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Peters & Nye LLP is pleased to present our inaugural edition of the *Peters & Nye Quarterly Digest*. In our ongoing efforts to share developments affecting our industry with our clients and friends, our Firm will circulate a synopsis of interesting and relevant legal decisions each quarter. We hope you will find this publication helpful in your day-to-day responsibilities. We welcome your suggestions on particular areas of interest you would like to see addressed in future editions.

Several Recent Judicial Decisions Find in Favor of the Exhaustion Provision

- *Fed. Ins. Co. v. Estate of Irving Gould, et al.*, No. 1:10-CV-1160 (S.D.N.Y. Sept. 28, 2011)

In a case involving the now defunct Commodore International Limited ("Commodore"), excess carriers sought a declaratory judgment on the pleadings arguing that their policies do not require them to "drop down" to fill a gap in coverage due to the insolvency of two of the underlying insurers. The defendants argued that the excess carriers' obligations were triggered once the covered losses exceeded the limits of the underlying insurance policies, regardless of whether the underlying insurers actually paid their limits. The claim at issue in this case was brought by the directors and officers of Commodore. As a result of Commodore's bankruptcy in 1994, its directors and officers were defending various global lawsuits that threatened the Insureds' entire $51 million coverage tower. Significantly, however, the second excess layer carrier, Reliance, had been ordered into liquidation in 2001. Subsequently, in 2003, the sixth excess layer carrier, Home Insurance Company, was also forced into liquidation.

In rendering its decision, the Court first noted that New York courts have unequivocally rejected an "automatic drop-down rule" and that relevant case law "clearly provide[s] that an excess insurer is not required to fill gaps in coverage created by the insolvency of an underlying insurer." Nonetheless, the Insureds attempted to argue that if the "sophisticated" excess carriers really intended to "disclaim responsibility for gaps in coverage resulting from the insolvency of an underlying insurer" they would have included "anti drop-down" language

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in their policies and that discovery was required in order to ascertain the parties' intent. The Court rejected the Insureds' argument that "there is an industry custom that an insurance contract's silence on drop down coverage represents the insurer's assent to provide such coverage." Rather, the Court found that the excess carriers had no obligation to drop down based on the insolvency of the underlying insurers.

Similarly, the Court rejected the defendants' argument that once the losses exceed the underlying coverage, such policies are deemed to be exhausted and that it is immaterial whether the underlying claims have been paid. The Court found that the language of the excess policies established "a clear condition precedent to the attachment of the Excess Policies." Thus, the excess coverage "will not be triggered solely by the aggregation of Defendants' covered losses."

Importantly, the Court distinguished this case from *Zeig v. Massachusetts Bonding & Ins. Co*., 23 F.2d 665, 666 (2d Cir. 1928), noting in that case, the "Insured agreed to accept partial reimbursement for his losses while maintaining responsibility for the uncompensated portion of his claim." The Court noted that "unlike the facts of *Zeig*, the excess carriers in the instant matter have a clear, bargained-for interest in ensuring that the underlying polices are exhausted by actual payment."

- *Citigroup Inc. v. Fed. Ins. Co.*, 649 F.3d 367 (5th Cir. Tex. 2011)

In another recent decision, an appellate court held an exhaustion provision contained within a D&O policy valid. In this case, Associates First Capital Corporation ("Associates") purchased integrated risk policies from Certain Underwriters of Lloyd's of London ("Lloyd's"), the primary insurer, and nine excess insurers. Pursuant to the integrated risk policies, Citigroup, Inc. ("Citigroup"), as successor-in-interest to Associates, timely notified the insurers of two actions filed within the policy period and asserted claims for coverage in connection with these matters. Initially, all of the insurers denied coverage, but later, Lloyd's settled with Citigroup for $15 million of its $50 million limit. The excess insurers continued to deny coverage and Citigroup filed suit. The district court granted summary judgment in favor of the excess insurers and Citigroup appealed.

On appeal to the Fifth Circuit, Citigroup attempted to argue that the excess insurers' policies were ambiguous because they have more than one reasonable interpretation and, therefore, under the *Zeig* rule, the Court should construe the policies strictly in favor of the insured. According to Citigroup, pursuant to the rule established in *Zeig*, its settlement with Lloyd's exhausted the primary insurance and the excess insurers were obligated to provide it with coverage.

However, Texas case law had not adopted the *Zeig* rule. Therefore, the Appellate Court held in favor of the excess insurers relieving them of any obligations under their policies, finding that the plain language of the policies dictated that the primary insurer pay the full amount of its limits of liability before excess coverage is triggered.

- *Goodyear Tire & Rubber Co. v. Nat'l Union Ins. Co.*, 2011 U.S. Dist. LEXIS 121866 (N.D. Ohio Sept. 19, 2011)

Additionally, an Ohio federal court addressed issues regarding exhaustion in connection with a claim involving securities actions brought against Goodyear Tire & Rubber Company ("Goodyear"). Goodyear had advised its excess carrier that it had reached an agreement with a lower carrier, wherein the excess carrier would pay only $10 million despite a $15 million limit of liability (and $5 million self-insured retention) in connection with $30 million of losses that had been incurred by Goodyear for legal and accounting costs in defending the underlying claim. However, relying on the wording of its policy, the excess carrier denied Goodyear's demand on the grounds that its policy had not been triggered due to the fact that the underlying carrier had not paid out its full limit.

Relying on an Ohio Supreme Court ruling, Goodyear asserted that the exhaustion provision was not enforceable "because the interest in enforcing it is outweighed by the strong Ohio public policy favoring settlements . . . [and encouraging the] freedom of contracts." While recognizing the compelling public policy espoused within Ohio case law, the *Goodyear* Court refused to find the exhaustion provision contained in the excess policy unenforceable, given that the Ohio precedent relied upon by the insured almost exclusively arose in the context of uninsured/underinsured motorist litigation and that D&O policy language is distinguishable.

The Court also disagreed with Goodyear's next argument "that settlement for an amount less than the full limits of the underlying limits is a failure of a condition precedent, which can result in the forfeiture of coverage only where the excess insurer is prejudiced." The Court reasoned that even if the underlying contract did contain a prejudice requirement, the excess carrier has actually been prejudiced by being required to litigate this case since 2008. Additionally, the Court recognized that the excess carrier rightfully had an expectation that its policy would be triggered at $15 million plus the $5 million self-insured retention. This was in fact what the carrier's premium had been based on and not some lesser amount. Thus, the Court found in favor of the excess carrier.

Coverage Denied for SEC Investigations

- *Office Depot, Inc. v. Nat'l Union Fire Ins. Co.*, 2011 U.S. App. LEXIS 20759 (11th Cir. Fla. Oct. 13, 2011)

Office Depot incurred more than $20 million in responding to an SEC inquiry and sought coverage for these costs under its D&O Policy. The carriers denied Office Depot's request for reimbursement and brought a declaratory action in the United States District Court for the Southern District of Florida. The issue in the *Office Depot* case was whether an informal SEC investigation and a subsequent formal SEC investigation constituted a covered claim within the Policy's definition of Securities Claim. The district court found in favor of the insurers, holding that both the formal and informal SEC investigations were not *proceedings*.

On appeal to the Eleventh Circuit, Office Depot presented four arguments in favor of coverage. First, Office Depot asserted that its defense costs were covered under the "Organization Insurance" section of the policy. This section provided coverage for Losses "arising from" Securities Claims and did not expressly exclude defense costs relating to SEC investigations. However, the Appellate Court's review of relevant policy wording did not support Office Depot's position. The "Organization Insurance" section defined a Securities Claim as, "a Claim, other than an administrative or regulatory proceeding against, or investigation of an Organization, made against any Insured . . . ." However, the section contained a "carve-back" for administrative or regulatory proceedings, but not for administrative or regulatory investigations. Thus, holding that the SEC's request for voluntary cooperation during pre-suit discovery amounted to an investigation, the Eleventh Circuit rejected Office Depot's argument in favor of coverage.

Next, Office Depot asserted that the indemnification of Insured Persons included SEC investigations. However, the Court disagreed, finding that the SEC's request requiring individuals to preserve certain documents and provide testimony did not constitute a claim under the policy, given that no violations had yet been made against any specific individuals.

Additionally, Office Depot contended that the policy contained no "temporal limitation" within the definition of Defense Costs to preclude coverage for costs incurred in the anticipation of a claim or actual claim. The relevant definition defined Defense Costs as "reasonable and necessary fees, costs, and expenses consented to by the Insurer . . . resulting solely from the investigation, adjustment, defense and/or appeal of a Claim against an Insured . . . ." Based on this wording the Court held that the policy unambiguously limited Defense Costs to such costs incurred *after* a Claim had been made.

Lastly, Office Depot argued that pursuant to the policy's Notice/Claim Reporting Provision the Claim "relates back" to when the insured provided the notice of circumstances and costs incurred. As such, any costs incurred during that time period should also be covered. Examining the policy as a whole, the Court rejected Office Depot's argument and found that the Notice/Claim Reporting Provision in no way expanded the definition of Claim under the policy, but rather is simply a notification process for Claims made both inside and outside the respective policy period. Thus, in an unpublished opinion, the Court affirmed the trial court's ruling.

U.S. District Court Imputes Fraud to Other Insureds

- *Scottsdale Ins. Co. v. RiverBank*, 2011 U.S. Dist. LEXIS 100834 (D. Minn. Sept. 7, 2011)

A United States District Court of Minnesota, applying Minnesota law, denied a bank's attempt to collect on an underlying judgment for negligence against an insured under a Business and Management Liability Indemnity Policy. According to the relevant wording of the policy, "Insurer shall not be liable for Loss . . . alleging, based upon, arising out of, attributable to, directly or indirectly resulting from, in consequence of, or in any way involving . . . criminal fraudulent or dishonest acts."

The insured's CEO had previously pled guilty to theft in connection with a $600,000 mortgage transaction involving the CEO and her husband. However, the bank argued that a state court had found the company and the CEO's husband negligent and liable to the bank, which was separate and distinct from the liability of the CEO, who had been sentenced for her criminal conduct related to the loan transaction at issue. Additionally, the bank asserted that because the company and the CEO's husband had not been adjudged guilty of any criminal conduct, the policy exclusions regarding intentional criminal acts did not preclude coverage with respect to these insureds pursuant to the "Innocent Insureds" provision, which prohibited imputing fraudulent acts against insureds who were not personally involved in the bad conduct.

Nonetheless, the Court recognized the policy wording also provided that the knowledge of the CEO shall be imputed to the company. Moreover, the Court relied on case law holding that "where substantive conduct is criminal or intentional, if it is undeniably causally connected to the alleged negligence, the criminal/intentional act exclusion applies to defeat coverage." The Court also noted that the word "negligence" was absent from the policy's grant of coverage. As such, the Court determined that the intent of the policy was to provide coverage for "honest mistakes." Therefore, it was held that the state judgment for negligence did not fall within the coverage provided by the policy.

New York Courts Continue to Uphold Consent to Settlement Provisions

- *Fed. Ins. Co. v. SafeNet, Inc.*, 2011 U.S. Dist. LEXIS 101845 (S.D.N.Y. Sept. 9, 2011)

The Court for the Southern District of New York, applying Maryland law, affirmatively applied the fraud exclusion—as well as the consent to settlement provision—contained within a D&O policy in connection with a stock option backdating case. Safenet's trouble began in 2006, when it disclosed that two reporting quarters for 2005 contained material errors resulting in an aggregate understatement of approximately $1.3 million. As a result of these disclosures, multiple lawsuits were filed against the insured, including securities actions. The company also received a subpoena from the United States Attorney for the Southern District of New York, as well as an inquiry from the SEC, regarding the granting of certain stock options. Certain criminal and civil enforcement actions were also commenced against the company and certain D&O's. In 2007, one of Safenet's CFO's, Carole Argo, pled guilty to a single count of securities fraud relating to the backdating claim. In 2009, another Safenet CFO, and three former Safenet accountants, agreed to settle the class action for $25 million, without admitting any wrongdoing. However, the insurer was not provided with prior notice of the settlement. Additionally, Safenet had incurred $20 million in defense costs in connection with this matter.

Subsequently, the insurer filed a declaratory action seeking a ruling, *inter alia*, that Ms. Argo was not entitled to coverage in light of her guilty plea to securities fraud, and that no coverage existed based on Safenet's failure to obtain the insurer's consent to settlement. In addressing the insurer's claims, the court held that Ms. Argo was not entitled to coverage based on the fraudulent acts exclusion, in light of her guilty plea to securities fraud. However, the Court declined to impute Ms. Argo's deliberate fraud to Safenet based on a finding that the policy wording only allowed "facts" and "knowledge" to be imputed to the company, and not a "judgment."

Nonetheless, while Safenet may have won the battle, it lost the war. There was no dispute between the parties that Safenet did not seek prior consent from its insurer before settling the class action claim. The court, citing New York case law, which holds that "consent to settlement provisions are a condition precedent to coverage and are routinely enforced," stated the only relevant issue was whether the insurer had denied or repudiated coverage. The court noted that the insurer had not issued a blanket declination of coverage and had in fact, on numerous occasions, advised the insured that it was "investigating its obligations under the policies." Thus, the court determined that Safenet was not excused from complying with the consent-to-settle provision in the policy, and therefore, was not permitted to recover the settlement amount. In addition, the court granted a partial rescission of the policy based on the fact that Argo's guilty plea, as Safenet's CFO, was imputed to Safenet.

Fiduciary Liability: The *Moench* Presumption

- *In Re: Citigroup ERISA Litigation*, No. 09-3804 (2d Cir. Oct. 19, 2011)[1]

In *Citigroup*, the Second Circuit adopted the *Moench* Presumption thereby affirming the dismissal of the Citigroup ERISA stock drop litigation. First articulated by the Third Circuit, the *Moench* Presumption provides that Employee Stock Owner Plan ("ESOP") Plans that give fiduciaries the option to offer company stock as an investment choice, are given a "presumption of prudence" entitling the fiduciary "to a presumption that it acted consistently with ERISA" by including company stock as an investment option. However, that presumption can be overcome if plaintiffs can demonstrate: 1) that there was a precipitous decline in the price of the company stock; and 2) the Plan fiduciary had knowledge of its impending collapse. *See, Moench v. Robertson*, 62 F.3d 553 (3d. Cir. 1995).

In adopting the *Moench* Presumption, the Second Circuit held that the Presumption is applicable to both ESOPs and Employee Individual Account Plans. The Court also clarified that the *Moench* presumption is not an evidentiary presumption but may be applied at the pleading stage. The Fifth, Sixth and Ninth Circuits have also adopted the *Moench* Presumption.

In terms of evaluating the Presumption, the Second Circuit offered several guiding principals. First, the Second Circuit opined that judicial scrutiny should increase with the degree of discretion a plan gives its fiduciaries to invest. For instance, if the plan's terms require—rather than merely permit—investment in company stock, a fiduciary's failure to divest from company stock is less likely to constitute an abuse of discretion. Second, the Court opined that the fiduciary's actions are judged based upon information available to them at the time of each investment decision. Third, and most importantly, in order to rebut the Presumption, the Court advised that there must be a showing that the fiduciaries either knew or should have known that the company was in the sort of "dire situation" that required them to override plan terms in order to limit participants'

1 The Second Circuit also issued a decision in the companion case captioned *Gearren, et al. v. The McGraw-Hill Companies, Inc., et al.*, Case No. 10-792 (2d Cir. October 19, 2011) wherein it also found that the plaintiffs had failed to rebut the *Moench* Presumption.

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investments in company stock. The Court elaborated that while proof of the company's impending collapse may not be required to establish liability, "mere stock fluctuations, even those that trend downhill significantly, are insufficient to establish the requisite imprudence to rebut [the Presumption]." Applying these guideposts, the Court determined that the plaintiffs had failed to make such a showing.

Lastly, the Court also rejected the plaintiffs' claims for failure to provide complete and accurate information regarding Citigroup and conveying inaccurate material information regarding the soundness of the Company's stock. The Court reasoned that the fiduciaries do not have an affirmative duty to provide plan participants with non-public information regarding the expected performance of company stock. Additionally, the Court concluded that the plaintiffs failed to allege any facts that would, if proven, demonstrate that the defendants were acting in a fiduciary capacity when making the relevant statements.

Multiple Claims Arising from Same *Modus Operandi* Constitute Single Claim

- *Cont'l Cas. Co. v. Howard Hoffman & Assocs.*, 2011 Ill. App. LEXIS 876 (Ill. App. Ct. 1st Dist. 2011)

A paralegal, who worked for a law firm practicing in the area of estate planning, pled guilty to embezzling from at least 16 different probate cases being handled by the firm. The law firm was sued by 12 separate estates that had suffered a theft. Upon tendering the matter to its insurer, a dispute arose between the parties regarding, among other things, the appropriate limit of coverage to be applied in connection with the underlying claims (i.e., $100,000 limit for single claim or a $300,000 aggregate limit). The relevant policy defined Claim to mean "a demand received by the Insured for money or services arising out of an act or omission, including personal injury, in the rendering of or failing to render legal services." The policy further defined "Related Claims" as "all claims arising out of related acts or omissions in the rendering of legal services and "related acts or omissions as "all acts or omissions in the rendering of legal services that are temporally, logically, or causally connected by any common fact, circumstance, situation, transaction, event, advice or decision." The policy also contained "claims first made" language. Related Claims would be subject to the $100,000 per claim limit.

The Insured, facing losses in excess of $300,000, asserted that the inclusion of the term "logically . . . connected" within the definition of related acts made the policy ambiguous on its face as a matter of law. In support of its position, the Insured cited to prior case law that held the word related could not be "equated" with the term "logical connection" because "logic, like beauty, was in the eye of the beholder and greatly depends upon the subjective mental process of the viewer." However, even though this was a novel issue for the Illinois Appellate Court, the Court found the prior cases distinguishable, given that the earlier cases did not include the term "logical" within the policy definition. Also, the Court noted that several subsequent rulings had refuted such a holding. Rather, the Court noted one such decision that stated "simply because 'at some point a logical connection may be too tenuous reasonably to be called a relationship' does not mandate that the concept of a logical connection cannot be applied to determine relatedness under a policy of insurance."

Applying this reasoning to the multiple claims asserted against the law firm, the Court held that even though the employee embezzled from multiple estates, the employee's embezzlement scheme can be viewed as an "action in general" or a "wrong or unlawful deed" and the carrying out of the scheme had "common ties" and involved the same "modus operandi." Thus the Court held that the underlying allegations were logically and causally connected to the employee's embezzlement scheme constituting a single claim.

Losses Limited to Money Damages

- *Passaic Valley Sewerage Com'rs v. St. Paul Fire and Marine Ins. Co.*, 206 N.J. 596 (N.J. 2011)

The Supreme Court of New Jersey addressed whether the definition of "money damages" contained in an insurance policy encompasses "value of services and assets." Passaic Valley Sewerage Commission ("PVSC") is a state agency that regulates the collection and disposal of wastewater. PVSC was sued by a wastewater treatment company, Spectraserv, Inc., for allegedly misusing its authority when it issued in excess of 180 violations against Spectraserv's monitoring station. Subsequently, PVSC and Spectraserv reached a settlement wherein PVSC essentially assigned certain of its business services to Spectraserv for a limited amount of time. PVSC made no monetary payment in connection with the settlement. Nonetheless, PVSC attempted to recoup the "value" of the business assigned to Spectraserv through the settlement from its insurance carriers.

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This was an issue of first impression for the New Jersey Supreme Court. However, the Court agreed with the analysis of other jurisdictions that have found "[t]he plain meaning of the term damages as used in the insurance context refers to legal damages and does not include equitable monetary relief." Moreover, the Court found that the policy at issue unambiguously defined "money damages" as "monetary compensation." The Court also noted that the insurance carrier's definition of "money damages," along with the exclusions for equitable relief, indicate that the carrier did not bargain for the valuation process involved in establishing the monetary value of the services. Thus, the Court held that PVSC was not entitled to indemnification from its carrier for the underlying settlement.

Patent/Trademark Infringements May Constitute Advertising Injury

- *Dish Network Corp. v. Arch Specialty Ins. Co.*, 2011 U.S. App. LEXIS 20955 (10th Cir. Colo. Oct. 17, 2011)

DISH Network Corporation ("Dish") brought a declaratory judgment action against its insurers for coverage in connection with a patent infringement action. The underlying plaintiff, RAKTL, claimed that Dish had "used" its "patented interactive telephone system" to market Dish's own pay-per-view services. Dish sought coverage from several of its CGL carriers. However, the insurers asserted that a patent infringement claim could never be an "advertising injury."

Although this was a novel issue under Colorado law, the trial court indicated that a claim for patent infringement could "properly give rise to coverage . . . where the insured established three elements: first, that it was engaged in 'advertising' during the relevant period; second, that the underlying complaint alleged a predicate offense under the policy language; and third, that a causal connection existed between the advertising and the alleged injury suffered by the patent holder." However, the trial court did not find that Dish's "use" of RAKTL's patented interactive telephone system to conduct its advertising constituted "misappropriation of advertising ideas . . . ." As such, the court ruled in favor of the insurers on summary judgment.

On appeal, the Tenth Circuit agreed with the trial court that patent infringement may, under certain circumstances, constitute "misappropriation of advertising ideas." However, the Tenth Circuit disagreed with the trial court's conclusion that the patented means of conveying advertising content at issue in the underlying litigation could not constitute "advertising ideas" within the meaning of the CGL policy. In reaching its decision, the Tenth Circuit applied a two-part test: first, whether the underlying complaint alleged an offense specifically listed in the definition of advertising injury; and second, whether there was any causal link between the patent holder's alleged injuries and the insured's advertising activities. The appellate court cited to numerous other jurisdictions and cases that have found "where an advertising technique itself is patented, its infringement may constitute advertising injury." The Court agreed with other cases holding that ordinary persons would not expect the words "misappropriation of advertising ideas" to exclude the misappropriation of a patented advertising idea, even if the words "patent infringement" is expressly referenced as an exclusion within the policy. Moreover, the Court found that because one of the Dish insurance policies expressly excluded "patent infringement" while the other did not, created an inconsistency and ambiguity that had to be construed in favor of coverage. The case was remanded back to the trial court for further proceedings.

Coverage Denied for Climate Change Lawsuit

- *AES Corp. v. Steadfast Ins. Co.*, 2011 WL 4139736 (Va. Sept. 16, 2011).

A claim arising in connection with climate change allegations was held not to constitute an Occurrence in a recent opinion issued by the Virginia Supreme Court. A Virginia energy company, The AES Corporation, was sued by citizens of an Alaskan barrier island in federal court in California involving allegations of *intentional* damage to their village due to global warming caused by AES's emission of greenhouse gases. Specifically, the plaintiffs asserted that the ice barrier that protected its shoreline from storm surges melted prematurely, which resulted in significant erosion. AES sought coverage with respect to the lawsuit under a CGL policy. The carrier issued a reservation of rights and pursued a declaratory judgment action in Virginia state court with respect to coverage. The Virginia trial court ultimately determined that the intentional discharge of greenhouse gases, as well as the expected consequences of this action, could not be deemed to be accidental. As such, there was no "occurrence" as defined by the operative policy.

On appeal, the Virginia Supreme Court noted that an

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insurer's duty to defend and indemnify its insured depends upon the policy wording and the allegations contained in the underlying Complaint (i.e., the "eight corners" rule). Thus, whether the matter involved an "occurrence" depended on whether the Complaint alleged an "occurrence." First, the Court noted that "[a]n intentional act is neither an 'occurrence' nor an 'accident' and therefore is not covered by the standard policy." However, the Court also noted that if the alleged injuries resulted from an "unforeseen cause that is out of the ordinary expectations of a reasonable person," the injury may be found to be an occurrence. Thus, the Court reasoned that the issue of coverage depended upon whether the plaintiffs' injuries were the result of unforeseen consequences that a reasonable person would not have expected from AES operations of deliberating releasing greenhouse gases into the atmosphere.

Ultimately, the Court found that the fact that plaintiffs alleged AES "knew or should have known" of the adverse effects of intentionally emitting the greenhouse gases was sufficient to establish the threshold requirement that a reasonable person would have expected the resulting damage. Therefore, the Supreme Court, finding in favor of the GL insurer, affirmed the lower court's ruling that there was no "occurrence" under the general liability policy.

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Please contact any one of the attorneys at Peters & Nye LLP for further information about this Digest or if you require assistance in your legal needs.

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Firm News

Peters & Nye LLP is happy to announce that **Scott Karalis** has recently joined the firm as an associate. Scott's practice will focus on professional liability insurance coverage and defense, including directors and officers liability and errors and omissions liability. Scott is a 2011 graduate of the University of Iowa College of Law with Distinction and was recently admitted to the practice of law in the State of Illinois. While at the University of Iowa College of Law Scott held the position of Executive Director of The Journal of Corporation Law and was honored with the Best Oral Advocate Award and Best Brief Award. Scott can be contacted at ScottKaralis@petersnye.com

Victor Peters and **Nancy Tordai** secured an Order from the U.S. District Court for the Southern District of Iowa granting its client judgment on the pleadings in the case of Area 15 Regional Planning Commission v. The Cincinnati Insurance Company, which is reported at 2011 U.S. Dist. LEXIS 66776. The Court was faced with the issue of whether a demand letter from an administrative agency is a claim under a non-profit liability policy. In granting Cincinnati judgment on the pleadings, the Court held that a demand letter from an administrative agency is not a claim and, hence, the insurer had no duty to defend.
In its twenty-page opinion, the Court found that the definition of "claim" – "any proceeding initiated against any of the insureds before any governmental body which is legally authorized to render an enforceable judgment or order for money damages or other relief" – is unambiguous. In this respect, the Court held that "proceeding" means some of type legal action to collect money damages.

In October 2011, **Natasha Nye** was invited to speak at the XL Insurance (Bermuda) Ltd 25th Anniversary Seminar held in Hamilton, Bermuda. The seminar focused on the XL Excess Liability Policy form over its twenty-five year history.