

*ABA Section of Litigation 2012 Insurance Coverage Litigation Committee CLE Seminar, March 1-3, 2012:
Please Excuse the Delay: The Consequences of Untimely Notice,
Slow Investigation, and the Failure to Communicate*

Please Excuse the Delay: The Consequences of Untimely Notice, Slow Investigation, and the Failure to Communicate

J. James Cooper
Jordan J. La Raia
Gardere Wynne Sewell LLP
Houston, Texas

Terrance J. Evans
Duane Morris LLP
San Francisco, California

Katherine E. Mast
Sedgwick LLP
Los Angeles, California

Miles C. Holden
Hanson Bridgett LLP
San Francisco, California

**American Bar Association Section of Litigation
Insurance Coverage Litigation Committee CLE Seminar
March 1–3, 2012, Tucson, AZ**

TABLE OF CONTENTS

	<u>Page</u>
I. Introduction.....	1
II. The “Notice” Condition.....	1
A. Typical Policy Language	1
B. Rules of Construction	2
1. California.....	2
2. Illinois.....	2
3. Nevada	2
4. New York.....	3
5. Texas	3
C. Effect of Untimely or Unreasonable Notice	3
1. California.....	3
2. Illinois.....	3
3. Nevada	3
4. New York.....	3
5. Texas	4
D. Proving Untimely Notice & Prejudice.....	4
1. Generally a Fact Question.....	4
a. California.....	4
b. Illinois.....	4
c. Nevada	5
d. Texas	5
2. Who Has Burden of Proof?.....	5
a. California.....	5
b. Illinois.....	5
c. Nevada	6
d. New York.....	6
e. Texas	6
3. Defining Untimely Notice & Prejudice	6
a. California.....	6
b. Illinois.....	6
c. Nevada	7
d. Texas	7
4. Evidentiary Issues.....	7
a. California.....	7
b. Illinois.....	7
c. Nevada	8
d. New York.....	8
e. Texas	9
1. Prejudice as a Matter of Law.....	12
a. California.....	12
b. Illinois.....	12
c. Nevada	12
d. New York.....	12
e. Texas	13
E. Waiver of Late Notice Defense.....	13
1. California.....	13

	2.	Illinois.....	14
	3.	Nevada	14
	4.	New York.....	15
	5.	Texas	15
F.		Claims-Made Policies—The Prejudice Rule May Also Apply.....	16
	1.	California.....	16
	2.	Texas	16
G.		Additional Insured Issues & Notice From Other Sources.....	17
	1.	California.....	17
	2.	Illinois.....	18
	3.	New York.....	18
	4.	Texas	19
III.		The “Settlement Without Consent” Clause	20
	A.	Typical Policy Language	20
	B.	Prejudice is Required	20
	1.	California.....	20
	2.	Illinois.....	21
	3.	Nevada	21
	4.	New York.....	21
	5.	Texas	22
	C.	Prejudice as a Matter of Law.....	23
	1.	California.....	23
	2.	Texas	23
	D.	Waiver.....	25
	1.	California.....	25
	2.	New York.....	25
	3.	Texas	26
	E.	Most Recent Developments	27
	1.	Nevada	27
	2.	Texas	27
		a. The Facts of the Case.....	27
		b. <i>Lennar II</i> : The Court of Appeals Reverses and Renders	28
		c. Why the Fourteenth Court of Appeals “Got It Wrong”—from the Policyholder Perspective	28
		i. Insurance Provisions Are Not Like Real Estate— Location Doesn’t Matter	29
		ii. What Does Matter—Is the Clause Material?.....	29
		iii. The Implications – Bad Policy	30
IV.		Claims Investigation	30
	A.	Carrier’s Obligations During Claims Investigation	30
	1.	First Party Policies.....	31
	2.	Third Party Policies.....	33
	B.	Policyholders’ Obligations During Investigation: The Duty to Cooperate and the Provision of Support for Claims.....	34
	1.	When the Failure to Cooperate Jeopardizes Coverage	35
	2.	Failure to Cooperate With the Investigation, Defense, and/or Settlement of Claims	36
	3.	Failure to Submit to an EUO	37

I. Introduction

Where to draw the line regarding delay and lack of communication concerning insurance claims can be tricky. And, of course, it can vary by jurisdiction. This paper explores insureds' delayed notice, the prejudice rule and consent-to-settle issues, carriers' late claims investigation and policyholders' duty to cooperate and provide information.

Though not intended to comprehensively address the law of all 50 states or even any one state on these issues, this paper strives to address pragmatic concerns about delay that counsel for policyholders and carriers alike encounter in insurance-coverage disputes and provide an informative summary of the law from some key jurisdictions.

II. The "Notice" Condition

A. Typical Policy Language

All commercial general liability policies require timely notice of an "occurrence" or accident. The insurer also requires additional notice if the "occurrence" results in litigation—typically referred to as "suit"—against an insured. The latest ISO general liability coverage form ("Occurrence" version) provides the following "Duties in the Event of Occurrence, Offense, Claim or Suit"—found under the "Conditions" section of the policy:

You must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim.

...

If a claim is made or "suit" is brought against any insured, you must . . . [notify us as soon as practicable].

ISO Commercial General Liability Form, CG 00 01 12 07 (ISO Properties, Inc., 2006).

Some states have mandated policy language concerning the sufficiency of the notice or the circumstances under which untimely notice can result in forfeiture of the insured's coverage. Two such states are New York and Texas.

In New York, Insurance Law Section 3420(a)(3) requires that all policies issued or delivered in New York provide that "notice given by or on behalf of the insured, or written notice by or on behalf of the injured person or any other claimant, to any licensed agent of the insurer in this state, with particular sufficient to identify the insured, shall be deemed notice to the insurer." In Texas, the State Board of Insurance has issued the following amendatory endorsement applicable to all general liability policies (with respect to coverage for bodily injury and property damage):

As respects bodily injury liability coverage and property damage liability coverage, unless the company is prejudiced by the insured's failure to comply with the requirement, any provision of this policy requiring the insured to give notice of action, occurrence or loss, or requiring the insured to forward demands, notices, summons or other legal process, shall not bar liability under the policy.

State Bd. of Ins., Revision of Texas Standard Provision for General Liability Policies-Amendatory Endorsement-Notice, Order No. 23080 (March 13, 1973) ("Board Order").

By contrast, states like California have not mandated language concerning the sufficiency of the notice or the circumstances under which untimely notice can result in forfeiture of the insured's coverage. As noted above, liability policies typically require the insured to provide notice of two events: an occurrence and a claim or suit. See, John K. DiMugno & Paul E. B. Glad, *California Insurance Law Handbook* §59:1 (2008). California courts have recognized that the purpose of a policy's notice provision is to allow the insurer to undertake an investigation "before the scent of factual investigation grows cold." DiMugno at §59:1; *Dalzell v. Northwestern Mut. Ins. Co.*, 218 Cal. App. 2d 96, 103 (Cal. Ct. App. 1963).

B. Rules of Construction

1. California

With the sole exception of "claims made and reported" policies, an insured's duty to provide notice is a condition subsequent, the breach of which results in a forfeiture of coverage. As such, the notice defense is disfavored and will defeat coverage only if the insurer is prejudiced by the insured's failure to provide timely notice. Under claims-made-and-reported policies, by contrast, notice to the insurer is an element of coverage. Thus, an insured's failure to report a claim to the insurer during the policy period will preclude coverage regardless of whether the insurer's ability to investigate is prejudiced. DiMugno at *Id.*

2. Illinois

Illinois courts do not favor forfeiture provisions in insurance policies and "should be quick to find facts which support coverage." See *A.D. Desmond Co. v. Jackson Nat'l Life Ins. Co.*, 585 N.E.2d 1120, 1122 (Ill. App. Ct. 1992) (insurance forfeitures are not favored, as insurance serves "important purposes in contemporary society, and courts should be quick to find facts which support coverage"); *Rice v. AAA Aerostar, Inc.*, 690 N.E.2d 1067, 1071 (Ill. App. Ct. 1998) ("Not every breach of a policy condition by the insured will allow the insurer to avoid payment under the policy. The law is also concerned with the rights of the public..."); see also *Sears Roebuck & Co. v. Acceptance Ins. Co.*, 793 N.E.2d 736, 740 (2003) (insurance policies are to be liberally construed in favor of coverage). But Illinois courts recognize that notice provisions are not merely technical requirements, but rather, reasonable prerequisites to insurance coverage. See *Berglund v. U.S. Risk Underwriters*, 921 N.E.2d 432, 440 (Ill. App. Ct. 2009); *Zurich Ins. Co. v. Walsh Constr. Co. of Ill. Inc.*, 816 N.E.2d 801, 805 (Ill. App. Ct. 2004); *Northbrook Prop. & Cas. Ins. Co. v. Applied Sys., Inc.*, 729 N.E.2d 915, 920 (Ill. App. Ct. 2000); see also *Country Mut. Ins. Co. v. Livorsi Marine, Inc.*, 856 N.E.2d 338, 343 (Ill. App. Ct. 2006) (notice provisions are "valid prerequisites to insurance coverage"); *Barrington Consol. High Sch. v. Am. Ins. Co.*, 319 N.E.2d 25, 27 (Ill. 1974) (same). Nonetheless, even if the policy requires "immediate" notice, Illinois courts will liberally interpret that to mean "within a reasonable time" so as to avoid forfeiture where possible. *W. Am. Ins. Co. v. Yorkville Nat'l Bank*, 939 N.E.2d 288, 293 (Ill. 2010).

3. Nevada

When an insurer denies coverage of a claim because notice of the claim was late, the insurer must show: (1) that notice was late; and (2) that it was prejudiced by the late notice. *Las Vegas Metropolitan Police Dept. v. Coregis Ins. Co.*, 256 P. 3d 958, 965 (Nev. 2011).

4. New York

Provisions in an insurance contract for furnishing notice and proof of loss are to be liberally construed in favor of the insured. *P.S. Auctions, Inc. v. Exch. Mut. Ins. Co.*, 480 N.Y.S.2d 610, 613 (N.Y. App. Div. 3d Dep't 1984).

5. Texas

In *PAJ, Inc. v. Hanover Ins. Co.*, 243 S.W.3d 630, 636 (Tex. 2008), the Texas Supreme Court reaffirmed that “[c]onditions are not favored in the law.” According to the Court, “when another reasonable reading that would avoid a forfeiture is available, [a court] must construe contract language as a covenant rather than a condition.” *Id.* The Supreme Court’s holding is consistent with long-standing Texas insurance law—courts should construe insurance policies so as to avoid a forfeiture of coverage. *See Coker v. Travel Ins. Co.*, 533 S.W.2d 400, 401 (Tex. Civ. App.—Dallas 1976, no writ); *see also Vernon v. Aetna Ins. Co.*, 301 F.2d 86, 90 (5th Cir. 1962) (Texas law) (noting that when examining an insurance contract, it is to be construed most strongly against a forfeiture).

C. Effect of Untimely or Unreasonable Notice

1. California

It is well established under California law that notice given by an insured to an insurer after any required time period does not excuse the insurer's obligations under the policy unless it can show actual prejudice from the delay. *See*, Cal. Prac. Guide Ins. Lit. Ch. 7A-L, 7:409; *see also, Campbell v. Allstate Ins. Co.*, 60 Cal. 2d 303, 308 (Cal. Ct. App. 1963); *Scottsdale Ins. Co. v. Essex Ins. Co.*, 98 Cal. App. 4th 86, 97 (Cal. Ct. App. 2002) (citing text); *Safeco Ins. Co. of America v. Parks*, 170 Cal. App. 4th 992, 1003–04 (Cal. Ct. App. 2009).

2. Illinois

The Illinois Supreme Court recently reaffirmed that an “insured’s breach of a notice clause in an insurance policy by failing to give reasonable notice will defeat the right of the insured to recover under the policy.” *West Am. Ins. Co. v. Yorkville Nat’l Bank*, 939 N.E.2d 288, 293 (Ill. 2010); *see also Berglind v. Paintball Bus. Ass’n*, 930 N.E.2d 1036, 1044 (Ill. App. Ct. 2010) (“notice provisions are not merely technical requirements but, rather, conditions precedent to the triggering of the insurer’s contractual duties”).

3. Nevada

In August of 2011, the Nevada Supreme Court joined the majority of states in adopting the notice-prejudice rule, and held that an insurer who denies coverage of a claim because of an insured’s failure to provide timely notice must prove that the notice was late and that the insurer was prejudiced by the late notice. *Coregis Ins. Co.* at 965.

4. New York

In January 2009, New York enacted Insurance Law § 3420(a)(5), abrogating the state’s longstanding “no-prejudice” rule for insurance policies issued after January 17, 2009. *Ponok Realty Corp. v. United Nat’l Specialty Ins. Co.*, 893 N.Y.S.2d 125, 127 (N.Y. App. Div. 2d Dep’t 2010); *Tower*

Ins. Co. of N.Y. v. Classon Heights, LLC, 920 N.Y.S. 2d 58, 62 (N.Y. App. Div. 1st Dep't. 2011). This section states in full:

(5) A provision that failure to give any notice required to be given by such policy within the time prescribed therein shall not invalidate any claim made by the insured, injured person or any other claimant, ***unless the failure to provide timely notice has prejudiced the insurer***, except as provided in paragraph four¹ of this subsection. With respect to a claims-made policy, however, the policy may provide that the claim shall be made during the policy period, any renewal thereof, or any extended reporting period, except as provided in paragraph four of this subsection. As used in this paragraph, the terms “claims-made policy” and “extended reporting period” shall have their respective meanings as provided in a regulation promulgated by the superintendent.

N.Y. INS. LAW § 3420(a)(5) (McKinney 2011) (emphasis and footnote added). Because this provision does not apply retroactively, few courts have had the opportunity to construe it. *See, e.g., Ponok Realty Corp. v. United Nat'l Specialty Ins. Co.*, 893 N.Y.S.2d 125, 127 (N.Y. App. Div. 2d Dep't 2010) (holding amendments inapplicable to policies issued and delivered before January 17, 2009); *Tower Ins. Co. of N.Y. v. Classon Heights, LLC*, 920 N.Y.S.2d 58 (N.Y. App. Div.. 1st Dep't 2011) (rejecting language of § 3420(a)(5) as applicable to insured's 2006 policy). Notably, the language of the statute seems to exclude claims-made policies from this new prejudice requirement by allowing insurers to require notice with respect to a claims-made policy “during the policy period, any renewal thereof, or any extended reporting period.”

5. Texas

When coverage for bodily injury or property damage is at issue, late notice voids coverage only if the insurer establishes that the delay prejudiced the insurer's position. *PAJ, Inc. v. Hanover Ins. Co.*, 243 S.W.3d 630, 636-37 (Tex. 2008) (rehearing denied); *Coastal Refining & Marketing, Inc. v. U.S. Fidelity and Guar. Co.*, 218 S.W.3d 279, 289-90 (Tex. App.—Houston [14th Dist.] 2007, pet. denied).

D. Proving Untimely Notice & Prejudice

1. Generally a Fact Question

a. California

Under California law, the question of whether an insured has complied with a policy's notice provisions is a question of fact on which the insurer has the burden of proof. DiMugno at §59:2; *Artukovich v. St. Paul-Mercury Indem. Co.*, 150 Cal. App. 2d 312, 326 (Cal. Ct. App. 1957).

b. Illinois

Whether notice has been given within a reasonable time depends upon the facts and circumstances of each case. *W. Am. Ins. Co. v. Yorkville Nat'l Bank*, 939 N.E.2d 288, 293 (Ill. 2010). The

¹ Subsection (4) as referenced by § 3420(a)(5) states in full:

(4) A provision that failure to give any notice required to be given by such policy within the time prescribed therein shall not invalidate any claim made by the insured, an injured person or any other claimant if it shall be shown not to have been reasonably possible to give such notice within the prescribed time and that notice was given as soon as was reasonably possible thereafter.

timeliness of an insured's notice to its insurer generally is a question of fact for the trier of fact. *Northbrook Prop. & Cas. Ins. Co. v. Applied Sys., Inc.*, 729 N.E.2d 915, 921-22 (Ill. App. Ct. 2000); *Univ. of Ill. v. Cont'l Cas. Co.*, 599 N.E.2d 1338, 1354 (Ill. App. Ct. 1992).

c. Nevada

Under Nevada law, the question of whether an insurer is prejudiced by an insured's late notice is a question of fact on which an insurer has the burden of proof. *Coregis Ins. Co.* at 965.

d. Texas

Whether an insurer is prejudiced by delayed notice is generally a question of fact. *Struna*, 11 S.W.3d at 359-60; *see also P.G. Bell Co. v. United States Fid. & Guar. Co.*, 853 S.W.2d 187, 191 (Tex. App.—Corpus Christi 1993, no writ) (reversing summary judgment in favor of insurer where fact question remained as to whether insurer was prejudiced by default judgment when insurer had actual notice of suit).

2. Who Has Burden of Proof?

a. California

It is well established under California law that the burden is on the insurer to prove that it suffered actual prejudice as a result of the insured's late notice, not merely a possibility of prejudice. Cal. Prac. Guide Ins. Lit. Ch. 7A-L, 7:410; *Northwestern Title Sec. Co. v. Flak*, 6 Cal. App. 3d 134, 141-42 (Cal. Ct. App. 1970); *see also* DiMugno at §59:2; *Moe v. Transamerica title Ins. Co.*, 21 Cal. App. 3d 289 (Cal. Ct. App. 1971).

To establish actual prejudice, the insurer must show a “substantial likelihood that, with timely notice, and notwithstanding its denial of coverage or reservation of rights, it would have settled the claim for less or taken steps that would have reduced or eliminated the insured's liability.” Cal. Prac. Guide Ins. Lit. Ch. 7A-L, 7.410; *citing Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 12 Cal. App. 4th 715, 763 (Cal. Ct. App. 1993); *Safeco Ins. Co. of America v. Parks*, 170 Cal. App. 4th 992, 1004 (Cal. Ct. App. 2009).

With respect to first-party property insurance, an insurer has the burden of proving that it suffered substantial prejudice as a result of the policyholder's breach of the policy's notice clause. Speculation regarding how the insurer might have investigated the loss had it received timely notice is irrelevant to the issue of prejudice. DiMugno at *Id.*; *Colonial Gas Energy System v. Unigard Mut. Ins. Co.*, 441 F. Supp. 765, 768-769 (N.D. Cal. 1977).

b. Illinois

Illinois courts have not provided clear authority as to which party—the insured or the insurer—has the burden of proving “reasonable notice.” One Illinois federal court has held that the burden of proof rests with the insurer. *Ace Am. Ins. Co. v. RC2 Corp., Inc.*, 568 F. Supp. 2d 946, 958 (N.D. Ill. 2008), *rev'd on other grounds*, 600 F.3d 763 (7th Cir. 2010) (“the burden was on [the insurer] to establish there is at least a genuine factual dispute that notice as to any particular underlying lawsuit was untimely.”). On the other hand, a more recent decision from another Illinois federal court appears to place that burden on the insured. *See Pacific Employers Ins. Co. v. Clean Harbors Envtl Servs., Inc.*, No. 08-C-2180, 2011

WL 813905, at *6 (N.D. Ill. Feb. 24, 2011) (“Clean Harbors has met its burden of proof that it gave notice of the Lopez suit to National Union within a reasonable time, pursuant to the NU Policy”).

c. Nevada

Under Nevada law, an insurer has the burden of proving that the notice was late and that the insurer was prejudiced by the late notice. *Coregis Ins. Co.* at 965.

d. New York

The burden of proof regarding prejudice shifts depending on how much time has passed since notice was required under the policy. In this regard, New York Insurance Law § 3420(c)(2)(A) states the following:

(2)(A) In any action in which an insurer alleges that it was prejudiced as a result of a failure to provide timely notice, the burden of proof shall be on: (i) the insurer to prove that it has been prejudiced, if the notice was provided within two years of the time required under the policy; or (ii) the insured, injured person or other claimant to prove that the insurer has not been prejudiced, if the notice was provided more than two years after the time required under the policy.

N.Y. INS. LAW § 3420(c)(2)(A) (McKinney 2011).

e. Texas

The insurer has the burden to prove that it was prejudiced by the insured’s failure to comply with the relevant condition. *See Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691, 692-94 (Tex. 1994).

3. Defining Untimely Notice & Prejudice

a. California

Under California law, where the insurer denies coverage, it may establish substantial prejudice by showing “a substantial likelihood that, with timely notice, and notwithstanding a denial of coverage or reservation of rights, it would have settled the claim for less or taken steps that would have reduced or eliminated the insured's liability.” Cal. Prac. Guide Ins. Lit. Ch. 7A-L, 7:417; *Safeco Ins. Co. of America v. Parks*, 170 Cal. App. 4th 992, 1004 (Cal. Ct. App. 2009).

b. Illinois

In determining whether the insured has given notice within a reasonable time, Illinois courts examine several factors, including: (1) the language of the policy’s notice provision; (2) the insured’s sophistication regarding insurance policies; (3) the insured’s awareness that an accident as defined by the policy has taken place; (4) the insured’s diligence in ascertaining whether policy coverage is available; and (5) whether the insurer was prejudiced by any delay in notice. *See West Am. Ins. Co. v. Yorkville Nat’l Bank*, 939 N.E.2d 288, 293-94 (Ill. 2010); *Northbrook Prop. & Cas. Ins. Co. v. Applied Sys., Inc.*, 729 N.E.2d 915, 921 (Ill. App. Ct. 2000). The presence or absence of prejudice to the insurer is but one factor to consider when determining whether a policyholder has fulfilled a policy condition requiring reasonable notice. *Country Mut. Ins. Co. v. Livorsi Marine, Inc.*, 856 N.E.2d 338, 344 (2006). However,

if it is determined that the insured's notice was unreasonably and inexcusably late, the insurer need not prove that it suffered prejudice. *Id.* at 342 (observing that if insurer did not receive reasonable notice of an occurrence or lawsuit, the insured may not recover under the policy regardless of whether the lack of notice prejudiced the insurer).

c. Nevada

The Nevada Supreme Court has recently held that "Prejudice exists where the delay materially impairs an insurer's ability to contest its liability to an insured or the liability of the insured to a third party." *Coregis Ins. Co.* at 965 (internal quotation omitted).

d. Texas

One of the most thorough opinions addressing the prejudice rule was penned by Justice Eva Guzman in *Coastal Refining Marketing, Inc. v. United States Fidelity and Guaranty Co.*, 218 S.W.3d 279 (Tex. App.—Houston [14th Dist.] 2007, pet. denied). According to the *Coastal Refining* court, an insurer must demonstrate a material change in position in order to establish prejudice. *Id.* at 288. "[T]he standard for determining if the insurer has been prejudiced by late notice is whether the insurer has suffered an adverse change in position due to the delay." *Id.* at 296.

4. Evidentiary Issues

a. California

The California Supreme Court has held that an insurer must prove that it suffered prejudice as a result of the insured's delayed notice in order to deny coverage based on the insured's failure to provide timely notice. *DiMugno* at §59:12; *Campbell v. Allstate Ins. Co.*, 60 Cal. 2d 303, 307 (Cal. Ct. App. 1963).

Additionally, the California Court of Appeal has explained that "Prejudice does not arise merely because a delayed or late notice has denied the insurance company the ability to contemporaneously investigate the claim or interview witnesses." The burden is on the insurer to show that, but for the delay in making a prompt investigation and in hiring an attorney at an early stage, there was a substantial likelihood that the insurer could have achieved a better result in the underlying action. *DiMugno* at *Id.*; *Northwestern Title Security Co. v. Flack*, 6 Cal. App. 3d 134, 142 (Cal. Ct. App. 1970).

b. Illinois

A lengthy delay in giving notice does not necessarily result in forfeiture of coverage. *See, e.g., West Am. Ins. Co. v. Yorkville Nat'l Bank*, 939 N.E.2d 288, 294-95 (Ill. 2010) ("With regard to the insured's diligence in ascertaining whether coverage is available, a lengthy delay in providing notice is not an absolute bar to coverage provided the insured's reason for the delay is justifiable under the circumstances."); *N. Ins. Co. of N.Y. v. City of Chicago*, 759 N.E.2d 144, 149 (2001) ("insured who knows a suit against it exists but allows considerable length of time to pass before notifying insurer does not automatically lose coverage"). Illinois courts have recognized that an insured's reasonable belief of noncoverage under a policy may be an acceptable excuse for the failure to give timely notice, even where the delay is lengthy. *See, e.g., Allstate Ins. Co. v. Carioto*, 551 N.E.2d 382 (1990) (2 ½-year delay excused because 19-year-old insured could not have reasonably known that the occurrence would have been covered by his mother's homeowner's policy); *Grasso v. Mid-Century Ins. Co.*, 536 N.E.2d 977

(1989) (two-year delay excused because insured did not reasonably believe that an accident in her boyfriend's Jeep was covered by her father's excess coverage insurance policy); *Brotherhood Mut. Ins. Co. v. Roseth*, 532 N.E.2d 354 (1988) (two-year delay excused because insureds did not reasonably believe that an accidental shooting that occurred outside their home would be covered by their homeowner's policy). In *Zurich Insurance Co. v. Walsh Construction Company of Illinois, Inc.*, 816 N.E.2d 810 (Ill. App. Ct. 2004), for example, the insured did not put Zurich on notice of the claim until five and a half years after the injury and three and a half years after litigation had commenced because it thought its claim would be covered under its Reliance policy. As the Zurich CGL policy contained an endorsement providing that its coverage was excess to any available "wrap-up" coverage, the court found that the insured's delay was justifiable despite the lengthy delay. The court ruled that the notice was "as soon as practicable" since there was no reason that a reasonably prudent person would have foreseen that the Zurich policy would become involved owing to the fact that it was originally excess to the Reliance policy until it became insolvent.

Illinois courts appear, however, unlikely to excuse ignorance as to the availability of coverage where the insured is a sophisticated business and has the ability to consult with counsel if it had chosen to do so. The Illinois Appellate Court ruled in *Northbrook Property & Casualty Insurance Co. v. Applied Systems, Inc.*, 729 N.E.2d 915 (Ill. App. Ct. 2000), that a trial court did not err in ruling that a computer software manufacturer failed to give timely notice of a competitor's copyright infringement suit. The First District ruled that the insured's two-year delay in providing notice was not justified by either the insured's subjective belief that it was not covered for intentional torts or alleged realization that coverage might apply after the plaintiff issued a third request for production of documents seeking information concerning the insured's marketing of the infringing software. The court ruled that the insured was a commercially sophisticated business represented by counsel that had failed to act as a reasonably prudent insured in assuming that there was no insurance coverage and failing to give notice of the plaintiff's suit to Northbrook. According to the court, if the insured had not understood the scope or availability of insurance coverage, it could easily have consulted with someone more expert in such matters.

c. Nevada

Under Nevada law, in order for an insurer to deny coverage of a claim based on the insured party's late notice of that claim, the insurer must show: (1) that the notice was late; and (2) that it has been prejudiced by the late notice. Prejudice exists "where the delay materially impairs an insurer's ability to contest its liability to an insured or the liability of the insured to a third party." *Coregis Ins. Co.* at 965.

d. New York

The New York Court of Appeals has yet to construe the prejudice requirement under the new law. The statute, however, offers some guidance in Section 3420(c)(2)(C) where it states the following:

(C) The insurer's rights shall not be deemed prejudiced unless the failure to timely provide notice materially impairs the ability of the insurer to investigate or defend the claim.

N.Y. INS. LAW § 3420(c)(2)(C) (McKinney 2011). Under New York's common law, this kind of showing of material impairment of an insurer's ability to investigate and defend would seem nonsensical or at least repetitive since prior to the abrogation of the "no-prejudice rule," New York courts consistently held that "the failure to provide timely notice" of an occurrence, by itself, was "a material breach of the insurance contract, and vitiates coverage." *QBE Ins. Corp. v. Adjo Contracting Corp.*, No. 601695/2009,

2011 WL 3505475 (N.Y. Sup. Ct. April 5, 2011). Furthermore, part of the rationale in maintaining the “no-prejudice” rule was the inherent prejudice the New York Courts found in untimely notice. In 2005 (prior to the current statute), New York’s highest court held that the “no-prejudice” rule should apply to late notice of claims and stated the following:

The rationale of the no-prejudice rule is clearly applicable to a late notice of lawsuit under a liability insurance policy. A liability insurer, which has a duty to indemnify and often also to defend, requires timely notice of lawsuit in order to be able to take an active, early role in the litigation process and in any settlement discussions and to set adequate reserves. *Late notice of lawsuit in the liability insurance context is so likely to be prejudicial to these concerns as to justify the application of the no-prejudice rule.*

Argo Corp. v. Greater N.Y. Mut. Ins. Co., 827 N.E.2d (N.Y. 2005) (emphasis added). Given the Court’s pre-statute stance on the inherent prejudice of untimely notice, it seems that the evidence required to prove prejudice would not be too onerous.

The lower courts have been reluctant to find prejudice even when insureds have not given notice until after default judgment has been entered or a motion for default judgment has been filed. In *American Transit Ins. Co. v. Hashim*, the court held that the insurer had not demonstrated prejudice despite the fact that the insurer received notice of the underlying action after a motion for default judgment was made but before the hearing on the motion for default judgment. 892 N.Y.S. 2d 78, 79 (N.Y. App. Div. 1st Dept. 2009). The insurer “could have appeared, opposed the motion, and filed for leave to file a late answer, but pursued none of these options.” *Id.* at 78-79. Similarly, in *Cifuentes v. Penn-Am. Group, Inc.*, No. 111613/05, 2010 WL 1945733, 910 N.Y.S.2d 761 (N.Y. Sup. Ct. March 26, 2010) (not selected for publication), the court held that the insurer had not suffered prejudice as a matter of law as the undisputed evidence demonstrated that, although the insurer’s first notice of the lawsuit was after default judgment had been entered, the insurer had sufficient opportunity to move to vacate the default. *Id.* at *5.

e. Texas

An insurer cannot prove prejudice based on speculative and conclusory assertions. “Courts finding prejudice have done so based on evidence of prejudice actually sustained, not on merely speculative or potential prejudice. . . . In such cases, prejudice was not presumed, but demonstrated.” *Coastal Refining*, 218 S.W.2d at 289; *see also Lianetz v. St. Paul Guardian Ins. Co.*, 2008 WL 2815561, at *3 (N.D. Tex. July 23, 2008) (finding that the insurer’s “speculative and conclusory assertions”—that timely notice would have allowed the insurer to assist in its insured’s defense and then in a subrogation recovery—“are insufficient to establish prejudice as a matter of law”).

In *Coastal Refining*, the insured gave its insurer notice over a year after the lawsuit had been filed and less than a month before trial. Nonetheless, the insurer was unable to provide sufficient evidence that it “actually sustained” prejudice. According to the court, the insurer “produced no evidence that the investigation and litigation by [the insured’s] attorneys was deficient, or that its own investigation was otherwise impaired by the delayed notice. . . . [The insurer] also failed to establish that, as a matter of law, [the insured’s] delayed notification prevented [the insurer] from defending the suit or controlling settlement negotiations after notice was received.” *Coastal Refining*, 218 S.W.2d at 292; *see also McGinnis v. Union Pacific R. Co.*, 612 F. Supp. 2d 776, 811 (S.D. Tex. 2009) (“To the extent that Lloyd’s suggests that its inability or failure to obtain a smaller settlement, or more favorable settlement,

constitutes prejudice sufficient to relieve an insurer of its duty to defend or indemnify its insured, any such assertion would not suffice to establish prejudice”).

In *East Texas Medical Center Regional Healthcare System v. Lexington Ins. Co.*, No. 6:04-CV-165, 2007 WL 2048660 (E.D. Tex. July 12, 2007), the insured gave its insurer written notice of a medical malpractice suit seven months after the suit was filed, 3 months before the court entered a partial motion for summary judgment on negligence, and one year before settlement. Over the insured’s objection, the trial court refused to submit a jury instruction on prejudice. After a jury trial in which the jury found for the insured on all claims, the trial court granted the insurer’s motion for judgment notwithstanding the verdict, holding that this notification was not “as soon as practicable” as required by the policy.

The Fifth Circuit upheld the trial court’s judgment that notice did not meet the policy requirements as a matter of law, but remanded to the Court for a finding of whether or not the insurer had been prejudiced. *East Texas Medical Center Regional Healthcare System v. Lexington Ins. Co.*, 575 F.3d 520, 528 (5th Cir. 2009).

On remand the trial court surveyed several Texas and federal court cases applying Texas law, and from those set out a three factor test for determining whether an insurer had suffered prejudice:

- (1) what rights [the insurer] had under the policy and whether they were lost due to [the insured’s] untimely notice;
- (2) whether [the insurer] has produced evidence that it would have exercised those rights; and,
- (3) whether [the insurer’s] summary judgment evidence establishes a fact issue that its putative actions would have impacted the outcome of the [late-noticed] lawsuit.

East Texas Medical Center Regional Healthcare System v. Lexington Ins. Co., No. 6:04-CV-165, 2011 WL 773452, *7 (E.D. Tex. Feb. 25, 2011). For the first factor the insurer argued that the right lost due to the untimely notice was the “right to participate.” The court held that in this instance, the only opportunity that the insurer “actually lost” was the ability to participate in the depositions of certain nurses who had admitted to the negligence of the insured in their depositions. *Id.* at *9. Because the insurer did not plan on participating in any of the other depositions post-notice and the insurer did not have a general practice of prospectively participating in depositions, the court voiced skepticism as to whether evidence existed to support a finding on the second factor - that the insurer would have exercised its right of involvement in the nurse’s depositions. However, it is the third factor that ultimately led the court to hold that the insurer could not prove prejudice as a matter of law. The court noted that even if the insurer had exercised its right to assist in the nurses’ deposition prep, insufficient evidence existed that the nurse’s testimony regarding negligence would have been more favorable with better preparation. As further support of its holding, the court also noted that any inconsistencies in the nurses’ depositions could have been briefed to the court post-notice since the insurer received notice before summary judgment.

In *Trumble Steel Erectors, Inc. v. Moss*, 304 Fed. App’x. 236 (5th Cir. Dec. 15, 2008) (not selected for publication in the Federal Reporter) (Texas law), the Fifth Circuit observed that a showing of prejudice requires ““more than the mere fact that [the insurer] cannot employ its normal procedures in investigating and evaluating the claim.”” *Id.* at 244. According to the court,

Evidence of an inability to investigate when and in the manner that an insurer would have liked merely creates the possibility that prejudice could occur. Yet, inability to investigate—even if that investigation involves specialized techniques such as shock-loss—does not in itself constitute material prejudice. Without more specific evidence regarding the prejudice that arose from the insurer’s inability to investigate, courts are powerless to bridge the gap between the creation of an environment in which prejudice could occur and the requisite prejudice showing.

Id. The court found the following facts sufficient to defeat the insurer’s prejudice defense as a matter of law: (1) the insurer had access to extensive investigations performed by three other entities; (2) the insurer pointed to no significant deficiencies in those investigations other than that they were presumably objective rather than aimed at decreasing liability; (3) the insurer received notice in the relatively short time of three months after the accident and had sufficient time to conduct discovery, settlement negotiations, and independent, albeit delayed, investigation; and (4) at his deposition, the insurer’s risk coordinator was unable to offer a clear indication of how a “shock-loss” investigation would have improved on the existing investigation information. *Id.* at 244. The insurer’s evidence that delayed notice deprived it of “lost opportunities to engage in early settlement talks, to attempt to persuade others to accept responsibility, and to perform its own investigation immediately” were inadequate to defeat the insured’s motion for summary judgment. *Id.*

One Texas federal court has held that an insurer can prove prejudice *only* under the following circumstances: (1) when the insurer, without notice or actual knowledge of suit, receives notice after entry of default judgment against the insured; (2) when the insurer receives notice of the suit and the trial date is fast approaching, thereby depriving it of an opportunity to investigate the claims or mount an adequate defense; (3) when the insurer receives notice of a lawsuit after the case has proceeded to trial and judgment has been entered against the insured; and (4) when the insurer receives notice of a default judgment against its insured after the judgment has become final and nonappealable. *St. Paul Guardian Ins. Co. v. Centrum G.S. Ltd.*, 383 F. Supp. 2d 891, 902 (N.D. Tex. 2003) (insurer failed to cite to any “cases in which a Texas court has held that an insurer’s inability or failure to obtain a smaller settlement, or more favorable settlement, constitutes prejudice sufficient to relieve an insurer of its duty to defend or indemnify its insured”); *but see Washington Mut. Bank v. Commonwealth Land Title Ins. Co.*, 2010 WL 135685, *3 n. 2 (Tex. App.—Corpus Christi January 14, 2010) (“[T]he critical question is whether Commonwealth was ‘denied the opportunity to answer for the insured, to litigate the merits of the suit, to appeal any adverse judgment against the insured, and to otherwise minimize the insured’s liability.’”).

Recently, in a case from the Western District of Texas, an excess insurer argued that it suffered prejudice under the third circumstance listed in the *St. Paul Guardian Insurance Company* case since it received its first written notice after judgment. *Berkley Regional Ins. Co. v. Philadelphia Indem. Ins. Co.*, No. A-10-CA-362-SS (April 27, 2011) [Dkt. 71] (mem. op.). In *Berkley*, the insured had two insurance policies that potentially covered its liability for a personal injury suit. The first company (Nautilus) provided primary liability insurance with a limit of \$1,000,000 per occurrence; whereas, the second company (Philadelphia) provided excess insurance with a coverage limit of \$20,000,000. The jury found against the insured, and after a fruitless appeal, the insured faced a judgment in excess of \$2 million. When the insured demanded payment from Philadelphia, it refused to pay, claiming that though the suit had been filed in February 2005, the insured did not give Philadelphia notice until October 2006. *Berkley Regional Ins. Co.*, No. A-10-CA-362-SS (April 27, 2011) [Dkt. 31], Ex. 14 at 1-2 (Philadelphia’s denial letter).

The court held that this situation was different than the third circumstance discussed in *St. Paul* because in that case, the court was “discussing situations in which the insured failed to notify its *primary insurer*; thus failure to notify in a timely fashion resulted in either no defense to the insured, or a defense based on completely inadequate investigation and preparation.” *Berkley Regional Ins. Co.*, No. A-10-CA-362-SS [Dkt. 71] at 20 (emphasis added). In this case the *Berkley* court held that Philadelphia could not prove prejudice because (1) the insured *did* give sufficient notice to Nautilus, its primary insurer, (2) no evidence existed that Nautilus’ defense was in any way compromised by the alleged late notice to Philadelphia, (3) all settlement discussion prior to trial were within Nautilus’s policy limits, and (4) Philadelphia’s argument that it “*might* have intervened in [the insured’s] defense, and it *might* have defended on a different theory, which theory *might* have been successful” was too attenuated to demonstrate prejudice. *Id.* at 21.

1. Prejudice as a Matter of Law

a. California

A federal court in California held that a post-trial tender was prejudicial as matter of law where the insured was aware of coverage and chose not to contact **the** insurer until after **the** trial, depriving the insurer of the opportunity to hire defense counsel at lower hourly rates, to seek reimbursement of defense costs on noncovered claims, and to show policy exclusions applicable (i.e., intentional injury and business operations exclusions). Cal. Prac. Guide Ins. Lit. Ch. 7A-L, 7:411.2 *citing Earle v. State Farm Fire & Cas. Co.*, 935 F. Supp. 1076, 1080 (N.D. Cal. 1996) (applying CA law).

b. Illinois

Illinois courts have found prejudice to be established as a matter of law under circumstances preventing the insurer from participating in the underlying lawsuit, including when the insurer received notice after: (1) default judgment had been entered against the insured; (2) a proof hearing had been held on the issue of damages; and (3) the underlying court has denied two efforts by the insurer to vacate the default judgment. *See Auto-Owners Ins. Co. v. Xtreme Auto Sales, Inc.*, No. 08-C-6608 (N.D. Ill. Feb. 7, 2011); *see also Vega v. Gore*, 730 N.E.2d 587, 589-90 (Ill App. Ct. 2000) (holding that an insurer may demonstrate prejudice when it does not receive notice of a suit until after a default judgment is entered); *Am. Country Ins. Co. v. Cash*, 524 N.E.2d 1016, 1018 (Ill. App. Ct. 1988) (holding that failure to inform insurance company of default judgment until after it had been entered constituted breach of notice provision).

c. Nevada

As noted above, under Nevada law, the question of whether an insurer is prejudiced by an insured’s late notice is a question of fact on which an insurer has the burden of proof. *Coregis Ins. Co.* at 965. In order for an insurer to deny coverage of a claim based on the insured party’s late notice of that claim, the insurer must show: (1) that the notice was late; and (2) that it has been prejudiced by the late notice. Prejudice exists “where the delay materially impairs an insurer’s ability to contest its liability to an insured or the liability of the insured to a third party.” *Id.*

d. New York

Under New York law, “an irrebuttable presumption of prejudice shall apply if, prior to notice, the insured’s liability has been determined by a court of competent jurisdiction or by binding arbitration; or if

the insured has resolved the claim or suit by settlement or other compromise.” N.Y. INS. LAW § 3420(a)(5) (McKinney 2011).

e. Texas

According to a recent opinion from the Corpus Christi court of appeals, “the crucial inquiry in determining whether an insurer was prejudiced as a matter of law is whether the insurer’s ability to defend against the claim has been irreparably impaired by an insured’s failure to comply with a notice-of-suit provision.” *Washington Mut. Bank*, 2010 WL 135685, at *3. “And whether an insurer has suffered such an impairment depends largely on the extent to which the insured defended against the claim before judgment was entered and became final and nonappealable.” *Id.*

Courts have generally held that an insurer is “irreparably impaired” as a matter of law when the insurer receives its first notice of a claim after entry of judgment. *See, e.g., Harwell v. State Farm Mut. Auto. Ins. Co.*, 896 S.W.2d 170, 174 (Tex. 1995) (holding that “[t]he failure to notify an insurer of a default judgment against its insured until after the judgment has become final and nonappealable prejudices the insurer as a matter of law”); *see also Windham v. Assurance Co. of America*, 2009 WL 2195898 (N.D. Tex. July 23, 2009) (“Although the appropriate time period for notice will generally vary with the facts of each case, Texas courts appear to agree that notice given after judgment has been entered is not timely notice.”); *St. Paul Guardian Ins. Co.*, 383 F. Supp. 2d at 903 (“Under such circumstances, Texas courts will hold that prejudice exists and that the insurer has no duty to defend or indemnify its insured.”).

One case stands in stark contrast to this general rule. In *Gibbons-Markey v. Tex. Med. Liab. Trust*, 163 Fed. Appx. 342, 344-46 (5th Cir. 2006), the insured failed to notify the insurer of a suit until five months after the entry of a default judgment. The insured contended that it was not properly served and was therefore unaware of the suit until the deadlines for filing a motion for new trial and an ordinary appeal had passed. Based on these facts, the Fifth Circuit refused to allow forfeiture of the insured’s coverage. In determining whether the insurer “suffered an adverse change in position due to the delay,” the court observed that at the time of the notice the insurer still had the ability—if not the duty—to set aside the default judgment through a bill of review.² “We find that, on these facts, TMLT has not succeeded in showing that it was prejudiced during the time between Gibbons-Markey discovery of the defective-service default and the time she notified TMLT so as to relieve it of the duty to seek the viable post-judgment relief still available at the time of notice.” *Id.* at 346.

E. Waiver of Late Notice Defense

1. California

Under California law, an insurer’s denial of coverage is ordinarily deemed a waiver of the defense that the policy’s notice provision has been breached. *DiMugno* at §59:15; *Wasson v. Atlantic Nat. Ins. Co.*, 207 Cal. App. 2d 464, 469 (Cal. Ct. App. 1962) (disapproved of on other grounds by *Campbell v. Allstate Ins. Co.*, 60 Cal. 2d 303 (Cal. 1963)). Additionally, an insurer’s failure to object to

² “Even if the language of a policy requiring an insurer ‘to defend any lawsuit’ against the insured does not explicitly require an insurer to seek post-judgment relief, it is illogical to suppose that the word ‘defense’ relates only to the trial of the action and does not embrace such relief.” *Gibbons-Markey*, 163 Fed. App’x at 346 (citing to 22 Eric M. Holmes, HOLMES’ APPLEMAN ON INSURANCE § 136.11 (2d ed.2003) (“recognizing that, by that reasoning, an appeal is likewise not a ‘defense’ by definition but is nonetheless, in some circumstances, encompassed within an insurer’s duty to defend”)).

the format and/or timing of the notice by the insured may constitute a waiver of the late notice defense. DiMugno at *Id.*; *Dickinson v. General Electric Acc. Fire & Life Assur. Corp.*, 147 F. 2d 396 (C.C.A. 9th Cir. 1945); see also *Lagomarsino v. San Jose Abstract & Title Ins. Co.*, 178 Cal. App. 2d 455, 459-60 (Cal. Ct. App. 1960).

2. Illinois

Under Illinois law, an insurer that fails to either defend its insured or file a declaratory action potentially waives all rights to assert the policyholder's failure to comply with the notice provision. See *Uhlich Children's Advantage Network v. Nat'l Union Fire Ins. Co. of Pittsburgh*, 929 N.E.2d 531 (Ill. App. Ct. 2010) (petition for leave to appeal denied by the Illinois Supreme Court on May 26, 2010); *Sullivan House, Inc. v. Fed. Ins. Co.*, 2008 WL 410208 (N.D. Ill. Feb. 7, 2008) (NO. 07 C 1774).

In *Uhlich*, a former employee of Uhlich Children's Advantage Network (UCAN) filed a charge with the EEOC alleging discrimination and then later sued UCAN in federal court. At the time of the initial claim, UCAN was insured under a claims-made and reported policy issued by National Union. *Uhlich*, 929 N.E.2d at 534. The policy required that notice be given "as soon as practicable" either during the policy period or within 30 days after the end of the period. *Id.* at 535. UCAN gave notice to National Union after its policy had expired and, National Union denied coverage. The Illinois appellate court noted that National Union had two options when it received UCAN's claim: (1) defend under a reservation of rights letter or (2) file a declaratory judgment action.³ *Id.* at 537, 542. An outright denial of coverage on the basis of late notice is not an option. Since there was potential for coverage under the policy, and National Union failed to defend under a reservation of rights or to file a declaratory judgment, the Court found that National Union was estopped from asserting late notice as a defense. *Id.* at 543. Thus, even though UCAN's notice was given after the expiration of the policy, National Union owed UCAN coverage under the policy. *Id.*

Similarly, in *Sullivan House*, the insurer (Federal) had issued a claims-made Employers Liability Policy to its insured (Sullivan House). *Sullivan House*, 2008 WL 410208 at *1, 4. An employment-related claim was made against Sullivan House during the policy period, but Sullivan House failed to report the claim to Federal until two years after the policy had expired and two and a half years after the claim was made. *Id.* at *2. Federal denied coverage based on Sullivan House's failure to comply with the Policy's notice provisions. *Id.* Similar to the claims-made Professional Liability Policy issued to Plaintiffs, the Federal policy made "written notice as soon as practicable" a condition precedent to coverage. *Id.* Relying on the same Illinois Supreme Court case addressed in the *Uhlich* case, the court held that Federal was required to either defend the employment case under a reservation of rights or seek a declaratory judgment that there was no coverage. *Id.* at *3. Since it chose neither option, Federal was estopped from asserting the defense of late notice. *Id.*

3. Nevada

The Nevada Supreme Court has held that an insurer does not waive its late notice defense when it denies a claim on other grounds provided that the insurer asserts its late notice defense in its initial denial letter. See *Coregis* at 961.

³ The court based its holding on the Illinois Supreme Court's decision in *Employers Insurance of Wausau v. Ehlo Liquidating Trust*, 708 N.E.2d 1122 (Ill. 1999).

4. New York

An insurer's late disclaimer will estop it from denying coverage on the grounds of late notice. See *QBE Ins. Corp. v. Adjo Contracting Corp.*, No. 601695/2009, 2011 WL 3505475, at *12 (N.Y. Sup. Ct. April 5, 2011) (citing *First Fin. Ins. Co. v. Jetco Contracting Corp.*, 1 NY3d 64, 67 (N.Y. 2003)) (holding that insurer's unexcused delay of 48 days in giving notice of denial based on late notice of insured precluded an effective disclaimer of coverage because such delay was unreasonable as a matter of law); *Hunter Roberts Const. Group, LLC v. Arch Ins. Co.*, 75 A.D.3d 404 (N.Y. App. Div. 1st Dep't 2010)). As one court explained, "[s]uch a reason for disclaimer would have been apparent upon examination of [insureds'] tenders," thereby making any delay in denying the claim an unreasonable delay as a matter of law. *Hunter Roberts Const. Group, LLC*, 75 A.D.3d at 409. Thus, for example, in *Hunter Roberts Construction Group, LLC v. Arch Insurance Company*, even though the insured had notified the insurer of its claims 10 months after learning of it and potentially not "as soon as practicable" as required by the policy, the insurers' failure to issue a denial until 4 months after receiving notice estopped the insurer from denying the claim on the grounds of late notice. *Id.*

Similarly, an insurer forever waives the defense of late notice by not asserting late notice in its initial denial of coverage letter. See *QBE Ins. Corp.*, No. 601695/2009, 2011 WL 3505475, at *12. In *QBE Insurance Corporation*, the insurer in its first denial letter of September 2008 disclaimed coverage on various grounds, but not on the ground of late notice. *Id.* Four months later, the insurer issued another denial letter citing late notice as an additional reason for denial. *Id.* The court held that the insurer had waived late notice as a ground to deny coverage because after disclaiming coverage, it could not "thereafter attempt to create other grounds for refusal to pay by demanding compliance by the insured with other incidental provisions of the policy with which it had not demanded compliance prior to its repudiation of liability." *Id.* (citing *Beckley v. Otsego County Farmers Co-op. Fire Ins. Co.*, 3 A.D.2d 190, 194 (N.Y.A.D. 3d Dep't 1957)).

5. Texas

An insurer may be precluded from arguing a late notice defense where it would have denied coverage regardless of the timing of notice. In *Bay Electric Supply Inc. v. Travelers Lloyds Insurance Company*, 61 F. Supp. 2d 611, 620 (S.D. Tex. 1999), the court held that an insurance company, which would have denied coverage regardless of the timing of notice, could not prove prejudice as a matter of law. However, *Bay Electric* has been distinguished by another federal judge in the Southern District of Texas on the grounds that the defendant insurer in *Bay Electric* (Travelers) did not premise its denial of coverage on late notice, and the insured in that case waited only five months to provide notice to Travelers. See *New Era of Networks, Inc. v. Great Northern Ins. Co.*, 2003 WL 23575897, *7 (S.D. Tex. Aug. 4, 2003). According to the *New Era of Networks* decision, an insurer that clearly and consistently maintains late notice as a defense would not be precluded from proving prejudice even if it would have denied the claim on other grounds.

An insurer may also waive its late notice defense—as well as other policy conditions—if it breaches its duty to defend or wrongfully denies coverage. See *McGinnis v. Union Pacific R. Co.*, 612 F. Supp. 2d 776, 811 (S.D. Tex. 2009) ("Furthermore, another consequence of a breach of the duty to defend is the inability to enforce against the insured any conditions in the policy"); *Gulf Ins. Co. v. Parker Prods., Inc.*, 498 S.W.2d 676, 679 (Tex. 1973) ("The insurance company may ordinarily insist upon compliance with this condition for its own protection, but it may not do so after it is given the opportunity to defend the suit or to agree to the settlement and refuses to do either on the erroneous ground that it has no responsibility under the policy.").

F. Claims-Made Policies—The Prejudice Rule May Also Apply

1. California

Under California law, the notice-prejudice rule does not apply to policies requiring that claims be both made and reported to the insurer during the policy period. Under such policies, notice to the insurer during the policy period is an express condition precedent to coverage. The issue is not one of failure to give timely notice, but rather that there is no covered loss until notice of the underlying claim is given. Cal. Prac. Guide Ins. Lit. Ch. 7A-L, 7:412.1; *Helmand v. National Union Fire Ins. Co. of Pittsburgh, PA*, 10 Cal. App. 4th 869, 888 (Cal. Ct. App. 1992).

2. Texas

Prior to the summer of 2009, both Texas state court and Fifth Circuit cases firmly held that an insurer need not show prejudice when an insured provides untimely notice under a claims-made policy. See, e.g., *Fed. Ins. Co. v. CompUSA, Inc.*, 319 F.3d 746, 754-55 (5th Cir. 2003); *Hirsch v. Tex. Lawyers Ins. Exch.*, 808 S.W.2d 561, 565 (Tex. App.—El Paso 1991, writ denied). Then the Texas Supreme Court changed the rules. In *Prodigy Communications Corp. v. Agricultural Excess & Surplus Ins. Co.*, 288 S.W.3d 374 (Tex. 2009), and its companion case *Financial Industries Corp. v. XL Specialty Ins. Co.*, 285 S.W.3d 877 (Tex. 2009), the Texas Supreme Court confronted the issue of whether an insurer must demonstrate prejudice to deny coverage under a claims-made policy based on an insured's breach of the "as soon as practicable" notice condition. The court held that, in the absence of prejudice to the insurer, the insured's failure to comply with the "as soon as practicable" provision does not defeat coverage.

The *Prodigy* case dealt with a claims-made-and-reported policy. A claims-made-and-reported policy limits coverage to only those claims that were made *and reported* during the policy period (or within a limited time thereafter if the contract so provides), no matter when the underlying event occurred. Since reporting during the policy period is the *sin qua non* of coverage in a claims-made-and-reported policy, notice within the policy period is considered material. See *Prodigy Communications Corp. v. Agricultural Excess & Surplus Ins. Co.*, 288 S.W.3d 374, 381 (Tex. 2009) ("Because the requirement that a claim be reported to the insurer during the policy period or within a specific number of days thereafter is considered essential to coverage under a claims-made-and-reported policy, most courts have found that an insurer need not demonstrate prejudice to deny coverage when an insured does not give notice of a claim within the policy's specified time frame."). However, a claim that is reported during the policy period but not "as soon as practicable" should not defeat coverage—unless the insurer can show it has been prejudiced by the insured's untimely notice. According to the *Prodigy* court, if late notice occurs during the policy period, the insurer does not lose the principal benefit of the claims-made policy. Therefore, unless the insurer is able to demonstrate that it has otherwise been prejudiced, the insured's breach will not be considered material.

The *Prodigy* court distinguished between a claims-made and a claims-made-and-reported policy for purposes of requiring notice within the policy period. The Court equated a claims-made policy—with "as soon as practicable" notice—to an occurrence policy that does not limit notice to the policy period and requires a showing of prejudice by the insurer. *Prodigy*, 288 S.W.2d at 379. The timing of when the "claim" itself is made against the insured is material to this coverage, not when the claim is reported to the insurer. Thus, following *Prodigy* to its logical conclusion, an insured under a claims-made policy

should not forfeit coverage for late notice *outside of the policy period* as long as (1) the claim was asserted against the insured during the policy period, and (2) the insurer is unable to show prejudice.⁴

A leading insurance treatise agrees that the prejudice requirement should be extended to notice—whether during or outside of the policy period—under a claims-made policy:

The prejudice requirement should, however, be applicable with regard to the notice given under a claims-made policy. Under both types of claims-made policies, no coverage exists unless a claim is first made against the insured during the policy period. The difference is that in a claims-made policy—like an occurrence type policy—timely notice constitutes one of the policy conditions to *retaining* the coverage that otherwise exists under the policy’s insuring clause; timely notice is not one of the *prerequisites* to the creation of coverage under the insuring clause. As a result, there is no reason why the prejudice requirement that courts have “written in” to the notice condition in occurrence policies would not be similarly “written in” to the notice condition in a claims-made policy.

Windt, INSURANCE CLAIMS AND DISPUTE § 1.7 n. 3.1 (4th Ed. 2004).

Since *Prodigy* and *XL Specialty*, a case out of the Northern District of Texas has applied this new principle of law to a claims-made policy, requiring an insurer to show prejudice even though it was undisputed that the insured had given notice twenty-seven days after the expiration of the policy. *Evanston Ins. Co. v. Keeway Am., LLC*, No. 3:09-CV-1115-M, 2010 WL 2652330, *3 (N.D. Tex. June 29, 2010) (slip op.). The insurer argued that it had suffered prejudice “because it was not able to close its books after the end of the policy period” and the insured’s failure to report the claim “impacted the rating of premiums for the Policy itself, as well as the calculation of premiums for a renewal quote provided to [the insured].” *Id.* Relying on *St. Paul Guardian Insurance Company*, discussed above, the court held that the insured had not pled one of the four types of actionable prejudice. *Id.* The court also noted that no evidence existed that the insured had issued a new inaccurately priced policy, and thus had sustained no actual prejudice.

G. Additional Insured Issues & Notice From Other Sources

1. California

Under California law, if the insurer is aware of facts giving rise to a duty of inquiry, it cannot complain about the lack of formal notice from the insured. California courts have held that there is no possibility of prejudice to the insurer under such circumstances. Cal. Prac. Guide Ins. Lit. Ch. 7A-L, 7:414; *See Moe v. Transamerica Title Ins. Co.*, 21 Cal. App. 3d 289, 302 (Cal. Ct. App. 1971).

⁴ In its *XL Specialty* opinion, the Supreme Court was presented with an opportunity to offer guidance on whether the prejudice requirement extends generally to a claims-made (not a claims-made-and-reported) policy where notice is given *outside* of the policy period. Unlike the *Prodigy* policy, *XL*’s claims-made policy required only that notice of a claim be given “as soon as practicable”—it did not contain a clear-cut reporting deadline. The Court chose not to address this issue—like the insured in *Prodigy*, the insured in *XL Specialty* had given notice within the policy period. Without distinguishing between the two types of claims-made policies, the Court repeated its earlier ruling that an insurer must show prejudice to deny payment on a claims-made policy “when the denial is based upon the insured’s breach of the policy’s prompt-notice provision, but the notice is given within the policy’s coverage period.” 285 S.W.3d at 289.

In *Wasson v. Atlantic Nat. Ins. Co.*, (1962) 207 Cal. App. 2d 464, the California Court of Appeal found that an additional insured's 13-month delay in giving notice was not untimely where he gave the notice to the insurer immediately after learning that he was qualified as an additional insured under the policy. DiMugno at §59:3; *Wasson* at 468 (disapproved of on other grounds by *Campbell v. Allstate Ins. Co.*, 60 Cal. 2d 303 (Cal. Ct. App. 1963)).

2. Illinois

Illinois courts do not appear to require strict compliance with a notice provision, including whether the insured itself must give notice of the claim to the insurer. In *West American Insurance Co. v. Yorkville National Bank*, 939 N.E.2d 288, 296 (Ill. 2010), the Illinois Supreme Court held that "where the insurance company has actual notice of the loss or receives the necessary information from some other source, there is no prejudice to the insurer from the failure of the insured to give notice of the claim." An insurance company is deemed to have "actual notice" of a lawsuit where it has sufficient information to locate and defend the suit. *Id.*; see also *Cincinnati Cos. v. W. Am. Ins. Co.*, 701 N.E.2d 499 (Ill. 1998); *Progressive Ins. Co. v. Universal Cas. Co.*, 807 N.E.2d 577 (Ill. App. Ct. 2004); *Federated Mut. Ins. Co. v. State Farm Mut. Auto. Ins. Co.*, 668 N.E.2d 627 (Ill. App. Ct. 1996).

Additionally, Illinois courts have ruled that it is not necessary that an insured give notice under a specific policy inasmuch as notice to the insurer is deemed to be notice under all policies issued by it to the policyholder. *Northbrook Prop. & Cas. Ins. Co. v. Applied Sys., Inc.*, 729 N.E.2d 915 (Ill. App. Ct. 2000); *Cas. Ins. Co. v. E.W. Corrigan Constr. Co.*, 617 N.E.2d 228, 233 (Ill. App. Ct. 1993)(notice of claim under worker's compensation policy also deemed to satisfy notice requirement under insurer's GL policy).

3. New York

Additional insureds have an implied duty, independent of the primary insured, to provide the insurer with the notices required under the policy. 23-08-18 *Jackson Realty v. Nationwide Mut. Ins. Co.*, 863 N.Y.S.2d 35, 36 (N.Y. App. Div. 2d Dep't 2008) (citations omitted). This is true even if the insurance policy only specifies that the named insured must provide notice. *Structure Tone, Inc. v. Burgess Steel Products Corp.*, 672 N.Y.S.2d 33, 34 (N.Y.A.D. 1st Dep't 1998). "The fact that an insurer may have received notice of the claim from the primary insured, or from another source, does not excuse an additional insured's failure to provide notice." 23-08-18 *Jackson Realty*, 863 N.Y.S.2d at 36-37 (quoting *City of New York v. St. Paul Fire & Mar. Ins. Co.*, 801 N.Y.S.2d 362, 366 (N.Y. App. Div. 2d Dep't 2005)).

However, where two or more insureds are defendants in the same action, notice of the occurrence or of the lawsuit provided by one insured will be deemed notice on behalf of both insureds where the two parties are united in interest or where there is no adversity between them. *Id.* at 37 (upholding denial of summary judgment additional insureds had failed to make a prima facie showing that were united in interest with the primary insured); but see also *Structure Tone, Inc.*, 672 N.Y.S.2d at 34 (holding that the notice of the primary insured did not constitute notice from additional insured, since additional insured took a position adverse to the primary insured in the underlying action). When looking at the united interest or adversity between the primary insured and the additional insured, the courts look at their relationship at the time notice is given. See *New York Tel. Co. v. Travelers Cas. & Sur. Co. of Am.*, 719 N.Y.S.2d 648, 648 (N.Y. App. Div. 1st Dep't 2001) (holding that the insureds interests were not adverse "at the time the summons and complaint were forwarded [to the insurer]").

The additional insured and the primary insured are not “united in interest” and adversity exists between them if they have asserted cross-claims against one another in the action for which they seek coverage. See *Time Warner Cable of New York City v Hylan Datacom & Elec., Inc.*, No. 0107798/2005, 2007 WL 2176562 (N.Y. Sup. Ct. April 13, 2007) (not selected for publication); *but see also 1700 Broadway Co. v. Greater New York Mut. Ins. Co.*, 863 N.Y.S.2d 434, 436 (N.Y. App. Div. 1st Dep’t 2008) (holding that the insureds interests were adverse at the time notice was given to insured “even though [the additional insured] and the primary insured had not yet formally served cross claims against each other” because the suit was for personal injury on a premises of which the additional insured was an “out-of-possession landlord” and the primary insured was a current tenant).

4. Texas

After the Texas Supreme Court’s decision in *Nat’l Union Fire Ins. Co. v. Crocker*, 246 S.W.3d 603 (Tex. 2008), additional insureds may no longer rely upon notice from other sources to satisfy their reporting obligations under a liability policy.

In *Crocker*, the Supreme Court was asked to decide whether an insurer’s actual knowledge of service on an additional insured established as a matter of law that the insurer *had not been prejudiced* by the additional insured’s failure to provide timely notice. The Court decided that actual notice of the claim does not prevent an insurer from showing prejudice. According to the Court:

Insurers owe no duty to provide an unsought, uninvited, unrequested, unsolicited defense. . . . Accordingly, because insurers need not provide coverage to additional insureds who never seek it, National Union had no duty either to inform Morris of available coverage or to voluntarily undertake a defense for him, and its actual knowledge did not establish lack of prejudice as a matter of law.

The Court also distinguished the facts and holding in *PAJ, Inc. v. Hanover Insurance Co.* (tardy notice of a covered claim will not defeat coverage unless the insurer was actually prejudiced by the delay) from those at issue in *Crocker*. The issue in *PAJ* was “whether a named insured’s untimely compliance with the notice-of-suit provision is excused if the delay inflicts no prejudice on the insurer,” whereas the additional insured’s notice in *Crocker* “was not merely late; it was wholly lacking. *PAJ*’s notice was tardy; Morris’s was nonexistent.” 246 S.W.3d at 609; *see also Maryland Cas. Co. v. American Home Assur. Co.*, 277 S.W.3d 107 (Tex. App.—Houston [1st Dist.] 2009, petition for review filed) (court applied *Crocker* and its progeny to find prejudice as a matter of law where subrogees of additional insured—claiming late disclosure of the policy providing additional insured coverage—failed to give notice to the insurer until after settlement, thus depriving the insurer of the opportunity to investigate or defend the claims made against the insured and review, consider and consent to the underlying settlement).

Crocker was extended by the Fort Worth Court of Appeals in *Jenkins v. State & County Mutual Fire Ins. Co.*, 287 S.W.3d 891 (Tex. App.—Fort Worth 2009, pet. denied). In *Jenkins*, the underlying claimant (Jenkins) suffered an injury when his foot was crushed after a tank skid fell from a truck negligently driven by Mark Lemmon, an insured driver under a business auto policy. Jenkins sued Lemmon and other insureds for negligence, obtaining service on all defendants except Lemmon. The served defendants timely notified State & County Mutual who agreed to defend. After Jenkins obtained service on Lemmon, Jenkins’ attorney informed the insurance company’s adjuster that service had been obtained on Lemmon and provided him with Lemmon’s suit papers. State and County nevertheless contended that Lemmon had not personally complied with the policy’s notice of suit condition. On the

basis of this technicality, and with full knowledge of the suit and service on its insured, the insurance company elected not to answer on behalf of Lemmon or otherwise provide a defense for him. The trial court thereafter rendered a default judgment against Lemmon.

On these facts, the Fort Worth Court determined that only an insured can provide effective notice of a claim in order to trigger an insurance company's duty to defend under a liability policy, and must specifically request a defense in order to obligate the insurance company to provide one. Even though the *claimant* fully complied with the policy's notice provision (providing notice, suit papers and proof of service), the *Jenkins* court nevertheless found the insurer was prejudiced as a matter of law because, no matter how timely, notice was not provided directly by the specific insured at issue, nor did that insured make a specific request for a defense.

III. The "Settlement Without Consent" Clause

A. Typical Policy Language

Duties In The Event Of Occurrence, Offense, Claim Or Suit

...

d. No insured will, except at their own cost, voluntarily make a payment, assume any obligation, or incur any expense, other than for first aid, without our consent.

See ISO Commercial General Liability Form, CG 00 01 12 07 (ISO Properties, Inc., 2006).

B. Prejudice is Required

1. California

California courts have found that a breach of the "no voluntary payments" provision in a liability policy typically occurs, if at all, before the insured has tendered its defense to the insurer; usually in the form of pretender fees and expenses paid to the insured's own counsel. Cal. Prac. Guide Ins. Lit. Ch. 7A-L, 7:439.5; *see also Truck Ins. Exch. v. Unigard Ins. Co.*, 79 Cal. App. 4th 966, 976 (Cal. Ct. App. 2000).

However, under certain circumstances, California courts have held that the "no voluntary payments" provision in a liability policy also applies to payments made by the insured after tender of the defense to the insurer. Cal. Prac. Guide Ins. Lit. Ch. 7A-L, 7:439.5; *see also Low v. Golden Eagle Ins. Co.*, 110 Cal. App. 4th 1532, 1546 (Cal. Ct. App. 2003).

Under California law, a voluntary payment by the insured in and of itself constitutes sufficient prejudice to the insurer. The insurer does not need to show other prejudice. Cal. Prac. Guide Ins. Lit. Ch. 7A-L, 7:439.10; *see also Jamestown Builders, Inc. v. General Star Indem. Co.*, 77 Cal. App. 4th 341, 350 (Cal. Ct. App. 1999)—no-voluntary-payment provision treated same as an exclusion; *Insua v. Scottsdale Ins. Co.*, 104 Cal. App. 4th 737, 746 (Cal. Ct. App. 2002)—"notice-prejudice rule" not applicable in evaluating denial of pretender costs; *Belz v. Clarendon America Ins. Co.*, 158 Cal. App. 4th 615, 627 (Cal. Ct. App. 2007).

2. Illinois

Under Illinois law, an insured breaches a “settlement-without-consent” or “voluntary payments” clause by settling a suit without the insurer’s consent. See *Myoda Computer Ctr., Inc. v. Am. Family Mut. Ins. Co.*, 909 N.E.2d 214, 218 (Ill. App. Ct. 2009). However, the general rule is that, to avoid liability for any such settlement, the insurer must demonstrate that it was prejudiced by the insured’s breach of the voluntary payments clause. See *Pekin Ins. Co. v. XData Solutions, Inc.*, No. 1-10-2769 (Ill. App. Ct. Sept. 30, 2011); *Westchester Fire Ins. Co. v. Heileman Brewing Co.*, 747 N.E.2d 955, 968 (Ill. App. Ct. 2001); *Commonwealth Edison Co. v. Nat’l Union Fire Ins.*, 752 N.E.2d 555, 567 (Ill. App. Ct. 2001); but see *Alliance Syndicate, Inc. v. Parsec*, 741 N.E.2d 1039, 1046 (Ill. App. Ct. 2000) (holding, without any discussion of a prejudice requirement, that where insurer was otherwise in compliance with the terms of the policy, insured violated voluntary payment provision by settling without insurer’s consent). To show prejudice, the insurer must demonstrate that either the decision to settle or the settlement amount was unreasonable. *Guillen v. Potomac Ins. Co. of Ill.*, 785 N.E.2d 1, 6 (Ill. 2003). In *Commonwealth Edison Co.*, for example, the Court held that the insurer could not avoid its duty to indemnify the insured despite the insured’s settlement without its consent where the record indicated that all the parties agreed that trial could result in a large jury verdict, that the settlement amount was reasonable, and that the insurer believed that the case should be settled. 752 N.E.2d at 567.

Notably, at least one Illinois court has suggested that breach of a policy’s voluntary payments provision is only a defense if the insured settled the case prior to tendering defense of the suit to the insurer. See *Myoda*, 909 N.E.2d at 218 (holding that insurer could not rely on voluntary payments clause as settlement took place *after* the insured tendered the matter to the insurer).

3. Nevada

It does not appear that the Nevada Supreme Court has yet construed a “no voluntary payments” provision under Nevada law. Nevertheless, in a case entitled, *Las Vegas Star Taxi, Inc. v. St. Paul Fire & marine Ins. Co.*, 714 P. 2d 562 (Nev 1986), the Nevada Supreme Court held that an insured’s decision to settle a lawsuit on its own without providing any prior notice of the settlement to its insurer and without the insurer’s consent violated the notice provisions under the policy. *Las Vegas Star Taxi, Inc.* at 562-564. If the Nevada Supreme Court were to apply a similar analysis to a “no voluntary payments” provision in a liability policy, the Nevada Supreme Court would likely conclude that a voluntary payment by an insured without the consent of its insurer violates the “no voluntary payments” provision in the policy.

4. New York

Under New York law, an insurance carrier “is not required to demonstrate prejudice to assert a defense of non-compliance” with a consent-to-settle provision. *New York Cent. Mut. Fire Ins. Co. v. Danaher*, 736 N.Y.S.2d 195, 197 (N.Y.A.D. 3d Dep’t 2002). In fact, some federal courts applying New York law have suggested that an insured’s failure to obtain consent before settlement will be strictly construed and will release the insured from contributing to settlement. See, e.g., *Sunham Home Fashions, LLC v. Diamond State Ins. Co.*, --- F. Supp. 2d ---, 2011 WL 3806129 (S.D.N.Y. 2011) (applying New York law) (holding without substantive discussion that insurers had no duty to reimburse insured for settlement amount when insured “[had] not shown that it made any attempt to notify [insurers] or obtain consent prior to entering settlement”).

5. Texas

It is well established under Texas law that an insured's failure to comply with a "settlement without consent" condition does not bar coverage unless the insurer suffers prejudice. See *Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691, 693-94 (Tex. 1994) (an insurer may not deny coverage based on a provision requiring the insurer's consent to settlement where the insurer failed to show prejudice); *Davis v. Allstate Insurance Company*, 945 S.W.2d 844, 845-46 (Tex. App.—Houston [1st Dist.] 1997, no pet.) ("when an insured breaches a settlement-without-consent clause in an insurance policy, the breach is material only if the insurer is prejudiced by the settlement"); *Comsys Information Technology Services, Inc. v. Twin City Fire Ins. Co.*, 130 S.W.3d 181, 192 (Tex. App.—Houston [14th Dist.] 2003, pet. denied) (stating insurer who failed to raise even an inference of collusion, fraud, or other connivance in the settlement agreement failed to prove prejudice from settlement without consent); *Lennar Corp. v. Great American Ins. Co.*, 200 S.W.3d 651, 690 (Tex. App.—Houston [14th Dist.] 2006, pet. denied) ("Texas law does not presume prejudice from 'settlement without consent' or lack of notice"); *Coastal Refining*, 218 S.W.3d at 295-26 (insurer's loss "of the opportunity to participate in the defense and settlement processes" does not constitute evidence of prejudice; the insurer did not come forward with proof that the claims were settled for an unreasonable amount or that it could have settled the suit for a lesser amount"); *Trumble Steel*, 304 Fed. App'x. at 244 (the mere fact that an insurer cannot employ its normal procedures in investigating and evaluating a claim is not proof that the insurer was prejudiced).

In *Coastal Refining & Marketing, Inc. v. Coastal Offshore Insurance Ltd.*, 218 S.W.3d 279, 281 (Tex. App.—Houston [14th Dist.] 2007, pet. denied), the insured notified its insurer of a lawsuit one month before trial and then settled the suit without the insurer's consent. The insurer filed suit seeking a declaration that it had no duty to indemnify the insured for the settlement because the insured had breached certain conditions of the policy, including the consent-to-settle clause. The trial court granted summary judgment for the insurer, but the court of appeals reversed.

On the consent-to-settle issue, the court observed that the insurer offered no proof of actual prejudice from the settlement but instead argued that the settlement was proof of prejudice as a matter of law because the settlement deprived the insurer "of the opportunity to participate in the defense and settlement processes and placed [the insurer] in the same posture as one who is presented with a final, appealable judgment and told to pay it." *Id.* at 295. The court noted that the insurer did not come forward with proof that the claims were settled for an unreasonable amount or that it could have settled the suit for a lesser amount. *Id.* at 296. On rehearing, the court reiterated that the insurer had failed to provide any proof of actual prejudice. *Id.*

The *Coastal Refining* court made it clear that prejudice is not presumed because an insurer was deprived of an opportunity to investigate a case or participate in settlement discussions:

If the abstract loss of the rights to investigate, defend, participate in, and control settlement negotiations were sufficient to show the necessary prejudice, then delaying notice to the primary insurer until after settlement would always result in forfeiture of coverage, because the settlement would necessarily foreclose the insurer's participation. But a review of the cases shows that Texas law does not presume prejudice merely from settlement without the insurer's consent.

Id. at 291 n. 14.

In *Ins. Co. of North Am. v. McCarthy Bros. Co.*, 123 F. Supp. 2d 373 (S.D. Tex. 2000), the court rejected the insurer's suggestion that it was prejudiced *per se* by the insured contractor's settling of a negligence suit brought by the owner by agreeing to make repairs before notifying its insurer of the suit. One of the factors found to be persuasive by the court was that the dispute involved a sophisticated commercial entity that actively attempted to limit its own liability, so that prejudice had not been shown. *Id.* at 379-80.

C. Prejudice as a Matter of Law

1. California

Under California law, an insurer's liability for pre-tender defense costs is a question of fact where an issue exists as to whether the payments were "voluntary" within the meaning of the voluntary payments provision in the policy. DiMugno at §58:3; *see also Fiorito v. Superior Court*, 226 Cal. App. 3d 433 (Cal. Ct. App. 1990).

California courts have held that a liability policy provision prohibiting the insured from making voluntary payments precludes coverage for pre-tender defense costs, regardless of whether the insured's untimely tender prejudiced the insurer. The insured's belief that the policy did not provide coverage did not create a factual issue regarding whether the insured involuntarily incurred the pre-tender defense costs. DiMugno at *Id.*; *see also Tradewinds Escrow, Inc. v. Truck Ins. Exchange*, 97 Cal. App. 4th 704 (Cal. Ct. App. 2002).

California courts have further held that "no voluntary payments" provisions are enforceable in the absence of any breach by the insurer (e.g., by refusal to defend) or other extraordinary circumstances. As such, an insurer need not reimburse its insured for amounts unilaterally paid to settle a claim without notice to the insurer in violation of a no-voluntary-payment clause. Cal. Prac. Guide Ins. Lit. Ch. 7A-L, 7:439.7; *see also Jamestown Builders, Inc. v. General Star Indem. Co.*, 77 Cal. App. 4th 341, 350 (Cal. Ct. App. 1999).

2. Texas

In *Motiva Enterprises v. St. Paul Fire and Marine*, 445 F.3d 381 (5th Cir. 2006), an excess carrier—which had apparently offered to provide a defense under a reservations of rights—was invited to attend a mediation in a suit against its insured. The representative of the excess insurer was asked to leave before the mediation was over (on the grounds that the insurer "never acknowledged coverage" for the claim) and, after the carrier left, the insured settled with the plaintiffs. Contending that the insured breached the "settlement-without-consent" clause in the policy, the insurer refused to contribute to the settlement and denied coverage. *Id.* at 383-84. Agreeing with the carrier that the insured had forfeited coverage, the Fifth Circuit found that the insurer was prejudiced *as a matter of law* by being excluded from the settlement:

As suggested by *Ridglea*, it is not entirely clear under Texas law whether an insurer must demonstrate prejudice before it can avoid its obligations under a policy where the insured breaches a prompt-notice provision or a consent-to-settle provision. . . . Assuming without deciding that an insurer must show prejudice to avoid its obligations under the policy when the insured breaches the consent-to-settle provision, based on the summary judgment evidence in this case, we are satisfied that National Union suffered prejudice as a matter of law. An insurer's right to participate in the settlement process is an essential

prerequisite to its obligation to pay a settlement. When, as in this case, the insurer is not consulted about the settlement, the settlement is not tendered to it and the insurer has no opportunity to participate in or consent to the ultimate settlement decision, we conclude that the insurer is prejudiced as a matter of law. Under these circumstances the breach of the consent-to-settle provision in the policy precludes this action.

Id. at 386-87 (footnote omitted).

From the policyholder's perspective, there are several flaws in the court's reasoning. First, it was well established before the *Motiva* decision that an insurer must demonstrate prejudice before it can avoid its obligations under a consent-to-settle provision. See cases cited on pages Q-10—Q-11 above. Additionally, the insurer in *Motiva* was in exactly the same position as the insurer in *Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691, 693-94 (Tex. 1994): the insurer was not consulted about the settlement, the settlement was not tendered to the insurer, and the insurer had no opportunity to consent to the ultimate settlement decision. In *Hernandez*, those facts were insufficient to show prejudice, yet in *Motiva* they constituted prejudice as a matter of law.

Bottom line: at least in the Fifth Circuit, an insured that deprives its insurer of the *opportunity* to participate in the settlement process risks a finding that the insurer was prejudiced as a matter of law, resulting in forfeiture of the insured's coverage under the "consent to settlement" clause. See also *Trumble Steel Erectors v Moss*, 304 Fed. App'x. 236, 242 (5th Cir. 2008) (approving the holding in *Motiva* and describing an insurer's "exclusion from settlement" as a deprivation of an "essential benefit of the bargain of its insurance contract" and "a more tangible and quantifiable loss" than the loss of an insurer's opportunity to investigate an occurrence due to late notice).

Shortly after *Motiva* was decided, the Fifth Circuit issued its opinion in *Clarendon National Insurance Co. v. FFE Transportation Services, Inc.*, 176 Fed. App'x. 559 (5th Cir. 2006) (per curiam). *Clarendon* involved a policy with a \$1 million self-insured retention—the insured to be responsible for the first \$1 million in damages arising from an accident. *Id.* at 560. One of FFE's vehicles was involved in an accident resulting in several claims. *Id.* FFE settled all but one of the claims for a total of \$219,861.99, and rejected an offer to settle the remaining claim for \$700,000. *Id.* The claim was tried to a verdict of \$1.1 million, reduced in a post-judgment settlement to \$1 million. *Id.* Three months after the trial, FFE gave its first notice of suit to its insurer, Clarendon, and subsequently sued for reimbursement of amounts it paid in excess of its self-insured retention. *Id.* On appeal, the Fifth Circuit stated that it "need not decide whether the presumed prejudice rule is still good law" because FFE's rejection of the settlement offer within the SIR limit resulted in actual prejudice. *Id.*; but see *Comsys Information Technology Services, Inc. v. Twin City Fire Ins. Co.*, 130 S.W.3d 181, 192 (Tex. App.—Houston [14 Dist.] 2003, pet. denied) ("The mere fact that the insurer owes money that it does not wish to pay does not constitute prejudice as a matter of law.").

United States District Judge Andrew Hanen had an opportunity to address this issue in *National Union Fire Ins. Co. of Pittsburgh, PA v. Puget Plastics Corp.*, 649 F. Supp. 2d 613 (S.D. Tex. 2009). Citing to the Fourteenth Court of Appeals opinion in *Coastal Refining*, Judge Hanen observed that, in order for the insured to forfeit its coverage under a "no voluntary payment" provision, "the insurer must have sustained actual prejudice, as opposed to theoretical or presumed prejudice." *Id.* at 626. On the facts presented to the court, Judge Hanen found a "lack of any prejudice caused by the voluntary payment." *Id.*

D. Waiver

1. California

Under California law, where the insurer has denied all liability under the policy, it cannot raise the “no voluntary payments” provision or other conditions as a defense. Furthermore, California courts have held that the insurer may not repudiate the policy, deny all liability, and at the same time be permitted to stand on a provision inserted in the policy for its benefit. Cal. Prac. Guide Ins. Lit. Ch. 7A-L, 7:439.15; *see also Maier Brewing Co. v. Pacific Nat'l Fire Ins. Co.*, 218 Cal. App. 2d 869, 878–80 (Cal. Ct. App. 1963); *Flintkote Co. v. General Acc. Assur. Co. of Canada*, (N.D. Cal. 2007) 480 F. Supp. 2d 1167, 1176 (applying Calif. law).

2. New York

Though “an insurer is not required to demonstrate prejudice to assert a defense of non-compliance, an insurer may be estopped to assert a defense of non-compliance based on its own conduct.” *New York Cent. Mut. Fire Ins. Co. v. Danaher*, 736 N.Y.S.2d 195, 197 (N.Y. App. Div. 3d Dep't 2002).

Some New York cases have held that inaction or silence by the insured is not enough to waive the defense. In *Danaher*, the Third Department held that an insurer's inaction when it knew of its insured's claim and settlement negotiations was not enough to even raise a fact issue that the insurer had waived its right to assert non-compliance with the consent to settle clause. 736 N.Y.S.2d 195, 197 (N.Y. App. Div. 3d Dep't 2002) (holding that that insured's counsel's “repeated telephonic requests for a copy of Jacob's insurance policy, made prior to the [the settlement] . . . and plaintiff's knowledge that defendant had asserted a claim [the policy]” did not raise a question of fact as to waiver). Similarly, in *State Farm Auto Insurance Company v. Blanco*, the court held that the insurer had not waived the requirement of prior written consent to any proposed settlement when the insured had sent the insurer a notice that a settlement “had been accepted, unless [the insured] receive[d] objection from [the insurer] within ten days,” and the insurer did not object in that ten day period. 617 N.Y.S.2d 898, 899 (N.Y. App. Div. 2d Dep't 1994)

When, however, the policyholder makes several attempts to obtain the insurer's consent or gives the insurer notice far enough in advance to give the insurer opportunity to participate, and the insurer still does not respond, the insurer's inaction may constitute a waiver. *See, e.g., In Re Allstate Ins. Co. v. Sullivan*, 646 N.Y.S.2d 359, 360 (N.Y. App. Div. 2d Dep't 1996) (holding that when insured made “several efforts” to obtain insured consent and sent a letter stating that it would settle the claim if insurer did not respond within thirty days, insurer waived its right to deny coverage based on failure to consent); *In re State Farm Mut. Ins. Co. v. Joan Del Pizzo*, 586 N.Y.S.2d 310, 311-312 (N.Y. App. Div. 2d Dep't 1992) (when insured notified the insurer of his intent to settle and enclosed a release reflecting the preservation of the insurer's subrogation rights, and insurer did not respond for four months, insurer had “waived its right to object to the [insured's] settlement”). Exactly how much advance notice is required to give the insurer an opportunity to participate largely depends on the individual circumstances of each case, and in particular, courts look at the amount of insurer awareness or involvement in the claim before notice of settlement or request for consent is given. *See, e.g., MBIA Inc. v. Federal Ins. Co.*, 652 F.3d 152, 170 (2d Cir. 2011) (applying New York law) (holding that 9 days notice allowed sufficient time for insurer to voice objection or lack of consent when insurer was aware of the nature of the claim and “had solid indications of the dollar amount of those claims”).

An insurer's denial or other affirmative statements that the insurer is no longer involved with the claim may also constitute waiver of the insurer's right to raise a defense based on the insured's failure to

obtain consent for settlement. “An insurer has an obligation to deal in good faith with its insured and may not arbitrarily withhold consent and at the same time argue that its insured has not complied with a condition precedent.” *In re State Farm Mut. Auto. Ins. Co.*, 680 N.Y.S.2d 39, 39 (N.Y. App. Div. 4th Dep’t 1998). In *State Farm Mutual Auto Insurance Company*, the insurer denied the insured’s claim six days after the accident and continued to maintain its denial even when the insured informed the insurer of the action’s progress. *Id.* The court held that the insurer’s continued denial precluded it from arguing that the insured had not complied with policy’s conditions requiring that the insured give notice and obtain consent of settlement). *Id.*; see also *Mier v. Valley Forge Ins. Co.*, 641 N.Y.S.2d 713 (N.Y. App. Div. 2d Dep’t 1996); *Gen. Star Nat’l Ins. Co. v. Universal Fabricators, Inc.*, 427 Fed. App. 32, 34-35 (2d Cir. 2011) (holding that insurer had waived its claim that insured breached duty to obtain consent to settlement when “at a time when it was anticipated that the underlying action would not implicate its coverage, [insurer told insured] to ‘handle [the matter] as [it] s[aw] fit’ and informed [the insured] that it had closed its file.”).

3. Texas

Texas court have generally held that when insurers deny coverage or the duty to defend, their insureds become free to settle or litigate the claims as they sees fit, and they are no longer bound by any of the conditions precedent to coverage, such as voluntary payments or no action. See *Rhodes v. Chicago Ins. Co.*, 719 F.2d 116, 120 (5th Cir. 1983); *Simon v. Maryland Cas. Co.*, 353 F.2d 608, 612 (5th Cir. 1965) (“an assured is entitled to exercise the judgment of a prudent uninsured person in compromising the claim when the insurer repudiates coverage”); *McGinnis v. Union Pacific R. Co.*, 612 F. Supp. 2d 776 (S.D. Tex. 2009) (“While it is true that ‘the insurance company may ordinarily insist upon compliance with this condition for its own protection,’ the law is well-settled that once an insurer has breached its duty to defend, the insured is free to proceed as he sees fit; he may engage his own counsel and either settle or litigate, at his option.”) (citations omitted); *Comsys Info. Tech. Servs.*, 130 S.W.3d at 192 (“Having declined to defend Comsys, Twin City [Fire Insurance Company] could not frustrate Comsys’ effort to defend itself by obtaining what it believed to be a favorable mediated settlement agreement. In other words, Twin City could not obstruct a settlement by refusing to attend the mediation conference and then assert the settlement was obtained without its consent.”); *Owens v. Watson*, 806 S.W.2d 871, 874 (Tex. App.—Corpus Christi 1991, writ denied) (“Here, both insurance companies had already denied coverage when Watson settled his suit. In short, he had done everything within his power to have the claim covered by his insurance companies. Because of the denial of coverage under the policy, appellants cannot use this defense [*i.e.*, a defense of voluntary payment of the settlement].”).

In *Montgomery Elevator Company v. Nutmeg Insurance Company*, 29 F. Supp. 761 (S.D. Tex. 1998), the insurer sought to relieve itself of liability on the grounds that it did not approve in writing the insured’s settlement of certain claims. The court responded as follows:

After completely ignoring Montgomery’s numerous requests by telephone and letter for determination as to the insurance coverage provided under the Hermann Hospital policy, Nutmeg now asked the Court to reward it for its own inaction. If this Court adopted such a ridiculous argument, every insurance company could escape liability simply by ignoring potential claimants. The audacity of Nutmeg borders on being sanctionable.

Id. at 764; see also *Tenneco Inc. v. Enterprise Products Co.*, 925 S.W.2d 640, 643 (Tex. 1996) (waiver can be established by silence or inaction for so long a period as to show an intention to yield the known right); *Comsys Info. Tech. Servs.*, 130 S.W.3d at 191 (“[R]emaining silent was not an option available under the terms of this policy—Twin City was required to either consent to the settlement or assume the

defense.”); *but see Munster Steel Co. v. Travelers Indem. Co.*, 620 S.W.2d 771, 772 (Tex. Civ. App.—Dallas 1981, no writ).

E. Most Recent Developments

1. Nevada

As noted above, in August of 2011, the Nevada Supreme Court joined the majority of states in adopting the notice-prejudice rule, and held that an insurer who denies coverage of a claim because of an insured’s failure to provide timely notice must prove that the notice was late and that the insurer was prejudiced by the late notice. *Coregis Ins. Co.* at 965. The *Coregis* case represents a landmark decision in Nevada with respect to the notice-prejudice rule, and it has profound implications with respect to how insurers address late notice issues in Nevada going forward.

2. Texas

One of the more recent developments in the arena of “settlement-without-consent” clauses is in a case decided by the Fourteenth Court of Appeals in April of 2011.⁵ This case is currently on appeal to the Texas Supreme Court.⁶ In this case, the Fourteenth Court of Appeals held that, due to the placement of the clause in the insuring agreement, the insurer need not prove prejudice.

a. The Facts of the Case

In the 1990s, the insured, Lennar, built several hundred homes in the Houston area using the barrier Exterior Insulation and Finish System, a synthetic stucco siding product known by its acronym “EIFS.” The manufacturers of EIFS marketed it as an ideal product for wood-framed homes. *Lennar Corp. v. Great American Insurance Co.*, 200 S.W.3d 651, 661 (Tex. App.—Houston [14th Dist.] 2006, pet. denied) (*Lennar I*). However, due to EIFS’s design, it traps water behind it and does not allow the water to drain. *Id.* Materials underneath the EIFS are damaged by ongoing exposure to moisture.

In 1999, a Dateline exposé described the severe property damage caused by EIFS. Shortly after that broadcast, concerned homeowners began calling Lennar about their EIFS-clad homes and asserting claims. Between 1999 and 2003, Lennar took steps to settle with its homeowners, which included removing and replacing the EIFS and repairing the underlying water damage.

Lennar purchased a commercial umbrella policy from Markel, effective June 1, 1999, with a \$25 million limit that was excess to Lennar’s primary policy. The Markel policy contained two settlement-without-consent provisions. One was located in the policy’s “Conditions” section,⁷ and the other was located in the definition of “Ultimate Net Loss,” which was incorporated into the policy’s insuring agreement.⁸ During the course of Lennar’s remediation process, Lennar notified Markel of the proposed

⁵ *Markel Am. Ins. Co. v. Lennar Corp.*, 342 S.W.3d 704 (Tex. App.—Houston [14th Dist.] 2011, pet. filed).

⁶ *Lennar Corp. v. Markel Am. Ins. Co.*, Supreme Court of Texas Case No. 11-0394 (briefing on the merits requested on December 16, 2011).

⁷ Condition E to the Markel policy provided that Lennar shall not, except at its own cost, voluntarily make any payment, assume any obligation, or incur any expense without Markel's consent. *Lennar I*, 200 S.W.3d at 695.

⁸ The policy provided in the insuring agreement that “[Markel] will pay on behalf of [Lennar] for that portion of ‘ultimate net loss’ in excess of the ‘retained limit’ because of . . . property damage to which this insurance applies” The policy further provided in the definition section that “‘Ultimate net loss’ may be established by

repairs to the homes and offered Markel the opportunity to inspect homes before repairs. Markel chose not to perform any inspections.

Lennar sued Markel to recover under the policy. Markel initially obtained a take-nothing summary judgment, but on appeal the court of appeals reversed that judgment and remanded for trial. Among the issues it addressed, the court of appeals determined that Markel must show that it had been prejudiced before it could establish a breach of Condition E. The court ruled that Markel had not established prejudice as a matter of law. *Lennar I*, 200 S.W.3d at 695. The court did not address the consent to settlement provision in the definition of “Ultimate Net Loss.”

At trial, one of the issues submitted to the jury was whether Markel was prejudiced from Lennar’s failure to obtain Markel’s consent to settlements with the homeowners. The jury decided that Markel had not suffered prejudice and awarded damages in favor of Lennar. The trial court entered judgment on the jury’s verdict and Markel appealed.

b. *Lennar II*: The Court of Appeals Reverses and Renders

In *Lennar II*, the Fourteenth Court of Appeals held that the jury’s finding that Markel did not incur any prejudice as a result of the Lennar companies’ settlements with homeowners was immaterial. *Markel Am. Ins. Co.*, 342 S.W.3d at 714-16. The court based its holding on the location of the settlement-without-consent provision in the policy—according to the court, the location of the clause within the insuring agreement changed the parties’ obligations. The court opined that Markel’s consent to a settlement is the “definition of coverage under the policy. It is not merely a condition.” *Id.* at 716. Thus, according to the *Lennar II* court, if the settlement-without-consent clause is incorporated into the policy’s insuring agreement rather than in the policy’s conditions, the insurer need not show prejudice. *Id.*

In reaching its decision, the court specifically rejected Lennar’s contention that such a holding would allow an insurer to avoid liability by the strategic placement of its settlement-without-consent language. Instead, the court of appeals relied on general language from the Texas Supreme Court requiring a “plain reading” of the policy language. *Id.* at 715. The court also rejected Lennar’s waiver argument—that Markel’s denial of coverage prevents it from enforcing the settlement-without-consent language—on the basis that “waiver cannot be used to rewrite an insurance policy and create coverage where none exists.” *Id.*

c. Why the Fourteenth Court of Appeals “Got It Wrong”—from the Policyholder Perspective

In *Lennar II*, the court of appeals should have required a showing of prejudice before Lennar’s failure to obtain consent defeated coverage because (1) duplicating condition language in the policy does not change the nature of the policy as a contract, (2) only a material breach forfeits contract rights, and (3) holding otherwise is bad public policy.

adjudication, arbitration, or a compromise settlement to which we have previously agreed in writing. . . .” *Markel Am. Ins. Co. v. Lennar Corp.*, 342 S.W.3d 704, 712 (Tex. App.—Houston [14th Dist.] 2011, pet. filed).

i. Insurance Provisions Are Not Like Real Estate—Location Doesn't Matter

An insurer should not be able to avoid liability simply by strategically placing its settlement-without-consent language in certain parts of the policy. The placement of this provision is not what makes it material. This is best illustrated by *Hernandez v. Gulf Group Lloyds*, 875 S.W.2d 691 (Tex. 1994). This Texas Supreme Court case involved a claim under an auto policy that the insured settled without the insurer's consent. Although the majority opinion referred to "a 'settlement without consent' exclusion clause," it did not make clear where the clause was located. The dissent explained, however, that the clause was in the insuring agreement: "The insuring agreement states" that the insurance "does not apply: (a) to bodily injury or property damage with respect to which the insured, . . . without written consent of the company, make[s] any settlement with any person . . . who may be legally liable therefore. . .". *Hernandez*, 875 S.W.2d at 694. The importance of this point is two-fold.

First, neither the majority nor dissent in *Hernandez* placed any importance on the location of this language within the overall policy structure. The issue is whether a breach is material; the issue is not one of contract construction based on where the policy locates the clause. Additionally, the clause was in the insuring agreement in *Hernandez* (at least one of the Justices thought so), but *Hernandez* adopted the prejudice rule and applied it to a clause in the insuring agreement.

Both policies have settlement-without-consent language, and both policies include that language in their insuring agreements. The result should be the same in both cases, but it wasn't.

As stated above, the court of appeals supported its holding, in part, based on contract construction principles and a "plain reading" of the policy. *Lennar II*, 342 S.W.3d at 715. However, this same kind of "plain reading" of the policy in *Hernandez* or in many of the other policies interpreted by the Texas Supreme Court (i.e. the policies in *Prodigy* or *PAJ*) might have required forfeiture of coverage as well, had not the Supreme Court inserted a prejudice requirement based on the immateriality of the clause.

ii. What Does Matter—Is the Clause Material?

In two similar decisions—namely, *PAJ v. Hanover Insurance Co.* and *Prodigy Commutations Corp. v. Agricultural Excess & Surplus Insurance Co.*, 288 S.W.3d 374 (Tex. 2009)—the Texas Supreme Court confirmed that the controlling issue is not the location of language in the policy, or the type of policy, but rather the materiality of the specific policy language and of any breach. See *PAJ*, 243 S.W.3d at 631-32 ("We agree with PAJ that only a material breach of the timely notice provision will excuse Hanover's performance under the policy."); *Prodigy*, 288 S.W.3d at 380 (applying prejudice rule to "claims-made-and-reported" policy).

In *Lennar II*, the settlement-without-consent clause in the insuring agreement simply mirrors consent language included in the policy conditions. There is no basis in Texas law for treating the same clauses differently because they fall under different sections of the contract, and to do so would create confusion and inconsistency in interpreting insurance policies. One need only review the two court of appeals decisions in the *Lennar* case to prove that point. Compare *Lennar I* (the court of appeals applied the prejudice rule to the settlement-without-consent condition in the Markel policy) with *Lennar II* (no showing of prejudice is required in connection with the settlement-without-consent provision in the insuring agreement of the same Markel policy).

iii. The Implications – Bad Policy

If the burden of proving the materiality of the insured's breach of the settlement-without-consent clause depended on whether the language was located in the conditions or in the insuring agreement/definitions, then insurers would be encouraged to deliberately move the language to the insuring agreement so that it would never have to show that it was prejudiced before it could deny coverage on this basis. Through the use of definitions and clever drafting, the entire policy could be incorporated into the insuring agreement. Insureds would then be worse off than a party to any other type of contract—a contract provision is not any more or less material based on its location in the contract. Texas has a strong public policy of protecting Texas insureds, not impairing them.

IV. Claims Investigation

An insurance carrier's claims investigation is guided by the specific policy terms, state regulations, and the obligations the applicable court has deemed implied into the type of insurance contract at issue as effected through the carrier's policies and procedures. Carriers may handle claims investigation internally, or retain a third-party administrator or outside counsel. During the evaluation process, communications with the insured or its counsel may be ongoing, as the information requested by the carrier is provided and as the insured continues to keep the carrier informed of developments and provides additional pertinent information.

With respect to first party claims, a carrier's focus is on whether a particular loss falls within the scope of coverage, while the policyholder's obligation is to provide the carrier with the required information supporting the claim. Preliminary investigation may include review of the policyholder's proof of loss, location of relevant policy forms, interviewing the policyholder and any witnesses, and examining any evidence specific to the loss.

In the context of a liability policy, carriers usually take steps to determine whether the allegations against the insured in the suit or other covered proceeding or demand tendered by the policyholder are within the scope of coverage provided by the policy or policies. Frequent initial steps include locating potentially applicable policies and coverage forms, obtaining relevant pleadings, motions and discovery in the underlying litigation, requesting and reviewing relevant contracts or agreements, as well as prior related correspondence between the claimant and insured and any documents previously provided by the claimant in support of its position, and requesting and examining any other pertinent information provided to it by the insured.

A. Carrier's Obligations During Claims Investigation

Generally, an insurance carrier has no duty to investigate the potential for coverage until the insurer has received notice that there is a claim to investigate. *California Shoppers, Inc. v. Royal Globe Ins. Co.*, 175 Cal. App. 3d 1, 57 (Cal. Ct. App. 1985) (“without actual presentation of a claim by the insured in compliance with claims procedures contained in the policy, there is no duty imposed on the insurer to investigate the claim”); *KPFF, Inc. v. Cal. Union Ins. Co.*, 56 Cal. App. 4th 963 (Cal. Ct. App. 1997) (“California Union was under no duty to investigate matters relating to coverage under the awareness provision until it received the written notice that the provision required.”).

Once notified of a potential claim, a carrier's obligation to investigate varies based on the specific policy terms and the obligations the applicable court has deemed implied into the type of insurance contract at issue. Because most insurance policies do not include provisions that set parameters for an

insurer's investigation, the scope of a carrier's duty to investigate, including any timing requirements or guidelines, is frequently based on the implied covenant of good faith and fair dealing as construed by the courts.

1. First Party Policies

Insurance contracts that provide first party coverage (i.e. to indemnify the insured for its covered losses) may imply different obligations than policies providing third party, or liability, coverage (to protect against covered claims made against the insured by third parties).

For example, California courts have found that, in first party cases, the implied covenant of good faith and fair dealing requires a carrier to make a thorough and prompt investigation of the insured's claim for benefits coupled with an obligation not to unreasonably delay or withhold payment of benefits. *Silberg v. California Life Ins. Co.*, 11 Cal. 3d 452, 461–462 (Cal. 1974); *California Shoppers, Inc. v. Royal Globe Ins. Co.*, 175 Cal. App. 3d 1, 54–55 (Cal. Ct. App. 1985).

Notably, duties related to claims investigation do not arise until the carrier has proper notice of the claim. 10 Cal. Code Regs. § 2695.7(b); *Paulfrey v. Blue Chip Stamps*, 150 Cal. App. 3d 187, 199–200 (Cal. Ct. App. 1983). One case determined that a carrier's duty to investigate a claim was not triggered until the insured has made a good faith effort to comply with the notice of claim provisions in the insurance policy: "(A)ny responsibility to investigate on an insurer's part would not arise unless and until the threshold issue as to whether a claim was filed, or a good faith effort to comply with claims procedure was made, has been determined. In no event could an insured fail to keep his/her part of the bargain in the first instance, and thereafter seek (extracontractual) recovery for breach of a duty to pay ..." *Paulfrey* at 199–200.

Once triggered, a carrier's duty to investigate is not generally excused by coverage litigation filed by the policyholder. E.g., *Jordan v. Allstate Ins. Co.*, 148 Cal. App. 4th 1062, 1076, fn. 7 (internal quotes omitted) (Cal. Ct. App. 2007) ("[A]n insurer's duty of good faith and fair dealing does not evaporate after litigation has commenced. To hold otherwise would effectively encourage insurers to induce the early filing of suits The policy of encouraging prompt investigation and payment of insurance claims would be undermined.").

To avoid or mitigate bad faith claims, carriers generally benefit from thoroughly investigating the foundation for any denial of a claim. *Egan v. Mutual of Omaha Ins. Co.*, 24 Cal. 3d 809, 819 (Cal. 1979). Some case law has articulated an insurer's obligation to investigate a claim thoroughly: "(I)t is essential that an insurer fully inquire into all possible bases that might support the insured's claim ... (A)n insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for its denial." See *id.*; *Shade Foods, Inc. v. Innovative Products Sales & Marketing, Inc.*, 78 Cal. App. 4th 847, 879 (Cal. Ct. App. 2000) (adequacy of investigation is "(a)mong the most critical factors bearing on the insurer's good faith").

Stating a general rule as to how much or what type of investigation meets the insurer's obligations is difficult, and varies by jurisdiction. Under California law, the test is reasonableness based on the "totality of the circumstances surrounding its [the carrier's] actions." *Wilson v. 21st Century Ins. Co.*, 42 Cal. 4th 713, 723 (Cal. 2007). Further, a "thorough" investigation is not necessarily a perfect investigation. A carrier may have failed to investigate all aspects of a claim, at least as identified in hindsight, without acting in bad faith. *Othman v. Globe Indem. Co.*, 759 F.2d 1458, 1464–65 (9th Cir. 1985) (applying Calif. law).

As part of the duty to investigate, a carrier may also be required to evaluate and respond to letters from the policyholder disputing its coverage position. *Shade Foods, Inc. v. Innovative Products Sales & Marketing, Inc.*, 78 Cal. App. 4th 847, 882 (Cal. Ct. App. 2000) (“The record suggests that [insurance carrier] looked the other way when confronted with facts revealing the possibility of first-party coverage, resisting both reasonable interpretation of policy language and a compelling history of negotiation to secure this coverage.”). Some states also impose an obligation to look beyond the facts and coverage theories asserted by the insured or its counsel. *Jordan* at 1062 (duty extends to whatever facts or coverage theories would support recovery under the policy; carrier must “fully inquire into possible bases that might support the insured’s claim”).

The duty to investigate may also incorporate an obligation to interview witnesses, including the policyholder, and to consult with appropriate experts. For example, under California law, insureds may be required to submit to examinations under oath “concerning all proper subjects of inquiry.” *Globe Indem. Co. v. Sup.Ct.*, 6 Cal. App. 4th 725, 731 (Cal. Ct. App. 1992). However, statutory restrictions limit inquiry to information that is “relevant and reasonably necessary to process or investigate the claim” in the context of fire insurance, residential property insurance and residential earthquake insurance.” *See* Cal. Ins. Code §§790.031; 2071.1(a)(2). In a claim for a burglary loss of insured jewelry, a carrier was found to have properly denied the insured’s claim when, at her examination under oath, she refused to provide information such as where she got the money to purchase the jewelry and whether the jewelry had been reported in her recent bankruptcy. *Robinson v. National Auto. & Cas. Ins. Co.*, 132 Cal. App. 2d 709, 714 (Cal. Ct. App. 1955); *see also* *Globe Indem. Co.* at 731-32 (“There can be no ‘unreasonable delay’ until the insurer receives adequate information to process the claim and reach an agreement with the insureds. *Globe* [insurer] did not receive adequate information to process the claim until after Aimee [insured] consented to examination under oath pursuant to the terms of the insurance policy. ... *Globe*’s delay in processing the claim was caused solely by plaintiffs’ [insureds’] failure to provide information about Aimee’s knowledge or lack of knowledge that the motorcycle was stolen. ... Reasonable minds cannot differ in determining that *Globe*’s delay in acknowledging the claim was caused by the refusal of plaintiffs, under advice of counsel, to allow Aimee to submit to ‘examination under oath’ as required by the terms of the insurance policy. In view of the fact coverage depended entirely upon whether or not Aimee was ‘[u]sing a vehicle without a reasonable belief that [she was] entitled to do so,’ *Globe*’s delay in acknowledging coverage was reasonable as a matter of law.”).

A carrier’s delay in performing any of the separate steps potentially encompassed in the implied duty to investigate that results in a delay of payment or other processing of the claim could lead to extracontractual liability, where the delay was also unreasonable. *See, e.g., Brehm v. 21st Century Ins. Co.*, 166 Cal. App. 4th 1225 (Cal. Ct. App. 2008) (“A delay in payment of benefits due under an insurance policy gives rise to tort liability only if the insured can establish the delay was unreasonable”); *but see Rappaport-Scott v. Interinsurance Exch. of Auto. Club*, 146 Cal. App. 4th 831, 837–38 (Cal. Ct. App. 2007) (delay in payment because of a genuine dispute as to the amount payable is not unreasonable).

In addition, a carrier may benefit from performing a thorough and timely investigation in that it may serve to preserve certain defenses to a bad faith claim, such as asserting a “genuine dispute” as to coverage as a reasonable basis for denial. *Jordan v. Allstate Ins. Co.*, 48 Cal. App. 4th 1062, 1074 (Cal. Ct. App. 2007) (failing to thoroughly investigate prevents assertion of “genuine dispute” defense because the carrier has “deprived itself of the ability to make a fair evaluation of the claim”).

Finding a balance between the obligation to thoroughly investigate and not unreasonably delay payment of policy benefits may, at times, be difficult, and is generally a fact specific analysis in the context of coverage litigation. However, where the policyholder’s conduct hinders or prolongs the

carrier's investigation, the carrier will generally not be found to have acted in bad faith. *Guebara v. Allstate Ins. Co.*, 237 F.3d 987, 994-96 (9th Cir. 2001) (applying California law); *Blake v. Aetna Life Ins. Co.*, 99 Cal. App. 3d 919-920 (Cal. Ct. App. 1979) (insured and/or its counsel has information essential to claim and ignored repeated requests for information by the carrier). For example, where a homeowner submitted numerous inconsistent statements regarding personal property lost in a fire, the insurance carrier was found not to have acted in bad faith by withholding payment of claimed insurance benefits. *Guebara*, at 994-96. The inconsistent statements, combined with other suspicious circumstances, also caused the carrier to hire additional investigators and prolonged the carrier's claim investigation. *Id.* The homeowner's subsequent bad faith claim was dismissed on summary judgment because the carrier's delay and denial of payment were attributable largely to the policyholder's conduct. *Id.*

However, not all U.S. jurisdictions imply obligations that a contract be performed within a certain time-frame under the penumbra of the duty of good faith and fair dealing. *See, e.g., Choharis v. State Farm Fire & Cas. Co.*, 961 A.2d 1080, 1088-89 (D.C. Ct. App. 2008) (in the context of a first party claim, the court affirmed that the tort of bad faith in the handling of insurance policy claims is not recognized in D.C.; other types of torts may still be viable arising from the mishandling of claims, including fraud, invasion of privacy, intentional or negligent infliction of emotional distress, slander, assault, negligence and conspiracy. Accordingly, a fraudulent or negligent misrepresentation claim may proceed if the facts alleged are separable from the terms of the contract, and there is a duty independent of that arising out of the contract, such that an action for breach of contract would reach none of the damages suffered by the tort. Delayed payments or refusal to make payments do not rise to this level.)

2. Third Party Policies

In the context of third party, or liability, coverage designed to protect against covered claims made against the insured by third parties, the covenant of bad faith and fair dealing may obligate a liability insurer to reasonably and promptly investigate claims; provide a defense where there is a potential for liability; and to attempt to reach, on a timely basis, reasonable settlements of third party claims within policy limits. *See Comunale v. Traders & Gen. Ins. Co.* 50 Cal. 2d 654 (Cal. 1958).

A carrier's potential liability for its investigation practices is frequently tied to the end result. i.e. liability for denial of a claim that is later determined to be covered, or liability where the carrier failed to accept a reasonable settlement demand for a covered claim. For example, a delay in payment based on a carrier's investigation process and other claim handling tactics that is determined to be unreasonable may expose a carrier to bad faith liability. *Waller v. Truck Ins. Exch., Inc.*, 11 Cal. 4th 1, 36, 44 (Cal. 1995) (internal quotes omitted) ([D]elayed payment based on inadequate or tardy investigations, oppressive conduct by claims adjusters seeking to reduce the amounts legitimately payable and numerous other tactics may breach the implied covenant because they frustrate the insured's right to receive the benefits of the contract in prompt compensation for losses."); *see also Major v. Western Home Ins. Co.*, 169 Cal. App. 4th 1197, 1209 (Cal. Ct. App. 2009). A carrier's delay in providing its coverage position may also leave the door open for bad faith liability—at least where a covered claim was denied. *Essex Insurance Company v Zwick*, (N.Y. App. Div., 4th Dept., March 17, 2006) (in denying a carrier's motion for summary judgment, the court concluded that the insurer failed to demonstrate that its delay in disclaiming coverage was reasonable as a matter of law).

Although much more difficult to prove, some decisions may also support a carrier's tort liability for unreasonable delays in investigation, even where a liability claim is ultimately paid or settled. *Dalrymple v. United Services Auto. Ass'n*, 40 Cal. App. 4th 497, 515 (Cal. Ct. App. 1995) ("There may be cases in which the insurer's delay in paying the claim or other misconduct causes special harm to the

insured even though the claim is ultimately paid or settled. Such payment fulfills the insurer's contractual obligations. However, under appropriate circumstances, tort liability may still be imposed for the insurer's misconduct apart from performance of the contract obligation.”).

However, a delay in investigating a third-party claim, without coverage, causes the policyholder no harm, and generally is not actionable—i.e. where there is no potential for coverage, the carrier owes no defense obligation, and therefore cannot be liable for delaying in providing a defense. See e.g. *Horsemen's Benevolent & Protective Ass'n. v. Insurance Co. of North America*, 222 Cal. App. 3d 816, 822 (Cal. Ct. App. 1990) (“the absence of coverage under the INA policy conclusively negates Horsemen's causes of action for bad faith breach of contract as no duty to indemnify or defend existed here”); *Schwartz v. State Farm Fire & Cas. Co.*, 88 Cal. App. 4th 1329, 1339 (Cal. Ct. App. 2001) (where there is a covered loss, bad faith liability may exist without breach of a consensual contract term); *but see Dalrymple v. United Services Auto. Ass.*, 40 Cal. App. 4th 497 (Cal. Ct. App. 1995) (“[T]here may be unusual circumstances in which an insurance company could be liable to its insured for tortious bad faith despite the fact that the insurance contract did not provide for coverage. . . . For instance, the insurance company might be liable if it unreasonably delayed in performing an investigation of a claim before concluding there was no coverage and the insured suffered consequential loss as a result of the delay.”)

Even in states where “bad faith” liability does not exist, per se, a carrier may benefit from investigating a claim for coverage as a precursor to making a determination of its defense obligation. A defending carrier may also benefit from, and in some states be obligated to, continue to stay informed of developments in the action so that it may evaluate its indemnity obligation and any potential settlement opportunities. During this stage, the policyholder's conduct in keeping the carrier informed and consulting with the carrier may be a necessary precursor to whether the carrier is able to maintain an updated evaluation of coverage for a liability claim as the related litigation evolves. As discussed later, where the policyholder fails to consult with and keep the carrier informed, it may risk breaching the policy's cooperation clause and provisions barring voluntary payments as well as ultimately setting the stage for a carrier to assert the defenses of unclean hands or failure to mitigate in any ensuing coverage litigation. This may be a particular problem in matters where the insured has a right to independent counsel or where the policyholder has a large self-insured retention and maintains control of the defense.

B. Policyholders' Obligations During Investigation: The Duty to Cooperate and the Provision of Support for Claims

In addition to triggering the insurance carrier's obligation to timely and properly investigate and process the claim, a policyholder's submission of a claim requires the insured to comply with its own duties to the insurer. Some of those duties, if met by the insured, will facilitate the carrier's claim-handling process. The policy's cooperation clause will generally govern a policyholder's obligation to, among other things, provide information relevant to the claim.

Provisions requiring that the insured cooperate with the carrier's investigation of a claim are not new to the insurance world. See, e.g., *Gross v. St. Paul F. & M. Ins. Co.*, 22 F. 74, 75 (C.C.D. Minn. 1884) (stating, regarding a clause requiring the submission to an examination under oath (“EUO”), “[i]t is akin to the stipulation requiring the insured to exhibit his books of account, invoices, etc.; one in the interests of justice and fair dealing. The insurer may insist on compliance, and the insured must comply or give a valid excuse therefore”) (citations omitted). Nowadays, cooperation clauses commonly require an insured to “cooperate with the insurer in the investigation, settlement, or defense of a claim or suit.” *Belz v. Clarendon America Ins. Co.*, 158 Cal. App. 4th 615, 625 (Cal. Ct. App. 2007).

"Any condition in the policy requiring cooperation on the part of the insured is one of great importance. . . . The basic purpose of a cooperation clause is to protect the *insurer's interests* and to prevent collusion between the insured and the injured party." *ASTRA 524(g) Asbestos Trust v. Transport Ins. Co.*, No. 09 C 458, 2011 U.S. Dist. LEXIS 110272 (N.D. Ill. Sept. 28, 2011), at *15 (emphasis in original) (citing *Waste Mgmt., Inc. v. Int'l Surplus Lines Ins. Co.*, 144 Ill. 2d 178 (Ill. 1991)). "Even were the express words 'duty to cooperate' omitted from the contract, such a duty could reasonably be inferred based merely on the principles of fairness and good faith." *ASTRA 524(g)*, 2011 U.S. Dist. LEXIS 110272, at *18 (citing *Waste Mgmt., supra*).

While furthering the processing of its insurance claim should be enough of an incentive for a policyholder to cooperate with the carrier's investigation, an insured's compliance with its duty to cooperate is also important to protect its rights under the policy. See *Martinez v. Infinity Ins. Co.*, 714 F. Supp. 2d 1057, 1061 (C.D. Cal. 2010) (noting that a requisite element of an insured's breach-of-contract claim against a carrier in a coverage action is the insured's own performance under the contract or excuse for non-performance thereunder). And while a policyholder's flat refusal to cooperate with its insurer in connection with a claim can excuse the carrier's performance under the policy, the insured's delay in cooperating and/or providing requested information about its claim can have the same effect.

1. When the Failure to Cooperate Jeopardizes Coverage

An insured's compliance with the cooperation clause of a policy has been interpreted as a condition precedent to coverage. *Martinez v. ACCC Ins. Co.*, 343 S.W.3d 924, 929 (Tex. Ct. App. 2011). But unless the policyholder's failure to cooperate is serious, minor delays and occasional hiccups in providing the cooperation requested by the carrier should not jeopardize the insured's coverage.

In many jurisdictions, to avoid its coverage obligations the insurer must demonstrate that the policyholder's failure to cooperate caused the carrier to suffer "prejudice", "substantial prejudice", or "actual, substantial prejudice". For example:

- In California, "an insured's breach of . . . a cooperation clause does not excuse the insurer's performance unless the insurer can show that it suffered prejudice" *Belz*, 158 Cal. App. 4th at 625, 629 (also explaining that to successfully assert the insured's breach of the cooperation as a defense to coverage, the insurer must show it has suffered "actual, substantial prejudice");
- In Illinois, "unless the alleged breach of the cooperation clause substantially prejudices the insurer in defending the primary action, it is not a defense under the contract." *Piser v. State Farm Mut. Auto. Ins. Co.*, 938 N.E.2d 640, 648 (Ill. App. Ct. 2010), petition for leave to appeal denied, 943 N.E.2d 1108 (Ill. 2011); and
- In Texas, "[a]n insured's failure to cooperate will not operate to discharge the insurer's obligations under the policy unless the insurer is actually prejudiced or deprived of a valid defense by the actions of the insured." *Martinez*, 343 S.W.3d at 930.

In New York, to properly disclaim coverage on the ground of an insured's lack of cooperation:

A heavy burden of establishing noncooperation is on the insurer, which must demonstrate that: (1) it acted diligently in seeking to bring about the insured's cooperation; (2) the efforts it employed were reasonably calculated to obtain the insured's cooperation; and (3) the attitude of the insured, after his cooperation was sought, was one of "willful and avowed obstruction".

Emigrant Mortgage Co., Inc. v. Washington Title Ins. Co., 913 N.Y.S.2d 251, 253 (N.Y. App. Div. 2010) (also stating "[t]he third prong may be established by an insurer's showing that its insured 'engaged in an unreasonable and willful pattern of refusing to answer material and relevant questions or to supply material and relevant documents'" (citing, *inter alia*, *Thrasher v. U.S. Liab. Ins. Co.*, 19 N.Y.2d 159 (N.Y. 1967); *see also* *Admiral Ins. Co. v. Grace Indus., Inc.*, 409 B.R. 275, 283 (E.D.N.Y. 2009).

Despite imposing this relatively high burden on carriers, apparently "prejudice" is not the focal point of New York courts' analysis with regard an insured's alleged breach of the duty to cooperate. *See, e.g., Allstate Ins. Co. v. United Int'l Ins. Co.*, 792 N.Y.S.2d 549, 551 (N.Y. App. Div. 2005) (stating "the defendant was not required to show prejudice as a result of [the insured's principal owner's] lack of cooperation").

So while policyholders should be acutely mindful of their general duty to cooperate with their carriers' investigation of a claim, many jurisdictions impose substantial burdens on insurers seeking to avoid their own policy obligations because of insureds' supposed failure to cooperate. In the majority of cases, the somewhat forgiving nature of such standards (from the policyholder's perspective) should allow a reasonably diligent insured to avoid a draconian forfeiture of rights under the policy.

2. Failure to Cooperate With the Investigation, Defense, and/or Settlement of Claims

Despite the carrier often being required to meet a relatively high burden to avoid its obligations under the policy for the insured's alleged failure to cooperate with the insurer's claim investigation, an insured should not get too brazen. Because though they might seem extreme, the case law is filled with descriptions of policyholders destroying their rights to coverage by breaching their policies' cooperation clauses.

In *Martinez, supra*, the Texas court found the insured's "failure to cooperate in the investigation, defense and settlement of the claims against her is sufficient grounds to support the summary judgment" for the carrier. (*Id.*, 343 S.W.3d at 929.) In that case, as a result of the insured's failure to cooperate with her insurer and its claim servicer:

(1) ACCC Claims incurred additional expense in its attempts to locate Romero to solicit her cooperation; (2) Best Texas and ACCC Claims were unable to confirm material facts regarding the alleged collision; (3) Best Texas and ACCC Claims were unable to determine the existence of potential claims or defenses that could be asserted on Romero's behalf; (4) Best Texas and ACCC Claims were prevented from developing a valid defense for Romero because they had no police report, no witnesses to the accident from which the facts could be objectively confirmed, and no client to assist with discovery and testimony at trial; and (5) Best Texas was exposed to a judgment due to Romero's failure to cooperate in her defense by notifying Best Texas that a default judgment had been taken against her.

Id. at 930.

The situation in *Ram v. Infinity Select Ins.*, No. C 09-2732, 2011 U.S. Dist. LEXIS 83555 (N.D. Cal. July 29, 2011), was less extreme. Yet the federal district court still found the insured "breached his duty to cooperate when he failed to produce the records requested", among other things. *Ram*, 2011 U.S. Dist. LEXIS, at *41. It concluded that the failure to produce income records prejudiced the carrier "by

making it difficult if not impossible to determine whether Plaintiff had motive to file a false claim." *Id.* at *44. The court went on to grant the insurer summary judgment, holding "the insurance policy is void based on Plaintiff's breach of the duty to cooperate." *Id.* at *45.

3. Failure to Submit to an EUO

Flagrantly avoiding contact with the carrier, or even withholding discreet information requested by the carrier or its counsel can undermine the insured's rights under the policy vis-à-vis the claim at issue. But a policyholder's refusal to submit to an EUO upon the insurer's request, where the policy provides for such a process, is a more surefire way to doom a claim. *See, e.g., Ram*, 2011 U.S. Dist. LEXIS 83555, at *36-37 (noting that, in California at least, refusal to submit to an EUO is "a breach of the duty to cooperate and therefore a breach of the insurance contract" that is "necessarily prejudicial to the insurer").

For example, *Abdelhamid v. Fire Ins. Exch.*, 182 Cal. App. 4th 990 (Cal. Ct. App. 2010), involved the destruction of a home by fire which the Sacramento Fire Department concluded resulted from arson, and the carrier—through its coverage counsel—chose to take the insured's EUO. Because the carrier suspected the insured might have had financial motives for the arson (e.g., possible overpayment for the home; simultaneously carrying multiple mortgages; prepaying for renovation work that was not completed and for which permits were not obtained; the recent discovery of asbestos in the property), its coverage counsel asked the insured questions about her business and personal finances. The insured "repeatedly refused to answer any questions" about such financial matters, including some questions about her bankruptcy a few years before and about her receipt of governmental assistance. *Abdelhamid*, 182 Cal. App. 4th at 996. The carrier then denied coverage, taking the position that, among other things, the policyholder's "refusal to answer questions during her EUO breached a condition precedent to her recovery under the policy" and that her "failure to cooperate was an independent basis for denying her claim." *Id.*

The insured commenced a coverage action against the carrier, the trial court granted the insurer summary judgment, and the appellate court affirmed. *Id.* at 998, 1008. The appellate court explained that "[a]n insured's compliance with a policy requirement to submit to an examination under oath is a prerequisite to the right to receive benefits under the policy" and that "failing to answer material questions" at an EUO "shows a failure to give the insurer that degree of cooperation required by the provisions of the policy" and constitutes a material breach of the policy. *Id.* at 1001 (citations and emphasis omitted).

Rather than risking running afoul of the cooperation clause, policyholders should engage with their carriers and ensure that they are responsive to the insurers' requests for information and other assistance in investigating their claims.