. App. Oct. 1, 2008): Expect this case to be cited as a substantial decision addressing the evidentiary burdens of proof between insured and insurer for primary and umbrella liability policies involving both state and federal common law issues. The decision is lengthy and we will not review the entirety of the case. Environmental contamination to land and water occurred over time from the insureds dismantling of retired navy ships. During the time the damage was occurring, the insureds were covered by various types of policies, primary and bumbershoot, marine and non-marine, which varied, in part, as some expressly defined an "occurrence" to require an "accident" causing property damage "neither expected nor intended from the standpoint of the insured" while some policies did not condition an occurrence as requiring an "accident." The appellate court reviewed Oregon law and federal maritime common law for the applicable burdens of proof between insured and insurer. The evidence reflected uncontrolled release/run-off of toxic materials from 1947 to 1978 during ship dismantling operations which caused environmental damage to the sediments in the Willamette River and the sub-surface soil around the insured's scrap operation site.

At trial, both parties argued that the other had the burden of proof under all policies with regard to whether the loss was "neither expected nor intended" by the insured and whether the damage was "fortuitous." Trial resulted in a partial award to the insureds and both insurer and insured appealed the burden of proof issues.

The appellate court first looked to policies governed by Oregon State law that also expressly defined occurrence as "an accident, . . . , which results in . . . property damage *neither expected or intended from the standpoint of the insured.*" The court held that because this definition defined the insuring triggering event, to "establish a *prima facie* case under those policies, the insured must allege and prove such a triggering event occurred." Notably, later the court states that Oregon law determines "neither expected or intended" based upon the "subjective" not "objective" intent of the insured and that this subjective intent is established if the insured "engaged in an act so certain to cause a particular kind of harm that the court will say the insured intended the harm." The insurers' argued the evidence was clear that insured had failed to meet its burden and they were entitled to judgment on appeal under these policies. The appellate court declined remitting these policies back to the trial court holding that "the court should only infer that the insured had a subjective intent to cause harm or injury as a matter of law when such subject intent is the *only* reasonable inference that may be drawn for the insured's conduct."

On the other hand, for those policies that did not expressly state that an occurrence required an "accident" causing property damage "neither expected nor intended" by the insured, the appellate court held that and insurer seeking to impose that restriction under the "implied fortuity" doctrine carried the burden to prove the applicability of the "implied fortuity doctrine as a defense to coverage." Moreover, the appellate court rejected the insurer's argument that this burden must be borne by the insured because it chose to institute the legal action against the insurer. Thus, proving lack of "fortuity" was the insurer's burden. What that burden actually meant is explained below.

Turning to the maritime bumbershoot policies, the appellate court recognized that federal maritime common law would control the issue if there were an established body of admiralty law addressing the burden of proof related to the doctrine of for-

tuity for maritime liability policies. The Oregon Appellate Court then delved into hair splitting of the highest order that begs the question of how any jury could possibly apply the jury instructions on the re-trial of the case. The insurers argued that maritime law has a well settled rule that marine insurance policies cover only fortuitous losses. To this point the appellate court concedes. However, the court notes the insured's reckless environmental conduct lies in the gray area between accidental negligence and the intention to cause harm. It then states that its review of maritime law leads it to conclude that "there is no established and controlling rule of admiralty law that excludes marine insurance coverage for *expected* but *unintended* damage." Thus the court claims under admiralty law, an insured could actually "expect" the damage due to its reckless actions but somehow not actually *intend* the damage and that this would suffice as a "fortuitous loss" under federal maritime law. Then as to whether the loss must be "unexpected," because it had found maritime law did not expressly impose that burden, it stated it would look to Oregon public policy law. Not surprisingly the appellate court then cites to an Oregon Supreme Court decision that held that Oregon "public policy" did not prohibit coverage for expected but yet unintended losses.

In sum, the Oregon Appellate Court consistently construed the law of Oregon and federal maritime law to promote its construction that places the burden on the insured *only* where the definition of occurrence expressly requires an accident causing damage neither expected or intended by the insured and otherwise it held that the burden of proof as to the insured's subjective state of mind lies with the insurer. Further, and very importantly, it broadly sought to nearly entirely diminish the relevance of an insured *expecting* the damage from its own conduct and sought to slide the scale as far as possible so that non-coverage should only occur where the insured's subjective intent was basically to intentionally cause the harm in question.

Am. Special Risk Mgmt. Corp. v. Cahow, 2008 Kan. LEXIS 465 (Kan. Sept. 12, 2008): In *Cahow*, the Kansas Supreme Court affirmed the lower courts' application of a two prong subjective-objective standard when determining the insured's knowledge of pending or threatened litigation for disclosure purposes in an application for E&O coverage under a claims-made policy. The insured bank sought to purchase an E&O endorsement to its Directors and Officers policy. When completing its application for the endorsement, the insured answered 'no' to a question on the application inquiring as to whether there were "any facts, circumstances, or situations... which could reasonably be expected to give rise to a claim."

Shortly after the policy became effective, the bank was implicated for negligence in a case involving conversion and embezzlement using the bank's accounts. The bank was aware of the facts upon which the claims were based at the time it completed the application but argued that the court should apply a fraudulent, intent to deceive standard, or alternatively, that the court should apply a subjective knowledge standard. The Supreme Court affirmed the trial and appellate courts' adoption of a subjective-objective standard.

Effectively, the test involves first looking at "the *subjective* question of whether the insured knew of certain facts," and then looking at "the *objective* question of whether such facts could reasonably have been expected to give rise to a claim." The basis of the Supreme Court's holding was the specific language of the policy. It found that the first part of the

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application question, “Are there any facts, circumstances or situations involving the Applicant . . . ,” required the *subjective* prong of the standard, and the second part of the question, “which could reasonably be expected to give rise to a claim,” required the *objective* prong of the standard. Applying this standard to the facts of the case, it held that not only did the bank have subjective knowledge of the embezzlement and conversion, but they also should have objectively known that these facts could give rise to the negligence case that began this litigation.

Best regards,
THE JOHNSON FIRM, LLC