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The 1st Party Report
A Property and Insurance Update

Identifying Hidden Coverage Issues in Your Liability Claims

By Brian M. Leepson

When confronted with a liability claim against an insured, an insurer is essentially presented with two primary questions: (1) Does the liability claim have merit? (2) To what extent is the insured entitled to coverage for that claim? Both these questions must be answered before an insurer can properly evaluate its own exposure for the claim alleged against the insured. Of course, the second question can become exceedingly complex. A typical insurance policy is filled with different coverage grants, exclusions, conditions, definitions and other terms and language which, depending on the facts of the underlying claim, can greatly affect an insured's entitlement to coverage. Given the breadth of the potential coverage issues, it can become all too easy for any particular coverage issue to be overlooked.

There are essentially five general questions that an insurer needs to ask to determine whether coverage is owed for a typical claim. First, does the person seeking coverage qualify as an "insured" under the policy? Second, does the claim presented against the insured fall within the basic terms of the insuring agreements contained in the policy? Third, do any of the exclusions contained in the policy apply? Fourth, has the insured breached any of the policy's conditions? Lastly, is there any other insurance which may provide coverage to the insured?

1. **Does the person seeking coverage qualify as an "insured" under the policy?**

   This issue is generally an obvious one, and it is often not even a real question. Many times, however, persons or entities who are "strangers" to the policy may have a right to coverage. For example, in homeowners' policies, the term "insured" is often defined to include relatives of the named insured who "reside" in the named insured's household. In many commercial general liability policies – especially in the construction context – insureds under a policy include persons or entities whom the named insured has agreed in a written contract to add as an additional insured under its policy. As another example, employees of the named insured can sometimes qualify as insureds under the policy for acts done in the scope of their employment and while performing duties for the named insured. Motor vehicle policies often define the term "insured" to include those who are driving a covered vehicle with the named insured's permission. This is just a representative sampling of some of the typical policy provisions that can give someone other than the named insured status as an "insured" under the policy, and when it comes to insurance coverage disputes, minor differences in policy language can have a major impact on the outcome. Therefore, it is important for a claims handler to carefully consider the policy language contained in the particular policy at issue before determining whether a person or entity qualifies as an "insured" under that language.

2. **Does the claim fall within the insuring agreement contained in the policy?**

   Next, an insurer should turn to the main insuring agreement in the policy, which contains the basic grant of coverage to the insured. For example, the main insuring agreements contained in many policies provide coverage for "bodily injury" or "property damage" for which the insured may be liable. In that regard, under the typical definition of "bodily injury" contained in insurance policies, Georgia courts have found that a mere emotional injury, unconnected with any physical injury to the body, does not constitute "bodily injury." A physical injury to the claimant is generally required. Similarly, with regard to "property damage," courts generally hold that there must be actual damage to tangible property or at least

a loss of use of tangible property in order to constitute "property damage." A simple economic loss, unconnected with any actual damage or loss of use of tangible property, is generally not "property damage."

Assuming that "bodily injury" or "property damage" is alleged, most policies provide that coverage is still only owed if such an injury or damage was caused by an "occurrence." The term "occurrence" is typically defined by insurance policies as an "accident." Thus, if the injury or damage was alleged to be caused intentionally (i.e., not "accidentally"), no coverage is generally afforded. Also, Georgia law provides that under the terms of a typical occurrence-based policy, coverage only exists if the damage or injury at issue was caused during the period of the subject policy. This principle can create serious coverage issues in cases involving property damage that occurs gradually and over the course of multiple policy periods (e.g., through moisture intrusion or some other similar cause). The issue of coverage becomes further complicated when other insurers have issued policies for some of those policy periods. In such circumstances, good arguments can be made that each separate insurer is liable for the portion of that property damage that occurred within the policy period(s) of its own policies. Such arguments can often provide a basis for obtaining contribution from the other insurers.

Again, it is important for an insurer to carefully consider the actual language contained in its own policies, as any one of these general conclusions can change depending on that language. Also, there are other coverages that are offered by many policies that have their own separate rules. For example, many policies do not just provide coverage for "bodily injury" or "property damage," but also provide coverage for "personal and advertising injury," which include a variety of different potential claims such as defamation, invasion of privacy, malicious prosecution, etc. Some of the rules outlined above do not apply to these other coverages, and these other coverages should be carefully examined as well.

3. **Do any of the policy's exclusions apply?**

Claims handlers considering coverage should next turn to the policy's exclusions. An orderly look through the exclusions section of the policy in conjunction with the claim itself should permit a claims handler to properly identify the exclusions which might apply. It is also important, of course, to keep in mind the policy's endorsements, which may contain additional exclusions that need to be considered.

4. **Has the insured breached the policy's conditions?**

Every policy of insurance contains a number of conditions, many of which require an insured to act in a certain manner when confronted with a claim. A breach by the insured of these conditions can sometimes excuse the insurer from providing coverage, even if coverage would otherwise be owed.

The "notice" condition is a frequently considered defense to coverage. Virtually every policy of insurance contains detailed provisions regarding notice, requiring the insured to provide notice to the insurer of an "occurrence" which may give rise to a claim and to send the insurer copies of any demands, summons, lawsuits, etc., that the insured may receive due to a claim. When describing the time-frame within which such notice must be given, policies typically use terms such as "immediately" and "as soon as practicable."

Georgia law is clear that an insured's breach of a policy's notice condition can serve to bar coverage to the insured in appropriate circumstances. However, Georgia courts do not apply a "bright-line" rule in determining when the lack of notice will result in such a lack of coverage under the policy. Rather, Georgia courts apply a more amorphous test, looking generally at the length of the delay in conjunction with the excuse offered by the insured for his lack of timely notice. Under Georgia law, an insurer is not required to show prejudice in order to rely on a notice defense, and courts should not consider the question of prejudice when determining whether the failure to provide notice constitutes a breach of the policy. That said, courts do sometimes let the question of prejudice impact their decision-making.

Regardless, the question of whether the insured's lack of notice excuses the insurer from providing any coverage is typically a question for a jury. As a result, insurers

should be somewhat cautious before choosing to rely on a notice defense, because juries are often not kind to insurers which seek to avoid coverage on technical grounds. That said, in egregious circumstances, an insurer may be able to obtain summary judgment on notice grounds, thereby preventing the issue from even reaching a jury.

5. **Is there other insurance available for the claim?**

Last, after considering all the foregoing questions, a claims handler should determine whether the insured may also be entitled to coverage under another insurance policy issued by another insurer. The existence of other insurance can have a major effect on an insurer's exposure under its own policy. In that regard, policies typically contain detailed provisions regarding the "priority" of policies when other insurance exists. For example, many policies declare themselves to be excess over such other insurance. Of course, the "other" insurance policy may contain the same language. In such a case, a Georgia court would likely declare that the other insurance language contained in both policies is "mutually repugnant" and that both policies, therefore, share primary coverage on a pro rata basis.

The important point, however, is that the outcome of "other insurance" issues – and the priority of coverage between various policies – is very dependent on the language contained in all of the potentially applicable policies. A court will carefully examine all of the various policies together and see if the "other insurance" language contained in each of the policies can be reconciled with the "other insurance" language contained in the other policies, and if so, the court will seek to apply that language. Therefore, if another insurance policy under which the insured may be entitled to coverage exists, a claims handler should obtain a copy of that policy and look at the "other insurance" language itself. The only way to determine the priority of your own insurance policy is by comparing its language with the language of the other potentially applicable policies.

In the end, while coverage issues can become somewhat thorny and complex, the first step is to identify what coverage issues exist. By asking the foregoing five questions, and then working through them in a methodical and careful way, a claims handler can increase his chances of identifying all the coverage issues that a claim may raise.

For more information on this topic, please contact Brian M. Leepson at 404.888.6135, or brian.leepson@swiftcurrie.com.

Update: Suit Against Us

By Michael H. Schroder

The Insurance Commissioner's various attempts to change the suit limitation period in the Standard Fire Policy left insurers uncertain about what limitation period applies to claims that arose during certain periods of time when "emergency regulations" were in effect. Last year, the Insurance Commissioner first issued a Notice of Emergency Rulemaking in an attempt to change the limitation period to four years. Emergency Regulation 120-2-20.02-0.19 provided that "no property, casualty, credit, marine and transportation or vehicle insurance policy providing first-party insurance coverage" should contain a suit limitation period less favorable than that of the four-year period in the revised Standard Fire Policy. These emergency regulations were effective for 120 days on policies written or renewed on or after March 1, 2006. They were not permanently adopted.

Instead, the Commissioner issued on June 9, 2006, another Notice of Emergency Rulemaking. The previous two proposed regulations were superseded by Emergency Regulations 120-2-19-.01-0.20 and 120-2-20-.02-0.21. These Emergency Regulations were permanently adopted by the Commissioner effective October 12, 2006, and became Regs. Sections 120-2-19-.01 and 120-2-20-.02. The new regulations changed the suit limitation period in the Standard Fire Policy to two years. Pursuant to 120-2-20-.02-0.21, the suit limitation period for property, casualty, credit, marine and transportation, as well as vehicle insurance policies providing first-party insurance coverage, was also changed to two years. These new regulations were effective on policies written or renewed on or after June 20, 2006. The Commissioner's proclamations do not address the question of whether the suit limitations

period in the emergency regulations apply only to policies written or renewed during the applicable 120-day period, or to all policies in existence during that 120-day period. The Commissioner's position is that the provision should only apply prospectively, that is, to policies issued or renewed during the applicable period. Accepting the Commissioner's position, insurers should apply the following rules when determining what suit limitation they are legally allowed to apply.

For claims arising:

Prior to March 1, 2006

- A one-year limitation is appropriate for all policies.

March 1, 2006 through June 8, 2006

- For policies issued/renewed prior to March 1, 2006, a one-year limitation applies.
- For policies issued/renewed March 1, 2006 or after, a four-year limitation applies.

June 9, 2006 and after

- For policies issued/renewed prior to June 20, 2006, a one-year limitation applies.
- For all policies issued/renewed June 20, 2006 or after, a two-year limitation applies.

Since the anniversary date of these new rules is upon us, application of the new rules will become less problematic as policies renewed during the last year and in the future will all become subject to the longer two-year limitation period. However, for claims arising during the "windows" noted above, different limitation periods will apply depending upon the issue date of the policies, and insurers should keep these in mind when adjusting these claims.

For more information on this topic, please contact Michael H. Schroder at 404.888.6126, or mike.schroder@swiftcurrie.com.

Recent Case Update

By William W. Downs

A House Divided

Southern General Ins. Co. v. Foy, 279 Ga. App. 385, 631 S.E.2d 419 (2006).

This case illustrates the need for insurers to proceed with caution before denying a defense to an insured or failing to settle a third-party claim. Insurers must develop the facts to make sure there are no possible grounds for coverage. The insured in *Southern General Ins. Co. v. Foy* wrecked his mother's car while the two were on a trip. She then brought suit against him for her injuries. The insurer failed to defend the insured, denying coverage on the grounds that the accident did not involve a "non-owned car" since the insured lived with his mother. A default judgment was entered against the insured for $250,000 and he assigned his rights under the policy to his mother. In denying the insurer summary judgment, the Court of Appeals noted that even though the two lived under the same roof, the insurer had pointed to no evidence that the two lived in the same "household." Indeed, the Court found evidence that each lived in different areas, were responsible for separate parts of the house and came and went independently. The insurer offered no evidence to show the insured and his mother lived in a "domestic establishment under single management." The Court of Appeals noted that the insurer could have questioned the insured and his mother about the details of their living arrangements to obtain evidence to support its position and create, at least, a question of fact for the jury. Because the insurer did not seek and obtain such evidence, the court affirmed summary judgment in favor of the insured's mother in her action against the insurance company. Insurers, therefore, must be cautious before denying a defense to an insured. Even though grounds for denial may seem obvious, failure to develop the facts can be fatal to the insurance company's defenses to coverage.

For more information on this topic, please contact William W. Downs at 404.888.6129, or william.downs@swiftcurrie.com.

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Friday, September 28, 2007, 9:30 am to 3 pm – *Swift Currie Workers' Compensation Seminar*

Friday, November 2, 2007, 9 am to 2:30 pm – *Swift Currie Property Seminar*

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The First Party Report is edited by Brian M. Leepson and Melissa K. Kahren. If you have any comments or suggestions for our next newsletter, please contact Brian or Melissa. The information contained in this newsletter should not be construed as legal advice or opinion on specific facts. For more information, please contact a Swift Currie attorney.