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Always the Last to Know

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Any person or company that has navigated insurance coverage challenges knows that notice to the insurance company is always a key component of the carrier's first analysis. Failure to provide notice timely may be outcome determinative issue as to whether an insured has coverage, regardless of whether a policy was in force or the claim for indemnity is covered within the terms of the policy. For business reasons, insureds can sometimes deliberately delay reporting losses to insurance companies. Doing so may jeopardize coverage and, for that reason, delayed notice should be carefully considered. Inadvertent failure to report claims also occurs frequently and can be particularly frustrating for busy insureds and their risk management leadership.

ALFA International's insurance practice group is ready to assist you and your teams in navigating these issues, including providing this quick resource setting forth the basic issues for you to consider when providing notice to your carriers.

The Policy

Where to start? In almost all instances, the first place to seek guidance is the insurance policy, which is, after all, is your contract. The carrier will start there and so will a court looking to resolve any dispute(s) about indemnity and defense obligations. There are three (3) key provisions to look at right away: (1) the effective dates; (2) the insuring agreement, namely whether this is a "claims-made" or "occurrence" policy; and (3) the policy's notice provisions, usually in the "General Conditions" section.

1. Effective Dates.

Start here and identify when your policy was originally issued (inception date), when it was renewed, and if it is still in effect. The resulting time span between either the inception date or retroactive date on one hand, and the end date of coverage (including any fee tail) is generally considered the "effective dates" of the policy. Here, you should compare the effective dates to when the events giving rise to the claim happened ("occurred" or also referred to as the "date of loss") against when the insured had reasonable notice that a claim was being presented to the insured as a result of the events at issue (the "notice" date).

2. Insuring Agreement.

A policy's "insuring agreement" is the provision in the policy that tells an insured in very broad terms what will be covered, without detailing definitions, exclusions, or other terms. For our purposes, we are looking at two (2) types of insuring agreements or policies: claims-made and occurrence policies.

3. Claims-Made Policies.

The insuring agreement in a "claims-made" policy provides coverage only if the claim is made while the policy is active, and regardless of when the actual events giving rise to the claim happened.[i] Claims-made policies often are issued for, among other things, professional liability risks (lawyers, doctors, accountants, wealth managers, architects, and individuals who require licensure to work in their fields), cyber-liability (data breaches), employment practices (harassment and wrongful termination), and mistakes of directors and officers (breach of fiduciary duty to shareholders, but not intentional act). Notably, claims-made policies contain applicable a "retroactive date" identified in the policy declarations or by endorsement, as well as any extended reporting periods that follow even after a policy's effective dates have ended.

A pure "claims-made" policy requires only that a claim be presented to the insured during the policy terms, with the insuring agreement typically reading as follows:

> This insurance applies to [injury or damage] . . . that did not occur before the retroactive date, if any, or after the end date of the policy . . . and . . . a claim for damage is first made against the insured during the policy period effective dates and any extended reporting period . . . . A claim is made when the insured or us [the insurance company] receives notice.

Previous versions of claims-made policies left room for debate about when a claim is made to the insured versus the carrier (notice provisions are addressed below), and that space often resulted in coverage disputes. For example, consider a situation in which a company is informed of a claim in 2023, but does not report it to its insurance company until 2025. Without question, there will be issues related to compliance with the notice requirements, particularly if the policy was issued for the first time (inception date) after the company was made aware of the claim.

As a result, most "claims-made" policies now have insuring agreements that clearly require the claim to be both *made and reported* to the insurance company while the claims-made policy is in effect. Strictly speaking, these policies are sometimes referred to as "claims-made and reporting" policies, although more often and in common parlance, they are still simply referred to as "claims-made" policies. Thus, most modern "claims-made [and reported]" insuring agreement language now appear as follows:

> This insurance applies to [losses from events] . . . that did not occur before the retroactive date, if any, or after the end date of the policy . . . and . . . a claim for damage is first made and reported to us [the insurance company] during the policy period effective dates and any extended reporting period.

This distinction is critically important. What's more, the bad news is that the insuring agreement may not be the only provision you need to look at before identifying what type of policy is in effect.

4. Occurrence Policies.

An occurrence-based policy covers losses that happen ("occur") during the policy's active period, regardless of when the claim is made. As a result and generally (not always, think construction defect), it is easier to identify whether the particular claim will be within the policy effective dates. Common occurrence based policies include commercial general liability, property and casualty, and automobile insurance. The insuring agreement will typically read as follows:

> This insurance applies to [injury or damage] . . . that occurs during the policy period.

This comparatively simpler analysis makes an early determination of potential coverage much easier. However, the tricky part comes with notice.

5. Notice and Loss Conditions.

All policies have notice provisions and general conditions. Sometimes they are labeled as "what to do in the event of a loss" or other synonymous terminology. Irrespective of designation, careful scrutiny of these terms also is needed at the outset.

Even a policy with a pure claims-made insuring agreement often is converted to a "claims-made and reported" policy simply by the wording of the notice provisions in a policy. Traditionally, a pure claims made policy required that claim be made to the insured or carrier during the policy period, and if made to the insured, notice to the insurance company (reporting) be made "as soon as practical [or possible]." This alone is a primary reason that pure claims-made policies are out of favor and most claims-made policies now require both that a claim be made and reported to the carrier during the relevant policy period. It's also the reason why even when the insuring agreement reads as a pure claims-made policy, careful scrutiny of the notice provision is required. Most claims-made policies now, and regardless of whether the insuring agreement specifies it as such, read as follows:

> The insured shall . . . give the insurer notice of any claim . . . such notice shall be given as soon a practicable . . . but in no event later than sixty (60) days following the end of the policy period.

The result is clear: one must read both the insuring agreement and the notice provisions together and more often that not, modern-claims made policies require both that the claim be made and notice to the insurance company given within the policy effective dates, or sixty (60) days thereafter.[ii]

Occurrence based policies have some varying notice provision terms. In a property and casualty policy (a homeowner's policy for example), the notice provision may read something along the lines of "you must give us prompt notice of the loss or damage." When a flood occurs, for example, property damage is readily apparent. When a slow pipe leaks, though, it may be less apparent. In a general liability policy notice, provisions in occurrence-based policies contain two (2) independent duties: first, the duty to provide notice of an accident or injury, an "occurrence;" and second, the separate duty to provide

notice of (or forward suit papers regarding) an actual claim being made as a result of the accident or injury. The recognition of these two (2) separate duties is important. In addition to the dual notice requirements, it is important to consider how other duties commonly set out in the notice clause—for instance, the duty to cooperate and the duty to avoid voluntary payments and settlement are also closely related to the notice issue. Almost always, the notice is required "as soon as practicable."

6. Late Notice Rules

Why does late notice matter? The answer lies in what type of policy is at issue and the risk objectives for both.

7. Majority Rule for Claims-Made Policies; Strict Compliance Condition Precedent.

The U.S. Court of Appeals for the First Circuit, in a high profile case involving Harvard, quoted a Massachusetts court explaining the significance of the strict notice requirement in claims-made policies:

> The purpose of a claims-made policy is to minimize the time between the insured event and the payment. For that reason, the insured event is the claim being made against the insured during the policy period and the claim being reported to the insurer within that same period or a slightly extended, and specified, period. If a claim is made against an insured, but the insurer does not know about it until years later, the primary purpose of insuring claims rather than occurrences is frustrated. Accordingly, the requirement that notice of the claim be given in the policy period or shortly thereafter in the claims-made policy is of the essence in determining whether coverage exists.

President and Fellow of Harvard Col. v. Zurich Am. Ins. Co., 77 F. 4th 33, 38 (1st Cir.) (citations omitted). The First Circuit went on to observe for itself that the strict notice provisions in claims-made policies are also intended "– just as importantly-to promote fairness in rate setting." *Id.* (Industry wide and across all lines, premiums for claims-made policies are significantly lower than those for occurrence policies).

In this case, Harvard College had placed its primary carrier, AIG on notice, and AIG was defending the matter. It did not place its excess carrier Zurich on notice. The First Circuit affirmed summary judgment in favor of Zurich. Interestingly, it did so despite Harvard's argument that its own failure to provide timely, written notice resulted in no prejudice whatsoever to Zurich, who likely had actual notice of the claim due to the nationwide and global media coverage of the litigation. The First Circuit dismissed the argument as:

> "little more than gaslighting. Arguing that the policy's notice requirement should not be enforced because Zurich may have had actual notice of the claim is simply another way of arguing that Zurich was not prejudiced by the lack of timely written notice. To honor such an argument would

> impermissibly collapse the critical distinction that the [Massachusetts' court] has made between occurrence-based and claims-made policies."
>
> *Id. at 39.*

As a result, the majority rule is that a late notice – notice of a claim after the policy period, any extended reporting, or grace period have expired – is a complete defense to coverage. Compliance with the policy's notice rules is a condition precedent to recovery under the policy and no showing or prejudice is required. *See, e.g.*, *Great Am. Ins. Co. v. Sea Shepherd Conservation Soc.*, 2014 WL 2170297, at *6 (W.D. Wash. May 23, 2014); *Yu v. Century Surety Co.*, 2014 WL 787880, at *4 (Cal. Ct. App. Feb. 27, 2014); *Fishman v. The Hartford*, 980 F. Supp. 2d 672, 680-81 (E.D. Pa. 2013); *ABCO Premium Fin. LLC v. Am. Int'l Group, Inc.*, 2012 WL 3278628, at *9 (S.D. Fla. Aug. 9, 2012); *Dardanelle & Russellville R.R. v. Certain Underwriters at Lloyd's, London*, 379 S.W.3d 734, 742-43 (Ark. Ct. App. 2011); *ITC Investments, Inc. v. Employers Reins. Co.*, 2000 WL 1996233, at *14 (Conn. Super. Ct. Dec. 11, 2000) (collecting cases).

8. Minority Rule for Claims-Made Policies; Notice-Prejudice.

There are a few exceptions to the majority rule and you should be mindful of the jurisdiction, whether by state to state in America, or internationally, by country to country.[iii] There are a few jurisdictions that have adopted a differing, minority rule; one other than strict compliance with notice provisions for claims-made policies. Some states have recognized a narrow exception and held that showing of prejudice resulting from the late notice is required if: (1) the underlying claim was made during the term of one policy, (ii) the insured was thereafter continuously insured under renewals of that policy, and (ii) the insured provided notice during one of those renewal terms. *E.g.*, *AIG Domestic Claims, Inc. v. Tussey*, 2010 WL 3603844 (Ky. App. Sept. 17, 2010); *Cast Steel Prods. v. Admiral Ins. Co.*, 348 F.3d 1298, 1300–01 (11th Cir. 2003); *Helberg v. Nat'l Union Fire Ins. Co.*, 657 N.E.2d 832, 833 (Ohio Ct. App. 1995).

Other states distinguish claims-made-and-reported policies from pure claims-made policies. Because those states find that the notice requirement in a pure claims-made policy does not define the scope of coverage, their courts subject those policies to the notice-prejudice rule (discussed further below). *See, e.g.*, *East Texas Medical Center v. Lexington Ins. Co.*, 2011 WL 773452, *2 n.5 (E.D. Tex. 2011).

In Maryland, the state's notice-prejudice rule does **not** protect an insured under a claims-made-and-reported policy, **if** the insured fails to give notice **of any kind** during the policy term. However, if the insured acts within the policy term, but merely fails to comply strictly with the requirements governing **how** notice must be given (*i.e.,* in writing or to a specific email box or online platform), then the insurer might be required to demonstrate prejudice. *See, e.g., Sherwood Brands, Inc. v. Great Am. Ins. Co.*, 418 Md. 300, 13 A.3d 1268, 1288 (Md. 2011); *Minn. Lawyers Mut. Ins. Co. v. Baylor & Jackson, PLLC*, 531 F. App'x 312, 325 (4th Cir. 2013).

9. Majority Rule for Occurrence Policies: Notice-Prejudice.

In contrast to the bright-line majority rule regarding strict compliance with notice provision for claims-made policies, for occurrence policies, the majority rule is that when late notice is provided, a showing of resulting prejudice must be made. The majority rule – often referred to as the Notice-Prejudice Rule – is that when notice is untimely, the carrier has the burden to prove resulting prejudice. In still a smaller number of states (Florida, Indiana, Iowa, Ohio, Tennessee, and Wisconsin) that adopt the majority rule requiring prejudice to void the coverage, the existence of prejudice is a rebuttable presumption. So, while prejudice is still required to avoid coverage, it is up to the policyholder to present evidence, meaning rebut the presumption that prejudice occurred due to the late notice.

10. Minority Rule #1: No prejudice is required even for occurrence based policies.

In two U.S. states (Idaho and Arkansas) even for occurrence policies, no showing of prejudice is required. If the policyholder does not comply with the notice provisions in the policy and reports the claim or loss late, there is no coverage.

11. Minority Rule #2: Prejudice is one Factor.

Illinois and Virginia do not expressly require a finding of prejudice, but permit evidence of an insurer's prejudice as a factor in deciding whether the notice was or timely under the policy.

I. What is Untimely or Late Notice?

As we have discussed, you first need to check the policy for its terms. Clearly, notice that is outside express limits in the policy is late notice. *Rentmeester v. Wis. Lawyers Mut. Ins. Co.*, 164 Wis. 2d 1 (1991)(notice provided after one-year requirement within policy constituted untimely notice). Beyond that, and particularly, because most occurrence policies require notice of claims or lawsuits "as soon as practicable," what is considered late or untimely depends on the circumstances and the reasonable, "practicable" conduct of the insured. For example, in *P.R. Mallory & Co., Inc. v. Am. Cas. Co. of Reading, PA.*, 920 N.E.2d 736 (Ind. Ct. App. 2010), the court considered that the insured had been operating one unlined waste disposal site from 1950 to 1963 and a second site from 1963 to 1980, during which the Indiana State Board of Health had received complaints regarding pollution in 1969 and 1972. What's more, in 1989 and 1991, the insured held board of directors' meetings regarding potential liability for cleanup of hazardous wastes sites. Based on this evidence, the court concluded that the insured's notice to the insurance company (assumed to have occurred in August of 2000) was unreasonably late notice of an occurrence and claim.

II. What is Prejudice?

What constitutes prejudice may, in some circumstances, be relatively easy to ascertain. There is little doubt that notifying a carrier after settlement of claims,[iv] after judgment in a lawsuit,[v] and after the entry of default judgment and attempts to vacate same by the insured,[vi] all constitute prejudice.

In *Earle v. State Farm Fire & Cas. Co.*, 935 F.Supp. 1076 (N.D. Cal. 1996), the court concluded prejudice existed as a *matter of law* where the underlying suit was filed in 1993, proceeded through trial in 1994, and resulted in a verdict exceeding $10 million, but was not tendered to the insurer until one (1) month after the verdict was entered. State Farm argued (and the Court agreed) that "the Earles' belated tender not only deprived State Farm of any opportunity to affect the outcome of the underlying case, but it also deprived State Farm of the ability to prove that it might have done so." Notably, the Court also gave credence to State Farm's contention that "due to the delayed tender, it cannot possibly quantify the potential benefit to State Farm or the Earles had it been able to participate in litigating the underlying action." State Farm specifically offered evidence that: (1) State Farm would not have been required to reimburse independent counsel at an hourly rate higher than the rate it actually pays attorneys retained by it in the ordinary course of business pursuant to California Civil Code § 2860(c); (2) it would have been allowed to seek reimbursement of fees and costs allocable to noncovered claims, which in this case, was every claim other than a defamation claim; (3) had a special interrogatory been propounded to the jury asking whether the defamation was intentional, there is a substantial likelihood that the jury would have answered in the affirmative (in light of the punitive damages award) and thus State Farm maintained that it would be relieved of the obligation to pay any portion of the judgment; and (4) had a special interrogatory been propounded to the jury asking whether the defamation arose out of Mr. Earle's business operations, there is a substantial likelihood that the jury would have answered in the affirmative, thus relieving State Farm of its obligation to pay the judgment due to the policy's business operations exclusion.

However, in most instances the inquiry is fact-specific. California courts have stated that an insurer must generally demonstrate a substantial likelihood that with timely notice the insurer would have taken steps to settle the claim for less, or taken steps that would have reduced or eliminated insured's liability." *See, e.g., Safeco Ins. Co. of Am. v. Parks* (2009) 170 Cal.App.4th 992, 1003.

Conclusion

Notice of claims to insurance companies is not merely an administrative hurdle and it does not matter whether a policyholder has been paying premiums for years or even decades. Often times, individuals and business alike, for fear of claim history resulting in increased premiums and, often coupled with a belief that a claim can be settled inside a deductible, choose not to report a claim. However, they do so at their peril for coverage and these decisions should be weighed carefully depending on the policy language itself, the type of policy at issue, and the jurisdictional rules regarding late notice.

This is true even in circumstances where the failure to provide notice is inadvertent.

Perhaps upper management or risk management did not know of a claim or suit and only mid-level supervisors or front-line workers were aware. Perhaps a lawsuit was served and the service of summons was not properly routed to the office mail room (an actual case litigated by this author). However, the rules are largely the same. In most jurisdictions, when an occurrence based policy is at issue, what constitutes prejudice to the carrier is a significant and expensive dispute that goes on behind the scenes or concomitantly during the defense of the actual underlying claim or lawsuit.

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[i] This brief summary of notice issues does not address *other coverage requirements and terms, including exclusions,* that are included in insurance policies. This paper is limited only to the threshold issue of notice to an insurance company of a loss and resulting claim.

[ii] The sixty (60) and sometimes ninety (90) day extension beyond the policy's end dates is due to many state insurance regulations, which require a grace period regardless of policy terms. Accordingly, some or most carriers use of industry-wide forms simply incorporate that requirement into the policy language itself.

iii This article cites U.S. case law from various jurisdictions. For most other countries, including the EU, while the majority and minority rules remain the same and the underlying policies are the same, the adoption of majority or minority position is most often nationwide, rather than state by state basis.

[iv] Sheehan Constr. Co. v. Cont'l Cas. Co., 938 N.E. 2d 685 (Ind. 2010) (notice after settlement of class action).

[v] Viani v. Aetna Ins. Co., 501 P2d 706 (Idaho 1972)(overruled on separate grounds; no demand was ever made on insurer to defend insured until after judgment against insured became final); Berkley Reg'l Ins. Co. v. Philadelphia Indem. Ins. Co. (5th Cir. 2015) 600 Fed. Appx. 230 (applying Tex. law).

vi N. Mgmt. Servs. Inc. v. Navigators Specialty Ins. Co., 608 F.Supp.3d 996 (D. Idaho 2022)(notice to carrier deemed untimely when provided after entry of default judgment and after attempts by insured to vacate same).