WHAT IS A "CLAIM" FOR CLAIMS-MADE PURPOSES?

by

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I. Introduction

Claims-made policies came into wide spread use in the 1970's as a means of reducing the tail on certain types of casualty business and making them easier to price.[1] As the claims-made concept was relatively new at the time, it was poorly understood by both insureds and the courts and numerous efforts were made to convert such coverage into occurrence based coverage by judicial fiat. This caused the drafters of such policies to take exceptional care in their drafting of the policy language.

Given the above, a definition of "claim" is a key ingredient in a claims-made policy so as to determine when, between the gleam in the eye of a potential claimant to the service of a summons and complaint, the policy is triggered.[2] Unfortunately, as policyholders and the judiciary have become more accustomed this type of coverage, the care in drafting has slackened. Thus, we have a recent case in which the court determined the meaning of "claim" without a definition to assist it: *In Re Ancillary Receivership of Reliance Ins. Co.*, 863 N.Y.S. 2d 415 (S.C. App. Div. 2008) *aff'd* 863 N.Y.S. 2d 415 (2009). The purpose of this article is to examine this case and other case law interpreting the meaning of "claim" when it is not defined in the claims-made policy.

II. *In Re Ancillary Receivership of Reliance Ins. Co.*

While Yale Club was insured under a Lloyds' D & O policy, it received an August 1993 letter from an attorney representing certain employees who claimed that they had been deprived improperly of tips and bonuses. The letter requested information in order to comply with the obligation to make reasonable inquiry before filing a suit. The insured did not inform Lloyds' of the letter. A Reliance D & O policy incepted November 23, 1993 and the following February, a suit was filed. Due to Reliance's insolvency, the insured sought coverage under the Lloyds' policy claiming that the August 1993 letter constituted a claim. The policy did not define a "claim".

Citing prior New York case law, the court found that a "claim", for purposes of a claims-made policy, constituted a demand received by the insured for money or services. The court went on to rule that the August 1993 letter was not a claim and that the Reliance policy was the one triggered:

> Plaintiff's mere awareness that an action was being contemplated by the attorney for the 13 Yale Club employees was hardly tantamount to notice that an action would be brought, since his investigation could have revealed that suit was unwarranted or subsequent events could have rendered an action unnecessary. The mere awareness of alleged wrongdoing is not a "claim" within the meaning of the typical claims-made policy (citation omitted).[3]

III. Other Case Law on Point

MGIC Indemnity Corporation v. Home State Savings Assoc., 797 F.2d 285 (6th Cir. 1986) involved a settlement by the insured of criminal charges by making restitution of certain fees for loan commitments. The settlement was motivated, in part, by a desire to avoid charges being filed against individual officers and directors. The savings association claimed that by the settlement, it had indemnified its officers and directors within the coverage provided by it D & O policy and sought reimbursement. The policy did not define a "claim". The court ruled for the insurer stating:

> In context, it seems to us, the only kind of "claim or claims" that could trigger the insurer's obligation to pay would be a demand for payment of some amount of money. . . .
>
> Home State suggests that there was a *potential* for demands against the officials for the payment of money, but a mere potential for such claims is not enough to meet the condition imposed by the policy.[4]

In Re Ambassador Group Litigation, 830 F.Supp. 147 (E.D. N.Y. 1993) involved a series of claims by a number of claimant, including two state receivers, against the proceeds of two consecutive D & O policies. Given the aggregate limits in the policies, the claimants were jockeying for position as to the year in which their claim fell. The Vermont receiver had sent letters in year one to the D & O insurer giving notice of a claim that certain officers and directors of Ambassador had committed acts compensable under the D & O policy. The Vermont receiver brought suit in year two. The policy did not contain a definition of "claim". The court found that that a "claim" for purposes of the claims-made policy, was not a mere contention of wrongdoing but a demand for relief based on such wrongdoing. The court found that the Vermont receiver's letters in year one did not meet this standard.[5]

A claim against retirement fund investment managers provided the backdrop for *Retirement Fund of Fur Manufacturers v. Republic Ins. Co.*, 755 F. Supp. 625 (S.D. N.Y.1991). Shortly before the expiration of a claims-made fiduciary liability policy, the attorney for the trustees sent a letter to the insurer entitled "claim for loss" and stating that the trustees were thereby making a claim related to the

actions of the investment managers. The policy did not define “claim”. Apparently based on the fact that the investment managers were not insureds, the court found that the letter was, merely, notice of a potential claim against the insured trustees and not notice of an actual claim.[6]

Ins. Corp. of America v. Dillon, Hardamon & Cohen, 725 F. Supp. 1461 (N.D. Ind. 1988) was a summary judgment ruling in which the court was attempting to sort out which, of numerous legal malpractice claims, were made within a particular policy year. The claims-made policy did not define “claim”. In defining the term the court stated:

> The word claim requires a demand for money or property or some specific relief, accompanied by an allegation of negligence, malpractice, or some kind of wrongdoing. . . .
>
> [A] claim is something distinct from mere awareness or even from written notice of an alleged injury. Simply becoming aware of an alleged injury is not enough to amount to a claim. Awareness is not a demand and the use of the word, claim, unless modified by other language, requires that a demand be made.[7]

An attorney malpractice claim was involved in *Phoenix Ins. Co. v. Sukut Construction Co.*, 136 Cal. App. 3d 673 (Ct. App. 1982). Shortly before the expiration of a Mission claims-made policy, an attorney met with his client who asked him, for no charge, to correct a defective mechanic’s lien which the attorney had filed. The attorney refused. After the inception of a Phoenix claims-made policy, the client filed a legal malpractice claim. It appears from the opinion that one or both of the policies did not define “claim”. The court ruled that the claim was made while the Mission policy was in effect since during the attorney’s meeting with his client he was asked to perform services (*i.e.* correct his mistake) and was not asked for an explanation or new services.

IV. Conclusion

Notwithstanding the fact that “claim” is a key term in a claims-made policy, it appears that case law will supply an adequate definition if it is not defined in the policy. The definition generally adopted by the courts – a demand for compensation or services as a result of wrongdoing covered by the policy – is similar to that commonly used by the more cautious policy drafters. This is certainly one of the happier instances in which the courts’ views and the insurers’ views of the meaning of policy language coincide.

ENDNOTES

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[1] During the late 1970’s and early 1980’s, the author drafted numerous claims-made policies for professional liability, product liability, directors’ and officers’ liability and excess liability.

[2] Policies commonly define a “claim” as a demand for money or services, including the receipt of a civil, criminal or administrative action.

[3] 863 N.Y.S. 2d 415 at 419-20.

[4] 797 F.2d 285 at 288 (emphasis in the original).

[5] 830 F. Supp. 147 at 155-6.

[6] 755 F. Supp. 625 at 630-1.
[7] 725 F. Supp. 1461 at 1469-70.