

Connecticut Insurance Coverage/Bad Faith Workbook 2010

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L A W O F F I C E S

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TABLE OF CONTENTS

1.	INSURANCE COVERAGE.....	1
A.	The Key Steps to a Successful Coverage Evaluation	1
1.	Pre-Suit	1
2.	Post-Suit.....	3
B.	When to Reserve Rights	4
1.	The Basic Elements of Reservation of Rights Letter	4
C.	When to Deny a Defense and Indemnity Under the Policy	5
1.	The Basic Elements of Denial of a Defense and Indemnity Letter.....	6
D.	The Law.....	6
1.	Law Regarding Duty to Defend	6
a.	When an Insurer Must Defend.....	6
b.	No Duty to Defend in Three Situations.....	7
c.	Different Theories of Recovery	8
d.	Consequences of a Wrongful Refusal to Defend.....	8
2.	Law Regarding Duty to Indemnify	8
3.	Interpreting Insurance Policies in Connecticut.....	8
4.	Policy Provisions Analyzed With Regard to Duty to Defend and Indemnify	10
a.	The Policy Period	10
b.	Who is an Insured.....	10
c.	The Insuring Agreement	11
(1)	Occurrence Requirement.....	11
(2)	Bodily Injury and Property Damage.....	11
d.	Exclusions.....	12
e.	Definitions	12
f.	Conditions.....	12
(1)	Notice	13
(2)	Duty to Cooperate	13
(3)	Concealment and Fraud.....	14
g.	Other Insurance Provisions	15
5.	Different Types of Coverage	17
a.	Personal Lines v. Commercial Policies.....	17
b.	Personal Injury Coverage.....	17
c.	Claims-Made Policies	18
6.	Common Coverage Problems.....	19
a.	Permissive Use in Coverage Analysis of Auto Policies....	19

	b.	Resident Relative as an Insured.....	21
	c.	Arising Out of an Auto.....	21
	d.	"Occurrence"/Intentional Acts Analysis	22
	e.	Mental Incapacity	24
	f.	Intoxication	25
	g.	Self Defense.....	26
	h.	Waiver and Estoppel	27
	i.	Choice of Law - Out-of-State Policies	28
	j.	Prejudgment Interest	28
	k.	Coverage for Punitive Damages	29
	7.	Policy Cancellation	29
E.		The Tools Used to Determine Whether an Insurer Owes Coverage.....	31
	1.	Declaratory Judgment Action.....	31
	2.	Intervene in Underlying Action.....	32
	3.	Third-Party Action	32
	4.	Defend to Judgment and Then Raise Coverage Defenses	32
F.		The Tools Used to Fix Insurance Problems	33
	1.	Rescission	33
	2.	Reformation.....	34
	3.	Equitable Subrogation.....	34
G.		Answers to Common Coverage Questions.....	36
H.		Final Thoughts About Coverage	37
2.		BAD FAITH	37
	A.	Causes of Action	37
		1. Common Law Bad Faith.....	38
		2. Negligence.....	39
		3. Statutory Claims - CUIPA and CUTPA	40
	B.	Who Can Sue for Bad Faith	41
	C.	Bad Faith Claims and Workers' Compensation Claims.....	42
	D.	Conduct Constituting Bad Faith.....	43
		1. Denial of Coverage	43
		2. Bad Faith Failure to Settle Within Policy Limits	43
		3. Bad Faith Claims Handling	44
		4. Multiple Claims - Limited Policy Coverage.....	45
	E.	Can You Have Bad Faith Where There is No Insurance Coverage?	45
	F.	Bad Faith and Uninsured/Underinsured Motorist Claims	46

G.	Damages for Bad Faith.....	47
1.	Recovery for Common Law Bad Faith.....	47
2.	Recovery Under CUIPA/CUTPA	47
H.	Statute of Limitations for Bad Faith Claims.....	47
I.	Discovery in Bad Faith Actions	48
J.	Advice of Counsel as a Defense to Bad Faith Claim.....	49
K.	How to Avoid Bad Faith.....	50
3.	SAMPLE "BOOK MARK" LETTER	51
4.	SAMPLE RESERVATION OF RIGHTS LETTER.....	52
5.	SAMPLE DENIAL LETTER.....	57
6.	BIOGRAPHICAL AND CONTACT INFORMATION ON LAWYERS WHO CAN HELP YOU ON COVERAGE AND BAD FAITH ISSUES	60

2010 CONNECTICUT INSURANCE COVERAGE/BAD FAITH WORKBOOK

Purpose of Synopsis

This Insurance Coverage Workbook is to provide you with a basic knowledge on how to analyze coverage issues. Once you have a working knowledge of how to analyze coverage issues we hope you will be better equipped to recognize coverage problems when they arise. We have also provided information regarding common coverage issues and tools for addressing common coverage problems.

The key to a successful coverage evaluation is to follow a methodical step-by-step approach from first determining if a policy exists to what policy applies. If you avoid the temptation of looking at the exclusions before you look at the insurance agreement you will improve your chances of a successful outcome. Keep in mind that this booklet is simply a guide. The law is always changing. We are only a phone call or email (coverage@nuzzo-roberts.com) away if you need help.

In addition, because a denial of coverage may result in a subsequent claim for bad faith, this synopsis includes the common causes of action for bad faith and the common issues associated with bad faith claims.

1. INSURANCE COVERAGE

A. The Key Steps to a Successful Coverage Evaluation

1. Pre-Suit

When you receive the first notice of claim, and you have not yet verified preliminarily that a policy applies and that the defendant is an insured, **do not** send a reservation of rights letter.

If you need more information to make a decision, write a letter requesting this information. Do not write a reservation of rights letter, but get what you need as quickly as you can and then send the reservation of rights letter. However, at the time additional information is requested from the insured it is wise to advise the insured that you are investigating the matter under a full and complete reservation of rights and that the insurance company does not waive any rights it has under the policy or under common law.

In a pre-suit analysis you are looking to determine whether coverage can possibly be triggered based on the information provided. You cannot make a determination as to the duty to defend because you will not know the allegations of a future lawsuit. Instead, the analysis will be based on the potential causes of action and allegations. If coverage is denied or a reservation of rights is issued, the insured should be asked to forward the complaint to the insurer, once suit is filed.

Once you have verified that you have the correct policy including all policy forms and endorsements, complete the following:

- a. Review the governing policy, with all the endorsements.
- b. Verify that the incident occurred within the coverage territory and during the policy period. Be sure to be aware of whether multiple policy periods are triggered.
- c. Determine that the person claiming a defense is an insured.

To determine "who is an insured," review the definition of insured in the policy itself. This definition is different in different sections of the policy, so it is essential to read the definition which applies to the relevant policy section.

- d. Determine if the claimed incident is an "accident." The substantive coverage analysis starts with this determination because insurers pay claims for accidents, not for events which are expected.¹

This is not an evaluation of an exclusion, but rather a determination as to whether the group of facts which give rise to the claim resulted from an "unexpected happening," thus constituting the type of event for which the insurer agreed to pay.

- e. Determine whether the injury alleged to have been caused by the insured meets the policy definition of either "bodily injury" or "property damage."²

¹ This step only applies for occurrence policies.

² This step will apply for most occurrence-based policies, but may not apply for all types of policies e.g. claims made policies, professional liability policies.

- f. Read the exclusions in order to determine whether any apply to the circumstances of this claim. Exclusions limit the scope of coverage by saying that certain conduct/events are not within the insuring agreement. The most common exclusion deals with "expected or intended" injury.
- g. Read the conditions, the most common of which are Notice and Duty to Cooperate. Denial of coverage on these bases require a showing of prejudice to the insurer. Typically, a late notice claim occurs at the beginning of a case. A claim of failure to cooperate can occur at any time, even during trial.
- h. Lastly, if there is a potential for the insured to be covered under another insurance policy or when the claim triggers multiple policy periods, review the "Other Insurance" clause of the liability section of the policy. Sometimes the only question is whether your policy or some other policy applies first. It is essential to compare the other carrier's policy before making a judgment as to priority of insurance coverage. Analyzing and determining whether your coverage is primary, prorated or excess is difficult, so it is best to consult counsel for assistance.

2. Post-Suit

Once suit is filed, the preceding analysis should be revisited. Now that you have the complaint to review, follow the above determinations looking at the two different duties - the duty to defend and the duty to indemnify. Every effort should be made to evaluate the duty to defend and the duty to indemnify prior to an appearance being entered on behalf of the insured.

Special problem: A suit is filed, and the filing is the first notice of the claim. This triggers analysis of the conditions section of the policy i.e. duty to give prompt notice and cooperation. Generally, the late notice and duty to cooperate conditions could provide a basis to deny a defense and indemnity or a basis to provide a defense and indemnity under a reservation of rights. This is discussed further below, including the requirement of insurer prejudice.

B. When to Reserve Rights

A reservation of rights should be issued with regard to the duty to defend and/or indemnify when there remains some question as to whether the allegations of the complaint trigger the insurer's duty to defend and a determination cannot be made that the allegations fall completely outside the policy's coverage.

An insurer should notify its insured of the reservations of rights, including all coverage defenses which may be raised, before the appearance is filed. Otherwise, the insurer may have waived its right to disclaim coverage. Basta v. U.S. Fid. & Guar. Co., 107 Conn. 446 (1928). If more time is needed in order to make a coverage determination, you should request that plaintiff's counsel permit you to have more time to review the coverage issues before defaulting the insured for failing to appear. In the event that defense counsel appears before a reservation of rights letter is sent out, a reservation letter should be sent out anyway. It should also be noted that coverage issues, particularly with regard to the duty to indemnify, may arise while a case is pending. In those circumstances, the insurer should complete its investigation and issue any necessary reservation of rights as soon as practicable.

1. The Basic Elements of Reservation of Rights Letter

As a general rule, the reservation of rights letter should be tailored to the particular facts of each situation. It is important to know the basic elements of a reservation of rights letter even though each letter will be different depending on the factual circumstances, the applicable policy provisions and the allegations being made against the insured.

A reservations of rights letter must: (a) acknowledge receipt of notification (letter/lawsuit); (b) identify the policy, policy number, named insured(s) and dates of coverage; (c) summarize the nature of the claim, e.g., auto accident, bar fight, etc., and state the date, location of the underlying event and provide limited facts; (d) indicate that there are certain sections of the policy that give rise to a question of whether the policy provides coverage, including quotation of the specific policy sections relied upon; (e) indicate that the insurer is reserving its rights not to provide indemnity or a defense and that the insurer may withdraw a defense; (f) indicate that further investigation is required, if applicable; (g) indicate that insurer reserves the right to litigate its coverage defenses; (h) note that punitive damages are not covered; (i) indicate the limits of coverage if indemnity is provided in the future; (j) indicate that the insurer does not waive its rights under the policy; and (k) if suit has been filed, identify the firm that will defend the case.

Additionally, where the damages exceed the policy limits, and an excess letter is being sent, it should be incorporated into the reservation of rights letter whenever there are coverage defenses. By example, if you are reserving the right to deny a defense and indemnity based on the claims alleged against the insured not being an occurrence and also being excluded as intentional acts, but you also know that the claimant's damages are \$100,000 and the policy limits are \$50,000 you should include in your letter that in the event there is a duty to indemnify you would only pay the claimant's damages up to \$50,000. If you were to simply send the excess letter without reserving your rights with regard to defense and indemnity, this could be thought of as inconsistent with the position that coverage is disputed. An insured would likely argue that the insurer either waived its right to disclaim coverage or is estopped by virtue of the excess letter from later disclaiming coverage. Under no circumstances should an excess letter be sent out where there is a dispute as to coverage unless it is incorporated into the reservation of rights letter.³

A reservation of rights letter should be sent only to the insured (via registered and regular mail) and to defense counsel and personal counsel, if any. The letter should not be sent to plaintiff's counsel since sending it may only encourage the plaintiff to proceed against the insured directly, by attaching the insured's personal assets and providing the insured with a potential argument for bad faith against the insurer. Note: Be sure that the reservation of rights is addressed to all insureds who are defendants to the underlying lawsuit.

C. When to Deny a Defense and Indemnity Under the Policy

A defense and indemnity can be denied when the individual seeking coverage does not qualify as an insured under the policy no matter what the allegations. Hoffman v. Mancini, 2002 WL 1816061 (July 2, 2002 Conn. Super.); Keithan v. Massachusetts Bonding & Ins. Co., 159 Conn. 128, 141-42 (1970). A defense and indemnity should also be denied when none of the allegations fall within the insuring agreement, e.g. no occurrence. Also, if all the claims or conduct alleged fall within an exclusion, you can deny a defense and indemnity. Keep in mind, however, that sometimes information from outside the complaint can trigger a duty to defend. Hartford Cas. Ins. Co. v. Litchfield Mut. Fire Ins. Co., 274 Conn. 457 (2005). See Section D.1., below. Whenever you can eliminate the duty to defend, there will be no duty to indemnify. DaCruz v. State Farm Fire and Cas. Co., 268 Conn. 675, 688 (2004)

³ Note that there is no requirement under law to send out an excess letter.

1. The Basic Elements of Denial of a Defense and Indemnity Letter

A denial letter, like a reservation of rights letter, should refer specifically to policy language and should provide all the grounds for disclaiming a defense and indemnity as well as a statement that the decision to deny a defense and indemnity has been based on a significant investigation of the facts surrounding the claim. Grounds for disclaiming a defense and indemnity which are not included in the denial letter may be waived. Barry Ostrager and Thomas Newman, Handbook on Insurance Coverage Disputes, §2.05[b] (2010). A denial letter should be sent only after appropriate investigation and appropriate file documentation verifying that there is no duty to defend and indemnify. These initial steps are essential as a denial made without investigation may form the basis for a bad faith claim.

NOTE: INSURERS ARE REQUIRED TO INCLUDE SPECIFIC LANGUAGE REGARDING INSURED'S RIGHT TO CONTACT INSURANCE COMMISSIONER WHEN A CLAIM IS DENIED.

In accordance with Connecticut General Statutes § 38a-323b, as of January 1, 2004 all insurers that deny a claim under a personal risk insurance policy must notify the insured of the denial in writing. This statute provides that the final paragraph of the denial letter shall include the following statement in twelve point font: "If you do not agree with this decision, you may contact the Division of Consumer Affairs within the Insurance Department." The insurer is required to include the address and toll free telephone number of the Division of Consumer Affairs as well as the Insurance Department's internet address. This information is as follows: 153 Market Street, Hartford, Connecticut 06103, 1-800-203-3447; www.ct.gov/cid.

D. The Law

1. Law Regarding Duty to Defend

a. When an Insurer Must Defend

An insurer's duty to defend depends on whether the complaint states facts, which appear to bring the claim within the policy coverage. The duty to defend is broader than the duty to indemnify and does not depend on whether the plaintiff/injured party will successfully maintain a cause of action against the insured, but on whether the plaintiff has in her complaint stated facts that bring the injury within the policy's coverage. DaCruz v. State Farm Fire & Cas. Co., 268 Conn. 675, 687-88 (2004). See also, Missionaries of Co. of Mary, Inc. v. Aetna Cas. & Sur. Co., 155 Conn. 104, 110 (1967);

Exel Logistics v. Maryland Cas. Co., 40 Conn. App. 415, 419 (1996). "If an allegation of the complaint falls even possibly within the coverage, then the insurance company must defend the insured." Moore v. Continental Cas. Co., 252 Conn. 405, 409 (2000).

The insurer cannot rely on facts outside of the complaint in determining whether to deny a defense. Missionaries of Mary, Inc., 155 Conn. at 112. There is an exception, however, to this "four corners" rule that permits an insurer to look outside of the complaint when determining whether the individual/entity is an insured under the policy. Keithan v. Massachusetts Bonding & Ins. Co., 159 Conn. 128 (1970).

However, note that the Connecticut Supreme Court has held that where information outside the complaint indicated that the claim may be covered the insurer must defend. Hartford Cas. Ins. Co. v. Litchfield Mut. Fire Ins. Co., 274 Conn. 457 (2005). The Connecticut Supreme Court stated that:

We agree with the New York Court of Appeals that we should not employ a wooden application of the 'four corners of the complaint' rule that would render the duty to defend narrower than the duty to indemnify and that the sounder approach is to require the insurer to provide a defense when it has actual knowledge of facts establishing a reasonable possibility of coverage.

Id. at 467, *citing*, Fitzpatrick v. American Honda Motor Co., 571 N.Y.S.2d 672 (1991) (internal quotations omitted).

b. No Duty to Defend in Three Situations

An insurer does not have a duty to defend in three situations. The first situation is where the defendant is not an insured under the policy. Keithan v. Massachusetts Bonding and Ins. Co., 159 Conn. 128, 141 (1970). The second situation is where the "four corners" of the complaint do not allege conduct within policy coverage. As noted, however, Connecticut Supreme Court case law now indicates that an insurer must defend where it has information showing that the claim is covered, notwithstanding that the allegations of the complaint do not plead into coverage. Hartford Cas. Ins. Co. v. Litchfield Mut. Fire Ins. Co., 274 Conn. 457 (2005). Lastly, an insurer does not have to defend a lawsuit based on events which are outside of the policy period.

c. Different Theories of Recovery

If only one of several counts or causes of action is covered, the insurer must defend those counts which, if proven, are within the coverage of the policy. Schurgast v. Schumann, 156 Conn. 471, 490 (1968). Defense counsel is obligated to defend an insured as to all counts, even those counts that are not covered. Connecticut Bar Association, Committee on Professional Ethics, Informal Opinion 92-7.

d. Consequences of a Wrongful Refusal to Defend

When an insurer does not defend a case that it should have, then it will be liable to the insured for all expenses incurred in defending the suit, including the costs of investigation and legal fees, as well as the amount of a settlement or judgment up to the policy limits. R.T. Vanderbilt Co., Inc. v. Continental Cas. Co., 273 Conn. 448, 470-71 (2005); Keithan v. Massachusetts Bonding & Ins. Co., 159 Conn. 128, 139 (1970). As discussed in a subsequent section, where the insurer acted in bad faith it may be required to pay the balance owed over the policy limits. Unless there is a showing of bad faith, the insurer is not responsible for attorney's fees incurred by the insured who prevails in a declaratory judgment action. ACMAT Corp. v. Greater New York Mut. Ins. Co., 282 Conn. 576 (2007).

Note that even if the claim would not have been covered, if the insurer wrongfully refuses to defend, it cannot then rely on the insurance contract to deny indemnity. Missionaries of Co. of Mary, Inc. v. Aetna Cas. & Sur. Co., 155 Conn. 104, 113-14 (1967). See also, Black v. Goodwin, Loomis & Britton, Inc., 239 Conn. 144, 153 (1996).

2. Law Regarding Duty to Indemnify

Whereas the duty to defend is triggered whenever a complaint alleges facts that potentially could fall within the scope of coverage, the duty to indemnify arises only if the evidence established at trial shows that the conduct actually was covered by the policy. DaCruz v. State Farm Fire and Cas. Co., 268 Conn. 675, 688 (2004). Because the duty to defend is significantly broader than the duty to indemnify, where there is no duty to defend, there is no duty to indemnify. Id.

3. Interpreting Insurance Policies in Connecticut

In Connecticut, the terms of an insurance policy are to be construed according to general rules of contract construction. Buell Industries, Inc. v. Greater New York Mut. Ins. Co., 259 Conn. 527, 538 (2002). The determinative question is the intent of the

parties, that is, what coverage the insured expected to receive and what the insurer was to provide. Id. at 538-39. A contract of insurance must be viewed in its entirety and the intent of the parties for entering it derived from the four corners of the policy. Flint v. Universal Machine Co., 238 Conn. 637, 643 (1996).

If the terms of the insurance policy are clear and unambiguous, then the language of the policy must be accorded its natural and ordinary meaning. Connecticut Medical Ins. Co. v. Kulikowski, 286 Conn. 1, 5 (2008). When an insurance contract term is susceptible to two equally reasonable interpretations, then the term at issue likely will be found ambiguous and construed against the insurer. Heyman Assocs. No. 1 v. Ins. Co. of the State of Penn., 231 Conn. 756, 770 (1995). Ambiguity must stem from the language of the insurance policy as “the mere fact that the parties advance different interpretations of the language in question does not necessitate a conclusion that the language is ambiguous.” Jacaruso v. Lebski, 118 Conn. App. 216, 223 (2009). Any ambiguity in the terms of an insurance policy must be construed in favor of the insured because the insurance company drafted the policy. Stephan v. Penn. Gen. Ins. Co., 224 Conn. 758, 763 (1993). In other words, where there are two reasonable interpretations, the court will choose the one which will sustain the claim and cover the loss. Simmes v. North American Co. for Life and Health Ins., 175 Conn. 77, 84 (1978).

If the policy is ambiguous, extrinsic evidence may be introduced to support a particular interpretation. Where there is an ambiguity, the factual background and circumstances under which a policy was sought and issued can be taken into account by the courts when interpreting a policy so as to reach a result consistent with the general purpose of the policy. Cooper v. RLI Ins. Co., 1996 WL 367721 (June 3, 1996 Conn. Super.), *citing*, Ceci v. Natl Indem. Co., 225 Conn. 165, 168-70 (1994). If the extrinsic evidence presents issues of credibility or a choice among reasonable inferences, the decision of the intent of the parties is a job for the trier of fact. Metropolitan Life Ins. Co. v. Aetna Cas. and Sur. Co., 255 Conn. 295, 306 (2001).

Where a policy is ambiguous and extrinsic evidence sheds no light on the intent of the parties, courts often apply the doctrine of *contra proferentem* to construe the ambiguity strictly against the insurer, in favor of the insured. Since the insurer drafts the policy and can prevent mistakes in meaning, doubts arising from an ambiguity are resolved in favor of the insured. Israel v. State Farm Mut. Auto. Ins. Co., 259 Conn. 503, 509 (2002). The contra-insurer rule does not apply, however, in disputes between insurance companies or strangers to the contract. Metropolitan Life Ins. Co. v. Aetna Cas. & Sur. Co., 255 Conn. 295, 306 (2001).

4. Policy Provisions Analyzed With Regard to Duty to Defend and Indemnify

To determine whether an insurer has a duty to defend and a duty to indemnify, the policy provisions must be analyzed as noted below.

a. The Policy Period

For occurrence-based policies, such as auto, homeowners and commercial general liability policies, the event must occur during the applicable policy period. This is known as the "trigger of coverage." Some events may occur over a period of time, implicating more than one policy. In that instance, all applicable policies must be analyzed. If an event does not fall within the policy period(s), there is no duty to defend or indemnify. Lee R. Russ & Thomas F. Segalla, Couch on Insurance 3d (2009) §102:21. However, courts treat the time of the occurrence differently with some courts finding that the time of the occurrence is when the wrongful act is committed with other courts finding that the occurrence is when the complaining party is actually damaged. Id.

The Connecticut Supreme Court has held that it is the event causing injury that triggers coverage under an occurrence policy and not the cause of the event. Tiedemann v. Nationwide Mut. Fire Ins. Co., 164 Conn. 439, 445 (1973). In a continuous exposure case Connecticut has found that it is the claimant's exposure to asbestos rather than the insured's failure to warn that is the occurrence. Metropolitan Life Ins. Co. v. Aetna Cas. & Sur. Co., 255 Conn. 295 (2001). See also, Harris v. Hermitage Ins. Co., 2009 WL 3740666 (Oct. 13, 2009 Conn. Super) (stating that the last event in the causal chain is what should be examined in order to determine whether an "occurrence has been alleged). But note that where the conduct forming the basis of the lawsuit/occurrence is ongoing, at least one court has found that there is a duty to defend despite the fact that the initial lawsuit/occurrence first happened prior to the policy period. Peck v. Public Service Mut. Ins. Co., 363 F. Supp. 2d 137 (D. Conn. 2005).

b. Who is an Insured

An individual claiming coverage must be an insured under the policy. To determine whether an individual is an insured under a policy requires analysis of the "Who is an Insured" section of the policy or the definition of an insured in the policy. This may also require analysis of additional insured endorsements depending on the specific policy. If a person is not a named insured, an omnibus insured, or insured under an endorsement to the insurance policy, "there is clearly no obligation to defend

regardless of the allegations of the petition and irrespective of the soundness or groundlessness of the claim asserted.” Keithan v. Massachusetts Bonding & Ins. Co., 159 Conn. 128, 141 (1970).

c. The Insuring Agreement

For an insurer's duty to defend and indemnify to be triggered, the events alleged must fall within the insuring agreement of the policy.

(1) Occurrence Requirement

For auto, homeowners and commercial general liability policies the events alleged must be an occurrence. An occurrence has been defined as an accident, i.e., “a sudden event or change occurring without intent or volition through carelessness, unawareness, ignorance, or a combination of causes and producing an unfortunate result.” Providence Washington Ins. Group v. Albarello, 784 F. Supp. 950 (D. Conn. 1992). However, the Connecticut Supreme Court recently held that acts taken in self defense, though possibly construed as intentional, could meet the occurrence requirement. Vermont Mut. Ins. Co. v. Walukiewicz, 290 Conn. 582, 594-95 (2009).

(2) Bodily Injury and Property Damage

Damages for bodily injury and property damage must also be sought. Homeowners policies and most commercial policies typically define bodily injury as bodily injury, sickness or disease sustained by a person, including death. The Connecticut Supreme Court has held that the definition of bodily injury in a homeowners insurance policy does not include emotional distress unaccompanied by physical harm/injury and that pure emotional distress is not bodily injury. Moore v. Continental Cas. Co., 252 Conn. 405 (2000). The Court also held that physical manifestations of emotional distress such as nausea, headache and high blood pressure are not bodily injury. Id. See also, Taylor v. Mucci, 288 Conn. 379 (2008). Damages for bystander emotional distress may be covered because the emotional distress is derivative of or arose out of another's bodily injury. Such damages are only recoverable under the each person limit applicable to the physically injured plaintiff; no separate coverage limit is triggered because emotional distress does not constitute bodily injury. Id. See also, Galgano v. Metropolitan Prop. and Cas. Ins. Co., 267 Conn. 512 (2004).

Property damage is typically defined as physical injury to tangible property, including all resulting loss of use and loss of use of tangible property that is not physically injured. Connecticut has held that property damage does not include purely

commercial loss unaccompanied by damage to or loss of use of the tangible property. Williams Ford, Inc. v. The Hartford Courant Co., 232 Conn. 559, 581 (1995). Therefore, a claim for economic loss which is not accompanied by damage to or loss of use of some sort of tangible property, does not constitute property damage within the meaning of an insurance policy.

d. Exclusions

If an event alleged in the underlying lawsuit falls within an exclusion in a policy, there is no duty to defend or indemnify. LaBonte v. Fed. Mut. Ins. Co., 159 Conn. 252 (1970). Exclusions are examined where there is coverage under the insuring agreement of the policy. Exclusions are limitations or restrictions on the insuring agreement; they eliminate coverage where, were it not for the exclusion, coverage would have existed. Hammer v. Lumberman's Mut. Cas. Co., 214 Conn. 573, 588 (1990). Although the insured bears the burden of proving the existence of coverage under a policy, the insurer has the burden of proving that an exclusion applies to bar coverage. Souper Spud, Inc. v. Aetna Cas. & Sur. Co., 5 Conn. App. 579 (1985), *abrogated on other grounds*, Travelers Ins. Co. v. Namerow, 261 Conn. 784 (2002). In order for an insurer to rely on an exclusion, it must be determined that the exclusion is not barred by any state statute or regulation. It should also be determined whether courts have held the exclusion to be unambiguous. When determining whether there is a duty to indemnify, each exclusion must be reviewed carefully to fully evaluate any potential limitations on coverage.

e. Definitions

When determining an insurer's duty to defend and indemnify, policy definitions must be carefully reviewed. The definitions section of a policy defines policy language and terms, such as an insured, bodily injury, property damage and exclusionary clause language. Generally, where a policy term is not defined the term will be accorded its natural meaning. See QSP, Inc. v. Aetna Cas. & Sur. Co., 256 Conn. 343, 351-53 (2001).

f. Conditions

An insurer may also raise an insured's failure to comply with policy conditions as a basis to issue a reservation of rights or to deny coverage. Often, policy conditions are not a sufficient basis to deny coverage because an insurer must show prejudice as a result of the insured's failure to comply with the condition. The insured has the burden of establishing lack of prejudice. Aetna Cas. & Sur. Co. v. Murphy, 206 Conn. 409

(1988). The most common policy conditions are an insured's duty to provide timely notice of a claim and duty to cooperate.

(1) Notice

The purpose of the policy's notice provision is to give the insurer an opportunity to make a timely and adequate investigation and to have an opportunity to make reasonable compromises and settlements. Aetna Cas. Sur. Co. v. Murphy, 206 Conn. 409, 418-19 (1988). As noted, late notice will not preclude the insurer's duty to defend or indemnify unless there is material prejudice to the insurer as a result of the delay in notice. Id. Connecticut cases suggest that this is a difficult burden to meet. Indeed, those cases that uphold an insurer's denial of coverage based on late notice have been based on extreme situations, such as where the insurer did not receive notice of a lawsuit until after a default judgment had been entered against the insured. See e.g., Wagner v. General Acc. Ins. Co., 1997 WL 41216 (Jan. 27, 1997 Conn. Super.). Accordingly, late notice in and of itself will not often provide a basis to deny coverage.

(2) Duty to Cooperate

The duty to cooperate provision, or "cooperation clause," in insurance policies generally requires the insured to assist the insurer in defending claims against the insured.⁴ Generally, absent estoppel, waiver or excuse, the cooperation of the insured in accordance with the provisions of the policy is a condition the breach of which puts an end to an insurer's obligation. Arton v. Liberty Mut. Ins. Co., 163 Conn. 127, 133 (1972). However, for an insurer to be relieved of its obligations under a policy based on the insured's breach of the cooperation clause, the lack of cooperation "must be substantial or material." O'Leary v. Lumbermen's Mut. Casualty Co., 178 Conn. 32, 38 (1979). Where an insurer raises a defense of lack of cooperation, the burden is on the insured to prove that he or she has cooperated. Id.; Manthey v. American Automobile Ins. Co., 127 Conn. 516, 519 (1941). Also, as with the notice requirement, prejudice is required in order to rely on the breach of the cooperation clause as a basis for denying coverage. If an insured can prove lack of prejudice on behalf of the insurer, the insurer cannot prevail on a lack of cooperation defense. Taricani v. Nationwide Mut. Ins. Co., 77 Conn. App. 139, 150 (2003).

The duty to cooperate extends even to instances where an insured has a criminal case pending against him. If an insured charged with criminal conduct fails to submit to

⁴ It should be noted that a duty to cooperate may exist even in the absence of an express contractual provision, by virtue of the duty of good faith and fair dealing, which applies to insurance contracts. See Hoyt v. Factory Mut. Liability Ins. Co., 120 Conn. 156, 159 (1935).

an examination under oath, he can be found in breach of the cooperation provision of his insurance policy. See Taricani v. Nationwide Mut. Ins. Co., 77 Conn. App. 139 (2003).

Untrue statements made by the insured or a failure by the insured to submit to an examination under oath do not necessarily lead to a finding that the insured failed to meet his duty to cooperate. See Rochon v. Preferred Acc. Ins. Co., 118 Conn. 190 (1934); Kovac v. Standard Fire Ins. Co., 1994 WL 577095 (Oct. 12, 1994 Conn. Super.). The insured's conduct may be excused if there is a valid reason for it. See O'Leary v. Lumbermen's Mut. Cas. Co., 178 Conn. 32 (1979).

In O'Leary v. Lumbermen's Mutual Casualty Co., 178 Conn. 35, where the insured failed to appear for trial because his car broke down, but never called his lawyer to advise him of the situation, the court found no breach of the cooperation clause because when the insurer was informed of the insured's failure to appear, it instructed defense counsel not to ask for a continuance or to make any further effort to locate the insured. Id. at 35-36. Based on this, the court found that the insurer “breached its duty to protect its insured's interests because of its decision not to ask for a continuance when [the insured] did not appear.” Id. at 40. A Connecticut court has held, however, that an insured materially and substantially breached the duty to cooperate clause in her insurance policy when she “disappeared” after an auto accident and could not be located by the insurer, even after a default judgment was entered. Arton v. Liberty Mut. Ins. Co., 163 Conn. 127 (1972).

(3) Concealment and Fraud

Most policies include a provision providing that the entire policy will be void if the insured intentionally conceals or misrepresents any material fact, engages in fraudulent conduct or makes any false statements related to insurance.

Where an insurer raises this provision as a special defense to an insured's lawsuit seeking payment of a claim policy, the insurer must prove that the insured willfully concealed or misrepresented a material fact with the intention of deceiving the insurer. Rego v. Connecticut Ins. Placement Facility, 219 Conn. 339, 346 (1991). The insurer does not have to prove that it actually relied on the misrepresentation or concealment or that it actually suffered injury. Id. at 346-47. Further, the standard of proof is preponderance of the evidence, the standard normally applied to contractual claims, and not the higher standard of clear and convincing evidence typically applied to common law fraud claims. Id. at 347. A false statement is material if it will affect that attitude or actions of the insurer or if it would discourage, mislead or deflect the insurer's

investigation. Fine v. Bellefonte Underwriters Ins. Co., 725 F.2d 179, 184 (2d Cir. 1984).

This policy provision is most often used to deny first party claims typically for property loss. It also generally only voids the policy as to that particular claim. Further, at least with respect to automobile insurance policy where there is a pending third party claim it is unlikely that the insurer will be able to rely on this provision to void the policy. See Section F 1, Recission; Munroe v. Great American Ins. Co., 234 Conn. 182 (1995).

g. Other Insurance Provisions⁵

Another policy condition is the “other insurance” provision. It applies if there is more than one insurance policy that might cover the same claim (i.e., the policies cover the same risk, interest and period). The “other insurance” provisions in all applicable policies must be evaluated to determine the priority and allocation of coverage among the insurers. An “other insurance” clause may provide that the policy is primary or excess, and an escape clause may provide that the policy does not cover the loss if one or more policies insure the same risk. Connecticut courts have held that “other insurance” clauses are enforceable, as long as there is no denial or diminution of coverage for the insured. Aetna Cas. and Sur. Co. v. CNA Ins. Co., 221 Conn. 779 (1992).

If one policy has an excess “other insurance” clause and a second policy covering the same risk does not, the policy with the excess clause will not be triggered until the limits of the first policy are exhausted. See, for example, Lee R. Russ & Thomas F. Segalla, Couch on Insurance 3d (2009) § 219:33. Where two policies “contemplate the particular risk equally,” such as where two policies both purport to be excess, the policies will be found to provide concurrent coverage. Sacharko v. Center Equities Ltd. Partnership., 2 Conn. App. 439, 447 (1984).

Where two or more policies provide concurrent coverage, an “other insurance” clause may designate the method of contribution. Common methods of contribution are the pro rata and equal share methods. An equal share clause provides that each insurer contributes equal amounts until it has paid its applicable limit of insurance.

A pro rata clause provides that each insurer's share is based on the ratio of its applicable limit of insurance to the total applicable limits of all other insurers. For

⁵ If multiple policies apply in an uninsured/underinsured motorist claim, the priority of coverage is governed by Connecticut General Statutes § 38a-336(d).

example, in Continental Cas. Co. v. Aetna Cas. & Sur. Co., 823 F.2d 708 (2d Cir. 1987) (applying Connecticut law), the Second Circuit Court of Appeals held that two excess/umbrella policies had similar, mutually repugnant, "other insurance" clauses and therefore the two insurers would bear their respective share of liability based on their proportion of the \$7 million of coverage available between the two carriers. Aetna, with a liability limit of \$2 million, would be required to pay 2/7, and Continental, with a liability limit of \$5 million, would be required to pay 5/7 of a settlement.

It should be noted, however, that two "excess" clauses will not always be found to be mutually repugnant and lead to a finding of concurrent coverage. If one "other insurance" clause has distinguishing language, such as a statement that the insurance "shall not, in any event, contribute with" other insurance, courts may give effect to that language instead of finding that the two excess clauses are disregarded as mutually repugnant. RLI Ins. Co. v. Hartford Accident and Indem. Co., 980 F.2d 120 (2d Cir. 1992) (applying Connecticut law) (holding that a policy which did not state it would ever be primary, and which stated that it would not contribute with any other insurance, was excess over another policy which purported to be excess but did, in certain situations, provide primary coverage and did not have any language about not contributing with other insurance). Therefore, it is crucial to examine the specific language of the "other insurance" clauses at issue, in order to determine priority and method of allocating coverage.

A provision in a car rental agreement making the lessee's coverage primary and the lessor's coverage (as a self-insurer) secondary, is valid and enforceable. Farmers Texas County Mut. v. Hertz Corp., 282 Conn. 535 (2007). Even though the lessee's personal auto policy stated that with respect to a non-owned auto, it was excess over other applicable liability insurance, this excess provision was not triggered because the lessee had declined to purchase the liability insurance supplement from the lessor, so there was no "other applicable liability insurance" to render the lessee's own coverage secondary. Id. For the purposes of determining priority of coverage in this situation, it was the rental contract, rather than the lessor's self-insurance policy filed with the Insurance Commissioner, that was controlling. Id.

Another situation where allocation of coverage issues arise is where multiple policy periods are triggered, based on an event occurring over time. There is little law in Connecticut on this issue, but at least one court adopted a pro-ratio allocation method based on a fraction in which the numerator is the number of years over which the injury occurred and the denominator is the number of years that the particular insurer was on the risk. Security Ins. Co. v. Lumbermens Mut. Cas. Co., 2001 WL 649167 (May 9, 2001 Conn. Super.), *rev'd on other grounds*, 264 Conn. 688 (2003). This case involved

bodily injury claims arising out of asbestos exposure. Similar allocation issues may arise in environmental property damage and toxic tort cases. Lee R. Russ & Thomas F. Segalla, Couch on Insurance 3d (2009) § 217:3.

Other considerations may be present, depending on the specific facts of each situation. However, the language of the "other insurance" provisions is the starting point, and should be carefully reviewed in each case where multiple policies exist.

5. Different Types of Coverage

a. Personal Lines v. Commercial Policies

Personal lines policies and commercial policies provide different coverages. Although commercial policies cover against accidental losses, they often provide additional coverage for different types of losses such as business interruption losses. Common exclusions found in commercial general liability policies aside from the intentional act exclusion are: contractual liability; liquor liability; workers' compensation claims; employers' liability; pollution; aircraft, auto or watercraft; mobile equipment; war; damage to specified property; damage to "your product"; damage to "your work"; damage to "impaired property" or property not physically injured; and recall of products, work or impaired property.

b. Personal Injury Coverage

Homeowners, commercial general liability and personal excess liability policies may provide personal injury liability coverage. This is often additional coverage an insured can choose to purchase. The Insurance Service Office (ISO) defines personal injury as follows:

"Personal injury" means an injury, other than "bodily injury" arising out of one or more of the following offenses:

- a. False arrest, detention or imprisonment;
- b. Malicious prosecution;
- c. Wrongful entry into, or eviction of a person from, a room, dwelling or premises that the person occupies;
- d. Oral or written publication of material that slanders or libels a person or organization or disparages a person's or organization's good, products or services; or

- e. Oral or written publication of material that violates a person's right of privacy.

There are many variations of the definition of personal injury, some which may provide greater coverage than the ISO definition. In some policies, for example, personal injury is defined as including invasion of privacy. Other policies define personal injury as including mental anguish, which is not an offense or tort and may be construed very broadly.

To fall within the personal injury coverage of a policy, a complaint must allege an injury that arose out of one of the listed offenses. QSP, Inc. v. Aetna Cas. & Sur. Co., 256 Conn. 343, 353-54 (2001). Many courts use definitions of tort causes of action to define the extent of personal injury coverage. Some courts hold that personal injury coverage applies only to claims for injuries arising out of the enumerated offenses or torts. Other courts hold that where the facts alleged in a complaint bring the claim within an enumerated offense or tort, coverage will apply regardless of the cause of action alleged. David L. Leitner, Law and Practice of Insurance Coverage Litigation, Vol. 1 § 6.7.

Policies often have an occurrence requirement and intentional act exclusion for personal injury coverage. In Connecticut, the occurrence requirement has been held inconsistent with personal injury coverage provisions which include intentional torts. Imperial Cas. and Indemn. Co. v. State, 246 Conn. 313, 327 (1998). Accordingly, there may be personal injury coverage for intentional acts and the occurrence requirement would not a basis to deny a defense and indemnity. Although the Imperial Court concluded that "the policy language must be interpreted to include coverage for intentional acts that result in personal injuries," it did not address whether an intentional act exclusion for personal injury coverage was invalid. There is an argument that an intentional act exclusion, precluding coverage for intended or reasonably expected injuries, is distinguishable from the occurrence requirement.

- c. Claims-Made Policies

In contrast to an "occurrence" policy, which provides coverage for acts or omissions that arise during the policy period, a "claims made" policy generally provides coverage for "acts or omissions that are reported during the policy period, even if those acts or omissions occurred prior to the effective date of the policy." McSweeney v. County Agency, Inc., 2003 WL 1963172, *1, n.1 (April 17, 2003 Conn. Super.). Under a claims-made policy, it is the making or reporting of a claim that triggers coverage. Mitchell v. Medical Inter-Ins. Exch., 101 Conn. App. 721 (2007).

However, while under a claims-made policy it is the claim and not the occurrence that triggers coverage, policies differ on when a claim will trigger coverage under the policy. For example, certain claims-made policies dictate that a claim is not considered made until an insured provides notice of the claim to the insurer. Consequently, an insured's failure to provide notice within the policy period may result in a loss of coverage. Barry R. Ostrager and Thomas R. Newman, Handbook on Insurance Coverage Disputes (15th ed., vol. 1) at 122-26.

A "claims-made and reported" policy requires that the claim first be made during the applicable policy period and that the claim be reported to the insurer during the policy period. Generally, "claims-made and reported" policies contain "awareness provisions" that allow the insured to report potential claims or circumstances that the insured reasonably believes may give rise to a future claim. If the insured provides such notice of a potential claim to the insurer and subsequently a claim arises out of the event or circumstances reported, then notice of the claim will be deemed to have been made during the policy period at the time the notice of the potential claim was first provided. Id.

Additionally, some claims-made policies contain a "savings" clause providing that claims made during a limited period of time after the policy period expires will be considered as having been made during the policy period, as long as the insured gives the insurer timely notice of the underlying facts and circumstances of the claim. Id.

Also, a claims-made policy often covers acts and omissions occurring either before or during the policy period. With regard to prior acts, the policy may provide either full retroactive coverage or only coverage for claims arising out of acts and omissions after the "retroactive date" as specified in the policy. Id.

Therefore, whenever addressing defense and indemnity obligations under a claims made policy, you must look at the policy's specific requirements.

6. Common Coverage Problems

a. Permissive Use in Coverage Analysis of Auto Policies

Where an insurance clause extends coverage to those persons with permission to use an insured vehicle, known as the omnibus clause, the test of permissive use is whether, at the time of the accident, the use of the automobile was with the permission of the named insured. Sunshine Mut. Ins. Co v. Mai, 169 F. Supp. 702 (D.N.D. 1959). In this context, "permission" means "something more than mere sufferance or toleration

without taking steps to prevent," and is used to mean "leave, license, or authority." Tomasetti v. Maryland Cas. Co., 117 Conn. 505, 508 (1933). If permission is expressed but limited to a particular purpose, a complete departure from the permitted use will prevent the driver from being covered as an insured. Libero v. Lumbermens Mut. Cas. Co., 143 Conn. 269 (1956).

Permission granted to another to use an insured vehicle, without more, does not give the permittee authority to grant the use of the vehicle to yet another person. State Farm Mut. Auto. Ins. Co. v. Williamson, 331 F.2d 517 (9th Cir. 1964). In this instance, the coverage analysis would focus on whether the grant of permission to the original driver was broad enough to impliedly include authority to give permission to another to use the vehicle. Rice v. Welch, 33 Conn. Supp. 523 (1976). This question of fact would depend on the surrounding circumstances.

Implied permission is based on "an inference arising from a course of conduct or relationship between the parties, in which there is mutual acquiescence or lack of objection under circumstances signifying consent" and is not limited to affirmative conduct. Mai, Supra., 169 F. Supp. at 705. Even if a named insured expressly prohibits the use of the vehicle by second drivers, some courts will find implied permission for operation of the vehicle by a second driver under certain circumstances such as (1) when the original driver is a passenger at the time of the accident, (2) when the vehicle is being used for the benefit of the named insured or the original driver at the time of the accident, (3) when the original driver has the equivalent of unfettered control over the vehicle, without supervision of the named insured, or has equitable title, (4) when the named insured has knowledge of past violations by the original driver of rules regarding use of the vehicle and still allowed the original driver to retain control over the vehicle, and (5) when an emergency arises. See Freeman v. Nationwide Mut. Ins. Co., 147 Conn. 713 (1960); Jones v. Smith, 1 Kan. App. 2d 331 (1977); Williamson, supra, 331 F.2d at 520; Gillen v. Globe Ind. Co., 377 F.2d 328 (8th Cir. 1967).

Generally, it is difficult to win on a permissive use issue unless the individual using the vehicle is doing so with permission of a person three or four people removed from the original permittee. Some common examples of where permissive use may be found include (1) where original permittee is drunk and is a passenger in the car while someone else drives it, or (2) original permittee is given permission only to drive to and from school, and someone else is driving original permittee to school in the vehicle. In these situations, the common element is that the original scope of permission is being carried out.

b. Resident Relative as an Insured

Many policies (auto, homeowners and personal umbrella policies) define insured to include "relative" or "family member." These policies then further define "relative" or "family member" as a person who is related to the named insured or named insured's spouse by blood, marriage or adoption and who resides in the same household as the named insured or named insured's spouse.

In order to determine whether an individual resides in a particular household, Connecticut courts apply a two-part "resident of household" test. D'Addio v. Connecticut Ins. Guar. Ass'n, 30 Conn. App. 729, 734 (1993). This test requires: (1) sufficient evidence that the plaintiff had a "close, family-type relationship" with other members of the household; and (2) sufficient evidence that the plaintiff "actually lived" in the household in question. Middlesex Mut. Assurance Co. v. Walsh, 218 Conn. 681 (1991).

Courts consider a conglomeration of factors in making this determination, including: the individual's intent; the frequency of contact between the individual and other members of the household; the frequency with which the individual spends time at the household; whether the individual maintains a separate residence; whether the individual is emotionally and financially capable of establishing and maintaining a separate residence; the location of personal belongings; and the address used for personal and business records, for mail and for formal purposes such as voting, licenses and income tax returns. Remington v. Aetna Cas. and Sur. Co., 240 Conn. 309, 314-15 (1997).

It is also possible for an individual to have more than one residence, for purposes of the "resident relative" analysis. In addition, an individual may continue to be a resident of his or her parents' household even after leaving home and moving to another state for work or school. Schratwieser v. Hartford Cas. Ins. Co., 44 Conn. App. 754 (1997).

It is important to note that each case is different and the precise circumstances of the individual's living arrangements must be evaluated. Because courts look to a number of different factors including the individual's intent, there are often fact questions that must be resolved by the trier of fact when the "resident relative" issue is litigated.

c. Arising Out of an Auto

There are several situations in which an insurer has to determine whether the conduct for which the insured seeks coverage arises or results for the maintenance, use

or operation of a motor vehicle. This question most commonly surfaces with respect to uninsured/underinsured motorist claims and the automobile exclusion in the homeowners policy. However, under certain circumstances this question can arise in an automobile liability policy and a commercial general liability policy.

It has been held that for the purposes of determining liability coverage it is generally understood that for an accident to arise out of the use of an automobile it is sufficient to show that the accident or injury was connected with, had its origins in, grew out of, flowed from or was incident to the use of the automobile in order to meet the requirement that there be a causal relationship between the accident and the use of the automobile. Hogle v. Hogle, 167 Conn. 572 (1975) (exclusion in homeowners policy). Courts have also found that the term "use" is to be given a broad interpretation to include all proper uses of the vehicle. Bd. of Educ. of the City of Bridgeport v. St. Paul Fire and Marine Ins. Co., 261 Conn. 37 (2002) (sexual assault of student after she departed the school bus was within CGL policy's coverage for bodily injury that results from the ownership, maintenance, use, loading or unloading of a covered auto).

d. "Occurrence"/Intentional Acts Analysis

When presented with a situation where the conduct for which the insured seeks a defense and indemnity appears to be intentional, you should first look to see if the conduct meets the definition of occurrence. The focus should be on the entire event, i.e., was the act plus the result an accident. As indicated above, most insurance policies define occurrence as an accident. Connecticut courts have defined accident as a "sudden event or change occurring without intent or volition through carelessness, unawareness, ignorance, or a combination of causes and producing an unfortunate result." Providence Washington Ins. Group v. Albarello, 784 F. Supp. 950 (D. Conn. 1992), *citing*, Webster's Third New International Dictionary of the English Language, (Merriam, 1976) at p. 11. The term accident has been defined in its ordinary meaning as an unexpected happening. Commercial Contractors Corp. v. American Ins. Co., 152 Conn. 31, 42 (1964). See also Vermont Mut. Ins. Co. v. Walukiewicz, 290 Conn. 582, 594 ("In short, the relevant inquiry in determining whether an accident has occurred is whether the injuries at issue were caused by the intentional design of the insured, or rather, by a sudden, unforeseen event"). The Connecticut Supreme Court has also stated that with regard to insurance coverage the "accident" is the event causing injury and not the cause of the event. Tiedemann v. Nationwide Mut. Fire Ins. Co., 164 Conn. 439 (1973).

In some circumstances, an event may still be an occurrence if the act entailed intentional conduct, but the result was accidental. Pacific Indem. Co. v. Balf Co., Docket No. 2:91 CV 00991 (PCD). For example, after a person intentionally pulls the trigger on

a BB gun in the course of target shooting a can, the bullet ricochets off the can, travels far off course and strikes an unseen bystander. In this instance, the entirety of the event – the act plus the result – may be viewed as an accident.

If the event cannot be removed from coverage based on the definition of "occurrence," then the next step is to determine if the intentional act exclusion applies. The focus should be on whether the individual intended the consequences or knew with substantial certainty that the consequences would follow from his actions.

The Connecticut Supreme Court has held that intentional conduct "extends not only to those consequences which are desired, but also to those which the actor believes are substantially certain to follow from what the actor does." American Nat'l Fire Ins. Co. v. Schuss, 221 Conn. 768 (1992). Accordingly, it is not necessary that the precise injury be intended, instead it is the intent to bring about the result that is necessary. Id. Therefore, if the insured knew with substantial certainty that damage would follow from his actions, the exclusion applies to bar coverage.

For example, a teenager walks up to another teenager who has his hands in his pockets, tells him he is going to hit him, and then strikes him in the eye. The insured claims that he intended to punch the teenager in the mouth, not in the eye. This assault would be considered an intentional act, even though the insured did not intend the exact injury which followed from his actions. It is enough that he intended to cause, or knew with substantial certainty that he would cause, injury to the other individual by striking him. It should also be noted that this event would not be considered an "occurrence."

Please note that under certain circumstances an insured's intent to commit an act may be negated where the insured did not understand the nature or wrongfulness of his conduct or was deprived of the capacity to control his actions, such as where an insured suffered a mental illness. Allstate Ins. Co. v. Barron, 269 Conn. 394 (2004).

Labeling conduct that is clearly intentional as negligent has been held not to be enough to bring the claim within coverage and avoid application of the intentional act exclusion. State Farm Fire & Cas. Co. v. Bullock, 1997 WL 309584 (May 30, 1997 Conn. Super.). Further, with respect to cases alleging sexual assault **of a minor by an adult**, there is a presumption of intent notwithstanding that the act is framed in terms of negligence. USAA v. Marburg, 46 Conn. App. 99 (1997).

e. Mental Incapacity

In Connecticut, an insured's mental incapacity may negate his intent for purposes of the occurrence requirement and the intentional act exclusion. Home Ins. Co. v. Aetna Life and Cas. Co., 35 Conn. App. 94, 104-05 (1994), *rev'd on other grounds*, 235 Conn. 185 (1995). In other words, a seemingly intentional act may be deemed an occurrence or accident due to an insured's mental incapacity. Id. Also, the criminal act exclusion will not apply if the insured's mental incapacity negated his criminal intent. Allstate Ins. Co. v. Barron, 269 Conn. 394 (2004).

An insured's actions are considered an occurrence or accident where, because of mental illness or defect, the insured does not appreciate the wrongfulness of his conduct, or is deprived of the capacity to control his actions regardless of his understanding of the wrongfulness of his action. Home Ins. Co., Supra., 35 Conn. App. 94. In Barron, Supra., 269 Conn. 394, the court noted that whether an insured's actions constitute an occurrence or accident by reason of mental incapacity for insurance coverage purposes is determined by the same test as for mental capacity in the criminal context, which is governed by General Statutes § 53a-13 (a).⁶

Accordingly, if an insured's mental incapacity is raised, the issue of whether the insured's actions were intentional will most likely be a factual issue to be determined by the trier of fact. In Home Ins. Co., Supra., 35 Conn. App. 94, for example, the court held that a trier of fact had to consider the insured/arsonist's mental condition and psychiatric treatment records in determining whether his conduct was intentional for purposes of the intentional act exclusion based on the above-noted test. In Barron, Supra., 269 Conn. 394, where an insured murdered her husband and two children and wrongful death actions were brought, the court held that if a trier of fact deemed the insured not responsible for her actions because of her mental incapacity, there would be coverage for the murders under the insured's homeowners policy.

A few decisions, however, have determined that an insured's actions were intentional despite claims of mental incapacity, as a matter of law. See Dorchester Mut. Ins. Co. v. Adams, No 3:93CV1461 (D. Conn., March 18, 1997) (where the court held that, despite the insured's claim that he suffered from an anxiety disorder that prevented him from understanding the nature of his actions, there was no coverage for a complaint alleging that he intentionally shot and killed another as his alleged conduct was "quite

⁶ This statute provides: "In any prosecution for an offense, it shall be an affirmative defense that the defendant, at the time he committed the proscribed act or acts, lacked substantial capacity, as a result of mental disease or defect, either to appreciate the wrongfulness of his conduct or to control his conduct within the requirements of the law."

purposeful"); Pacific Indem. Co. v. Balf Co., No. 93-7678 (where the court granted summary judgment for the insurer holding that the insured's firing a rifle into a storefront window was not accidental even though the insured offered an affidavit from his psychiatrist stating that he suffered from a "generalized anxiety disorder," which prevented him from being able to discern right from wrong). In another case, a superior court rejected an insured's claim that he was entitled to coverage for fatally stabbing another man, because he acted under an "extreme emotional disturbance," thinking that the decedent had molested his daughter. U.S.A.A. v. Edington, 2009 WL 3839392 (Oct. 26, 2009 Conn. Super.). In granting summary judgment to the insurer, the court noted that a forensic psychiatrist had concluded that the insured was under the influence of extreme emotional disturbance, but still was able to appreciate the wrongfulness of his conduct and conform his conduct to the requirements of the law, and that the insured had pleaded guilty to a criminal offense requiring intent.

f. Intoxication

No Connecticut appellate court has decided whether intoxication may transform an otherwise intentional act into an accidental act. In Marlowe v. Hermitage Ins. Co., No. 3:94CV1146 (DJS) (Sept. 26, 1996), the court held that a complaint alleging an assault while the insured was drunk triggered an insurer's duty to defend. The court found that the complaint could be construed to allege that the insured was so drunk as to be unable to intend or expect the injuries he inflicted.

In Carvey v. Aetna Cas. & Sur. Co., 2001 WL 576660 (May 7, 2001 Conn. Super.), however, the court refused to consider evidence of the insured's intoxication in determining whether his homeowners insurer had a duty to defend and indemnify him for an assault case. The court found that the allegations of the complaint sounded in intentional conduct. It further stated "it would be against public policy to relieve citizens of the consequences of their acts based upon their voluntary intoxication. . . . [A]n insured cannot . . . argue that he did not intend to do an otherwise intentional act on the basis that he was voluntarily intoxicated. . . ." Id.

Outside of Connecticut, jurisdictions are split as to the effect intoxication has on an insured's intent. Some jurisdictions, including Michigan, Missouri and Texas, hold that voluntary intoxication cannot transform an intentional act into an accidental one. See Group Ins. Co. of Mich. v. Czopek, 440 Mich. 590 (1992) (no occurrence where insured, while intoxicated, resisted arrest and injured police officers). Many other jurisdictions, including Georgia, Oregon and Massachusetts, hold that an insured's intoxication is a factor to be considered in determining whether an incident was accidental. See Hunter v. Farmers Ins. Co., 135 Or. App. 125 (1995) (insured's

intoxication prevented him from acting with volition when he struck someone in a bar; therefore, there was an occurrence).

g. Self Defense

In 2009, the Connecticut Supreme Court ruled on the issue of insurance coverage for intentional acts done in self-defense. In Vermont Mut. Ins. Co. v. Walukiewicz, 290 Conn. 582 (March 17, 2009), the court held that when an insured engages in legitimate acts of self-defense, the conduct falls within the definition of "occurrence" because "when a policyholder is faced with a harm-threatening situation, the decision to defend one's self is not a choice. It is an instinctive necessity." The court also stated that "acts in self-defense can be an accident where the third party's actions provoking the self-defense response were the unforeseen and unexpected element in the causal chain of events making the insured's acts in self-defense unplanned and involuntary." With respect to the intentional act exclusion, the court noted that the exclusion is triggered when the insured subjectively expects or intends that bodily injury will occur, and not merely when an ordinary reasonable person would be able to foresee injury resulting. Interpreting an exclusion for bodily injury "which is expected or intended by the insured," the court stated, "When a person legitimately acts in self-defense, his primary intent is not to cause injury to another, but to prevent harm to himself."

Although the court in Walukiewicz was not ruling on the duty to defend, it did note at the outset that "[t]he insurer has a duty to defend any claim within coverage; if intentional acts of self-defense are within coverage, the insurer has a duty to defend the insured whenever the insured claims he or she acted in self-defense and the plaintiff was injured thereby." The decision does not specifically state what constitutes a "legitimate" act of self-defense. However, the court noted in a footnote that for purposes of determining whether an intentional act exclusion applies, "whether an act of self-defense is legitimate is not predicated on whether the defendant's belief that the degree of force used was necessary is objectively reasonable, as it is in criminal cases raising the defense of self-defense."

It should be noted that some courts outside of Connecticut that permit coverage for otherwise intentional conduct done in self defense, find that if excessive force is used in the course of self defense, it will be considered intentional conduct. Transamerica Ins. Group v. Meere, 143 Ariz. 351 (1984); Brasseaux v. Girouard, 269 SO.2d 590 (La. App. Ct. 1971).

h. Waiver and Estoppel

Under the principles of waiver and estoppel, certain acts or statements of the insurer may be used by the insured to claim that the insurer has given up its right to raise some or all coverage defenses.

Waiver is the intentional relinquishment of a known right. Jenkins v. Indem. Ins. Co., 152 Conn. 249 (1964). Waiver may be express or implied from acts or conduct of the insurer. An insurer may only waive noncompliance with policy conditions such as an insured's duty to provide timely notice of a claim. The doctrine of waiver cannot be used against an insurer to create coverage where it did not exist. Heyman Assoc. No. 1 v. Ins. Co. of Penn., 231 Conn. 756 (1995). In other words, if a policy does not provide coverage for certain losses, the policy will not be held to provide such coverage merely because of a waiver by the insurer.

Estoppel occurs when the insurer says or does something calculated or intended to induce the insured to believe that coverage is not being contested, and causes the insured to act on that belief and change his position in reliance on that belief, to his detriment or prejudice. Hanover Ins. Co. v. Fireman's Fund Ins. Co., 217 Conn. 340 (1991); Boyce v. Allstate Ins. Co., 236 Conn. 375 (1996). Some courts have noted that, for estoppel to exist, "there must be misleading conduct resulting in prejudice to the other party." Lunn v. Tokeneke Ass'n, Inc., 227 Conn. 601, 607 (1994).

Estoppel may result in an insurer being prohibited from raising substantive defenses. For example, if an insurer defended a suit without a reservation of rights and then discovered that an exclusion barred coverage, a court could hold that the insurer is precluded from asserting the exclusion under the doctrine of estoppel. In some states, where an insurer undertakes the defense of a suit without a reservation of rights and then untimely disclaims, prejudice will be presumed so as to estop the insurer from asserting substantive coverage defenses. Bluestein & Sander v. Chicago Ins. Co., 276 F.3d 119 (2d Cir. 2002). The theory is that the insured is prejudiced because he surrendered control of his defense. Other states hold that where an insurer undertakes a defense without reserving its rights and then untimely disclaims, the insured must show prejudice to estop the insurer from raising substantive coverage. Loss of a favorable settlement opportunity, an inability to produce experts, and a withdrawal of coverage so near the time of trial that it hampers an insured's defense are factors to consider in determining whether there is prejudice to the insured. Pennsylvania Gen. Ins. Co. v. Discronics, Inc., 5 F.3d 538 (9th Cir. 1993).

Whether estoppel applies in any given situation is a factual question, and it is the burden of the insured asserting estoppel to establish that the elements of estoppel have been met. Middlesex Mut. Assurance Co. v. Walsh, 218 Conn. 681 (1991).

i. Choice of Law - Out-of-State Policies

Choice of law analysis arises when it must be determined whether the law of one state applies to the issues presented in an action rather than the law of another state. Generally, if there is a choice of law issue with regard to interpretation of an insurance policy, the forum state's (where the suit is brought) choice of law rules apply. Klaxon Co. v. Stentor Electric Mfg. Co., 313 U.S. 487, 496 (1941). Therefore, if Connecticut is the forum state, i.e., the state in which the lawsuit was filed, then its choice of law rules apply.

In Connecticut, if an insurance policy does not contain a choice of law provision, then the "most significant relationship" test is used to determine which state's law applies to interpret the policy. Reichhold Chemicals, Inc. v. Hartford Acc. and Indem. Co., 252 Conn. 774, 781 (2000). This test first applies a rebuttable presumption in favor of application of the law of the state where the principal location of the insured risk is located. Id. at 782. This law applies unless another state has a more significant relationship to the transaction and the parties. Id.

The Connecticut Supreme Court applied the location of the insured risk presumption in a case involving a movable risk -- an auto policy covering a vehicle that was garaged primarily in Florida but used for part of the year in Connecticut. American States Ins. Co. v. Allstate Ins. Co., 282 Conn. 454 (2007). The Court applied Florida law because the vehicle was registered and located in Florida for at least seven months of the year, and because the policy was purchased and issued in Florida. Previously, some lower courts refused to apply the location of the risk presumption to automobile policies.

j. Prejudgment Interest

If prejudgment interest is stated to be damages in the insuring agreement of a policy then prejudgment interest is construed as damages subject to the policy limit. As such, the insurer will not be liable for prejudgment interest in excess of the policy limits. If a prejudgment interest provision is in a supplemental benefits portion of the policy, however, then the insurer will be liable for prejudgment interest over the policy limits. Rotella v. Head, 1999 WL 818612 (Sept. 21, 1999 Conn. Super.). Compare Cox v. Peerless Ins. Co., 774 F. Supp. 83 (D. Conn. 1991) (where policy was silent as to

prejudgment interest, it was properly included within "defense costs" rather than "damages," so insurer was liable to pay prejudgment interest in addition to policy limits).

k. Coverage for Punitive Damages

Under Connecticut law it is against public policy to provide insurance coverage for punitive damages or statutory multiple damages. Tedesco v. Maryland Cas. Co., 127 Conn. 533 (1941). However, insurance coverage is afforded where an insured is found vicariously liable as it has been held that this is not a violation of public policy. Avis Rent A Car System, Inc. v. Liberty Mut. Ins. Co., 203 Conn. 667 (1987). Thus, it is not necessary that the insurance policy include a specific exclusion for punitive damages.

7. Policy Cancellation

Many insurance policies will include provisions regarding cancellation of the policy including how notice of cancellation will be given. However, there are also some statutory requirements that need to be kept in mind.

Conn. Gen. Statute §38a-343 applies to the cancellation of motor vehicle policies. Under the statute, notice must be sent at least 45 days prior to the effective date of cancellation and may be sent by registered or certified mail or by mail evidenced by a certificate of mailing. However, where cancellation is for non-payment of the first premium on a new policy at least 15 days notice must be given and where cancellation is for non-payment of any other premium at least 10 days notice must be given. If the policy has been in effect for less than 60 days, 45 days notice must be given except that 15 days notice shall be given where cancellation is for non-payment of the first premium on a new policy and 10 days notice for non-payment of any other premium or for material misrepresentation. The notice of cancellation must specify the reason for cancellation.

An insurer's certificate mailing log as evidence of notice of cancellation in accordance with Conn. Gen. Statute §38a-343 is sufficient. Echavarria v. National Grange Mut. Ins. Co., 275 Conn. 408 (2005). The court did not decide whether the insurer needed to prove that notice was actually received because the plaintiffs had not set forth any evidence to support their claim that they never received notice. Thus, if an insured was able to provide sufficient evidence that he/she never received the notice of cancellation, an insurer may be obligated to present additional evidence showing that notice was actually received. A superior court has held that actual receipt of a cancellation notice or knowledge by the insured of the notice is required under

§ 38a-343(a), where cancellation is for nonpayment of premium. Starr v. Pistone, 2009 WL 323461 (Jan. 9, 2009 Conn Super). In this case, the insurer produced a certificate of mailing showing the date the notice had been mailed, and a copy of the envelope of the certified letter indicating that it was unclaimed and was returned to sender. The insured submitted an affidavit stating that she never received the cancellation letter, and the court noted that the insurer produced no evidence that it attempted to notify the insured that the policy was being cancelled, after receiving the cancellation letter back as unclaimed.

Cancellation of commercial risk policies except workers' compensation policies is addressed in Conn. Gen. Statute § 38a-324. Under Conn. Gen. Statute § 38a-324, where the policy has been in effect for more than 60 days it can only be cancelled for the reasons listed in that statute, which include non-payment of premium, fraud and misrepresentation. At least 10 days notice must be given if cancellation is for non-payment; otherwise 60 days notice is required. The notice of cancellation shall be sent by registered or certified mail or by mail evidenced by a certificate of mailing.

Conn. Gen. Statute § 38a-325 governs cancellation or discontinuation of professional liability insurance and provides that notice shall be mailed or delivered to the insured at least 45 days prior to the effective date of cancellation.

In a decision issued by the Connecticut District Court, the Court stated that for commercial policies and professional liability policies, the insurer must show that actual notice of the cancellation was received. Bepko v. St. Paul Fire & Marine Ins. Co., 2006 WL 2331076 (Aug. 10, 2006 D. Conn.). The Court based its decision on the wording of the statutes finding that the language of the statutes related to commercial policies and professional liability policies was more mandatory than the statute governing automobile policies.

There is no specific statutory provision related to homeowners policies. Therefore, the policy language should prevail.

Note: Due to the uncertainty regarding an insurer's obligation to show proof of the insured's receipt of the notice of cancellation, as well as the Superior Court decision requiring actual receipt of notice of cancellation of an auto policy for nonpayment of premium, it is recommended that all notices of cancellation be sent by certified mail, return receipt requested.

E. The Tools Used to Determine Whether an Insurer Owes Coverage

1. Declaratory Judgment Action

If there is a strong basis for denying coverage even though the complaint could be read as pleading into coverage (i.e. facts alleged create a question as to whether the loss is within the policy coverage), a declaratory judgment is used to determine the insurer's obligations before a costly defense of the underlying suit. The objective is to terminate the insurer's obligations entirely (i.e., enable them to withdraw a defense and not provide any coverage), or to shrink the insurer's exposure as in the case of a multi-count complaint alleging some acts which are covered and some which are not.

A declaratory judgment action is a lawsuit that is separate from the underlying action. It requests a court to make determinations regarding the rights and obligations of the parties instead of requesting money damages. When the insurer files a declaratory judgment action, it asks the court to determine whether or not the insurer owes a defense to an insured. A declaratory judgment action permits an insurer to withdraw from a defense without risking the penalty for a wrongful refusal to defend, as noted above.

The general strategy would be for the insurer to attempt to terminate obligations as early as possible by filing a motion for summary judgment. This is a request that the court decide a case, before trial, based on deposition testimony, affidavits, the insurance policy and other documentary evidence. When a court grants summary judgment in a declaratory judgment action filed by an insurer, it essentially decides whether, based on the established facts, there is or is not coverage as a matter of law. By moving for summary judgment, there is a chance that the declaratory judgment action may be resolved before the trial of the underlying action.

In DaCruz v. State Farm Fire & Cas. Co., 268 Conn. 675, 689-91 (2004), the court noted that where an insurer seeks to resolve both its duty to defend and its duty to indemnify, a declaratory judgment action is appropriate. Where there is no basis to challenge a duty to defend and an insurer seeks only to determine its duty to indemnify, however, the court noted that the more appropriate remedy may be for the insurer to wait to challenge its duty to indemnify in a direct action against it pursuant to Connecticut General Statutes § 38a-321, as discussed below.

In a Connecticut superior court decision, the court granted summary judgment for the insured on the issue of insurer's duty to defend in the declaratory judgment action brought by the insurer. National Grange Mut. v. Mallozi, 2006 WL 3859735 (Dec. 12, 2006 Conn. Super.). The insured then asked the court to grant summary judgment as to the duty to indemnify and dismiss the insurer's declaratory judgment complaint arguing that once the court finds there is a duty to defend it cannot address the duty to indemnify before resolution of the underlying action. The insured asserted that the appropriate remedy is Connecticut General Statutes § 38a-321. The court rejected this argument and denied this portion of the insured's motion for summary judgment.

2. Intervene in Underlying Action

When a coverage question is presented, the insurer also can defend the action and then attempt to intervene as a defendant in the underlying action. C.G.S. §52-102. The insurer is made a party to the action for the limited purpose of presenting the jury with special interrogatories, such as "was the act intentional?", in order to identify the grounds on which the jury makes its decision and to delineate the grounds for denial of coverage. This procedure is used only if the matter is tried to conclusion. However, courts are often reluctant to permit insurers to intervene. See Hunter v. Peters, 2001 WL 34093937 (Dec. 13, 2001 Conn. Super).

3. Third-Party Action

A third-party action is a lawsuit attached to the underlying suit, but which is initiated by the insured. It works the same way as a declaratory judgment action. The third-party action may be the most effective tool in determining coverage since it is linked to the underlying action and could be resolved along with the underlying action. The problem with the third-party action, however, is that it is only initiated by the insured, who usually does not want to spend the funds to pursue such an action.

4. Defend to Judgment and Then Raise Coverage Defenses

If a plaintiff prevails at trial, he can then sue the insurer directly under the subrogation or "direct action" statute, Connecticut General Statutes §38a-321, to recover the judgment. Subrogation/direct action allows a plaintiff who prevails against a defendant/insured to be substituted in place of the defendant/insured in an action against the insurer on the insurance policy. At the time of subrogation/direct action, the insurer then can raise any available coverage defenses. The disadvantage to this process is that a coverage decision comes years after the incident. Also, the judgment is liquidated and

could be substantial. Therefore, the risks to the insurer in waiting to assert coverage defenses at subrogation/direct action are high.

F. The Tools Used to Fix Insurance Problems

1. Rescission

Rescission of an insurance contract occurs when the policy is voided, with the same effect as if the policy was never in existence in the first place. One Connecticut court described rescission as the “unmaking of a contract.” Paul Revere Life Ins. Co. v. Pastena, 52 Conn. App. 318, 325 (1999). The issue of rescission may arise when fraud was committed by an applicant (potential insured) at the time the policy was created. For example, providing false information on an insurance application may, in some cases, be the basis for rescission of the policy.

Rescinding an insurance contract may only be accomplished in certain circumstances and through certain procedures. In order for a misrepresentation made on an insurance policy application to defeat coverage the misrepresentation must be material and be known by the insured to be false when made. Middlesex Mut. Assurance Ins. Co. v. Walsh, 218 Conn. 681, 692 (1991). Innocent or negligent misrepresentations are not sufficient. Id. Where there has been a false material misrepresentation the proper remedy is for the insurer to rescind the policy ab initio (from the beginning). See Northwestern Mut. Life. Ins. Co. v. Gil, 2009 WL 276086, *5 (Feb. 5, 2009 D. Conn.) (stating that the “effect of rescission is to legally erase the existence of a contract ab initio”).

Where there is a basis to rescind the policy, the insurer should follow the procedures set forth either in the policy or by the applicable state statute. Also, one superior court indicated that the insurer should rescind within a reasonable time after discovering the basis to do so, otherwise it may waive the right to rescind. Janush v. Nationwide Mut., 2000 WL 254560, *3 (Feb. 23, 2000 Conn. Super.). When the policy is rescinded any premiums paid by the insured should be returned.

Where a third party has made a claim and rescission of the insurance policy would deny recovery to that third party the Connecticut Supreme Court has held that an insurer cannot rescind the policy for material misrepresentation. Munroe v. Great American Ins. Co., 234 Conn. 182 (1995). The basis for the court's decision in Munroe was that automobile liability insurance coverage is compulsory. Therefore, it is unclear whether this rule would apply to other types of coverage such as homeowners and commercial general liability coverage.

2 Reformation

An insurance contract may be reformed where it (1) does not conform to the actual agreed-upon contract, (2) does not express the intention of the parties, and (3) was executed as a result of a mutual mistake, or a mistake of one party coupled with fraud or inequitable conduct on the part of the other. Lopinto v. Haines, 185 Conn. 527 (1981). A mutual mistake has been defined as one that is common to both parties and affects a result that neither party intended. Inland/Wetlands & Water Course Agency of the City of Middletown v. Landmark Inv. Group, Inc., 218 Conn. 703, 708 (1991). If there was not a meeting of the minds between the parties to the insurance contract or if each party had a different intent, there can be no reformation. Hoffman v. Fid. & Cas. Co. of New York, 125 Conn. 440 (1939). The party seeking reformation must prove that there is a basis for reformation by clear, substantial, and convincing evidence. Lopinto, 185 Conn. at 534. Reformation of an insurance policy is rare since the insured and insurer will usually argue different interpretations of a policy, rather than the same mutual mistake.

3. Equitable Subrogation

A claim for equitable subrogation can be brought when an insurer wishes to recover monies it has paid to its insured which should have been paid by another insurer or other person who was obligated to pay these sums. This tool is generally used to resolve disputes between insurers. However, equitable subrogation has been used with respect to individuals. For example, in Allstate Ins. Co. v. Palumbo, 2006 WL 3878072 (Dec. 15, 2006 Conn. Super.), *aff'd*, 109 Conn. App. 731 (2008), *cert. granted*, 289 Conn. 954 (2008), the insurer paid its insured for a fire loss claim, then brought an equitable subrogation claim to recoup the full amount paid from the insured's live-in boyfriend who started the fire.

The doctrine of equitable subrogation does not arise as a result of a contractual relationship between the parties, but instead is the result of a matter of equity. Westchester Fire Ins. Co. v. Allstate Ins. Co., 236 Conn. 362, 371 (1996). "As now applied, the doctrine of equitable subrogation is broad enough to include every instance in which one person not acting as a mere volunteer or intruder, pays a debt for which another is primarily liable and which in equity and good conscience should have been discharged by the latter." *Id.* (internal quotation marks omitted). In Westchester Fire v. Allstate Ins. Co., an underinsured motorist insurer sought reimbursement for benefits paid to its insured as a result of the liability insurer's wrongful denial of coverage. Similarly, in Great American Ins. Co. v. Aetna Life & Cas. Co., 1990 WL 270293 (June 4, 1990 Conn. Super.) an equitable subrogation claim was brought by a homeowner's insurer against the insurer for a little league franchise for defense and

indemnity damages where the issue was whether the coach who was an insured under the homeowners policy was also an insured under the league's policy.

However, a claim for equitable subrogation is not permitted where the insurer is considered to be acting as a mere volunteer and is not obligated to pay the claim. For example, a claim for equitable subrogation was not permitted in Allstate Ins. Co. v. Lerer, 2001 WL 85141 (Jan. 16, 2001 Conn. Super.). The court specifically noted that the insurance company made payment as a volunteer instead of under an obligation to do so by contract. In this case, the insurance company was seeking to collect money it had paid for defense and settlement of a motor vehicle accident case against its insured's doctor. The court felt that this was not a true equitable subrogation claim because the doctor should have been brought in to the original action under Connecticut's apportionment statute. Instead, the insurer was making payment of a third-party claim and then seeking to collect the money from a joint tortfeasor. On the other hand, in American States Ins. Co. v. Allstate Ins. Co., 94 Conn. App. 79 (2006), the court held that the personal umbrella insurer that stepped in to provide a defense after the primary auto liability carrier denied a defense, was not acting as a volunteer and was therefore entitled to bring an equitable subrogation action against the primary insurer. The court noted that the umbrella carrier had a contractual obligation to provide coverage for claims not covered by its insured's other policies, and understood that as the secondary insurer, it had an obligation to defend after being advised of the primary carrier's refusal to defend their mutual insured.

There may be other limitations on an insurer's ability to pursue a claim for equitable subrogation, depending on the factual circumstances of the claim. For example, while a homeowner's insurer can bring an equitable subrogation claim against a social guest of the insured for causing fire damage to the home, such a claim cannot be brought if the individual causing the damage was the insured's tenant. See Allstate Ins. Co. v. Palumbo, 109 Conn. App. 731 (2008), *aff'd*, 109 Conn. App. 731 (2008), *cert. granted*, 289 Conn. 954 (2008) (allowing an equitable subrogation claim by homeowner's insurer against homeowner's boyfriend who caused a fire, and who was determined to be a social guest rather than a tenant or boarder); Wasko v. Manella, 269 Conn. 527 (2004) (allowing insurer to maintain subrogation action against houseguest of insured who negligently burned down insured's vacation home); DiLullo v. Joseph, 259 Conn. 847 (2002) (holding that in the absence of an express agreement between the parties covering the question, a landlord's fire insurer has no right of subrogation against the landlord's tenant).

G. Answers to Common Coverage Questions

1. Should the insurer look at every case to determine coverage?

Yes.

2. If a coverage question is raised, should the person handling the underlying claim conduct the investigation?

No.

3. Should the person handling the underlying claim write the reservation of rights/denial letter?

No.

4. Should a form excess letter be sent if there is a question of coverage?

No.

5. When should a reservation of rights letter be sent?

As soon as you know the basis for the reservation of rights, but no later than when you assign counsel to defend.

6. When should the insurer hire counsel?

- a. When the person sued is an insured and you cannot determine on the face of the lawsuit that the claim is not within the scope of the insurance agreement; and
- b. The claim happened in the policy period; and
- c. You cannot determine on the face of the lawsuit that an exclusion applies.

7. Can an insurer waive a coverage defense?

You can waive some coverage defenses, such as late notice, lack of cooperation or consent to settle. You cannot create coverage by remaining silent where, for example, a person is not an insured. However, you can create coverage if you give an insured the impression that there is

coverage, and consequently the insured relies on your actions to his detriment, i.e. through the principle of estoppel.

8. If an insurer needs legal advice on coverage, who should it call?

You should call the attorney who represents the carrier, not the attorney who is assigned to represent your insured. **UNDER NO CIRCUMSTANCES SHOULD YOU ASK THE ATTORNEY WHO IS REPRESENTING THE INSURED FOR COVERAGE ADVICE.**

9. What is coverage advice?

Coverage advice is any legal advice and analysis that tends to limit or eliminate coverage to the insured.

10. If an insurer makes a mistake about coverage, what are the consequences?

In addition to paying the claim and the costs of litigation, an insurer can be held to pay punitive damages under Connecticut bad faith statutes.

H. Final Thoughts About Coverage

Typically, you will not have a problem if you follow a methodical step by step approach. You should create clear and consistent records of your actions, which should exhibit a conscientious and logical approach to the problem. Your objective is to pay legitimate claims and to fairly inform your insured of those claims which are not covered in a straightforward, timely and honest manner.

2. BAD FAITH

Bad faith is a claim that an insurer failed to fulfill its obligations under a policy of insurance with an intent that would constitute "bad faith."

A. Causes of Action

There are three types of bad faith claims: (1) common law claim based on breach of an implied covenant of good faith and fair dealing; (2) negligence claims; and (3) statutory claims based on violation of the Connecticut Unfair Insurance Practices Act, C.G.S. § 38a-815, et seq. (CUIPA) and the Connecticut Unfair Trade Practices Act, C.G.S. § 42-110a, et seq. (CUTPA).

1. Common Law Bad Faith

A common law bad faith claim derives from a duty of good faith and fair dealing implied in every contract or contractual relationship. Hoskins v. Titan Value Equities Grp., Inc., 252 Conn. 789, 793 (2000). A contractual relationship is a prerequisite to bringing a common law claim. Carford v. Empire Fire and Marine Ins. Co., 94 Conn.App. 41, 45-46 (2006). Courts have characterized this claim as sounding in both tort and contract. Most Connecticut courts have adopted the view that a bad faith claim is an independent tort claim separate from any claim for breach of contract. Grand Sheet Metal Prod. Co. v. Protection Mut. Ins. Co., 34 Conn. Supp. 46 (1977); United Technologies Corp. v. American Home Assurance Co., 118 F. Supp. 2d 181, 188 (D. Conn. 2000).

Connecticut courts have not clearly defined a single standard for a bad faith claim, but they have nonetheless defined bad faith as follows:

- Bad faith is not simply bad judgment or negligence, but rather it implies the conscious doing of a wrong because of dishonest purpose. It contemplates a state of mind operating with furtive design or ill will. Buckman v. People Express, Inc., 205 Conn. 166, 171 (1987); see also, PSE Consulting, Inc. v. Frank Mercede and Sons, Inc., 267 Conn. 279, 305 (2004) (defining bad faith as requiring an “improper motive” or “dishonest purpose”).
- Fraud or a design to mislead or deceive another, or a neglect or refusal to fulfill some duty or contractual obligation, not prompted by an honest mistake, but by some interested or sinister motive. Habetz v. Condon, 224 Conn. 231, 237 (1992); see also, De La Concha of Hartford, Inc. v. Aetna Life Ins. Co., 269 Conn. 424, 433 (2004).
- Reckless indifference to the rights of others or egregious conduct is required. Bergen v. Standard Fire Ins. Co., 1997 WL 809957, *15 (Dec. 31, 1997 Conn. Super.).
- Failure to give the insured's interests equal consideration with the insurer's own interests. United Services Auto. Ass'n. v. Glens Falls Ins. Co., 350 F. Supp. 869, 871 (D. Conn. 1972).

2. Negligence

In Connecticut, the law is not well defined and courts have taken varying approaches to bad faith claims premised on the insurer's negligent conduct. Older decisions permitted negligence claims for an insurer's bad faith. See Turgeon v. Shelby Mut. Plate Glass & Cas. Co., 112 F. Supp. 355 (D. Conn. 1953). The standard for such a claim is a failure to use good faith and honest judgment or failure to use that level of care and diligence which a person of ordinary prudence would exercise in the management of his own business. Hoyt v. Factory Mut. Liab. Ins. Co., 120 Conn. 156 (1935). Given the standard for bad faith claims more recently set forth, it is questionable whether negligence claims for bad faith are still viable.

Some lower courts have accepted such claims, holding that claims based on negligent conduct (with no allegation that the conduct was extreme, malicious or done with a bad motive) will support a bad faith claim, but will only support an award of compensatory, not punitive, damages. See e.g., Masik v. Costa, 2000 WL 1513789 (Sept. 7, 2000 Conn. Super.) (holding that allegations that do not rise to the level of extreme conduct are still viable for compensatory damages as long as the complaint alleges more than the fact that the insurer failed to pay the claim); Chapman v. Georgine Realty, 2008 WL 4307618 (Aug. 29, 2008 Conn. Super.) (recognizing that some courts have not required proof of ill will or sinister motive to prove bad faith). One court stated, "... an insurer who acts unreasonably and in bad faith by withholding insurance benefits may be liable in tort. Yet, only if the insured sues for punitive damages must the tortious conduct be alleged in terms of wanton and malicious injury, evil motive and violence and outrageous conduct." Hennessey v. Travelers Prop. Cas. Ins. Co., 1999 WL 240231, *2 (Conn. Super. Ct. April 14, 1999), *citing*, L.F. Pace & Sons, Inc. v. Travelers Indem. Co., 9 Conn. App. 30, *cert. denied*, 201 Conn. 811 (1986).

Some cases distinguish between claims for compensatory and punitive damages, but still hold that more than negligence is required, even for compensatory claims. In Uberti v. Lincoln Nat.'l Life Ins. Co., 144 F. Supp. 2d 90 (D. Conn. 2001), the District Court found that the insurer's arbitrary coverage decision was "more than negligence or honest mistake," and therefore supported an award of compensatory damages for bad faith. However, it found that the conduct did not support an award of punitive damages because there was insufficient indicia of "bad motive, wantonness, or outrageousness." See also, Advanced Fin. Services, Inc. v. Savers Prop. & Cas. Ins. Co., 2005 WL 648279 (Feb. 9, 2005 Conn. Super.) (holding that bad faith means more than mere negligence; however, claims that do not involve wanton and malicious injury, evil motive and outrageous conduct are still viable to obtain compensatory damages).

Several recent decisions have reaffirmed the rule that bad faith requires more than mere negligence. See, e.g., Crespan v. State Farm Mut. Auto. Ins. Co., 2006 WL 280009 (Jan. 13, 2006 Conn. Super.) (granting insurer's motion to strike in case involving denial of medical payments benefits, noting that even though "the plaintiff may have proven that the defendant did something wrong, bad faith requires more than mere negligence"); Keegan v. New London County Mut. Ins. Co., 2005 WL 2854006 (Oct. 11, 2005 Conn. Super.) (plaintiff failed to prove bad faith because it did not demonstrate that the insurer acted with a sinister motive or dishonest purpose); Bernard v. Buendia, 2005 WL 1971238 (July 20, 2005 Conn. Super.) (insurer's motion to strike plaintiff's bad faith claim granted because the plaintiff failed to allege facts that demonstrated that the insurer acted with a dishonest purpose or otherwise in bad faith); Bepko v. St. Paul Fire and Marine Ins. Co., 2005 WL 3619253 (D. Conn. 2005) (bad faith requires more than "bad judgment or negligence" and "[a]llegations of a mere coverage dispute or negligence by an insurer will not state a claim"); 1049 Asylum Ltd. v. Kinney Pike Ins., Inc., 2005 WL 3163931 (Conn. Super.) (insurer entitled to summary judgment on bad faith claim because there was no evidence that it was motivated by a dishonest purpose or sinister motive); Martin v. American Equity Ins. Co., 185 F. Supp. 2d 162 (D. Conn. 2002) ("bad faith claim must be alleged in terms of wanton and malicious injury, evil motive and violence"); Acoustics, Inc. v. Travelers Ins. Co., 2004 WL 1559214 (May 28, 2004 Conn. Super.) (noting that "bad faith requires more than mere negligence or unreasonable conduct," although unreasonable conduct can be evidence of improper motive).

3. Statutory Claims - CUIPA and CUTPA

The Connecticut Unfair Insurance Practice Act (CUIPA) governs bad faith claims against insurance companies. C.G.S. §38a-815 et seq. CUIPA prohibits unfair or deceptive acts or practices in the business of insurance and also prohibits twenty-two specifically listed acts or practices. C.G.S. §38a-816. One of those twenty-two acts/practices is unfair claim settlement practices, which has fifteen sub-parts, including not promptly and fairly settling where liability has become reasonably clear. C.G.S. §38a-816(6). CUIPA applies to any legal entity engaged in the business of insurance, and can include agents, brokers and adjusters.

Although CUIPA does not explicitly create a private right of action, some lower courts have allowed a private cause of action against an insurer. See e.g., Sambuco v. Aetna Cas. & Sur. Co., 1991 WL 86160 (May 14, 1991 Conn. Super.); Schott v. Great American Ins. Co., 10 Conn. L. Rptr. 4 (1993). Cf. Conway v. Travelers Cas. & Sur. Co. of America, 2000 WL 1918051, *15 (Dec. 15, 2000 Conn. Super.) (recognizing a split of authority whether CUIPA affords a private right of action for individuals). Generally,

however, a plaintiff will bring a cause of action for a violation of CUIPA under the Connecticut Unfair Trade Practices Act (CUTPA), C.G.S. §42-110a et seq., which prohibits unfair or deceptive acts or practices in the conduct of any trade or commerce.

Under Mead v. Burns, 199 Conn. 651 (1986), a plaintiff may not bring a CUTPA claim which is not also a violation of CUIPA if it concerns misconduct related to the insurance industry. To support a CUIPA/CUTPA action for unfair settlement practices, C.G.S. §38a-816(6), one must allege and prove a general business practice, which Connecticut courts have defined as more than a single act of misconduct. Lees v. Middlesex Ins. Co., 229 Conn. 842 (1994). However, for other violations such as misrepresentation, C.G.S. §38a-816(1) and (2), one violation is sufficient. Ferreira v. Safeco Ins. Co. of America, 1996 WL 411999 (July 5, 1996 Conn. Super.).

To prevail on a CUTPA claim, the plaintiff must establish both that the defendant engaged in a prohibited act and that as a result of this act, the plaintiff suffered injury. Abrahams v. Young & Rubicam, 240 Conn. 300, 306 (1997). In order to show that the injury was the result of the prohibited act, the plaintiff must show that the prohibited act was the proximate cause of the plaintiff's injury or harm. Id.

B. Who Can Sue for Bad Faith

Insureds under a policy can sue for bad faith. Under both common law and CUIPA/CUTPA, third parties do not have a right to sue an insurer directly for bad faith. On this point, the Connecticut Appellate Court held that only contracting parties may enforce the implied covenant of good faith and fair dealing and that an insurance company does not owe a duty of good faith and fair dealing to third-party claimants. Carford v. Empire Fire and Marine Ins. Co., 94 Conn. App. 41 (2006). In the same case the Connecticut Appellate Court also held that third parties to the insurance contract cannot bring a claim directly against an insurer for a violation of CUIPA prior to obtaining a judgment against the insured. Id. In Hayden v. Main, 2007 WL 1297247 (April 17, 2007 Conn. Super.), a superior court held that an insured's admissions of fault at his deposition and in requests to admit did not constitute a judicial determination of liability giving a third party plaintiff grounds to sue an insurer for common law and statutory bad faith. The court reemphasized the Carford holding that a third party has no bad faith claim against an insurer until a final judgment is issued.

A third party to an insurance policy may bring a bad faith claim against an insurer, pursuant to the direct action statute, C.G.S. § 38a-321. The direct action statute allows a plaintiff who recovers a judgment against a defendant/insured, which judgment is not satisfied within thirty days, to become subrogated to the rights of the

defendant/insured. This means that a plaintiff/judgment creditor can bring a direct action against the defendant's insurer to the same extent that the defendant could have enforced a claim against the insurer had the defendant paid the judgment. A third party can bring both common law bad faith and CUIPA/CUTPA claims against the defendant's insurer via the direct action statute. Peck v. Public Serv. Mut. Ins. Co., 114 F. Supp. 2d 51, 54 (D. Conn. 2000).

A third party may also sue an insurer based on a stipulated judgment (essentially, a court approved settlement) which transfers rights to the plaintiff that the defendant/insured would have had against the insurer, including bad faith claims. Black v. Goodwin, Loomis & Britton, Inc., 239 Conn. 144 (1996). Note that where a third party sues an insurer based on a stipulated judgment, the insurer can still challenge the stipulated judgment on the grounds of fraud and collusion even if the insurer breached its duty to defend. Continental Ins. Co. v. McAuliffe, 2007 WL 127315 (Jan. 3, 2007 Conn. Super.).

C. Bad Faith Claims and Workers' Compensation Claims

In the workers' compensation context, the Connecticut Supreme Court in DeOliveira v. Liberty Mut. Ins. Co., 273 Conn. 487 (2005), held that a cause of action against an insurer for claims arising out of the workers' compensation claims handling process including claims alleging bad faith such as improperly contesting a claim and unduly delaying payment, are barred by the exclusivity provision of the Workers' Compensation Act, General Statutes § 31-284(a) as the commissioners have the authority to hear claims arising from misconduct in the processing of workers' compensation claims. The court noted, however, that if an insurer's conduct in the processing of a claim, apart from nonpayment, was so egregious that the insurer no longer could be deemed to be the agent of the employer, a claim arising from such conduct would not fall within the scope of the Workers' Compensation Act. See Desmond v. Yale-New Haven Hosp. Inc., 2009 WL 792346 (Mar. 23, 2009 D. Conn.) (upholding DeOliveira's bar on claims against insurers for bad faith processing of a workers' compensation claim). The Connecticut Supreme Court subsequently indicated that its ruling also include claims for negligent infliction of emotional distress when alleged in the context of handling a workers' compensation claim. Almada v. Wausau Bus. Ins., 274 Conn. 449 (2005).

D. Conduct Constituting Bad Faith

1. Denial of Coverage

Bad faith claims may concern an insurer's breach of its duty to defend and indemnify under a policy. Peck, Supra., 114 F. Supp. 2d 51; Martin v. American Equity Ins. Co., 185 F. Supp. 2d 162 (D. Conn. 2002). Breach of contract claims for an insurer's failure to defend and indemnify and bad faith claims based on this same conduct are commonly brought together. City of West Haven v. Liberty Mut. Ins. Co., 1989 WL 190242 (June 1, 1989 D.Conn.). However, breach of the duty to defend and indemnify, by itself, may not amount to bad faith. Mullany v. Liberty Mut. Ins. Co., 2006 WL 3524560 (Nov. 17, 2002 Conn. Super.) (bad faith claim arising out of failure to defend and indemnify was legally insufficient because there were no allegations of bad faith or misconduct beyond breach of contract; court noted that the "insurer's refusal to defend and indemnify, if wrongful, reasonably could have been prompted by an honest mistake as to its duties").

2. Bad Faith Failure to Settle Within Policy Limits

Bad faith claims may also be brought for an insurer's bad faith failure to settle within the policy limits. The mere fact that a verdict may exceed the policy limits does not mandate an offer of the policy. Peterson v. Allcity Ins. Co., 472 F.2d 71 (2d Cir. 1972). In Connecticut, an insurer may refuse to settle within the policy limits if its rejection of a settlement offer is reasonable. Pascale v. Great American Ins. Co., 2004 WL 1149488 (May 20, 2004 D. Conn.). Moreover, an insurer's failure to pay a claim alone does not give rise to a bad faith claim. Fuhr v. GEICO, 2000 WL 192437 at *1 (Feb. 3, 2000 Conn. Super.). Rather, other tortious misconduct must be alleged in addition to an insurer's failure to pay a claim. Ferriolo v. Nationwide Ins., 1998 WL 128821 at *2 (March 11, 1998 Conn. Super.). The Connecticut superior court has continued to require that something more be shown than that an offer was made within the policy limits. In Hernandez v. Allstate Ins. Co., 2006 WL 2458575 (Aug. 9, 2000 Conn. Super.), the plaintiff obtained a judgment against the insured and brought a direct action the insurer which included claims of bad faith. On the insurer's motion for summary judgment, the court noted that the insurer's failure to accept a policy limits offer would not amount to bad faith unless it could be shown that the insurer acted with design to mislead or deceive, or a dishonest purpose. Note the court denied the insurer's motion for summary judgment due to a potential issue of fact.

Bad faith failure to settle may be shown where the severity of the plaintiff's injuries is such that any verdict against the insured is likely to be greatly in excess of the

policy limits and when the facts indicate that a defense verdict on the issue of liability is doubtful. Peterson, Supra. 472 F.2d 71. Other factors that may show a bad faith failure to settle are when the insurer: failed to adequately investigate the claim; failed to give appropriate or equal consideration to the insured's interests including the effect of a judgment against the insured; failed to follow the advice of counsel; failed to accept a settlement within the limits of the policy; failed to disclose and/or timely disclose settlement demands and offers and the potential excess liability of the insured; failed to seek reduction of a settlement demand in excess of the policy limits; and failed to give the insured an opportunity to contribute additional money necessary to meet the plaintiff's demand. Acoustics, Inc., Supra., 2004 WL 1559214; Grand Sheet Metal Products Co., Supra., 34 Conn. Supp. 51; Young, Supra., 416 F.2d 906.

3. Bad Faith Claims Handling

Claims-handling misconduct may include the manner in which an insurer investigates, handles, manages or denies a claim. If an insurer fails to investigate facts for the purpose of remaining ignorant of facts, for example, it can be found liable for bad faith. PSE Consulting, Inc., Supra., 267 Conn. 279. Further, an insurer may be liable for negligent infliction of emotional distress. Carrol v. Allstate Ins. Co., 262 Conn. 433 (2003) (jury's finding that insurer's investigation of a fire claim was hasty, incomplete and ill-reasoned supported claim for negligent infliction of emotional distress). In Carrol v. Allstate, the court found that an award of \$500,000 was not excessive notwithstanding that the insured's compensatory damages were only \$26,468 and he had limited treatment for emotional distress. A mere coverage dispute or an insurer's negligence in conducting an investigation alone, however, do not state a claim for bad faith. Martin v. American Equity Ins. Co., 185 F.Supp.2d 162, 165 (D.Conn. 2002).

In Bruce v. Progressive Halcyon Ins. Co., 2007 WL 447230 (Jan. 26, 2007 Conn. Super.), the court acknowledged that a bad faith claim requires more than an allegation that the insurer denied the plaintiff's claim for benefits. However, the court found that the plaintiff stated a sufficient bad faith claim by alleging that the insurer engaged in the following conduct: failed to promptly notify its insured that it was not paying his claim for fire damage to his motor vehicle; failed to conduct a proper investigation; initially agreed to pay the claim and then later reneged on the agreement; insisted that the insured provide numerous statements and depositions in an attempt to confuse him and obtain inconsistent statements that could be used to deny the claim; insisted that the insured provide numerous documents when it had already decided that it was not going to pay the claim; failed to interpret and apply the policy terms in good faith by trying to take technical advantage of the policy clauses; wrongfully withheld payment,

compelling the insured to engage counsel; and refused to enter into reasonable adjustment or settlement negotiations.

In addition, the court denied the insurer's motion for summary judgment on a bad faith claim arising out of an auto property damage claim, where the insurer was alleged to have pushed its insured to terminate the services of her auto body shop and move her vehicle to one of the insurer's preferred auto body shops, telling her that the preferred shop would fix the vehicle for less money and guarantee the work. Voisine v. Cormier, 2006 WL 3755330 (Nov. 30, 2006 Conn. Super.). The court found that there was a factual dispute as to whether this allegation was accurate; however, the court noted that "such allegation, if true, would amount to a practice commonly referred to as steering, which is a violation of Connecticut law and thus an indicator of bad faith."

4. Multiple Claims - Limited Policy Coverage

As a general rule, the terms of an insurance policy give an insurer the right to settle claims, and the duty to settle ends when the limit of liability is exhausted. Connecticut law recognizes that an insurer can settle multiple claims and exhaust the policy limits even though other claims may remain unsettled. Bartlett v. Travelers Ins. Co., 117 Conn. 147 (1933). See also, General Accident Group v. Gagliardi, 593 F.Supp. 1080 (D.Conn. 1984). However, an insurer is obligated to exercise its right to settle in a reasonable and prudent manner. General Accident Group v. Gagliardi, Supra. Where an insurer fails to exercise due care and good faith with respect to settlement within the policy limits it may then be subject to a direct action by the claimant (also known as the judgment creditor). Id. Note that it is only once the claimant obtains a judgment against the insured that a claimant can then seek to enforce a judgment against an insurance company pursuant to Connecticut's direct action statute found at C.G.S. §38a-321. Id.; Carford v. Empire Fire & Marine Ins. Co., 94 Conn.App. 41 (2006). Additionally, courts in jurisdictions outside of Connecticut also recognize an insurer's right to settle multiple claims even where it results in an exhaustion of the policy limits and leaves claims unpaid. See, e.g. Pino v. Bailey, 815 So. 2d 188 (La. App. Ct. 2002); Castoreno v. Western Indemnity Co., Inc., 213 Kan. 103 (1973); Miller v. Georgia Interlocal Risk Management Agency, 232 Ga. App. 231 (1998).

E. Can You Have Bad Faith Where There is No Insurance Coverage?

Some courts hold that there can be no bad faith against an insurer without a breach of the insurance policy by reason of the insurer's failure to defend or indemnify, i.e., substantive bad faith. Corriveau v. Aetna Cas. & Sur. Co., 1996 WL 156109 (March 15, 1996 Conn. Super.). See also, Rancourt v. Allstate Ins. Co., 2008 WL

5255560 (Dec. 1, 2008, Conn. Super.) (denying plaintiff's motion to strike insurer's special defense that where it is has already been determine there is no coverage, CUIPA/CUTPA and common law bad faith claim not valid). Other courts hold, however, that a bad faith claim may exist for an insurer's procedural bad faith or claims-handling misconduct without a breach of the insurance policy. United Technologies Corp., Supra., 118 F. Supp. 2d 181. In the United Technologies Corp. case even though there was no wrongful withholding of payments due under the policy, the insurer was found liable for bad faith because it "parked" a claim while misleading and deceiving the insured into believing that productive steps were being taken to resolve the claim, did not adequately investigate the claim and never communicated a coverage decision to the insured. Id. at 185. A Connecticut superior court recognized the holding of United Technologies Corp., stating that Connecticut recognizes an independent common law tort for bad faith regardless of an insurer's duty to defend. Fortin v. Hartford Underwriters Ins. Co., 2006 WL 3524562 (Nov. 20, 2006 Conn. Super.). In Fortin v. Hartford Underwriters Ins. Co., the court found that the insurer breach its duty to defend and entered judgment for the insured as to this issue leaving a claim for bad faith. The insurer sought to take an immediate appeal on the issue of its defense obligations arguing that the issue of bad faith was inextricably intertwined with its duty to defend because a claim for bad faith was only available were the insurer breached the insurance contract. The court rejected this argument and would not permit the appeal.

Out of state courts have even permitted bad faith claims for an insurer's claims handling misconduct where the insurer made payments under the policy. Rawlings v. Apodaca, 726 P.2d 565 (Ariz. 1986).

F. Bad Faith and Uninsured/Underinsured Motorist Claims

The Connecticut Supreme Court has held that where an insured prevails on his or her uninsured motorist claim and subsequently brings claims for common law bad faith, violation of the Connecticut Unfair Insurances Practices Act and violation of the Connecticut Unfair Trade Practices Act, the subsequent common law and statutory bad faith claims are barred by the doctrine of res judicata because the claims could have been asserted in the initial lawsuit. Powell v. Infinity Ins. Co., 282 Conn. 594 (May 29, 2007, Conn.Super.). The Court found that both lawsuits stemmed from the same transaction. The effect of this decision has been the inclusion of bad faith claims with uninsured/underinsured motorist claims on a more routine basis.

G. Damages for Bad Faith

1. Recovery for Common Law Bad Faith

A common law bad faith claim allows recovery of compensatory damages including the amount of a judgment in excess of the policy limits. United Services Auto. Assoc. v. Glenn Falls Ins. Co., 350 F. Supp. 869 (D. Conn. 1972). Compensatory damages may also include an award for emotional distress. Buckman, Supra., 205 Conn. at 173-74. Punitive damages may also be awarded if the insurer acted intentionally or with reckless indifference. L.F. Pace & Sons, Inc. v. Travelers Indem. Co., 9 Conn. App. 30, 48, cert. denied, 201 Conn 811 (1986). Connecticut limits common law punitive damages to expenses incurred during the litigation. Berry v. Loiseau, 223 Conn. 786 (1992).

2. Recovery Under CUIPA/CUTPA

Pursuant to CUTPA, a plaintiff may recover damages for an ascertainable loss of money or property, which includes an unpaid judgment. C.G.S. § 42-110g (a); Peck, Supra., 114 F. Supp. 2d at 58. A plaintiff can also recover costs and reasonable attorneys' fees. C.G.S. § 42-110g (d). A plaintiff may also recover punitive damages, C.G.S. § 42-110g (a), and these damages may be broader than common law punitive damages which are limited to the costs of litigation. For an award of punitive damages under CUTPA, the evidence must show a reckless indifference to the rights of others or an intentional and wanton violation of those rights. Chapman v. Norfolk and Dedham Mut. Fire Ins. Co., 39 Conn. App. 306 (1995).

H. Statute of Limitations for Bad Faith Claims

A claim based on breach of the implied covenant of good faith and fair dealing is governed by the six year statute of limitations for contracts found in Connecticut General Statutes § 52-576. Bellemare v. Wachovia Mortgage Corp., 94 Conn. App. 593 (2006), aff'd, 284 Conn. 193 (2007). Claims under CUTPA and CUIPA are subject to a three year statute of limitations. Connecticut General Statutes § 42-110g(f).

Note that there is one lower court has held that the policy's contractual one-year statute of limitations applied to the bad faith claim. State Building Co. v. Holyoke Mut. Ins. Co., 12 C.L.T. No.14, 39 (1985). However, this prior to the Connecticut Appellate Courts decision in Bellemare v. Wachovia Mortgage Corp., Supra. Connecticut courts have also held that in situations such as worker's compensation, the insurer may have a continuing duty to indemnify the insured and, therefore, the statute of limitations does

not run during that time. DeOliveira v. Liberty Mut. Ins. Co., 2002 WL 2005777 (July 25, 2002, Conn. Super.). See also, City of West Haven v. Commercial Union Ins. Co., Supra. (insurer's breach of the duty to defend was continuous, therefore limitations period for bad faith claims was tolled).

I. Discovery in Bad Faith Actions

Many Connecticut superior courts have held that an insurer's claims file must be disclosed to the plaintiff in a bad faith action. Marello v. Nationwide Mut. Fire Ins. Co., 2000 WL 38168 (Jan. 7, 2000 Conn. Super.); O'Leary Ltd. P'ship v. Travelers Prop. Cas. Co., 2001 WL 417698 (April 5, 2001 Conn. Super.). The reasoning behind this holding is that a bad faith action can only be proven by showing the underlying claims process. Farricielli v. Nationwide Mut. Fire Ins. Co., 1996 WL 488851 (Aug. 13, 1996 Conn. Super.).

In Connecticut, a plaintiff's need for privileged material in the claims file to prove his bad faith action does not mandate disclosure of the privileged material. Hutchinson v. Farm Family Cas. Ins. Co., 273 Conn. 33, 43 (2005). Attorney-client privileged communications must be disclosed in a bad faith action only in two circumstances. The first circumstance is where the insurer puts attorney-client communications at issue in the case such as by asserting a defense of reliance on the advice of counsel or by asserting a routine handling defense. Id. at 39, 44. The second circumstance is pursuant to the crime-fraud exception to the attorney-client privilege. Under this exception, a plaintiff alleging bad faith against his insurer is entitled to a court's in camera review of privileged materials when he establishes, on the basis of non-privileged materials, probable cause to believe that (1) the insurer acted in bad faith and (2) the insurer sought the advice of counsel to conceal or facilitate its bad faith conduct. Hutchinson, Supra., 273 Conn. 42-43.

A claim of privilege as to attorney client privileged communications with coverage counsel protects documents at least until such time as there is showing of bad faith. Royal Indem. Co. v. Terra Firma, Inc., 2007 WL 806034 (Feb. 16, 2007 Conn. Super.)

Where the insurer is sued for bad faith and breach of the insurance contract, many courts have allowed the insurer to bifurcate or stay discovery of the bad faith claim until resolution of the breach of contract claim due to prejudice to the insurer. Khanthavong v. Allstate Ins. Co., 1996 WL 704366 (Dec. 3, 1996 Conn. Super.); Serrano v. Allstate Ins. Co., 1998 WL 203340 (April 17, 1998 Conn. Super.). Other courts have denied motions to bifurcate or stay discovery of bad faith claims

reasoning that bifurcation would be inconvenient and less efficient and that the prejudice to the insurer is minimal. Hennessey v. Travelers Prop. Cas. Ins. Co., 1999 WL 240231 (April 14, 1999 Conn. Super.); Celentano v. Home Ins. Co., 1992 WL 335759 (Nov. 5, 1992 Conn. Super.).

J. Advice of Counsel as a Defense to Bad Faith Claim

A majority of courts throughout the United States find that advice of counsel is not a complete defense to a bad faith claim. As stated by the New York Court of Appeals, an allegation of reliance on advice of counsel does not for the purposes of a motion for summary judgment, negate the charge of bad faith as a matter of law. Decker v. Amalgamated Mut. Cas. Ins. Co., 324 N.E.2d 552 (N.Y. 1974). See also, Sheetz Inc. v. Bowles Rice McDavid Graff & Love, PLLC, 209 W.Va. 318 (2001) (advice of counsel is not an absolute defense). Instead, advice of counsel is a factor to be considered in determining whether the insurer acted in bad faith. Roesler v. TIG Ins. Co., 251 Fed. Appx. 489 (10th Cir. 2007) (reliance on advice of counsel must be reasonable); T.G.S. Transp., Inc. v. Canal Ins. Co., 216 Fed. Appx. 708 (9th Cir. 2007).

However, where advice of counsel cannot be said to be independent, it will not be considered in determining whether an insurer acted in bad faith. See Liquor Liab. Joint Underwriting Ass'n of Massachusetts v. Great American Ins. Co., 16 Mass. L. Rptr. 268 (Mass. Super. Ct. 2003) (counsel had been "closely intertwined" with LLJUA since it was created by the legislature and counsel was recommended by the Massachusetts Division of Insurance partly because counsel represented other legislatively created underwriting entities). Also, it has been held that an insurer cannot delegate its duty of good faith, even to counsel. Hamilton Mut. Ins. Co. of Cincinnati v. BATTERY, 220 S.W.3d 287, 294 (Ky. Ct. App. 2007) (insurer remains ultimately responsible for its statutory duty to properly investigate claims and to adjust claims in harmony with the terms and conditions of the insurance policy).

Although Connecticut's courts have not ruled on the effect of asserting advice of counsel as a defense to a bad faith claim, the Connecticut District Court has considered an insurer's retention of counsel in determining whether the insurer was liable for bad faith in failing to properly investigate and resolve claims. United Technologies Corp. v. American Home Assurance Co., Supra. Further, where an insurer relies on advice of counsel as a defense, any materials ordinarily subject to the attorney-client privilege will have to be disclosed. Hutchinson v. Farm Family Cas. Ins. Co., Supra. (See discussion above under Discovery.)

K. How to Avoid Bad Faith

Although there is no set formula for determining bad faith, a few steps can be taken to reduce the chances of a bad faith claim:

1. Take every bad faith claim seriously. If, during the course of handling a claim, an allegation is made that the insurer is acting in bad faith, this warning should not be ignored, no matter how frivolous the allegation appears to be. Further, every bad faith claim should be responded to in a professional and courteous manner.
2. Establish credibility by carefully preparing every entry in the claims file. A well documented claims file is evidence of a competent and professional individual who is acting in good faith in handling a claim. Remember that if a bad faith action is brought, the entire claims files will be subject to discovery.
3. Every conclusion or evaluation made should be well supported by evidence. Whether evaluating liability, or placing a value on a claimant's damages, evidence and a logical rationale should support each conclusion drawn. A thorough investigation is the key.
4. Be flexible in changing your evaluations as new developments arise. Do not ignore changes that should affect your analysis of liability and damages. For example, you view a case as one of questionable liability based on documents and the insured's recorded statement. Subsequently, the insured is deposed and you are advised that he is a very poor witness who is not likely to be believed by a jury. This should be accounted for in updating your analysis of liability in this case.
5. Remember that advice of counsel can also be evidence of good faith in handling a claim. Seeking such advice when appropriate will demonstrate thorough and professional handling of a claim. However, as noted above, be careful if counsel advises you that a case should be settled. If this advise is ignored, and the insured subsequently has a judgment rendered against him in excess of the policy limits, advice of counsel may be used as evidence for the plaintiff's case.

Above all, remember that the best way to protect against claims of insurer misconduct is to act with common sense.

SAMPLE "BOOK MARK" LETTER

Date

VIA CERTIFIED MAIL AND REGULAR MAIL

Ms. Suzy Insured
10 Maple Street
Any Town, USA 06000

Re: Insured: Suzy Insured
Claimant: Joe Plaintiff
Claim No.: xxxxxxxxx
Date of Loss: xx/xx/xx

Dear Ms. Insured:

This letter will acknowledge receipt of the lawsuit filed against you by Joe Plaintiff. ABC Insurance Company is investigating whether it has any obligations to you under your homeowners policy with respect to that lawsuit. This coverage investigation is being conducted under a full and complete reservation of rights. ABC Insurance Company does not waive any rights it has under the policy or under applicable law. Once ABC Insurance Company's investigation is complete, we will notify you of its coverage position.

If you have any questions, please contact the undersigned.

Sincerely,

Annie Adjuster
ABC Insurance Company
800-555-0000

SAMPLE RESERVATION OF RIGHTS LETTER

Date

VIA CERTIFIED AND REGULAR MAIL

Ms. Suzy Insured
10 Maple Street
Any Town, USA 06000

Re: Insured: Suzy Insured
Claimant: Joe Plaintiff
Claim No: xxxxxxxxxx
Date of Loss: xx/xx/xx

Dear Ms. Insured:

ABC Insurance Company previously acknowledged receipt of a complaint, dated xx/xx/xx, filed against you by Joe Plaintiff. This letter is to advise you that ABC Insurance Company will be providing you with a defense subject to a reservation of rights. This means that, while ABC Insurance Company will provide you with an attorney to defend you against Joe Plaintiff's claims, it may have no duty to pay any judgment or settlement in connection with these claims. ABC Insurance Company reserves the right not to indemnify you for these claims and also reserves the right to withdraw from providing you with a defense, if it is determined that there is no duty to defend the claims. In addition, ABC Insurance Company reserves the right to seek an allocation of defense costs between covered and non-covered counts or claims and to seek reimbursement of defense costs from you.

This reservation of rights is based on the terms and conditions of your homeowners policy, number xxxxxxxxxx, with a policy period of xx/xx/xx to xx/xx/xx and limits of xxxxxx. The policy contains the following relevant provisions:

SECTION II – LOSSES WE COVER

COVERAGE F – PERSONAL LIABILITY

We will pay all sums for **bodily injury** and **property damage** to others for which the law holds **you** responsible because of an **occurrence**. This includes prejudgment interest awarded against **you**.

We will defend **you**, at **our** expense with counsel of **our** choice, against any suit or claim seeking these damages. **We** may investigate, negotiate, or settle any suit or claim.

We are not obligated to pay any claim or judgment or defend any suit if **we** have already exhausted the limit of liability set forth in the Declarations by paying judgments or settlements.

SECTION II – LOSSES WE DO NOT COVER

UNDER COVERAGE F - PERSONAL LIABILITY AND COVERAGE G - MEDICAL PAYMENTS TO OTHERS, WE DO NOT COVER:

1. **bodily injury** or **property damage** which is reasonably expected or intended by **you** or which is the result of **your** intentional and criminal acts. This exclusion is applicable even if **you** lack the mental capacity, for whatever reason, to govern **your** conduct.
2. **bodily injury** or **property damage** arising out of or in connection with **your business** activities. This exclusion applies but is not limited to an act or omission, regardless of its nature or circumstance, involving a service or duty rendered, promised, owed, or implied to be provided because of the nature of the **business**.

SECTION II – CONDITIONS

3. **Your Duties In The Event of An Accidental Loss.** In the event of an accident or **occurrence**, **you** must do the following things:
 - A. Promptly notify **us** or **our** representatives, in writing, stating:
 1. **your** name and policy number.
 2. the date, place and circumstances of the accident.
 3. the name and address of anyone who might have a claim against **you**.
 4. the names and addresses of any witnesses.

- B. Immediately send **us** any legal papers relating to the accident.

- C. At **our** request, **you** must:
 - 1. cooperate with **us** and assist **us** in any matter concerning a claim or suit.

 - 4. help **us** in collecting and giving evidence and obtaining the attendance of witnesses.

GENERAL DEFINITIONS

'BODILY INJURY' means any bodily harm, sickness or disease. This term includes required care, loss of services and death if it is a result of such bodily harm, sickness or disease.

'BUSINESS' or **'BUSINESS PURPOSES'** means:

- 1. Any full or part time activity of any kind engaged in for economic gain, and the use of any part of any premises for such purposes.

'OCCURRENCE' means an accident, including continuous or repeated exposure to substantially the same general harmful conditions, resulting in **bodily injury** or **property damage** during the term of the policy.

'PROPERTY DAMAGE' means physical damage to or destruction of tangible property, including loss of use of this property.

'WE,' 'US' and **'OUR'** mean the Company named in the Declarations.

'YOU' and **'YOUR'** mean:

The person or persons named in the Declarations and if a resident of the same household.

Joe Plaintiff brought a lawsuit against you dated xx/xx/xx in the judicial district of xxxxxxxx. The complaint contains three counts alleging intentional infliction of emotional distress, assault and battery, respectively. All claims stem from your alleged harassment and assault of Joe Plaintiff at work.

The first count sounding in intentional infliction of emotional distress alleges the following: (Set forth allegations of the first count).

The second count sounding in assault reincorporates all paragraphs of the first count. It additionally alleges the following: (Set forth allegations of the second count).

The third count sounding in battery reincorporates all paragraphs of the first and second counts. It additionally alleges the following: (Set forth allegations of the third count).

Joe Plaintiff claims: money damages for lost wages, medical expenses and mental and emotional harm; a permanent injunction prohibiting you from engaging in the behavior which intimidated and traumatized him; counsel fees and costs; prejudgment interest; punitive damages; and such other relief as the court deems just and equitable.

Your homeowners policy provides coverage for sums for bodily injury or property damage to others because of an occurrence. The policy defines an occurrence as an accident. ABC Insurance Company may have no duty to defend or indemnify you under the policy because the conduct alleged in the complaint may not constitute an occurrence or accident. All counts allege intentional conduct and repeated harassment designed to injure over the course of several months. Second, for this same reason, the intentional and criminal act exclusion may preclude coverage for all counts. Third, the business pursuits exclusion may preclude coverage for all counts as it is alleged that your conduct occurred at work. Fourth, injunctive relief and punitive damages sought are not covered by the policy.

Lastly, the policy provides that ABC Insurance Company must be promptly notified of an accident or occurrence and must immediately be sent any legal papers relating to the incident. The incidents giving rise to Joe Plaintiff's complaint occurred as far back as xx/xx/xx. The complaint is dated xx/xx/xx with a return date of xx/xx/xx. However, ABC Insurance Company did not receive notice of the incident or the lawsuit until xx/xx/xx. Therefore, ABC Insurance Company may not be obligated to provide a defense and indemnity for your failure to comply with the notice provision of the policy.

This reservation of rights means that, while ABC Insurance Company is paying for an attorney to provide you with a defense at this time, ABC Insurance Company may not be obligated to pay any judgment or settlement in connection with the Joe Plaintiff lawsuit and may withdraw from providing you with a defense, if it is determined that there is no duty to defend these claims.

NUZZO & ROBERTS, L.L.C.

ABC Insurance Company reserves the right to litigate its coverage defenses and to seek an allocation of defense costs between covered and non-covered counts and claims as well as reimbursement of defense costs from you. ABC Insurance Company also reserves the right to further supplement this reservation of rights and to amend its coverage position in the event it receives additional information. ABC Insurance Company does not waive any rights that it has under the policy or under applicable law.

ABC Insurance Company has hired the Law Offices of _____ in _____, Connecticut to defend you. Please contact that office regarding the defense of the lawsuit.

If you have any questions regarding this letter, please contact me.

Sincerely,

Annie Adjuster
ABC Insurance Company
800-555-0000

cc: Defense Counsel
Personal Counsel

SAMPLE DENIAL LETTER

Date

VIA CERTIFIED AND REGULAR MAIL

Ms. Suzy Insured
10 Maple Street
Any Town, USA 06000

Re: Insured: Suzy Insured
Claimant: Joe Plaintiff
Claim No: xxxxxxxxxx
Date of Loss: xx/xx/xx

Dear Ms. Insured:

ABC Insurance Company acknowledges receipt of your letter dated xx/xx/xx in which you make a claim for uninsured/underinsured motorist benefits in connection with a motor vehicle accident in Mexico on xx/xx/xx. This letter is to advise you that there is no coverage for an uninsured or underinsured motorist claim under the auto policy ABC Insurance Company issued.

Policy number xxxxxxxxxx is an auto policy issued to you with a policy period from xx/xx/xx to xx/xx/xx. This policy provides uninsured/underinsured motorist coverage with limits of \$250,000 per person and \$500,000 per accident. The policy contains the following relevant provisions.

GENERAL

This policy is a legal contract between **you** and **us**. The coverage applies only when a premium for it is shown on the Policy Declarations. If more than one **auto** is insured, premiums will be shown for each **auto**. If **you** pay the premiums when due and comply with the policy terms, the Company, relying on the declarations, makes the following agreements with you.

When And Where The Policy Applies

Your policy applies only during the policy period. During this time, it applies to losses to the **auto**, accidents and occurrences within the United States of America, its territories or possessions, Puerto Rico, or Canada, or between their ports. The policy period is shown on the Policy Declarations.

PART V Uninsured Motorist Insurance Underinsured Motorist Insurance Coverage A

If a premium is shown on the Policy Declarations for Coverage A, Uninsured Motorist Insurance and Underinsured Motorist Insurance, **we** will pay those damages which an insured person is legally entitled to recover from the owner or operator of an uninsured auto or underinsured auto because of **bodily injury** sustained by an insured person. **Bodily injury** must be caused by accident and arise out of the ownership, maintenance, or use of an uninsured auto or underinsured auto. We won't pay any punitive or exemplary damages.

Based on your letter, you were injured in a bus accident in Mexico. The ABC Insurance Company auto policy does not provide any coverage for claims arising out of the bus accident because the accident did not happen within the territorial limits covered by the policy. The ABC Insurance Company policy expressly limits coverage to "losses to the auto, accidents and occurrences within the United States of America, its territories or possessions, Puerto Rico, or Canada, or between their ports." This limitation is contained in the General section of the policy, and therefore limits coverage under all sections of the policy to the specified territorial limits. This is consistent with Connecticut Regulations §38a-334-8, ("Minimum Provisions For Automobile Liability Insurance Policies Covering Motor Vehicles") which states, "Policies shall provide coverage during the period the policy is in effect and within the territorial limits of the United States and Canada, or, as regards private passenger automobiles only, between ports thereof." Since the bus accident happened in Mexico, which is not within the United States, its territories or possessions, Puerto Rico, or Canada, there is no uninsured/underinsured motorist coverage available under your ABC Insurance Company policy.

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Based on the above, ABC Insurance Company hereby denies any obligation to pay uninsured or underinsured motorist benefits in connection with the bus accident. Other policy defenses and provisions may apply, in addition to those discussed herein. ABC Insurance Company reserves the right to assert additional policy defenses if new information is obtained. ABC Insurance Company does not waive any rights that it has under the policy or under applicable law.

If you have any additional information that you believe would be relevant to our coverage evaluation, please advise us in writing. In addition, if you should have any questions regarding the above, please feel free to contact the undersigned.

If you do not agree with this decision, you may contact the Division of Consumer Affairs within the Insurance Department at P.O. Box 816, Hartford CT, 06142-0816; telephone number 860-297-3900; toll free number 1-800-203-3447; website www.ct.gov/cid.

Sincerely,

Annie Adjuster
ABC Insurance Company
800-555-0000

cc: Personal Counsel

About Our Coverage/Bad Faith Attorneys

ANTHONY NUZZO, JR.

Contact: anuzzo@nuzzo-roberts.com, (203) 250-2000, ext. 228

Born New Haven, Connecticut; admitted to Bar, 1968, Connecticut and District of Columbia; 1969, U.S. District Court, District of Columbia and U.S. Court of Appeals, District of Columbia; 1971, U.S. District Court, District of Connecticut. Appointed Public Defender for District of Columbia, 1968-1970. Education: University of Connecticut (B.A., 1965; J.D., 1968). Member: Cheshire Board of Education, 1981-1985; American Arbitration Association Advisory Board; New Haven County, Connecticut and American Bar Associations; Association of Trial Lawyers of America; Connecticut Trial Lawyers Association. Positions held: President, Connecticut Defense Lawyers Association, 1994; President, New Haven County Bar Association, 1998-1999. NHCBA Seminar: "Avoid Legal Malpractice Claims by Doing the Obvious."

JANE S. BIETZ

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Born New Haven, Connecticut; admitted to Bar, 1994, Connecticut; 1995, U.S. District Court, District of Connecticut. Education: Bowdoin College (B.A., 1991); University of Connecticut School of Law (J.D., with honors, 1994); Notes and Comments Editor, *Connecticut Law Review*, Connecticut Moot Court Board.

MICHELE C. CAMEROTA

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Born New Britain, Connecticut; admitted to Bar, 1998, Connecticut; 1999, U.S. District Court, District of Connecticut. Education: Central Connecticut State University (B.A., 1993); University of Connecticut School of Law (J.D., 1998). Phi Sigma Alpha. Member: Connecticut Bar Association, Connecticut Defense Lawyers Association. Secretary, Newington Town Plan and Zoning Commission, 2009 - Present.

AMBER J. HINES

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Born Middletown, Connecticut; admitted to Bar, 1999, Connecticut; 2004, U.S. District Court, District of Connecticut. Education: College of New Rochelle (B.A., *summa cum laude*, 1994); Quinnipiac University School of Law (J.D., *cum laude*, 1999); Editor, *Quinnipiac Probate Law Journal*, 1997. Member: Connecticut Bar Association.

MICHAEL F. LETTIERO

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Born New Haven, Connecticut; admitted to Bar 2009, Connecticut; 2010, New York. Education: Villanova University (B.A., *cum laude*, 2005); University of Connecticut School of Law (J.D., with honors, 2009); Book review editor of the Connecticut Journal of International Law and member of Moot Court Board. Member: Connecticut Bar Association and New Haven County Bar Association.

QUESTIONS?

Appellate Work:

- Rick Roberts, rroberts@nuzzo-roberts.com, (203) 250-2000, ext. 229

Bad Faith:

- Tony Nuzzo, anuzzo@nuzzo-roberts.com, (203) 250-2000, ext. 228
- Michele Camerota, mcamerota@nuzzo-roberts.com, (203) 250-2000, ext. 259
- Amber Hines, ahines@nuzzo-roberts.com, (203) 250-2000, ext. 226
- Jane Bietz, jbietz@nuzzo-roberts.com, (203) 314-3319

Complex Litigation:

- Tony Nuzzo, anuzzo@nuzzo-roberts.com, (203) 250-2000, ext. 228
- Rick Roberts, rroberts@nuzzo-roberts.com, (203) 250-2000, ext. 229

Construction Litigation:

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- Kevin Hines, khines@nuzzo-roberts.com, (203) 250-2000, ext. 255

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- Jane Bietz, jbietz@nuzzo-roberts.com, (203) 314-3319

Employment:

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- Nicole Chomiak, nchomiak@nuzzo-roberts.com, (203) 250-2000, ext. 274

Fraud and Strategic Investigations:

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Premises Liability:

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- Rob Chomiak, rchomiak@nuzzo-roberts.com, (203) 250-2000, ext. 285

Products Liability:

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Professional Liability:

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Third-Party Claims and Indemnity:

- Rick Roberts, rroberts@nuzzo-roberts.com, (203) 250-2000, ext. 229

Trials:

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- Rick Roberts, rroberts@nuzzo-roberts.com, (203) 250-2000, ext. 229
- Nicole Chomiak, nchomiak@nuzzo-roberts.com, (203) 250-2000, ext. 274
- Rob Chomiak, rchomiak@nuzzo-roberts.com, (203) 250-2000, ext. 285

Uninsured Motorist:

- Tony Nuzzo, anuzzo@nuzzo-roberts.com, (203) 250-2000, ext. 228

Workers' Compensation:

- David Weil, dweil@nuzzo-roberts.com, (203) 250-2000, ext. 242
- Jane Carlozzi, jcarlozzi@nuzzo-roberts.com, (203) 250-2000, ext. 284

Or please contact us at coverage@nuzzo-roberts.com or (203) 250-2000 with any questions.

NUZZO & ROBERTS, L.L.C.

L A W O F F I C E S

Firm Profile

Nuzzo & Roberts, L.L.C., an insurance defense law firm, handles trials and appeals in all federal and state courts in Connecticut. For almost thirty years, we have remained committed to working closely with our clients to provide cost-effective, proactive and practical service. The firm is dedicated to continuing this high level of service as we face a changing insurance world.

At Nuzzo & Roberts we pride ourselves on providing high quality yet efficient service to our clients. Our attorneys in every practice area focus on the core issues of each case and work closely with our clients to resolve matters effectively. We value excellent communication, early diagnosis, active versus reactive decision making and a driving desire to bring matters to a successful conclusion.

We understand that the insurance world is changing, and not only comply with the letter of our client's guidelines, but the spirit of those guidelines by developing strategies with our clients to resolve cases successfully and expediently.

Our Attorneys and Staff

The firm's attorneys are highly trained, effective advocates for our clients. We encourage our attorneys to become active members in local, state and national bar associations and other professional organizations. Nuzzo & Roberts attorneys serve as mediators and arbitrators, are frequent writers and speakers on all issues of tort litigation and hold a statewide reputation as excellent trial attorneys.

Nuzzo & Roberts also employs over thirty staff members, including thirteen highly skilled paralegals. The use of seasoned paralegals enables the firm to provide particularly cost-effective service to our clients. In addition, a competent and attentive staff ensures that our clients receive prompt, accurate and personalized attention.

Our Practice Areas

Bad Faith/ Coverage

Nuzzo & Roberts' clients benefit from our extensive knowledge of coverage issues and our reputations as tough negotiators and litigators. The Bad Faith/Coverage Group provides direct representation to insurers in matters of coverage, coverage litigation and

bad faith. The firm's coverage attorneys have vast experience analyzing all types of claims and lawsuits and providing clear and concise coverage analysis of all issues that apply to each claim to assist insurers in properly reserving rights, preserving coverage issues and, when appropriate, denying claims based on coverage. The group also represents insurers in declaratory judgment actions in both state and federal court involving issues of insurance coverage. Additionally, Nuzzo & Roberts represents insurers in complaints before the insurance commission and in bad faith claims, providing advice, support, experience and our highly effective litigation skills.

Construction Litigation

The Construction Litigation Group represents general contractors, subcontractors, project managers, developers, design professionals, architects, engineers and property owners in various disputes arising out of negligence, design and construction defects, product defects, breach of contract, breach of warranty, unfair trade practices, insurance coverage issues and indemnity claims. The group represents clients in all Connecticut state and federal courts, tribal court and arbitrations. Our clients range from large construction firms to small businesses. We pride ourselves in providing clients in the construction industry with knowledgeable representation in complex and technical matters.

Employment Litigation

The Employment Litigation Group primarily represents management, either the business entity itself or managers and supervisors who have been sued individually, in employment-related matters. The group has handled all types of employment litigation, including representation before the Equal Employment Opportunity Commission and the State of Connecticut Commission on Human Rights and Opportunities, as well as representation in federal and state courts. We handle a variety of employment litigation, including employment discrimination (including sexual and racial harassment complaints, disability discrimination, equal pay claims and sexual orientation claims), wrongful discharge, breach of employment contracts, employment-related torts (including defamation and misrepresentation), and violations of federal and related state laws (including the Family Medical Leave Act, the Fair Labor Standards Act and Occupational Safety statutes).

Motor Vehicle Tort

The Motor Vehicle Tort Group is made up of highly skilled and able attorneys that can handle any matter, whether simple or complex. We handle all types of motor vehicle cases, from simple soft-tissue claims to catastrophic losses, including wrongful death claims. The trial attorneys in our group have tried over 80 cases since the late 1990s alone, and have handled numerous arbitrations and mediations.

We have a particular expertise in uninsured and underinsured motorist law, and have argued over ten appeals in that area of law alone. We are often called upon to try cases on the eve of trial and are able to respond to the challenge. When necessary, we work with accident reconstructionists, high quality investigators and members of the medical community who routinely testify in Connecticut.

Premises Liability

The Premises Liability Group has vast experience in premises liability and homeowner's liability matters. Cases can range from slip and falls and dog bites to inadequate security and nuisance claims. We have litigated virtually every kind of defect from snow and ice to raised sidewalks, handicap ramps, fire escapes, curbs and stairways. We are familiar with applicable building codes and work with experts in the fields of forensic engineering, human factors, accident reconstruction and security. We also focus on shifting liability to third-parties through apportionment and indemnity claims, and aggressively seek the defense and indemnity from other insurers particularly in landlord tenant matters.

Product Liability

Nuzzo & Roberts' Product Liability Group has successfully represented product manufacturers, designers, distributors and retailers of a wide variety of consumer, industrial, automotive, recreational and health related products. We pride ourselves on gathering the facts immediately and familiarizing ourselves with the steps that go into the manufacture, assembly and installation of each product. When appropriate, we aggressively seek voluntary withdrawals when our client's products were either not involved or played no role. We also work to shift liability to third parties and seek defense and indemnity through vendor's endorsements. The group has worked with a variety of experts in different product fields in order to effectively defend our client's interests.

Professional Liability

Nuzzo & Roberts is one of the leading Connecticut firms in the area of Professional Liability. We are sensitive to both protecting our client's reputations and finances, as well as the negative personal impact related to being charged with malpractice. We pride ourselves in seeking early creative solutions and avoid protracted litigation, though our attorneys are experienced in trials as well as Alternative Dispute Resolution. We also utilize risk management to both avoid potential claims, as well as minimize future claims.

NUZZO & ROBERTS, L.L.C.

The Professional Liability Group represents professionals in a number of different industries, including:

- Legal
- Healthcare (hospitals, doctors, nursing homes, nurses and nursing agencies, home health aides and agencies, psychiatrists, psychologists, therapists, naturopathic doctors and chiropractors)
- Directors and Officers
- Insurance (agents, brokers, third-party administrators, claims professionals, adjusters and investigators)
- Real Estate
- Accounting

Toxic Tort

The Toxic Tort Group has represented manufacturers, premises owners and contractors in a variety of toxic tort and environmental litigation. We have handled cases ranging from mold litigation, gas leaks, oils spills and exposure to hazardous substances, such as asbestos and other chemicals and substances.

Workers' Compensation

The Workers' Compensation Group works with workers' compensation insurers, third-party administrators and self-insured employers in the representation of employers in workers' compensation claims at informal hearings, pre-formal hearings and formal hearings. The group also handles intervening complaints in third-party litigation, as well as appeals to the Compensation Review Board and the Connecticut Appellate Court. The group also counsels employers on risk management issues, including taking actions to reduce risk of worker injury.

The firm's attorneys try cases in all civil courts in the State of Connecticut. In addition to jury trials, our attorneys are involved in mediation, arbitration, courtside trials and administrative proceedings. Nuzzo & Roberts' attorneys have also argued numerous cases in the Appellate and Supreme Courts of Connecticut, including precedent setting cases in the field of uninsured motorist law.

Newsletters

Nuzzo & Roberts publishes monthly and quarterly newsletters with analysis of recent superior and appellate court case law relevant to the interests of our clients. The newsletters include case details as well as editorial comment, and keep our clients abreast of important changes and developments in Connecticut law.

Our Commitment

Nuzzo & Roberts is committed to fulfilling our mission of working in concert with our clients to make a difference in the outcome of the case by delivering timely, highly skilled legal services while minimizing cost and exposure. We take pride in our firm's attorneys, paralegals and staff and work to continually provide the best service possible to our clients.

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