From the Chair

Annual Meeting: Program and Elections

Believe it or not, the State Bar of Michigan’s Annual Meeting will be here in just a few months. This year the Annual Meeting will be held at the DeVos Place in Grand Rapids and our Section's annual business meeting and program will be held on September 20, 2012, from 10:00 a.m. to 11:30 a.m. Everyone who can attend should plan to be there. In past years our Section has put on very well-received programs and this year will be no different. The program topic this year is “Insurance Coverage Conflicts and the Role of Independent Defense Counsel.”

Apart from an interesting program and a chance to meet your colleagues in the Section, we also have elections this year. Our Section has adopted two elections policies that we think promote a more productive and representative section. First, for the officers, the practice has been that each will serve for two years in one position and then progress to the next. The result is that by the time someone becomes chair of the section, he or she knows how things work (or don’t) and what should be improved. This is the year when the officers will move up – and in the case of the current chair, out. That means that there will be a vacancy for the Treasurer’s position.

The second practice we have adopted is that all council elections are open. Incumbents who are not term-limited can be on the ballot, but any member who wants to serve on the council can also be listed. Our goal with these two practices is to make keep a core of expertise by having continuity in the officers, but also make sure that the council is representative of and responsive to the membership. If you would like to be listed on the ballot as a candidate for Council member or for the Treasurer’s position, just send an email to our unofficial election supervisor, Hal Carroll at HOC@HalOCarrollEsq.com.

Past and Future

Since this is the end of my two-year term, it’s a good time to look back and look forward. Our membership has increased from 400 to 560, and as I pointed out in my last From the Chair column our members are now from several states and spread through nearly the entire state. We are pleased with the breadth of our membership in geographical terms and we want it to continue to be broad in terms of issues and orientation. The Section has a strong policy of being neutral as between insureds and insurers, and we want our membership to be diverse as well.

Over the last two years we have, I hope, laid the foundation to allow for the long-term stability of the section, provide it with direction, continuity and set achievable goals so that
the section continues to provide value to its members. To that end, our largest project was to draft and adopt a two-year strategic plan to guide the Section in future growth. We now – through our Strategic Planning Committee – are working on the outline for a five-year plan that will continue to provide framework and guidance for the Section’s future leadership that will hopefully allow those future leaders to focus their time and energy on providing substantive programs and resources to the membership.

Additionally, we now have staffed our core committees – Membership, Programs and Publications – but we are always looking for more and new volunteers. One of our biggest goals in the strategic planning process was to make our committees actual working committees; we are on our way to having that happen. We also now have a healthy treasury with cash on hand to help fund future programs. We have many goals to make the section a sustained resource to all of members including the expanding the number of programs we provide, continuing to provide our signature resource – the Journal – in top quality form, providing a platform for our members to share their expertise and opinions, developing a directory of our membership to exchange expertise among our members and to expand our pre-holiday party so that our members can network. In one of my earlier columns as Chair I summarized our goals for the Section and those still stand today:

- One of the goals and purposes of the Insurance and Indemnity Law Section is to be a resource for other sections. We do not advocate for one side or the other when it comes to coverage and indemnity issues; instead, we see ourselves as a mechanism for the exchange of information, both among our members and with practitioners in other areas.

- Another purpose of our Section is to provide networking opportunities for our members. Members who are new to this area of practice can benefit from contacts with the more experienced members. If you are new to this area you will find no shortage of “mentors-in-waiting” who are willing to answer questions.

- Participation is the key to both of these themes. By enhancing the performance of the Section, you will also improve your own skill and expand your network of contacts.

I hope that you find our membership in our Section to be useful. The Council members have worked hard over the last two years to put this still new and growing section in a place where it can be sustained and productive. I also hope that you get involved. We are always looking for new ideas.

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**INSURANCE COVERAGE QUESTIONS OR REFERRALS?**

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**WE WOULD LOVE TO HEAR FROM YOU.**

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**Greg Drutchas**
- 35 years experience
- AV®-rated Martindale-Hubbell
- Michigan Super Lawyer 2006-2010
- Former Chair, Insurance Law Committee, State Bar of Michigan
- Former Chair, Health Care Law Section, State Bar of Michigan

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**Adam Kutinsky**
- 12 years experience
- Chartered Property Casualty Underwriter (CPCU®)
- AV®-rated Martindale-Hubbell
- Michigan Super Lawyers Rising Star 2011
- 2012 DBusiness Top Lawyer
- Officer and Council Member, Insurance and Indemnity Section, State Bar of Michigan

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Title insurance protects owners and mortgagees against loss associated with the state of title or priority of interests in real property. Specifically, an owner will purchase title insurance to assure that its title is in the condition anticipated at closing on the property and a lender will purchase title insurance to assure that its mortgage is of the priority promised by the owner during the loan process. Although there are different ways in which owners and mortgagees can obtain assurances that their interests in land are protected, title insurance is currently the most effective and common manner in which this is accomplished.

The process of obtaining title insurance begins with contacting an experienced and licensed title agent who will obtain the necessary information to prepare a title commitment for the property. This is usually done well ahead of a sale or refinance transaction so the parties can identify any problems with title that need to be resolved ahead of closing. A title commitment provides an offer by the insurer to issue a policy of title insurance to the insured owner or lender under certain conditions at the time of closing. The commitment will remain valid for a stated period of time, typically for 6 months, and includes specified “requirements” that must be met before the policy is issued. Common requirements include the discharge of any pre-existing mortgages or liens paid off at closing, payment of outstanding taxes, and the recording of the deed or mortgage creating the insurable interests. Should the proposed insured satisfy the requirements, a title policy will be issued in exchange for a premium paid as part of the closing transaction.

Under Michigan law, because title policies usually include an integration clause, the title policy supersedes and abrogates the commitment. See, Archambo v Lawyers Title Insurance Corporation, 466 Mich 402 (2002). So once the commitment requirements are met and the title policy is issued, the insured and the insurer look exclusively to the policy terms and not the commitment to evaluate coverage.

Owner’s policy and lender’s policy

As indicated above, two different title policies are usually issued at closing - one to the owner that purchases the land and another to the lender that funds the primary loan. An owner purchases title insurance to protect against the risk that its title to the land will not be in the condition assured at the closing. The lender purchases its own title policy to protect against the risk that its mortgage will not be in the priority assured at closing. It is not uncommon for a lender that issues a “second mortgage” – meaning one that is not entitled to maintain a first priority lien against the property – to not purchase title insurance at all. Likewise, owners do not always purchase title insurance, although it is certainly in their best interest to do so.

Most title policies are issued on forms generated by the American Land Title Association (ALTA’), which is the title insurance equivalent to ISO’. Over time title insurance policy forms have evolved and are providing ever-increasing coverages to insureds.

continued on the next page
two different title policies are usually issued at closing - one to the owner that purchases the land and another to the lender that funds the primary loan. An owner purchases title insurance to protect against the risk that its title to the land will not be in the condition assured at the time of closing. The lender purchases its own title policy to protect against the risk that its mortgage will not be in the priority assured at closing.

**ALTA 1992 Policies**

For years the standard owner’s and loan policies issued were the ALTA 1992 form policies. These policies provide basic, broad coverages. For example, the 1992 owner’s policy provides four basic coverages. It insures against loss or damage not exceeding the policy amount if:

- Title to the estate or interest described not being vested as stated.
- There is any defect, lien or encumbrance on the title.
- The title is unmarketable. “Marketability of title” is not equivalent to “fair market value” of the property. Marketability means the capability to sell the property to a third party free of unknown liens or encumbrances, not the ability to sell the property for a certain value.
- There is a lack of right of access to the land.

The policy also provides for the defense of the title as insured.

The 1992 loan policy contains eight basic coverages, including the four from the owner’s policy and four additional coverages that relate to the invalidity, enforceability and priority of the insured mortgage and any assignments of the mortgage.

**1997 – Eagle Policy Expands Coverage**

In approximately 1997 First American Title Insurance Company created the Eagle Policy for single family properties, which expanded basic insuring and defense provisions of the 1992 policy. The Eagle Policy provided built-in zoning coverage, *i.e.*, that the property could be used as a single family dwelling. It also expanded the right of access coverage. The Eagle policy insures that there is both vehicular and pedestrian access to the property, which is essentially that the property has practical access. Interestingly, a Missouri court has held that a goat path that was traversable only by foot or horseback was sufficient to access property under this coverage.

As the Eagle policy expanded coverages it also provided deductibles for insureds for some of the new coverages. For example, the Eagle policy provides that if an insured is not able to obtain a building permit or is forced to correct or remove a building violation, those items would be covered by the policy, subject to a deductible of 1% of the policy amount or $5,000 whichever is less. Also, the maximum amount of liability for those coverages is $25,000.

**2006 ALTA Policy Additional Expansions of Coverage**

In 2006 ALTA promulgated the 2006 policy. The 2006 policy expanded the coverages of the 1992 policy in detail. For example, the 2006 policy insured against any defect in or lien or encumbrance on the title, including but not limited to insurance against loss from:

- forgery, fraud, undue influence, duress, incompetency, incapacity, or impersonation;
- failure of any person or entity to have authorized a transfer or conveyance;
- a document not properly created, executed, witnessed, sealed, acknowledged, notarized, or delivered, etc.

**Survey Coverage**

The 2006 policies also automatically provided survey coverage. Previously insureds were encouraged by the title company to obtain a survey of the land and obtain an inspection of the building or structure which may reveal defects that would not be discovered by a review of the recorded instruments with the register of deeds. If a satisfactory survey was presented at or prior to a closing, the general exceptions to title would be removed or endorsed over. These exceptions included rights of parties in possession and matters affecting title which would be disclosed by an accurate survey such as unrecorded easements or encroachments. The 2006 policies’ Covered Risks section includes, “Any encroachment, encumbrance, violation, or adverse circumstance affecting title that would be disclosed by an accurate survey of the Land. The term ‘encroachment’ includes encroachments of existing improvements located on the Land onto adjoining land, and encroachments onto the Land of existing improvements located on adjoining land.”
Creditor’s Rights Coverage

The 2006 policies also include creditor’s rights coverage including transactions occurring prior to the transaction creating the interest insured. Another added coverage in the 2006 policies is the post-policy title insurance for the gap. This means coverage is automatically given for matters arising between the date of policy (which was previously the transaction date) and the date the recording of the deed. This coverage was not automatically provided under the early policy forms.

The Exclusions From Coverage provisions were rewritten in the 2006 policies in simpler terms and the Conditions and Stipulations were also modified. Most notably the section entitled, “Determination and Extent of Liability” was changed. Under the 2006 policy if an insurer elects to defend or prosecute the title and is unsuccessful in doing so the policy amount is automatically increased by 10%. In addition, the insured is then given the choice of determining the date of loss. The insured can either pick the date the claim was made or the date the claim is settled and paid as the date of loss.

Proofs of Loss

The “Proof of Loss” provisions in the 2006 policies were also amended. The 1992 policy requires the insured to provide a proof of loss within 90 days of when the insured learned of the facts giving rise to the claim. Under the 2006 policy the Insurer must first attempt to determine loss and if it unable to do so it may require the insured claimant to furnish a signed proof of loss. If the claimant under a 1992 policy did not provide a proof of loss, and if the insurer was prejudiced as a result, the insurer’s obligation to the insured could terminate. This provision has been removed from the 2006 policy. However, an insurer can withhold payment of loss under the 2006 policy until the insured claimant signs a proof of loss if requested to do so.

“Marketability of title” is not equivalent to “fair market value” of the property. Marketability means the capability to sell the property to a third party free of unknown liens or encumbrances, not the ability to sell the property for a certain value.

Definition of Insured

The 2006 policies have expanded the “Definition of Insured” in the policy. The 1992 policy defines the insured as whoever is named in Schedule A of the policy. In the instances where an insured has conveyed to a trust or LLC by quit claim deed, and an endorsement is not obtained to amend the named insured, coverage under the policy may terminate because the title holder is no longer the named in Schedule A of the policy. The 2006 policy has expanded the definition of insured to include a grantee, if the grantee is wholly-owned by the insured or is wholly-owned by an affiliated entity of the named insured. Also if the grantee is a trustee or beneficiary of a trust created by a written instrument for estate planning purposes it is not automatically an insured under the 2006 policy.

ALTA 2010 Homeowner’s Policy – Plain Language

The newest available policy form is the ALTA 2010 Homeowner’s Policy. This is a plain-language policy, which is easier for a lay person to understand. This policy applies to an improved lot with a one-to-four single family residence on it. This ALTA form policy is basically the 2006 policy with the additional coverages and deductibles of the Eagle policy, but it is written in consumer-friendly terms. However, it does go a step further. Title policies generally provide coverage as of Date of Policy and insure against matters occurring before that date. The ALTA 2010 Homeowner's Policy provides coverage for matters occurring after the policy date for six of the covered title risks. They include:

- Someone else owns an interest in your land.
- Someone else has a right affecting your title because of leases, contracts or options.
- Someone else claims to have rights affecting your title because of forgery or impersonation.
- Someone else has an easement on your land.
- Your title is defective because of defective documents or proceedings.

Identity Theft

For example, if an insured’s property is stolen through identity theft it will be covered by the policy. Under previous policies forms this would be a post-policy matter and would have been excluded from coverage.

Inflation Endorsement

The ALTA 2010 Homeowner’s Policy also has a built in “Inflation Endorsement”, which means that the policy amount will increase by 10% each year for the first five years up to 150% of the original policy amount.

Continuation of coverage for an insured under the ALTA 2010 Homeowner’s policy is similar to the provision in the Eagle policy where an insured is insured forever, even if the insured no longer has title to the property. Other types of policies provide continuation of coverage for an insured owner continued on the next page
after conveying title only if the insured had conveyed title by a warranty deed.

Available Endorsements to Increase Coverage

In addition to the policies themselves, title insurance companies also offer many endorsements to cover unique risks, some of which may be added to a title policy for no additional premium. For this reason, it is prudent for the proposed insured to request a list of endorsements offered by the insurance company and the corresponding additional premium charged for each. Of course, many of the endorsements may not be applicable to the particular transaction, but without requesting the information, the insured may be leaving potential coverage on the table. Some typical types of endorsements that can be requested are (some may be applicable only to owner’s policies or only to loan policies):

- Encroachments endorsements
- Manufactured Housing endorsements
- Survey Endorsements
- Condominium endorsements
- Restriction, encroachment and mineral endorsements
- Zoning endorsements
- Environmental Protection Lien endorsements
- Location Endorsements

Regardless of the type of policy that is issued, the entire policy including the endorsements, must be read as a whole in order to determine the coverage provided. In addition to the Covered Title Risks contained in the policy jackets, the title policy also contains Exclusions From Coverage, Conditions and Stipulations, and the transaction-specific Exceptions From Coverage. Matters excepted from coverage are listed on Schedule B of the policy. These exceptions are generally based on what has been previously recorded against the property, and are meant to carve out title defects that the underwriter has no way of protecting against.

In the event of a title defect, insureds should submit a claim to the title underwriter directly whose name is listed on the policy, not the title agent that may have closed the transaction. The title underwriter, not the title agent, has the primary obligation to the insured. Submitting the claim directly to the underwriter assures that the claim will be forwarded to the appropriate claims handler as soon as possible. The policy jacket contains an address where claims can be submitted. Also, claims can be submitted via the Internet to the major underwriters. Once a title underwriter receives the claim, it will be acknowledged and assigned to a claims handler. The claims handler will investigate the claim and determine whether or not the claim is covered. The type of claim and if there is pending litigation or not will determine how the claim will be handled. In some instances an attorney will be retained to correct the title defect by bringing a lawsuit to quiet title or to seek other forms of relief. Of course, title insurance also provides a defense to the insured in the event that a lawsuit is brought against it that is covered by the title policy. In other cases, a determination of loss will be made and damages may be paid to the insured.

About the Authors

Beth Schreiber is a Vice President and Senior Claims Counsel for the Midwest Claim Center of First American Title Insurance Co. She can be reached at 630-799-7153 or bschreiber@firstam.com.

Adam Kutinsky is a shareholder with the Kitch law firm and co-chair of its insurance coverage practice group. He may be reached at 313-965-6731 or adam.kutinsky@kitch.com.
Supreme Court Action

One-Year-Back Rule Means What It Says

As readers of this column are well aware, the Michigan Supreme Court ruled, in *Cameron v ACIA*, 476 Mich 55; 718 NW2d 784 (2006), that the minority and insanity savings provision of the Revised Judicature Act, MCL 600.5851(1) did not toll that application of the One-Year-Back Rule, found in MCL 500.3145(1). This ruling effectively eliminated claims for decades-old attendant care service benefits, except in this case involving fraud on the part of the insurer.

However, as a result of a shift in the governing philosophy of the Michigan Supreme Court, following the November 2008 general election, the new majority of the Michigan Supreme Court overruled *Cameron* and *University of Michigan Regents v Titan Ins Co*, 487 Mich 289; 791 NW 2d 897 (2010). In *Regents*, the Michigan Supreme Court ruled that the One-Year-Back Rule, set forth in MCL 500.3145(1) was, in fact, tolled during the injured person's period of minority or "insanity." Once again, the door was opened to decades-old claims for attendant care service benefits for persons who may have suffered a traumatic brain injury many years ago in an automobile accident.

However, another philosophical shift took place as a result of the November 2010 general election, in which Justice Mary Beth Kelly defeated then-Justice Alton Davis. In 2011, with the new majority in place, the Michigan Supreme Court granted the no-fault insurer's bypass application for leave to appeal in *Joseph v ACIA*, docket no. 142615. In its order, the court asked the parties to brief the issue of whether *Regents* was correctly decided.

On May 15, 2012, the Michigan Supreme Court released its long-awaited opinion in *Joseph v ACIA*. The majority opinion was authored by Justice Mary Beth Kelly who, as noted above, defeated then-Justice Alton Davis in the November 2010 general election. In her opinion, joined by Chief Justice Robert Young Jr. and Justices Steven Markman and Brian Zahra, the court overruled *Regents*, and reinstated *Cameron*, in no uncertain terms:

"We once again hold that the minority/insanity tolling provision, which addresses only when an action may be "brought," does not preclude the application of the One-Year-Back Rule, which separately limits the "amount" of benefits that can be recovered. These distinctions were recognized in Michigan law both in *Cameron* as well as several decisions of this Court that predate *Cameron*. Yet this Court's decision in *Regents* conflated these distinct concepts in order to effectuate what the *Regents* majority believed was a broader social good served by extending the right to recover benefits beyond those allowed by law. We recognize the necessity for, and value of, stability in the law and take no pleasure in overruling a precedent of recent vintage by this Court. But *Regents* itself simply failed to apply our then recent decision in *Cameron*, resulting in a decision that patently failed to enforce the requirements of the statutes that it interpreted. Because the holding in *Regents* contravened the Legislature's clear and unambiguous language in MCL 500.3145(1) and MCL 600.5851(1), *Regents* is overruled and we reinstate *Cameron*.

*Joseph*, slip opinion at page 2.

Accordingly, the Supreme Court remanded this matter back to the Macomb County Circuit Court for entry of an order granting defendant AAA's motion for partial summary disposition, and limiting plaintiff's recovery of benefits to one year back from the date suit was filed.

In addition, the Supreme Court resurrected the rationale enunciated by the Michigan Court of Appeals in *Liptow v State Farm*, 272 Mich App 544; 726 NW 2d 442 (2006), regarding claims filed by political subdivisions. In *Liptow*, the Michigan Court of Appeals ruled that political subdivisions providing medical treatment to or on behalf of an injured claimant (such as the University of Michigan Medical Center) were bound by the One-Year-Back Rule, set forth in MCL 500.3145(1), even though the Revised Judicature Act states that political subdivisions are not bound by any statute of limitations, with regard to an attempt to recover payment of medical expenses incurred by an injured claimant. In this regard, the Supreme Court, in *Joseph*, noted that the One-Year-Back Rule is not a statute of limitations. Rather, it is simply a damage limitation provision. Therefore, while a political subdivision, such as the University of Michigan Medical Center, "may bring an action at any time pursuant to MCL 600.5821(4), it cannot recover benefits for any portion of the loss incurred more than one year before the date on which the action was commenced." *Joseph*, slip opinion at page 11.

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Generally speaking, Supreme Court decisions are given retroactive application. There is nothing in the court’s majority opinion that indicates that it is to be applied prospectively only. Accordingly, the One-Year-Back Rule applies in all cases currently pending in the Michigan court system, regardless of the status of the person bringing the claim.

Justice Marilyn Kelly (who authored the court’s majority opinion in Regents), joined by Justice Michael Cavanagh and Justice Diane Hathaway, issued a strong dissent. In doing so, these justices relied on the rationale expressed in the majority opinion in Regents, to which they were all signatories.

To put it simply, the One-Year-Back Rule means what it says. There is no longer any exception or tolling of the One-Year-Back Rule for minors or “insane” individuals.

Uninsured Motorist Carrier Entitled To Enforce 30-Day Notice Provision, Even Though It Was Not Prejudiced By The Claimant’s Failure To Provide Timely Notice

On May 30, 2012, the Michigan Supreme Court released its decision in DeFrain v State Farm, docket no. 142956. At issue in DeFrain was a 30-day notice provision, found in State Farm’s UM coverage section, which required the injured claimant to report the accident “to the police within 24 hours and to [State Farm] within 30 days.” This provision is found in almost all uninsured motorist policies sold in this state. In DeFrain, plaintiff sustained severe head injuries after being struck, as a pedestrian, by a hit-and-run motorist on May 31, 2008. Plaintiff’s insurance carrier, State Farm, did not receive notice of the potential claim for uninsured motorist benefits until August 25, 2008, well after the 30-day period had lapsed. After State Farm denied the claim, plaintiff filed suit against State Farm arguing that State Farm could not enforce its 30-day notice provision unless it could show that it was actually prejudiced by the failure to give notice.

In this regard, plaintiff relied upon the Michigan Supreme Court’s decision in Koski v Allstate Ins Co, 456 Mich 439, 572 NW 2d 636 (1998), which imposed a prejudice requirement in the context of a notice-of-suit provision found in a homeowner’s policy. Defendant, in turn, argued that there was no requirement that it show prejudice as a result of the failure to provide notice, relying on the Supreme Court’s decision in Rory v Continental Ins Co, 473 Mich 457, 703 NW 2d 23 (2005), and the Supreme Court’s order in Jackson v State Farm, 472 Mich 942 (2005), which interpreted a provision virtually identical to the contractual provision at issue in DeFrain. The trial court denied State Farm’s motion for summary disposition.

State Farm filed an interlocutory appeal with the Michigan Court of Appeals which, after briefing and oral argument, affirmed the decision of the lower court to deny State Farm’s motion for summary disposition. In doing so, the Court of Appeals relied not only on the Supreme Court decision in Koski, supra, but also on its earlier decision in Bradley v State Farm, 290 Mich App 156, 810 NW 2d 386 (2010), which required State Farm to show prejudice as a result of Plaintiff’s failure to comply with an insurance policy’s joinder provision. State Farm subsequently filed an application for leave to appeal with the Supreme Court, which was granted in 2011.

In a 4-3 decision, the Supreme Court ruled that Jackson determined the outcome of this litigation, even though the Jackson decision was not a full opinion, but simply an order vacating the judgment of the Court of Appeals and reinstating the order of the trial court, dismissing Plaintiff’s cause of action “for the reasons stated in the Court of Appeals’ dissent.” Justice Zahra, writing for the majority, noted that, “an order of this Court is binding precedent if it constitutes a final disposition of an Application and contains a concise statement of the applicable facts and reasons for the decision,” citing People v Crall, 444 Mich 463, 510 NW 2d 182 (1993). Justice Zahra observed that, by referring to the Court of Appeals’ dissent, the Supreme Court adopted the facts and reasoning of the dissenting judge “as if they were their own.” Accordingly, Jackson was binding precedent, which should have been followed by both the lower court and Court of Appeals.

Thereafter, Justice Zahra noted that the Supreme Court’s earlier decision in Rory controlled the interpretation of the contractual provision at issue, because the contractual provision was unambiguous and not in violation of law or public policy.

Finally, the majority overruled the Court of Appeals’ earlier decision in Bradley, and limited the application of a prejudice requirement to contractual provisions “requiring notice immediately or within a reasonable time.”

Justice Cavanagh, joined by Justices Marilyn Kelly and Diane Hathaway, dissented and argued that a prejudice requirement should be incorporated onto contractual notice provisions, relying upon case law from the “vast majority of jurisdictions” that have considered this issue.

Supreme Court to Clarify Scope of Benefits Compensable in Catastrophic Losses

As noted in our prior issue, the Supreme Court held oral argument on an application for leave to appeal filed in Admire v Auto-Owners, docket no. 142842. At issue in Admire was whether or not a no-fault insurer was responsible for the entire
cost of a modified van for a catastrophically injured claimant, or just the cost of the modifications themselves.

Shortly after oral argument took place, the Supreme Court issued an order on March 23, 2012, granting the application for leave to appeal. The leave order is interesting, as it requires the parties to address the following issues:

“The parties shall include among the issues to be briefed: (1) whether MCL 500.3107(1)(a) allows the plaintiff to recover the full cost of handicapped-accessible transportation or whether the plaintiff’s recovery is offset to the extent that the handicapped-accessible transportation replaces the plaintiff’s other transportation costs; (2) if the plaintiff’s recovery is offset, what procedure a fact finder must undertake in calculating the amount of the plaintiff’s recovery and what evidence is relevant to that calculation; (3) whether there is any basis in MCL 500.3107(1)(a) to treat transportation costs differently from other household expenses, such as food or housing, that every person incurs whether injured or not; and (4) whether the principles and standards articulated in Griffith v State Farm, 472 Mich 521 (2005), are sufficient to resolve this dispute.”

Griffith has been broadly interpreted to require a no-fault insurer to pay only for those goods or services that are required specifically as the result of injuries suffered by the injured claimant. Items which are just as necessary for an injured person as they are for an uninsured person, such as food, room and board, clothing and the like are generally not compensable under the No-Fault Insurance Act. The Griffith analysis has proved somewhat problematic in cases involving, say homeless individuals who are catastrophically injured in a motor vehicle accident. In such cases, is the no-fault insurer required to purchase an entire house for the catastrophically injured claimant? Alternatively, how does an insurer calculate what the base cost of the injured claimant’s housing needs would be, where the injured claimant has none? This writer anticipates that the Supreme Court’s decision in Admire may finally provide no-fault insurers, in this state, with some much-needed guidance in this rather complex area of the law.

Court of Appeals Action

No-Fault Insurers of Divorced Parents Are Equally Responsible for Payment of No-Fault Benefits.

In Grange Ins Co of Michigan v Lawrence, ___ Mich App __: ___ NW 2d ___ (docket no. 303031, rel’d 4/24/2004), the Court of Appeals held that no-fault insurers of divorced parents were equally responsible for payment of no-fault benefits incurred by their minor children, even though only one parent had primary physical custody of the child. In Grange, one Laura Rosinski was involved in an auto accident while operating a vehicle insured by Farm Bureau. The accident resulted in the death of her minor child, Josalyn Lawrence. At the time of the accident, Ms. Rosinski and the child’s father, Edward Lawrence, were divorced. Although the judgment of divorce provided that both parents shared joint legal custody, the mother, Ms. Rosinski, had “primary physical custody.” The father owned a motor vehicle insured with Grange Insurance Company. Farm Bureau paid the no-fault benefits, but demanded that Grange reimburse Farm Bureau for 50 percent of the benefits paid by Farm Bureau. Grange denied Farm Bureau’s request, relying on a policy provision that defined the term “family member” as follows:

“If a court has adjudicated that one parent is the custodial parent, that adjudication shall be conclusive with respect to the minor child’s principal residence.”

Grange then instituted a declaratory judgment action asking the court to determine whether or not the deceased child, Josalyn, would be considered an “insured” under its policy. The trial court granted summary disposition in favor of Farm Bureau. Grange appealed, arguing that the lower court erred because Michigan law did not recognize “dual domiciles” for a minor child of divorced parents.

The Court of Appeals affirmed the determination of the lower court and ruled that, based upon the evidence presented, the child was actually a resident of both households and, as such, both insurers were responsible for payment of the minor child’s no-fault benefits. The court further determined that the contractual provision at issue in the Grange Insurance Company policy was invalid, as being in violation of the Michigan No-Fault Insurance Act.

An Injured Claimant, Living in “ Transitional Housing For Drug Rehabilitation” Following His Release From an In-Patient Drug Rehabilitation Program, Was Nonetheless Domiciled in His Father’s House

In Rossman v Titan Ins Co, docket no. 302720, unpublished decision rel’d 5/15/2012, the Court of Appeals addressed a rather interesting residency issue regarding domicile for a young adult with prior issues of drug abuse. The injured claimant, Ian Rossman, was involved in a motor vehicle-pedestrian accident with an uninsured motor vehicle. Titan Insurance Company was initially assigned to handle the claim by the Assigned Claims Facility. However, Titan’s investigation revealed that the owner of the motor vehicle, involved in the accident with Mr. Rossman, was the co-owner of another vehicle insured with AAA. AAA then picked up the claim and, after further investigation, determined that Mr. Rossman’s father owned a motor vehicle insured with Bristol West Insurance Company. Bristol West denied AAA’s request for reimbursement, on the basis that Mr. Rossman was not domiciled

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with Bristol West’s insured at the time of the accident. The lower court granted Bristol West’s motion for summary disposition, finding that the injured claimant was not domiciled in his father’s household at the time of the accident.

On appeal, the Court of Appeals reversed. The Rosman decision discusses, at some length, the factors to be utilized by a court in determining domicile and how the various factors referenced in the Court of Appeals’ decision in Dairyland Ins Co v Auto-Owners, 123 Mich App 675; 333 NW2d 322 (1983) apply in any given circumstance. In this case, the Court of Appeals determined that, because everyone must have a “domicile” somewhere, “it would appear that the only logical and viable place to designate as Rosman’s domicile at the time of the accident was his father’s household,” because Mr. Rossman’s stay at the transitional living facility was only for “a mere special or temporary purpose”; i.e., to seek recovery related to his ongoing drug problems. Although the case is rather fact-specific, the Court of Appeals’ analysis should prove useful to those practitioners dealing with issues of domicile. ■

**No-Fault Corner**
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**Insurance and Indemnity 101**


Every general liability (GL) policy, and most automobile policies, have an “other insurance” clause. As the name suggests, the clause is supposed to address the situation where another policy (or policies) also covers the claim. Some of the most interesting questions come up where two policies are on the risk, and each one modestly steps back and invites the other to pay first.

As with everything relating to insurance, the words control, and each “other insurance” clause has to be read carefully. But there are common forms of the clause, and they fall into three types: The sharing clause, the excess clause and the escape clause.

If the two conflicting clauses are of the same type, then the solution is easy. In effect they cancel each other, and the policies will then pay the loss in proportion to their respective policy limits. That’s the default result. If the loss is $100,000 and policy A has a $100,000 limit, while policy B has a $200,000 limit, policy A will pay $33,333 and Policy B will pay $66,666.

Nothing complicated there, but the fun part is when the clauses are of different types. For quite a while we have had a partial answer, but a report in last April’s issue of the *Journal* provides the basis for solving the whole trilogy.¹

This is the trilogy: “sharing,” “excess,” and “escape.”

The sharing clause may either be a “pro rata” clause or an “equal shares” clause. If it’s a pro rata clause, it says something like “we will share the loss with the other company in proportion to our respective policy limits.” If it is an equal shares clause, then it says “we will share equally in the loss.” Either way, the essence of the clause is that it does not seek to avoid the obligation to pay, but only to share it.

The excess clause says, in effect, “our coverage is excess to the other coverage, so they pay first, and then we pay.”

The escape clause says, in effect, if there is other insurance, then we won’t pay anything; the usual language is “this coverage will not apply.”

With three clauses, it’s tempting to try some sort of “rock breaks scissors” methodology, but that’s not how it works. The relationship between a sharing and an excess clause has been known for some time now. It’s the escape clause that had not been discussed until recently. Probably this is because escape clauses are used less frequently than sharing and excess.

The Supreme Court held that clauses of different types do not necessarily cancel each other. Instead, the language of the three types of other insurance clauses must be compared and given effect. Thus, for example, where one policy provides that it will pay “prorata” with other insurance, and the other policy states that its coverage is “excess” to other insurance, the “prorata” policy will pay its limits before the policy with the “excess” clause pays.
Sharing vs Excess. For a while the courts treated an “other insurance” clause of the “excess” species as making the policy’s coverage into excess coverage. This added more confusion to the mix, because if Policy A1 was a primary policy and was linked to an umbrella (i.e., excess) policy (“A2”), then Policy B, a separate primary policy with an “excess” other insurance clause, was moved up to the same level as Policy A2, the umbrella policy. The Michigan Supreme Court nixed this in *Frankenmuth Mutual v Continental Ins*, where it distinguished between a “true excess” policy (like an umbrella policy) and a primary policy with an other insurance clause of the “excess” type.

“True” excess insurance is analogous to umbrella insurance in that a single insured by specific design layers coverage. The logical rule that we adopt in “true” excess insurance cases is that the “true” excess insurer is liable for defense costs only after the primary insurer is excused under the terms of its policy.3

In *St. Paul Fire & Marine Ins Co v American Home Assurance Co*, the Supreme Court held that clauses of different types do not necessarily cancel each other. Instead, the language of the three types of other insurance clauses must be compared and given effect. Thus, for example, where one policy provides that it will pay “prorata” with other insurance, and the other policy states that its coverage is “excess” to other insurance, the “prorata” policy will pay its limits before the policy with the “excess” clause pays. The same would be true for a “sharing” clause versus an “excess” clause; the sharing clause policy pays its limits ad then the “excess” clause policy pays. Both of them are still primary, though, and would pay before a “true excess policy” pays.

By the way, if there is more than one “true excess” (umbrella policies, each might have its own “other insurance” clause, and the analysis has to be applied to them as well.

But to return to our simple hypothetical of two primary policies, we know this:

- If two clauses conflict they cancel and the loss is shared in proportion to policy limits.
- As between a sharing and an excess clause, the sharing policy exhausts its limits before the policy with the excess clause pays.

Excess vs. Escape. But what about the “escape” clause, the one that says if there is other insurance then this policy provides no coverage at all? That was the unanswered question. On the one hand, since denying coverage entirely is a more extreme position that simply declaring the coverage to be “excess,” maybe the hierarchy should be that “excess” beats “sharing” and “escape” beats sharing and excess.

The case reported in the last issue takes a different and more nuanced view. *Beddingfield v Vaughn* is unpublished and therefore not binding, but its analysis deserves close attention. One of the policies there had an “excess” clause (“this policy applies as excess coverage”) and the other had an “escape” clause (“this coverage will not apply”). The Court of Appeals held that under these clauses, neither the policy with the “excess” clause nor the policy with the “escape” clause constituted “available coverage” from the perspective of the other policy, so that the clauses could not be reconciled. Because the clauses conflicted, the default rule applied and each policy shared in the loss in proportion to its policy limits.

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**Insurance Coverage Counsel**

**Opinions | Litigation | Appeals | Creative Resolutions**

Timothy F. Casey  
248-351-5471  
Timothy.Casey@CEFLawyers.com

Deborah A. Hebert  
248-351-5446  
Deborah.Hebert@CEFLawyers.com

Noreen L. Slank  
248-351-5444  
Noreen.Slank@CEFLawyers.com

Collins, Einhorn, Farrell & Ulanoff, PC  
4000 Town Center, Suite 909  
Southfield, Michigan 48075-1473

(248) 355-4141  
collins.einhorn@CEFLawyers.com  
CEFLawyers.com
Common Law
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All of this leaves us with a workable solution:

• “Excess” beats “sharing.”
• “Escape” beats “sharing.” Beddingfield did not have that question before it, but the result seems unavoidable.
• “Excess” and “escape” conflict, therefore cancel and therefore the default rule of sharing in proportion to policy limits applies.

There is an application for leave pending in Beddingfield, so the story may not be over yet, and anyway it is still necessary to read each clause carefully for any variations that may change the result.

Endnotes

1 Beddingfield v Vaughn, Unpublished per curiam opinion, January 19, 2012, no. 300471, app lv pending, reported in Significant Insurance Decisions, by Deborah Hebert, April 2012 issue.
3 Frankenmuth, 450 Mich at 435-436.
The Miller-Davis case teaches the bench and bar a lot about natatoriums and, in the process, a lot about the nuts and bolts of construction contract litigation. We first met the Sherman Lake YMCA complex in Miller-Davis v Ahrens Constr, 285 Mich App 289 (2009). The Court of Appeals decided the subcontractor that erected the wooden roofing system covering the Y’s natatorium could not be successfully sued by the general contractor. The statute of repose barred the suit. The Supreme Court reversed and decided that the statute of repose doesn’t apply to breach of contract lawsuits challenging whether a contractor built an improvement the way the specifications required. As between the contracting parties, only the six-year contract statute of limitations governs. Miller-Davis v Ahrens Const, 489 Mich 355 (2011).

The case recently returned to the Court of Appeals for the next installment of “Leaky Natatorium, Wherein General Contractor Tries Again.” Miller-Davis v Ahrens Constr, ___ Mich App ___ (2012); 2012 WL 967840. Most of the new opinion considers when the six-year breach of contract claim accrued. The panel relied on MCL 600.5827 and pointed out that “a contract claim accrues when the wrong occurs, i.e., when the promise is breached, regardless of when damage results.” The resolution of the question is very straightforward. The general alleged that the subcontractor’s allegedly nonconforming work was substantially complete was provided within six years of the lawsuit filing did not change the panel’s statute of limitation ruling. Neither did a claim that the subcontractor’s allegedly nonconforming work was completed, the moisture problem must be remedied, or recovered against the general contractor. The panel also used a belt and suspenders approach to the indemnity claim. It decided that, even if the YMCA’s insistence that the moisture problem must be remedied was a “demand” within the meaning of the indemnity term, the general still did not prevail on its claim. The panel does not accept that the general contractor demonstrated a causative link between the subcontractor’s allegedly nonconforming work and the moisture problem. It characterized the general’s causation proofs as relying solely on an inference from the fact that, once the corrective work was completed, the moisture problem resolved. Not good enough. “The logical force of this inference is totally lacking because the corrective work contained three important elements—that were not present in the original plans and specifications.”

The panel decides that “because no claims or demands were ‘made, brought or recovered against’ [the general], this provision of the contract was not breached by the [the subcontractor].” It felt compelled to apply the hold harmless clause the way “such contracts have traditionally been applied: to apportion liability among the contracting parties for liability to third parties.” The Court of Appeals said: “Indemnification clauses are not intended to be used as a sword or shield in disputes between the contracting parties with respect to the performance of the contract itself.” That’s a nicely-turned phrase bound to be quoted in many a brief.

Moving on to what natatorium law can teach us about indemnity law, in 2003, within six years of filing suit, the general incurred substantial costs and attorney fees to correct the moisture problems. Its indemnity claim, observed the Court of Appeals, was filed timely. But was it a proper claim? The Court of Appeals answered “no.”

A familiar and broadly-worded indemnity contract term was at issue. The subcontractor agreed to indemnify the general for just about everything (except the general’s sole negligence):

…from and against all claims, damages, losses, demands, liens, payments, suits, actions, recoveries, judgments, and expenses including attorney fees, interest, sanctions, and court costs which are made, brought or recovered against [the subcontractor] by reasons of or resulting from, but not limited to, any injury, damage, loss, or occurrence arising out of or resulting from the performance or execution of this Purchase Order and caused, in whole or in part, by an act or omission, fault, negligence, or breach of the conditions of this Purchase Order by [the subcontractor], its agents, employees, and subcontractors ***
Sixth Circuit Update

Failure to Adequately Plead Fraud Precludes Reliance on Statute of Limitations Exception

*Cataldo v US Steel Corp*, 676 F3d 542 (6th Cir April 13, 2012).

As is increasingly common with production facilities, the steel mills involved here changed ownership many times over two decades. This resulted in changes to the way in which pension benefits were determined by the different plans. The employees/plan participants here alleged they were led to believe that benefits would be determined as if a previous plan applied, but were later told that the current plan would instead control. The plan was not amended to reflect what plaintiffs were allegedly led to believe. After accepting an early retirement option, the plaintiffs began to receive significantly less than what they believed they were promised. Subsequently, plaintiffs sued under ERISA for alleged breach of fiduciary duty based upon misrepresentations as to how their pension benefits were calculated.

ERISA contains a statute of limitations regarding breach of fiduciary claims which bars actions commenced either: (a) six years after the last alleged breach occurred; or (b) three years after a plaintiff obtained actual knowledge of the alleged breach or violation. 29 USC § 1113. In addition, the statute contains an exception for fraud or concealment, in which case an action will be barred if it is commenced more than six years after the discovery of such breach or violation. Id. The Plan defendants raised a statute of limitations defense here, claiming that the plaintiffs had actual knowledge they would not receive the benefits allegedly promised well more than three years prior to filing the complaint. The district court dismissed on that basis.

On appeal, the Sixth Circuit considered whether the statute of limitations fraud or concealment exception might apply. There is a split in the circuits regarding whether the fraud or concealment exception applies if a claim is based on fraud, yet there are no allegations relating the fraud to an attempt to conceal the alleged fiduciary violations, as was the case here.

The Sixth Circuit found that it was unnecessary to rule on that issue because the plaintiffs did not adequately plead their allegations of fraud with particularity so as to survive a 12(b)(6) motion. Thus, it remains unclear which side the Sixth Circuit might choose when squarely presented with that issue.

The Sixth Circuit also held that, although a claim for equitable estoppel can apply to a pension plan under the precedent of *Bloemker v Laborers’ Local 265 Pension Fund*, 605 F3d 436 (6th Cir, 2010), the special facts giving rise to liability in that earlier case were absent here. Notably, the plaintiffs here failed to adequately plead the elements of fraud or deception (as noted above). Further, the plaintiffs could not satisfy the justifiable reliance requirement because the Plan documents here allowed the plaintiffs to precisely calculate their pension benefits. Thus, the plaintiffs could not establish reasonable or justifiable reliance on allegedly inconsistent representations to the contrary.

There is a split in the circuits regarding whether the fraud or concealment exception applies if a claim is based on fraud, yet there are no allegations relating the fraud to an attempt to conceal the alleged fiduciary violations, as was the case here.

Plaintiffs here also argued that the Plan defendants failed to provide requested plan documents in violation of ERISA under 29 U.S.C. § 1024(b)(4). However, the court found that the Plan defendants provided all documents requested. Further, the court held that the Plan defendants had no duty to provide those documents which were not expressly requested or obviously referred to, such as actuarial reports, even though those documents were properly considered “Plan documents” subject to the residual clause of 1024(b), and must otherwise be produced in response to a request. The court was careful not to require plan participants to expressly identify a requested document by name, but instead noted that the plaintiffs here failed to frame a request that would reasonably embody an actuarial report such that production would be mandatory.

**Income Used to Repay a 401(k) Plan Loan is Protected; Additional Voluntary Contributions Are Not**


By way of background, the federal Bankruptcy Code exempts a debtor’s inalienable beneficial interest in an ERISA-qualified account from a bankruptcy estate. Thus, retirement plan savings accounts are generally protected from repayment of debts that may be discharged in bankruptcy. However, until recently, an open question existed as to the treatment of a debtor’s income sought to be used for new voluntary retire-
ment plan contributions made after the bankruptcy petition is filed.

Under the Bankruptcy Code, if the trustee or an unsecured creditor objects to confirmation of a Chapter 13 plan, then the court may not approve the plan unless it provides that all of the debtor’s “projected disposable income” to be received in the applicable period will be applied to make payments to unsecured creditors under the plan. 11 U.S.C § 1325(b)(1)(B). “Disposable income” is generally defined as monthly income received by the debtor, less amounts reasonably necessary for the debtor’s maintenance or support. “Projected disposable income” is not defined by the Code, but the Supreme Court has offered the guidance that when calculating disposable income at the time of confirmation of a plan, a court may account for known or virtually certain changes in a debtor’s income or expenses.

The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 (the “BAPCPA”), enacted primarily to ensure that debtors devote their full disposable income to repaying creditors, while also offering new protections for retirement funds, provides that any amount required to repay a 401(k) loan shall not constitute “disposable income.” Prior to the enactment of that statute, neither 401(k) loan repayments nor 401(k) contributions were considered disposable income. However, the BAPCPA did not so clearly provide how 401(k) contributions were to be treated.

In this case, two 401(k) plan participants filed for Chapter 13 bankruptcy protection, and the cases were consolidated to determine whether each could exclude from the bankruptcy estate property and projected disposable income any post-petition earned income proposed to be used for future 401(k) retirement plan contributions.

As part of the respective Chapter 13 plans, each debtor agreed to repay loans from their 401(k) retirement plans prior to the end of the five year bankruptcy commitment period. As of the petition filing, the debtors were not making any new contributions to their retirement account. Both debtors proposed that once their 401(k) loans were repaid in full, they would begin to contribute again to their retirement accounts. However, the bankruptcy plan Trustee objected, claiming any funds that were “freed up” as a result of no longer needing to make payments toward the 401(k) loans should instead be used to pay unsecured creditors as required by 11 U.S.C § 1325(b). The Trustee argued that new retirement contributions could only be excluded from the property of the bankruptcy estate and disposable income under 11 U.S.C. § 541(b)(7) if those contributions were being made at the time the bankruptcy petition was filed.

The Sixth Circuit considered competing views of different district and bankruptcy courts and concluded that only retirement plan contributions already in existence at the time the petition is filed are excluded from the property of the bankruptcy estate, and do not constitute disposable income. Thus, the court held that any income made available as a result of full repayment of a 401(k) loan must be applied toward repayment of unsecured creditors, and not for voluntary retirement contributions.

**Officers of Company Not Personally Liable for Unpaid Contributions**

*Sheet Metal Local 98 Pension Fund v. Airtab, Inc.*, 2012 WL 1940229, No. 09-3121 (unpubl. 6th Cir. 5/29/2012)

Under a collective bargaining agreement with the Sheet Metal Workers Union, Airtab agreed to contribute to the multi-employer pension fund. When it failed to make the required contributions, the Fund sued the company and some of its officers alleging that they were Plan fiduciaries under ERISA and breached their fiduciary duties by failing to ensure that Airtab made the required contributions.

In an unpublished opinion, the Sixth Circuit held that the “alleged refusal to pay... does not rise to the level of exercising discretionary control or authority” that is required for being a fiduciary under ERISA. Because the individuals were not fiduciaries under ERISA, they could not breach an ERISA fiduciary duty. The court noted, but did not decide, the question of whether the unpaid contributions constituted ERISA plan assets.

**Union’s Agreement to Indemnify Employer Enforceable**

*Shelter Distribution, Inc. v. General Drivers, Warehousemen & Helpers Local Union No. 89, 674 F.3d 608 (6th Cir. 2012).*

This case is unlikely to be seen again. The parties entered into a collective bargaining agreement pursuant to which the company’s union employees participated in a multi-employer pension plan. The company contributed to the plan on the employees’ behalf. When the collective bargaining agreement was up for renewal, the parties began negotiations, but before any agreement, the union disclaimed its representation of the employees. This triggered a “complete withdrawal” from the pension fund and a $57,291.50 withdrawal liability claim against the employer.

When the fund asserted its withdrawal claim against the employer, the employer asserted that it was entitled to indemnity from the union by virtue of a provision in the collective bargaining agreement which said:

“The Union shall indemnify the Company for any contingent liability which may be imposed under the Multiemployer Pension Plan Amendments Act of 1980.”

The union argued that this provision was unenforceable because it was against public policy. The Sixth Circuit disagreed.

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ERISA Case Summary
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It noted that ERISA provides that an agreement purporting to relieve a fiduciary from liability is void as against public policy, ERISA 410(a), but that ERISA 410(b) explicitly allows the purchase of insurance to cover any liability. The provision at issue did not relieve the employer from liability; it merely provides that the union will compensate the employer if it is liable. Further, quoting an earlier decision, it said that since “a fiduciary could purchase insurance to cover any potential liability, ‘it would be illogical to interpret the statute as prohibiting indemnification agreements which accomplish the same thing.’” Thus the provision did not violate public policy and was ordered enforced.

Bigamy Doesn’t Pay – At Least for Wife Number 2!

IBEW Pacific Coast Pension Fund v. Lee, 2012 WL 447490, No. 10-6433 (unpubl. 6th Cir. 2/13/2012).

This column has previously discussed a number of cases where an employee names a spouse as life or pension beneficiary, gets divorced, and fails to file a new beneficiary designation. This case raises the opposite situation – Wayne Lee apparently never divorced his first wife, Cleta, before he married Lois. When he retired and applied for pension benefits, he told the plan he was married to Lois and designated married Lois. When he retired and applied for pension benefits, he told the plan he was married to Lois and designated Lois to receive any spousal annuity after his death. Thus the provision did not violate public policy and was ordered enforced.

District Court Update

Who Has Authority To Adopt A Plan?


This is another case where a multi-employer fund brought suit against an employer for failing to make contributions to the fund. The twist in this case is that the employer never actually signed a collective bargaining agreement or participation agreement. The fund, however, relied on the apparent authority of office personnel, custom and practice, and ratification. This case has broader application because in CIGNA v Amara, the US Supreme Court held that for a plan document to be effective, it must have been legally adopted by the plan sponsor.

Martin McMahon worked as a plasterer for many years. During that time, he was a member of the Plasterers’ Union, Local 67 and received various employee benefits through his union membership. In 1995, he decided to start his own business, but wanted to continue the union-related benefits. He and his then-wife (who was Secretary and Treasurer of the company) had several meetings in which one or both of them were informed of the requirements to participate in the benefits funds; his wife helped prepare at least one document; and Martin received benefits from the fund for several years. However, neither Martin nor his wife signed any agreement. The company contributed only for Martin and not for any of its other employees. The funds were suing for the unpaid contributions for the other employees.

Under the Labor-Management Relations Act (“Taft-Hartley”), an employer is only bound to contribute to a fund if it has agreed, in writing, to do so. The written agreement need not be actually signed by the employer. The obligation is non-existent without the written agreement. Although, admittedly, Martin never signed an agreement to contribute, the funds argued that the company was bound by virtue of (a) the ex-wife’s actual and/or apparent authority, (b) the course of dealings, and (c) the company’s actions constituted a ratification. The court rejected each of these arguments.

First, it was undisputed that the ex-wife did not have actual authority to bind the company. And apparent authority can only be established by the principal’s acts – not the agent’s acts; moreover, the union representative testified that he did not believe that the ex-wife had authority to bind the company and thus did not rely on her acts.
Significant Insurance Decisions

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

Michigan Supreme Court

UM time limitation enforced
DeFrain v State Farm Mut Auto Ins Co
___ Mich ___ (May 30, 2012)

In this case, the State Farm UM policy covered hit-and-run accidents only if reported to the police within 24 hours and only if reported to the insurer within 30 days. While a pedestrian in Florida, plaintiff insured was struck and fatally injured by a hit-and-run car. Although the accident was reported to the police within 24 hours, it was not reported to the insurer until nearly three months later. Both the trial court and the Court of Appeals found coverage on the ground that the insurer was not prejudiced by the late notice (the trial court also found an ambiguity in the notice provision). As previously reported in this Journal, the Court of Appeals declined to follow Jackson v State Farm Mutual Automobile Insurance Company, 472 Mich 942 (2005), in which the Supreme Court summarily reversed a Court of Appeals decision that similarly refused to enforce this 30-day notice requirement. In its opinion in this case, the Supreme Court reminds bench and bar that its orders have the same precedential effect as opinions when the order contains a statements of the facts, the reasons for the ruling, and results in a final disposition of the case. The court then went on to hold that specific notice periods, such as the 30-day requirement for hit-and-run accidents, will be enforced regardless of any prejudice to the insurer. In contrast, where the notice is required to be given “immediately or within a reasonable time,” the courts will require actual prejudice.

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Important Insurance Decisions
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Leave granted on question of priority of PIP coverage for vehicle used in the business of transporting passengers

Farmers Ins Exchange v Michigan Ins Co
S Ct Order of May 23, 2012

The Supreme Court has granted leave to address a priority dispute over the payment of first-party no-fault benefits. At issue is whether the involved vehicle was being used for the commercial transportation of passengers, which would determine whose policy would apply. Under prior case law, the Court of Appeals has answered this question by considering the vehicle’s “primary purpose.” In an order issued May 23, 2012, the Supreme Court granted leave and directed the parties to address ‘whether the ’primary purpose/incidental nature’ test for determining whether a commercial vehicles is being used in the business of transporting passengers is consistent with the language of MCL 500.3114(2) and if so, whether it was applied properly to the facts of this case.”

The Insurance and Indemnity Law Section has been invited to file an amicus brief.

Although the failure to name defendant husband as a driver was a material misrepresentation because it would have increased the premium, policies may not be reformed where the result would be adverse to an innocent insured, and where the insurer could have “easily ascertained” the missing information when the contract was formed.

Unpublished Court of Appeals Decisions

No fraud in the insurance application where missing information was “easily ascertainable”

Titan Ins Co v Auto-Owners Ins Co
Unpublished per curiam of March 13, 2012 (Docket No. 302191)

Defendant wife purchased auto insurance from Titan through an independent agency. She informed the agent that her husband also drove the insured vehicle but the agent did not include that information on the application submitted to Titan. A month after the policy was issued, defendant husband was involved in an accident that resulted in a fatality.

Titan filed suit to reform the liability coverage to the statutory limit of $20,000, but both the trial court and the Court of Appeals declined that relief. Although the failure to name defendant husband as a driver was a material misrepresentation because it would have increased the premium, policies may not be reformed where the result would be adverse to an innocent insured, and where the insurer could have “easily ascertained” the missing information when the contract was formed.

Fire contractor does not have direct claim against the homeowners insurer

Sparkle Builder, Ltd v Boines
Unpublished per curiam of March 15, 2012 (Docket No. 301893)

Farmers Insurance issued a homeowners policy to the defendant homeowners. When their home was damaged by a fire, they hired plaintiff contractor to make the repairs. The contract for repairs authorized the contractor to negotiate directly with Farmers and receive insurance proceeds. After the contractor completed the temporary repairs, the homeowners terminated the contract. When Farmers later issued payment for the final repairs, it did not include plaintiff contractor on the check, which led to a lawsuit against both the homeowners and Farmers for breach of contract. The trial court granted summary disposition for Farmers, and that order was affirmed on appeal. Farmers had no contract with plaintiff and was not otherwise obligated to place plaintiff’s name on the final check.

Insureds established the negligence of their insurance agent

Lemberg v Korotkin-Schlesinger & Assoc, Inc
Unpublished per curiam of March 15, 2012 (Docket No 301116)

Plaintiff insureds filed suit against their insurance agent for negligently representing that a rider on their policy to cover a diamond engagement ring was for replacement value. After the ring was lost, it was appraised at $107,000, but the policy covered only $36,776. The court found sufficient evidence of a special relationship between plaintiffs and the agent to justify a jury trial on negligence. The fact that the insureds had a duty to read their policy did not bar the negligence claim because reasonable reliance is not an element of negligence. Rather, the insured’s failure to read the policy went to the question of comparative negligence. This opinion also contains an extended discussion of the evidence at trial.
No undue influence in change of life insurance beneficiaries

United Omaha Life Ins Co v Nees
Unpublished per curiam of March 22, 2012
(Docket No. 302639)

In this interpleader action concerning the proper distribution of life insurance proceeds, the Court of Appeals affirmed the lower court’s finding of a valid change in beneficiaries while the decedent was in the hospital, shortly before his death, with no undue influence.

Statutory limits for non-members of the named insured’s household

Kammers v Pioneer State Mut Ins Co
Unpublished per curiam of April 19, 2012
(Docket No. 303726)

An auto policy issued by Pioneer provided liability limits of $300,000 if the insured vehicle was being operated by the named insured or a member of the named insured’s household. For anyone else, the liability limits were the statutory minimum of $20,000, a provision allowed under Michigan no-fault law. Because the Pioneer-insured vehicle was being operated by a person not a member of the named insured’s household, the Court confirmed that Pioneer’s liability coverage was limited to $20,000. After that, a policy issued by State Farm was required to pay its limit of $50,000.

Proof of loss time limitation is enforced

Johnson v Memberselect Ins Co
Unpublished per curiam of April 24, 2012
(Docket No. 302469)

Renter’s insurance policy required a sworn proof of loss within 60 days of the loss. Plaintiff insured sustained a fire in his apartment and reported the claim but failed to timely submit the proof of loss (he was a week late). During the 60-day interim, the insurer asked the insured for documents such as the police and fire reports, photographs of the apartment contents, records of purchases of destroyed property, etc, but the insured failed to respond. When the insurer refused to cover the claim, the insured sued on theories of substantial compliance, and waiver and estoppel. Both the trial court and the Court of Appeals enforced the 60-day proof of loss requirement. Plaintiff had not substantially complied in light of his failure to respond to requests for documents and there was no evidence of conduct on the part of the insurer to support plaintiff’s theories of waiver or estoppel.

the Court of Appeals characterized the class action as a suit for property damage (rather than for personal and advertising injury) and concluded that the insurer was obligated to defend because the insured may not have intended to send faxes to unwilling recipients. Given this possibility, the court found a potential “occurrence” and refused to apply the “expected or intended” injury exclusion as a matter of law.

Duty to defend a claim of “blast faxing”

Erie Ins Exchange v Lake City Industrial Products, Inc
Unpublished per curiam of May 17, 2012
(Docket No. 302889)

The defendant insured was sued in a class action by the recipients of unsolicited advertisements through “blast faxing,” a practice that violates the Telephone Consumer Protection Act (TCPA). Plaintiff was the defendant’s liability insurer. Without describing the alleged damages pled in the underlying case, the Court of Appeals characterized the class action as a suit for property damage (rather than for personal and advertising injury) and concluded that the insurer was obligated to defend because the insured may not have intended to send faxes to unwilling recipients. Given this possibility, the court found a potential “occurrence” and refused to apply the “expected or intended” injury exclusion as a matter of law. Whether there was coverage for indemnity would have to await findings in the underlying case.

Lack of notice creates actual prejudice for title insurer

Huntington National Bank v First American Title Ins Co
Unpublished per curiam of May 24, 2012
(Docket No. 303496)

Plaintiff bank held the mortgage on property covered by a title insurance policy issued by defendant. Two construction lien holders sued on their liens and the property ended up in foreclosure. Neither the bank nor the property owner notified the title insurer of the claims until 16 months into the litigation. The insurer declined coverage because of the late notice. Both the trial court and the majority opinion of the Court of Appeals agreed that the late notice resulted in actual prejudice and barred coverage. Although trial had not yet commenced and no judgment had been entered by the time notice was given, two orders had been entered establishing the priority of the construction liens over the bank’s mortgage. These orders materially impaired the insurers’ interest and resulted in actual prejudice.