

CHAPTER 1

The Basic Types of Policies and Coverages

Chapter Contents

- § 1.01 **Components of an Insurance Policy**
 - [1] **Declarations**
 - [a] **Per Occurrence and Aggregate Limits**
 - [b] **SIRs and Deductibles**
 - [2] **Insuring Agreement**
 - [a] **Duty to Defend**
 - [b] **Duty to Indemnify**
 - [3] **Exclusions**
 - [4] **Definitions**
 - [5] **Conditions**
 - [6] **Endorsements**
- § 1.02 **Other Evidence of Insurance**
- § 1.03 **Types of Insurance Policies**
 - [1] **Claims Made vs. Occurrence**
 - [2] **Primary vs. Excess**
 - [a] **Primary Insurance**
 - [b] **Excess Insurance**
 - [c] **Umbrella Insurance**
 - [3] **Subscription/Participation Policies**
 - [4] **“Manuscript” Policies**
 - [5] **Fronting Insurance**
 - [6] **Retrospectively Rated Insurance**
- § 1.04 **Types of Coverages**
 - [1] **Comprehensive General Liability**
 - [a] **Property Damage/Bodily Injury**
 - [b] **Personal Injury**
 - [c] **Advertising Injury**
 - [d] **Contractual Liability**

- [2] **First-Party Property**
 - [a] **Named Peril**
 - [b] **All Risk**
 - [c] **Business Interruption**
 - [3] **Directors' & Officers' (D&O) Liability**
 - [4] **Products Liability**
 - [5] **Errors & Omissions (E&O) Liability**
 - [6] **Fidelity/Dishonesty Coverage**
 - [7] **Professional Liability**
 - [8] **Environmental Impairment Liability (EIL)**
 - [9] **Employers Liability**
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§ 1.01 Components of an Insurance Policy

Although the physical appearance and contents of an insurance policy may vary greatly depending on the issuing insurer, the type of coverage involved, and when the policy was issued, there are certain basic components typically found in almost any insurance policy. The most significant of these are discussed in this Chapter.

[1]—Declarations

Most insurance policies contain a section entitled the “Declarations.” Often, policy “Declarations” are contained on a separate “Declarations Page,” typically attached as the first page of the policy. The purpose of the “Declarations” is to set forth certain basic information about the parties and the type of insurance coverage involved. Thus, the “Declarations” section usually will contain information concerning the following:

- the identity of the insurer providing the coverage;
- the identity of the policyholder(s) covered by the policy;
- the type of insurance coverage provided (e.g., comprehensive general liability, directors' & officers' liability, professional liability, etc.);
- the effective dates of the insurance coverage;
- the amount of coverage provided (i.e., the policy's dollar limits of coverage), including any aggregate limits;
- the applicable policy retention or deductible;
- the identity of any insurance agent or broker involved in placing the coverage; and
- the amount of premium to be charged for the insurance coverage.

[a]—Per Occurrence and Aggregate Limits

The “Declarations” section of liability insurance policies indicates that the limits of liability of the policy are being provided on either a “per occurrence” and/or “aggregate” basis. As the name suggests, “per occurrence” limits are the dollar limits of insurance coverage available for each and every occurrence, accident or loss covered by the policy. “Aggregate” limits identify the total dollar amount that the insurer will pay under the policy with respect to claims or losses covered by the “Aggregate” limits provisions.

A policy providing “per occurrence” limits of liability without any “aggregate” limits will be required to pay the “per occurrence” limit for each and every covered occurrence, no matter how many such occurrences take place. Such policies provide a theoretically limitless amount of insurance coverage, subject only to a cap on the amount of insurance provided with respect to each particular occurrence. In contrast, policies containing “aggregate” limit provisions place a limitation on the total amount of coverage that will be provided under the policy. Once the “aggregate” limit of the policy is reached, the insurer typically will not be obligated to provide coverage with respect to any further occurrences.

Policies may provide for “aggregate” limits with respect to some types of claims and occurrences but not others. For example, general liability policies issued in the 1960’s and 1970’s frequently provided aggregate limits of liability with respect to products/completed operations claims, but provided per occurrence limits without aggregate limits with respect to other types of property damage and bodily injury claims. Thus, care must be taken in examining the “Declarations” section of any policy in attempting to determine whether “aggregate” limits are applicable to a particular type of claim. Moreover, provisions contained in the text of the policy, such as a “Limits of Liability” provision, may provide further guidance concerning the nature and scope of any aggregate limits contained in the policy.

Some courts have concluded that asbestos claims may be covered under the premises/operations coverage of general liability insurance policies. For example, one court has concluded that asbestos claims against an insulation installation company fell under the premises/operations coverage of general liability insurance policies issued to the installation company (coverage that was not subject to an aggregate limit), and not under products hazard coverage that the company did not purchase and which would normally be subject to an aggregate limit.¹ It is important to keep in mind, however, that

¹ Commercial Union Insurance Co. v. Porter Hayden Co., 698 A.2d 1167, 1207-1209 (Md. App. 1997).

even if “premises” or “operations” coverage is not subject to aggregate limits, the coverage remains subject to “per occurrence” limits of liability. Thus, the number of occurrences will be an important factor in calculating the limits of available coverage for a particular class of claims—if a group of asbestos claims results from a single occurrence, a single per occurrence limit of liability will be available for those claims.

[b]—SIRs and Deductibles

Although some insurance policies provide coverage from the very first dollar of the policyholder’s loss or liability, many policies contain some sort of deductible or self-insured retention (“SIR”) requiring the policyholder to bear some portion of the loss or liability before the insurer’s obligations under the policy are triggered. Deductibles and SIRs often are referred to interchangeably. There are, however, subtle distinctions between deductibles and SIRs that may be significant.

An SIR reflects the amount of loss or liability that must be incurred and paid by the policyholder before the insurer must respond. For example, an insurer under a policy with \$100,000 in limits subject to a \$25,000 SIR would not have to respond until the loss or liability at issue exceeded \$25,000. As the term “self-insured retention” suggests, the policyholder is generally responsible for payment of the first \$25,000 of any loss or liability.²

In contrast, and properly used, the term “deductible” refers to that portion of the insurer’s limit of liability that must be reimbursed by the policyholder to the insurer. A deductible is unlike an SIR in that the insurer is generally obligated to pay the full amount of the third-party claim (up to the upper limit of the policy) and then seek reimbursement of the deductible from the policyholder. For example, a policy providing \$100,000 of coverage with a \$25,000 deductible generally would require the insurer to pay the full amount of a claim subject to applicable policy limits and then seek to recover the \$25,000 deductible from its policyholder. In a deductible policy, the insurer generally cannot argue that the policyholder’s inability to reimburse the insurer for the amount of the deductible excuses the insurer’s obligation to pay the full amount of a covered claim. In cer-

² The “self-insured retention” should not, however, be confused with actual insurance. Most courts agree that the policyholder’s agreement to retain responsibility for a portion of its losses and liabilities before turning to its insurance carriers does not transform the policyholder into a “insurer,” for example, for purposes of applying “other insurance” clauses of liability insurance policies. See § 14.06 *infra*.

tain instances, a policy may define the deductible in a manner that more resembles an SIR.

Although deductibles and SIRs may on their face appear functionally equivalent, there are several important distinctions between the two. First, the impact of a deductible on the insurance company's limits of liability is different from the impact of an SIR. In the example noted above, and absent policyholder inability to pay or insolvency, the insurer's limits of liability are effectively reduced from \$100,000 to \$75,000 by operation of the \$25,000 deductible. In contrast, the hypothetical \$100,000 policy subject to a \$25,000 SIR continues to provide \$100,000 in coverage; coverage simply does not attach until the SIR is exceeded.

Second, liability insurance policies containing a duty to defend provision³ may be impacted differently by the presence of a deductible provision as opposed to an SIR. A policy containing a deductible provision normally is deemed to attach and the insurer is required to respond for duty to defend purposes at the first dollar level, i.e., as soon as the claim or lawsuit is brought against the policyholder. The duty to defend under a policy containing an SIR, however, may not be triggered until such time as the policyholder has exhausted its SIR by virtue of making defense payments on its own behalf.

Finally, it is worth noting that deductibles and SIRs stated to apply on a per-occurrence or per-claim basis sometimes are subject to "aggregate" provisions. Certain policies, for example, provide that the policyholder's obligation to pay a deductible or SIR is eliminated when the total amount of such payments by the policyholder has reached the aggregate limit figure.

[2]—Insuring Agreement

Most insurance policies contain a separate, clearly identified clause that sets forth the insurer's basic agreement to provide coverage. These provisions typically are referred to as "insuring agreements." The insuring agreement of a policy usually will set forth the nature of the losses, liabilities and/or claims covered by the policy and identify the nature of the insurer's obligation with respect to covered claims. For example, the insuring agreement generally should identify whether the insurer's obligation is limited to indemnifying the policyholder for covered losses, liabilities or claims, or whether the insurer's obligation also extends to defending the policyholder against claims.

³ See Chapter 8 *infra*.

[a]—Duty to Defend

Most insurance policies containing a duty to defend provision require the insurer to undertake the defense of any claims against the policyholder of the type covered by the policy. Some policies, however, provide only that the insurer has the right to associate with the policyholder in the defense of covered claims. Still other policies obligate the insurer to “pay on behalf of” the policyholder the costs of defending covered claims or, alternatively, to reimburse the policyholder for such defense costs.⁴

[b]—Duty to Indemnify

The central obligation of the insurance company undertaken in most commercial insurance policies is the obligation to indemnify the policyholder against covered losses, liabilities, or claims. This obligation typically requires the insurer to reimburse the policyholder for amounts paid in defense, settlement or satisfaction of judgment with respect to matters covered by the policy. Some policies, however, require the insurance to pay such amounts “on behalf of” the policyholder.

[3]—Exclusions

Insurance policies generally contain a separate section setting forth the losses, activities or events that are excluded from coverage. Policy provisions that have the effect of limiting or excluding coverage, however, also may be located in other portions of the policy or in separate endorsements to the policy.⁵ Policy exclusions are, as a matter of black letter insurance law, generally construed narrowly and against the insurer, with all doubts as to their application construed in favor of the policyholder.⁶

[4]—Definitions

Insurance policies typically contain a separate section devoted to definitions of certain terms used in the policies. When a word or term used in an insurance policy is not defined, courts generally will ascribe to such word or term its plain and ordinary meaning, as opposed to a technical or special meaning.⁷ In the absence of a policy definition, courts often consult dictionary definitions in order to

⁴ The duties and obligations imposed by various defense provisions are discussed in detail in § 2.03[4] and Chapter 8 *infra*.

⁵ See § 1.01[6] *infra* for a discussion of policy endorsements.

⁶ See § 7.02[4] *infra*.

⁷ See § 7.02[1] *infra*.

determine the “plain and ordinary meaning” of words and phrases contained in insurance policies.⁸

[5]—Conditions

Most insurance policies have distinct segments setting forth the various conditions that the policyholder must satisfy. Conditions that often are imposed on policyholders include:

- payment of the applicable premium;
- notification to the insurer and/or its designated agent of losses or claims under the policy;
- assistance to and cooperation with the insurer in its investigation of losses and claims under the policy; and
- in the case of first-party insurance (e.g., property coverage, business interruption insurance, fidelity bonds), submission of proofs of losses claimed to be covered under the policy.

The conditions section of the policy also may set forth other limitations on the policyholder’s rights to pursue or obtain coverage, such as “suit limitation” clauses that require the policyholder to initiate any litigation concerning a claim under the policy within a specific time period.⁹ Policy conditions also may regulate the insurer’s rights with respect to contribution from “other insurance” that also covers a policyholder’s loss or liability.¹⁰

[6]—Endorsements

Endorsements usually are separate documents appended to a policy that may alter, add or delete policy terms, conditions, definitions and/or exclusions. Endorsements may be made a part of the policy’s provisions at the outset, or may be added at a later time during the term of the policy. Endorsements that are added after the issuance of

⁸ State Courts:

Illinois: Lapham-Hickey Steel Corp. v. Protection Mutual Insurance Co., 655 N.E.2d 842, 847 (Ill. 1995) (referring to the Oxford English Dictionary for the lay meaning of the word “suit”).

New Hampshire: Coakley v. Maine Bonding & Casualty Co., 618 A.2d 777, 785 (N.H. 1992) (consulting Webster’s Third New International Dictionary for the definition of the word “damages”).

Rhode Island: Ellis v. Rhode Island Public Transit Authority, 586 A.2d 1055, 1058 (R.I. 1991) (using Black’s Law Dictionary to define the word “policy”).

Washington: Port of Seattle v. Lexington Insurance Co., 48 P.3d 334, 337 (Wash. App. 2002).

⁹ See § 2.02[5] *infra*.

¹⁰ See § 14.06 *infra*.

the policy, however, often are made effective as of the inception date of the policy.

The scope and nature of policy endorsements can be virtually limitless. Endorsements frequently serve the function of adding more detailed information concerning the policyholders covered by the policy. The inclusion of “additional insureds” under the policy typically is also accomplished by way of endorsement. The form of the endorsement extending “additional insured” status may determine whether coverage is extended to additional insureds for liabilities resulting from their own acts or omissions or only for their vicarious liability for the acts of the named insured.¹¹ Thus, care must be used in assessing the extent of coverage afforded by virtue of an “additional insured” endorsement. Endorsements also often are used to update or revise policy terms that must be changed during the term of the policy such as, for example, a change of the location to which notice of a loss or claim should be sent.

Many policies contain endorsements that set forth specific language changes that are mandated by a particular state’s insurance regulator. These endorsements, which are commonly labeled “amendatory endorsements,” reflect the public policy goals of a particular state insurance regulator with respect to insurance policies issued under its jurisdiction. Common amendatory endorsements include more specific and more stringent requirements that must be satisfied before an insurer can cancel a policy. Certain state regulators also require endorsements that delete mandatory arbitration provisions or narrow coverage for punitive damages in order to reflect that state’s public policy goals. State amendatory endorsements often expand the rights and protections provided to policyholders, so it is important to identify any state-mandated endorsements that bear upon the specific insurance coverage issue being analyzed.

In addition, endorsements can be used to expand the coverage of the policy beyond the basic policy text. For example, for many years comprehensive general liability (“CGL”) policies were endorsed to expand coverage beyond basic “bodily injury” and “property damage” liability insurance to include coverage for “personal injury” or “advertising injury.” Similarly, first party policies might, for example, contain endorsements expanding coverage to include business interruption insurance or coverage for valuable papers or computers.

¹¹ *Garcia v. Federal Insurance Co.*, 969 So.2d 288 (Fla. 2007) (answering a question certified by the United States Court of Appeals for the Eleventh Circuit, the Florida Supreme Court concluded that coverage under an additional insured endorsement that extended coverage “with respect to liability because of acts or omissions of the named insured” was limited to instances in which the additional insured is vicariously liable for the acts of the named insured).

On the other hand, endorsements also can be used to narrow or add exclusions to the basic policy form. The limited “pollution exclusion”¹² introduced in 1970, for instance, originally was promulgated as an endorsement to be attached to various liability insurance policies. In more recent years, exclusions for asbestos-related and lead-related liabilities also have been added to CGL policies by endorsement.

Given their possibly broad nature and scope, policy endorsements must be reviewed carefully when considering the coverage available under any insurance policy. In keeping with general rules of contract construction, a specific provision in a policy endorsement usually will govern over a general provision contained within the text of the policy.¹³

¹² See § 10.01[1] *infra*.

¹³ **State Courts:**

California: Jane D. v. Ordinary Mutual, 32 Cal. App.4th 643, 650, 38 Cal. Rptr.2d 131, 135 (Cal. App. 1995) (noting that “[e]ven if the general liability policy covers plaintiff’s claims, the . . . specific endorsements prevail over the more general terms of the general liability policy”).

New Mexico: Weldon v. Commercial Union Assurance Co., 710 P.2d 89 (N.M. 1985) (citing cases that stand for the proposition that “a specific provision relating to a particular subject will govern in respect to that subject, as against a general provision”).

New York: Aguirre v. City of New York, 625 N.Y.S.2d 597 (N.Y. App. Div. 1995) (applying the rule that “[w]here there is an inconsistency between specific provisions and a general provision of [an insurance] contract, the specific provision controls”).

§ 1.02 Other Evidence of Insurance

A variety of written instruments apart from an insurance policy itself may provide evidence of insurance.¹ Some of the more common types of secondary insurance instruments are discussed below.

Binders are documents issued by insurance brokers or intermediaries when an insurer agrees to provide a particular type and amount of coverage to a particular insured. A binder usually will set forth only the most basic information about the coverage being bound, such as the identity of the policyholder and insurer, type of insurance, amount of coverage, and policy period. Binders often contain a disclaimer stating that the insurance policy itself, once issued, will control in the case of any conflict between the policy and the binder.

Certificates of insurance and cover notes are similar to binders, but generally contain more detailed information about the terms, conditions and exclusions of the coverage. Certificates of insurance and cover notes may be issued by insurance brokers or other intermediaries as evidence of the provision of coverage pending issuance of the actual insurance policy. Again, certificates and cover notes often expressly state that the insurance policy itself will govern in the event of any conflict in terms. Certificates and cover notes often were used in connection with the placement of insurance in the London market (i.e., with Lloyd's of London and London market insurance companies) due to the sometimes very substantial lapse in time between placement of the insurance coverage and issuance of the policy wording.

Placing slips are documents used in the procurement of insurance from Lloyd's of London and London market insurance companies.² Placing slips contain basic information about the policyholder and the terms, conditions and exclusions of coverage. Typically, the applicable policy provisions are designated by reference to standardized policy forms and endorsements used by underwriters in the London market. Thus, the placing slip serves as a shorthand version of the policy wording, which is compiled and issued at a later date.

The legal effect of placing slips is a matter of some controversy. The later-issued insurance policy usually is deemed to be the governing document in the event of any conflict between the placing slip

¹ For a discussion of the use of such instruments, as well as other evidence, to establish the existence and contents of lost or missing insurance policies, see § 6.03[3] *infra*.

² For a more detailed discussion of the process of placing insurance in the London market, see § 13.01 *infra*.

and the policy.³ In the absence of a policy issued by the underwriters, however, a placing slip may be given legal effect as a binding contract of insurance.

³ Youell v. Bland Welch & Co., 2 Lloyd's Rep. 423 (1990).

§ 1.03 Types of Insurance Policies

[1]—Claims Made vs. Occurrence

As a matter of general principle, insurance policies typically fall into two distinct categories: “claims made” policies and “occurrence” policies. Although claims made policies have been used for many years in directors’ and officers’ (“D&O”) liability insurance, it was not until 1985 that a standardized, claims made form was developed for use in the CGL insurance arena. In contrast, occurrence based insurance coverage has been in existence since at least the 1930’s or earlier (although the standard CGL “occurrence” policy was not promulgated until 1966).

“Claims made” coverage is a term of art that encompasses a variety of insurance products that provide coverage for claims made against the policyholder during the period of the insurance policy. The exact formulation of the coverage-triggering event under “claims made” policies may differ dramatically from policy to policy. These policies usually require, however, both that the claim be made against the policyholder *and* reported by the policyholder to the insurer during the effective dates of the coverage. Claims made policies usually provide the policyholder “tail” coverage or a “discovery” period that permits the policyholder to notify the insurer of claims within a specified period of time (typically 90 days) after the expiration date of the policy without forfeiting coverage.

“Occurrence” coverage, conversely, provides coverage for injury, damage or loss that occurs during the term of the policy, regardless of when a claim is made or a lawsuit is brought against the policyholder as a result.¹ Exactly what constitutes the “occurrence” of damage or injury during the policy period, however, has been the subject of great debate.²

[2]—Primary vs. Excess

In the world of commercial insurance, policyholders usually are unable to satisfy all of their insurance needs by purchasing a single policy of insurance from a single insurer. Commercial policyholders may require insurance against a variety of potential losses, claims and lia-

¹ See, e.g., *Century Indemnity Co. v. Hearrean*, 120 Cal. Rptr.2d 66, 72 (Cal. App. 2002) (“In our case, the trigger of coverage, the continuous and progressive injury to the hotel property caused by defective design and construction, occurred during the policy period and activated [the insurer’s] defense and indemnity obligations. To require the claim of the third party . . . to arise during the policy period, ‘would unduly transform [an occurrence-based CGL policy] into a “claims made” policy.’”).

² See § 9.04 *infra*.

bilities, in amounts totalling tens or even hundreds of millions of dollars. As a result, commercial insureds frequently have complex insurance coverage programs involving multiple insurers and coverages.

A typical commercial policyholder may have several distinct subprograms of insurance, providing coverage, for example, for (1) first-party losses, (2) third-party liabilities for bodily injury, personal injury, and property damage, and (3) liabilities due to the acts or omissions of directors and officers. Each of these subprograms, in turn, may consist of a series of insurance policies organized in “layers” of coverage, each layer attaching at a distinct dollar level and providing coverage on particularized terms. At some level, the disparate subprograms may merge under an “umbrella” of coverage that encompasses a wide variety of risks of different types.

The discussion that follows illustrates some of the basic types of insurance policies purchased by corporate policyholders.

[a]—Primary Insurance

The term “primary insurance” often is used to refer to insurance coverage that attaches at the first dollar of the policyholder’s loss or liability. This term includes policies containing deductibles, as long as the insurer’s obligations to the policyholder arise at the first instance of loss or liability. In contrast, policies subject to self-insured retentions (“SIRs”) often are not referred to as “primary” insurance, although policies attaching directly in excess of an SIR do in fact provide the primary level of insurance protection to the policyholder.

The other defining characteristic of primary liability insurance is that, in most cases, it provides some form of defense coverage to the policyholder. As discussed in § 1.01[2][a] *supra*, this defense coverage can take the form of a direct obligation to defend potentially covered third-party claims brought against the insured, or may consist of an obligation to pay for or reimburse the costs of such defense.

Significantly, primary CGL insurance policies may provide defense coverage in addition to the limits of liability available under the policy for indemnity purposes. Insurers under policies providing for defense in addition to limits would, therefore, be required to continue to provide defense coverage even though the amounts expended in defense might exceed the policies’ indemnity limits.

[b]—Excess Insurance

The term “excess insurance” is generally used to refer to policies that provide coverage in excess of the coverage provided by other insurance policies, either primary policies or other excess policies. As noted above, policies attaching in excess of an SIR also may be

referred to as “excess” policies, especially if they contain no defense obligation.

There are many different types of excess insurance policies. Generally, however, excess policies fall into two broad categories: “stand-alone” policies and “following form” policies.

As the name implies, “stand-alone” excess policies contain their own full and complete set of terms, conditions and exclusions. Although the dollar point at which these policies attach may be in excess of the coverage provided by other insurance policies, stand-alone policies do not rely upon, adopt or incorporate the provisions of the policies that underlie them.

“Following form” excess policies, however, will (to one extent or another) adopt or incorporate certain of the provisions of the policies underlying them. Structurally, following form policies usually consist of a relatively short policy text containing its own set of provisions, one of which states that the policy is subject to the terms, conditions and exclusions of some underlying policy or policies.

Certain provisions of underlying policies, such as the limits of liability, the amount of premiums, where the policyholder should direct notice of claims, and the attachment point of coverage will not be incorporated in a following form policy. The extent to which other terms, conditions and exclusions of underlying policies are adopted will, however, be defined by the following form provision of the excess policy. In some instances, virtually all of the provisions of the underlying policy or policies will be adopted; in other instances, the extent to which underlying terms, conditions and exclusions are adopted will be more limited. Thus, the language of the following form policy defining what provisions of underlying coverages actually are followed must be closely scrutinized in each case.

In any event, however, a following form excess insurer generally is not automatically bound by the decision of a primary insurer to settle a claim. The Massachusetts Supreme Court has concluded that:

An excess carrier’s intent to incorporate the same words used in a separate agreement between the primary insurer and the insured does not imply an intent by the excess carrier to accept decisions made by the primary carrier about the extent of its obligations under its own agreement. By adopting the form of words used by [the underlying insurer], the underwriters did not cede to it the right to make decisions about the underwriters’ obligation to perform in various circumstances. To conclude otherwise would undermine the distinct and separate nature of each insurer’s contract with [the policyholder].³

³ Allmerica Financial Corp. v. Certain Underwriters at Lloyd’s London, 871 N.E.2d 418, 428 (Mass. 2007).

There are two additional considerations of importance with respect to following form excess policies. First, such policies must be examined carefully to determine which underlying policy or policies are being followed. When the following form policy sits in a layer of coverage in excess of several other layers, occupied by numerous policies issued by numerous insurers, there is a significant risk that the identification of the policy or policies being followed may be imprecise or confusing.

If the wording of all the underlying policies is the same, then this presents no significant issue. In some instances, however, the underlying coverages may contain significantly different conditions and exclusions, which could materially impact the coverage available under the following form policy depending upon which of the competing underlying policies is selected as controlling. In such cases, in keeping with the general rule that policy ambiguities or uncertainties should be construed against the insurer, the policyholder should be given the benefit of the underlying coverage provisions that are most favorable to it.

Second, as noted above, following form policies usually contain at least some of their own terms, conditions and exclusions. As a result, issues may arise if the following form policy contains an express provision that conflicts with a provision contained in an underlying policy to which it purportedly follows form. Some following form policies will address this issue by providing that they follow the form of the designated underlying policies “except as otherwise provided” or except where the underlying policies are inconsistent with the express provisions of the following form policy.⁴ Where the following form policy is silent on how to resolve conflicts in wording with the underlying policy or policies it purports to follow, however, the conflict should be resolved in the manner most favorable to the policyholder.

[c]—Umbrella Insurance

“Umbrella” insurance is a special type of coverage that can incorporate elements of both primary and excess coverage. Umbrella coverage is designed to provide insurance for a defined variety of different types of liabilities. Where the insured has purchased primary insurance coverage as to a particular liability risk, the umbrella policy serves as excess coverage. An umbrella policy can attach at several different points with respect to different coverages where the pol-

⁴ XL Specialty Insurance Co. v. Agoglia, 2009 WL 513747 (S.D.N.Y. 2009) (finding that provision in excess policy superseded contrary provision in primary policy where excess policy followed form “except as specifically set forth in the provisions of this Policy”).

icyholder has separate primary policies with different limits of liability covering different risks.

In addition, umbrella policies may serve as primary coverage with respect to liabilities covered by the umbrella but not by any primary coverage held by the policyholder. Thus, umbrella coverage may serve as primary insurance with respect to certain areas of liability while serving as excess coverage with respect to others.

An umbrella insurance policy, for example, might provide both general liability coverage and products liability coverage, each in excess of one of two separate primary policies, one providing CGL coverage and the other products liability coverage. The attachment point of the umbrella policy may be different with respect to each of these coverages. The same umbrella policy also might function as primary advertising injury coverage (subject, in all likelihood, to a self-insured retention) if the policyholder did not have a separate primary policy covering such risks.

According to a study by the Northern California Chapter Society of Chartered Property and Casualty Underwriters, the umbrella policy was first introduced into the United States by underwriters at Lloyd's, London in 1947. By 1955, umbrella policies were being sold on a widespread basis in the American market.⁵

[3]—Subscription/Participation Policies

Insurance policies, especially those sold by insurers in the United States, usually are contracts entered into by a policyholder and a single insurance company. However, some insurance coverages (especially those placed in the London insurance market) are placed on a subscription or participation basis, meaning that several insurers agree to provide coverage under one insurance contract.

Subscription or participation coverage has been placed by some United States insurance brokers. These placements typically take the form of a document designated as a “certificate of insurance” or “cover note” that is agreed to by several different insurers, each being responsible for a designated percentage of the coverage provided. Each insurer then may or may not issue its own separate insurance policy document reflecting its agreement to provide coverage under the terms of the certificate or cover note.

In the London insurance market, coverage is frequently placed on a subscription or participation basis. Coverage often is split into a

⁵ Northern California Chapter Society of CPCUs, “Umbrella Liability Coverage,” 13 C.P.C.U. Annals 243, 244, 247 (Summer 1960) (hereinafter “Umbrella Liability Coverage”).

Lloyd's of London segment and a London Companies segment, each of which is then further subdivided among many different Lloyd's Syndicates or London Companies. A separate policy document usually is issued reflecting the Lloyd's participation in the coverage, with one or more policy documents issued with respect to each group of subscribing London Companies.

[4]—“Manuscript” Policies

In many instances, insurance policies are standardized documents issued on preprinted forms prepared by the insurer and used in coverage sold to dozens, hundreds, or even thousands of policyholders. Although the terms, conditions and exclusions of the policies may be altered or amended through the use of endorsements, even the endorsements may be preprinted form documents drafted by the insurer.

Some insurance policies, however, are not issued as preprinted forms. Any insurance policy not consisting of a preprinted form is referred to generically as a “manuscript” policy. Manuscript policies may include insurance policies that have been specially drafted and prepared for an individual insured as the result of negotiations.

The fact that a policy does not consist of preprinted forms and is characterized as a “manuscript” policy, however, does not necessarily indicate that the policy language is the product of negotiation. Some manuscript policies, while not being preprinted forms, consist in whole or in part of terms, conditions or exclusions drafted and regularly used by the insurer. The “manuscript” nature of the policy may derive, for instance, from the fact that the insurer has decided to take standardized provisions from several different form policies and combine them into a single policy for a particular insured.

[5]—Fronting Insurance

Some insurance coverage is characterized as “fronting” insurance. “Fronting” insurance falls, for the most part, into two classifications: (1) coverage that is reinsured and (2) coverage that is self-insured by the policyholder.

In some cases, an insurer may wish to issue coverage to a policyholder but be unable to do so directly for a variety of reasons. Under these circumstances, the insurer may be able to provide the insurance indirectly through the use of a “fronting” arrangement whereby another insurer issues the actual policy of insurance, which is then reinsured in whole or substantial part by the first insurer. The insurer issuing the policy bears the credit risk that the reinsurer may become insolvent or otherwise unable to pay, but otherwise effectively is on

the risk in name only, with all parties fully aware that the reinsuring company is the real party in interest.

“Fronting” insurance also sometimes serves as a form of self-insurance. In these instances, the “fronting” policy typically will contain a deductible in an amount that equals the policy’s limits of liability (e.g., the policy will provide \$1 million in limits subject to a \$1 million deductible). The result is that the policyholder is effectively self-insured for the amount of coverage involved in the “fronting” policy.

This type of fronting arrangement may be necessary where the policyholder must show evidence of insurance for regulatory purposes, or in order to provide certificates of insurance to third parties. The self-insured fronting policy also may be used by a policyholder for purposes of obtaining a “primary” policy from the provisions of which can be adopted and followed by excess insurers.

[6]—Retrospectively Rated Insurance

Some insurance policies, particularly primary liability insurance policies, are designed so that premium payments under the policies are “retrospectively rated.” These policies essentially provide that the amount of premium paid by the policyholder will depend on the level of covered losses incurred. A typical retrospective premium provision would require an annualized determination of the amount of covered losses incurred under the policy, with the policyholder then paying a designated percentage of that amount to the insurer.

Not surprisingly, retrospectively rated insurance programs can take many different forms. Some are designed as primary level self-insurance programs with a claims handling element. Under these programs, the insurer handles the investigation, defense and settlement of claims. The policyholder then is required to pay 100% of the covered losses incurred, plus an additional percentage to account for the claims handling function performed by the insurer.⁶

Other retrospectively rated programs contain various limitations that preserve some element of pure insurance for the policyholder. The amount of each covered occurrence or loss subjected to retro-

⁶ An interesting issue arises when a policyholder claims that an insurer failed to defend a covered claim under a policy containing a retrospective premium provision. Where the retrospective rating provision would require the policyholder to pay 100% of the loss together with an additional amount for handling, does the policyholder suffer any damages based on the insurer’s failure to handle a covered claim? Arguably, the insurer should not be permitted to fully enforce the retrospective premium provision when it breaches its duty to defend, as the policyholder under such circumstances has been denied the benefits of the claims handling arrangement for which it contracted.

spective rating may, for example, be limited. Aggregate amounts that can be retrospectively rated under a particular policy may be established in addition or as an alternative to per occurrence or per loss limits. Finally, temporal limitations can be placed on retrospective adjustments, permitting the insurer to obtain additional premium payments only during a limited time period.

§ 1.04 Types of Coverages

As might be expected, there are an extremely large number of different insurance coverages available to commercial insureds. These coverages span the entire range of risks faced by corporate America, including risks of loss of or damage to properties and facilities owned and operated by the policyholder as well as risks posed by claims, demands and lawsuits brought by third parties seeking to impose liability upon the policyholder. This section outlines the principal features and components of some of the more significant types of coverages typically purchased by commercial concerns.

[1]—Comprehensive General Liability (CGL)

Perhaps the most significant type of coverage usually obtained by corporate policyholders is comprehensive general liability (“CGL”) insurance.¹ As the name suggests, CGL coverage provides a broad range of insurance against a variety of potential liabilities facing the ordinary corporate policyholder. One of the principal defining characteristics of CGL coverage is that it typically obligates the insurer to defend the policyholder against potentially covered claims in addition to indemnifying the policyholder for its liability as a result of covered claims.

[a]—Property Damage/Bodily Injury

Much of the CGL coverage sold by United States insurers has been written on standardized policy forms drafted, developed and promulgated by insurance industry trade organizations. The first standardized CGL form was created in approximately 1940. The original CGL form provided coverage for the policyholder’s liability resulting from bodily injury and property damage “caused by accident.” Although much of the CGL coverage issued during the 1940’s (and earlier, before the development of an industry standard form) was written on an “accident” basis, many early policies also substituted the term “occurrence” for “accident.”²

Historically, the hallmark of CGL insurance has been the provision of broad coverage in the form of both defense and indemnity against third-party claims and liabilities. The wording of the 1955 standard

¹ CGL coverage is sometimes referred to as “commercial general liability” or “general liability” insurance. This difference in terminology is, as a practical matter, one of form rather than substance. For purposes of this section, “CGL” refers to coverages denominated as “comprehensive general,” “commercial general” and/or “general” liability insurance.

² An endorsement modifying coverage from an “accident” to “occurrence” basis was developed as early as 1943.

CGL policy is illustrative of the CGL coverage available to commercial insureds during the 1940's, 1950's and first half of the 1960's. The insuring agreement of the 1955 CGL form set forth the insurer's basic obligations as follows:

I. Coverage A—Bodily Injury Liability

To pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury, sickness or disease, including death at any time resulting therefrom, sustained by any person and caused by accident.

Coverage B—Property Damage Liability

To pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of injury to or destruction of property, including the loss of use thereof, caused by accident.

II. Defense, Settlement, Supplementary Payments

With respect to such insurance as is afforded by this policy, the company shall:

- (a) defend any suit against the insured, alleging such injury, sickness, disease or destruction and seeking damages on account thereof, even if such suit is groundless, false or fraudulent; but the Company may make such investigation, negotiation and settlement of any claim or suit as it deems expedient; . . .

“Accident” was not defined in the policy form. The terms “bodily injury” and “property damage” were not separately defined or described outside of the insuring agreement.

Standard exclusions in the CGL policies of this period included exclusions for:

- damage to property owned, occupied or rented by the insured;
- liability assumed under all but a narrow, defined type of contract;
- liability arising out of “products hazards” and “completed operations;”
- property damage from explosion or collapse; and
- property damage to underground property (e.g., pipes, sewers, wires).

The 1955 CGL form also contained a series of standard conditions, including:

- the provision of aggregate limits of liability for certain coverages;
- the requirement that the insured give notice to the insurer of an accident “as soon as practicable”;
- the requirement that the insured “immediately” give notice of a claim or suit to the insurer; and
- an “other insurance” clause stating that the insurer would not be liable for a greater proportion of a covered loss than the proportion of its limits of liability to the limits of “all [other] valid and collectible insurance” against the loss.

In 1966, a CGL policy form that adopted “occurrence” as the industry standard was promulgated by the National Bureau of Casualty Underwriters (“NBCU”), an organization of insurance underwriters that, among other things, drafted standard wording for use by domestic insurers. The insuring agreement of the 1966 CGL form states:

The company will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of

[Coverage] A. bodily injury or
[Coverage] B. property damage

to which this [insurance] applies, caused by an occurrence, and the company shall have the right and duty to defend any suit against the insured seeking damages on account of such bodily injury or property damage, even if any of the allegations of the suit are groundless, false or fraudulent, and may make such investigation and settlement of any claim or suit as it deems expedient, but the company shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of the company’s liability has been exhausted by payment of judgments or settlements.

“Occurrence” was defined in the 1966 standard CGL policy as “an accident, including injurious exposure to conditions, which results, during the policy period, in bodily injury or property damage neither expected nor intended from the standpoint of the insured.”

Several other significant changes were implemented in the 1966 CGL wording. “Bodily injury” and “property damage” were sepa-

rately defined. Also, new exclusions were added to the policy relating to products liability.

A “business risks” exclusion barred coverage for injury or damage resulting from the failure of the insured’s products or work “to perform the function or serve the purpose intended” if such failure was due to design-related error. The “business risks” exclusion, however, did not apply to injury or damage resulting from the “active malfunctioning” of the products or work.

A “sistership” exclusion³ barred coverage for “damages claimed for the withdrawal, inspection, repair, replacement, or loss of use” of the insured’s products or work, or any property of which the insured’s products or work formed a part. The exclusion, however, applied only if the involved products, work or property were “withdrawn from the market or from use because of any known or suspected defect or deficiency therein.”

The definition of “occurrence” was modified in the 1973 edition of the standard CGL form to provide coverage for “an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured.” The requirement that bodily injury or property occur “during the policy period” was incorporated in the definitions of those terms.

The 1973 form also included a “pollution exclusion,” which was first promulgated in 1970 as a separate policy endorsement by the Insurance Rating Board (“IRB”) and Mutual Insurance Rating Bureau (“MIRB”), the successors to the NBCU. The “pollution exclusion” consisted of two parts. The first part excluded coverage for bodily injury and property damage “arising out of the discharge, dispersal, release or escape” of various pollutants “into or upon land, the atmosphere or any water-course or body of water.” The exclusion, however, did not apply where the “discharge, dispersal, release or escape” was “sudden and accidental.” The second part of the “pollution exclusion” excluded all coverage for the “discharge, dispersal, release or escape” of oil or petroleum substances “into or upon any watercourse or body of water” with respect to a list of designated oil and gas operations.

Another major revision of the standard CGL form occurred in 1986. At that time, the Insurance Services Office, Inc. (“ISO”), the successor organization to the IRB and MIRB, promulgated two new CGL forms, one operating on an occurrence basis and one operating on a claimsmade basis. The new forms included an “absolute” pollu-

³ See § 10.01[2][b] *infra* for a discussion of the sistership exclusion.

tion exclusion that further restricted coverage for liabilities resulting from injury or damage caused by pollution. The “absolute” exclusion included in the 1986 ISO form reads as follows:

This insurance does not apply to . . . :

f. (l) “Bodily injury” or “property damage” arising out of the actual, alleged or threatened discharge, dispersal, release or escape of pollutants: (a) at or from premises you own, rent or occupy; (b) at or from any site or location used by or for you or others for the handling, storage, disposal, processing or treatment of waste; (c) which are at any time transported, handled, stored, treated, disposed of, or processed as waste by or for you or any person or organization for whom you may be legally responsible; or (d) at or from any site or location on which you or any contractors or subcontractors working directly or indirectly on your behalf are performing operations: (i) if the pollutants are brought on or to the site or location in connection with such operations; or (ii) if the operations are to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize the pollutants.

(2) Any loss, cost, or expense arising out of any governmental direction or request that you test for, monitor, clean up, remove, contain, treat, detoxify or neutralize pollutants. Pollutant means any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes materials to be recycled, reconditioned or reclaimed.

Subsequently, this exclusion was revised to apply to the “seepage” and “migration” as well as “discharge,” “dispersal,” “release” or “escape.”

[b]—Personal Injury

Some insurance policies use the term “personal injury” to either mean or encompass “bodily injury.” “Personal injury” coverage more typically, however, refers to insurance against liabilities arising out of a number of business torts.

Although it had been underwritten by insurance companies to a limited extent for many decades theretofore, “personal injury” coverage first emerged on a widespread scale during the late 1940’s and

⁴ See Berry, “Umbrella Liability Insurance,” Unpublished MBA Thesis, Wharton School, University of Pennsylvania, at Appendix B (1961) (hereinafter “Berry Thesis”).

early 1950's, when umbrella liability policies were introduced. The original Lloyd's umbrella policy, introduced in 1947, provided that "personal injuries"

include, but not by way of limitation: (a) bodily injury, mental injury, mental anguish, shock, sickness, disease, disability, false arrest, false imprisonment, false eviction, detention, malicious prosecution, discrimination, humiliation, invasion of privacy, libel, slander or defamation. . . .⁴

Other early umbrella policies followed this formulation, providing that their personal injury coverage "include[d], but not by way of limitation," certain injuries and intentional torts.⁵

The coverage provided under this definition of personal injury is "virtually unlimited."⁶ In fact, the broad coverage afforded by the use of the phrase "but not by way of limitation" was touted as a selling point of these umbrella policies. Lukis, Stewart & Company, a Lloyd's and London Companies broker, noted in a brochure on umbrella coverage that the personal injury coverage was "very broad," and concluded that "[t]hrough use of phrase 'but not by way of limitation', [the] personal injuries definition is not limited to exposures specified in definition."⁷

The insurance industry subsequently drafted different definitions of personal injury. Nevertheless, the "but not by way of limitation" language remained in the standard umbrella policies of various insurers, including Continental Casualty Company and Employers' Surplus Lines Insurance Company, until at least 1960.⁸ This language, moreover, can be found in many policies issued by Lloyd's, London Companies, and various domestic insurers as late as the 1970's and 1980's.

The standard umbrella policies drafted beginning in 1960, however, moved away from the "but not by way of limitation" language. Leslie R. Dew, a prominent Lloyd's underwriter who was largely responsible for the 1960 revisions in the Lloyd's umbrella policy, noted that "I have avoided the use of that dreadful expression 'shall include, but not by way of limitation.'"⁹ Instead, the Lloyd's umbrel-

⁵ See Berry Thesis at Appendix G (Continental Casualty Company umbrella form, 1958; Employers' Surplus Lines Insurance Company umbrella form, January 1959).

⁶ See The Umbrella Book, Introduction at 7 (Griffin Communications, Inc. Oct. 1987 Rev.).

⁷ Lukis, Stewart & Company, Umbrella Coverage brochure, May 1958.

⁸ See Berry Thesis at Appendix H, K.

⁹ December 18, 1959 letter from Leslie R. Dew to Vincent McKerrow, Plaintiff's Exhibit 1769 in *In re Asbestos Insurance Coverage Cases*, California Superior Court, Judicial Coordination Proceeding No. 1072 (1986).

la provided that personal injury “means bodily injury, mental injury, mental anguish, shock, sickness, disease, disability, false arrest, false imprisonment, wrongful eviction, detention, malicious prosecution, discrimination, humiliation. . . .”¹⁰ Policies drafted by other companies provided that personal injury “shall mean” bodily injury, malicious prosecution, and the like.¹¹

The ISO Personal Injury Liability Insurance coverage part, 1973 edition, took a slightly different approach, providing coverage for injury

arising out of one or more of the following offenses committed in the conduct of the named insured’s business: Group A—false arrest, detention or imprisonment or malicious prosecution; Group B—the publication or utterance of a libel or slander or other defamatory or disparaging material . . . ; Group C—wrongful entry or eviction, or other invasion of the right of private occupancy.

The 1986 ISO standard commercial general liability policy retains the “arising out of one or more of the following offenses” language, with a slightly modified list of covered intentional torts.

Commentary and analysis from insurance industry representatives demonstrates a clear and long-standing recognition that, absent a limiting definition, “personal injury” coverage extends to injuries and damages suffered by business entities as well as natural persons. A former president of the South Jersey Chapter of the C.P.C.U. and director of C.P.C.U. courses at Rutgers University wrote in 1958 that personal injury coverage extended to libel claims “arising from a carelessly written letter by a subordinate which results in damaging the reputation of a *person, firm or corporation.*”¹² A former executive of Crum & Forster who also worked at various times for American Casualty Company, Zurich Insurance Company, and American States Insurance Company, also wrote that “a corporation has been held by the Supreme Court of the United States to be a person. Thus, all types of corporate injury . . . would be advanced as covered wrongs” under personal injury coverage.¹³

¹⁰ The Umbrella Book, Introduction at 12 (Oct. 1987 Rev.).

¹¹ See Berry Thesis at Appendix N (Continental Casualty Company umbrella form, late 1960).

¹² Clark, “The Liability Protection,” 10 C.P.C.U. Annals 56, 57 (January 1958) (emphasis added).

¹³ Sheehan, “Beware the Broad Form Excess or Umbrella Excess Policies,” 22 C.P.C.U. Annals 165, 167 (June 1969).

The insurance industry also long has acknowledged the seemingly obvious fact that personal injury coverage provides insurance against the commission of intentional torts. As one commentator noted, the “very nature of personal injury torts of libel, slander, defamation of character, false arrest, false imprisonment and the like, require the intent to effect the publication or wrongful act and thereby cause the resultant personal injury.”¹⁴ Another commentator noted that “[l]egal liability for bodily injury from negligence is only one type of tort. The term ‘personal injury’ opens up the whole book of torts.”¹⁵

Thus, personal injury coverage is “sufficiently broad to extend coverage to liability for punitive damages and, in some cases, to harm inflicted intentionally by the insured.”¹⁶ Indeed, one early insurance industry proponent of personal injury coverage noted the financial risks to business from “acts of transgressions” such as libel, slander, false imprisonment “and other personal injury actions” and concluded that “the insurance industry has the responsibility to emphasize these potential hazards to the insuring public, and to advocate the inclusion of coverage for their protection.”¹⁷

The insurance industry also has acknowledged for many years that personal injury coverage extends to claims against policyholders alleging antitrust violations, unfair competition, and unfair business practices. Indeed, coverage for antitrust and unfair competition claims was actively promoted under policies containing the “shall include but not by way of limitation” definition of personal injury. One umbrella policy sales brochure stated that the policy would cover “with very few exceptions the complete tort liability of the policyholder.”¹⁸ The brochure listed “Unfair competition” and “Maintaining a monopoly” as specific examples of covered exposures.¹⁹ Moreover, commentators have expressly acknowledged that this formulation of personal injury coverage extended to claims alleging “unfair business practices;”²⁰ and “patent infringement, antitrust damages, Securities and Exchange Commission liabilities, and so forth.”²¹ And several

¹⁴ *Id.*

¹⁵ Daenzer, “Excess Liability, Umbrella, Aggregates, and Deductibles,” in Long and Gregg, *Property and Liability Insurance Handbook* 600, 608 (1965).

¹⁶ Farbstein & Stillman, “Insurance for the Commission of Intentional Torts,” 20 *Hastings L.J.* 1219, 1239 (May 1969).

¹⁷ Clark, “The Liability Protection,” 10 *C.P.C.U. Annals* 56 (January 1958).

¹⁸ “Umbrella Liability Coverage,” 13 *C.P.C.U. Annals* 243, 245 (Summer 1960).

¹⁹ *Id.*, 13 *C.P.C.U. Annals* at 246.

²⁰ See, e.g., Daenzer, “Excess Liability, Umbrella, Aggregates, and Deductibles,” in Long and Gregg, *Property and Liability Insurance Handbook* 600, 608 (1965).

²¹ Sheehan, “Beware the Broad Form Excess or Umbrella Excess Policies,” 22 *C.P.C.U. Annals* 165, 167 (June 1969).

insurance companies have now included express *exclusions* for claims raised under the antitrust laws, implicitly recognizing that their policies would otherwise provide coverage for antitrust claims.²²

[c]—Advertising Injury^{22.1}

The standard ISO 1973 CGL Policy Form was revised in 1981 to add a Broad Form Comprehensive General Liability Endorsement that extended coverage beyond the “bodily injury” and “property damage” risks covered by the basic CGL policy. Among the risks encompassed by the Broad Form CGL Endorsement was coverage for “advertising injury.” The Broad Form CGL Endorsement defined “advertising injury” as:

injury arising out of an offense committed during the policy period occurring in the course of the named insured’s advertising activities, if such injury arises out of libel, slander, defamation, violation of right of privacy, piracy, unfair competition, or infringement of copyright, title or slogan.

The 1986 ISO standard CGL policy incorporates coverage for “advertising injury” in the basic policy text. “Advertising injury” is defined in the 1986 ISO form as “injury arising out of one or more of the following offenses”:

- a. Oral or written publication of material that slanders or libels a person or organization or disparages a person’s or organization’s goods, products or services;
- b. Oral or written publication of material that violates a person’s right of privacy;
- c. Misappropriation of advertising ideas or style of doing business; or
- d. Infringement of copyright, title or slogan.

²² More recent policies underwritten by X.L. Insurance Company, Ltd., for example, contain an exclusion for liability relating to “antitrust or the prohibition of monopolies, activities in restraint of trade, unfair methods of competition or deceptive acts and practices in trade and commerce including, without limitation, the Sherman Act, the Clayton Act, the Robinson-Patman Act, the Federal Trade Commission Act and the Hart-Scott Rodino Antitrust Improvements Act.” More recent policies issued by companies in the Safeco insurance group also contain an exclusion for claims “arising out of violation of anti-trust laws, restraint of trade or unfair competition not directly related to and alleged in conjunction with torts specified in . . . Coverage Agreements.”

^{22.1} See § 9.03[4] *infra* for a full discussion of advertising injury coverage.

ISO revised its CGL policy form in 1998 (the “1998 CGL Policy Form”). The 1998 CGL Policy Form combined “advertising injury” and “personal injury” into “personal and advertising injury,” and defined that term as “injury, including consequential ‘bodily injury,’ arising out of one or more of the following offenses. . . . g. *Infringing upon another’s copyright, trade dress or slogan in your ‘advertisement.’*”^{22.2} The 1998 CGL Policy Form ostensibly clarifies two areas of confusion that arose with respect to the 1986 CGL Policy Form. The 1998 CGL Policy Form purports to clarify the previously undefined terms “advertising” and “in the course of advertising” by defining “advertisement” as “a notice that is broadcast or published to the general public or specific market segments about your goods, products or services for the purpose of attracting customers or supporters.”^{22.3}

ISO issued yet another revision to its CGL policy form in 2001 (the “2001 CGL Policy Form”). The 2001 CGL Policy Form retains coverage for “[i]nfringing upon another’s copyright, trade dress or slogan in your ‘advertisement.’”^{22.4} At the same time, the 2001 CGL Policy Form adds a new exclusion for “‘Personal and advertising injury’ arising out of the *infringement of copyright*, patent, trademark, trade secret or other intellectual property rights.”^{22.5} There is also an exception to this exclusion for “infringement, in your ‘advertisement,’ of *copyright*, trade dress or slogan.”^{22.6}

The 2001 CGL Policy Form also purports to clarify aspects of previous ISO forms in a manner that is favorable to policyholders. Specifically, the definition of “advertisement” was expanded to make it clear that “[f]or purposes of this definition: a. Notices that are published include material placed on the Internet or on similar electronic means of communication; and b. Regarding web-sites, only that part of a web-site that is about your goods, products or services for the purposes of attracting customers or supporters is considered an advertisement.”^{22.7} An exclusion for certain policyholders in “advertising” and Internet-related businesses also clarifies that “[f]or the purposes of this exclusion, the placing of frames, borders or links, or advertising, for you or others anywhere on the Internet, is not by itself, considered the business of advertising, publishing or telecasting.”^{22.8} In addition, the definition of “coverage territory” clarifies that

^{22.2} Insurance Services Office, Inc., Form CG 00 01 07 98 (emphasis added).

^{22.3} *Id.*

^{22.4} Insurance Services Office, Inc., Form CG 00 01 10 01.

^{22.5} *Id.* (emphasis added).

^{22.6} *Id.* (emphasis added).

^{22.7} Insurance Services Office, Inc., Form CG 00 01 10 01.

^{22.8} *Id.*

the 2001 CGL Policy Form provides coverage for “personal and advertising’ offenses that take place through the Internet or similar electronic means of communication.^{22,9}

[d]—Contractual Liability

The 1981 Broad Form Endorsement to the 1973 CGL Policy Form also extended coverage for “contractual liability.” Under that endorsement, such coverage extends to bodily injury or property damage for which the policy holder assumed liability under any “written contract or agreement relating to the conduct of the named insured’s business,” but excluded coverage for injury or damage that occurred prior to the execution of the contract.

[2]—First-Party Property

One of the most prevalent and commonly purchased first-party insurance coverages is first-party property insurance. The purpose of this insurance is to provide coverage for loss or damage to the policyholder’s property, whether real or personal. Coverage can be limited to a single building or facility owned by the policyholder, or can extend to all of the insured’s buildings, facilities and their contents. Coverage can include assets such as valuable papers, computers and electronic equipment, and other, more esoteric items.

[a]—Named Peril

One common type of first-party property coverage provides insurance only with respect to damage caused by certain perils specifically identified in the policy. A typical named peril policy will provide coverage for loss or damage resulting from lightning, wind storm, hail, vandalism and malicious mischief.

[b]—All Risk

In contrast to named peril policies, many first-party policies provide coverage for all risks of loss not expressly excluded by the policy. Although the designation “all risk” connotes a very broad form of coverage, care must be taken nevertheless to carefully examine the policy’s definition of covered property and identification of excluded risks. Buildings, business personal property, and the personal property of others that is within the insured’s care, custody or control usually are identified as covered property.

^{22,9} *Id.*

[c]—Business Interruption

First-party property policies often include coverage for losses caused by the closure of the policyholder's business. This "business interruption" coverage normally applies when the insured is unable to conduct its normal business operations as a result of damage to covered property caused by a covered risk. The function of "business interruption" coverage is to provide insurance for certain ongoing business expenses incurred and profits lost by the policyholder during the time that its business is inoperable as a result of a covered loss.

The amount of business interruption coverage applicable to a particular loss usually is derived by complex calculations involving the insured's net income and operating expenses prior to the occurrence of the loss. In addition, the calculation of the amount of loss covered may, under the terms of the policy, involve a determination of whether the insured resumed its operations (in whole or in part) as soon as possible after the occurrence of the loss.

(Text continued on page 1-29)

[3]—Directors' & Officers' (D&O) Liability

Directors' & Officers' ("D&O") Liability Insurance usually consists of two components of coverage provided to separate insureds. The first component typically provides defense and indemnity coverage directly to directors and officers covered by the policy.²³ This coverage applies to liabilities resulting from their "wrongful acts," as defined in the policy.

The second component of D&O insurance provides coverage to the insured company for amounts it expends to indemnify its directors and officers against claims alleging "wrongful acts." Thus, if the involved directors and officers are entitled to indemnification from the insured company with respect to a claim covered by the policy, the policy indemnifies the insured company. If the directors and officers are not entitled to such indemnification, the first component of the policy provides insurance directly to the directors and officers with respect to the claims made against them.

Many D&O policies also include a third component of insurance, known as "entity" coverage. Entity coverage, as the name suggests, provides insurance directly to the insured company for its own liability arising out of covered claims. Entity coverage thus serves to eliminate possible disputes between the company and its officers and directors over whether and to what extent defense costs, settlements and judgments must be "allocated" between them.

In contrast to CGL policies, D&O policies typically do not require the insurer to defend claims against the insured directors, officers or company. Instead, D&O policies usually either require or permit the insurer to advance defense costs to the insured or to pay such costs on behalf of the insureds. D&O policies, again unlike their CGL counterparts, may contain a further provision that allows the insurer to obtain reimbursement of advanced defense costs from the insured(s) in the event it ultimately is established that the claims against the insured(s) are not covered.

D&O policies often contain aggregate limits of liability. D&O policies with aggregate limits typically provide that payment of defense costs serves to erode the policy's limits.

D&O coverage historically has been written on a claims-made basis. Prospective insureds under D&O policies normally are required

²³ The definition of persons constituting covered directors and officers may differ from policy to policy. In addition, coverage under D&O policies often is extended by endorsement to encompass individuals who technically are not "directors" or "officers" of the insured company.

to submit detailed applications to the insurer that is considering issuance of the coverage. Perhaps the most significant aspect of the application is the requirement that prospective insureds disclose the existence of any claims of which they know, or acts of which they know that could give rise to claims, against the individuals and entities applying for coverage. One possible consequence of a failure to disclose is rescission of the policy by the insurer. The insurer's right to rescind, however, may be limited. Some applications for D&O coverage and some D&O policy forms themselves contain "severability" provisions that limit the effect of an insured's failure to disclose solely to forfeiture of coverage for those matters that were the subject of nondisclosure.

Unlike CGL coverage, there is no industry standard form D&O liability policy. Instead, individual insurers or groups of affiliated insurers have developed their own D&O policy forms. Although the D&O forms used by different companies and company groups are similar in many respects, the various policy forms do contain differences in their terms, conditions and exclusions.

By way of illustration, a 1986 D&O form used by National Union Fire Insurance Company of Pittsburgh, Pa. (a member of the American International Group ("AIG") of companies) defines a "Wrongful Act" covered by the policy as:

any breach of duty, neglect, error, misstatement, misleading statement, omission or act by the Directors or Officers of the [insured] Company in their respective capacities as such, or any matter claimed against them solely by reason of their status as Directors or Officers of the [insured] Company.

A standard D&O form contemporaneously used by Federal Insurance Company (a member of the Chubb Group) defines a covered "Wrongful Act" as:

any error, misstatement, misleading statement, act, omission, neglect or breach of duty committed, attempted, or allegedly committed or attempted, by any Insured Person individually or otherwise, in his Insured Capacity, or any matter claimed against him solely by reason of his serving in such Insured Capacity.

D&O policies usually contain a number of exclusions, among which are exclusions for losses arising out of:

- criminal, dishonest and/or fraudulent acts committed by the insureds;²⁴
- the insureds' gaining of personal profit or advantage to which they are not legally entitled;
- claims brought by an individual insured or the insured company (the "insured versus insured" exclusion);
- claims brought by certain regulatory agencies such as the FDIC and FSLIC;
- bodily injury and/or property damage;
- claims involving actual or attempted takeovers of the insured company.

Specialized types of D&O policies have been developed to provide additional coverage for non-indemnified liabilities of the individual insured directors and officers, and also to protect against possible efforts by D&O insurers to rescind coverage. One such policy is the "Side A Excess" policy, which provides additional coverage and policy limits solely with respect to non-indemnified ("Side A") claims.

Some D&O policies provide "Difference in Conditions" ("DIC") coverage. Such coverage can vary greatly from insurer to insurer and policy to policy. DIC coverage can be in a stand-alone DIC policy or can be a component of coverage in a D&O policy that provides other types of coverage in addition to DIC coverage. Typically, however, DIC policies provide coverage in the event other D&O coverage is rescinded (or sought to be rescinded), or where the other D&O insurance is unavailable due to the insolvency of the insurer. DIC policies thus are intended to provide an extra layer of protection against contingencies that otherwise might leave a director or officer uninsured.

[4]—Products Liability

As noted above, standard CGL policies usually contain "products hazard" exclusions that severely restrict coverage for a policyholder's

²⁴ Under some D&O policies this "dishonesty" exclusion does not apply unless there is a "final adjudication" establishing that the insured committed those acts. Exclusions with this proviso will bar coverage only when there is an adjudication or similar finding that the insured's acts were criminal or fraudulent. See, e.g.:

Second Circuit: PepsiCo., Inc. v. Continental Casualty Co., 640 F. Supp. 656, 659 (S.D.N.Y. 1986).

Fourth Circuit: Atlantic Permanent Federal Savings & Loan Association v. American Casualty Co., 839 F.2d 212, 216-17 (4th Cir. 1988), cert. denied 486 U.S. 1056 (1988).

Seventh Circuit: National Union Fire Insurance Co. v. Continental Illinois Corp., 666 F. Supp. 1180, 1197-1198 (N.D. Ill. 1987).

Ninth Circuit: National Union Fire Insurance Co. v. Seafirst Corp., 662 F. Supp. 36, 38-39 (W.D. Wash. 1986).

liabilities for bodily injury or property damage caused by the policyholder's products. The 1973 CGL form policy defined the "products hazard"—as to which coverage was excluded—as including "bodily injury and property damage arising out of the named insured's products or reliance upon a representation or warranty made at any time with respect thereto, but only if the bodily injury or property damage occurs away from premises owned by or rented to the named insured and after physical possession of such products has been relinquished to others."

The 1986 CGL form policy promulgated by ISO similarly defines the "products-completed operations hazard" as encompassing all bodily injury and property damage occurring away from premises owned or rented by the insured and arising out of any good or products "manufactured, sold, handled, distributed or disposed of" by the insured. The "products" exclusion in the 1986 form also applies to "warranties or representations made at any time with respect to the fitness, quality, durability or performance" of the insured's "products."

Thus, policyholders desiring products liability insurance coverage usually must take one of two approaches. The policyholder may be able, for an additional premium, to have the "products hazard" exclusion deleted from its CGL policy. Alternatively, the policyholder may purchase coverage for products liabilities under a separate policy specially insuring against such risks.

[5]—Errors & Omissions (E&O) Liability

Errors and omissions ("E&O") liability insurance typically provides coverage for the negligent acts, errors or omissions of the insured and/or the insured's employees. Thus, E&O coverage sometimes serves as a companion to D&O coverage, expanding the policyholder's insurance portfolio to protect against losses occasioned by acts, errors and omissions of persons other than the directors and officers of the insured company.

As a result, the nature and scope of E&O coverage closely parallels that of D&O policies. In some instances, E&O and D&O coverage is provided under a single policy, with separate insuring agreements for each type of coverage.

[6]—Fidelity/Dishonesty Coverage

Fidelity and dishonesty coverage generally is provided in the form of a "bond" rather than an "insurance policy." As a practical matter, however, this is a distinction without a material difference. Fidelity and dishonesty bonds serve the traditional function of insurance: shifting the risk of loss to another in exchange for the payment of a premium.

In the case of fidelity/dishonesty coverage, the risks insured against are losses to the insured resulting from dishonest or fraudulent acts of

the insured's employees, including officers.²⁵ Because fidelity/dishonesty insurance is expressly meant to cover losses resulting from fraudulent or dishonest conduct, which losses are not covered under most D&O and E&O policies, it is an obvious companion coverage for those policies.²⁶

One of the principal requirements of fidelity/dishonesty coverage is that the involved employee must have acted with the "manifest intent" to cause the insured to suffer the loss. Another standard requirement is that the employee must have acted with that intent to obtain a financial benefit *other than* salaries, bonuses, commissions and the like. Fidelity/dishonesty bonds also often contain provisions requiring submission of a proof of loss to the insurer within a specified time period after discovery of the loss. In addition, the bond may require that any action against the insurer be brought no later than a designated period of time after such discovery.

[7]—Professional Liability

As its name suggests, Professional Liability insurance provides coverage against liabilities arising out of the acts or omissions of professionals, including physicians, surgeons, dentists, hospital administrators, lawyers, accountants, engineers, architects and surveyors. A typical insuring agreement of a Professional Liability insurance policy (in this example, insuring lawyers) provides as follows:

The [insurance] company will pay on behalf of the insured all sums which the insured shall be legally obligated to pay as damages because of any act or omission of the insured, or of any other person for whose act or omission the insured is legally responsible, which occurs during the policy period and arises out of the performance of professional services for others in the insured's profession as a lawyer.²⁷

Like their CGL counterparts, professional liability policies generally require the insurer to defend the policyholder against suits seeking damages for claims to which the policies apply.

²⁵ Bonds also can insure against losses as a result of theft, robbery, "mysterious unexplainable disappearance," forgery, alteration and various other causes.

²⁶ Indeed, insureds sometimes may find themselves in the difficult position of simultaneously being denied coverage under a D&O policy on the grounds that the relevant acts were fraudulent, and being denied coverage under a fidelity/dishonesty bond on the grounds the relevant acts were not fraudulent.

²⁷ This insuring agreement is found in the ISO 1981 Lawyers Professional Liability Insurance form policy.

Professional liability insurance historically has been available on an occurrence basis. The standard professional liability policy forms promulgated by ISO in the early 1980's, however, were available on either an occurrence or a claims-made basis.

Many professional liability policies contain a clause requiring the insurer to obtain the prior consent of the policyholder before settling a claim. As a general matter, such clauses reflect a recognition that the reputation of the insured may be a factor in determining whether or not to settle a claim. Policies requiring the prior consent of the insured to settlement, however, also often contain a "hammer clause" that is triggered in the event the insured refuses to enter into a settlement recommended by the insurers. Under these circumstances, the "hammer clause" obligates the insured to assume the defense of the claim and to bear responsibility for paying any damages in excess of the settlement amount recommended by the insurer.

[8]—Environmental Impairment Liability (EIL)

Environmental Impairment Liability ("EIL") insurance, sometimes referred to as "Pollution Liability Insurance," is a specialized form of coverage designed solely and specifically to insure against environmental contamination and pollution damage. Although some EIL policies were developed and marketed in the 1970's, it was not until the early 1980's that the EIL coverage became widely available.²⁸

Most insurers providing EIL coverage require their prospective policyholders to submit to an environmental audit, with any identified problems excluded from coverage. EIL policies generally provide coverage on a claims-made basis.

[9]—Employers' Liability

Employers' liability insurance has become increasingly popular in light of the proliferation of claims alleging discrimination, sexual harassment, wrongful termination, and other employment-related acts brought by present, former or prospective employees of the insured. As a result, a number of insurance companies have developed their own employers' liability insurance contracts. Although the general purpose of these insurance policies is the same, subtle differences in available coverage can be significant factors in purchasing such policies and, when and if necessary, evaluating claims under the policies.²⁹

²⁸ 4 The Law of Hazardous Waste: Management, Cleanup, Liability and Litigation at 19-167 (Matthew Bender 1995).

²⁹ See Machson & Monteleon, "Insurance Coverage for Wrongful Employment Practices Claims under Various Liability Policies," 49 The Business Lawyer 689, 725-727 (February 1994).

For example, the insuring agreements of employers' liability policies can differ significantly in their definitions of the types of third-party claims that are covered. Although some policies cover claims of discrimination brought by disappointed applicants for employment, others extend such coverage only to claims made by persons who actually are or have been employed by the policyholder.

Some policies contain broad grants of coverage for all manner of alleged discrimination and harassment, while others limit coverage solely to certain defined types of discrimination, such as discrimination based on sex, religion or ethnic background.