The Journal of Insurance & Indemnity Law

A quarterly publication of the State Bar of Michigan's Insurance and Indemnity Law Section

Volume 16, No. 2 ■ April 2023

In this Issue

Section News

Feature Articles

Columns

This journal is published by the Insurance and Indemnity Law Section, State Bar of Michigan

Hal O. Carroll, Journal Editor ■ www.HalOCarrollEsq.com ■ (734) 645-1404

Opinions expressed herein are those of the authors or the editor and do not necessarily reflect the opinions of the section council or the membership.

From the Chair

Rabih Hamawi, *Law Office of Rabih Hamawi*

Due to the many resources that our Section offers, including the quarterly *Journal* and our educational programs, our Section's membership continues to grow. We are now at nearly 1,150 members with an account balance exceeding $74,000.

Our Section also continues to increase its presence and participation within the legal community. We are making strides to coordinate with other organizations in our ongoing effort to broaden the resources available to all of our members and to provide you with value for your membership in the Section. We are currently in discussions with the Young Lawyers Section, the Cannabis Law Section, and the Greater Detroit Chapter of the CPCU Society to jointly present educational programs. Details on these anticipated programs will be announced as soon as they are finalized.

New Administrative Assistant and Social Media Pages

The Section has hired Joan O'Sullivan as a part-time administrative assistant. Joan will assist the Chair and the Council in all day-to-day administrative needs of the Section.

In addition to our existing Facebook page, the Section has created an Instagram and LinkedIn pages. We plan on using those social media pages to promote the Section, its events and meetings, and to increase engagement between our membership. If you haven't already followed them, the links are below, so please follow and share.

- *https://www.linkedin.com/company/sbm-insurance-indemnity-law-section/?viewAsMember=true*
- *https://www.instagram.com/sbminsind/*
- *https://www.facebook.com/SBMIILS*

Journal

The *Journal* is now in its 16th year. It has featured articles, case updates, analyses, and opinions of interest. Please take the time to check it out. Effective with the October 2023 issue, the *Journal* will be transitioning to a digital version, and will be distributed electronically with an opt-in option. if you are a member of the Section or a member of the judiciary and would like to continue to receive the print version, please email the editor before October 1, 2023, at *HOC@HalOCarrollEsq.com*.

Scholarship

The Section's 2023 Scholarship Program accepted essays through February 28, 2023, and Council is in the process of reviewing the submissions. A winner of the $5,000 Scholarship will be selected during our April 13, 2023's Business Meeting, and will be announced at the following Business Meeting on July 13, 2023, with publication of the winning essay in our July edition of the *Journal*. This is the sixth year for our Scholarship Program, and we will have distributed a total of $30,000 in prize money to Michigan law students.

For next year, we hope to add a prize for the second and third-place winners, depending on the number of submissions that we receive.

Bar Leadership Forum

The Section will be sending Council Members to attend the State Bar Leadership Forum (BLF) at the Grand Hotel on Mackinac Island on June 9 and June 10. The BLF is attended by incoming presidents of local and special purpose bar associations, chairs of sections, and members of the Board of Commissioners. The BLF has skilled presenters on topics that are intended to help Bar leaders enhance what their Sections offer their members. It is also an opportunity to interact and network with the leaders of other Sections.

WLAM

The Women Lawyers Association of Michigan (WLAM) will mark its 105th anniversary this year. WLAM has asked the Section to sponsor WLAM's 105th annual meeting, which will be held on June 2, 2023, at the Graduate Hotel in East Lansing. The Section plans on sponsoring this event.

Feedback and Next Business Meeting

As we continue our journey to keep improving the Section, we are always open to receiving any constructive feedback that would help us improve the Section. Please feel free to email me at *rh@hamawilaw.com*.

Your input is invaluable! Please let us know what you would like to see from your membership in the Insurance and Indemnity Law Section. Please share your ideas for topics. I look forward to seeing you at our next Section's Business Meeting on July 13, 2023, starting at 4:00 p.m., which will be held in person at a location to be determined. ■


Editors' Notes

By Hal O. Carroll, *Editor* and Christine Caswell, *Assistant Editor*

The *Journal* is a forum for the exchange of information, analysis and opinions concerning insurance and indemnity law and practice from all perspectives. All opinions expressed in contributions to the *Journal* are those of the author. The *Journal* – like the Section itself – takes no position on any dispute between insurers and insureds. We welcome all articles of analysis, opinion, or advocacy for any position.

And you do not have to be a member to contribute.

The *Journal* is published quarterly in January, April, July, and October. Copy for each issue is due on the first of the preceding month (December 1, March 1, June 1, and September 1). Copy should be sent in editable format either to the editor at *HOC@HalOCarrollEsq.com* or to the assistant editor at *christine@caswellpllc.com*

The *Journal* will be going digital effective with the October 2023 issue. The basic distribution format will be distributed electronically, but there will be an option to continue to receive print copies.

If you would like to continue to receive the print version, please send an email to *sbminsuranceindemnity@gmail.com*. ■

Water Damage: What Does the Seepage and Leakage Exclusion Actually Exclude?

By Douglas G. McCray, *McCray Law Office PLLC*

Introduction

At the risk of stating the obvious, Michigan Winters are cold. Reliably, when the snow falls and ice coats the roads retired "snowbirds" fly south to Florida, planning to return in the Spring. Those who can't avoid the entire season plan mid-winter vacations, sometimes for several weeks. During the insured's temporary absence, a relative or neighbor may keep an eye on the house. However, on other occasions weeks or even months may pass with little direct observation of the structure. Unfortunately, plumbing components occasionally fail, regardless of whether anyone is home. With respect to pressurized lines and connected fixtures, this can result in hundreds of gallons of water cascading through the house in a matter of hours. When the owner is gone the problem becomes much worse because significant time may pass before a relative, neighbor or the city water department realizes anything is amiss, resulting in tens- or hundreds-of-thousands of gallons cascading through the structure, causing massive destruction.

Fortunately, most owner-occupied homes are insured under homeowners policies employing something like the ISO HO-3 form, which provides coverage on an "all-risks" basis.[1] Generally, all-risk policies insure against any "risk of direct physical loss to property," subject to the policy exclusions and other limitations. Furthermore, with one exception, abrupt failures of above-ground plumbing system components are almost never excluded. Consequently, an insured snowbird whose house is destroyed by, say, 100,000 gallons of water coursing through it should be able to rebuild. However, a small number of insurers disagree, at least in part. With a few exceptions (e.g. freezing losses),[2] such insurers will acknowledge coverage when the deluge continues for a day, or three or thirteen. However, if the insured fails to discover the problem for exactly fourteen days, some take the position that due to a policy exclusion relating to long-term "seepage or leakage," coverage evaporates not only for future water damage but for that resulting from the failed pipe on days one through 13. The author submits that this position conflicts with both the

language and purpose of the exclusion, which exists to protect insurance companies from hazards resulting from an insured's failure to repair slow leaks that because of their small volume can only cause damage over a period of "weeks, months or years." Conversely, it is not an escape hatch to let insurers avoid liability for the sort of catastrophic, high-volume water losses their own policies indicate are covered if an insured is unlucky enough to remain ignorant of the loss for 14 days because he or she is out of town.

Furthermore, with one exception, abrupt failures of above-ground plumbing system components are almost never excluded.

Backdrop: "Morale" or "attitudinal" hazards and lazy insureds

Many readers will be familiar with the phrase "moral hazard," defined in part by Black's Law Dictionary (9th Ed) as "[t]he risk that an insured will destroy property or allow it to be destroyed (usu. by burning) in order to collect the insurance proceeds. . . . [and] an insured's potential interest, if any, in the burning of the property . . . ."[3] Note the focus on morality, defined as "principles concerning the distinction between right and wrong or good and bad behavior."[4] A smaller number will recognize the phrase "morale hazard," sometimes referred to as "attitudinal" or "personal" hazard. These have little to do with morality, good and evil and other weighty concepts. Rather, as the name implies they have to do with *morale*, defined as "the confidence, enthusiasm, and discipline of a person or group at a particular time."[5] In other words, they relate to laziness. "Morale hazards" are defined in by the Property and Casualty Pathfinder used to train insurance agents as:

> A situation which increases the likelihood of loss occurring due to the insured's indifference, carelessness, laziness, disorderliness or lack of concern for the insured property. . . . .[6]

Another source describes them as hazards that "arise out of carelessness or indifference to loss [that] often results from the presence of insurance."[7] A "moral" hazard exists when there is a financial incentive to actively destroy one's own property. A "morale" hazard exists when an insured has no incentive to prevent a loss because (for instance) if those pesky termites finish eating the garage the insurance will pay for a new one. One of the better attempts to distinguish between "morale" from "moral" hazards states:

> The term moral hazard is loosely used. It should mean the hazard of the insured setting fire to the property or making a fraudulent claim. Another term should be used to indicate the hazard of poor housekeeping, carelessness, or a neglect of maintenance when these are not intended by the insured to set the property on fire. Some underwriters use the term *personal hazard* rather than moral hazard to include the two classes. The latter class is at times called *morale hazard*.[8]

As the above passage implies, the line between moral and morale hazards is not always clear and definitions vary. However, most sources contemplate a "morale hazard" involving a situation in which an insured fails to do something he or she should (e.g. calling an exterminator or fixing a slow leak), resulting in a preventable loss.

What does an insurer need to do to protect itself against moral and morale hazards? With respect to the former nothing at all, since insurance only protects against "fortuitous" events, defined as those that are "to a substantial extent beyond the control of either party; happening by chance; accidental . . ."[9] It does not cover intentional losses, so even in the absence of an exclusion an arson fire or faked theft is not covered. Nonetheless, most policies contain exclusions barring coverage for losses that are intentional from the insured's standpoint.

The picture is more complex for "morale hazards," in part because while the insured in these situations could have been more conscientious, the loss was not intentional and thus fortuitous. With respect to all-risk fire insurance policies, this means that the loss is likely to be covered despite the insured's nonchalant attitude unless it is specifically excluded. Accordingly, homeowners' policies contain copious exclusions relating to "the hazard of poor housekeeping, carelessness, or a neglect of maintenance," barring coverage for damage directly caused by insects or vermin, wear and tear, rust and other gradual, long-term destructive processes.

The seepage and leakage exclusion

So what do morale hazards have to do with our snowbirds and vacationers? An abrupt pipe failure or toilet overflow can destroy a house in a couple of days, and does not seem like the sort of thing that would result from an insured's "indifference, carelessness, laziness, disorderliness or lack of concern for the insured property. . . ." Such sudden, catastrophic events are the reason insurance exists. Indeed, the typical homeowners policy's personal property coverage (which is issued on a "named peril" rather than "all risk" basis) specifically lists "accidental discharge or overflow of water or steam from within a plumbing . . . system or from within a household appliance" as a covered peril. Nonetheless, insurers often take the position that even if water damage results immediately following the failure of a pipe or fixture, no coverage exists if the loss is not discovered for two weeks, citing one or another version of the following exclusion:

> **1.** "We" do not insure "physical loss" caused by:
>
> * * *
>
> **h**. Constant or repeated seepage or leakage of water or the presence or condensation of humidity, moisture or vapor, over a period of weeks, months or years unless such seepage or leakage of water or the presence or condensation of humidity, moisture or vapor and the resulting damage is unknown to all "insured" and is hidden within the walls or ceilings or beneath the floors or above the ceilings of a structure. [10]

Note that under the above provision, only losses caused by leakage or seepage that occurs over a span of *weeks* (at a minimum) are excluded. By definition, those that occur in an hour, a day or a week are not. Thus, the exclusion is specifically geared toward water losses that can only occur if the owner ignores an ongoing, low volume water problem, such as seepage around the base of a toilet or a slow drip under a sink. Gradual processes like these can take years to cause appreciable damage, and because of the extended time-frame are likely to be detected and repaired by a homeowner long before (for example) the wood-rot is so severe that the bathroom floor starts caving in. In that regard, the exclusion is a classic example of one designed to address the morale hazards resulting from "indifference, carelessness, laziness, disorderliness or lack of concern for the insured property. . . ." Conversely, the exclusion is not designed to address situations in which a pressurized suddenly pipe fails, sending thousands of gallons of water through a house in a day. However, when the event is not promptly discovered because the insured is out of town, some insurers take the position that if water flowed for more than two weeks the exclusion is triggered and coverage lost, even with respect to damage occurring in the first 13 days.

Michigan law regarding the exclusion: *Cincinnati Insurance Company v Kaeding*

The leading (albeit unpublished) Michigan case regarding this topic is *Cincinnati Insurance Company v. Kaeding*[11], in which the Michigan Court of Appeals focused on both the meaning of "leakage" and the timing aspect of the exclusion. In *Kaeding,* a water line separated from an upstairs bathroom wall. Apparently, the insured maintained dual residences in Ohio and Michigan and the separation occurred at the Michigan house while the insured was out of town. Unfortunately, because he was not present when it occurred the insured was unaware of the situation for 27 days. However, the court made it clear that this was a high-water volume event, and that the "amount of water that was released into defendant's home would have caused significant damage within hours or days." Cincinnati denied the claim based upon the above exclusion, claiming that the stream of water spraying from the open water line constituted "leakage" for purpose of the policy. While not expressly stated, Cincinnati must have also argued that even though this was a high-volume water event, coverage was barred because the period over which the purported "leak" occurred exceeded two weeks.

> So what do morale hazards have to do with our snowbirds and vacationers? An abrupt pipe failure or toilet overflow can destroy a house in a couple of days, and does not seem like the sort of thing that would result from an insured's "indifference, carelessness, laziness, disorderliness or lack of concern for the insured property. . . ." Such sudden, catastrophic events are the reason insurance exists.

In ruling in the insured's favor, the trial court agreed with the insured's contention that the word leakage *as used in this specific context* "did not encompass the nature of the loss or damage in this case." Specifically:

> "the use of "seepage" and "leakage" in the same phrase as "condensation, humidity, moisture or vapor" supported [the insured's] position. In addition . . . the exclusion stated that the "leakage" must occur over a period of weeks, months, or years. . . . "[S]eepage" and "leakage" were more akin to a slow release of a small amount of water consistent with "humidity, moisture and vapor." . . . [W]eeks, months, or years were the periods of time that it would take for a small discharge of water to cause damage. . . .

The Michigan Court of Appeals agreed, stating:

> It is undisputed that the insurance policy does not define the term "leakage." If a term of a contract is not defined, it must read in accordance with its commonly used meaning. . . . We conclude that the commonly used meaning of "leak" refers to a gradual or low volume water event. In addition, looking at the exclusion as a whole supports this conclusion. For the exclusion to apply, the "leakage" or "seepage" is required to be "constant" or "repeated" "over a period of weeks, months or years." This time requirement of weeks, months, or years is necessary for a low volume gradual water "leakage" or "seepage" to cause significant damage to a home. As the trial court found, the terms of the exclusion demonstrate plaintiff's intent to avoid coverage for losses

> that are caused by a homeowner's neglect, failure to maintain, and failure to occupy a home.
>
> This does not describe what occurred in defendant's home. The amount of water that was released into defendant's home would have caused significant damage within hours or days because the separated pipe essentially caused flooding.

While one or two other courts interpreting Michigan law have addressed the exclusion, as far as the author knows *Kaeding* is the only one to do so with respect to a high volume water loss, as opposed to the sort of "gradual or low volume water events" it is designed to address.

> Conversely, the exclusion is not designed to address situations in which a pressurized suddenly pipe fails, sending thousands of gallons of water through a house in a day. However, when the event is not promptly discovered because the insured is out of town, some insurers take the position that if water flowed for more than two weeks the exclusion is triggered and coverage lost, even with respect to damage occurring in the first 13 days.

Kaeding, viewed in light of the Michigan Supreme Court decisions addressing proper interpretation of contracts and statutes

In deciding as it did, the *Kaeding* Court looked to both the "commonly used meaning" of the word "leaking" and (more importantly) its context in the policy. Specifically, the court recognized that the exclusion as a whole dealt with "low volume gradual water" incidents that could only cause damage over "weeks, months, or years," and not high-volume losses that "would have caused significant damage within hours or days." This approach was consistent with Michigan law regarding contract and statute interpretation, which looks to dictionary definitions, but not *only* to dictionary definitions. As stated by our supreme court (interpreting a statute):

> However, the [statutory subsections being interpreted], as with all other provisions of law, are not to be read discretely, but as part of a whole. The dissent errs in first reading these subsections "alone" and then asserting that it is reading these subsections "together" when it merely combines its "alone" interpretations . . . . Rather, to read the law as a whole, it must, in fact, be read as a whole. The interpretative process does not. . . remove words and provisions from their context, infuse these words and provisions with meanings that are independent of such context, and then reimport these context-free meanings back into the law. The law is not properly read as a whole when its words and provisions are isolated and given meanings that are independent of the rest of its provisions.[12]

While *Kaeding* did not use the phrase "morale hazard," its reference to "low volume gradual water incidents that could only cause damage over 'weeks, months, or years' " and the (Plaintiff) insurer's intent to avoid coverage for losses caused by "neglect" illustrate that the panel was aware that the exclusion (here, the context of the word "leaking") is designed to protect against such hazards. Conversely, it is not designed to bar coverage for the sort of "accidental discharge[s] or overflow[s] of water . . . from within a plumbing . . . system or from within a household appliance" referenced in the (named peril) personal property coverage unless the "discharge" is of such a small volume that it will take weeks, months or years for it to do any damage. In other words, a loss caused by a slow drip over months is excluded. A geyser that drenches a house in hours is not, even if the insured is out of town when it happens. *Kaeding* involved the precise sort of analysis contemplated by the Supreme Court.

The *Kaeding* court's analysis was also consistent with the interpretative canon "*noscitur a sociis*," defined by the Michigan Supreme Court as follows:

> This principle states that when several words 'are associated in a context suggesting that the words have something in common, they should be assigned a permissible meaning that makes them similar. The canon especially holds that 'words grouped in a list should be given related meanings. . . ."[13]

Recently, in *Honigman Miller Schwartz & Cohn v. City of Detroit*[14] the Supreme Court explained the rationale underlying *noscitur a sociis*, recognizing that while listed words (here, "performed" and "rendered") should generally not be treated as synonyms, they should be treated as having similar meanings when doing so would be consistent with the purpose of the statute as a whole. In a footnote, the *Honigman* Court stated:

> . . . [T]his Court will not attribute distinctive meanings to distinctive terms where, in viewing these terms in context, the coherence of the statutory provision as a whole would be undermined. A statute must be read in its entirety and words must be assigned meanings that are in harmony with the

> whole of the statute. . . More specific exceptions may also pertain in circumstances . . . in which words located within a listing have related meanings, *see, e.g.*, *Rovas* , 482 Mich. at 114-115, 754 N.W.2d 259 (defining "mislead," "deceive," and "false" in a similar fashion by applying *noscitur a sociis* , which is " 'the principle that words grouped in a list should be given related meaning' ") . . . .

In this case, the language preceding "seepage and leakage" does more than "suggest" that they the two words something in common. Rather, it expressly states that coverage for losses caused by either is only lost if the claimed damage occurs over a span of (at a minimum) "weeks." Consistent with this language, every dictionary definition of "seepage" contemplates the sort of a "gradual or low volume water event" referenced by the *Kaeding* court.[15]

Taking into account the initial "two weeks" language applicable to both words (i.e. viewing them in context, as contemplated by the *Michigan PSC* Court) and employing the *noscitur a sociis* principle discussed in *Honigman*, the *Kaeding* court correctly determined that "leakage" had to be interpreted to mean something similar (if not identical) to "seepage."

Other jurisdictions, and the significance of "weeks, months or years"

For the most part, courts in other jurisdictions have rejected insurer contentions that the exclusion bars coverage for high-volume water events that cause damage property within hours, but are not discovered for weeks. In a fair number, insureds have taken the position that even if a high-volume event is considered "leakage," coverage exists because: (1) the exclusion only bars coverage for damage caused by "weeks, months or years" of exposure; and (2) the event caused some or all of the water damage prior to the 14-day threshold. For instance, in *Wheeler v. Allstate Insurance Company et. al.*,[16] Allstate denied a claim for a pipe failure in the insured's seasonal cabin. While water flowed for roughly two months before the problem was discovered, the insured asserted that the damage would have been essentially complete within the first week.

The district court did not contest that coverage would exist for such early damage, and (consistent with this) cited Allstate's experts' testimony that the exclusion was intended to address "morale hazards" that "occur[ ] and/or [are] increased because of a less-than-conscientious attitude on the part of the homeowner toward the proper maintenance and care of the property insured."[17] However, the district court also indicated that because the damage was not found for 60-70 days, "it [wa]s difficult if not impossible for the Court to determine exactly what amount of damage would have occurred in the first few hours and days," and ruled against the insured.[18] On appeal, the 10th Circuit reversed, noting that: (1) the policy language did not support Allstate's position that "the Policy terminates coverage when a long-term water release occurs, even absent a causal link between the duration of the release and the damages claimed"; and (2) it was inappropriate for the court to determine, on summary judgment, that the i-nsured could not prove damages occurred within the initial 13-day window.[19]

In *Hicks v. American Integrity Insurance Company of Florida*[20] the Florida Court of Appeals again ruled in the insured's favor. In that case, the trial court had correctly indicated that: "[i]f the 'loss' was realized between days 1 and 13 it is not excluded, even though the 'condition' may have remained on the property for 14 days or longer." However, the trial court had ruled in favor of the insurer based upon its contention that it was "not so sure that the time frame of these particular facts would allow for that determination" (i.e. the portion of the loss occurring in the initial 13 days). On appeal, the court recognized that in so ruling, the trial court inappropriately shifted the burden of proving that coverage was barred by the exclusion to the insured, stating: "In an all-risks policy, once the insured establishes a loss within the terms of a policy, the burden shifts to the insurer to prove that a particular loss arose from an excluded cause".[21] The Court then remanded for entry of summary judgment in the insured's favor.

Landrum v. Allstate Insurance Company[22] involved the failure of an ice-maker supply line, resulting in water flowing for 25 days. In that case, the court ruled against the insured because "[u]nlike the evidence in *Wheeler* and *Hicks*, none of the evidence in this record establishes that the damages were caused by less than 25 days of leakage." However, it also acknowledged that coverage did exist for damage occurring in the first 13 days, implying that if the insured had presented evidence of damage during that initial time period it would have been covered.

Not every foreign case has indicated that damage within the first 13 days is covered. For instance, in *Karon v Safeco Insurance Company of America*[23] the US District Court for Arizona inexplicably held that damage occurring within the first 13 days, but discovered later, was excluded because due to the late discovery damage continued after the 14-day threshold. The author submits that as a matter of logic damage that occurred on, for instance, day 2 could not have occurred (to quote the policy) "over a period of weeks, months or years." In any event, cases like *Karon* are unusual, and most foreign cases hold that regardless of whether the cause of loss is considered "leakage," damage occurring before the 14-day threshold is covered.

Conclusion

Kaeding provided a detailed treatment of the "seepage and leakage" exclusion, and consistent with Michigan law looked at the definition of "leakage" in the context of the policy as a

whole and the exclusion's purpose. Even if *Kaeding* did not exist and (for instance) a geyser producing a thousand gallons per day could be considered "leakage," the exclusion's effect is limited by its own language to losses caused by (and sometimes "consisting of") at least two weeks of water exposure. Unlike the seepage and leakage the exclusion is designed to address (i.e. "low volume gradual water 'leakage' or 'seepage' " events that "take weeks, months, or years . . .to cause significant damage to a home"), high-volume water events like these "cause[ ] significant damage within hours or days."[24]

Nonetheless, even after *Kaeding* Michigan insurers continue to assert that damage from high-volume plumbing failures that can destroy a house in days are barred by this "morale hazard" exclusion if it takes an insured vacationer a couple of weeks to discover the catastrophe. The author submits that this position is unsupportable in light of: (1) the exclusion's language; (2) Michigan law regarding contract interpretation, as set forth by the Supreme Court; (3) *Kaeding*; and (4) the foreign cases holding that damage occurring in the first 13 days is covered even for "leakage." ■

About the Author

Doug McCray *is the senior member at McCray Law Office PLLC (MLO). For 26-odd years, he has been involved in various types of insurance litigation. For the last 20, Doug has represented insureds (and applicants) against insurance companies and agents in the fire insurance context. He is listed as an author on several published articles addressing legal and scientific topics, and is a member of the State Bar of Michigan Insurance and Indemnity Law Section council.*

Endnotes

1 *See, e.g.,* National Association of Insurance Commissioners ("NAIC") Dwelling, Fire, Homeowners Owner-Occupied, and Homeowners Tenant and Condominium/Cooperative Unit Owner's Insurance Report: Data for 2019 (2022), pp. 4-5.

2 The exception is losses caused by freezing of a plumbing (or other water-containing) system when the insured has failed to exercise reasonable care to: (1) maintain heat; or (2) shut off the water supply and drain the system. Precisely what constitutes "reasonable care" in this context could be the topic of a separate article. However, the scope of this one is limited to situations in which the snowbird has either left the heat on or shut off the water and drained the system.

3 Black's Law Dictionary (9th Ed., 2009), definition of "hazard: moral hazard." This edition of Black's also references "[a] hazard that has its inception in mental attitudes, such as dishonesty, carelessness, or insanity." The author is unaware of any other source that refers to risks resulting from "insanity" as a moral hazard (or morale hazard, discussed below), and most sources from the last 50 years would define risks arising from "carelessness" as "morale," not "moral," hazards, at least when the carelessness is a result of the existence of insurance.

4 The New Oxford American Dictionary, Oxford University Press (2001 Ed).

5 Id.

6 Property & Casualty Pathfinder, Commemorative Ed. (Pathfinder Publishers, 2010). In contrast, it defines "moral hazard" as "[a] circumstance in which the insured attempts to defraud the insurance company through intentional and deliberate destruction of the insured property. . . "

7 Launie, J.J., Lee, J. Finley and Baglini, Norman, *Principles of Property and Liability Underwriting* (Insurance Inst. of America, 3d Ed., 1986).

8 Reed, Prentiss B., Fire Insurance Underwriting (McGraw-Hill Book Co., Inc. 1940), p. 6.

9 Gordis, Philip, *Property and Casualty Insurance: A Guidebook for Agents and Brokers* (12th Ed., Revised 1965, The Rough Notes Co. As examples of "fortuitous" events Gordis lists "fire, windstorm, explosion, flood, etc.." Obviously, given that the list is preceded by "happening by chance; accidental" and includes "windstorm" and "flood," he was referencing accidental fires.

10 *Cincinnati Insurance Company v. Kaeding,* Mich. Ct. App. 332559 (7-20-2017; unpublished). Other versions of the exclusion use: (1) "caused by or consisting of" (instead of "caused by"); (2) "continuous" instead of "constant"; and/or (3) "14 days or more" instead of "weeks, months or years." The author has not seen the clause pertaining to seepage or leakage hidden within walls in any other policy, but it is generally consistent with the purpose of these provisions.

11 Mich. Ct. App. 332559 (7-20-2017; unpublished), leave den. 501 Mich. 1037, 909 N.W.2d 233 (Mem).

12 *Mayor of City of Lansing v. Michigan PSC*, 470 Mich. 154, 680 N.W.2d 840, 848 (2004). These principles apply to contracts. *See, e.g.*, *Loiacano v. Home-Owners Ins. Co*., Mich. Ct. App. 351876 (2-18-2021; unpublished) ("Words in a contract must be construed in context and in light of both the contract as a whole and any distinct provision within the contract where the word is used"); Carrol, Hal, *Location, Location, Location*, J. of Ins. and Indemn. L., Vol. 15, No. 4 (April 2015) (discussing importance of context with respect to insurance policies).

13 *Atlantic Casualty Ins. Co. v. Gustafson*, 315 Mich App 533, 541, 891 NW 2d 499 (2016).

14 505 Mich. 284, 317 n. 32, 952 N.W.2d 358 (2020). *Noscitur a sociis* applies to contracts (including insurance policies) as well as statutes (*see, e.g.*, *Opperman v. Heritage Mut. Ins. Co*., 1997 SD 85, 566 N.W.2d 487, 490-491 (1997); *Anderson v. Southeastern Fidelity Ins*. Co., 251 Ga. 556, 307 S.E.2d 499, 500 (1983)).

15 *See, e.g.*, The New Oxford American Dictionary (Oxford University Press, 2001 Ed), defining seepage as "n. the slow escape of a liquid or gas through porous materials or small holes . . . ."

16 *Wheeler v. Allstate Ins. Co.,* No. 15-4159 (CA 10, 5-4-2017).

17 *Wheeler v. Allstate Ins. Co.,* No. 2:12-cv-193-BCW (D. Utah, 9-29-2015), p. 7.

18 Id. at 18.

19 *Wheeler v. Allstate Ins. Co.,* No. 15-4159 (CA 10, 5-4-2017), under 2(a) "Exclusion 3."

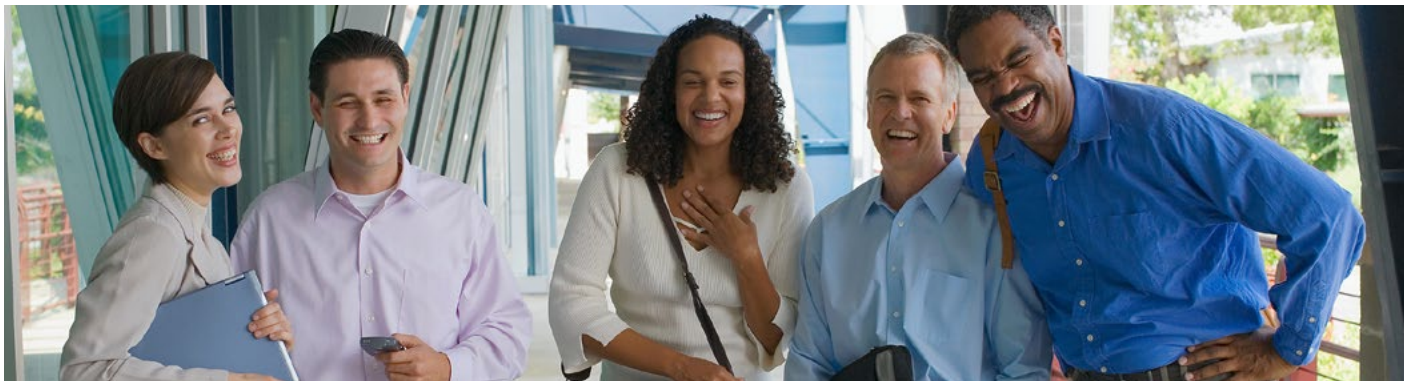
20 *Hicks v. American Integrity Insurance Company of Florida,* No. 5D17-1282, (Fla. D. Ct. App. 2-23-2018).

21 Id. at 4. Michigan employs the same rule. See, e.g. *Heniser v. Frankenmuth Mut. Ins.*, 449 Mich. 155, 534 N.W.2d 502, 505 n. 6 (1995) (". . . the 'insured bears the burden of proving coverage, while the insurer must prove that an exclusion to coverage is applicable'."

22 Case No. 5:18-cv-00458 (M.D. Ga 10-9-2019), aff'd. CA 11 Case No. 19-14539 (5-11-2020).

23 *Karon v. Safeco Ins. Co. of Am.,* No. CV-20-01522-PHX-DJH (D. Az. 08-05-2021).

24 *Kaeding*, *supra*.



Invite someone you know to join the fun.

Invite someone to join the section. Section membership forms can be found at http://www.michbar.org/sections

Leasing Issues Related to Indemnification and Insurance Issues in Premises Cases

By Matthew J. Consolo, *Secrest Wardle*

Copyright 2022 Secrest, Wardle, Lynch, Hampton, Truex and Morley, P.C.

A nuts & bolts analysis of when and under what circumstances an insured owes indemnification; when to tender the defense; when to accept or decline the tender; and when to defer those decisions strategically

In order to properly analyze the tender of defense issues and strategies, it is necessary to examine the lease as a whole, and, in particular, the three types of lease clauses that go directly to this issue. They are:

1. Lease clauses that define the "leased premises";
2. Indemnification clauses (and related lease clauses that go to the issue of the intention to indemnify); *and*
3. Insurance clauses.

Lease clauses that define the "leased premises":

1. Examples of when this becomes an issue whenever there is a multi-tenant situation;
2. The case law definition of the phrase "in, on, or about the leased premises";
3. Related documents that define the footprint or the dimensions of the rented space;
4. Related lease clauses that help you define the "leased premises";
5. Interrelated issues regarding possession and control; and
6. Regardless of what the lease says, who really does the maintenance in the area, and for the circumstances, in which the plaintiff was injured?

Analysis of indemnification clauses themselves:

1. Success in tendering the defense and/or obtaining indemnification is directly related to the language of the indemnification clause itself.
2. Examples of indemnification clause language, starting with the least helpful to the most helpful:
   A. "Tenant assumes all risk of injury to its customers";
   B. "Tenant agrees to indemnify and hold harmless landlord";
   C. "Tenant agrees to hold harmless and indemnify landlord from and against any and all claims";
   D. "Tenant agrees to hold harmless and indemnify landlord from and against any and all claims that arise in, on, or about the leased premises from any cause whatsoever";
   E. "Tenant agrees to hold harmless and indemnify landlord from and against any and all claims that arise in, on, or about the leased premises from any cause whatsoever, including where the landlord itself is partially negligent. However, this indemnification provision does not apply where the landlord is solely negligent in causing the injury"; and
   F. "Tenant agrees to hold harmless, defend, and indemnify landlord from and against any and all claims that arise in, on, or about the leased premises from any cause whatsoever, including where the landlord is partially negligent, but provided that the landlord is not solely negligent in causing the injury, including all settlements, judgments, attorney fees, and court costs."
3. Case law tells us that:
   A. An indemnity contract is construed in the same fashion as are contracts generally;
   B. Indemnity contracts should be construed to effectuate the intent of the parties, which may be determined by considering the language of the contract, the situation of the parties, and surrounding the making of the contract; and
   C. C. An indemnity contract will be construed against the party who drafts the contract and the party who is the indemnitee.
4. Other related lease clauses that go to the heart of the intent to indemnify.

Insurance-related clauses:

1. Simple clauses that just require liability insurance with specified limits;

2. Clauses that say, "For the benefit of" the other party, but not necessarily requiring that the other party be named as "an additional named insured";
3. The difference between a mere "certificate holder" and "an additional named insured"; and
4. What happens where the insured is supposed to give the other party either a "certificate of insurance" or name them as "an additional named insured" but fails to do so?

Analysis of Indemnification Clauses and Evaluating Liability Based Upon Them

Contractual indemnity can arise only from an express agreement between the parties to a contract. An indemnity contract creates a direct, primary liability between the indemnitor and indemnitee that is original and independent of any other obligation.[1] An indemnity contract creates a direct, primary liability between the indemnitor and the indemnitee that is original and independent of any other obligation.[2]

As with any other contract, a court's primary task in construing a contract for indemnification is to give effect to the parties' intention at the time they entered into the contract. [3] The court determines the parties' intent by examining the language of the contract according to its plain and ordinary meaning.[4] In doing so, the court avoids an interpretation that would render any portion of the contract nugatory.[5]

Where parties have expressly contracted for indemnification, "the extent of the duty must be determined from the language of the contract." To this end, the indemnity clauses in the parties' contract are critical in applying general indemnification principles to the facts of this case.[6]

Generally, the language in an indemnity contract such as "from and against any and all claims" and "from any and all causes whatsoever" is generally construed to protect the indemnitee, which is generally the landlord, from the landlord's own negligence. "[T]here cannot be any broader classification than the word 'all.' In its ordinary and natural meaning, the word 'all' leaves no room for exceptions."[7]

Moreover, a contract may provide for indemnification for the indemnitee's own concurrent negligence, if this intent can be ascertained from other language in the contract, surrounding circumstances, or the purpose sought to be accomplished by the parties.[8] Therefore, a careful analysis of the indemnification language is necessary to properly evaluate liability pursuant to the indemnification clause. Although some of these clauses may be lengthy, they are not that difficult to analyze in accordance with the above case law.

Keep in mind that there is a statute in Michigan that precludes indemnification in favor of an indemnitee who is solely negligent in connection with a contract for the "repair or maintenance of a building," regardless of what the indemnification clause says.[9] That statute holds that such an indemnification provision would be void as against public policy. Additionally, exculpatory clauses in residential leases that negate a landlord's statutory duties are unenforceable because they violate public policy.[10] However, in these types of cases, the comparative negligence of the plaintiff still counts in determining the issue of "sole negligence" of the indemnitee. Accordingly, indemnification would still be owed to the indemnitee, notwithstanding that statute, if the plaintiff was guilty of some comparative negligence.

The same rules apply toward the analysis of whether or not indemnification is owed for accidents arising out of common or shared areas. If a tenant agrees to indemnify a landlord for all accidents that occur "in, on, or about the leased premises," but the lease defines the "leased premises" as only that store in the strip mall that the tenant has rented, then the tenant would not owe the landlord indemnification for someone that fell in a parking lot. On the other hand, if the indemnification provision itself, or the definition of "leased premises" in the lease includes common areas, with phrases such as "common areas allocated to the leased premises," then the tenant would owe the landlord indemnification for a parking lot type accident.[11]

Therefore, in order to properly evaluate indemnification claims, you must thoroughly analyze not just the indemnification language, but all of the other language of the lease and/or contract as well.

Claims for express contractual indemnity must generally be filed within six years after accrual of the claim.[12] This period, however, may be shortened by agreement of the parties.[13]

Analysis of Leases Involving Pro-Rata Share of Expenses for Maintenance of Common Areas Where the Plaintiff Is Injured in a Common Area

Often a lease will require a tenant to pay its pro-rata share of the maintenance costs of common areas. This is typically based on the percentage of a strip mall that is occupied by the tenant. The question is whether or not such a lease provision creates a duty owed to plaintiffs in those common areas, and whether or not the tenant can be sued on that basis, where common area maintenance was clearly needed but never done. The answer is that the tenant cannot be liable under such circumstances, and would not owe a separate and distinct duty to the plaintiff, using the classic "possession and

This rule even applies where the tenant is the sole tenant of the property.[14] In that case, the court held that possession and control of the premises is critical in determining whether or not a landlord, the tenant, or both will be liable for injuries sustained in common areas. In that case, the decision as to which repairs were necessary, and the actual maintenance on the parking lot itself was done exclusively by the landlord.

Moreover, it was the landlord's failure to make the necessary repairs. Accordingly, even where the tenants ultimately pay for such common area repairs, common area accidents are generally the responsibility of the landlord only in the absence of indemnification or other lease provisions. Again, in order to properly evaluate liability for a common area accident, it is necessary to thoroughly analyze the entire lease. ■

About the Author

Matthew Consolo *is the Executive Partner of Secrest, Wardle, Lynch, Hampton, Truex and Morley, P.C., and practices in the Troy office.*

Endnotes

1 *Miller-Davis Co v Ahrens Constr, Inc*, 495 Mich 161, 848 NW2d 95, *rehearing denied,* 495 Mich 998, 845 NW2d 742 (2014).

2 Id.

3 Id. At 165

4 *Miller-Davis*, supra at 165. See also *MSI Construction Managers, Inc v Corvo Iron Works, Inc*, 208 Mich App 340; 527 NW2d 79 (1995).

5 *MSI Construction Managers, Inc v Corvo Iron Works, Inc*, 208 Mich App 340; 527 NW2d 79 (1995); *Triple E Produce Corp v Mastronardi Produce*, 209 Mich App 165; 530 NW2d 772 (1995).

6 *Miller-Davis Co v Ahrens Constr, Inc*, 495 Mich 161, 174; 848 NW2d 95 (2014).

7 *Pritts v JI Case Co*, 108 Mich App 22; 310 NW2d 261 (1981); *See also City of Birmingham v Royal Oak Landscaping*, 2005 Mich App LEXIS 1082 (2005).

8 *Sherman v DeMaria Building Co, Inc*, 203 Mich App 593; 523 NW2d 187 (1994).

9 MCLA 691.991.

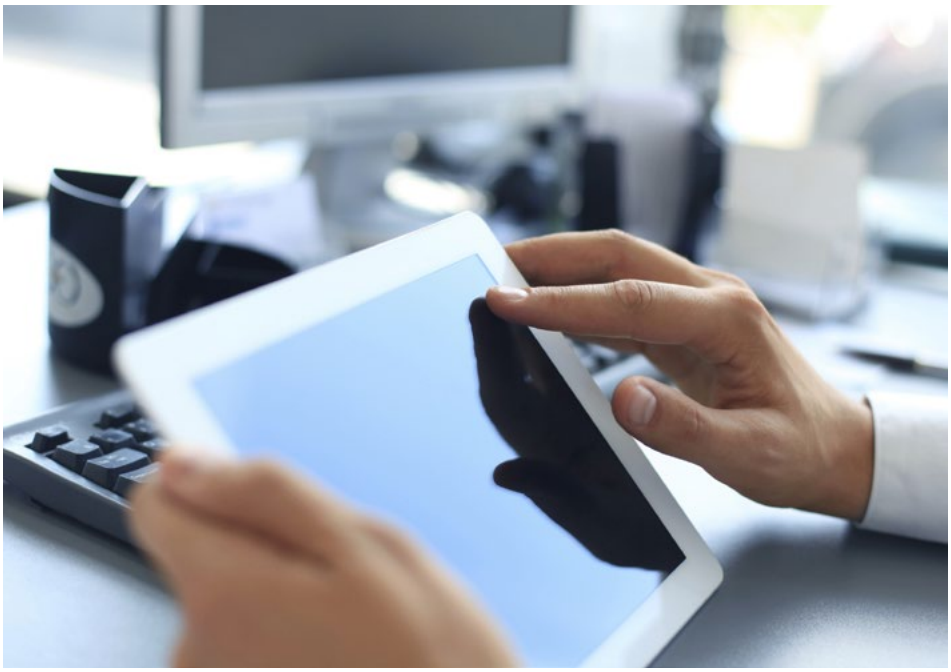
10 *Wendzel v Feldstein*, ___NW2d___; 2015 Mich. App. LEXIS 2147, at *7-8 (Ct App, Nov. 17, 2015).

11 *Schoening v Kia Motor Engineering, Inc,* 1997 Mich App LEXIS 2539 (1997).

12 MCL 600.5807(8); *Insurance Co of North America v Southeastern Elec Co, Inc*, 405 Mich 554, 275 NW2d 255 (1979).

13 *Rory v Continental Ins Co*, 473 Mich 457, 703 NW2d 23 (2005).

14 *Shackett v Schwartz*, 77 Mich App 518; 258 NW2d 543 (1977).



The *Journal* is going digital

The Journal, now in its 16th year, will be going digital effective with the October 2023 issue. The basic distribution format will be electronic, but any section member or member of the judiciary can continue to receive the print version, by sending an email to the Editor at HOC@HalOCarrollEsq.com


LEGISLATIVE UPDATE

New Year, New Session, New Districts, New Lawmakers

By James J. Hunter and Katharine Buehner Smith, Collins, Einhorn, Farrell PC

The legislative session began January with its newly drawn districts, many represented by new lawmakers—54 of the 110 members of the House are new, and nearly half of the Senate is new, as well.

There is a two-person Democratic majority in both chambers, but at the same time, the recent redistricting means that many seats are now highly competitive. It's possible that this will lay the groundwork for some meaningful bipartisan policy.

The Legislature opened up the new session by introducing 284 House bills, and 177 bills in the Senate, referring several to the insurance committees. The Senate Finance, Insurance, and Consumer Protection received many tax-related bills, and a bill to make Juneteenth a public holiday and to create the History Museum Authorities Act. It has not received any bills focused on the Insurance Code. The House Insurance and Financial Services Committee received the following:

- **Insulin co-pay cap –** HB 4015 amends the Insurance Code to provide a cap to the amount an insured can be required to pay for insulin.
- **Insurers' electronic meetings –** HB 4077 amends the Insurance Code to clarify procedures for private insurance companies' electronic meetings, and to remove a September 2022 sunset.
- **Coverage for telemedicine –** HB 4131 amends the Insurance Code to expand coverage for health care services provided through telemedicine by preventing an insurer from excluding coverage for telemedicine, placing a specific annual or lifetime cap on telemedicine services, or requiring prior authorization for telemedicine treatment.
- **Uniform Securities Act –** HB 4197 amends the Uniform Securities Act to include protections for financial exploitation.
- **Credit history and hiring decisions –** HB 4240 creates the Job Applicant Credit Privacy Act. The act would prohibit employers from making certain inquiries and/or recruiting or hiring decisions based on an individual's credit history and would provide remedies when an employer violates it. ■

INSURANCE AND INDEMNITY 101 – NO 2

Occurrence-Based and Claims-Made Insurance Policies

By Rabih Hamawi, CPCU®, CIC, CRM, LIC, MSF, *www.hamawilaw.com*

Copyright © 2023 Rabih Hamawi

Generally, there are two types of liability insurance policies: occurrence-based and claims-made policies. Occurrence-based are the more common type of liability policies. Auto, homeowners, and commercial general liability policies are occurrence-based. Professional and pollution liability policies are generally claims-made policies.

Although the distinction between the two may appear simple at first, successive policy periods, including renewals with different insurers, and changing retroactive dates, may complicate the ultimate question: Which insurer owes the duty to defend and indemnify?

Occurrence-based policies cover any claim that arises out of an "occurrence," as defined in the policy. The "occurrence" must take place during the policy period, and must be reported timely to the insurer. For the types of claims covered by occurrence-based policies, the liability-causing event can easily be traced to a specific date because it is based on a specific event, usually an "occurrence" causing injury.

Claims-made policies provide coverage that is triggered when a claim is made against the insured during the policy period (or during the extended reporting period if the policy has expired, and there is no successive policy), regardless of when the wrongful act that gave rise to the claim took place. Some pollution liability policies may require that any claim be discovered *and* reported to the insurer during the policy period.

Claim-made policies typically have a retroactive date, which is a provision that eliminates coverage for claims produced by an injury or wrongful acts that took place before a specified date, even if the claim is first made during the policy period.

Claims-made policies are generally more restrictive than occurrence-based policies, and the initial premium is correspondingly less, but it will significantly increase as the date between the policy period and the retroactive date widens. For example, a solo attorney who has been practicing for 20 years will pay more premium for a legal malpractice policy than an attorney that just started his or her practice, in large part, due to the length of the retroactive date's period.

Apart from these practical reasons, the insurer has economic incentives as well. Since the insurer's exposure for occurrence-based claims can lie dormant until a statute of limitations expires, the insurer can't "close its books" at the end of a policy year. But if the insurer is only obligated for a claim when the claim itself is made in a policy year, then its exposure is significantly less.

In distinguishing the two types of policies, the Michigan Supreme Court has held that "[a]n 'occurrence' policy protects the policyholder from liability for any act done while the policy is in effect, whereas a "claims made policy' protects the holder only against claims made during the life of the policy."[1]

Claims-made policies "are of relatively recent origin and were developed primarily to deal with situations in which the error, omission or negligent act is difficult to pinpoint and may have occurred over an extended period of time."[2]

Because the two types of policies have fundamental differences, the attorney who is evaluating coverage must fully read the policies somewhat differently and look for different triggers. The attorney must also review any policy applications because "the policy application, declarations page, and the policy itself construed together constitute the contract."[3]

Retroactive Date

If a claims-made policy covers a claim that is made and reported during the policy year, is there any limitation on how long before the policy's inception date the underlying occurrence, wrongful act, or liability-causing event must have occurred?

Insurers love claims-made policies because it limits the extent of their exposure. This is what a "retroactive date" does. It will usually be stated in the declarations page or a policy endorsement, and it specifies the date after which the underlying event must have occurred for coverage to be triggered. If the underlying event occurs before the retroactive date, then there may be no coverage, and the insured may be out of luck.

If a claims-made policy doesn't contain a retroactive date, then generally, the retroactive date is the initial policy's inception date. But if the insured renews, then the retroactive date is usually the first date on which the insurer initially provided coverage to that specific insured. If the insured renews with a different insurer, then the insured must request that the retroactive date be the date of the inception of the very first policy. For example, if an insured buys a policy that took effect on January 1, 2020, with no explicit retroactive date, then the retroactive date is January 1, 2020. If the insured renews with a different insurer on January 1, 2021, then the insured must request an endorsement with a retroactive date of January 1, 2020, the date of the very first policy period. If the insured doesn't, then the renewal insurer may choose a retroactive date of January 1, 2021 for the renewal policy, leaving the insured with no coverage for wrongful acts occurring between January 1, 2020, and January 1, 2021.

Tail or Extended Reporting Period Coverage

When an insured switches his or her claims-made policy from one insurer to another, the insured must pay close attention to the actual effective periods of coverage. With occurrence-based policies, this is generally not a problem. But with claims-made policies, it can be serious. That is why it is also important to look at the policy's "tail" coverage. A "tail" or an extended reporting period (ERP) provision permits an insured to report a claim even after the policy has expired. ERP is usually a valuable endorsement for those who may be changing their career path, winding down their practice, or retiring.

Reporting Requirement

Another characteristic of claims-made polices is that in addition to requiring that the claim be made in the policy period, it must also be reported to the insurer during the policy period, within the time limits reflected in the policy. Most policies allow a short grace period, so that if a claim comes in the last day of the policy year, the insured will not be deprived of coverage by late reporting. Even when a policy doesn't include a short grace period, depending on the purpose of the policy, and whether coverage is required due to a statute or a regulation, there may be an automatic additional grace period for claims-reporting purposes.[4]

Late Notice and Prejudice

On the one hand, in *Schubiner v New England Ins Co,* 207 Mich App 330; 523 NW2d 635 (1994) holds that "[w]e decline to apply the general insurance principle that the insurer

must show prejudice where it is claiming lack of notice." On the other hand, MCL 500.3008 makes no distinction at all between claims-made and occurrence-based polices and provides that the failure to give timely notice "shall not invalidate any claim made by the insured if it shall be shown not to have been reasonably possible to give such notice within the prescribed time and that notice was given as soon as was reasonably possible."

Michigan law disfavors forfeitures, and courts have consistently also held that "untimely notice will not excuse an insurer's obligation unless [the insurer] can prove it was actually and materially prejudiced by the delay."[5] This actual-prejudice requirement is especially important in heavily regulated and statutorily required insurance policies because the parties' freedom of contract can't annul statutes or regulations.

In expressing their disfavor, Michigan courts focus on the purpose of the notice provisions in an insurance policy which is to "allow the insurer to make timely investigation…in order to evaluate claims and to defend against fraudulent, invalid, or excessive claims."[6]

Whether a late notice actually prejudiced an insurer's right is generally a question of fact to be left to the jury.[7] In determining whether an insurer's position has actually been prejudiced by the insured's untimely notice, courts consider whether the delay has materially impaired the insurer's ability: 1) to investigate liability and damage issues to protect its interests; 2) to evaluate, negotiate, defend, or settle a claim or suit; 3) to pursue claims against third parties; 4) to contest the liability of the insured to a third party; and 5) to contest its liability to its insured.[8]

Read the Insurance Policy, including any Policy Applications

Regardless of whether it is an occurrence-based or claims-made policy, to ascertain whether a policy insures a specific peril, occurrence, or wrongful act, it is always crucial to read the whole policy, including the declarations page, the policy's endorsements, and the policy's applications, which when construed together constitute the insurance contract.[9] ■

About the Author

Rabih Hamawi *is the chairperson of the Insurance and Indemnity Law Section. He is a principal at Law Office of Rabih Hamawi, P.C. and focuses on representing policyholders in fire, property damage, and insurance-coverage disputes with insurers and in errors-and-omissions cases against insurance agents. He has extensive expertise in insurance coverage and is a licensed property and casualty, life, accident, and health insurance producer and counselor (LIC). He earned the Chartered Property and Casualty Underwriter (CPCU), Certified Insurance Counselor (CIC), and Certified Risk Manager (CRM) designations. He is a frequent author on insurance and indemnity topics. His email address is rh@hamawilaw.com*

Endnotes

1 *Stine v Continental Casualty Co,* 419 Mich 89, 98; 349 NW2d 127 (1984).

2 *Id.* at 98-99.

3 *Royal Prop Group, LLC v Prime Ins Syndicate, Inc*, 267 Mich App 708; 706 NW2d 426 (2005).

4 Federal and state law, as well as regulations from the United States Environmental Protection Agency, require that all underground storage tanks (UST) pollution liability insurance policies to have a six-month ERP for all claims. These regulations date back to 1976 when Congress enacted the Resource Conservation and Recovery Act to "protect human health and the natural environment from the hazards of UST." 40 CFR 280.97(b)(2). These regulations require all UST liability insurance policies to include a six-month ERP after a policy's nonrenewal or cancellation date for first- and third-party claims. "Each [UST] insurance policy must be amended by an endorsement or worded or evidenced by a certificate of insurance [stating] the insurance covers claims otherwise covered by the policy that are reported…within six months of the effective date of cancellation or non-renewal of the policy." *Id.*

5 *Wendel v Swanberg*, 384 Mich 468, 477-79; 185 NW 2d 348 (1971); *Weller v Cummins*, 330 Mich 286, 47 NW2d 612 (1951); *Burgess v Am Fid Fire Ins Co*, 107 Mich App 625, 628-29; 310 NW2d 23 (1981).

6 *Wendel* at 477.

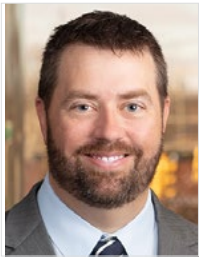
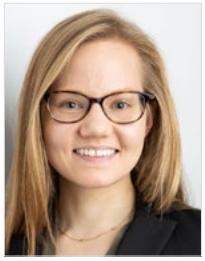
7 *Id.* at 478.

8 *Aetna Cas & Sur Co*, 10 F Supp 2d at 813 (citing *Wendel*, 384 Mich at 478-79, 185 NW2d at 353).

9 *Royal Prop Group, LLC v Prime Ins Syndicate, Inc*, 267 Mich App 708; 706 NW2d 426 (2005).

Insurance and Indemnity Law Section Mission Statement

The mission of the Section is to provide a forum for an exchange of information, views and expertise from all perspectives on both insurance coverage issues and indemnity issues, and to provide information and assistance to other persons or organizations on matters relating to insurance and indemnity. Membership is open to all members of the State Bar of Michigan.

Recent Notable No-Fault Opinions

By Eric Conn and Samantha McLeod, *Jacobs and Diemer, PC*

Published Court of Appeals Opinions

The More Specific Statute Should Control

Markise Steanhouse v Michigan Aut omobile Insurance, et al, ___ Mich App ___, docket number 359576 (December 22, 2022)

The plaintiff was injured in a car accident in Ohio and applied for PIP benefits through the Michigan Assigned Claims Plan. *Id*., at *1. Plaintiff's suit was brought against defendants, MACP and MAIPF, which asserted allegations of unlawfully refusing to assign an insurer to fund plaintiff's PIP benefits. The MACP and MAIPF moved for summary disposition on the basis that the plaintiff "was ineligible for PIP benefits because his accident occurred outside of Michigan." *Id*. The trial court denied defendants' motion because "MCL 500.3172 conflicts with MCL 500.3111 and otherwise cannot be interpreted as depriving assigned coverage to Michigan residents simply because they were injured in accidents in other states." *Id*., at *2.

To be eligible for PIP benefits under the MACP, you must meet the requisite criteria of MCL 500.3172, not MCL 500.3111. "Although MCL 500.3111 generally provides PIP benefits for claimants when an accident occurs outside of Michigan, it does not dictate the terms by which claimants may receive PIP benefits through the MACP and MAIPF." *Id*., at *5. Because the plaintiff was seeking PIP benefits through the MACP, it would be improper to rely upon MCL 500.3111.

Therefore, the Court of Appeals reversed the trial court's prior denial of the MACP and MAIPF's motion for summary disposition. The Court held that MCL 500.3172 requires a claimant seeking PIP benefits through the MACP to establish that the accident occurred in Michigan. Because plaintiff's accident occurred in Ohio, the defendants were entitled to summary disposition.

Takeaway: "When interpreting differing provisions of an act, we construe the act 'as a whole to harmonize its provisions and carry out the intent of the Legislature.'" *Id*. at *4, quoting *Macomb Co Prosecutor v Murphy*, 464 Mich 149, 159; 627 NW2d 247 (2001). However, if two provisions of a statue conflict, consideration must be given to their different purposes and the more specific statute should control.

Failure to File a Substitution of Party Leads to Dismissal

Lisa Bradley v Progressive Maration Ins Co, et al ___ Mich App ___, docket number 358796 (December 29, 2022)

In this case to recover PIP benefits, there was a dispute as to priority. One of the defendants filed a motion for summary disposition, which was pending when the plaintiff filed a Suggestion of Death pursuant to MCR 2.202. *Id*., at *1-2. The defendant's motion for summary disposition was adjourned multiple times pending substitution of the plaintiff's estate as the real-party-in-interest plaintiff. *Id*., at *2. The plaintiff did not file a substitution within 91 days as required by MCR 2.202(A)(1)(b) and the defendants moved to dismiss the case. The plaintiff's attorney failed to appear at the hearing and the trial court granted the motion to dismiss noting plaintiff's failure to comply with MCR 2.202. *Id*., at *2-3. The plaintiff appealed.

In a published opinion, the Court of Appeals affirmed. The primary question on appeal was a determination of whether a showing of lack of prejudice had to be demonstrated by the defendants to prevail. *Id*., at *4. The Court of Appeals, recognizing a "death of published caselaw discussing MCR 2.202(A)(1)(b)," determined the defendants did not have the burden to demonstrate prejudice. *Id*., at *5. Instead, the Court determined that the burden of demonstrating no prejudice to the defendants was on the plaintiff had she moved for substitution. *Id*., at *5-6. Given that she had not, the Court of Appeals determined that the trial court did not abuse its discretion in granting the motion to dismiss. *Id*., at *6.

Note: This matter is now pending on an application for leave to appeal to the Michigan Supreme Court.

Takeaway: Like many Michigan procedural rules, MCR 2.202 has an analogous federal counterpart, FRCP 25. Using federal counterparts is an important process that can aid

the Court in in its decision-making. Further, diligence in all aspects of the case is extremely important.

Trigger Date for Increased Liability Coverage under No-Fault Reform

Progressive Marathon Ins Co v Pena, et al,
___ Mich App ___, docket number 358849
(January 26, 2023)

In this declaratory judgment action, the plaintiff insurer sought to enforce the stated limits of its liability coverage to $20,000/$40,000 because its policy was issued *before* the No-Fault Reforms that increased the mandatory minimum liability coverage. *Id.*, at *1-2. Contrarily, the defendants sought enforcement of the new mandatory minimum coverage amounts and sought reformation of the plaintiff's policy to afford liability coverage in the amount of $250,000/$500,000. *Id*. The trial court denied the plaintiff's motion for summary disposition and pursuant to MCR 2.116(I)(2) granted summary disposition in favor of the defendants. *Id*. The plaintiff appealed, and the Court of Appeals reversed and remanded. *Id*.

The Court of Appeals published opinion performed a straightforward statutory analysis of the No-Fault reforms that increased the mandatory minimum liability coverage found in MCL 500.3009. *Id.*, at *3-4. The court's focus was on the phrase "delivered or issued for delivery" as the operative terms for the outcome of this case. *Id*. The court reasoned that if the policy was "delivered or issued for delivery" before the trigger date for the increased liability coverage required by the No-Fault Reform, then the mandatory minimum would be set at $20,000/$40,000. *Id*. Conversely, if the policy were "delivered or issued for delivery" after the trigger date for the increased liability coverage required by the No-Fault Reform, then the increased liability coverage would apply. *Id.*, at *4-5.

The Court of Appeals found that the policy, which was issued for delivery before the trigger date in the No-Fault Reform was subject to the prior mandatory minimum coverage amounts of $20,000/$40,000. *Id*.

Takeaway: The Courts are slowly clarifying the changes of the No-Fault Reforms, and this case provides insight into how that will be accomplished. Notably, the Court of Appeals also looked at the entire statute for support for its position, thus practitioners are encouraged to enlist a wholistic approach to statutory interpretation.

Provider Becomes Real Party in Interest Upon Execution of Assignment

Marcel Farrar v Focus Imaging, LLC, et al
___ Mich App ___, docket numbers 358872, 358884
(February 9, 2023)

In this case, the plaintiff suffered an injury while she was a passenger on a bus that was hit by a car. Because of her injuries, she sought treatment from numerous medical providers and subsequently executed an assignment of benefits for receiving treatment, including an assignment from intervening-plaintiff. Defendant filed a summary disposition motion which was ultimately denied by the trial court because it found that Focus Imaging's claims could relate back to the filing of plaintiff's complaint. The trial court also rejected the argument that providers became the real parties in interest as to plaintiff's claims once assignments were executed. This appeal was the result.

The Court of Appeals found the trial court mistakenly denied defendant's motion for summary disposition. In its reasoning, the Court determined that Focus Imaging's claims were barred by the one-year-back rule under MCL 500.3145(2) and did not relate back because Focus Imaging is "a different party that is not seeking to add new claims, but rather the same claims as plaintiff as a different party." Finally, the court found that "upon execution, these providers became the real parties in interest with respect to their claims for benefits, and only they could sue to recover those benefits. Plaintiff, therefore, did not have standing to sue to recover the benefits associated with those providers, and the trial court erred when it concluded otherwise."

Takeaway: Once an assignment is executed, a provider becomes a real party in interest with respect to its claim for benefits, and that provider has the ability to sue to recover those benefits.

Assignment to Healthcare Provider Allows for Direct Cause of Action Against Insurer

Centria Home Rehabilitation, LLC v Philadelphia Indemnity Insurance Company, et al
___ Mich App ___, docket numbers 359371, 359372
(March 2, 2023)

As a result of a commercial vehicle accident, plaintiff provided attendant care services to the injured party. The plaintiff submitted a claim for reimbursement from defendant-insurer and was then issued a check for only a portion of the amount with an explanation that the payment was lower due to a "market survey" that was recently conducted. Plaintiff brought suit and the defendant-insurer moved for summary disposition on the basis there was not a valid cause of action for dissatisfaction of payment against the insurer. The trial court granted summary disposition in favor of the defendant-insurer and adopted defendant-insurer's analysis relying on *McGill v Auto Ass'n of Mich*, 207 Mich App 402; 526 NW2d 12 (1995), and *LaMothe v Auto Club Ins Ass'n*, 214 Mich App 577; 543 NW2d 42 (1996), that because the injured party has no cause of action against the defendant-insurer for the remaining balance owed, a cause of action could not be assigned to the plaintiff.

The Court of Appeals found the reasoning in *Mich Institute of Pain & Headache, PC v State Farm Mut Automobile Ins Co*, unpublished per curiam opinion of the Court of Appeals, is-

sued June 24, 2021 (Docket No. 353033), cited by the plaintiff, to be persuasive. The court held that when a "health care provider, acting under an assignment of rights from an insured or under a direct cause of action under MCL 500.3112, seeks to recover the balance due for PIP benefits from an insurer and there is a dispute over the reasonableness of the charges, the health care provider has standing to bring such a claim directly against the insurer."

Takeaway: When there has been an assignment of rights from an insured to a healthcare provider, the healthcare provider has the ability to assert a direct cause of action against an insurer to recover the reasonable balance owed.

Coordination of Client's Health PPO Plan and No-Fault Policies

Advance Therapy & Rehab v Auto-Owners Ins Co.
___ Mich App ___, docket number 359673
(March 2, 2023)

An injured motorist had elected to coordinate his health and no-fault policies. The health insurance policy was a PPO, which allowed for coverage for both in- and out-of-network treatment, but at different coverage amounts and deductibles. The injured motorist sought treatment from the assignee-plaintiff, who was out-of-network in the PPO plan. Because the injured motorist had not yet met his out-of-network deductible, the PPO applied the charges to the deductible but did not pay the balance due because, under the plan, it was 100% the responsibility of the injured motorist. The assignee-plaintiff then sought payment from the defendant, which was denied on the basis of the Michigan Supreme Court's decision in *Tousignant v Allstate Ins Co*, 444 Mich 301 (1993). The assignee-plaintiff filed suit in district court and the defendant moved for summary disposition. Summary disposition was denied, and the defendant sought leave to appeal in the Circuit Court which was denied. Leave to Appeal was then granted in the Court of Appeals.

In a published opinion, the Court of Appeals affirmed the denial of summary disposition. The court's analysis looked at the *Tousignant* decision for guidance and found that "there is nothing in *Tousignant* that requires an insured to minimize the cost of a secondary no-fault insurer by maximizing the amount that the primary health insurer will cover. Rather, when an insured chooses to coordinate the two policies, the insured must seek to recover expenses from the primary health insurer before turning to the secondary no-fault insurer." Because the injured motorist and assignee-plaintiff did exactly that before seeking reimbursement from the defendant, its obligation under the coordinated policies was met.

Takeaway: No-fault insurance requires knowledge of more than just the No-Fault Act. Successful no-fault lawyers must also understand and have the ability to review health policies to ensure that clients' rights are properly protected and prosecuted.

Unpublished Court of Appeals Opinions

Assigned Insurer Successfully Obtained Summary Disposition Based on Fraud

Rodriguez v Farmers Ins Exch.
Unpublished Opinion, docket number 359067
(January 26, 2023)

This unpublished Court of Appeals opinion reads like an old-school *Bahri* [1]decision. In his application for insurance benefits submitted to the Michigan Assigned Claims Plan, the plaintiff provided an application for benefits that revealed some, *but not all of*, his medical and accident history. After the plaintiff filed suit seeking PIP benefits, the defendant filed a motion for summary disposition based on fraud pursuant to MCL 500.3173(a)(2). The trial court granted the defendant's motion for summary disposition and the plaintiff appealed.

The Court of Appeals affirmed. In a laundry list that reads like a greatest hits album, the Court listed many omissions from the plaintiff's application for benefits that it determined were relevant and material. From there, the Court recognized "the above extensive omissions leaves no question that plaintiff was dishonest in his application for no-fault benefits. A reasonable juror could not conclude that the plaintiff was unaware that he was submitting false information." On that basis, the Court of Appeals determined the trial court did not err in granting summary disposition.

Takeaway: For those lawyers that are prosecuting or defending cases assigned to the MACP, focus and attention must be paid to issues related to fraud given the statutory defense. While fraud has in other manners become a question for the jury, this case reveals there is an opportunity for insurers to successfully seek summary disposition.

Proving Domicile Requires Fact Intensive Analysis and May be Left to the Trier of Fact

Farm Bureau v State Farm
Unpublished Opinion, docket number 358675
(February 21, 2023)

This is a first-party dispute between Farm Bureau General Insurance Company of Michigan ("Farm Bureau") and State Farm Mutual Automobile Insurance Company ("State Farm"). Farm Bureau filed a summary disposition motion arguing that there was no question of fact concerning the injured party's domicile – his parents' house. State Farm countered that it was entitled to summary disposition because, based on the fact that the injured party's domicile was his girlfriend's parents' house. The trial court granted summary disposition in State Farm's favor and this appeal followed.

To determine which residence was in fact the injured party's domicile, the Court of Appeals did a robust analysis of the factors set forth within *Workman v Detroit Auto Inter-Ins Exchange*, 404 Mich 477, 496-497; 274 NW2d 373 (1979) and *Dairyland Ins Co v Auto Owners Ins Co*, 123 Mich App 675, 681; 333 NW2d 322 (1983).

All factors considered, the Court of Appeals determined that neither residence was favored even though the injured party's intent was to reside at his girlfriend's parents' house. Therefore, a factual dispute remained regarding the injured party's domicile. As such, the Court reversed and remanded the case for resolution from the trier of fact.

Takeaway: The question of a party's domicile is typically straightforward – exactly what each insurance company thought when it filed its respective motion for summary. However, this case demonstrates how fact intensive and dense the analysis to determine a person's domicile can be.

Cases to Watch

In this section, we will provide information about cases that may have an impact in this area. This section will not speculate as to how the cases will or should be decided but will simply advise what issues (or the main issues) that have been raised.

Andary v USAA, MSC docket number 164772.

Oral argument on *Andary v USAA* was held on March 2, 2023. Below is a link to access the video recording of oral argument on the Supreme Court's YouTube page:

https://www.youtube.com/watch?v=PXQZqKVWOBM&list=PL_3bNEgGS-Tbg1pphy40NqQPuMuZqfuhR&index=4 ■

Endnote

1 *Bahri v IDS Property Casualty Ins Co,* 308 Mich App 420, 864 NW2d 609 (2014).

ERISA Decisions of Interest

K. Scott Hamilton, *Dickinson Wright PLLC*

Sixth Circuit Update

Plaintiff's ERISA §510 Claim for Interference with Rights Under Plan Was Properly Dismissed on Summary Judgment

Hrdlicka v. General Motors, LLC
59 F.4th 791 (6th Cir. 2023)

The Sixth Circuit affirmed summary judgment for the defendant on the plaintiff's claims for violation of the Americans with Disabilities Act ("AD"), Michigan's Persons with Disabilities Civil Rights Act ("MPWDCRA"), the Family Medical Leave Act ("FMLA"), and §510 of ERISA for improper interference with rights under an ERISA plan.

The plaintiff began missing work or arriving late at GM beginning in May 2019. Although she did not know it at the time, she had a brain tumor and persistent depressive disorder. She asserted numerous excuses and explanations for her absences and tardiness, such as that her daughter was ill, that she had a "family situation," that she was taking a vacation day, or simply that she would be late or would not be coming in with no reason at all. After her employer gave her an "Attendance Letter" warning her that further absences and tardiness could result in termination because her "erratic work schedule" was disruptive to other employees, she was terminated on August 21, 2019 "due to her repeated violations of the Attendance Letter immediately after it was issued."

She appealed the termination under GM's administrative employment procedures in August 2019. While that appeal was pending, she was diagnosed with Persistent Depressive Disorder, and in November 2019, before the appeal was decided, she was diagnosed with a brain tumor that was removed soon after it was discovered. In late November 2019, her termination was upheld.3

She then sued GM, alleging claims under the ADA and MPWDCRA, FMLA and §510 of ERISA, all of which the district court dismissed on summary judgment.

On appeal, with respect to the §510 ERISA claim (as well as the others), the Sixth Circuit affirmed summary judgment.

Section 510 provides that "[i]t shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan, . . . or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan."

The Court reviewed the analytical framework for §510 claims as follows:

> To establish a violation of Section 510 of ERISA, an employee must show "the existence of (1) prohibited employer conduct (2) taken for the purpose of interfering (3) with the attainment of any right to which the employee may become entitled. *Smith v. Ameritech,* 129 F.3d 857, 865 (6th Cir. 1997). Importantly, the employer must have had a "specific intent to violate ERISA." *Humphreys v. Bellaire Corp.,* 966 F.2d 1037, 1043 (6th Cir. 1992) (quoting *Rush v. United Techs., Otis Elevator Div.,* 930 F.2d 453, 457 (6th Cir. 1991)). The employee must show that interfering with her rights was at least a "motivating factor" in the decision. *Id.* (citations omitted). Once the employee establishes a prima facie case, the employer can rebut by offering a "legitimate, nondiscriminatory reason for its challenged action." *Id.* (citation omitted). If the employer does so, then the employee has the burden to prove that interference was nonetheless a motivating factor or to establish that the explanation was pretextual. *Id.* (citations omitted).
>
> 59 F.4th at 809.

Applying these principles, the Sixth Circuit held that GM had a legitimate, non-discriminatory reason for denying the plaintiff's appeal of the decision to terminate her employment, that she failed to show that the reason for termination was pretextual, and that she failed to show that interference with her rights under the plan was a motivating factor in her termination. The decision affirming appeal of her termination was based on her chronic and uncorrected attendance issues. And although the plaintiff argued that her administrative appeal was denied shortly after she was diagnosed with a brain tumor, the Sixth Circuit held that "simply pointing out the temporal proximity does nothing to rebut the fact that the decision was based" on facts "that were available to General Motors *at the time it terminated Hrdlicka."* The Court concluded that "[h]er post-termination diagnosis did not factor into the analysis," that she "has offered no evidence to the contrary," and that "[h]er ERISA claim therefore fails." 59 F.4th at 810.

District Court Properly Weighed Insurer's Conflict of Interest in Affirming Administrative Decision Denying Benefits Under Disability Plan.

Sandeen v Unum Group Corp
Case No. 22-5374 (6th Cir., Mar 7, 2023) (unpub)

The Sixth Circuit affirmed the district court's judgment on the administrative record despite "evidence that, due to claims-tracking reports, certain of Unum's employees had a financially based conflict of interest or bias towards the denial of benefits."

In June 2015 the plaintiff submitted a claim for long term disability benefits based on irritable bowel syndrome and fibromyalgia. The defendant insurer paid benefits until November 2017 when the insurer determined the plaintiff's condition did not prevent her from performing the duties of her occupation. She sued and the district court, applying the arbitrary and capricious standard of review, entered judgment for the defendant on the administrative record.

The Sixth Circuit affirmed the district courts' finding that the "quantity and quality of the evidence used by [the defendant] in its decision-making [wa]s robust," and that the insurer's "reliance on file-reviewing doctors – rather than on treating physicians or an independent medical exam – was acceptable both as a matter of law and under the facts of this case, explaining that the file-reviewing doctors 'gave thorough explanations' for their decisions and that 'many' or 'most' of [the plaintiffs] medical providers had similarly concluded that [she] could perform her occupation."

The thrust of the plaintiff's argument on "appeal concern[d] the courts' assessment of [the insurer's] conflict of interest" which "must be weighed as factor in determining whether there is an abuse of discretion."

The Sixth Circuit held that despite the evidence of bias based on financial self-interest and claim denial tracking reports, many facts weighed against that bias, such as that "(1) Unum paid benefits under a reservation of rights for 29 months while processing the claim, (2) the assessment was extremely thorough, and (3) employees were dogged in requesting documents from her doctors. Moreover, (4) most of the employees involved with her claim did not know about the tracking reports and (5) the Director who did know made decisions that were beneficial to her."

The Sixth Circuit concluded that the district court did not create or impose on the plaintiff the burden of showing that the bias "heavily influenced" the decision, but rather, that it "properly weighed the conflicts/bias argument as one factor – as precedent requires – and concluded that conflict/bias alone was not *heavy* enough to tip the balance in [the plaintiff's] favor." (emphasis in original). ■

Selected Insurance Decisions

By Christopher T. Lang, *Collins, Einhorn, Farrell PC*

Sixth Circuit Court of Appeals

Published Opinion

To demonstrate that the claimant remains disabled under an ERISA plan, he or she must present a preponderance of evidence that he or she remains disabled.

Messing v Provident Life & Accident Ins Co.
No. 21-2780, 2022 WL 4115873
(CA 6, September 9, 2022)

The attorney plaintiff obtained a long-term disability benefit insurance policy from the defendant in 1985. In 1994, the plaintiff began suffering from depression, which prevented him from practicing law. Beginning in 2000, the plaintiff received monthly disability benefits under the defendant's policy. In 2018, the defendant began a review of the plaintiff's claim in order to determine if he was still disabled from practicing law. Following an investigation, and medical multiple examinations, the defendant terminated benefits on the basis that the plaintiff could return to work. The district court upheld the termination, but the 6th Circuit reversed on appeal.

The 6th Circuit ultimately found that the plaintiff, by a preponderance of evidence, demonstrated that he remained disabled from the practice of law. Specifically, the court noted that each of the medical examiners found that the plaintiff's mental health was fragile, that a stressful working environment could cause a relapse of major depression, and one of the doctors concluded that the plaintiff could not return to work while the other two doctors did not offer a specific opinion regarding his ability to return to work.

In addition, the 6th Circuit also noted that the plaintiff provided affidavits from three other lawyers stating that the practice of law was not only a stressful profession, but that the plaintiff was unable to effectively practice law after nearly 20 years out of practice. Regarding the defendant's counterclaim for an equitable lien for alleged overpayment of benefits, the court found that the defendant failed to demonstrate that the plaintiff's alleged misrepresentations regarding his ability to practice law induced an overpayment of benefits. Finally, the court also held that the plan at issue did not provide any remedy to the defendant for a recoupment of any overpayment of benefits.

Michigan Court of Appeals

Published Opinion

Claimant must strictly comply with requirements of policy to change beneficiaries.

Sec Mut Life Ins Co of New York v Amira-Bell
___ Mich App _____, No. 357105
(Mich Ct App, July 21, 2022)

This case concerns the determination of the proper beneficiaries under an insured's life-insurance policy. Security Mutual Life Insurance Company of New York issued a life insurance policy to Omari Bell. When Bell first obtained this policy, in December 2018, he designated five beneficiaries the selection of which was confirmed by Security Mutual Life Insurance. One year later, in January 2019, Bell completed a beneficiary designation change form requesting a change to

Moving? Changing Your Name?

In order to safeguard your member information, changes to your member record must be provided in one of the following ways:

- *Login to SBM Member Area* with your login name and password and make the changes online.
- *Complete contact information change form* and return by email, fax, or mail. Be sure to include your full name and P-number when submitting correspondence.
- *Name Change Request Form*—Supporting documentation is required

Forms can be found at https://www.michbar.org/programs/address_change

the beneficiaries on the policy and naming his estate as the sole beneficiary.

Mistakenly, Bell also designated a second beneficiary also receive 100% of the benefits in a separate capacity. In February 2019, Security Mutual Life notified Bell that the requested change could not be processed due to this error. Nine months later, without having completed a new change-of-beneficiary form, Bell died. The trial court found that Bell had substantially complied with the policy's change of beneficiary requirements and ordered the funds be released solely to the estate.

On appeal, the Court of Appeals overturned the ruling and held that Bell's policy required Security Mutual Life Insurance to first approve of the change for any modification to be effective. The Court of Appeals found that Security Mutual Life Insurance, by notifying Bell of the error and mailing him a new form to complete, never approved of the change to the beneficiaries. The Court of Appeals ultimately held that this requirement was unambiguous and Bell's attempt to modify – regardless of intent – did not satisfy the policy's modification requirements.

Unpublished Opinions

Absent a showing of a special relationship, an independent insurance agent does not have a duty to advise an insured of the adequacy of coverage.

Cloverleaf Car Co v Cascade Underwriters Inc
Unpublished Opinion of the Court of Appeals
Issued June 16, 2022
(Docket No. 357435), 2022 WL 2182474

In this case, the insureds claimed that the defendant agents breached their fiduciary duty to them regarding the scope of their coverage, had made "errors and omissions" in the policy obtained, and had committed silent fraud. Specifically, the insureds alleged that the defendant agents breached their duty to *advise* them as the adequacy of the coverage provided. The Court of Appeals, however, disagreed and found that the defendant agents did not have a duty that required them to advise regarding the adequacy of coverage because there was no "special relationship" between the insurer and the insured.

In finding that no special relationship or duty existed between the parties, the Court of Appeals noted that the insureds: (1) never requested "full coverage" for their property and buildings, (2) they never asked defendants any questions regarding the adequacy of their coverage, (3) there was no evidence that the defendant agents misrepresented the nature or extent of the coverage offered, and (4) there was no evidence that the defendant agents promised to provide all of the coverage needed.

Failure to identify a co-owner of a vehicle constituted a material misrepresentation that allowed for recission.

Kodra v Am Select Ins Co
Unpublished Opinion of the Court of Appeals
Issued June 23, 2022
(Docket No. 356166), 2022 WL 2285584

The plaintiff, in her insurance application, verified that she was the sole owner of the 2004 Ford Escape that she sought to be insured. However, this vehicle was in fact co-owned by her fiancé, who had a suspended driver's license. After the policy was issued, the plaintiff removed the 2004 Ford Escape from the policy and added a 2015 Chrysler 200C to the policy that was also co-owned by her fiancé. Once again, the plaintiff failed to disclose this co-ownership to the defendant.

After the plaintiff was sued for third-party benefits, the insurer learned of this co-ownership. The defendant then produced an affidavit indicating that it would not have issued the policy to the plaintiff had it known of the vehicles' co-ownership. In reversing the trial court's denial of the defendant's motion for summary disposition, the Court of Appeals found that that the plaintiff's misrepresentation was material and a valid basis for recission. While the trial court found that any misrepresentation was immaterial because the plaintiff's fiancé was not driving the vehicle at the time of the subject accident, the Court of Appeals disagreed and held that the plaintiff's misrepresentation occurred when the policy was enacted, rather than at the time of the accident.

A Pizza Hut delivery driver does not satisfy a public or livery conveyance exclusion.

Michigan Pizza Hut, Inc v Home-Owners Ins Co.
Unpublished Opinion of the Court of Appeals
Issued July 14, 2022
(Docket No. 356737), 2022 WL 2760358.

In this case, Justin Kiry worked as a pizza hut delivery driver, and used his mother's 2005 Nissan Altima to deliver pizzas for Pizza Hut. The 2005 Nissan Altima was insured by the defendant. After Kiry was injured in a motor vehicle accident, while in the course and scope of his employment, the defendant denied coverage under the policy's "public or livery conveyance" exclusion. The Court of Appeals, however, found that this exclusion did not apply under these circumstances. In reaching this holding, the Court of Appeals relied on its prior interpretation of this exclusion, specifically that the exclusion requires that the at-issue conveyance to be for the public in order to be triggered. The Court of Appeals found that the act of delivering pizzas for profit did not equate to holding out for public use. On that point, the Court of Appeals held that the use of a vehicle in the capacity of delivering pizzas for Pizza Hut was limited to a specific client base, rather than the public at large. ■

Insurance & Indemnity Law Section 2022-2023 Officers and Council

Chair
Rabih Hamawi
Law Office of Rabih Hamawi PC
e-mail: rh@hamawilaw.com

Chair-Elect
Patrick D. Crandell
Collins, Einhorn, Farrell PC
patrick.crandell@ceflawyers.com

Secretary
Ann-Marie E. Earls
Melamed Levitt Milanowski & Earls PC
annieearls@mlmepc.com

Treasurer
John M. Sier
Kitch Drutchas Wagner Valitutti & Sherbrook
john.sier@kitch.com

Ex Officio
Lauretta A. Pominville
McNish Group
lpominville14@yahoo.com

Commissioner Liaison
James William Low, Royal Oak

Nicholas S. Andrews
Term Ends 2023
Liss Seder & Andrews PC
nandrews@lissfirm.com

Stephanie Martin Brochert
Term Ends 2023
Plunkett Cooney
sbrochert@plunkettcooney.com

Allison L. Eicher
Term Ends 2023
Michigan Farm Bureau
aeicher@michfb.com

Nina Marie Jankowski
Term Ends 2024
Giarmarco, Mullins & Horton, PC
njankowski@gmhlaw.com

Robert B. June
Term Ends 2023
Law Offices of Robert June PC
bobjune@junelaw.com

Elizabeth Anne King
Term Ends 2024
FabianSklar, King & Liss, PC
eking@fabiansklar.com

Douglas G. McCray
Term Ends 2024
McCray Law Office PLLC
doug@mccraylawoffice.com

Glen Howard Pickover
Term Ends 2024
Gregory, Meyer & Chapnick PC
gpickover@gregorylaw.com

Gail L. Storck
Term Ends 2024
Law Office of Gail L. Storck
storckg1@nationwide.com

Milea M. Vislosky
Term Ends 2023
Miller & Tischler PC
mvislosky@msapc.net

SBM

State Bar of Michigan

Michael Franck Building
306 Townsend St.
Lansing, MI 48933-2012

NONPROFIT
U.S. POSTAGE PAID
LANSING, MI
PERMIT NO. 191