As we approach the end of our second year of operation (our annual meeting is in September), we can pause briefly and take stock of where we stand. In the next issue, someone else, elected by the members will be sitting in this virtual “chair” and expressing his or her hopes and plans for the next year.

**Annual Meeting.** But first, let’s look ahead to the next annual meeting and program, which will take place on September 17 at 10 a.m. during the State bar’s annual meeting at the Hyatt Regency in Dearborn. Tim Casey is working on the program and we will also have our business meeting then, to elect new officers and council members. At the outset, we agreed, informally, that the officers would serve for two years, though the terms in the bylaws are set at one year. Your current officers have now served their second years, so it is time for a transfer.

At present the council membership is set at eight, but that can be increased if enough people are interested in serving. The council usually meets about five times a year, and alternates between sites on the east side, Lansing, and the west side. If you are interested in serving on the council, send us an email. We need to know ahead of time in case we need to amend the bylaws.

As the date approaches, we will send an e-mail to all members with more details about the meeting, but if you are interested in a more active role, be sure to let us know.

**Amicus Brief.** The Supreme Court has invited our Section to file an amicus brief on the issue currently before it involving the scope of the state’s regulatory authority, and its application to the current issue of “credit scoring” – using credit ratings as a factor in setting premiums on certain policies. The Section Council has met to discuss the issue, and we are working toward a resolution.

**Work with other sections.** Two of our council members, Amy Iannone and Deborah Hebert, have been working with the Real Property Law Section on the development of a joint program.

**Membership.** Our membership continues to grow steadily. We are at 358 at the last tally. Be sure to tell others about us, and let’s see if we can break through the 400 mark. Our treasury is doing well too, with over $9000. The largest expense is this Journal.

**A personal note.** This will be my last “From the Chair” report, since my term will end at the September meeting. Looking back, I feel a certain sense of pride (and relief) that we have made our new section a success. We have made a good start and built the basis for continued success. I thank all of my colleagues on the Section Council, the State Bar’s outstanding support staff, and the members who contributed to our success.

Hal O. Carroll
Introduction

A relaxed trial judge once told me, “In recent years, the only cases that go to trial in my courtroom arise from property damage rather than personal injury, because litigators are more emotional about their houses than their own bodies.” A contractor joined in litigation learns that the hard and expensive way. This article will describe how to temper the harsh reality of insurance coverage related construction litigation in which contractors have very little control.

The contractor’s first notice of a claim or suit sets this potential nightmare in motion, and a contractor’s first response to notice should be to call the lawyer. Even if a contractor is insured, a call to a lawyer who is experienced in construction litigation and insurance coverage should be the first call. Doing so almost certainly saves money, even if the contractor is well insured and so experienced in litigation that he is on a first name basis with his insurance agent and adjustor.

The advantage of an aggressive response, which starts with the call to an experienced construction litigator, applies regardless of the contractor’s perception of the strength of the defense. Even if the contractor is also a lawyer who believes he has seen it all before, that contractor’s legal expertise probably does not include insurance coverage, indemnification, the strategic assertion of defenses arising from the statute of repose, Funk v General Motors, MCR 2.116(C) 7 and 8, lack of standing as a third party beneficiary, or absence of privity of contract, or the experience, resources, and manpower necessary to immediately finance and coordinate the use of that expertise in attacking the procedural and substantive flaws in the pending cause of action. By way of example, and due to limitation of length, this article will limit its scope to a description of the early use of the statute of repose defense in a manner which does not jeopardize insurance coverage.

Statute of Repose

In 1985, a densely worded statute of repose was enacted for the protection of contractors, architects, and engineers. Three years later the Court of Appeals defined that statute’s purpose as the protection of these professionals and businesses from “stale claims and to eliminate open ended liability for ‘defects in workmanship’.” Abbott v John E Green Co.

If the statute of repose was enacted and initially interpreted with this clear intention, its application has been inconsistent at best and at worst a speed bump on the road to extorting money from the very contractors it was enacted to protect. The problem starts with the fact that it is difficult to make sense of the statute of repose, and from there it gets worse.

The statute of repose is difficult to understand because it is almost comically poorly written, and because even the crustiest defense-oriented conservative recognizes its harsh effect from the perspective of a homeowner dissatisfied with her house after completion of its construction. The difficulty in understanding and enforcing the statute of repose starts with the nearly impenetrably dense language of the statute, which in most relevant part includes:

No person may maintain any action to recover damages for any injuries to property, real or personal, or for bodily injury or wrongful death, arising out of the defective and unsafe condition of an improvement to real property, nor any action for contribution or indemnity for damages sustained as a result of such injury, against any state licensed architect or professional engineer performing or furnishing the design or supervision of construction of the improvement, or against any contractor making the improvement, more than six years after the time of occupancy of the completed improvement, use, or acceptance of the improvement, or one year after the defect is discovered or should have been discovered, provided that the defect constitutes the proximate cause of the injury or damage for which the action is brought and is a result of gross negligence on the part of the contractor or licensed architect or professional engineer. However, no such action shall be maintained more than ten years after the time of occupancy of the completed improvement, use, or acceptance of the improvement. Distilled to its essence, if that is possible, this statute prohibits suit against the contractor more than six years after the time of occupancy, or one year after the defect is discovered, or ten years after occupancy regardless of gross negligence allegations or when the defect is discovered. This statute is the
result of a compromise between the interests of the certainty of finality offered by a normally shorter statute of limitations versus the right to an extended opportunity for redress arising from any hidden defect in design or construction.

The Contractor’s Risk

The primary practical obstacle to a contractor’s enforcement of this statute arises from the “catch 22” in which a contractor is either punished for trying to treat a customer fairly, or risks the business and its reputation by turning down repair work due to fear of incurring uninsured liability arising from original construction. The fact pattern is simple and typical; after construction is completed and the occupancy permit is issued, the homeowner moves in, and eventually a repair need arises years later. As a satisfied customer, the homeowner calls the contractor, who is still on speed dial, and the contractor readily agrees to make the repairs on a time and materials basis without the need for a written contract or consideration of warranty issues. While performing the repair work, the busy contractor is focused on a solution rather than whether the cause of the problem relates to lack of homeowner maintenance, defective materials, or defective original design or construction.

Ninety-nine times out of one hundred, the contractor’s post occupancy repair satisfies the homeowner, and she remains a satisfied customer and potential referral source for the contractor. However, on that rare occasion when the contractor’s post occupancy repair effort fails to satisfy the homeowner, perhaps because for unrelated reasons she cannot be satisfied, and instead she hires counsel to write threatening letters to the contractor, does the contractor have the protection of the statute of repose?

Unfortunately, the current state of Michigan law answers, “that depends.” That frustrating answer is a problem, because this uncertainty can drive a contractor out of business, even if the contractor is well insured.

The cost of defense in litigation is powerful leverage in a construction dispute before and after suit is filed. That leverage increases to the point of extortion if the extent of uncertainty (does the Statute of Repose apply?) prevents the parties from knowing if the court will recognize or create a “post completion of construction repair” exception to the statute of repose. If the statute of repose is read to recognize or create an exception for post-completion repair, the effect is to punish the contractor, who is only guilty of trying to satisfy a challenging customer, by creating a liability for a risk which is probably not insured.

More specifically, if an exception is recognized or created, for even a single count in the homeowner’s complaint, the statutory purpose of elimination of “open ended liability for defects in workmanship” has been eviscerated and the contractor is without the protection of either the statute of repose or insurance coverage.

The homeowner’s exploitation of this uncertainty of the application of the statute of repose occurs in the form of a complaint filed against the contractor which capitalizes on the post construction repairs by the contractor, and his communications with the homeowner, by alleging breach of repair contract, promissory estoppel, equitable estoppel, negligent and intentional misrepresentation, violation of the Consumer Protection Act, and fraud. From the perspective of a contractor, these allegations and this purported exception spell dirty pool, and set up a miscarriage of justice, while from the perspective of a homeowner, this is the best means of extorting a pound of flesh from a contractor she no longer trusts, because he built a house which fails to satisfy her.

These mostly uninsured allegations, with or without substance, applied to the post construction repair exception, form the second horn of the contractor’s catch 22 dilemma by risking a loss of the contractor’s insurance coverage protecting against a risk which should have been extinguished by the statute of repose.

If the statute of repose is read to recognize or create an exception for post-completion repair, the effect is to punish the contractor, who is only guilty of trying to satisfy a challenging customer, by creating a liability for a risk which is probably not insured.

Assuming that under a standard commercial general liability (CGL) policy, no liability insurer will offer a defense on a construction litigation case without issuing a reservation of rights letter, any decision on a statute of repose summary disposition motion strategy must be carefully scrutinized for its impact on the insurer’s duties to defend and indemnify. If the dispositive motions result in a compromise decision which leaves counts which do not trigger coverage, such as fraud and intentional misrepresentation, the contractor’s partial victory on its statute of repose summary disposition motion may be worse than a defeat. This is because if the insurer responds by withdrawing the contractor’s defense, the only thing standing between possible bankruptcy and a default judgment against the contractor is the contractor’s ability to finance the defense.

The cost of that defense, which will easily exceed low six figures, then becomes the low end of the range of the settlement value of the pending litigation. That expense is a steep price to pay for a small time and material repair job intended to keep a satisfied customer satisfied.

Solutions

This contractor’s dilemma is easier to prevent than defend or solve. Of course, in litigation the contractor is engaged in a fight over money, and thus money is the solution to the
The Additional Insured Endorsement

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

Introduction
A typical construction contract almost always contains a clause providing for the indemnification of the general contractor by the subcontractor for all claims, damages or losses arising out of the performance of the subcontractor’s work. The construction contract also typically requires the subcontractor to purchase a liability insurance policy protecting the general contractor from all claims which may arise out of or result from the subcontractor’s operations.

Named Additional Insured
The subcontractor, to fulfill the obligations of the contract, may secure an “Additional Insured Endorsement” to its existing Commercial General Liability policy specifically identifying the general contractor as an insured under the policy. A certificate of insurance is also usually provided to the general contractor reciting that it is an additional insured. However, all additional insured endorsements are not created equal. It is the actual wording or lack of wording in the construction contract that requires the subcontractor to list another organization, entity or general contractor together with language in the additional insured endorsement that is the first step in determining who is actually covered in a dispute.

Consider the following language in the Insurance Services Office (ISO) clause:

WHO IS AN INSURED (Section II) is amended to include as an insured the person or organization shown in the Schedule, but only with respect to liability arising out of your ongoing operations performed for that insured.

The intent of the above endorsement is to provide insurance coverage for the “additional insured” (the general contractor) only in those situations where the additional insured may have liability arising out of the named insured’s negligence at the construction site. A clause written in this form is not intended to indemnify the additional insured for claims arising out of the additional insured’s own negligence.

Blanket Additional Insured
Another form of an Additional Insured Endorsement is called Automatic Additional Insureds-Construction Contracts:

Any person(s) or organization(s) (hereinafter called “Additional Insured”) with whom you agreed in

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.

a written construction contract to name as an insured is an insured with respect to liability arising out of ongoing operations performed by you or on your behalf on the project specified in the construction contract, including acts or omissions of the Additional Insured in connection with the general supervision of such operations.

This type of Additional Insured Endorsement specifically extends coverage to the additional insured for those lawsuits alleging negligence by the additional insured in connection with the general supervision of the construction site.

Most courts have interpreted the foregoing additional insured endorsement and similar versions quite broadly in construing phrases “arise out of operations” or “arising out of your ongoing operations”. Coverage was generally found to apply to the additional insured even if the additional insured’s negligence was the sole cause of the injury – it was not necessary for the named insured to have caused the accident. The named insured’s work or operations need not be the proximate cause of the loss to satisfy the coverage condition. Fault is immaterial to the coverage determination. “But for” causation is enough to provide coverage to the additional insured.

Broadly or vaguely worded additional insured endorsements have surprised many insurers, who have learned that coverage extended by additional insured endorsements was not as limited as they thought. The language of the endorsement together with other policy provisions defines the extent to which the policy provides coverage for an additional insured. If coverage is intended to be limited to risks “within the control of” the named insured or to occurrences in which the named insured was “primarily” or “actively” negligent, or to claims that the additional insured is only vicariously liable, that limitation should be clearly and unambiguously expressed in the endorsement.

2004 ISO Revision
In 2004 the ISO form was changed to eliminate coverage for the additional insured’s sole negligence, but provides
coverage for the additional insured’s contributory negligence.

**Section II-WHO IS AN INSURED** is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule, but only with respect to liability for “bodily injury”, “property damage” or “personal and advertising injury” caused, in whole or in part, by:

1. Your acts or omissions; or
2. The acts or omissions of those acting on your behalf, in the performance of your ongoing operations for the additional insured
3. At the location(s) designated above.  

This version provides coverage to the additional insured that is broader than just vicarious liability arising out of acts of the named insured. It provides coverage for the additional insured but only with respect to liability for bodily injury, property damage, personal injury or advertising injury caused in whole or in part by the named insured’s acts or omissions or those acting on behalf of the additional insured. The revision eliminates the phrase “arising out of” and replaces it with a fault based standard. The language of the 2004 revision requires fault - a casual connection between the named insured’s acts or omissions and the additional insured’s liability.

In sum, if the additional insured is concurrently or jointly negligent along with the named insured (or others acting on behalf of the named insured), the 2004 revised additional insured endorsement will provide coverage to the additional insured to the extent of the additional insured’s liability. The additional insured does have coverage for its own negligence, provided it is in conjunction with the named insured’s negligence. For example, a subcontractor’s employee is injured on a construction site and sues the general contractor for failure to provide a safe workplace. Courts construing the old form held that “but for” the injured plaintiff’s employment with the named insured, the accident would not have happened. The employment relationship itself satisfies the coverage condition. But not under the 2004 ISO form. Now, the general contractor will have to establish that there is at least a possibility that its liability to the subcontractor’s employee arises out of his employer’s (the named insured’s) acts or omissions in order for the additional insured (general contractor) to be covered.

**Conclusion**

Additional insured endorsements differ from each other and reflect a great discrepancy in the breadth of coverage provided to additional insureds. The issues that underlie coverage are numerous and complex. Many ISO additional insured endorsement forms contain a bevy of limitations and exclusions intended to restrict coverage afforded additional insureds.

Broadly or vaguely worded additional insured endorsements have surprised many insurers, who have learned that coverage extended by additional insured endorsements was not as limited as they thought.

No matter what version of the additional insured endorsement you are dealing with, it is absolutely necessary for counsel to read the construction contract, insurance contract, certificate of insurance and the case law of the jurisdiction that will be applied by the court in deciding the coverage dispute.

Do not rely on certificates of insurance naming the client as an additional insured, because they do not create coverage.

Ask for copies of the subcontractors insurance policies. Insurance policies are contracts and unless you read them carefully you will not focus on the important issues of your case.

Moreover, there is as yet scant case law on the 2004 ISO Additional Insured Endorsement.

How to determine if and when the general contractor - additional insured is entitled to a defense by the subcontractor-named insured’s insurance carrier is a topic for another day. Stay tuned.

James A. Johnson, a trial attorney assists lawyers as co-counsel in insurance coverage dispute litigation. Mr. Johnson is a member of the Michigan, Massachusetts, Texas and U.S. Supreme Court Bars. He can be reached at johnsonjajmf@hotmail.com or (248) 351-4808

**Endnotes**

1  ISO Coverage Form CG 20 10 10 93.
2  ISO Coverage Form CG 799 (7-87) emphasis added.
3  ISO Coverage Form CG 20 10 emphasis added.

**Don’t forget to check the website**

Important section information, including this newsletter, can be found at http://www.michbar.org/insurance/
Anti-Concurrent Causation Clauses

By Daniel P. Hale, J.D., CPCU, ARM, CIC, AAI, LIC, AIS, API, Cambridge Property & Casualty, dhale@cambridge-pc.com

Under Michigan law a loss is not covered when it is concurrently caused by the combination of a covered cause and an excluded cause. Regardless of the number or sequence of covered perils that might contribute to a loss, insurance companies can deny all coverage as long as one of those perils was excluded. This principle was most recently illustrated by the Sixth Circuit in Iroquois on the Beach, Inc v General Star Indemnity Company.1

The Iroquois Hotel is a forty-six-bed hotel and dining room located on historic Mackinac Island. In the summer of 2005, the Iroquois hired a contractor to make certain repairs to the windows and exterior surfaces. During the repairs, the building was inspected by both an architect and a structural engineer. On November 11, 2005, the structural engineer issued a report which identified decay in several areas of the building and expressed a concern about the potential for collapse.

An anti-concurrent causation clause operates to exclude coverage regardless of any other cause or event that contributes concurrently or in any sequence to the loss.

The architect explained that water was entering the building envelope because of an insufficient steel frame that failed to protect the building in windy conditions. He suggested that the damage occurred gradually over the course of several years. The repairs associated with the structural damage totaled between $1.5 and $1.6 million.

The Iroquois sought coverage under the terms of its property insurance policy through General Star Insurance Company (“General Star”). General Star promptly denied the claim on the basis of five different exclusions but relying in large part on the exclusion for damage arising out of “… continuous or repeated seepage or leakage of water, or the presence or condensation of humidity, moisture or vapor, that occurs over a period of 14 days or more.”

Subsequently, the Iroquois filed a lawsuit against General Star alleging that coverage was wrongfully denied. The hotel argued that the continuous seepage exclusion did not contain an “anti-concurrent or anti-sequential” causation clause where as other exclusions did.

An anti-concurrent causation clause operates to exclude coverage regardless of any other cause or event that contributes concurrently or in any sequence to the loss. Most recently, we have seen anti-concurrent causation provisions applied in the aftermath of Hurricane Katrina. In those cases, most of the property damage resulted from flooding rather than wind. Subsequently, many property owners turned to their homeowners insurance for relief, only to find that coverage did not apply on the basis of the flood exclusion. The policyholders, on the other hand, argued that coverage should apply since wind was a covered peril which occurred prior to the flooding. Since most policies included an anti-concurrent causation provision, most claims were denied.

In Iroquois, the policyholders argued that the omission of an anti-concurrent causation clause within the continuous seepage exclusion indicated that the insurer intended to provide coverage where the loss was caused by wind if it was the first or last step leading to the seepage or leakage of water.2 The federal district court disagreed and granted General Star’s motion for summary judgment - relying on the continuous seepage exclusion. The Iroquois appealed.

In its opinion, the federal court of appeals pointed out that many jurisdictions have adopted the doctrine of “efficient proximate cause," or what Michigan courts call the theory of “dual or concurrent causation.”3 Under this doctrine, “[i] f the cause which is determined to have set the chain of events in motion, the efficient proximate cause, is covered under the terms of the policy, the loss will likewise be covered.”4 Jurisdictions that have adopted this doctrine generally allow parties to contract out of its application by adopting an anti-concurrent, anti-sequential clause.5 Said another way, in jurisdictions where the efficient proximate cause doctrine has been adopted, courts will ignore policy exclusions as long as the loss was primarily caused by a covered cause of loss. On the other hand, if the policy included an anti-concurrent causation provision, courts will enforce all exclusions as written, regardless of the primary covered cause of loss.

... in Michigan the policy need not contain an anti-concurrent causation provision in order to avoid the doctrine of efficient proximate cause.
The Iroquois argued that the court should apply the efficient-proximate cause doctrine because there were two causes, one of which was excluded (seepage of water) and one of which was covered (windstorms), and the covered cause (windstorms) set in motion the chain of events leading to the loss.

The Supreme Court of Michigan has expressly declined to adopt this doctrine, explaining that it found no reason “to introduce a legal theory or doctrine that departs from the literal interpretation of an unambiguous insurance contract.”

Michigan courts must give effect to every word, phrase, and clause in a contract and avoid an interpretation that would render any part of the contract surplusage or nugatory. Moreover, “the language of the parties’ contract is the best way to determine what the parties intended.”

The court also pointed out that in Michigan the policy need not contain an anti-concurrent causation provision in order to avoid the doctrine of efficient proximate cause. If Michigan followed the doctrine of efficient proximate cause, then the adoption of an anti-concurrent causation clause would allow the parties to contract out of the application of that doctrine. Id. But since Michigan does not follow the doctrine, the addition of such a clause would be surplusage. Consequently, the absence of an anti-concurrent causation clause does nothing to alter Michigan's default rule that a loss is not covered when it is caused by a combination of a covered risk and an excluded risk.

In conclusion, since Michigan has not adopted the doctrine of efficient proximate cause, a loss is not covered when it is concurrently caused by the combination of a covered cause and an excluded cause, regardless of whether an anti-concurrent causation clause exists within the policy. ■

Daniel P. Hale is vice president of Cambridge Property & Casualty (website: www.cambridge-pc.com), a commercial insurance agency located in Livonia. Mr. Hale specializes in insurance coverage and risk management consulting.

Endnotes
1  550 F3d 585 (Mich 2008)
3  Iroquois at 588.
5  Id.
8  Id at 476.
9  Id at 476.
10  Id.
...the statute of repose must be used as a club to keep the contractor in business, rather than a confusing technicality that allows a fraudulent contractor to skate away from obligations.

Legal Response to Pending Litigation

Because of the frustrating uncertainty of the “that depends” state of Michigan's court's interpretation of the statute of repose and the “post completion of construction repair” exception, the trial court judge must be immediately engaged in motion practice and in chambers discussions which forcefully advocate for the survival of the contractor's business. Most bluntly stated, the statute of repose must be used as a club to keep the contractor in business, rather than a confusing technicality that allows a fraudulent contractor to skate away from obligations.

The statute of repose must be broadly construed to effectuate its statutory purpose of “eliminat[ing] open ended liability,” because if it is not, the contractor will lose insurance coverage and bleed to death in the discovery morass which costs the contractor more than the settlement value of the litigation, or even the value of the house itself.

If the summary disposition motion is unsuccessful, or only partially successful, the contractor should proceed with a motion for reconsideration, an application for interlocutory appeal, and motions to stay proceedings and for protective order. These procedural protections block or delay expensive discovery and allow pursuit of either court ordered facilitative mediation or arbitration.

If these steps are taken early and effectively, the contractor will have the maximum possible protection available under its insurance coverage.

That insurance coverage, while strictly not the concern of defense counsel hired by a carrier, is explicitly precarious under the terms of the reservation of rights letter. Therefore, the more aggressively and effectively the contractor educates the court in early motion practice, the more likely it is the contractor solves its litigation problem with the insurer's money, and without the expense and complication of also filing a declaratory judgment suit against the carrier.

Dealing with the Post-Construction Repair Problem

There are three means by which a contractor can avoid losing the protection intended under the statute of repose in the context of the threat of post completion of construction repair litigation.

The first is to decline all requests for repair work from satisfied customers. That is impractical, and not a serious option.

The second is to lobby for an amendment to the statute of repose which explicitly excludes this exception. That is needed, but of no help today.

The third is the distasteful but prudent proactive precaution of drafting and requiring use of a repair contract which expressly limits potential damages and which requires waiver of the customer's potential rights under a post completion of construction repair exception to the statute of repose. While any repair contract of this description is bound to raise questions and increase attorney involvement, it reduces the risk of uncertainty and will serve as added protection to the contractor.

Conclusion

The strict ethical line between a lawyer's duty to serve the interests of his or her client over the interests of the client's bill-paying insurer has not been erased. However, in construction litigation, the bigger picture demands that a contractor's competent legal representation includes a highly informed sensitivity to the complications posed by the assertion of a defense which threatens coverage.

Paul Van Oostenburg became a shareholder at Smith Haughey Rice & Roegge in 1986, after working for the City of Detroit Law Department, the free legal aid clinic, and Michigan Supreme Court Justice Blair Moody. He is an AV peer rated and Who’s Who in America trial lawyer whose practice focuses on civil litigation and professional licensing.

Endnotes
1 Funk v General Motors, 392 Mich 91; 220 NW2d 641 (1974)
2 MCL 600.5839
4 MCL 600.5939(1)
There are significant differences between occurrence-based policies and claims-made liability policies. Each has its own advantages and disadvantages for different types of risks, and each presents different coverage issues.

Essentially, an occurrence-based policy potentially applies when there is an “occurrence” during the policy period, regardless of when the claim itself is made. A sample policy provision might read: “This insurance applies to bodily injury and property damage only if the bodily injury or property damage occurs during the policy period.” A claims-made policy potentially applies when the claim is made during the policy period, regardless of when the occurrence took place. A sample provision might read: “This policy applies only to claims first made against the insured during the policy period and reported to the insurer in writing during the policy period or any applicable extended reporting period.”

For example, if the event at issue took place in 2007, then an occurrence-based policy in effect in 2007 potentially would apply, even though a subsequent lawsuit was not filed until 2009. If there had been a claims-made policy in effect in 2007, it would not apply to that event. A claims-made policy in effect in 2009, however, would potentially apply to the claim made in 2009, even though the actual event took place in 2007.

Occurrence-based policies include the advantage that the policyholder is protected (assuming the policy otherwise applies) regardless of whether or not a claim or lawsuit is filed during that year or during a subsequent year. As long as a policyholder maintains occurrence-based policies in force, there should be no gaps in coverage. With certain types of losses taking place over several years, it is possible that multiple occurrence policies could be applicable when a lawsuit eventually is filed against the insured.

Claims-made policies are more restrictive in the sense that they potentially apply only to a claim actually made during the policy period; however, they may be more appropriate for certain types of risks when the loss date might not be easily defined. Also, claims-made policies typically would be less expensive, and such policies might make it easier to insure for appropriate limits on a more timely basis, and they lessen the concern that an older occurrence-based policy and/or the carrier which issued it might no longer be around when a suit is filed.

Michigan’s Supreme Court addressed these distinctions in Stein v Continental Casualty Co., and noted some of the reasoning behind the differences in these types of policies. Occurrence policies typically are used in auto, homeowners and many general liability situations and relate to a definite, easily identifiable event, and insurers’ actuarial considerations and premiums are based on their assessment of such events taking place. Claims-made policies typically address situations in which the time of the event/negligent act is difficult to pinpoint and may have occurred over an extensive period of time, and generally are used in professional liability and errors and omissions policies. Insurers compute the premiums with the understanding that any liability under the policy would be limited to claims actually made during that policy term and the carrier would not have to be concerned about claims made in the future for an occurrence during that policy term.

Analysis of coverage issues under either an occurrence or claims-made policy still focuses on the specific policy language used, since there can be several variations. For example, some claims-made policies may apply only if there actually was an occurrence and a claim made during the policy period. Claims-made policies also may have a retroactive date which establishes a limiting date prior to the policy of when the occurrence must have taken place. A claims-made policy typically offers an extended reporting period or “tail” which allows reporting of a claim for a short period of time after the original policy expiration date. Given these differences, a policyholder changing from one type of policy to the other needs to take particular care to obtain the necessary endorsements to try and avoid any gaps in coverage.

One of the more common coverage issues which sometimes causes confusion when analyzing these two types of policies relates to “notice.” An occurrence-based policy typically contains a condition precedent requiring a policyholder to provide timely and sufficient notice of an occurrence, claim and suit, and Michigan courts have held that an insurer must prove prejudice to disclaim coverage based on the insured’s non-compliance with that provision. Koski v Allstate Insurance Co.

Under a claims-made policy, however, the peril insured is the actual claim itself. When a claims-made policy requires as part of its insuring agreement that the policy applies only to a claim made and reported during the policy period, the reporting of the claim is an element of the insuring agreement, not simply a condition precedent, so that if the claim is not properly reported during the policy period, there is no coverage and the insurer need not demonstrate prejudice to disclaim coverage. Stein, supra; Schubiner v New England Insurance Co. Note as well that a claims-made policy still may contain a notice condition precedent requiring timely and sufficient notice of a claim which is made during the policy period, even assuming the insuring agreement requirements are satisfied.
Supreme Court Activities

The impact of Justice Hathaway’s election victory over former Chief Justice Clifford Taylor, in the November 2008 election, is beginning to be felt in the area of No-Fault. One of the decisions handed down by the former majority in December 2008 regarding the standard of causation in no-fault cases has been vacated. Reconsideration has been granted on another case regarding the Michigan Catastrophic Claims Association’s ability to review a no-fault insurer’s payments for “reasonableness.” In the third case, the court was unable to muster a majority in favor of reconsideration, as one of the justices had to recuse himself due to a familial relationship with counsel for one of the parties. The Supreme Court’s actions on these three cases may very well indicate a willingness, on the part of the new majority, to re-examine the decisions issued by the previous major from 1999 through 2008.

Reasonableness of Payments – Review by Catastrophic Claims Fund

*USF&G v MCCA*, 482 Mich 414, 759 NW2d 154 (2008)

This case was discussed at some length in our prior issue. In *USF&G v MCCA* and the companion case, *Hartford v MCCA*, the Michigan Catastrophic Claims Association refused to reimburse the no-fault insurers for attendant care payments above $22.05 per hour and $20.00, respectively, where the no-fault insurers were paying attendant care rates of $54.84 per hour (in the case of *USF&G*) and $30.00 per hour (in the case of *Hartford*). The MCCA argued, and the former majority agreed, that it was authorized by statute to audit a no-fault insurer’s payments for “reasonableness” because, in the words of Justice Young, “unreasonable” charges that may have been paid by a no-fault insurer are not “sustained under personal protection insurance coverages” set forth in the No-Fault Insurance Act. Justice Weaver, joined by Justices Cavanagh and Kelly, authored a dissent, arguing that the MCCA lacked the statutory authority to review a no-fault insurer’s payments for “reasonableness.”

On March 27, 2009, Justice Hathaway, joined by the dissenting Justices Weaver, Kelly and Cavanagh, granted the insurers’ Motion for Rehearing. Justice Markman, who had issued a separate opinion concurring in the former majority’s decision, also joined in the order granting the insurers’ motion for rehearing. Almost immediately, the MCCA filed a motion to recuse newly elected Justice Diane Hathaway. Numerous briefs in support of and in opposition to the MCCA’s motion for recusal of Justice Hathaway have been filed and, as of June 15, 2009, no decision has been made on the motion to recuse Justice Hathaway. The author is hopeful that a decision on rehearing will be handed down before the court’s current term expires at the end of July.

Penalty Attorney Fees


This case was also discussed in our last issue. On former Chief Justice Taylor’s last day on the bench, the Michigan Supreme Court released its decision in *Moore v Secura Insurance Company*, reversing a published opinion of the Michigan Court of Appeals, which had awarded no-fault penalty attorney fees to the plaintiff because the insurer had failed to reconcile the conflicting medical opinions of the plaintiff’s treating physician with the opinions expressed by defendant’s IME physician. The majority opinion simply noted that there was nothing in the No-Fault Insurance Act which required a no-fault insurer to “go beyond” the medical opinion of the IME physician. In a passage that could have ramifications throughout this area of practice, the Supreme Court also noted:

MCL 500.3148(1) further provides that an attorney may only receive fees for representing a claimant in an action for “benefits which are overdue.” In MCL 500.3142(2), the legislature explains that overdue benefits refer to those benefits “not paid within thirty days after an insurer receives reasonable proof of the fact and of the amount of loss sustained.” Neither MCL 500.3142(2) nor MCL 500.3148(1) permits the recovery of attorney fees for actions in which a Court awarded Plaintiff benefits that were reasonably in dispute, or, stated slightly differently, benefits not yet overdue.

*[Moore, 482 Mich 507, 519]*

Is the court implying that no-fault penalty interest under MCL 500.3142(2) may not be awarded in cases where benefits were “reasonably in dispute” because the “benefits [are] not yet overdue”? Just a thought . . .

On April 3, 2009, the Supreme Court issued an Order Denying Plaintiff’s Motion for Rehearing. Interestingly, Chief Justice Kelly, along with Justice Weaver and newly elected Justice Hathaway, would have granted the Motion for Rehearing. Justice Cavanagh did not participate in the motion, due to his familial relationship with counsel of record. The remaining three Justices of the former majority obviously voted to deny the Motion for Rehearing.
Standard of Causation

*Scott v State Farm*, ___ Mich ___, ___ NWd ___ (2009)

On December 3, 2008, the Supreme Court, in a 4-3 decision, partially vacated the Court of Appeals’ opinion, which held that, with regard to the causation standards under MCL 500.3105(1), “almost any causal connection or relationship will do.” 482 Mich 1074, 758 NW2d 2149 (2008). Rather, the former majority ruled that the causal relationship between the injury or condition, and the motor vehicle accident, must simply be more than incidental, fortuitous or “but for.”

However, on June 5, 2009, the Supreme Court granted the plaintiff’s motion for reconsideration and vacated its earlier order dated December 3, 2008. The court then denied the defendant’s application for leave to appeal, thereby leaving intact the Court of Appeals’ decision found at 178 Mich App 578, 751 NW2d 51 (2008).

In her concurring opinion, Chief Justice Kelly enunciated what is arguably a lesser standard of causation:

Precedent makes clear that an injury requires more than a fortuitous, incidental or “but for” causal connection, but does not require proximate causation. As *Bradley v DAIIE*, 130 Mich App 34, 343 NW 2d 506 (1983) states, “almost any causal connection will do.” Nothing suggests that these two standards are in opposition or cannot be applied together. They logically build on one another and stand for the same basic proposition. Taken together, they mean that evidence establishing almost any causal connection will suffice when it more than merely fortuitous, incidental or but for. But it need not be much more; almost any causal connection or relationship will do.

Justice Corrigan, joined by Justices Markman and Young, dissented from the Court’s decision to grant the motion for reconsideration, and would have allowed the Court’s prior order to stand.

Court of Appeals Activity

“Use” of a Vehicle – Contiguous 30 Days Penalty Attorney Fees

*Detroit Medical Center v Titan Insurance Company*, ___ Mich App ___, ___ NW 2d ___ (2009)

This case addressed the issue of whether the plaintiff’s patient, Maria Jimenez, who was operating an uninsured motor vehicle owned by her boyfriend, was disqualified from recovering no-fault benefits under MCL 500.3113(b), as she “had the use” of her boyfriend’s vehicle for a period of time greater than thirty days. The lower court determined that Ms. Jimenez was not an “owner” of her boyfriend’s motor vehicle, thereby allowing her medical provider to recover payment of its medical expenses. However, the lower court also denied plaintiff’s request for no-fault penalty attorney fees, finding that there existed a legitimate issue of statutory interpretation.

On appeal, the Michigan Court of Appeals affirmed the lower court’s decision in all respects. Although initially released as an unpublished opinion, the Court of Appeals approved the opinion for publication on June 16, 2009. The court held that in order for a person’s use of a motor vehicle to rise to the level of “ownership,” there must be a “transfer of a right to use” as opposed to “an agreement to periodically lend.” The court also implied that the permission must be for “a contiguous thirty days,” as opposed to being sporadic permission. The court also noted that the person must have “regular” use of the uninsured motor vehicle. The facts in this case were simply insufficient to establish “ownership,” under these standards.

However, the Court of Appeals also affirmed the lower court’s refusal to award no-fault penalty attorney fees under MCL 500.3148(1). Citing the Supreme Court’s decision in *Moore*, the Court of Appeals noted:

In denying attorney fees in this case, the trial court concluded that the initial denial of fees was not unreasonable giving some indicia of ownership, and that the question of statutory construction was legitimate. We find no clear error in this determination. Although we have concluded that Jimenez’ need for permission to use the vehicle and her sporadic use thereof contraindicated ownership, the facts in *Ardt v Titan Insurance Company*, 233 Mich App 685, 593 NW 2d 215 (1999) and *Chop v Zielinski*, 244 Mich App 677, 624 NW 2d 539 (2001) gave rise to a justifiable contrary argument. Thus, the benefits were “reasonably in dispute” and therefore not overdue. Accordingly, the trial court properly declined to award attorney fees to plaintiff.

Again, the court found that attorney fees were not appropriate because the benefits were “reasonably in dispute” and therefore not “overdue.” Because the benefits are not “overdue,” can any no-fault penalty interest be awarded? Just a thought . . .

An application for leave to appeal has been filed with the Supreme Court.

One-Year Back Rule-Fraud Claim–Reliance


In this case, plaintiff sought to recover no-fault insurance benefits going back to 1983, when ten-month-old Nancy
Eastman was severely injured in a motor vehicle accident. The no-fault insurer paid attendant care services at the rate of $20.00 per day through April 1990, at which point the insurer increased the payments to $21.00 per day. Suit was not filed until July 2006 and the complaint alleged that defendant insurer had made material misrepresentations concerning the benefits available for Eastman’s care, because it had informed the providers that they were not entitled to recover any benefits beyond the $20.00, or $21.00, per day payments. The lower court applied the One-Year-Back Rule set forth in MCL 500.3145(1) and barred any recovery for benefits incurred prior to July 20, 2005.

Applying the “cautionary notes” from the Michigan Supreme Court’s opinion in Cooper v ACIA, 481 Mich 399, 751 NW 2d 443 (2008), the Michigan Court of Appeals affirmed the decision of the lower court and determined that the plaintiff could not satisfy the reliance element necessary to pursue any fraud claim. The court noted that because plaintiff had other means, including consulting with a lawyer, to verify whether the insurer’s statements were true, her fraud claim failed. The court noted that there was nothing in the record that would indicate that the insurer, in any way, attempted to dissuade her from consulting with an attorney to determine the truthfulness of the insurer’s representations. Because plaintiff had the means to verify the accuracy of the statements, but failed to do so, the fraud claim was barred. Although initially released as an unpublished opinion on March 24, 2009, the opinion was approved for publication on May 12, 2009.

An application for leave to appeal is currently pending before the Michigan Supreme Court.

Contractual Indemnity Law Unchanged by Supreme Court

Zahn v Kroger Company

By Noreen L. Slank
Collins, Einhorn, Farrell & Ulanaoff, noreen.slank@ceflawyers.com

The Zahn v Kroger Company, 483 Mich 34 (2009) opinion was long-awaited partly because Michigan’s Supreme Court doesn’t often write in contractual indemnity cases. The leave grant order directed the parties to brief five meaty questions:

1. Whether a contractual indemnification clause limiting the indemnitor’s liability to the indemnitor’s own negligence, but including delegation of the indemnitee’s duties, can support an award of indemnification arising out of the settlement of a negligence claim made against the contractual indemnitee;

2. Whether MCL 600.2956 and the abolition of joint and several liability has had any effect on the potential contractual indemnification liability of employers for injuries sustained by their employees;

3. Whether a settlement of a suit brought by an injured employee against alleged tortfeasors may legally be viewed as encompassing the damages attributable to the negligence of the employee’s employer, where the employer has no tort liability exposure to the injured employee by virtue of the Worker’s Disability Compensation Act exclusive remedy, MCL 418.131(1), but has contractually assumed a duty of care owed by an indemnitee;

4. Whether, despite the WDCA’s exclusive remedy provision, the third-party defendant employer in this case voluntarily subjected itself to liability for the payment to its employee of damages attributable to its own negligence by entering into the indemnification agreement; and

5. Whether the holding in Gerling Konzern Allegemeine Versicherungs AG v Regents of the Univ of Michigan, 472 Mich 44; 693 NW2d 149 (2005), has any effect on the appropriate resolution of this case.

The Supreme Court answered (1) yes, (2) no, (3) no, (4) yes, and (5) apparently no (because there was no mention of Gerling Konzern Allegemeine Versicherungs AG).

Indemnity law is substantively unchanged. If a company’s employee sues someone the employer agreed to indemnify, the employer can still be liable under the contract. The exclusive remedy of the WCDA still can’t protect an employer who agrees to indemnify someone its employee sues. Contracts that shift liability only to the extent of the indemnifying party’s own negligence can still accomplish that. The abolition of joint tort liability isn’t going to re-landscape contractual indemnity law.

Zahn is authored by Justice Hathaway. All seven Justices agree on the “ayes” and “nays.” But unanimity of result bred no content in the Hall of Justice. The three concurring justices, Young, Markman and Corrigan, in two opinions, found reason to be sharply critical of parts of the majority opinion.
Insurance Decisions of Interest

By Deborah A. Hebert, Collins, Einhorn, Farrell & Ulanaoff, deborah.hebert@ceflawyers.com and Adam Kutinsky, Kitch, Drutchas, Wagner, Valitutti & Sherbrook, adam.kutinsky@kitch.com

Michigan Supreme Court

Credit Scoring

Insurance Institute of Michigan et. al v Commissioner, OFIS
___ Mich ___ (2009)

On May 7, 2009, the Michigan Supreme Court granted leave to consider a number of important procedural and due process issues pertaining to rules promulgated by the Office of Financial Services for personal line policies in Michigan. These rules prohibit insurers from using credit scores as a rating factor or as a basis for denying or limiting coverage. The rules also require insurers to make rate adjustments going forward, which adjustments are designed to eliminate the effect of the industry’s past discounting of rates for insureds with good credit scores. The Court of Appeals decision, published at 280 Mich App 333 (2008), yielded three different opinions. Two of the judges voted to reverse, for different reasons, the trial court’s order permanently enjoining OFIS from enforcing the rules.

The Insurance and Indemnity Law Section, among others, has been invited to file an amicus brief. Council members are exploring whether there is a consensus position on any of the issues presented.

Michigan Court of Appeals Opinions - Published

Construction Defects: No Occurrence – No CGL coverage

Liparoto Construction, Inc v General Shale Brick, Inc, et al,
___ Mich App ___ (2009)

The insured, a general contractor, built a house with Sonora brick. The homeowners later filed an administrative complaint with the Department of Consumer and Industry Services claiming that the brick had become discolored. It was determined by the manufacturer that the discoloration was due to an acid cleaner applied by the contractor, contrary to the manufacturer’s cleaning instructions. The general contractor sought coverage for the claim under its general business liability policy with State Auto Property & Casualty. When the claim was denied, the contractor resolved the claim and then sued State Auto for breach of contract. The Court of Appeals affirmed, in a published decision, the trial court’s conclusion that there was no insurance coverage because there was no “occurrence.” The insured failed to present any evidence that there were damages beyond the insured’s own work product - as opposed to damage to the property of others, which would have been a covered “occurrence” under the policy.

Small Employer Group Health Coverage Act: Minimum Contribution Requirements May Not be Imposed on Employers as Condition to Issuing Health Benefit Plans

Priority Health, et al v Commissioner of the OFIS,
___ Mich App ___ (2009)

In this case, the Michigan Court of Appeals resolved the following question of first impression: “Does Chapter 37 of the Insurance Code of 1956, MCL 500.3701, et seq.,
allow petitioner to impose employer minimum contribution requirements as a condition to obtaining and maintaining health insurance benefits?” After an extensive discussion of statutory interpretation, the Court of Appeals stated: “we hold that respondent correctly ruled that the Small Employer Group Health Coverage Act does not allow petitioner to impose minimum contribution requirements on employers as a condition to issuing of a health benefit plan.”

No Individual Right to Bring a Derivative Action Against a Fraternal Benefit Society

Averill v. Dauterman, et al.,
__ Mich App __ (2009)

Plaintiff, a member of a fraternal benefit society providing insurance to its members, filed a derivative suit on behalf of the society against the board of directors for breach of their fiduciary duties in managing the society. The trial court dismissed the lawsuit under the Insurance Code, which does not permit individual members to bring derivative actions on behalf of a fraternal benefit society. In upholding the trial court’s order, the Michigan Court of Appeals relied on MCL 500.8191(5), which states, in relevant part: “An action under this section shall not be recognized in any court of this state unless brought by the attorney general upon request of the (insurance) commissioner.” The court rejected the plaintiff’s reliance on the common law as creating a separate right of action.

“Insurance Specialists” Liable to Company for Fraud in Connection with Misrepresented Health Insurance Plan

Unibar Maintenance Services, Inc v. Saigh, et al.,
__ Mich App __ (2009)

Plaintiff corporation prevailed in a jury action for fraud, misrepresentation, constructive fraud, and innocent or negligent misrepresentation against four licensed insurance agents and their companies in connection with the sale of a self-funded benefit plan represented as a first dollar, full coverage health insurance plan. Plaintiff claimed that as a result of the misrepresentation, its employees were unable to receive care from their health care providers or obtain prescriptions. In some instances, employees were even sued by their health care providers for unpaid services rendered. Plaintiff had to contend with hundreds of employee complaints and employees who quit their jobs because of the lack of health insurance. The Court of Appeals upheld the verdict of $1,282,575 in compensatory and exemplary damages, finding sufficient evidence that the defendants misrepresented the type of plan sold and that the plaintiff detrimentally relied upon those misrepresentations.

Several issues before the court are relevant to insurance. First, the defendants held themselves out as health insurance specialists and therefore, were subject to a standard of care applicable to specialists. Second, it was reasonable for the plaintiff to rely upon the information provided by the defendants based upon their claim that they were specialists in the field. Third, exemplary damages may be awarded in favor of a corporation based upon loss of reputation as a skillful and competent company.

Pollution Exclusion Endorsement Found Ambiguous on Issue of Heating Equipment

Auto Owners Ins Co v Ferwerda Enterprises, Inc.
___ Mich App ___ (2009)

Holiday Inn maintained a swimming pool for its guests in a building attached to the hotel. The building was equipped with an integrated boiler and pool filter system that both heated and treated the pool, and heated the building. A maintenance employee made repairs to the system but failed to turn off the chemical feed, which caused a cloud of gas to enter the pool area when the system was turned back on. A family using the pool at the time sued the hotel for bodily injuries. The question was whether the hotel’s liability policy provided coverage given a pollution exclusion endorsement that excepted bodily injury claims “sustained with a building . . . caused by smoke, fumes, vapor or soot from equipment used to heat a building.” The circuit court found coverage under the policy, but the Court of Appeals found a question of fact as to whether the pollutant was released by the heating system or the chlorine injector. The court also found a question of fact as to whether coverage was excluded under another provision of the pollution exclusion, on the theory that the insured brought the pollutants (the chemicals) onto the premises in connection with performing its operations.
Title Insurance Case Approved for Publication


**Michigan Court of Appeals - Unpublished Opinions**

Water Loss Excluded Under Commercial Property Policy

**Legal Services Plan of Eastern Michigan v Citizens Insurance Company of America**

(Unpublished, April 30, 2009, Docket No. 278110)

Citizens Insurance issued a commercial property insurance policy for plaintiff’s business premises. During the policy period, the city engaged a construction company to replace the sidewalk and plant trees near the plaintiff’s building. While removing layers of concrete from the sidewalk, workers exposed an area of plaintiff’s basement and failed to secure it before a storm occurred, causing significant water damage to plaintiff’s property. Plaintiff sued Citizens for coverage but the courts determined that the loss was expressly excluded under the “surface water” and “construction activity” exclusions contained within the policy.

Deceased Entitled to Michigan No-Fault Benefits Arkansas Residency only Temporary

**Estate of Han v Michigan Insurance Group**

(Unpublished, May 19, 2009, Docket No. 285038)

A married couple owned a house in Michigan, with the husband temporarily living and working in Arkansas. He owned and drove a car registered and insured in Arkansas, under a policy that identified him as the only named insured and was issued by a company not certified to provide Michigan no-fault benefits. The wife owned a vehicle registered in Michigan and maintained her own insurance policy with defendant Michigan no-fault insurer. She was the only named insured under her policy and her vehicle was the only listed vehicle. The husband was killed in an automobile accident and the issue before the Court was whether he was a resident of Michigan for purposes of no-fault coverage under his wife’s policy. The Court of Appeals applied the “domicile” test and found that, under the totality of the circumstances, the husband was a Michigan resident (he shared a Michigan home with his wife; owned the Michigan home, which housed his immediate family; lived in Arkansas on a temporary basis; had no intent to become a permanent resident of Arkansas; never acquired real estate or rented an apartment in Arkansas). Therefore, the husband was found to be a Michigan resident entitled to no-fault benefits as the spouse of the insured.

---

**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. Burmingham, AAI, LIC
- Mary A. Foucard, AAI, CIC, CPCU
- Ronald R. Gaffney, LIC
- Cynthia Gascoyne, CIC, AAI
- Tina Gelardi, CISR, LIC, CIC
- Heather M. Greffe, 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
- Kary 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-Schwah, JD, MBA
- Albert W. Papa, CLU, ChFC
- Leslie J. Payment, CISR
- Patricia A. Perez, CIC, AAI, LIC
- Jonathan Pope, MSF, CIC, RMS, BCA, CMS, RPA
- Tracey E. Rose, CPA, MSF
- Jack Saks, JD
- David J. Setlock, CPA, AAI, LIC, CIC, CPCU
- Christal J. Smith, AAI, LIC, CISR
- Robert L. Stearns, JD, CPCU, CIC, AAI, LIC, ARM
- Joann K. Wiliford, CLU, CPCU
- Heather Wilson, JD

**www.InsuranceAgentExperts.com**

or contact Michael S. Hale, JD, CPCU, CIC, AAI at T: 734.525.2414

---

State Bar of Michigan Insurance and Indemnity Law Section 15
2008-2009
Insurance & Indemnity Law Section
Officers and Council

Officers
Hal O. Carroll, Chairperson
Vandeveer 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
Plunkett Cooney
Bloomfield Hills

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
Vandeveer 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

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_extst.pdf and join your colleagues!