

The *Journal of*
Insurance & Indemnity Law

A QUARTERLY PUBLICATION OF THE STATE BAR OF MICHIGAN'S INSURANCE AND INDEMNITY LAW SECTION

April 2009

From the Chair

Volume 2 Number 2

Table of Contents

Casey on Coverage:
 Policy Types: First-Party and
 Third-Party Insurance2
 Penalty Attorney Fees Under the
 No-Fault Act3
 Announcements from Other Sections..4
The Drafting Table:
 Less is More, More is Less.....5
 The Examination Under Oath:
 "Let me ask you this . . ."7
 Wrap-Up Insurance Programs—
 Scrutinize Carefully.....8
 No-Fault Corner 11
Insurance Case Summary:
 Insurance Decisions of Interest 13

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

Hal O. Carroll, Journal Editor
 hcarroll@VGpcLAW.com or
 (248) 312-2800

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.



Hal O. Carroll

What You Can Do for Your Section

Spring has arrived at last, and it's time to start planting and building, which is by way of introducing the theme of "**what you can do**," in which we suggest small steps that each of you, as a member of our section, can take to make a good section even better. We are grateful that the section has succeeded so well in its first year and a half, but we on the council are all still new at running a section and making it a success, so member participation is crucial.

Membership. We have done very well, but we can do better. Some other State Bar sections and other non-Bar groups have actually lost membership in the difficult climate that exists today, but our section continues to grow, and we are now over 350 members. But we can grow even more. The main obstacle is just that there are many attorneys who have not yet heard of us. **What you can do:** Just **spread the word**. Talk us up to the attorneys you meet. Take the *Journal* with you to motion days, so that others will see it. Our section doesn't need a hard sell. Just letting people know we are here and what we do is enough.

The Journal. The *Journal* has been a success so far, but we are continuing to look for ways to expand and improve it. One way is to include more regular pieces on specific topics, such as we have in this issue on no-fault insurance issues. **What you can do: First**, if you have a specialty within our area, **write a regular column** and share your expertise with the section's members and with the legislators and judges who receive the *Journal*. Something in the area of 800 words is a good length for a regular column. **Second**, if you joined because you are not an expert but want to become one or at least learn more, **contact a council member** (they're listed at the back) and tell her or him what you would like the section to do.

Other Sections. We have been in touch with other State Bar sections, to explore the possibility of presenting programs jointly, or providing speakers for their programs, and we have received several expressions of interest that we are exploring. **What you can do:** If you are in another section, **suggest a topic or a program**. contact a council member with an idea for a topic or a program or talk to the section chair or a council member of the other section. There are plenty of good topics out there.

In short, we have a good thing going, but if we work together we can make it even better. ■

Hal O. Carroll

**Casey on
Coverage**

Policy Types: First-Party and Third-Party Insurance

By Timothy F. Casey, Kelley, Casey & Moyer PC, case@kcmlaw.com

There are numerous types of insurance policies, but one way to categorize them generally is first-party insurance and third-party insurance. Each of these can be obtained as a standalone coverage or combined in a single policy. The nature of each type of insurance is distinct and requires separate coverage analysis. The distinction in general can be stated as follows:

First-party insurance is a contract between the insurer and the insured to protect the insured from its own actual losses and expenses. Property insurance, fidelity insurance, and medical/health insurance are all examples of first-party insurance.

Third-party insurance is a contract to protect the insured from losses resulting from actual or potential liability to a third party. This protection may involve defending the insured from suit, paying or settling a claim against the insured, or a combination of both. Liability insurance is third-party insurance.¹

Similarly, as stated by the court in *Great Northern Ins Co v Mount Vernon Fire Ins Co*:²

Insurance contracts generally are assigned to one of two classes: either “first-party coverage” or “third-party coverage.” “First-party coverage” pertains to loss or damage sustained by an insured to its property; the insured receives the proceeds when the damage occurs. In contrast, if the insurer’s duty to defend and pay runs to a third-party claimant who is paid according to a judgment or settlement against the insured, then the insurance is classified as “third-party insurance.” Thus, wholly different interests are protected by first-party coverage and third-party coverage.³

An example of a first-party property coverage form might read as follows:

We [the insurer] will pay for direct physical loss of or damage to Covered Property at the premises described in the Declarations caused by or resulting from any Covered Cause of Loss.

This type of insurance will have its own terms, provisions, definitions, exclusions, and conditions which need to be examined in evaluating whether coverage applies to a particular loss. Any claim dispute in first-party coverage typically involves only the policyholder and insurer, and any covered payment by the insurer would be made directly to the insured.

Examples might include a fire loss under a homeowner’s policy or damages to a motor vehicle sustained in a collision.

Any claim dispute in first-party coverage typically involves only the policyholder and insurer, and any covered payment by the insurer would be made directly to the insured.

Third-party insurance, by contrast, requires the involvement of a “third party” besides the policyholder and carrier. This insurance is involved in the situation of the policyholder becoming obligated to pay damages to a third party. An example of third-party general liability language might read:

We [the insurer] will pay those sums that the insured becomes legally obligated to pay as damages because of “bodily injury” or “property damage” to which this insurance applies. We will have the right and duty to defend the insured against any “suit” seeking those damages. However, we will have no duty to defend the insured against any “suit” seeking damages for “bodily injury” or “property damage” to which this insurance does not apply.

Coverage analysis under a third-party policy, then, involves evaluating not only the policy coverage provisions, but the underlying third-party claim or suit being asserted against the insured. As with the first-party policy, the third-party policy also contains its own terms and provisions, definitions, exclusions, and conditions. Examples of when a third-party policy may apply would include certain injuries in auto accidents and construction site accidents. In those situations, if there is covered liability, the insurer would pay the underlying claimant, not the insured.

Many insurance policies combine both first-party and third-party liability coverages in the same policy. While a particular event may give rise to coverage under one or the other type of coverage, it is not unusual for the same event to potentially involve both first-party and third-party coverage claims. For example, an auto accident could give rise to a first-party property claim for damage to the vehicle, as well as the policyholder seeking a defense in connection with a third-party liability suit filed by the other driver. A fire in a building might give rise to a first-party property loss claim, but also might involve third-party liability claims filed by injured tenants.

It is important to be aware of which type of coverage is involved, or whether both types are involved, so that a proper coverage evaluation can be made. Each type of coverage has its own provisions. In a situation involving both types, for example, notice requirements under each coverage provision are different and need to be carefully examined.

While a particular event may give rise to coverage under one or the other type of coverage, it is not unusual for the same event to potentially involve both first-party and third-party coverage claims.

If there is a coverage dispute under a first-party policy, the policyholder is also the claimant and could sue the carrier directly. If there is a coverage dispute in a third-party claim, the policyholder could sue the carrier to seek coverage, but

the underlying third-party claimant cannot directly sue the insurer in the original action brought by the injured person. MCL § 500.3030. In short, each type of coverage addresses different risks and needs to be evaluated independently. ■

The views expressed in this article are those of the author and do not necessarily represent the views of the author's law firm or its clients and do not constitute legal advice as to any particular matter.

Endnotes

- 1 *Couch on Insurance*, Third Edition, Section 198:3.
- 2 92 NY2d 682; 708 NE2d 167 (1999).
- 3 Internal citations omitted.

Penalty Attorney Fees Under the No-Fault Act

By Jack L. Hoffman, *Kuiper Orlebeke PC*, hoffman@kuiperorlebeke.com

MCL 500.3148 provides that “[a]n attorney is entitled to a reasonable fee for advising and representing a claimant in an action for personal or property protection insurance benefits which are overdue.” On May 7, 2008, the Michigan Supreme court clarified that a trial court’s decision whether a no-fault insurer acted unreasonably for the purpose of an award of no-fault penalty attorney fees under MCL 500.3148 is a mixed question of law and fact.¹ On December 30, 2008, in *Moore v Secura*,² the Supreme Court applied the holding in *Ross* to overrule *Liddell v DAIIE*,³ which had held that the standard of review was “clearly erroneous.” The Supreme Court’s rejection in *Ross* of the clearly erroneous standard of review in cases under MCL 500.3148 corrects a 38-year error in the construction of section 3148.

Liddell was decided by the Court of Appeals on January 6, 1981, and had a major impact on the application of §3148 in two respects. The first impact was the specific ruling of the Court of Appeals affirming the decision of the trial court that a claim representative, when faced with a factual uncertainty as to whether the insured was able to return to work, had a duty to reconcile the uncertainty. Under this ruling, for a no-fault insurer to avoid sanctions under §3148 it was not sufficient that a factual uncertainty existed as to the continuation of the effects of the injury suffered in the motor vehicle accident. The trial court found that the insurer acted unreasonably because the claim representative, when faced with the factual

uncertainty, failed to take the additional step of reconciling the inconsistent reports.

The second impact of *Liddell* was to enshrine in Michigan no-fault case law a clearly erroneous standard of review: “A trial court’s finding of unreasonable refusal or delay will not be reversed on appeal unless it is clearly erroneous.” This standard was applied as recently as 2008 in *Bonkowski v Allstate Ins Co*.⁴

The Supreme Court’s rejection in *Ross* of the clearly erroneous standard of review in cases under MCL 500.3148 corrects a 38-year error in the construction of section 3148.

It is instructive to trace back the chain of authorities on which the *Bonkowski* opinion relied for this standard. *Bonkowski* cited *McCarthy v Auto Club Ins Ass’n*, a 1994 decision.⁵ *McCarthy* in turn cited *United Southern Assurance Co v Aetna Life & Casualty Ins Co*, decided in 1991.⁶ *United Southern* cited *Conway v Continental Ins Co*, a 1989 decision,⁷ which in turn cited *Kondratek v Auto Club Ins Ass’n*, (1987),⁸ which cited *Nelson v DAIIE*, (1984),⁹ which had cited *Butler v DAIIE*,¹⁰ which in turn cited *Liddell*.

Where did *Liddell* get this standard? The *Liddell* court cited the pre-no-fault opinion in *Motorists Mutual Ins Co v Howard*¹¹

Continued on next page

Penalty Attorney Fees . . .

Continued from page 3

. . . the more fundamental issue—ignored by *Liddell* and its progeny—was whether a trial court’s decision that a insurer acted unreasonably under §3148 is a pure finding of fact.

and 1963 GCR 517.1, the predecessor to MCR 2.517. But the prior and the current rules merely require the trial court to make findings of fact without mentioning a standard of review. So, essentially, *Liddell* treated the trial court’s decision whether an insurer acted unreasonably for purposes of §3148 as a pure question of fact, and merely applied the existing standard of appellate review with regard to pure questions of fact decided by the trial court.

No one would dispute that the clear error standard of review applies to a pure question of fact decided by a trial court. But the more fundamental issue—ignored by *Liddell* and its progeny—was whether a trial court’s decision that a insurer acted unreasonably under §3148 is a pure finding of fact. The Supreme Court in *Ross* decided that it was not. “The trial court’s decision about whether the insurer acted reasonably involves a mixed question of law and fact. What constitutes reasonableness is a question of law, but whether the defendant’s denial of benefits is reasonable under the particular facts of the case is a question of fact.” *Ross*, 481 Mich at 7. It is interesting that for this analysis of the issue as a mixed question of law and fact, the Supreme Court did not rely on a no-fault case, but on the general discussion of the distinction between pure and mixed questions of fact in *Sweebe v Sweebe*.¹² *Sweebe* was in fact a divorce case, and the issue of the distinction between pure and mixed questions of fact arose in that case the context of waiver.

The *Ross* opinion did not mention *Liddell*, but the implied rejection of *Liddell*’s characterization of a §3148 decision as a pure question of fact indicated a potential weakness in the reasoning of the *Liddell* Court.

The ax fell on *Liddell* on December 30, 2008 in *Moore, supra*: “We overrule *Liddell*.”¹³ The overruling of *Liddell* stemmed directly from the *Ross* analysis of the issue as a mixed question of law and fact. “We acknowledge that the trial court’s decision about whether an insurer acted reasonably presents a mixed question of law and fact [citing *Ross*]. We hold that the trial court here erred as a matter of law.” *Id.* In other words, in the view of the *Ross* opinion, the court in *Liddell* made a decision as to “what constitutes reasonableness” by ruling that a no-fault insurer had a duty “to go beyond” the existing factual uncertainty and attempt to “reconcile” the conflicting opinions. Requiring an insurer to resolve a factual uncertainty was a holding that went to the definition of reasonableness as a matter of law. As such, the holding was subject to a de novo standard of review. The *Liddell* Court of Appeals panel went astray by treating the holding of the trial court as to what constituted reasonableness as a finding of fact subject to a clear error standard of review. As a result, the *Liddell* Court accorded undue deference to a legal ruling of the trial court, and *Liddell* was therefore overruled.

Requiring an insurer to resolve a factual uncertainty was a holding that went to the definition of reasonableness as a matter of law. As such, the holding was subject to a de novo standard of review.

Legal realism compels a recognition that *Moore* was a 4-2 decision with Justices Young, Markman, and Taylor concurring with Justice Corrigan and Justices Kelly and Weaver dissenting. Justice Cavanaugh did not participate because of a “familial relationship with counsel for Secura.” Nevertheless, the decision seems well grounded in the language of the statute. As Justice Corrigan pointed out, “Nothing in the plain language

Announcements from Other Sections

Senior Lawyers Section

The Senior Lawyers Section annual meeting will be held at Crystal Mountain Resort August 21-23, 2009. In addition to section business meetings, there will be plenty of time for golf, fellowship, and the chance to visit a member’s lakeside cottage. Mark you calendar now and watch for further announcements. ■

of MCL 500.3148(1) requires an insurer to reconcile conflicting medical opinions.” *Moore* at 6. The holding of the trial court in *Liddell* that this was required appears to be correctly analyzed as a ruling of law, and not a finding of fact. ■

Jack Hoffman is a partner in Kuiper Orlebeke PC, and practices extensively in the area of healthcare charging litigation, representing no-fault insurers and other third-party payers.

Endnotes

- 1 *Ross v Auto Club Group*, 481 Mich. 1, 7; 748 NW2d 552 (2008).
- 2 482 Mich 507; 759 NW2d 833 (2008).
- 3 102 Mich App 636; 302 NW2d 260(1981).
- 4 *Bonkowski v Allstate Ins Co*, 281 Mich App 154; ___ NW2d ___ (2008).
- 5 208 Mich App 97, 103; 527 NW2d 524 (1994).
- 6 189 Mich App 485; 474 NW2d 131 (1991).
- 7 180 Mich App 447, 451; 447 NW2d 761 (1989).
- 8 163 Mich App 634, 638; 414 NW2d 903 (1987).
- 9 137 Mich App 226; 359 NW2d 536 (1984).
- 10 121 Mich App 727, 742; 329 NW2d 781 (1982).
- 11 21 Mich App 146, 149; 175 NW2d 351 (1970).
- 12 474 Mich 151, 154; 712 NW2d 708 (2006).
- 13 *Id.*, 2008 WL 5505410 at 6.

Don't forget to check the website

Important section information, including this newsletter, can be found at
<http://www.michbar.org/insurance/>

The Drafting Table

Less is More, More is Less

By Hal O. Carroll, *Vandever Garzia, PC*, hcarroll@VGpcLAW.com

The common formulation is “less is more,” but the inverse is equally true and more apt when it comes to drafting insurance or indemnity clauses.

Edgar Allen Poe could teach lawyers a lot about drafting. Poe was a critic as well as a writer. He said that in a novel, the writer can take excursions from the story line. Think *Moby Dick*, in which Melville describes in detail how whaling was done in the mid-nineteenth century. But, Poe said, in a short story, every word either plays a part or it should be left out. This is good advice for drafters of policies and contracts, too, even though some look as though the authors thinks they are novelists.

One application of this principle is in the overuse of words. For example, definition clauses in some policies often begin with the intonation, “As used in this policy, ‘claim’ shall mean...” “As used in this policy”? As opposed to what? When it was used in 1997 in an article in the *New York Times*? Seriously, what is the risk that the omission of the phrase “as used in this policy” would have sent the reader out into the world thinking that the policy’s definition of “claim” applied anywhere but the policy?

And what about “shall mean”? “Shall” is the language of command. Who needs to be commanded? Would the result be different if the phrase said “means” instead of “shall mean”? Would a judge really say, “Oh, then it’s just a suggestion, not binding on anyone, since it doesn’t say ‘shall mean’”?

Edgar Allen Poe could teach lawyers a lot about drafting. . . . in a short story, every word either plays a part or it should be left out. This is good advice for drafters of policies and contracts, too . . .

Still, some would argue that this is straining at gnats and that the exuberant and prolix use of unnecessary words is harmless at worst. That is a pretty weak defense of including words that are meaningless in a document where meaning is paramount, and it can be addressed for fully in a future installment. The test is simply stated. The test is not “Does this language hurt?” but “Does this language help?” If not, leave it out.

For now, let’s put the issue of empty phrases aside and look at some actual substantive language.

Here is an “other insurance” clause in a professional liability policy. The clause goes on at great length, with a lot of excess verbiage. When all of that is peeled away, here is the nub of the clause. Actually, there are three nubs.

1. The coverage provided by this policy is in excess of any and all other defense and indemnification arrangements and/or insurance policies, whether primary, excess, umbrella, or contingent and whether collectible or not....
2. The coverage herein does not apply if the assured has other valid and collectible insurance of any kind whatsoever.
3. This policy is specifically excess over coverage provided by policies issued by professional associations of which the assured is a member.

Every other insurance clause should have a “one-nub” limit. In the well-known triumvirate of other insurance clauses (pro rata, excess and escape), this other

Continued on next page

Drafting Table

Continued from page 5

insurance clause uses not one, but two. It starts with an excess clause, then an escape clause, and then back to an excess clause. In the case in which the policy was at issue, an escape clause would mean the insurer paid nothing. An excess clause meant that the insurer paid its limits. The result was that the insurer paid its limits.

Even though it is well established that the subjective intent of the drafter counts for little, it is still fair to ask, from the *Drafting Table's* perspective, what the drafter of this clause was thinking. The difference between part 2 and parts 1 and 3 is stark.

This example is not all that rare. It is the kind of thing that attorneys who represent insureds look for. That is why "manuscript forms," the ones that are drafted by the insurer itself, as opposed to a standard ISO (Insurance Services Office®) form, are the first focus of the insured's attorney. If coverage gold is to be found, it is most likely there.

Let's look at an indemnity clause, as well. These are all "manuscript forms," of course. They are all written by an attorney or, worse, the client. There is no ISO of indemnity.

Here is the situation. Client owns a large public park and earns revenues from public attendance. The park is in an area with a high water table, so it contracts with a company to install drainage systems and maintain a pumping station. Failure of the station will result in significant loss of revenue, so it wants an indemnity clause. Client's attorney drafts a simple clause of the type:

Contractor agrees to indemnify Park for any losses in revenue or damages to property arising from the Contractor's performance of or failure to perform this contract.

Client consults with business associates (not lawyers), who are concerned that the clause is too short. More specifically, they think that indemnity has to do with fault, so that should be in the clause, and it should be more formal, and that a more formal expression of indemnity involves "mutual indemnity." They change the clause to read:

Park and Contractor mutually agree that each will indemnify the other for any liability arising from the negligent performance of this contract.

This, as the client saw it, was a "more sophisticated" clause. "Mutually agree" sounds more sophisticated. But how would it really work? Well, since the park does not perform the contract, except to write checks, it cannot cause a loss, so the contractor will never owe indemnity. On the other hand, since the contractor is the active performer of the contract, it can cause a loss, and this clause will then require the client to indemnify it.

The net result is that the client would never get indemnity, but might well have to pay it.

So irrational exuberance in the use of language is more than mere esthetics, though there is nothing wrong with esthetics in writing either. But verbosity can be dangerous. There may well be no area of law where words have more power, and where the expression of the power of words is more condensed, than in insurance coverage and indemnity obligations. ■

Insurance Coverage Counsel

Opinions ▲ Litigation ▲ Appeals
Settlements ▲ Creative Resolutions

Timothy Casey
(586) 563-3500
tcasey@kcmlaw.com



KELLEY, CASEY & MOYER, P.C.
ATTORNEYS AND COUNSELORS

Teaming With Clients for Superior Results.

Need a Speaker?

Want to Be a Speaker?

If you belong to a group that would like to have a speaker from the Insurance and Indemnity Law Section address your group on a topic of interest, just let us know the topic, and we'll try to arrange a speaker. If you are not sure of a topic, call anyway, and we'll work something out.

If you are a member of the section and would like to be on our list of speakers, please contact:

Hal O. Carroll
hcarroll@VGpcLAW.com
or call at
(248) 312-2800

The Examination Under Oath: "Let me ask you this . . ."

By James A. Johnson, *johnsonjajmf@hotmail.com*. ©2009 James A. Johnson

The "examination under oath" (EUO) is an important tool to help an insurance company to prevent fraud. The purpose of the examination is to enable the insurer to obtain information necessary to process the claim. An examination under oath is taken under the authority provided by a condition of the insurance policy. The policyholder is required to appear and give sworn testimony on the demand of the insurer. A certified shorthand reporter is present to give the oath to the witness-insured and take down the testimony.

The insurer is not required to show that it was prejudiced by the insured's refusal or failure to appear at an examination under oath.

The attorney representing the insurance company questions the policyholder in a manner similar to an oral deposition in a lawsuit, but the attorney representing the insured has no legal right to question or cross-examine the insured. The EUO is not a deposition as set out in the court rules. The EUO arises out of a provision in the contract of insurance and is a condition precedent to the insurer's liability. The genesis of the EUO arises from the standard fire policy and is most common in property insurance policies.

Michigan has recognized EUO provisions in many types of insurance policies since long before the advent of no-fault automobile insurance.¹ Examination under oath provisions may be included in automobile no-fault policies, but are only enforceable to the extent that they do not conflict with statutory requirements of the No-Fault Act.² An examination under oath provision that contravenes the requirements of the No-Fault Act by imposing some greater obligation upon one or another of the parties is, to that extent, invalid. A policy provision requiring the insured to submit to a EUO was invalid as a condition precedent to pay first-party no-fault benefits, and State Farm had a statutory obligation to pay within 30 days after receiving reasonable proof of the fact and the amount of the loss.³ However, a EUO provision for uninsured motorist benefits under the policy that required the insured making a claim to answer questions under oath and

. . . the examination under oath can be an effective procedure for the policyholder to prove his or her claim, especially where evidence was destroyed by fire, water, or otherwise unavailable.

to sign copies of answers was enforceable. The availability of uninsured benefits is covered by the policy and not the No-Fault Act.⁴

The attorney representing the insurance company questions the policyholder in a manner similar to an oral deposition in a lawsuit, but the attorney representing the insured has no legal right to question or cross-examine the insured.

The insured's failure to submit to the insurance company's requests for an examination under oath and her failure to provide documents requested during the insurer's investigation of the claim for benefits under a fire insurance policy was held to be willful noncompliance with policy conditions. The insurance company was justified in denying the insured's claim.⁵

The insurer is not required to show that it was prejudiced by the insured's refusal or failure to appear at an examination under oath. Failure to appear is a breach of a policy condition.⁶ Submission to a EUO, if the request is reasonable, is strictly construed as a condition precedent to the insurer's liability. A provision in homeowners' insurance policy that required the insured to submit to examination under oath barred suit on the policy when the insured failed or refused to comply.⁷

Numerous other jurisdictions follow the same reasoning and conclusion. Here are some examples:

In *Rymsha v Trust Co*,⁸ the insured failed or refused to provide financial records, including income tax returns and credit card information regarding the purchase of items reported stolen. The insurer denied her claim.

The Indiana Supreme Court, in *Morris v Econ Fire & Cas Co*,⁹ held that breaches of examination under oath clauses do not require a showing of prejudice; an insurance company only need show a material breach to prevail.

The California Court of Appeal concluded in *California Fair Plan Assoc v Superior Ct of Los Angeles Cty*¹⁰ that, "as a matter of law," the insured:

violated the requirement of the insurance policy that he submit to an examination under oath; that the insurer could on that basis deny his claim without a showing of prejudice; **that the availability of a deposition in litigation does not excuse his breach of the examination under oath**

Continued on next page

The Examination . . .
Continued from page 7

requirement; that he had no valid bad faith claim; and that the court properly dismissed his action.¹¹

Not to be overlooked is that the examination under oath can be an effective procedure for the policyholder to prove his or her claim, especially where evidence was destroyed by fire, water, or otherwise unavailable. ■

James A. Johnson is a litigator and a member of the Michigan, Massachusetts, Texas, and U.S. Supreme Court Bars. His e-mail address is johnsonjajmf@hotmail.com.

Endnotes

- 1 *Gordon v St Paul Fire & Marine Ins Co*, 197 Mich 226, 230; 163 NW 956 (1917).
- 2 MCL 500.3101 *et seq.*
- 3 *Cruz v State Farm Mut INS Co*, 466 Mich 588, rehearing denied 467 Mich 1208 (2002); 648 NW 2d 591 (2002); MCL 500.3142 (3).
- 4 MCL 500.3145; 500.3151.
- 5 *Allen v Michigan Basic Property Ins Co*, 249 Mich App 66 (2001); 640 NW 2d 903 (2001).
- 6 *Id.*
- 7 *Thompson v State Farm Ins Co*, 232 Mich App 38; 592 NW 2d (1998).
- 8 746 NE 2d 561 (Mass App Ct 2001).
- 9 848 NE 2d 663; 666 (Ind 2006).
- 10 9 Cal Rptr 3d 746, 115 Cal App 4th 158 (Cal App 2004).
- 11 *Id.*, emphasis added.

Wrap-Up Insurance Programs—Scrutinize Carefully

By Donald S. Malecki, CPCU, *Malecki, Demling Nielander & Associates*,
don.malecki@mdnconsults.com

Wrap-up insurance programs require careful scrutiny by all parties concerned. Briefly, a wrap-up program, also known as a consolidated insurance program (CIP), is a program in which the interests of the project owner, general contractor, construction manager, architect, engineers and approved subcontractors of all tiers are combined (“wrapped up”) into a single, centrally managed insurance program covering job-site risks.

Although wrap-ups, both owner-controlled (OCIP) and contractor-controlled (CCIP), have been in existence for several decades, they still present some complications for the participants, the producers of the wrap-ups, and the insurers of all parties.

When properly implemented, the CIP can eliminate costs of overlapping coverages and delays due to coverage disputes, which are likely to occur if each enrolled party maintains its own insurance. Whether an OCIP or CCIP, it typically involves a safety program that monitors and maintains records on claims by injured workers and others.

With its primary objective being savings—particularly on workers’ compensation—the owner-controlled program (OCIP) was initially the more common of the two approaches. But along with contractors’ expertise in construction matters, site safety, control, and opportunities for profit, the CCIP has grown in popularity.

Some problems

When a problem arises, there usually is plenty of fault to go around to everyone involved in a wrap-up program. Not even the producer of a wrap-up is immune. In *SMI Owen Steel Company v Marsh USA Inc*, 520 F3d 432 (5th Cir., Texas 2008), a subcontractor sued the broker that administered the CCIP for negligent failure to procure insurance.

. . . the broker sent an inaccurate certificate of insurance stating that SMI had professional liability insurance under the CCIP, when in fact no policy had been issued.

As part of the CCIP scheme, the insurance consisted of professional liability (which included design errors and omissions), subcontractor default, and excess liability. Under the contract between the owner and general contractor, coverages were required for both, including related entities, but not for subcontractors.

What had happened was that a subcontractor (SMI) was awarded a bid to design, engineer, and install structural steel and foundation work. The insurance information booklet furnished by the broker stated that enrolled subcontractors of all tiers would be covered and provided with professional liability insurance. In fact, the broker issued insurance certificates representing that SMI was an additional named insured on the owner’s professional liability policy.

Unknown to SMI, however, was the fact that the broker’s project manager advised his employees to stop issuing insurance certificates for professional liability coverage to subcontractors and to amend the contractor handbook accordingly. Despite this



Advertise in *The Journal of Insurance & Indemnity Law*

For details, contact:
Hal O. Carroll
hcarroll@VGpclAW.com
(428) 312-2800

warning, the broker sent an inaccurate certificate of insurance stating that SMI had professional liability insurance under the CCIP, when in fact no policy had been issued.

As it turned out, suit was filed against SMI in a dispute where it learned for the first time that the broker never obtained professional liability insurance for it.

SMI alleged that because of the two inaccurate certificates and their usual disclaimers, along with the handbook, it was led to detrimentally rely on the broker to procure professional liability insurance. With the evidence sufficient for such a finding, both the trial and appeals courts ruled against the broker.

. . . when an OCIP or CCIP is implemented, it is necessary for contractors of all tiers to have their insurers informed of the coverages to be provided by the wrap-up so that they can be excluded under their own insurance portfolio.

This is a case worth reading because of the various defenses raised by the producer, and the testimonies of the expert and underwriter, the latter over the insured vs. insured exclusion. It would appear that the underlying problem here was a misunderstanding and miscommunication over what was to be provided to the respective enrolled parties.

Producers for participating subcontractors (referred to interchangeably as contractors of all tiers) also are confronted with problems. One of these is in arranging coverage under the subcontractors' own liability insurance portfolio in the event the wrap-up coverage falls short of expectations.

As producers have come to learn, when an OCIP or CCIP is implemented, it is necessary for contractors of all tiers to have their insurers informed of the coverages to be provided by the wrap-up so that they can be excluded under their own insurance portfolio. Once an insurer learns about a subcontractor's involvement, its commercial general liability and workers' compensation policies will be modified with endorsements precluding coverage being provided by a wrap-up.

The challenges in arranging coverage, even with a manuscript endorsement, are many, and the wording selected to apply coverage must be carefully crafted.

The one ISO-type endorsement issued by insurers to preclude coverage is Exclusion-Designated Operations Covered by a Consolidated (Wrap-Up) Insurance Program CG 21 54, which excludes both ongoing and completed operations. With contractors' limitation endorsements commonly applicable to umbrella/excess liability policies, coverage for wrap-up

programs is automatically excluded.

The hard part for producers, with regard to the liability policies issued to their subcontractor insureds, is to arrange excess or difference in conditions coverage in the event of any gaps or shortage of limits within the wrap-up program. This is not an easy task, particularly when insurers are reluctant to issue such endorsements.

With no standard endorsement available for this purpose, one generally has to be manuscripted. One such endorsement, which was issued as part of an insurer's CGL policy for a subcontractor, provided automatic excess cover that read: "This insurance is excess over any other insurance available to you covering liability for damages arising out of a consolidated insurance (wrap-up) program to which you have been added as an insured. If no other insurer defends you, we will undertake to do so, but will be entitled to rights against others."

The challenges in arranging coverage, even with a manuscript endorsement, are many, and the wording selected to apply coverage must be carefully crafted. For example, the wording selected for the endorsement should address the characteristics of the wrap-up program involved, the exposures posed by a given wrap-up, and the coverage chosen to cover it.

Complicating Matters

The foregoing suggestions are easier said than done. Another problem area is that many participating contractors of all tiers are ill-informed about the coverages provided by an OCIP or CCIP or do not fully understand the implications and do not always communicate their insurance needs properly to their insurance providers.

How can producers, for example, arrange for coverage beyond a wrap-up unless contractors communicate their insurance needs? Actually, these contractors not only have to understand the coverage shortages, but also communicate them to their producers.

A complication here is that it is sometimes difficult to understand some of the insurance provisions; some, in fact, could be appropriately labeled as a trick or trap. One such example concerns completed operations.

Completed Operations Coverage

As a general rule, completed operations coverage should apply for as long as the appropriate statute of repose, which is the time within which claim can be made after the work has been completed. In Michigan, the statute of repose is 10 years, MCL 600.5839.

If some repair work were to be necessary after the completion of work, any bodily injury or property damage emanating from the repair work would be subject to completed operations coverage. This is spelled out in the definition of the "products-completed operations hazard," which states: "Work

Continued on next page

Wrap-Up Insurance . . .

Continued from page 9

that may need service, maintenance, correction, repair or replacement, but which is otherwise complete, will be treated as completed.” This provision, incidentally, has been a part of CGL policy provisions since at least 1941.

As a general rule, completed operations coverage should apply for as long as the appropriate statute of repose . . .

The trick or trap here is that some insurers of a wrap-up will add an endorsement to their CGL policy, which may appear to be a coverage extension but is actually a limitation. One such endorsement is titled “Limited Coverage—Repair Work.”

This endorsement states, in effect, that the insurance is extended for an additional period with respect to bodily injury or property damage arising from repair work. This extension is stated to commence on the date the work is completed and ends as of (1) the expiration of any express warranty for the named insured’s work; (2) the statutory time period for such repair work; or (3) up to 24 months from the date of completion of the named insured’s work, whichever comes first.

What this means is that even though completed operations coverage is provided for as long as 10 years, a subcontractor may have completed operations coverage for only 2 years. Any injury or damage occurring after the two-year period and involving repair work would not be subject to the wrap-up! The subcontractor would either have to have some type of excess liability coverage on a difference-in-conditions basis, or be forced to retain the financial consequences of any claim or suit.

Contractors of all tiers are not the only ones who are exposed to coverage gaps. Owners also can find themselves assuming too much of the exposure without being able to

rely on insurance. During review of one such program, it was noted that the insurer inserted a waiver of rights of recovery (waiver of subrogation) that stated, in effect, that the owner was to waive all rights of recovery against the insurer and all contractors who are accepted into the OCIP or CCIP. A waiver of subrogation should apply only to the extent of applicable insurance coverage.

For reasons such as these, reference to owner-controlled or contractor-controlled programs may be misnomers because the one who is in control is not the owner or general contractor but, instead, the insurer.

Having said this, wrap-ups are nonetheless necessary because they enable contractors of all tiers to obtain work and coverage that might not otherwise be available in traditional work projects where every participant must supply its own insurance.

Contractors, however, should not be satisfied simply with having the opportunity to obtain work involving a wrap-up and nothing more. They need to understand the shortcomings of these programs, and they need to communicate them and their needs to their producers. These contractors also need to understand that their producers may not always be in a position to close the loopholes. Much may depend on the contractors’ business longevity, loss history, and potential for growth. ■

Donald S. Malecki, CPCU, has spent 48 years in the insurance and risk management consulting business. He currently is a principal of Malecki Deimling Nielander & Associates L.L.C. headquartered in Erlanger, Kentucky.

Editor’s Note: This article is adapted, with permission, from an article that first appeared in *Rough Notes* magazine, November 2008.

Attorneys Needed to Identify Accessibility Issues for People with Disabilities

The State Bar of Michigan will be conducting an online survey during the next few months to better understand the current issues related to access to justice for people with disabilities.

Two attorney populations are asked to participate –attorneys with disabilities, and attorneys who have represented clients with disabilities within the past two years. If you are a member of either of these populations and are willing to share your experiences and views, please submit your contact information by going to: <http://www.michbar.org/participate.cfm>.

The aim of the survey is to determine the availability of policies and programs and the responsiveness to accommodation requests over the past few years, and to formulate strategies that will ensure fairness and accessibility within the justice system. The survey is a follow up to a study done by the now-defunct Open Justice Commission in 2001. That study’s findings can be found at www.michbar.org/programs/ATJ/pdfs/disabilities.pdf.

Questions about the online survey can be directed to Kathleen Conklin, Justice Initiatives program manager, at (517) 346-6307 or kconklin@mail.michbar.org.

No-Fault Corner

By Ronald M. Sangster, Jr.
Law Office of Ronald M. Sangster, rsangster@sangster-law.com

Welcome to the newest feature in the *Journal of Insurance and Indemnity Law*—the No-Fault Corner. It is my hope to provide readers with a brief analysis of recent cases issued by the Michigan Supreme Court and the Michigan Court of Appeals, and how those cases will impact on this particular area of the law.

Supreme Court Activities

Since Justice Diane Hathaway assumed the Supreme Court bench in January of 2009, there have been no substantive opinions released by the Michigan Supreme Court that affect No-Fault. However, in the waning days of former Chief Justice Cliff Taylor's tenure on the bench, the Supreme Court issued three significant opinions which are of interest to No-Fault practitioners. Two of the decisions were 4-3 decisions, with the former conservative majority (Justices Markman, Corrigan, and Young, along with former Chief Justice Taylor) making up the majority. It remains to be seen how the newly constituted Court will resolve similar issues in the future.

. . . in the Supreme Court's opinion, the Court of Appeals improperly focused on plaintiff's "normal life" as it existed before the first automobile accident.

Second Accident and Serious Impairment

Benefiel v Auto Owners Insurance Company, ___ Mich ___; 759 NW 2d 814 (2008).

In *Benefiel*, plaintiff was involved in a motor vehicle accident, which rendered him disabled. During his period of disability, plaintiff was involved in a second motor vehicle accident. The circuit court granted summary disposition in favor of defendant, based upon the Supreme Court's decision in *Kreiner v Fischer*, 471 Mich 109; 683 NW 2d 611 (2004), as there was no showing that plaintiff's lifestyle, before and after the *second* accident, was impacted by the injuries suffered in the second accident. On appeal, the Michigan Court of Appeals reversed the decision of the circuit court and concluded, as a matter of law, that plaintiff had suffered a serious impairment of body function, as that term is defined in MCL 500.3135(7), based upon a comparison of plaintiff's lifestyle prior to the *first* accident, and after the *second* accident.

On appeal, the Supreme Court, by a 4-3 majority, issued a peremptory order on December 12, 2008, vacating the

opinion of the Court of Appeals and remanding the case to the circuit court for further proceedings. In its ruling, the court concluded that defendant was not entitled to summary disposition (thereby reversing the decision of the circuit court), as defendant had "failed to show that, as a matter of law, the plaintiff cannot establish a serious impairment of body function." At the same time, the court vacated the Court of Appeals analysis because, in the Supreme Court's opinion, the Court of Appeals improperly focused on plaintiff's "normal life" as it existed before the *first* automobile accident. Rather, the focus must be on plaintiff's lifestyle between the *first* and *second* motor vehicle accidents. As noted by the Court:

Therefore, the Plaintiff must prove that his existing impairment is temporary in order to have his pre-impairment lifestyle considered as his "normal life." It follows that, in this situation, Plaintiff must show either that his pre-existing impairment was exacerbated or that his recovery was prolonged *as a result of* the subsequent accident for which he seeks non-economic damages. Furthermore, the *subsequent* impairment must meet the statutory threshold in order for Plaintiff to recover non-economic damages.

Justice Cavanagh, joined by Justice Weaver and Justice Kelly, concurred in part and dissented in part. Justice Cavanagh accused the majority of inserting a permanency requirement into the No-Fault Insurance Act's definition of "serious impairment of body function," set forth in MCL 500.3135(7). Since the Supreme Court released its decision on December 12, 2008, there has been no further appellate court activity.

Catastrophic Claims Fund Can Review Reasonableness of Payments

USF&G v MCCA, 482 Mich 414; 759 NW 2d 154 (2008)

On December 29, 2008, the Supreme Court released its long-awaited decision in *USF&G v MCCA*, 42 Mich 414, 759 NW 2d 154 (2008). In yet another 4-3 decision, the Supreme Court affirmed the ability of the Michigan Catastrophic Claims Association (MCCA) to review a no-fault insurer's payments for "reasonableness." In this regard, the Michigan Supreme Court reversed the decision of the Court of Appeals, found at 274 Mich App 184; 731 NW 2d 481 (2007).

The underlying facts were rather straightforward. In *USF&G v MCCA*, the plaintiff was severely injured as the result

Continued on next page

No-Fault

Continued from page 11

of a motor vehicle accident in 1981. Since then, he required 24-hour attendant care services. USF&G entered into a consent judgment with plaintiff and his father in 1990, under which the future attendant care payments would increase from \$17.50 per hour by 8.5 percent, compounded annually. As a result, USF&G was compelled to pay attendant care services at the rate of \$54.84 per hour as of 2003. The MCCA refused to reimburse USF&G for any amount above \$22.05 per hour, which the MCCA considered to be "reasonable."

Supreme Court affirmed the ability of the Michigan Catastrophic Claims Association (MCCA) to review a no-fault insurer's payments for "reasonableness."

In the companion case, *Hartford v MCCA*, the parties entered into a settlement agreement in 2003, whereby Hartford agreed to pay \$30.00 per hour for attendant care for three years, through 2006. The MCCA refused to reimburse Hartford for any amounts above \$20.00 per hour, which it considered to be a "reasonable" hourly rate.

Both the Hartford and USF&G filed suit against the MCCA, requesting that the MCCA reimburse each insurer in full for the attendant care payments made pursuant to the consent judgment and settlement agreement, respectively. The circuit court ruled in favor of USF&G, determining that the statutory scheme governing the operation of the MCCA did not permit the MCCA to review an insurer's claims payment for "reasonableness." In *Hartford*, the court ruled in favor of the MCCA, holding that it could refuse to reimburse "unreasonable" charges made by an insurance company. On appeal, the Court of Appeals ruled in favor of both insurers.

The Supreme Court, in a 4-3 decision, reversed the decision of the Court of Appeals. Justice Young authored the majority opinion, in which he noted that because the insurer's policy required it to provide coverage only for "reasonable charges," the MCCA had authority to refuse to indemnify "unreasonable charges." Justice Young rationalized that "unreasonable" charges, which may have been made by a no-fault insurer, are not "sustained under personal protection insurance coverages" set forth in the No-Fault Insurance Act. Therefore, such "unreasonable" payments "do not trigger the MCCA's obligation to indemnify '100 percent' of the claimed loss." Justice Weaver, joined by Justices Cavanagh and Kelly, authored a dissent, essentially adopting the opinion of the Court of Appeals.

On January 20, 2009, USF&G filed a motion for rehearing. The MCCA filed its response on February 3, 2009.

The Coalition Protecting Auto No-Fault filed an amicus brief on February 6, 2009. The Michigan Association for Justice filed its amicus brief on February 27, 2009. It may very well be that the new majority is taking a second look at this decision.

Penalty Attorney Fees

Moore v Secura, 482 Mich 507; 759 NW 2d 833 (2008)

On Chief Justice Taylor's last day on the bench, the Michigan Supreme Court released its decision in *Moore v Secura Insurance Company*, 42 Mich 507; 759 NW 2d 833 (2008). In a 4-2 decision (with Justice Cavanagh recusing himself due to a familial relationship with defense counsel), the Supreme Court reversed the published opinion of the Court of Appeals, which had awarded no-fault penalty attorney fees to plaintiff because the insurer had failed to reconcile the conflicting medical opinions of plaintiff's treating physician with the opinions expressed by defendant's IME physician. Both the lower court and the Court of Appeals had based their decision to award no-fault penalty attorney fees to plaintiff on the Court of Appeals' decision in *Liddell v DAIE*, 102 Mich App 636; 302 NW 2d 260 (1981). In its opinion, though, the Michigan Supreme Court overruled *Liddell* and noted that:

The plain language of MCL 500.3101 *et seq.* does not impose an independent duty on insurers to "go beyond" the medical opinion of their physicians and the IMEs that those physicians perform.

The Court further noted that:

We conclude that an insured need not resort to a "tie-breaker" to resolve conflicting medical reports, but we note that an insurer acts at its own risk in terminating benefits in the face of conflicting medical reports. Here, however, Defendant's decision not to seek out another physician to prepare yet another IME in order to reconcile the conflicting opinions of Dr. Walter [Plaintiff's treating orthopedic surgeon] and Dr. Xeller [Defendant's IME physician] was not unreasonable under the fact-specific inquiry mandated by MCL 500.3148.

[*Moore*, 759 NW 2d at 841]

Justice Kelly, joined by Justice Weaver, issued a dissenting opinion, essentially adopting the Court of Appeals' analysis.

Plaintiff filed a motion for rehearing with the Michigan Supreme Court on January 20, 2009. Counsel for Secura filed its answer to the motion for rehearing on January 30, 2009. As of this writing, the Michigan Supreme Court has not issued a decision regarding the motion for rehearing. ■

**Insurance
Case
Summary**

Insurance Decisions of Interest

By Deborah A. Hebert, Collins, Einhorn, Farrell & Ulanaoff, deborah.hebert@ceflawyers.com

Michigan Supreme Court

60-day vacancy exclusion in property insurance policy

Ellis v Farm Bureau Ins Co

Order, December 19, 2008 (Case No. 136069)

As reported last issue, the Supreme Court heard arguments in early December on Farm Bureau's application for leave to appeal from a decision of the Court of Appeals holding that an exclusion of coverage for vacant or unoccupied property did not apply. It was undisputed that the insured home was rental property that had not been occupied by a tenant for some months prior to the fire. Both lower courts held that the exclusion did not apply because the property was undergoing renovations. On December 19, 2008, the Supreme Court reversed. The plain terms of the insurance contract excluded coverage where the property had been left "vacant or unoccupied" for 60 consecutive days or more.

Michigan Court of Appeals Opinions—Published

Property insurance denied because of vacancy of more than 30 days

Sherman-Nadiv v Farm Bureau Gen'l Ins Co of Michigan

November 20, 2008 (Docket No. 279302)

The insured owned rental properties insured with Farm Bureau. She spent several months refurbishing one of these properties, which she leased to a new tenant on May 1, 2004. Two weeks later, defendant discovered significant water damage in the home as the result of a broken pipe. The tenant had never moved in. Farm Bureau refused to pay the claim because the property was unoccupied, and the insurance policy expressly excluded coverage for damage to property caused by the accidental discharge of water from a pipe "if the dwelling has been vacant for more than 30 consecutive days immediately before the loss. A building being constructed is not considered vacant." *Sl op*, p 3. The Court of Appeals interpreted "constructed" to mean being erected from the ground up, "a discrete event with a beginning and an end." *Id.* It did not include repairs and renovations. Coverage was properly denied.

6th Circuit Court of Appeals

Long-term disability benefits wrongfully denied

DeLisle v Sun Life Assurance Co of Canada

___ F3d ___ (6th Cir 2009)(Case No. 08-1142)

Sun Life was found to have arbitrarily and capriciously denied plaintiff benefits for long-term disability. A review of its decision making process revealed a conflict of interest on the part of Sun Life's claims reviewers, who received improper communications from the insurer's in-house attorneys regarding the reason for plaintiff's termination from employment. And the reviewers failed to acknowledge plaintiff's Social Security disability determination and the medical evidence reflecting her progressive disability.

Court of Appeals—Unpublished Opinions

CGL mold exclusion upheld; but coverage was provided under the umbrella policy

Aladdin's Carpet Cleaning, Inc. v Farm Bureau Gen'l Ins

February 26, 2009 (Docket No. 278605)

The insured was in the business of remediating properties with water damage. Its primary CGL policy contained the standard mold exclusion; its umbrella policy did not. When the insured was sued for failure to properly remediate a customer's water-damaged home, which resulted in further damage, including mold, the insurer refused to defend under either policy. The Court upheld the insurer's refusal to defend under the primary policy. That policy expressly excluded coverage for claims of damage that "would not have occurred, in whole or in part, but for the actual, alleged, or threatened . . . contact with, exposure to, existence of, or presence of any fungi or bacteria . . ." But the court reviewed the insuring agreement in the umbrella policy, which covered claims not covered by the underlying insurance, and did not expressly exclude mold claims. Because the umbrella policy also provided a defense for covered claims, the insurer breached its duty to defend and indemnify under that policy.

Continued on page 15

Insurance Decisions

Continued from page 13

UIM coverage – settlement with tortfeasor bars coverage

Feldkamp v Farm Bureau Ins Co

January 15, 2009 (Docket No. 272855)

Plaintiff was injured in a motor vehicle with the driver of an underinsured motor vehicle. When the insurer of that vehicle offered to settle for policy limits on the condition of a release, plaintiff asked her UIM insurer to consent. The request was denied, pending a creditor's exam of the tortfeasor. Plaintiff moved for an order compelling consent, and the trial court granted the request. That decision was reversed on a prior appeal, but plaintiff had settled with the tortfeasor. On remand, the UIM insurer moved for summary disposition based on the lack of coverage given that plaintiff had destroyed its subrogation rights. The trial court again ruled for coverage, but that decision was reversed on appeal. The language of the UIM policy clearly stated that if the insured settled a claim without following the procedures outlined in the UIM policy, coverage was lost.

Burden was on party seeking arbitration of a UM claim to show an agreement to arbitrate

Buckman v Allstate Ins Co

December 23, 2008 (Docket No. 280171)

Plaintiff looked to his insurer for UM benefits, claiming serious injuries from an accident with an uninsured vehicle. When Allstate denied benefits, plaintiff petitioned the circuit court for arbitration, citing a clause in an incomplete copy of the auto policy. Allstate apparently could not produce the full certified policy but did offer testimony and other documentary evidence showing that the policy was issued with an endorsement that required all disputes to be resolved in a court of competent jurisdiction. The trial court ordered arbitration, but the Court of Appeals reversed, because it was plaintiff's burden to show an arbitration agreement and he failed to do so.

Homeowner's coverage lost for all insureds because of the fraudulent statements of one

Home Owners Ins Co v Selfridge

December 18, 2008 (Docket No. 280112)

The insureds' young grandson, visiting on Christmas Eve, pulled or tipped over a large coffee urn with hot coffee and sustained serious burns. Home Owners defended the grandparents against a lawsuit subsequently filed by the child's parents. The insured grandfather made false statements during the course of the litigation that were material to coverage, which prompted Home Owners to seek a declaratory judgment voiding coverage due to collusion. A provision in the policy

stated "[t]his entire policy is void if, whether before, during or after a loss, *any insured* has . . . engaged in fraudulent conduct . . . or made false statements relating to this insurance." The Court of Appeals held that the language of the policy was clear: if *any insured* misrepresented a matter relevant to coverage, the entire policy was void. This meant a loss of coverage for the insured grandmother as well.

Homeowner's coverage not lost because of fraudulent statements about property loss

Smith v Farm Bureau Ins Co

March 5, 2009 (Docket No. 281034)

Plaintiff's home was destroyed by fire. She claimed the loss of personal property that she did not own. Farm Bureau invoked the fraud provision of its policy to avoid coverage altogether, but the Court of Appeals held that the misrepresentation, though material, was not made with the intent to defraud. As to her claim for the value of the structure, the Court found that the jury's award for replacement value had to be reduced to actual cash value because the policy allowed replacement value only if the building was replaced.

Venue in an insurance dispute

McCorkle v Nationwide Ins Co

February 10, 2009 (Docket No. 280152)

An action for PIP benefits is viewed as a contractual claim, governed by the venue provisions of MCL 600.1621. Nationwide moved to change venue from Washtenaw County to Oakland County, where the accident occurred, on the basis of the statutory nature of the claim. Nationwide relied on MCL 600.1627. But the Court of Appeals held that even if the claim were statutory rather than contractual, "plaintiff would be entitled to choose between \$1621 and \$1627," and so venue was not improper. Defendant failed to show grounds for a change of venue on the basis of convenience.

Title Insurance—property owner cannot sue for negligence

Wormsbacher v Phillip R. Seaver Title Co, Inc

February 19, 2009 (Docket No. 281209)

Plaintiffs sued their title insurance company for negligence and negligent misrepresentation, after learning of the existence of an injunction barring any commercial development on their property. The trial court and the Court of Appeals both held that Michigan does not recognize a cause of action in negligence against title insurers. Plaintiffs were limited to claims for breach of contract.

Loss of business income—no proofs

Farm Bureau General Ins Co of Michigan v Dynamic Land, LLC

February 24, 2009 (Docket No. 282072)

The insured was renovating its commercial property when a sprinkler pipe burst and caused enough damage to make the building uninhabitable for some months. The insured claimed 12 months of lost rental income. But the evidence showed that one of the two floors had not been rented for the six-month period immediately preceding the fire and the other floor had been rented on a month-to-month tenancy, but the tenant had been asked to leave prior to the renovations. The insured intended to sell the building after the renovations were complete and felt that it would show better vacant. The policy covered only “actual loss of business income sustained.” SI op, p 2. Coverage was denied because “defendant failed to present any evidence that the pipe break caused it to lose any rental income that it otherwise would have received.” *Id.*

Damage to roof not covered under homeowner’s policy

Holliday v Pioneer State Mut Ins Co

March 5, 2009 (Docket No. 281319)

The insured sustained damage to the roof of one of his rental properties and sought coverage under his homeowner’s property. But the sections of the policy relied on by the

insured limited coverage to landlord furnishings and personal property. Damage to the roof was neither. The policy also excluded coverage for damage caused by “constant or repeated seepage or leakage of water or the presence of condensation or humidity, moisture, or vapor, over a period of weeks, months or years.” The insurer produced evidence that the roof was not damaged by a strong windstorm but had been leaking for a long period of time.

Warehouse coverage

Overall Trading, Inc v Hastings Mutual Ins Co

January 15, 2009 (Docket 278859)

Overall Trading sustained water damage to personal property stored in a warehouse insured by Hastings Mutual. One issue concerned proof of loss. There were two separate occasions of water damage, and the insurer argued that it was entitled to a separate proof of loss for each occasion. The Court held that where an insured submits a proof of loss that the insurer deems insufficient, it is the insurer’s obligation to inform the insured what more is needed. There was no evidence that Hastings Mutual did so here. Another issue concerned covered loss. This policy did not cover damage caused by surface water. The Court found a question of fact about the cause of loss on the first occasion, and remanded for proceedings on that issue. But there was no question concerning the cause of the second loss, which was a roof leak and was covered. ■

Insurance Issue? Why Deal with the Light Weights?



At Cambridge Property & Casualty our recognized insurance attorneys and other coverage experts can assist with insurance issues including:

- Expert witness consultation and testimony
- Insurance agent errors & omissions evaluation
- Evaluation of integrity of business and personal insurance programs
- Placement of commercial or personal insurance

Our Wealth of Experts:

Robin R. Ballard, LIC, CISR, AAI
 Kevin Bates, CLU, ChFC
 Tracey L. Birmingham, AAI, LIC
 Mary A. Foucard, AAI, CIC, CPCU
 Ronald R. Gaffney, LIC
 Cynthia Gascoyne, CIC, AAI
 Tina Gelardi, CISR, LIC, CIC
 Heather M. Grefke, CISR, AAI, LIC, CIC
 Daniel P. Hale, JD., CPCU, CIC, ARM, LIC, AAI, AIC, AIS, API
 Kenneth R. Hale, JD., CPCU, AAI, CIC, LIC
 Michael S. Hale, JD., CPCU, CIC, AAI
 Katy Hampton, CISR
 Judith A. Johnson, CISR
 Cam Kennedy, CPA

Amy L. Kitson, LIC, AAI, CIC
 Steven McCain, RHU
 Shauna L. McFarlane, CISR, AAI, LIC, CIC
 Monique E. Merritt, API, AIS
 Kathleen M. Murphy-Schwab, J.D., MBA
 Albert W. Papa, CLU, ChFC
 Leslie J. Payment, CISR
 Patricia A. Perez, CIC, AAI, LIC
 Jonathan Pope, MSF, CEBS, GBA, CMS, RPA
 Stacey E. Rose, CPA, MSF
 Jack Saks, J.D.
 David J. Setlock, CPA, AAI, LIC, CIC, CPCU
 Christal J. Smith, AAI, LIC, CISR
 Robert L. Stein, JD., CPCU, CIC, AAI, LIC, ARM
 Joann K. Wilford, CLU, CPCU
 Heather Wilson, J.D.



www.InsuranceAgentExperts.com
 or contact Michael S. Hale, J.D., CPCU, CIC, AAI at
T: 734.525.2414

2008-2009
Insurance & Indemnity Law Section
Officers and Council

Officers

Hal O. Carroll, Chairperson

Vandevor Garzia, PC

Troy



Timothy F. Casey, Chairperson-Elect

Kelley, Casey & Moyer, PC

St. Clair Shores



Mark G. Cooper, Secretary

Jaffe, Raitt, Heuer & Weiss

Southfield



Elaine M. Pohl, Treasurer

Kupelian, Ormond & Magy

Southfield

Council

Marty Brown

Foremost Insurance Company

Caledonia



M. J. Stephen Fox

Fox & Associates

Ada



Edward M. Freeland

Garan Lucow Miller, PC

Troy



Deborah A. Hebert

Collins Einhorn Farrell & Ulanoff, PC

Southfield



Amy H. Iannone

Barton Malow

Southfield



Daniel P. Steele

Vandevor Garzia

Troy



Kathleen A. Lopilato

Auto-Owners Insurance Company

Lansing



D. Andrew Portinga

Miller Johnson

Grand Rapids



Information Services

Geoffrey M. Brown

Collins, Einhorn, Farrell & Ulanoff, PC

Southfield



State Bar Liaison

Julie I. Fershtman

Zausmer Kaufman August Caldwell & Tayler PC

Farmington Hills

SBM

STATE BAR OF MICHIGAN

MICHAEL FRANCK BUILDING

306 TOWNSEND STREET

LANSING, MI 48933-2012

www.michbar.org

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



The Officers and Council Members

Seated: Hal O. Carroll, chairperson; Mark G. Cooper, secretary; Timothy F. Casey, chairperson-elect; Elaine Murphy Pohl, treasurer. Standing: council members Marty Brown, Edward Freeland, D. Andrew Portinga, Kathleen Lopilato, Daniel Steele, Deborah Hebert, and Amy Iannone.

Not shown: M. J. Stephen Fox.

Join our Section!

The Insurance and Indemnity Law Section is the newest section of the State Bar of Michigan.

Insurance and indemnity law touches many, if not most, areas of practice.

Whether you are an expert and want to share your expertise, or want to learn from the expertise of others, joining the Insurance and Indemnity Law Section is a worthwhile investment.

Use the registration form at http://www.michbar.org/sections/pdfs/app_03v2_exst.pdf and join your colleagues!