SURVEY OF ILLINOIS LAW: INSURANCE LAW

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INTRODUCTION

This article analyzes significant Illinois opinions relating to insurance law issued from October 1, 2002, through September 30, 2003. The purpose of this survey is to highlight the changes, modifications, or extensions of existing law, and not necessarily to present every decision announced during this period. The focus is on significant developments in recent case law in order to present to the practitioner emerging issues and foreshadow potential changes in insurance law. This article is divided into eight sections. Section I addresses the formation of the insurance contract. Section II reviews cases about the duties of the parties to the contract. Commercial liability issues are analyzed in Section III. Section IV examines automobile policies. Section V discusses medical and health insurance. Section VI explores subrogation issues. Section VII reviews bad faith. The article's conclusion is in Section VIII.

I. CONSTRUCTION OF THE INSURANCE POLICY, APPLICATIONS, FORMATION AND MODIFICATION

A. An "Instrument of Writing" Under the Illinois Interest Act

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In *Adams v. American International Group, Inc.*,[1] the court held that the settlement of a tort action documented with a release of all claims, which

acknowledged that consideration had been paid, was not an "instrument of writing" as contemplated by the Illinois Interest Act.[2] Therefore, no interest was due under that document. The plaintiff brought an action against a nursing home which was settled for $250,000. The oral settlement agreement provided for the payment in two installments.[3]

The plaintiff executed a release on October 27, 2000 discharging the nursing home and its insurers.[4] The release was executed in "consideration of the payment of the total sum of Two-Hundred Fifty Thousand Dollars." Payment was conditional upon the plaintiff obtaining court approval of the settlement.[5] The total was to be paid in two equal installments of $125,000. There was no due date for the payments or any mention of interest. The two payments were paid on April 15, 2002 and December 15, 2002. Two weeks after receiving the final payment, the plaintiff filed suit against the insurer alleging that the insurer did not make a timely payment of the installments. The plaintiff sought prejudgment interest pursuant to the Illinois Interest Act[6] based on a theory of unjust enrichment.[7]

The Illinois Interest Act provides in part as follows: "[c]reditors shall be allowed to receive at the rate of five (V) per centum per annum for all monies after they become due on any bond, bill, promissory note, or other instrument of writing . . ."[8] The plaintiff alleged that the release was an "instrument of writing" under the Illinois Interest Act.[9] The Illinois Interest Act "instrument of writing" provision incorporates two requirements into a claim for interest based upon a written instrument. First, the instrument must establish a "debtor/creditor relationship."[10] Second, the instrument must contain a specific due date. The court of appeals found that the release did not contain either

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1. 339 Ill. App. 3d 669, 791 N.E.2d 26 (1st Dist. 2003).
2. *Id.* at 674, 791 N.E.2d at 30.
3. *Id.* at 671, 791 N.E.2d at 28.
4. *Id.*
5. *Id.*
6. 815 ILL. COMP. STAT. 205/2 (2003).
7. *Adams*, 339 Ill. App. 3d at 672, 791 N.E.2d at 28–29.
8. 815 ILL. COMP. STAT. 205/2 (2003).
9. *Adams*, 339 Ill. App. 3d at 674, 791 N.E.2d at 30.
10. *Id.*

of these items. The court held that the underlying obligation to pay the settlement proceeds did not arise because of the release.[11] It arose by virtue of the oral settlement agreement which preceeded the execution of the release. The recitals in the release merely acknowledged the consideration given by the parties. The release did not create the necessary debtor/creditor relationship.[12]

Even if the relationship had been established, the release did not have a specific due date for the debt.[13] The plaintiff argued that upon settlement and release, a court could infer that payment would be made at the time that the release was executed. If an agreement was made to accept two installments, the first installment would be due on the date of the release and the second installment no more than thirty (30) days later. The court did not adopt this position and noted that no support was provided for it. The court held that the release was not an instrument of writing under the Interest Act.[14]

As to the plaintiff's allegation of unjust enrichment, the Illinois Supreme Court had held that a claim of unjust enrichment must allege that the "defendant has unjustly retained a benefit to the plaintiff's detriment, and that the defendant's retention of the benefit violates the fundamental principals of justice, equity, and good conscience."[15] The insurer argued that an action for unjust enrichment that seeks to impose an implied contract cannot be maintained if express contract governs the parties. The court adopted this position and found that the subject matter of the settlement agreement was the same as the implied contract which the plaintiff sought to have imposed. The unjust enrichment claim arose out of the settlement agreement that governed the payment of the settlement proceeds. Therefore, dismissal of the unjust enrichment claim was proper.[16]

B. The Duty to Maintain Proof of Mailing

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11. *Id.*
12. *Id.*
13. *Id.*
14. *Id.*
15. HPI Health Care Servs., Inc. v. Mt. Vernon Hosp., Inc., 131 Ill. 2d 145, 160, 545 N.E.2d 672, 679 (1989), *cited in Adams*, 339 Ill. App. 3d at 675, 791 N.E.2d at 30–31.
16. *Adams*, 339 Ill. App. 3d at 676, 791 N.E.2d at 31.

In *Guillen v. Potomac Insurance Co. of Illinois*,[17] the Supreme Court of Illinois held that an insurer who mailed notice to its insured of a material change in an insurance policy must maintain proof of the mailing.[18] The proof must be on a recognized Postal Service form, a form acceptable to the Postal Service or other commercial delivery service pursuant to Section 143.17a(a) and (b) of the Insurance Code.[19] Even with an assignment, when the insurer breached its duty to defend, a claimant has a right to indemnification from the insurer because of the language "legally obligated to pay."[20]

A tenant filed a complaint against her former landlord alleging bodily injury due to exposure to lead-based paint.[21] Shortly after receiving the complaint, the insureds tendered the claim to their insurer, Potomac Insurance Company, under their commercial liability policy. The insurer refused and denied any obligation to defend or indemnify the insureds due to a lead exclusion endorsement that had been recently added to the policy. After refusing the tender, the insurer did not take any other action and did not defend under a reservation of rights.[22] The tenant and insured entered into a settlement agreement releasing the insured from liability in exchange for $600,000. The insureds' obligation to make payment was conditional upon satisfaction "solely through the assignment" of the insureds' right to payment under their commercial liability policy.[23]

The tenant filed a declaratory judgment action against the insurer seeking recovery of the $600,000.[24] The tenant argued that the insurer failed to comply with the statutory notice requirements that governed the addition of the lead exclusion because it failed to maintain proof of mailing, which was necessary under the Insurance Code.[25] The insurer argued that it maintained sufficient proof of mailing, and in support, it offered an unsigned copy of a letter which was purportedly sent to the insured and an affidavit of an employee that described the insurer's custom and practice with respect to mailing notice of material change. The insurer further argued that it was under no obligation to pay the

17. 203 Ill. 2d 141, 785 N.E.2d 1 (2003).
18. *Id.* at 154, 785 N.E.2d at 9.
19. 215 ILL. COMP. STAT. 5/143.17a(a), (b) (2003).
20. *Guillen*, 203 Ill. 2d at 160–62, 785 N.E.2d at 13.
21. *Id.* at 143, 785 N.E.2d at 3.
22. *Id.* at 144, 785 N.E.2d at 3.
23. *Id.*, 785 N.E.2d at 4.
24. *Id.*
25. 215 ILL. COMP. STAT. 5/143.17a(b) (1992).

settlement amount because the insured's assignment of recovery was invalid.[26]

The circuit court found that the insurer failed to comply with the notice requirements of Section 143.17a(b) of the Insurance Code.[27] The circuit court further held that the tenant failed to establish a claim for indemnification against the insurer. The appellate court upheld the finding regarding notice and reversed the indemnification decision in favor of the insurer. The insurer subsequently filed petition for leave to appeal.

The Illinois Supreme Court began its notice analysis by quoting the notice requirements of Section 143.17a of the Insurance Code, which provided in pertinent part:

> Notice of Intention Not to Renew. a. No company shall fail to renew any policy of insurance . . . unless it shall send by mail to the named insured at least 60 days advance notice of its intention not to renew. The company shall maintain proof of mailing of such notice on one of the following forms: a recognized U.S. Post Office form or a form acceptable to the U.S. Post Office or other commercial mail delivery service.
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> b. [N]o company may . . . impose changes in deductibles or coverage that materially alter the policy, unless the company shall have mailed or delivered to the named insured written notice of such . . . change . . . The company shall maintain proof of mailing or proof of receipt whichever is required.[28]

The Illinois Supreme Court concluded that the term "proof of mailing" found in section (b) should be given the same effect as the term "proof of mailing" found in the preceding section (a).[29] "Proof of mailing" in (a) means proof on a recognized U.S. Post Office form or a form acceptable to the U.S. Post Office or other commercial mail delivery service. By not complying with Section (b), the modification never became a part of the insurance policy and the insurer breached its duty to defend by denying coverage.[30]

Reviewing the insured's assignment of recovery under the policy, the court interpreted the policy language "those sums the insured

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26. *Guillen*, 203 Ill. 2d at 146, 785 N.E.2d at 4–5.
27. *Id.*, 785 N.E.2d at 5.
28. 215 ILL. COMP. STAT. 5/143.17a(a), (b) (1992).
29. *Guillen*, 203 Ill. 2d at 152–53, 785 N.E.2d at 8.
30. *Id.* at 157, 785 N.E.2d at 11.

becomes legally obligated to pay as damages" in the context of a breach of the duty to defend.[31] The insurer argued that the insured was never "legally obligated" to pay damages under the settlement agreement because the payment obligation never placed the insured in any personal financial risk.[32] The court concluded that once an insurer has breached its duty to defend, the insurer was not in a position to demand that the insured be held to a strict accounting under the policy language. The court added that fairness requires that the insured, wrongfully abandoned by the insurer, be afforded a liberal construction of the "legally obligated to pay" language. As such, the court rejected the insurer's argument regarding the validity of the insured's assignment.[33]

II. DUTIES OF THE INSURER AND INSURED

A. The Duty to Defend

In *Mutlu v. State Farm Fire and Casualty Co.*,[34] the court held that an insurer's duty to defend did not arise for a claim alleging loss of use of tangible property unaccompanied by physical damage or destruction to the property.[35] The policy defined "property damage" solely as "physical damage to or destruction of tangible property, including loss of use."[36] The plaintiff had initially filed suit against a condominium association. The association filed a counterclaim against the plaintiff alleging that the plaintiff always ran his hot water. State Farm refused to defend the plaintiff on the association's counterclaim. The plaintiff filed suit against his insurer for denying coverage under a condominium unit owner's policy. The plaintiff argued a duty to defend existed under the policy.[37]

The court stated that "'property suffers a physical injury when the property is altered in appearance, shape, color or in other material

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31. *Id.* at 158, 785 N.E.2d at 11.
32. *Id.* at 159, 785 N.E.2d at 12.
33. *Id.* at 163, 785 N.E.2d at 14.
34. 337 Ill. App. 3d 420, 785 N.E.2d 951 (1st Dist. 2003).
35. *Id.* at 431, 785 N.E.2d at 960.
36. *Id.* at 422, 785 N.E.2d at 954.
37. *Id.* at 424–25, 785 N.E.2d at 955.

dimension.'"[38] The plaintiff argued that continuously running the hot water altered the material dimensions of the water supply, causing property damage. Finding the water, and not the water supply, constituted the tangible property, the court rejected the plaintiff's argument.[39]

The plaintiff also argued the insurer had a duty to defend, since the counterclaim alleged the loss of use of hot water.[40] However, the insurer argued that under the policy's definition of "property damage," there must be "physical injury" to the tangible property before the loss of use is covered. After analyzing cases from other jurisdictions, the court found no duty to defend existed absent an allegation that the loss of use of tangible property was accompanied by physical damage or destruction. To hold otherwise resulted in "property damage" being defined in the policy as "'physical injury to . . . tangible property, including non-physical injury.'"[41] The court refused to apply this contradictory definition and held that "property damage" in the policy is to be given its ordinary meaning and "there can be no coverage for the loss of use of tangible property unaccompanied by physical damage or destruction."[42]

B. ESTOPPEL

In *Mitchell v. State Farm Fire & Casualty Co.*,[43] the court held that an insurer may be estopped from denying coverage for a loss caused by a fire after the expiration of the policy's one-year limitations period when the insurer indicated to the insured that the insurer may agree to reconsider coverage.[44] The plaintiffs sought coverage under a policy issued by the defendant for a November 11, 1999 fire which destroyed their home. The defendant moved to dismiss the claim on the ground that the suit was barred by the policy's one-year limitation period. The policy provided that

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38. Traveler's Ins. Co. v. Eljer Mfg., Inc., 197 Ill. 2d 278, 312, 757 N.E.2d 481, 502 (2001), *quoted in Mutlu*, 337 Ill. App. 3d at 426, 785 N.E.2d at 956 (internal quotations omitted).
39. *Mutlu*, 337 Ill. App. 3d at 426, 785 N.E.2d at 956.
40. *Id.* at 431, 785 N.E.2d at 960.
41. Ehlers v. Johnson, 476 N.W.2d 291, 293 (Wis. Ct. App. 1991), *quoted in Mutlu*, 337 Ill. App. 3d at 428, 785 N.E.2d at 958.
42. *Mutlu*, 337 Ill. App. 3d at 431, 785 N.E.2d at 960.
43. 343 Ill. App. 3d 281, 796 N.E.2d 617 (4th Dist. 2003).
44. *Id.* at 286, 796 N.E.2d at 621.

> [t]he action [against the insurer] must be started within one year after the date of loss or damage. This one-year period is extended by the number of days between the date that proof of loss was filed and the date the claim is denied in whole or in part.[45]

The appellate court began its analysis by citing Section 143.1 of the Illinois Insurance Code[46], which provides:

> Whenever any policy or contract for insurance . . . contains a provision limiting the period within which the insured may bring suit, the running of such period is tolled from the date proof of loss is filed, in whatever form is required by the policy, until the date the claim is denied in whole or part.[47]

The court noted that the plaintiffs did not file suit until October 21, 2001, nearly two years after the loss, but the court found mitigating factors.[48] One factor was that on November 11, 2000, the plaintiffs filed a sworn proof of loss with their agent. The agent indicated that the insurer was willing to settle the claim. However, rather than settle the claim, the insurer sent a letter explaining that the plaintiffs failed to comply with the policy's terms and restated their May 8, 2000 denial.[49]

The appellate court held that the insurer's May 8, 2000 "denial" letter was a denial, but it was not final because it was obligated to respond to new information.[50] The court stated that the insurer had to respond to the plaintiff's proof of loss. Otherwise insurers could ignore meritorious proofs of loss, pretend to consider the proof, and wait for the one-year limitations period to expire. The court concluded the defendant's actions could have lured the plaintiffs to believe that the insurer was still willing to settle the claim.[51]

The dissent argued that nothing in the majority's opinion excused the plaintiffs' nearly two-year delay in filing suit against the insurer. The dissent also felt the insurer did not lull the plaintiff into a false sense of security, because all of the insurer's correspondence to the

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45. *Id.* at 284–85, 796 N.E.2d at 620.
46. 215 ILL. COMP. STAT. 5/143.1 (2000).
47. *Id.*
48. *Mitchell*, 343 Ill. App. 3d at 283, 796 N.E.2d at 619.
49. *Id.*
50. *Id.* at 285, 796 N.E.2d at 620.
51. *Id.* at 286, 796 N.E.2d at 621.

plaintiff made it clear the plaintiffs' claim had been denied on May 8, 2000.[52]

C. Estoppel for Intentional Conduct

In *American Country Insurance Co. v. Williams*,[53] the court held that a conviction for misdemeanor battery collaterally estops the insured, as well as the underlying tort plaintiff, from re-litigating whether the insured's conduct was intended or expected.[54] The underlying tort plaintiff was hit by a taxi. The insurer issued a policy insuring the taxi company and the driver. The driver was convicted of misdemeanor battery. The tort plaintiff filed suit against both the driver and the taxi company. The insurer undertook the defense of both insureds, reserving all rights to deny coverage with respect to the driver.[55]

The driver filed a declaratory judgment action against the insurer and the court granted the tort plaintiff leave to intervene.[56] On cross-motions for summary judgment, the trial court held the driver's conviction established his acts were intentional and excluded under the policy's intentional acts exclusion. This excluded "[b]odily injury . . . expected or intended from the standpoint of the 'insured.'"[57] The tort plaintiff's motion to reconsider was denied and the tort plaintiff appealed.

The appellate court began its analysis by explaining that the tort plaintiff had standing in the coverage dispute between the insurer and its insured, since under Illinois law underlying claimants have a substantial interest in the resolution of insurance disputes.[58] The court found *American Family Mutual Insurance Co. v. Savickas*,[59] directly on point with respect to the collateral estoppel issue. In *Savickas*, the Illinois Supreme Court held:

> There are three threshold requirements which must be met before the doctrine [of collateral estoppel] may be applied. First, the issue decided in the prior adjudication must be identical with the one

52. *Id.* at 288, 796 N.E.2d at 622.
53. 339 Ill. App. 3d 835, 791 N.E.2d 1268 (1st Dist. 2003).
54. *Id.* at 844, 791 N.E.2d at 1275.
55. *Id.* at 837–38, 791 N.E.2d at 1270.
56. *Id.* at 838, 791 N.E.2d at 1270–71.
57. *Id.* at 839, 791 N.E.2d at 1271.
58. *Id.* at 840–41, 791 N.E.2d at 1272–73.
59. 193 Ill. 2d 378, 739 N.E.2d 445 (2000).

> presented in the suit in question. Second, there must have been a final judgment on the merits in the prior adjudication. Third, the party against whom estoppel is asserted must have been a party or in privity with a party to the prior adjudication.[60]

The court found all three of the *Savickas* requirements were met because: (1) whether the driver "intended or expected" to injure the tort plaintiff was at issue in this civil case and the driver's criminal case; (2) the driver was convicted of misdemeanor battery; and (3) the driver was a party to both suits and the tort plaintiff's rights against the insurer were wholly derivative of the driver's right to indemnity, thereby placing the tort plaintiff in privity with the driver.[61] The court held the driver and the tort plaintiff were collaterally estopped from contesting whether the driver's actions were intended or expected.

The court also noted that a conflict could have existed with agency issues involving the driver and the taxi company.[62] The court explained that for purposes of liability, it would be in the driver's best interest to have been found to be an agent. However, it would be in the taxi company's best interest to establish the exact opposite. The conflicts issue presented questions of material fact and the court remanded the case with explicit instructions to allow the tort plaintiff to assert the driver's conflict of interest claim. This would attempt to estop the insurer from denying coverage on the intentional acts exclusion.[63]

D. Arbitration, Mediation and Alternative Dispute Resolution

In *Stratford West Homeowners Association v. Country Mutual Insurance Co.*,[64] the court held that an arbitration clause within an insurance policy is not binding and does not waive the right to file suit unless it is clear and unambiguous.[65] A Homeowners Association filed an insurance claim with Country Mutual for damage from a hail storm. The parties submitted a dispute over the evaluation of the claim to arbitration as provided in the policy. The arbitration clause stated that the two parties would each select an appraiser who would then select an impartial umpire. "A written agreement signed by any two of these

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60. *Id.* at 387, 739 N.E.2d at 451.
61. *Williams*, 339 Ill. App. 3d at 843–44, 791 N.E.2d at 1274–75.
62. *Id.* at 845, 791 N.E.2d at 1276.
63. *Id.* at 847, 791 N.E.2d at 1278.
64. 338 Ill. App. 3d 288, 788 N.E.2d 342 (3d Dist. 2003).
65. *Id.* at 291, 788 N.E.2d at 343–44.

three will set the amount of loss."[66] The umpire determined the loss. The Homeowners Association disagreed with the evaluation and filed a complaint against Country Mutual. Country Mutual claimed that the appraisal process was a binding process.

The court in *DeGroot v. Farmers Mutual Hale Insurance Co. of Iowa*,[67] had held that a decision by an appraiser was not binding on the parties because the policy did not clearly indicate that the insured was giving up the right to file suit.[68] The provision in the *Stratford West* case was an arbitration clause governed by the Uniform Arbitration Act.[69] The Act states that "[a] written agreement to submit [an issue] to arbitration . . . is valid, enforceable and irrevocable."[70] However, non-binding arbitration does not exist in Illinois and neither the Act nor Illinois case law mandates that all arbitration must be binding. Any waiver of the right to file suit must be clear and unambiguous. Therefore, the appraisal in the present case did "not operate as a final and binding resolution of the party's dispute" and did "not foreclose either party from maintaining an action in a court of law."[71]

66. *Id.* at 290, 788 N.E.2d at 343.
67. 267 Ill. App. 3d 723, 643 N.E.2d 875 (3d Dist. 1994).
68. *Id.* at 725, 643 N.E.2d at 876.
69. *Stratford West*, 338 Ill. App. 3d at 291, 788 N.E.2d at 343.
70. 710 ILL. COMP. STAT. 5/1 (2003).
71. *Stratford West*, 338 Ill. App. 3d at 291, 788 N.E.2d at 344.

III. COMMERCIAL GENERAL LIABILITY (CGL) INSURANCE

A. Trigger, Tender of Defense and Duty to Defend

In *American National Fire Insurance Co. v. National Union Fire Insurance Co. of Pittsburgh, PA*,[72] the court held that an insured can lose the right to elect a targeted tender due to a delay of three years.[73] Camosy, Inc. ("Camosy") was the general contractor on a construction project. Camosy entered into a contract with a subcontractor which required the subcontractor to procure and maintain insurance coverage listing Camosy as an additional insured. The subcontractor obtained the insurance from National Union Fire Insurance Company of Pittsburgh, PA ("National Union"). The subcontractor in turn sub-contracted part of the project to Area Erectors, Inc. who was insured with American National Fire Ins. Co. ("American National"). Camosy and the subcontractor qualified as additional insureds under the American National policy.[74]

During the construction project, an employee of Area Erectors, Inc. was injured on the job site. The employee filed suit against the general contractor alleging that he was injured as a result of Camosy's violation of the Structural Work Act[75] and Camosy's negligence. Various tenders were made pursuant to the decision in *Institute of London Underwriters v. Hartford Fire Insurance Co*.[76] Camosy tendered to the sub-subcontractor's insurer, American National, but did not tender directly to the subcontractor's insurer, National Union.[77]

Camosy filed a declaratory judgment action against the subcontractor and its insurer, National Union, seeking a determination that National Union owed a duty to defend and indemnify Camosy.[78] The sub-subcontractor's insurer, American National, settled the underlying litigation. American National filed an amended complaint on behalf of itself and as the subrogee of Camosy. The complaint alleged that National Union owed a duty to defend and indemnify

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72. 343 Ill. App. 3d 93, 796 N.E.2d 1133 (1st Dist. 2003).
73. *Id.* at 104–05, 796 N.E.2d at 1142–43.
74. *Id.* at 95, 796 N.E.2d at 1135.
75. 740 ILL. COMP. STAT. 150/0.01 – 150/9 (1994) (repealed).
76. 234 Ill. App. 3d 70, 599 N.E.2d 1311 (1st Dist. 1992) (allowing an insured to target one of several potential insurers for its defense and indemnification).
77. *Am. Nat'l*, 343 Ill. App. 3d at 96, 796 N.E.2d at 1135.
78. *Id.*, 796 N.E.2d at 1135–36.

Camosy, or alternatively, that American National had a right to recover based on equitable contribution. Summary judgment motions were filed. The trial court found that Camosy tendered its defense and indemnification to the subcontractor's insurer, American National. However, Camosy did not make a direct tender to National Union before filing the declaratory judgment action.[79]

On appeal, the court held that pursuant to *Institute of London*, Camosy and the subcontractor both held the right to select which insurer was to defend and indemnify the insured.[80] Both held the right to tender the defense to either their primary insurer or the secondary insurer. Camosy had the right to select its own insurer, National Union, or American National to defend and indemnify it in the underlying suit because Camosy was an additional insured under both companies' policies. The subcontractor did not have the right to interfere with the selection. Also, the subcontractor was not National Union's agent. Therefore, it was Camosy's responsibility to tender its defense directly to the insurer it wished to target. National Union did not receive any notice of the suit until Camosy filed a declaratory judgment action. Due to the late notice, Camosy was precluded from electing a targeted tender to National Union for its defense.[81]

The National Union policy contained a notice provision requiring that any insured must "immediately send us copies of any demands, notices, summonses or legal papers received in connection with the claim or 'suit.'"[82] Camosy's failure to immediately send copies of the demands or legal papers it received in connection with the underlying suit was a violation of the notice provision. Pursuant to *Northern Insurance Co. of New York v. City of Chicago*,[83] Camosy's delay in providing notice of the suit relieved National Union of its obligation to provide a defense or indemnification for the underlying suit.[84] Justice Quinn's concurrence criticized the insured's right to use a targeted tender.[85]

American National may signal the beginning of restrictions on the targeted tender rule. The court held that the targeted tender rule still

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79. *Id.*, 796 N.E.2d at 1135.
80. *Id.* at 100–01, 796 N.E.2d at 1139.
81. *Id.* at 101, 796 N.E.2d at 1140.
82. *Id.* at 102, 796 N.E.2d at 1141.
83. 325 Ill. App. 3d 1086, 759 N.E.2d 144 (1st Dist. 2001).
84. *Am. Nat'l*, 343 Ill. App. 3d at 105, 796 N.E.2d at 1143.
85. *Id.* at 106–07, 796 N.E.2d at 1144.

exists, but it required the additional insured to satisfy a policy condition in order to obtain coverage.[86]

B. Coverage for Employer Liability

In *West Bend Mutual Insurance Co. v. Mulligan Masonry Co. Inc.*,[87] the court held there may be potential coverage under an employer's Commercial General Liability ("CGL") policy for a general contractor's allegations against the employer.[88] The general contractor sought indemnification and contribution for injuries to an employee. This potential coverage may arise despite the existence of an exclusion for bodily injury to an employee. Mulligan Masonry Co., Inc. ("Mulligan") was the named insured under a CGL policy issued by West Bend. Mulligan was also insured under a worker's compensation and employer's liability policy issued by Virginia Surety Co. R.C. Wegman Construction Co. ("Wegman") was a general contractor on a construction project. Wegman hired Mulligan to do masonry work. The Wegman-Mulligan contract contained an indemnification clause in favor of Wegman. The policy issued by West Bend only provided coverage for liability arising out of negligence by Mulligan.[89]

Donald Weeks, a Mulligan employee, was injured by falling brick while working on a scaffold.[90] Weeks brought a negligence action against the general contractor, Wegman. Wegman brought a third-party complaint against Mulligan. Mulligan tendered the third-party complaint to its insurer, West Bend. West Bend denied coverage and filed a complaint for declaratory judgment. The third-party complaint was amended several times and in its final form sought contribution. The complaint alleged that Mulligan was negligent and claimed breach of contract alleging "liability assumed by contract" based upon the indemnification clause.[91]

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86. *Id.* at 104, 796 N.E.2d at 1142.
87. 337 Ill. App. 3d 698, 786 N.E.2d 1078 (2d Dist. 2003).
88. *Id.* at 707–08, 786 N.E.2d at 1085–86.
89. *Id.* at 700, 786 N.E.2d at 1080.
90. *Id.*
91. *Id.* at 701, 786 N.E.2d at 1080.

West Bend denied coverage based in part upon the "contractual liability" exclusion.[92] The exclusion covered liability that the insured assumed in the contract. Mulligan argued that the exclusion did not apply because of an exception for liability assumed by the insured under an "insured contract."[93] The policy defined an "insured contract" as follows:

> That part of any other contract or agreement pertaining to your business . . . under which [the insured] assumes the tort liability of another party to pay for 'bodily injury' or 'property damage' to a third person or organization. Tort liability means a liability that would be imposed by law in the absence of any contract or agreement.[94]

The Wegman-Mulligan contract contained an indemnification clause similar to clauses found in construction contracts.[95] Mulligan was required to indemnify and hold harmless Wegman and its agents from claims arising out of the performance of Mulligan's work. However, the claim must have involved bodily injury or property damage caused by negligent acts of Mulligan or anyone for whose acts Mulligan may be liable. It did not matter if the negligence was partially caused by Wegman. The indemnification obligation did not contain any limit on the amount or type of damages payable under the Illinois Workers' Compensation Act.[96] The trial court found that West Bend had to defend Mulligan for the claims in the second amended third-party complaint.[97]

The court of appeals found that the decision in *Michael Nicholas, Inc. v. Royal Insurance Co. of America*[98] controlled.[99] In *Michael Nicholas*, the court held that as a joint tortfeasor, a general contractor could be held jointly and severally liable for all of the employee's damages.[100] This liability was the general contractor's "tort liability" even though a portion of that liability may have been attributable to the subcontractor's negligence.[101] In Illinois, the subcontractor's liability arising from an injury to its employee typically would be limited to the

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92. *Id.*, 786 N.E.2d at 1081.
93. *Id.*
94. *Id.* at 703, 786 N.E.2d at 1082 (alteration in original).
95. *Id.* at 705, 786 N.E.2d at 1084.
96. *Id.* at 701, 706, 786 N.E.2d at 1080, 1084–85.
97. *Id.* at 701, 786 N.E.2d at 1081.
98. 321 Ill. App. 3d 909, 748 N.E.2d 786 (2d Dist. 2001).
99. *Mulligan*, 337 Ill. App. 3d at 705, 786 N.E.2d at 1084.
100. *Michael Nicholas*, 321 Ill. App. 3d at 914, 748 N.E.2d at 791.
101. *Id.*, 748 N.E.2d at 790–91.

amount of its worker's compensation liability pursuant to the decision in *Kotecki v. Cyclops Welding Corp.*[102] However, by agreeing to indemnify the general contractor, the subcontractor waived its "*Kotecki* cap" and was potentially liable for the entire amount that the general contractor would be required to pay the subcontractor's employee.[103] Under the indemnity agreement, the subcontractor agreed to assume the tort liability of the general contractor.

The *Mulligan* court saw no reason to depart from the decision in *Michael Nicholas*.[104] If the employer's *Kotecki* cap is less than the damages attributable to its negligence, then, by joint and several liability, the general contractor can be held liable for the difference.[105] Relying on the indemnification clause, Wegman attempted to recover this difference. If Mulligan waived its *Kotecki* cap, then it assumed liability that otherwise would have been imposed against Wegman. West Bend also argued that the decision in *Michael Nicholas* interfered with the "dovetailing" coverage provided under the CGL and the Workers' Compensation/Employer's Liability policies. The court disagreed and held that an employee exclusion within the CGL policy contained the "insured contract" exception. This exception contemplated that some losses from an injury to an employee of the insured would be covered. To the extent that the general contractor sought contribution beyond the employer's *Kotecki* cap, there was a potential for coverage and West Bend owed Mulligan a defense.[106]

Justice McLaren authored an extensive dissent, opining that the decision in *Michael Nicholas* requires reevaluation.[107] Justice McLaren stated that the analysis contained in *Michael Nicholas* characterized aspects of tort liability that were assumed under the indemnification contract, even though the aspects were preexisting and imposed by operation of law. Justice McLaren further noted that the major deficiency in the *Mulligan* and *Michael Nicholas* decisions are that they ignored the distinction between matters imposed by law and matters assumed by the insured through the indemnification contract. *Michael Nicholas* failed to address the paradox that one cannot assume a

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102. 146 Ill. 2d 155, 585 N.E.2d 1023 (1991).
103. *Michael Nicholas*, 321 Ill. App. 3d at 914, 748 N.E.2d at 791.
104. *Mulligan*, 337 Ill. App. 3d at 705, 786 N.E.2d at 1084 (*Michael Nicholas* stated that a party's tort liability is not necessarily based on its own negligence.).
105. *Id.* at 706, 786 N.E.2d at 1084–85.
106. *Id.* at 708, 748 N.E.2d at 1086.
107. *Id.*

preexisting duty. Justice McLaren agreed with West Bend's position that if an insured waived the *Kotecki* cap, it waived an affirmative defense and did not assume tort liability that did not already exist.[108]

When a plaintiff's employer produces a tender under a CGL policy, the first reaction is to consider denying the tender based upon an exclusion for bodily injury to an employee. Yet *Mulligan* points out a way the insured may claim potential coverage and also a duty to defend, or if the insured has waived a defense to tort liability or assumed a legal obligation under an "insured contract," there may be coverage and a duty to defend the insured.[109]

108. *Id.* at 711, 748 N.E.2d at 1088–89.
109. *Id.* at 708, 748 N.E.2d at 1086.

C. Allegations and Medical Trust Fund Not "Bodily Injury"

In *HPF, L.L.C. v. General Star Indemnity Co.*,[110] in the context of an insurer's duty to defend, the court held that allegations of misrepresentation and the creation of a medical trust fund to monitor individuals was not "bodily injury" under a CGL policy.[111] The plaintiff filed a declaratory judgment action against its insurer seeking a declaration of the parties' rights and duties under a CGL policy. The plaintiff had been sued in the underlying litigation for various violations regarding the unlawful labeling, distribution, and promotion of an herbal supplement. The underlying suit sought injunctive relief and the creation of a medical trust fund to monitor all people who used the plaintiff's product. The plaintiff tendered its defense of the underlying complaint to the insurer. The insurer denied that it had a duty to defend. The insurer claimed that the underlying complaint did not seek damages for "bodily injury."[112] However, the trial court disagreed and held the establishment of a medical monitoring fund was sufficient to allege "bodily injury." Summary judgment was granted for the plaintiff. The insurer appealed.[113]

After examining the allegations of the complaint, the appellate court held that none of the allegations alleged "bodily injury."[114] The court defined "bodily injury" as bodily injury, sickness, or disease. The court added that the establishment of a medical monitoring fund constituted a remedy and was not sufficient to allege "bodily injury." The court held that the insurer did not have a duty to defend the plaintiff in the underlying action.[115]

D. A Duty to Defend All Potentially Covered Claims

In *Illinois Emcasco Insurance Co. v. Northwestern National Casualty Co.*,[116] the court held that in order to deny coverage, all allegations in

110. 338 Ill. App. 3d 912, 788 N.E.2d 753 (1st Dist. 2003).
111. *Id.* at 918, 788 N.E.2d at 758.
112. *Id.* at 915, 788 N.E.2d at 755.
113. *Id.*
114. *Id.* at 917, 788 N.E.2d at 757.
115. *Id.* at 918, 788 N.E.2d at 758.
116. 337 Ill. App. 3d 356, 785 N.E.2d 905 (1st Dist. 2003).

a complaint must preclude coverage under a policy.[117] If a potential for coverage exists for any allegation, the insurer is required to defend under reservations of rights, or file a declaratory judgment action. Northwestern National Casualty Company ("Northwestern") issued a CGL policy to a subcontractor. The Northwestern policy added the general contractor as an additional insured.[118] However, the policy limited coverage to liability imputed to the general contractor for the subcontractor's acts. The general contractor was insured under his own CGL policy issued by Illinois Emcasco Insurance Company ("Emcasco"). When the general contractor was served with a suit by an injured worker, the general contractor tendered it to the subcontractor's insurer, Northwestern. Northwestern denied the tender. The tender was picked up by the general contractor's insurer, Emcasco.[119]

Emcasco sued Northwestern and alleged that Northwestern breached its insurance contract because it refused to defend the general contractor.[120] The trial court acknowledged that the general contractor "might be liable in the underlying suit based on imputed liability for [the subcontractor's] conduct."[121] On its face, the complaint did not sufficiently suggest that the general contractor's liability would fall under the coverage of Northwestern's policy. The trial court granted summary judgment for Northwestern.

The court of appeals reviewed the additional insured endorsement which provided that the policy covered the general contractor "'only with respect to liability imputed to [the general contractor] as the result of negligent acts or omissions of [subcontractor].'"[122] The injured worker filed suit against both the general contractor and subcontractor and alleged that the subcontractor worked on the project. The plaintiff alleged that both the general contractor and subcontractor "'through [their] duly authorized agents'" violated a duty to keep the work site reasonably safe.[123] However, the plaintiff in the underlying action made no allegations about the relationship between the general contractor and the subcontractor. On its face, the complaint did not

117. *Id.* at 361, 785 N.E.2d at 910.
118. *Id.* at 357, 785 N.E.2d at 906.
119. *Id.* at 357–58, 785 N.E.2d at 906–07.
120. *Id.* at 358, 785 N.E.2d at 907.
121. *Id.*
122. *Id.*
123. *Id.* (alteration in original).

establish if the subcontractor was one of the general contractor's duly authorized agents.[124]

While relying on *United States Fidelity & Guaranty Co. v. Wilkin Insulation Co.*,[125] the court of appeals stated that "the insurer had a duty to defend because the policy's provisions 'do not preclude potential coverage under the policy.'"[126] The court restated an insurer's duty as follows:

> This application merely rephrased the test stated previously: an insurer must defend if the insurance contract might possibly cover the alleged source of liability. The insurer may refuse to defend only if the insurance contract cannot possibly cover the liability arising from the facts alleged, and the contract cannot possibly cover that liability only when the terms of the policy clearly preclude the possibility of coverage.[127]

The court of appeals distinguished *American Country Insurance Co. v. Cline*.[128] The *Cline* court placed the burden upon the drafter of the complaint to raise the possibility of coverage.[129] The court of appeals in *Illinois Emcasco* did not agree with *Cline*. The court found that the insurer has a duty to defend "unless the allegations of the underlying complaint demonstrate that the plaintiff in the underlying suit will not be able to prove the insured liable, under any theory supported by the complaint, without also proving facts that show the loss falls outside the coverage of the insurance policy."[130] An insurer may refuse to defend only if the allegations of the underlying complaint preclude any possibility of coverage.

This decision clearly states that the burden is upon the insurer to review the complaint and find the allegations which preclude coverage under a policy. If a complaint leaves open the possibility of potential coverage, a duty to defend will arise.[131]

Northwestern argued that the liability of the subcontractor would not be imputed to the general contractor because of the subcontractor's

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124. *Id.*
125. 144 Ill. 2d 64, 758 N.E.2d 926 (1991).
126. *Illinois Emcasco*, 337 Ill. App. 3d at 359, 785 N.E.2d at 908 (quoting *Wilkin*, 144 Ill. 2d at 81, 758 N.E.2d at 934).
127. *Id.* at 359–60, 785 N.E.2d at 908.
128. 309 Ill. App. 3d 501, 722 N.E.2d 755 (1st Dist. 1999).
129. *Id.* at 515, 722 N.E.2d at 766.
130. *Illinois Emcasco*, 337 Ill. App. 3d at 361, 785 N.E.2d at 909.
131. *See id.* at 362, 785 N.E.2d at 910.

status as an independent contractor.[132] The court found that the face of the complaint did not establish these facts. Therefore, an insurer can rely upon such extraneous evidence only if they bring a declaratory judgment action. "[A]n insurer that simply refuses to defend may lose the right to present such evidence."[133] Northwestern failed to file a declaratory judgment action or defend the insured under reservation of rights. On remand, Northwestern was estopped from raising any policy defenses to coverage[134] as required in *Employers Insurance of Wausau v. Ehlco Liquidating Trust*.[135]

Prior to the decision in *Illinois Emcasco v. Northwestern*, courts had varied in the degree of burden placed upon an insurer to demonstrate that a complaint did not raise the possibility of coverage. With this decision, the insurer must specifically locate allegations within a complaint that remove the possibility of coverage under a policy. If a complaint leaves open the possibility of coverage, a duty to defend the insured may arise.

E. Excess Verses Primary Coverage, Horizontal Exhaustion is Required

In *Travelers Indemnity Co., v. American Casualty Co.*,[136] the court held that an excess policy is not required to contribute towards a settlement in the underlying action on a *pro rata* basis with three primary policies.[137] Travelers Indemnity Company ("Travelers") issued a primary CGL policy to a hospital. The policy covered any employee for acts committed within the scope of their employment. Travelers also issued a comprehensive excess policy to the hospital. The excess policy contained several endorsements. One endorsement listed the Travelers primary policy as an underlying policy and deemed it as a part of the self-insurance plan and retention. The Travelers excess policy also contained an "other insurance" provision. This provision stated that,

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132. *Id.* at 361, 785 N.E.2d at 910.
133. *Id.*
134. *Id.* at 362, 785 N.E.2d at 910.
135. 186 Ill. 2d 127, 708 N.E.2d 1122 (1999).
136. 337 Ill. App. 3d 435, 786 N.E.2d 582 (1st Dist. 2003).
137. *Id.* at 436, 786 N.E.2d at 583.

> this insurance is excess over any other insurance available to the [i]nsured (including a policy purchased by any additional insured hereunder). Amounts collectible under a self-insured trust plan or other self-insured plan shall be deemed other insurance. This clause does not apply to excess insurance written specifically to be in excess of this policy.[138]

American Casualty Company ("American") issued professional liability insurance to three nurses.[139] Each American policy contained an "other insurance" clause. This clause stated "[i]f you have other insurance which applies to injury or damages resulting from your professional services, the other insurance must pay first. It is the intent of this policy to apply to the amount of loss which is more than the limit of other insurance."[140] In the underlying medical malpractice suit, the parties settled for approximately $4.5 million. Travelers filed a declaratory judgment action against American seeking a priority of coverage regarding the policies. The circuit court stated that the Travelers excess policy and the American policies contribute *pro rata* towards the settlement. Travelers appealed.[141]

The appellate court began by noting that the first issue in priority of coverage determination is whether the policies are on the same level.[142] This is relevant because usually primary and excess policies cover different risks and attach at different stages. After reviewing the Travelers excess policy, the court held that Travelers' policy met all the criteria for an umbrella excess policy.[143] The court noted two additional factors that precluded treating the Travelers excess policy and the American policies as being on the "same level."[144] First, there was no language that limited the Travelers excess policy to the Travelers primary policy. Second, the express language of the "other insurance" clause in the Travelers excess policy did not contemplate a *pro rata* contribution with other applicable insurance. Based on the facts, the court held the Travelers excess policy should be required to contribute only after the limits of the American policies were exhausted.[145]

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138. *Id.*
139. *Id.* at 436–37, 786 N.E.2d at 584.
140. *Id.* at 437, 786 N.E.2d at 584.
141. *Id.* at 439, 786 N.E.2d at 585.
142. *Id.*, 786 N.E.2d at 586.
143. *Id.* at 441, 786 N.E.2d at 587 (policy was above the limits of all other contracts and its premiums were smaller than the Travelers primary policy).
144. *Id.* at 443–44, 786 N.E.2d at 589–90.
145. *Id.* at 444, 786 N.E.2d at 590.

F. Allocation, Number of Occurrences

In *Whitman Corp. v. Commercial Union Insurance Co.*,[146] the court held that there was no coverage under a CGL policy for a breach of an indemnification agreement that contemplated reimbursement for environmental clean-up expenses.[147] Pneumo Abex ("Abex") sold assets to B.F. Goodrich Company ("BFG"). The assets included facilities at four separate locations. The Asset Purchase Agreement included indemnification provisions regarding environmental liability. The parties agreed to indemnify each other for certain environmental remediation expenses. Three years after the sale, Abex filed a complaint against BFG and alleged a violation of the indemnification terms.[148] BFG filed a counterclaim against Abex and alleged a breach of contract and sought indemnification for the environmental expenses. Abex filed a third amended complaint alleging that several insurance companies were under a duty to defend Abex for the BFG counterclaim. The trial court granted the insurer's motion to dismiss. The trial court found that the breach of the Asset Purchase Agreement did not amount to property damage caused by an "occurrence" as defined by the policies.[149] The insured appealed and the court of appeals reviewed whether the BFG counterclaim satisfied the definition of property damage caused by an "occurrence."[150]

The insurers provided both a general liability and umbrella coverage under forty-six separate policies in effect from 1960 through 1985.[151] A similar definition for "occurrence" was in the policies. They defined "occurrence" as "'an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured.'"[152] Under the Asset Purchase Agreement between Abex and BFG, "environmental liabilities" included "[l]osses or expenses incurred for response and compliance measures undertaken as a result

146. 335 Ill. App. 3d 859, 782 N.E.2d 297 (1st Dist. 2002).
147. *Id.* at 872–73, 874–75, 782 N.E.2d at 308–09.
148. *Id.* at 861, 782 N.E.2d at 298–99.
149. *Id.*, 782 N.E.2d at 299.
150. *Id.*
151. *Id.*
152. *Id.* at 861–62, 782 N.E.2d at 299.

of Environmental Laws and relating to the ownership of the Purchased Assets or operation of the Purchased Business."[153]

The court of appeals had to determine whether there was coverage. The allegations in the counterclaim stated that the "'counterclaims arise out of the transactions or occurrences, relating to the parties' actions and obligations to each other under the Agreement with respect to the covered environmental matters.'" The remaining allegations addressed the Agreement and the breach of the Agreement. The court of appeals found that these allegations did not allege "'an accident, including continuous or repeated exposure to conditions, which [resulted] in bodily injury or property damage neither expected nor intended from the standpoint of the insured.'"[154] The counterclaim sought indemnification for expenses incurred while remediating environmental contamination "contemplated by the parties in the asset purchase agreement."[155] The expenses could not have arisen from an unforeseen occurrence because they were contemplated by the parties. The allegations in the counterclaim against BFG concerned the failure to comply with an Asset Purchase Agreement indemnification provision. The relief sought was not for "physical injury to tangible property" but instead money owed as a result of a breach of an indemnification agreement.[156]

The court reviewed *Indiana Insurance Co. v. Hydra Corp.*[157] In *Hydra*, a construction contract provided for arbitration in the event of a dispute.[158] The plaintiff in *Hydra* filed a complaint against the subcontractor seeking enforcement of an arbitration award to repair damage to concrete.[159] The *Hydra* court found that the complaint did not allege damages from an unforeseen occurrence as required by the policies.[160] The breach of contract was not covered under the policies issued to *Hydra*.[161]

153. *Id.* at 862, 782 N.E.2d at 300.
154. *Id.* at 869, 782 N.E.2d at 305 (alteration in original).
155. *Id.*
156. *Id.* at 871, 782 N.E.2d at 307.
157. 245 Ill. App. 3d 926, 615 N.E.2d 70 (2d Dist. 1993).
158. *Id.* at 927–28, 615 N.E.2d at 72.
159. *Id.* at 928, 615 N.E.2d at 72.
160. *Id.* at 930, 615 N.E.2d at 73.
161. *Id.* at 932, 615 N.E.2d at 75.

As in *Hydra*, the environmental liabilities referred to in BFG's counterclaim arose from the Asset Purchase Agreement.[162] Therefore, the damage was not property damage or the result of an "occurrence," but it "[was] the result of a breach of the Asset Purchase Agreement."[163]

G. "Bodily Injury" Not Ambiguous in a CGL Policy

In *Scottsdale Insurance Co. v. Robertson*,[164] the court held that a CGL policy's definition of "bodily injury" did not make a $1 million per occurrence limitation ambiguous.[165] Several individuals died and others were injured when carbon monoxide poisoned their apartments. The claimants' estates sued the owner of the building. The owner was insured under a CGL policy issued by the plaintiff. The insurer acknowledged liability and offered to settle the suit for $1 million, the policy's per occurrence limit. The claimants rejected the offer and demanded $2 million. They claimed that $2 million was due under the policy because the bodily injury provisions were ambiguous.[166]

The court of appeals rejected the argument that the definition of "bodily injury" made the policy's per occurrence limit ambiguous. "Bodily injury" referred to the "sickness . . . [of] a person."[167] The claimants asserted that when read in conjunction with the per occurrence limit, "bodily injury" implied that each person who was injured has their own per occurrence limits. The claimants' argument ignored existing Illinois law. The applicable law states that the number of occurrences is determined by the number of causes, not the number of effects. The court concluded that the claimants' argument resulted in an unreasonable reading of the policy.[168]

H. Policy Terms and Conditions: A "Suit" is Not Always Required

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162. Whitman Corp. v. Commercial Union Ins. Co., 335 Ill. App. 3d 859, 875, 782 N.E.2d 297, 309 (1st Dist. 2002).
163. *Id.*
164. 338 Ill. App. 3d 397, 788 N.E.2d 279 (1st Dist. 2003).
165. *Id.* at 398, 788 N.E.2d at 280.
166. *Id.* at 399, 788 N.E.2d at 280.
167. *Id.* at 404, 788 N.E.2d at 284.
168. *Id.* at 405–06, 788 N.E.2d at 286.

In *Central Illinois Light Co. v. The Home Insurance Co.*,[169] the court held that filing suit was not a condition precedent to indemnity with an excess CGL policy when the term "suit" was not mentioned in the policy's insuring agreement.[170] This litigation arose out of environmental liabilities at three manufactured gas plants ("MGPs"). The insurers issued several high level excess policies. The insured agreed with the Illinois Environmental Protection Agency ("IEPA") to be responsible for investigation and remediation at the MGPs. The insured incurred substantial costs at several of the MGPs and sought coverage under the excess policies. The insurers moved for summary judgment and alleged that the insured was not legally obligated to pay for the costs of remediation in the absence of a "suit." The trial court granted the motions for summary judgment.[171]

The court looked at the plain language of the polices.[172] The policy language stated that the insured would be indemnified for liability imposed by law or assumed under contract or agreement. The insurers cited to *Outboard Marine Corp. v. Liberty Mutual Insurance Co.*,[173] for the proposition that a "suit" is a condition precedent to indemnity under the excess policies.[174] However, there was no "suit" requirement in the policies' insuring agreements. The court explained that the proper analysis was whether the insured faced legal liability for the environmental remediation.[175]

After a discussion of liability under the "Comprehensive [sic] Response Compensation and Liability Act of 1980"[176] ("CERCLA"), and strict liability under the Illinois Enviromental Protection Act,[177] the court held that the cleanup was not voluntary.[178] The insured was legally obligated to comply with environmental regulations under state and federal law. The court held the insured was "legally obligated" to remediate the MGPs and entitled to indemnity under the excess policies.[179] The court rejected the rationale of the First Appellate

169. 342 Ill. App. 3d 940, 795 N.E.2d 412 (3d Dist. 2003).
170. *Id.* at 953, 795 N.E.2d at 424.
171. *Id.* at 948–49, 795 N.E.2d at 420.
172. *Id.* at 953, 795 N.E.2d at 424.
173. 154 Ill. 2d 90, 607 N.E.2d 1204 (1992).
174. *See id.* at 107–08, 607 N.E.2d at 1212.
175. *Central Illinois Light*, 342 Ill. App. 3d at 954, 795 N.E.2d at 425.
176. 42 U.S.C. §§9601– 9675 (2003).
177. 415 ILL. COMP. STAT. 5/22.2(f) (2003).
178. *Central Illinois Light*, 342 Ill. App. 3d at 955, 795 N.E.2d at 426.
179. *Id.* at 959, 795 N.E.2d at 429.

District. That District has held that a suit was required before an insurer's duty to indemnify began.[180]

I. Policy Exclusions: Intentional Acts Exclusion Does Not Encompass Negligent Hiring

In *American Family Mutual Insurance Co. v. Enright*,[181] the court held that negligent hiring under a general liability policy may be covered despite the exclusion of an intentional act committed by an employee.[182] Northshore Ultrasound, Inc. ("Northshore") was insured under a business owners' policy issued by American Family Insurance Co. ("American"). This policy provided general liability coverage for business practices or activities of the firm. Ace American Insurance Company ("Ace") issued a professional malpractice policy to Northshore. Northshore employed a licensed ultrasound technician at one of its facilities. During an ultrasound examination of a minor, the technician allegedly sexually assaulted the patient. The technician plead guilty to aggravated criminal sexual abuse. A complaint was filed against Northshore alleging negligent hiring and battery. [183]

Northshore tendered its defense to American and Ace.[184] Both insurers denied coverage and filed a declaratory judgment action against Northshore and the employee. American argued that its policy excluded coverage of bodily injury for intentional injuries and injuries arising out of sexual molestation. The policy also contained a professional liability exclusion that excluded bodily injury arising out of any "rendering of or the failure to render professional services by any insured . . ."[185] American argued that the act of hiring the employee was intentional and not an "occurrence" as defined by the policy.

The court noted that under Illinois law, negligent hiring is a tort separate from the employee's intentional conduct.[186] To determine whether an occurrence is an accident, Illinois courts have focused on

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180. *See* Zurich Ins. Co. v. Carus Corp., 293 Ill. App. 3d 906, 689 N.E.2d 130 (1st Dist. 1997); N. Ill. Gas Co. v. Home Ins. Co., 334 Ill. App. 3d 38, 777 N.E.2d 417 (1st Dist. 2002).
181. 334 Ill. App. 3d 1026, 781 N.E.2d 394 (2d Dist. 2002).
182. *Id.* at 1033–34, 781 N.E.2d at 401.
183. *Id.* at 1029, 781 N.E.2d at 396.
184. *Id.*, 781 N.E.2d at 397.
185. *Id.* at 1030, 781 N.E.2d at 398.
186. *Id.* at 1031, 781 N.E.2d at 398.

whether the injury is expected. In the complaint there were no allegations that Northshore intended to injure the minor plaintiff. Coverage would not be invoked for an employer because the policy did not cover the employee for their intentional acts. The allegations sought to hold Northshore liable for its own negligent conduct which was a claim within the scope of coverage under the general liability policy. American had a duty to defend and indemnify Northshore.[187]

The court addressed the liability policy issued by Ace.[188] The policy provided coverage for "all amounts up to the limit of liability" and stated "that the insured becomes 'legally obligated to pay as a result of injury or damage.'"[189] "The injury or damage 'must be caused by a medical incident arising out *professional services* by [Northshore] or anyone for whose professional services [Northshore is] legally responsible.'"[190] The allegations were based upon administrative acts that had nothing to do with the Northshore technician's professional training, skill, experience, or knowledge as a sonographer. Other courts have held that allegations of negligence in hiring and supervising an employee are administrative actions that do not fall within a professional services policy.[191] There was no coverage under the professional liability policy because the negligent hiring did not occur in the course of rendering a professional service. As a result, Ace had no duty to defend Northshore for the underlying allegations.[192]

The professional liability policy issued by Ace to Northshore was a malpractice policy covering liability arising from errors or omissions that occurred during the rendering of professional services.[193] While assuming that the employee was to be considered under the policy, the court held that the insured's acts were expected or intended and therefore excluded.

The professional liability policy also contained an exclusion for claims arising out of sexual abuse. The exclusion provided as follows:

> you shall be provided with a defense against any claim or suit which may be brought against you for any such alleged act, provided that the

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187. *Id.* at 1034, 781 N.E.2d at 401 (The court did not discuss the issue regarding premature determination of the indemnification issue.).
188. *Id.*
189. *Id.*
190. *Id.* (emphasis in original).
191. *See* Mork Clinic v. Fireman's Fund Ins. Co., 575 N.W.2d 598 (Minn. Ct. App. 1998).
192. *Enright*, 334 Ill. App. 3d at 1036, 781 N.E.2d at 402.
193. *Id.*, 781 N.E.2d at 403.

> defense shall be limited to the amount of professional coverage. No damages shall be paid for you or on your behalf and no defense or appeal shall be provided when a judgment or final adjudication adverse to you establishes that such act or acts occurred.[194]

Ace argued that the employee pleaded guilty to a criminal charge and therefore no defense was owed to the employee.[195] The court agreed and found that because a judgment adverse to the employee established that the abuse occurred, Ace had no duty to defend or indemnify the employee.

J. Employment Related Practices Exclusion Does Not Apply to All Acts

In *American Alliance Insurance Co. v. 1212 Restaurant Group, L.L.C.*,[196] the court held that defamatory statements made against an employee were covered under a commercial liability policy.[197] The statements were covered despite the existence of an employment-related practices ("ERP") exclusion. The statements were not made in the context of employment and were not sufficiently related to the employment relationship. 1212 Restaurant Group, LLC ("1212") operated a restaurant located in Chicago called The State Room. The restaurant and its managers were insureds under a CGL policy issued by American Alliance. Demetri Alexander was hired under a three-year contract by the restaurant owners to be the Creative Director and Front House Manager. Alexander was injured when a piece of equipment was dropped on Alexander's foot by the one of the owners crushing his toe and foot. When he returned to work, Alexander wore a brace and used crutches. After one-year of employment, Alexander was terminated.[198]

Alexander sued the restaurant and its owners alleging breach of contract, defamation *per se*, and intentional infliction of emotional distress.[199] Alexander alleged that after he returned to work, the owner told him to "lose the shoe."[200] Alexander alleged that during his

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194. *Id.* at 1037, 781 N.E.2d at 403 (italics omitted).
195. *Id.*
196. 342 Ill. App. 3d 500, 794 N.E.2d 892 (1st Dist. 2003).
197. *Id.* at 509, 794 N.E.2d at 900.
198. *Id.* at 502–03, 794 N.E.2d at 895.
199. *Id.* at 503, 794 N.E.2d at 895.
200. *Id.* (meaning not to wear his brace because they did not want a "gimp" at the front of the restaurant).

employment the owner repeatedly called him names including "gimp," "cokehead," "faggot," and "homo," in front of other employees.[201] On the day of his termination, the owner gave Alexander a separation agreement and stated that if Alexander did not sign the agreement the owner would tell people that Alexander was "robbing the joint."[202] In his complaint, Alexander claimed that the owner told people "Alexander had his hand in the till and was robbing 'the joint.'"[203]

Both 1212 and the owners tendered their defense to American Alliance.[204] The American Alliance policy contained the following employment-related practices exclusion:

> B. The following exclusion is added to Paragraph 2., Exclusions of Section I)Coverage B)Personal and Advertising Liability:
> This insurance does not apply to:
> 'Personal and Advertising Injury':
>
> 1. A person arising out any;
> (a) refusal to employ that person;
> (b) termination of that person's employment; or
> (c) employment)related practices, policies, acts or omissions such as coercion, demotion, evolution, reassignment, discipline [sic] defamation, harassment, humiliation, discrimination directed at that person.[205]

Based upon this exclusion, American Alliance denied coverage, refused to provide a defense, and filed a declaratory judgment action against 1212 and the owners.

The court of appeals noted that no Illinois court had yet addressed the ERP exclusion within a CGL policy.[206] Other jurisdictions, including California have interpreted this exclusion. California's interpretation is that if the occurrence was "directly related" to the insured's employment, the exclusion would be applicable. The fact that the events occurred before or after termination do not alone render the ERP exclusion inapplicable.[207] California courts have also found that the ERP exclusion is not ambiguous when it is used in its ordinary

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201. *Id.*
202. *Id.*
203. *Id.*
204. *Id.*
205. *Id.*
206. *Id.* at 506, 794 N.E.2d at 897.
207. Loyola Marymount Univ. v. Hartford Accident & Indem. Co., 219 Cal. App. 3d 1217, 1223, 271 Cal. Rptr. 528, 531 (Cal. Ct. App. 1990).

sense.[208] When the alleged statements are made in the context of employment and are directed at the individual's performance during that employment, they are "related to employment" and therefore excluded pursuant to the ERP exclusion.[209] The Ninth Circuit has supported the analysis that the timing of the statement is not the determining factor.[210] The key factor is whether the statement is related to employment. Defamatory remarks must have been made during the termination or "directly and proximately result[ing] from the termination."[211]

The Illinois appellate court found that regardless of whether the defamation occurred post termination, it was not sufficient to remove it from the reach of the ERP exclusion.[212] The issue was whether "the alleged defamatory statements were made in the context of Alexander's employment and related to his employment performance."[213] The complaint alleged that during and after Alexander's termination, the employers referred to Alexander's sexual activities and stated that he was a "drunk" and a "coke head."[214] The court found that these statements constituted personal insults and lewd comments separate from his employment. The nexus between the defamatory statements and Alexander's employment was missing. The content of the statements was not about Alexander's work performance. Therefore, the defamatory statements did not fall within the ERP exclusion. The ERP exclusion did not exclude coverage and American Alliance was under a duty to defend 1212 and its owners against the Alexander complaint.[215]

In a similar decision, the court in *Waffle House, Inc. v. Travelers Indemnity Co. of Illinois*,[216] held that an ERP exclusion for "'personal injury' *arising out of* any . . . termination of employment . . . coercion, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination, or other employment- related practices, policies,

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208. Frank & Freedus v. Allstate Ins. Co, 45 Cal. App. 4th 461, 471, 52 Cal. Rptr. 2d 678, 684 (Cal. Ct. App. 1996).
209. *Id.* at 471–472, 52 Cal. Rptr. 2d at 684.
210. HS Service, Inc. v. Nationwide Mut. Ins. Co. 109 F.3d 642, 645 (9th Cir. 1997).
211. *Id.* at 647.
212. Am. Alliance Ins. Co. v. 1212 Rest. Group, L.L.C., 342 Ill. App. 3d 500, 509, 794 N.E.2d 892, 900 (1st Dist. 2003).
213. *Id.* at 510, 794 N.E.2d at 900.
214. *Id.*
215. *Id.*, 794 N.E.2d at 901.
216. 114 S.W.3d 601 (Tex. Ct. App. 2003).

acts or omissions" was not ambiguous.[217] The provision did not exclude coverage for defamatory allegations intended to dissuade employees from working for a competitor. The court reviewed the timeframe of the statements, and although two years passed between the termination and the statements, it was the lack of causal connection to the employment that prevented application of the ERP exclusion.[218] The Texas court briefly reviewed and agreed with the California court's decision in *Frank & Freedus v. Allstate Insurance Co.*,[219] requiring a relationship between the statements and the employment in order for the ERP exclusion to apply.[220]

Under a CGL policy containing an ERP exclusion, defamatory statements made regarding an employee's performance and in the context of employment will likely be excluded from coverage.[221] However, comments made outside of the context of employment, or comments that do not relate to the claimant's employment, may be covered under a CGL policy. The question is whether the allegations in a complaint are sufficiently connected to employment to be excluded under the policy. The personal statements and the most derogatory statements[222] may not have a sufficient nexus to the employment to fall within the ERP exclusion. Particular attention should be paid to the nature of the alleged defamatory statements and whether the statements do relate to the employment of the claimant.

K. Exclusions: Use of An Automobile

In *Sears, Roebuck and Co. v. Acceptance Insurance Co.*,[223] the court held that an automobile exclusion in a CGL policy precluded a duty to defend and indemnify the insured in a suit claiming bodily injury caused by the insured's employee.[224] The policy provided an exception for "parking an auto." The plaintiff was injured when a car was being backed out of the maintenance bay at a Sears Automotive Center. Sears sought coverage under a primary CGL policy issued by Acceptance and an excess policy issued by Travelers. Acceptance denied that it

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217. *Id.* at 607 (alteration in original) (internal quotations omitted).
218. *Id.*
219. 45 Cal. App. 4th 461, 52 Cal. Rptr. 2d 678 (Cal. Ct. App. 1996).
220. *Waffle House*, 114 S.W.3d at 610.
221. *See* Am. Alliance Ins. Co. v. 1212 Rest. Group, L.L.C., 342 Ill. App. 3d 500, 509, 794 N.E.2d 892, 900 (1st Dist. 2003).
222. Such as statements related to promiscuity, sexual orientation, appearance, or other personal attacks.
223. 342 Ill. App. 3d 167, 793 N.E.2d 736 (1st Dist. 2003).
224. *Id.* at 175–76, 793 N.E.2d at 743.

had any obligations under its policy because of an exclusion for use of an automobile. Travelers argued that it could not have any obligations as an excess carrier if Acceptance had no duties under the primary policy.[225]

The court of appeals explained that the CGL policy unambiguously excluded coverage for the maintenance or use of any auto.[226] There was no coverage because the underlying suit was clearly predicated on the use of an auto receiving maintenance. However, the automobile exclusion contained an exception for parking autos on or next to the premises owned by the insured. Sears argued that this exception applied because the car was being "un-parked" from the maintenance bay.[227] The court rejected the argument because the car was being backed out of the bay in order conduct a road test. The court felt that a road test constituted maintenance of the auto. The court held that the "parking on" exception to the automobile exclusion did not apply.[228]

L. Exclusions: Lead Paint is Lead Paint

In *Pope v. Economy Fire & Casualty Co.*,[229] the court held that no cause of action exists for anticipatory breach against an insurer where the allegations raised are excluded by a policy exclusion.[230] The insured, Nancy Basta, purchased a fifteen unit apartment complex in Chicago. She acquired a business owner's liability policy issued by Hanover Insurance Company that was effective for three and one half months. After the Hanover policy, Basta was insured by Economy under a multi-liability policy that was effective for four years. During both policies, the minor plaintiff and his family were residents of one of the apartments. During the second policy, Basta received a letter from the City of Chicago stating that lead bearing paint was found in the building. The building had to be immediately abated. At a hearing in connection with the City's notice, Basta stated she was aware of the

225. *Id.* at 170, 793 N.E.2d at 739.
226. *Id.* at 175, 793 N.E.2d at 743.
227. *Id.* at 174–75, 793 N.E.2d at 742–43.
228. *Id.* at 176, 793 N.E.2d at 743.
229. 335 Ill. App. 3d 41, 779 N.E.2d 461 (1st Dist. 2002).
230. *Id.* at 49, 779 N.E.2d at 468.

minor's lead paint poisoning claim. Basta had the lead paint abated, but did not provide notice to her insurer of the lead poisoning claim.[231]

Two years later, the minor's attorney sent Basta an attorney's lien letter that informed her of the plaintiff's claims.[232] A complaint was filed the next day. Before Basta was served with the complaint, she forwarded a copy of the attorney's lien letter to her insurers. Economy responded by denying coverage because the injury was due to "'alleged exposure to lead paint.'"[233] An exclusion in the policy stated that "bodily injury" arising out of exposure to lead paint was not covered. One month later, Basta was served with a complaint that alleged lead paint poisoning. Basta notified Hanover of the suit, but she did not provide Economy with notice of the suit. Hanover defended Basta under a reservation of rights and filed a declaratory judgment action. The underlying lawsuit was dismissed by agreement. The agreement stated that Hanover was to pay $60,000, Basta was to assign all of her rights against Economy to the plaintiff, and the plaintiff would receive $2 million from Economy through the assignment. Economy was never notified of the settlement agreement.[234]

As assignee, the plaintiff in the underlying lawsuit brought a declaratory judgment action against Economy and alleged a breach of its duty to defend.[235] The plaintiff argued that Economy's denial before receiving notice of the suit was anticipatory breach of the insurance contract. The trial court found no breach of duty when it compared the allegations and the lead paint exclusion. On appeal, the court was unable to find any prior cases in any jurisdiction addressing an anticipatory breach of an insurance contract by an insurer. The doctrine of an anticipatory breach had been applied in Illinois mainly to bilateral executory contracts where there is a duty to perform an act in the future.[236]

Unlike contracts where there is a duty of future performance, the duty to defend is contingent upon the facts alleged in a complaint.[237] Economy's duty to defend under its contract with Basta was contingent upon receipt of a covered claim from a third-party. The court held that

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231. *Id.* at 43, 779 N.E.2d at 463.
232. *Id.* at 43–44, 779 N.E.2d at 463.
233. *Id.* at 44, 779 N.E.2d at 464.
234. *Id.* at 45, 779 N.E.2d at 464.
235. *Id.*
236. *Id.* at 45–46, 779 N.E.2d at 465.
237. *Id.* at 46, 779 N.E.2d at 465.

in order for the plaintiff to be able to maintain a cause of action for anticipatory breach, it must review (1) whether there was a repudiation of the contracts; (2) whether the conditions of the contract could have been fulfilled had the contract not been repudiated; and (3) whether damages resulted from the alleged repudiation. The court defined an anticipatory repudiation as "a manifestation by one party to a contract of an intent not to perform its contractual duty when the time fixed in the contract has arrived."[238]

The court found that although the denial letter based on the attorney's lien was potentially a premature repudiation, the plaintiff was required to prove that the conditions in the contract could have been fulfilled had the contract not been repudiated.[239] Economy's duty to defend was contingent upon the potential for coverage. When comparing the allegations of the complaint to the language of the policy, the allegations did not give rise to a potential for coverage. The policy's lead paint exclusion barred coverage for "bodily injury," which was alleged in the complaint. Additional allegations of negligence and violation of city code were also premised upon exposure to lead-based paint. These allegations were not based upon any other condition of habitation. Therefore, the allegations were encompassed by the exclusion within the policy. The plaintiff did not establish that the condition could have been fulfilled if the contract had not been repudiated because the allegations were insufficient to have created the potential for coverage.[240]

The plaintiff also alleged that Economy was estopped from raising policy defenses.[241] The court held that estoppel will apply only if the insurer is later found to have wrongfully denied coverage under the policy. Economy's duty was never triggered. Therefore, Economy was not estopped from raising coverage defenses.[242]

M. Exclusions: Professional Services are Professional Services

In *Gould & Ratner v. Vigilant Insurance Co.*,[243] the court held that a claim arising from legal representation was not covered under a CGL

238. *Id.*
239. *Id.* at 47, 779 N.E.2d at 466.
240. *Id.* at 49, 779 N.E.2d at 468.
241. *Id.* at 51–52, 779 N.E.2d at 469–70.
242. *Id.*
243. 336 Ill. App. 3d 401, 782 N.E.2d 749 (1st Dist. 2002).

policy because of a professional services exclusion.[244] The law firm of Gould & Ratner was insured under a CGL policy issued by Vigilant Insurance ("Vigilant"). Gould & Ratner was sued by a former client who alleged that the firm defamed him and breached its fiduciary duty by faxing several letters, containing unfavorable statements about the client, to various people. Gould & Ratner tendered the complaint to Vigilant, which denied the tender. Gould & Ratner sued Vigilant for breach of contract and Vigilant filed a declaratory judgment stating that Gould & Ratner were not covered under the policy.[245]

Vigilant brought a motion for summary judgment based upon a professional exclusion contained in the policy. The trial court granted the motion. The court of appeals reviewed whether the complaint alleged facts within or potentially within the policy's coverage. The policy's professional exclusion provided in part as follows:

> This insurance does not apply to any claim or suit against the Insured for:
>
> a. rendering or failing to render written or oral professional legal services or advice; or
>
> b. rendering or failing to render any other written or oral services or advice that are not ordinary to the practice of law;
>
> whether or not the Insured is acting in the capacity of a lawyer.[246]

The court stated the test in the present case as follows: "The proper inquiry was 'whether the claimant is seeking to impose liability for acts which were taken in the course of providing professional services and which drew upon (or at least should have drawn upon) the professional's training, skill, experience, or knowledge.'"[247]

The complaint did not allege claims "for" rendering or failing to render professional services.[248] Instead, the complaint alleged claims "as a result" of written statements made by the insured.[249] The court turned to the American Heritage College Dictionary, which defined "for" and "due to" as "because of."[250] The court held that the word

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244. *Id.* at 412, 782 N.E.2d at 758.
245. *Id.* at 404, 782 N.E.2d at 752.
246. *Id.* at 403, 782 N.E.2d at 751.
247. *Id.* at 408, 782 N.E.2d at 756.
248. *Id.* at 408, 782 N.E.2d at 756.
249. *Id.* at 408–09, 782 N.E.2d at 756.
250. AMERICAN HERITAGE COLLEGE DICTIONARY 424, 532 (3d ed. 2000).

"for" should be accorded the same meaning as "due to."[251] The court held that the defamation and breach of fiduciary duty occurred while rendering professional services, because the allegations in the complaint arose while an attorney was actually performing services. Therefore, the acts were excluded by the professional services exclusion.[252]

N. Exclusions: No Valid Driver's License Means No Reasonable Belief to Drive

In *Century National Insurance Co. v. Tracy*,[253] the court held that individuals who did not hold a valid driver's license cannot reasonably believe that they are entitled to use a motor vehicle in the state of Illinois.[254] Individuals who do not hold a valid drivers license are not covered under an insurance policy because they are persons who do not reasonably believe that they are entitled to operate the vehicle. Century National issued an automobile policy to a company owned by James and Debra Tracey. Debra was the only individual listed as a driver on the application for insurance. The policy contained an endorsement for Illinois underinsured motorists coverage ("UIM"), excluding coverage for "'anyone using a vehicle without a reasonable belief that the person is entitled to do so.'"[255] James's driver's license was suspended. When the insurance agent prepared the application, the agent knew "James did not have a valid license and told James that he would not be covered by the policy."[256]

Debra allowed James to drive the vehicle and James was involved in an accident and sustained personal injuries.[257] James collected $50,000 from the other driver's insurance company and sought to recover under the Century National UIM coverage. Century National filed a declaratory judgment action and alleged that James was not covered by the policy. The trial court agreed. On appeal, James argued that the policy did not contain an explicit provision excluding unlicensed drivers. James also argued that his failure to possess a valid

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251. *Gould*, 336 Ill. App. 3d at 409, 782 N.E.2d at 756.
252. *Id.* at 410, 782 N.E.2d at 757.
253. 339 Ill. App. 3d 173, 789 N.E.2d 833 (2d Dist. 2003).
254. *Id.* at 176, 789 N.E.2d at 836.
255. *Id.* at 174, 789 N.E.2d at 834.
256. *Id.*
257. *Id.*

driver's license did not show that he could not have a reasonable belief that he was entitled to drive the truck. The court of appeals found that the insurance policy contained an exclusion stating that the policy did not cover anyone using a vehicle without a reasonable belief that they were entitled to do so. The exclusion encompassed unlicensed drivers. The absence of an explicit exclusion was of no consequence.[258]

James second argument[259] was an issue of first impression in Illinois.[260] A prior decision had found that the term "any person" in conjunction with "family members" was ambiguous.[261] Also, an unlicensed driver who had not driven his girlfriend's car before did not have a "reasonable belief" that he was entitled to operate the car.[262] However, the *Economy Fire & Casualty Co. v. State Farm Mutual Insurance Co.*,[263] court found that the lack of a license was "but one factor" to consider.[264]

In *Tracy*, the court found that factors such as ownership are relevant, but without a valid drivers license, an individual cannot reasonably believe that he or she is entitled to use a motor vehicle in Illinois.[265] Therefore, James could not reasonably believe that he was entitled to drive the truck and no UIM coverage was available for James.

O. Workers' Compensation Coverage

In *General Casualty Co. of Illinois v. Carroll Tiling Service, Inc.*,[266] the court held that a rejection form purporting to withdrawal an employee from worker's compensation coverage under a worker's compensation policy, alone, is ineffective.[267] The rejection did not withdraw the employee from the provisions of the Workers' Compensation Act

258. *Id.* at 175, 789 N.E.2d at 835.
259. *Id.* James argued that failure to possess a valid driver's license did not demonstrate that he could not reasonably believe he was entitled to drive the truck.
260. *Tracy*, 339 Ill. App. 3d at 175, 789 N.E.2d at 835.
261. Hartford Ins. Co. of Ill. v. Jackson, 206 Ill. App. 3d 465, 476, 564 N.E.2d 906, 912 (2d Dist. 1990).
262. Econ. Fire & Cas. Co. v. State Farm Mut. Ins. Co., 153 Ill. App. 3d 378, 382–83, 505 N.E.2d 1334, 1336–37 (2d Dist. 1987).
263. 153 Ill. App. 3d 378, 505 N.E.2d 1334 (2d Dist. 1987).
264. *Id.* at 383, 505 N.E.2d at 1337.
265. *Tracy*, 339 Ill. App. 3d at 176, 789 N.E.2d at 836.
266. 342 Ill. App. 3d 883, 796 N.E.2d 702 (2d Dist. 2003).
267. *Id.* at 893–94, 796 N.E.2d at 710.

("Act").[268] A worker's compensation claim was filed by an employee of the insured. To reduce its worker's compensation premiums, the insurer provided the insured with a rejection form. According to the form, several specific employees were excluded from coverage under the policy. The form did not mention a withdraw from the Act. One individual excluded from coverage was eventually injured. He sought coverage from the insured, but the insured denied coverage because the individual was excluded from coverage.[269]

The court of appeals found that under certain circumstances, an employee may be removed from worker's compensation insurance as well as from the Act.[270] One circumstance is that an express category of *bona fide* officers may withdraw from operation of the Act. However, the rejection form made no mention of the Act and was limited to withdrawing employees from insurance coverage. The court held that the form was ambiguous because it purported to withdraw the employee from the insurance and not from the operation of the Act and it was not directed to the employee in his proper capacity. The rejection form was limited to excluding the employee from coverage under the policy. The court also concluded that the Act prohibits an employer and its carrier from selectively omitting an employee from coverage under a policy an insurer has issued to an employer.[271]

P. Statutory and Contractual Periods of Limitation

In *Hale v. Country Mutual Insurance Co.*,[272] the court held that the purpose of a two year arbitration demand limitation clause was notification to the insurer.[273] The limitation was not a trap for insureds failing to use the precise wording suggested by the insurer. Country Mutual Insurance Coompany ("Country Mutual") issued an auto policy to Mark Hale which contained $100,000 in UIM coverage. Hale was in an accident with another vehicle that had liability limits of $50,000.

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268. 820 ILL. COMP. STAT. 305/1–305/30 (2003).
269. *Carroll Tiling*, 342 Ill. App. 3d at 889, 796 N.E.2d at 706.
270. *Id.* at 892–93, 796 N.E.2d at 709.
271. *Id.* at 894–95, 796 N.E.2d at 710–11.
272. 334 Ill. App. 3d 751, 778 N.E.2d 721 (5th Dist. 2002).
273. *Id.* at 754–55, 778 N.E.2d at 723.

County Mutual's policy also contained a suit limitation provision as follows:

> Legal Action Against Us: No suit, action[,] or arbitration proceedings for recovery of any claim may be brought against us until the insured has fully complied with all the terms of this policy. Further, any suit, action, or arbitration will be barred unless commenced within 2 years after the date of the accident. Arbitration proceedings will not commence until we receive your written demand for arbitration.[274]

Twenty-three months after the accident, Hale's attorney sent a letter to County Mutual stating that he was retained by the insured. The letter also stated that "'[i]t appears that we have an underinsured claim. At this time, I ask that you disclose the underinsured motorist and medical payments policy limits of Mr. Hale.'"[275] More than four months later, County Mutual responded and supplied a claim number which included an "Underinsured Motorists Notice of Claim" form.[276] The form was immediately completed and returned to County Mutual. Within two weeks, County Mutual responded stating it was denying coverage because the arbitration was not demanded before the two year anniversary of the accident.[277]

Hale filed a declaratory judgment action seeking to find that his UIM claim was timely made.[278] The court of appeals noted that the two year limitation in the County Mutual policy had been challenged and upheld. The court was required to review whether Hale made an arbitration demand, because the policy contained a requirement that arbitration be demanded within two years of the *accident*. The court held that the language used "by Hale's attorney was not perfect but served the purpose of notifying County Mutual of the underinsured-motorist claim. County Mutual obviously received this notification, because it acknowledged the letter" and sent a claim form.[279] While these actions did not rise to the level of estoppel, they did acknowledge notification. This satisfied the purpose of the contractual limitation. Timely notification of a UIM claim was sufficient to satisfy the arbitration requirement. The court held that "the purpose of the

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274. *Id.* at 752–53, 778 N.E.2d at 722 (alteration in original) (citations omitted).
275. *Id.* at 753, 778 N.E.2d at 722.
276. *Id.*
277. *Id.*
278. *Id.*
279. *Id.* at 755, 778 N.E.2d at 723.

limitations clause is notification-not a trap for insureds failing to use the precise wording suggested by the insurer."[280]

County Mutual's two year limitation suffered its first limitation from an Illinois court. Previously, courts required unequivocal demands for arbitration within the two year time limit established in the County Mutual policy. Under *Hale*, notice provided by an insured to the insurer stating that the insured is requesting UIM benefits will be sufficient to satisfy the two year arbitration demand.

In *Nelson v. Old Line Life Insurance Co. of America*,[281] the court held that a thirty-one day grace period for receipt of late premiums in a life insurance policy did not toll the six month statutory non-forfeiture provision of Section 234(1) of the Illinois Insurance Code.[282] The plaintiff sought recovery of proceeds under a life insurance policy issued to his wife. The trial court entered judgment in favor of the defendant and the plaintiff appealed. The Insurance Code states that "no life company . . . shall declare any policy forfeited or lapsed within six months after default in payment of any premium."[283] The policy defined "default" as "the date a premium is due and unpaid."[284] The policy also contained a provision providing a thirty-one-day grace period for receipt of late premium payments.[285] The policy remained in force during the grace period. The appellate court rejected the plaintiff's argument that the policy's thirty-one-day grace period tolled the six month non-forfeiture period under Section 234(1) based on the statute's unambiguous language. The statute allows insurers to cancel a policy six months after default. The appellate court reversed the trial court's decision, because the plaintiff's wife died six months after the date of default.[286]

IV. AUTOMOBILE INSURANCE

A. Policy Terms, Conditions and Exclusions: A Nexus Between Use and Accident

280. *Id.*, 778 N.E.2d at 724.
281. 341 Ill. App. 3d 144, 792 N.E.2d 796 (2d Dist. 2003).
282. *Id.* at 148, 792 N.E.2d at 800; 215 ILL. COMP. STAT. 5/234(1) (2003).
283. 215 ILL. COMP. STAT. 5/234(1) (2003).
284. *Nelson*, 341 Ill. App. 3d at 146, 792 N.E.2d at 798.
285. *Id.* at 145, 792 N.E.2d at 797.
286. *Id.* at 147–49, 792 N.E.2d at 799–800.

In *SCR Medical Transportation Services, Inc. v. Browne*,[287] the court held that in order for an accident or injury to come within an automobile policy's coverage, a "causal relation or nexus must exist between the accident or injury and the ownership, use, or maintenance of the vehicle."[288] The plaintiff alleged that Robert Britton was transporting her from a hospital to her home when he sexually assaulted her inside the van. At the plaintiff's house, Britton allegedly entered her home and he sexually assaulted her a second time. Britton was employed as a driver for SCR Medical Transportation, Inc. ("SCR"). Britton, also known as Robert Vaughn, was convicted of the sexual assaults. The plaintiff's complaint sought damages from SCR under theories of negligence, negligent hiring, assault, intentional infliction of emotional distress, and negligent supervision.[289]

SCR filed a declaratory action against its auto liability insurer, Empire Fire and Marine Insurance Company and Empire Indemnity Insurance Company (Empire). SCR sought a finding that Empire was under a duty to defend it against Browne's complaint. The policy stated: "[w]e will pay all sums an 'insured' legally must pay as damages because of 'bodily injury' or 'property damage' to which this insurance applies, caused by an 'accident' and resulting from the ownership, maintenance or use of a covered 'auto.'"[290]

While a motion for summary judgment was pending in the declaratory action, Browne filed her sixth amended complaint and added a count for negligence against SCR and Britton. The count alleged Britton was negligent in that he:

> A. Failed to travel upon recognized streets using the most direct route possible;
>
> B. Operated the SCR medical transportation vehicle through and upon an unnamed alley;
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> C. Failed to control his bodily movements so that he caused AISHA to be in fear of her personal safety, although he knew or should have known that his proximity to AISHA would have frightened and injured her;

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287. 335 Ill. App. 3d 585, 781 N.E.2d 564 (1st Dist. 2002).
288. *Id.* at 589, 781 N.E.2d at 568.
289. *Id.* at 587, 781 N.E.2d at 566.
290. *Id.*, 781 N.E.2d at 567.

> D. Failed to call her back-up support to assist AISHA with her disembarkation from SCR medical transportation vehicle, although he knew or should have known that his proximity to AISHA would have frightened and injured her;
>
> E. Negligently assessed the situation when he attempted to assist AISHA with her disembarkation from the SCR medical transportation vehicle, although he knew or should have known that his words or actions would have frightened and injured AISHA; and
>
> F. Was otherwise negligent in placing AISHA in a situation which reasonably caused her to experience strong anxiety and fear.[291]

The court of appeals held that "[t]he policy provides the damages must be caused by an 'accident,' 'resulting from the ownership, maintenance, or use' of the covered vehicle."[292] In order for an accident or injury to come within an automobile policy's coverage, "[a] causal relation or nexus must exist between the accident or injury and the ownership, use, or maintenance of the vehicle."[293]

Addressing the amended pleadings, the court of appeals found that the amendments were "rushed . . . when it became obvious the first eight counts . . . would not support a duty to defend. The trial court . . . made it clear it was finding for the insurance company. Summary judgment [was] entered for SCR . . . it would be in Browne's interest to have SCR covered by Empire."[294] The allegations relating to the use of the vehicle were a "device without substance."[295] The court held the "fact that a vehicle is the site of an injury or incident is insufficient to create a connection between the 'use' of the vehicle and the injury so as to bring the injury within policy coverage."[296] The summary judgment for the insurer was upheld.

B. Vehicle Coverage Terms: Use of An Auto

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291. *Id.* at 587, 781 N.E.2d at 567.
292. *Id.* at 588, 781 N.E.2d at 568.
293. *Id.* at 589, 781 N.E.2d at 568.
294. *Id.*
295. *Id.*, 781 N.E.2d at 569.
296. *Id.*

In *Mount Vernon Fire Insurance Co. v. Heaven's Little Hands Day Care*,[297] the court held that bodily injury resulting from leaving an infant in a vehicle used to transport the infant was not a normal or reasonable consequence of the use of the vehicle.[298] The vehicle became the situs rather than the cause of the injury. The injury does not arise out of the use of a vehicle. A nine month old infant died as a result of heat stroke when left unattended in a van operated by a daycare center. As a result of the infant's death, suit was filed against the daycare center and the driver. The complaint alleged negligence in the operation of the vehicle as well as failure to properly supervise and provide sufficient safety procedures for the children left in the daycare center's custody. Mt. Vernon Fire Insurance Company ("Mt. Vernon") filed a declaratory judgment action and alleged that it did not owe a duty to defend any insured. Mt. Vernon insured the daycare center under a CGL policy. The policy contained an exclusion for liability arising out of the ownership, maintenance, operation, or use of a vehicle.[299]

Mt. Vernon argued that the allegations relating to the infant's death arose from events as a result of the use or operation of the vehicle.[300] The insurer argued that the death did not arise out of the operation or use of the vehicle because the vehicle was merely the situs of the injury. "[N]othing in the inherent nature of the vehicle is alleged to have contributed to the child's death."[301] Prior Illinois decisions have held that if the liability of an insured arose from negligent, non-auto-related conduct, a general liability policy should be applicable regardless of an automobile exclusion or that an automobile was involved.[302] In order for an injury to arise from the use of a vehicle, a causal relationship or nexus must exist between the accident or injury and the ownership, use or maintenance of the vehicle.[303]

The court held that the "death of an infant from heat stroke when left unattended in a vehicle for an eight-hour period is attenuated from the actual legitimate purpose of the van."[304] The child's death resulted from non-vehicular conduct on the part of the defendant. The van was merely the situs, rather than the cause of the infant's death. As a result,

297. 343 Ill. App. 3d 309, 795 N.E.2d 1034 (1st Dist. 2003).
298. *Id.* at 320, 795 N.E.2d at 1043.
299. *Id.* at 313, 795 N.E.2d at 1038.
300. *Id.* at 315, 795 N.E.2d at 1039.
301. *Id.* at 316, 795 N.E.2d at 1040.
302. *Id.* at 317–18, 795 N.E.2d at 1041–42.
303. *Id.* at 318, 795 N.E.2d at 1041.
304. *Id.* at 319, 795 N.E.2d at 1043.

the insurer of the automobile was not under a duty to defend the insured. Mt. Vernon was under a duty to defend its insured.[305]

C. Vehicle Coverage: A Named Driver Exclusion is Permissible

In *St. Paul Fire and Insurance Co. v. Smith*,[306] the court held that an exclusion for a named driver on an insurance card did not contravene Illinois public policy and is a statutorily created exception to the mandatory insurance law.[307] William Smith was killed in an automobile accident while driving a car owned by his father and insured by St. Paul Fire and Insurance Company ("St. Paul") under a personal insurance package policy including homeowner's and automobile liability insurance. Smith was also insured under his own policy with Valor Insurance Company ("Valor"). The St. Paul policy listed Smith's parents as the insureds and drivers under the policy. St. Paul removed Smith from his parents' policy 6 months before the accident because of Smith's prior driving offenses.[308] St. Paul also required Smith's parents to sign a named driver exclusion which excluded liability for any accidents or losses incurred while the car was driven by Smith.[309]

Suit was filed by the estate of the parties of the vehicle that Smith hit.[310] Smith's parents tendered the matter to Valor, but not to St. Paul. A verdict of $5 million was entered against Smith's father and Smith's estate. Valor paid its policy limits of $20,000 to the deceased claimant's estate. During the pending court action, St. Paul filed a declaratory judgment action arguing that there was no coverage because of the named driver exclusion in the St. Paul policy. St. Paul argued that the named driver exclusion operated to bar any coverage obligation. The claimants and insureds argued that the named driver exclusion violated Illinois public policy, as contained in the mandatory insurance requirements of the Illinois Vehicle Code.[311] They "also argued that the exclusion was ambiguous, was not attached to the

305. *Id.* at 321, 795 N.E.2d at 1044.
306. 337 Ill. App. 3d 1054, 787 N.E.2d 852 (1st Dist. 2003).
307. *Id.* at 1062, 787 N.E.2d at 858.
308. These offenses included a suspended and a revoked license due to driving under the influence of alcohol.
309. *Id.* at 1057, 787 N.E.2d at 854.
310. *Id.*
311. 625 ILL. COMP. STAT. 5/7–601(a) (2003).

insurance policy and did not apply to bar claims of negligent entrustment."[312]

The trial court found that the named driver exclusion contained in the automobile liability policy was void as against public policy.[313] St. Paul appealed. The appellate court reviewed an issue of first impression regarding whether a named driver exclusion in an automobile liability policy violated Illinois public policy. The exclusion provided: "We will not be liable for any accidents or losses while any auto or motor home is driven by: William R. Smith[.]"[314] The exclusion was signed by Smith's parents.[315] The mandatory insurance provision of the Illinois Vehicle Code requires that all vehicles be insured through liability insurance policy.[316] Section 7–317(b)(2) of the Code's Safety Responsibility Law requires that a motor vehicle liability policy "insure the person named therein and any other person using or responsible for the use of such motor . . . vehicles with the expressed or implied permission of the insured."[317] The Supreme Court interpreted this provision as mandating as a "'liability insurance policy issued to the owner of the vehicle must cover the named insured and any other person using the vehicle with the named insured's permission.'"[318] The claimants alleged that the Code's reference to "any other person" included a driver who may be excluded by the named driver exclusion. This argument assumed that the driver had the insured's permission to operate the vehicle. St. Paul responded that the named driver exclusion did not violate public policy and argued that Section 7–602 of the Code created a limited exception to the mandatory insurance laws. The court of appeals agreed. Section 7–602 discusses the requirements for insurance cards and provides in relevant part as follows:

> If the insurance policy represented by the insurance card does not cover any driver operating the motor vehicle with the owner's permission, or the owner when operating a motor vehicle other than the vehicle for which the policy was issued, the insurance card shall

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312. *St. Paul*, 337 Ill. App. 3d at 1057, 787 N.E.2d at 855.
313. *Id.*
314. *Id.* at 1058, 787 N.E.2d at 855 (alteration in original).
315. *Id.*
316. 625 ILL. COMP. STAT. 5/7–601(a) (2003).
317. 625 ILL. COMP. STAT. 5/7–317(b)(2) (2003).
318. State Farm Mut. Auto. Ins. Co. v. Smith, 197 Ill. 2d 369, 373, 757 N.E.2d 881, 883 (2001), quoting State Farm Mut. Auto. Ins. Co. v. Universal Underwriters Group, 182 Ill. 2d 240, 244, 695 N.E.2d 848, 850 (1998).

> contain a warning of such limitations in the coverage provided by the policy.[319]

The court held that the plain language of this statue recognizes that insurance policies may exclude named drivers from coverage.[320] However, this section may conflict with the mandatory insurance requirements of Section 7–601 and 7–317(b)(2).[321] When there is an alleged conflict between two statutes, a court should interpret the statutes to avoid inconsistency and, if possible, give effect to both statutes. The language concerning policy limitations is contained in the same mandatory insurance article and shares the same effective date. The court of appeals held that by enacting Section 7–602, the legislature intended to create an exception for limited driver exclusions to the mandatory insurance laws.[322]

Section 7–602 also authorizes the Secretary of State to prescribe Rules and Regulations concerning the form, content, and issuance of insurance cards.[323] The Regulations concerning insurance card requirements provide that "[t]he insurance card shall contain the following insurance information . . . a warning of excluded drivers or vehicles, when applicable."[324] The court held that the named driver exclusion in the St. Paul policy was not contrary to Illinois public policy because the legislature created a limited exception to the mandatory insurance laws.[325]

D. Liability Limits and Stacking of Coverage

In *Country Companies v. Universal Underwriters Insurance Co.*,[326] the court held that an insurer that files a certificate of insurance with the Illinois Secretary of State stating specific coverage limits for an automobile waives the right to decrease policy limits for some drivers.[327] The insurer will be bound to the limits contained in the certificate of insurance. As part of his job, Seckler was driving a

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319. 625 ILL. COMP. STAT. 5/7–602 (2003).
320. *St. Paul*, 337 Ill. App. 3d at 1060, 787 N.E.2d at 856.
321. *Id.* (noting 625 ILL. COMP. STAT. 5/7–601(a) (2003); 625 ILL. COMP. STAT. 5/7–317(b)(2) (2003)).
322. *Id.*, 787 N.E.2d at 857.
323. 625 ILL. COMP. STAT. 5/7–602(d) (2003).
324. ILL. ADMIN. CODE tit. 50, § 8010.20(d) (2003).
325. *St. Paul*, 337 Ill. App. 3d at 1060, 787 N.E.2d at 857.
326. 343 Ill. App. 3d 224, 796 N.E.2d 639 (3d Dist. 2003).
327. *Id.* at 228, 796 N.E.2d at 642.

vehicle owned by a second party and insured under a garage policy issued by Universal Underwriters Insurance Company ("Universal") to a third party. Seckler got into an accident and an individual was injured. The Universal policy had coverage limits for most drivers, but contained an exception to the limits for certain drivers, including permissive users. Seckler was a permissive user of the vehicle at the time of the accident. For permissive users, the policy decreased coverage within a "step–down" provision that provided coverage limits of $100,000.[328]

Universal had filed a certificate of insurance with the Illinois Secretary of State.[329] The certificate stated that it was providing the owner of the vehicle with bodily injury coverage limits of $300,000 per person. Seckler argued that filing the certificate with the Secretary of State's office was a waiver of the step-down provision within the policy. Although the certificate was not presented at the trial level, the court of appeals held that it could take judicial notice of the filing of the certificate. The filing was a waiver of the step-down provision within the Universal policy. Thus, Universal was bound by the representation made to the Secretary of State to provide liability limits of $300,000.[330]

E. Uninsured Motorists (UM) and Underinsured Motorist (UIM) Coverage

In *Samek v. Liberty Mutual Fire Insurance Co.*,[331] the court held that in an underinsured motorist provision in an auto policy, a trial *de novo* provision that allowed the rejection of an arbitration award above the statutory financial minimum limits was void and unenforceable.[332] Nancy Samek filed a claim with her insurance carrier for UIM coverage because of an accident with underinsured vehicle. Her insurer, Liberty Mutual Fire Insurance Company ("Liberty"), denied the claim. The claim was submitted to a 3-person arbitration panel as provided in the policy. The panel entered an award for $50,000 in favor of Ms. Samek. Liberty rejected the arbitration award and made

328. *Id.* at 227–28, 796 N.E.2d at 642.
329. *Id.* at 228, 796 N.E.2d at 642.
330. *Id.* at 229, 796 N.E.2d at 643.
331. 341 Ill. App. 3d 1045, 793 N.E.2d 62 (1st Dist. 2003).
332. *Id.* at 1051, 793 N.E.2d at 66.

a demand for a trial *de novo* pursuant to the arbitration provision in the policy. Ms. Samek filed a petition in circuit court to confirm the arbitration award. During cross-motions for judgments on the pleadings, Liberty argued that the policy gave it the right to demand trial *de novo* since the arbitration award exceeded $20,000.[333] The trial court denied Liberty's cross-motion for judgment and granted Ms. Samek's petition to confirm the arbitration award. The court reasoned that the trial *de novo* clause in the policy was contrary to public policy and therefore void. The court of appeals reviewed "whether trial *de novo* clauses violate public policy."[334] This issue had been addressed in other districts, but had not been reviewed by the First District.[335]

The policy contained a provision that permitted either party to reject an arbitration award that exceeded $20,000 and to demand a trial *de novo.* The clause provided as follows:

> Arbitration: The amount of damages. This applies only if the amount does not exceed the minimum limit for bodily injury liability specified by the financial responsibility law of the state in which your covered auto is principally garaged. If the amount exceeds that limit, either party may demand the right to a trial.[336]

Provisions that allow for the rejection of an arbitration award and the request for a trial are referred to as "trial *de novo* provisions."[337] The court noted that in judicial parlance, this clause is known as an "escape hatch."[338]

The Illinois Supreme Court reviewed this issue in *Reed v. Farmers Insurance Group*.[339] In *Reed*, the Illinois Supreme Court reviewed the Illinois Insurance Code which required that a vehicle policy of insurance contain a clause requiring arbitration if the claimant and the insurer are unable to agree on the amount of compensation that the claimant could receive under the policy's uninsured motorist coverage.[340] The *Reed* court upheld a trial *de novo* provision and found that the legislature had determined that UM coverage must contain a

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333. *Id.* at 1046, 793 N.E.2d at 63.
334. *Id.* at 1047, 793 N.E.2d at 63.
335. *Id.*
336. *Id.*
337. *Id.*
338. *Id.*
339. 188 Ill. 2d 168, 720 N.E.2d 1052 (1999).
340. *Id.* at 172–73, 720 N.E.2d at 1056; 215 ILL. COMP. STAT. 5/143a (1996).

trial *de novo* provision.[341] The trial *de novo* provision did not violate public policy because it was required by statute to be in UM policies.[342] However, the decision in *Reed* addressed only UM coverage.

Other courts considered trial *de novo* provisions in combination with UIM coverage. In *Fireman's Fund Insurance Co. v. Bugailiskis*,[343] and *Parker v. American Family Insurance Co.*,[344] the courts held that the trial *de novo* provision in a UIM provision was inherently unfair because it provided a remedy to the insurers, but denied a remedy to the insured.[345] Although neither party is bound by a high award, only the insurer would likely reject the award. The *Bugailiskis* and *Parker* courts both held that trial *de novo* provisions in UIM clauses were unenforceable and contrary to public policy.[346] The *Reed* court held that trial *de novo* provisions within UM clauses were not contrary to public policy.[347]

The *Samek* court agreed with the proposition that the insurance company would likely invoke the trial *de novo* provision on high awards.[348] In so holding, the court in *Samek* stated: "While this court, as did the *Parker* and *Bugailiskis* courts, wants to make it clear that nonbinding arbitration is permissible in Illinois, trial *de novo* provisions disturbingly take on the character of adhesion contracts because they lack a mutuality of remedy between the insurer and the insured."[349] The court held that trial *de novo* clauses contained in UIM policies violate public policy.

In a dissenting opinion, Justice Hoffman opined: "I can conceive of no difference in the public and private interest factors which are relevant to a determination as to the propriety of permitting trial *de novo* clauses to be included in arbitration provisions governing uninsured-motorist coverage as compared to those governing underinsured-motorist coverage."[350] Justice Hoffman stated that he would decline following *Bugailiskis* and *Parker* and instead hold that trial *de novo*

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341. *Reed*, 188 Ill. 2d at 174, 720 N.E.2d at 1057.
342. *Id.*
343. 278 Ill. App. 3d 19, 662 N.E.2d 555 (1996).
344. 315 Ill. App. 3d 431, 734 N.E.2d 83 (2000).
345. *Id.* at 435, 734 N.E.2d at 86; *Bugailiskis*, 278 Ill. App. 3d at 23–24, 662 N.E.2d at 558.
346. *Id.*
347. *Reed*, 188 Ill. 2d at 175, 720 N.E.2d at 1057.
348. Samek v. Liberty Mut. Fire Ins. Co., 341 Ill. App. 3d 1045, 1050, 793 N.E.2d 62, 65–66 (1st Dist. 2003).
349. *Id.* at 1051, 793 N.E.2d at 66.
350. *Id.* at 1053, 793 N.E.2d at 68 (italics added).

clauses governing both UIM coverage, as well as UM coverage, do not violate public policy.[351]

It would appear the practitioner has little hope of going to trial with an UIM claim. However, the *Samek* court offered an avenue to avoid the binding effect of arbitration. The court expressly stated that "non-binding arbitration is permissible in Illinois . . ."[352] This statement would appear to support several possibilities. First, insurers could simply make their UIM provisions non-binding in all situations. By removing the trial *de novo* clause and making the arbitration non-binding, either party could then proceed to trial. Second, prior to entering into arbitration, the parties themselves could agree to enter into non-binding arbitration in a separate agreement supported by consideration. Presumably, in both of these situations the claimants would have already received the statutory minimum from a tortfeasor or a portion of the tortfeasor's minimum liability limits. The UIM insurer would be entitled to a set-off for the full limits of the tortfeasor's policy. Consequently, an arbitration award under $20,000 would result in no additional recovery by the claimant.

Lastly, several insurers have policy language similar to the following: "[a]ny dispute as to coverage and the amount of damages shall be submitted to arbitration . . . [a]ny decision made by the arbitrators shall be binding for the amount of damages not exceeding the minimum financial responsibility limits of the Illinois Vehicle Code for bodily injury or death."[353] Noticeably absent from this clause is a trial *de novo* provision. Since there is no impermissible clause, a court would be faced with striking not just an offending clause, but it would have to insert an additional clause requiring the arbitration to be binding in all cases in order to achieve the same result as prior decisions, that is, removing the right to reject an award. This would materially change the contract that was originally intended by the parties.

Several insurers have been modifying their policies over the last few years and have approached this issue with an apparent plan to merge their UM and UIM coverage. At least one insurer no longer provides for separate UM and UIM limits, but instead, provides only UM coverage and in the definitions of its policy defines an

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351. *Id.*

352. *Id.* at 1051, 793 N.E.2d at 66.

353. Based upon the author's experience with various insurers.

"underinsured vehicle" the same as an "uninsured vehicle." Again, there is no impermissible trial *de novo* clause with the UIM coverage.[354]

The Illinois legislature has determined that it is the public policy of the state to allow the rejection of a UM arbitration award.[355] This was an express statement of public policy within the UM statute. The UIM statute is silent regarding a similar arbitration provision. The Supreme Court in *Reed* reviewed this legislation and determined that the legislature made an express pronouncement that a trial *de novo* provision is required.[356] Therefore, this provision does not violate public policy. The appellate courts have reviewed the silence of the statute as an express statement that public policy must prohibit a trial *de novo* clause within UIM coverage. Rather than relying upon an express pronouncement by the legislature or any similar overt indication that a trial *de novo* clause violates public policy, the appellate courts have interpreted the silence as a statement that UIM arbitration rejection is against public policy. In the courts' view, the inherent unequal bargaining position is sufficient to find the clause void and unenforceable in light of the legislature's silence. As many courts have stated, this issue may best be left to the legislature which can resolve this issue in a much more expedient and cost effective manner by merely including a single sentence within the UIM statute either permitting trial *de novo* clauses or prohibiting them.

F. UM/UIM Coverage: Application Requirements

In *Lee v. John Deere Insurance Co.*,[357] the Illinois Supreme Court held that the rejection of UM/UIM limits equal to liability limits must be made during the application process.[358] The application process ends when the policy is issued. Tak Kwong Lee was a delivery truck operator employed by Asia Distributors, Inc. ("Asia"). He was fatally injured after being pinned between an underinsured car and an Asia delivery truck. Lee's estate brought a declaratory judgment action seeking a determination of the limits for his underinsured motorist coverage in a policy issued by John Deere Insurance Co. ("John

354. *Id.*
355. *See* Reed v. Farmers Insurance Group, 188 Ill. 2d 168, 170, 720 N.E.2d 1052, 1055 (1999).
356. *Id.* at 174, 720 N.E.2d at 1057.
357. 208 Ill. 2d 38, 802 N.E.2d 774 (2003).
358. *Id.* at 49, 802 N.E.2d at 781.

Deere"). The president of Asia was Andy Lin. Lin contacted Elite Insurance Agency, Inc. by telephone and spoke to an agent. Based upon their conversation the agent prepared an application form with John Deere. The agent explained the nature of UM/UIM coverage and Lin declined the increased UM/UIM limits. Lin denied he was offered increased limits.[359]

The application shows coverage limits of $1 million for liability and a $40,000 aggregate limit for UM/UIM coverage. A temporary binder was issued reflecting these limits. A separate form was forwarded to the agent entitled "John Deere Ins. Co. Selection/Rejection of Uninsured/Underinsured Motorist coverage-Illinois."[360] Approximately one month after the binder was issued, John Deere requested the completed form back from the insured. The form was returned. However, in a deposition, Lin testified that the signature on the form was not his. One month after returning the form, the policy was canceled for non-payment of premiums. A new policy was written that contained the same limits as the first policy. The new policy contained a different policy number and was effective two months after the cancellation of the first policy. A second Selection/Rejection form was sent to the insured. An executed form was returned to John Deere. Lin testified that the signature was not his.[361]

Approximately one year later John Deere renewed the policy without requiring an execution of an additional Selection/Rejection form.[362] The same liability limits applied to the renewal policy. The employee was injured during the term of the renewal policy. Lee's estate made a claim for underinsured motorist coverage under the renewal policy. Predicated upon the tortfeasor's payment of $20,000, John Deere offered to pay Lee's estate $20,000 in UIM benefits. Lee's estate declined the offer and filed a declaratory judgment action. Lee argued that the issuance of coverage violated Section 143a-2(2)[363] by failing to include a space for the applicants Selection or Rejection of increased UM/UIM coverage limits. Lee argued that the use of a separate form was ineffective.[364]

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359. *Id.* at 41, 802 N.E.2d at 776.
360. *Id.*
361. *Id.*
362. *Id.*
363. 215 ILL. COMP. STAT. 5/143a–2(2) (1992).
364. *Lee*, 208 Ill. 2d at 41–42, 802 N.E.2d at 777.

The trial court found that the application form did not indicate a rejection and it reformed the policy to reflect the higher $1 million limit.[365] The court of appeals reviewed the arguments that the use of a separate Selection/Rejection form violated Section 143a–2(2) and the failure to include a space for the applicant's Selection or Rejection of increased UM/UIM coverage on the form. Section 143a–2(2) required an application for motor vehicle coverage contain a space for indicating the rejection of additional uninsured motorist coverage.[366] The court of appeals found this section to be unambiguous in that it only applied to "uninsured" motor vehicle coverage. The court then considered "underinsured" motor vehicle coverage as defined in Section 143a–2(4).[367] The court of appeals refused to insert terms not provided by the legislature. As a result, the application and signature requirements of Section 143a–2(2) were inapplicable and irrelevant.[368]

The Illinois Supreme Court reviewed whether the failure to strictly comply with the statutory requirements that mandate a space in an application form for the applicant to sign or initial indicating rejection of UM coverage imposed UIM coverage equal to the bodily injury liability limits.[369] The court held that subsection (2) of section 143a–2 "prescribes an exclusive means of effecting a rejection of additional coverage."[370] UM limits must equal UIM limits when UM limits exceed the minimum limits required by Section 7–203 of the Illinois Vehicle Code.[371] The court had ruled that whatever UM limits are elected, UIM limits "will be set, mandatorily, at the [UM] coverage level."[372]

Although the limits of UM and UIM must be equal and an ineffective rejection of UM is also an ineffective rejection of UIM, the court's analysis did not stop there.[373] The remaining issue was whether the John Deere form complied with the statute. The form contained an explanation of coverage, advised applicants of the right to reject

365. *Id.* at 42, 802 N.E.2d at 777.

366. "No rejection of that coverage may be effective unless the applicant signs or initials the indication of rejection." 215 ILL. COMP. STAT. 5/143a–2(2) (2003).

367. *Lee*, 208 Ill. 2d at 44, 802 N.E.2d at 778.

368. *Id.*

369. *Id.* at 50, 802 N.E.2d at 781–82.

370. *Id.* at 44, 802 N.E.2d at 778.

371. *Id.*; 215 ILL. COMP. STAT. 5/143a–2(4) (2003).

372. *Lee*, 208 Ill. 2d at 44, 802 N.E.2d at 778 (citing DeGrand v. Motors Ins. Corp., 146 Ill. 2d 521, 533, 588 N.E.2d 1074, 1080 (1992)).

373. *Id.*

coverage, a place for indicating a rejection, a date line, and a signature line. The form was submitted to the Director of Insurance and was filed. The court found that if the information were submitted simultaneously with the application in two documents it would likely have satisfied the statutory requirements. However, the record showed that the policy was issued prior to the submission of the rejection form. The statute requires that the "applicant" submit the rejection form.[374] This means the form must be submitted during the application process and the application process may continue with the issuance of a binder. However, upon the issuance of a policy, the process is ended and there would no longer be an "applicant." In *Lee*, the policy was issued before the submission of the UM/UIM rejection form. Therefore, the rejection form was ineffective and the UM/UIM limits were equal to the liability limits.[375]

The court cited *Isaacson v. Country Mutual Insurance Co.*[376] *Isaacson* recognized that an insurer could accept a rejection form after issuing a policy because the policy itself provided UIM coverage equal to the bodily injury limits.[377] Neither of these alternatives were exercised in *Lee*.[378]

The practitioner should compare this decision with the prior decision from the First District in *Harrington v. American Family Mutual Insurance Co.*,[379] wherein the court found that a CGL policy with an auto endorsement must contain an offer of UM coverage.[380] *Harrington* discussed only UM coverage and blurred the distinction between the requirements for UM and UIM coverage.[381]

G. UM/UIM Setoffs by the Guaranty Fund

374. *Id.* at 47, 802 N.E.2d at 780.
375. *Id.* at 50, 802 N.E.2d at 781–82.
376. 328 Ill. App. 3d 982, 767 N.E.2d 862 (2002).
377. *Id.* at 986, 767 N.E.2d at 866.
378. *Lee*, 208 Ill. 2d at 50, 802 N.E.2d at 781.
379. 332 Ill. App. 3d 385, 773 N.E.2d 98 (1st Dist. 2002).
380. *Id.* at 391, 773 N.E.2d at 102.
381. *Id.* at 392–93, 773 N.E.2d at 103–04.

The court in *Burton v. Ramos*,[382] held that the Illinois Insurance Guaranty Fund and a judgment debtor are entitled to a set-off against a judgment.[383] The set-off was equal to the limits of the judgment creditor's UM coverage without regard to whether a claim for UM benefits was made or if any UM benefits were paid. This litigation arose out of a 1997 automobile accident. The plaintiff filed suit and was awarded $6,000 during mandatory arbitration. The defendant's automobile liability carrier was subsequently declared insolvent and the Illinois Insurance Guaranty Fund (the "Fund") undertook the defendant's defense. The defendant filed a rejection of the arbitrator's award. The rejection was denied by the trial court. The trial court entered judgment against the defendant for $6,000. The defendant filed a post-judgment motion to declare the judgment satisfied. He argued that he was entitled to a set-off equal to the amount of the plaintiff's UM coverage, which was $20,000. The trial court denied this motion and the defendant appealed. The plaintiff's UM carrier sought a declaration from the trial court that it owed no UM coverage to the plaintiff, because her UM claim was untimely filed.[384]

In reversing the trial court's decision, the appellate court looked to the language and public policy behind the "Other Insurance" provision of the Illinois Insurance Guaranty Fund, which provides, in part:

> An insured or claimant shall be required . . . to exhaust all coverage provided by any other insurance policy . . . [and t]he Fund's obligations . . . shall be reduced by the amount recovered or recoverable, whichever is greater, under [the] other insurance policy. Where . . . [the] other insurance policy provides uninsured or underinsured motorist coverage, the amount recoverable shall be . . . the full applicable limits of . . . coverage. To the extent that the Fund's obligation . . . is reduced . . . the liability of the person insured by the insolvent insurer's policy for the claim shall be reduced in the same amount.[385]

The court found that the language granted the defendant the right to a set-off against the judgment. The set-off would be equal to the limits

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382. 341 Ill. App. 3d 122, 792 N.E.2d 362 (1st Dist. 2003), *withdrawn*, Nos. 1–01–0735, 2003 Ill. App. LEXIS 901 (Ill. App. Ct. June 17, 2003).

383. *Id.* at 125, 792 N.E.2d at 364.

384. *Id.* at 124, 792 N.E.2d at 364.

385. 215 ILL. COMP. STAT. 5/546(a) (2003).

of the plaintiff's UM coverage regardless of whether she actually received a payment.[386]

Section 5/546(a) requires a plaintiff to collect as much as she can under her UM coverage.[387] The *Burton* court noted that the Illinois Supreme Court held that a plaintiff who settles with a UM carrier for less than policy limits will be deemed to have received an amount equal to the policy limits and the Fund will be entitled to a set-off in that amount.[388] The fact that the plaintiff failed to preserve her right to recover the full amount of her UM policy was of no consequence under section 5/546(a).[389]

H. Rental Agencies and Car Dealers: Manipulation of Coverage by the Insured

In *State Farm Mutual Automobile Insurance Co. v. Hertz Claim Management Corp.*,[390] the court held that rental car agencies and drivers may contractually agree that the driver's policy will provide primary coverage.[391] The Illinois Vehicle Code and the public policy of Illinois do not require rental car owners' insurers to provide primary coverage on a rental vehicle. The State Farm insured driver rented a vehicle from Hertz and was involved in an accident. The accident resulted in a claim against the driver of the Hertz vehicle. State Farm sought a determination that the Hertz' coverage was primary to the State Farm policy.[392]

When the State Farm insured driver rented the vehicle, the contract stated that if he did not purchase a liability insurance supplement from the rental agency, his insurance would provide primary coverage.[393] The driver did not purchase the liability insurance supplement. The rental vehicle was insured by National Union. A certificate of financial responsibility filed with the Illinois Secretary of State pursuant to the Illinois Vehicle Code[394] stated the coverage provided under National

386. *Burton*, 341 Ill. App. 3d at 125, 792 N.E.2d at 364–65.
387. Urban v. Loham, 227 Ill. App. 3d 772, 777, 592 N.E.2d 292, 295 (1st Dist. 1992).
388. *Burton*, 341 Ill. App. 3d at 126, 792 N.E.2d at 365 (citing Hasemann v. White, 177 Ill. 2d 414, 421, 686 N.E.2d 571, 574 (1997)).
389. *Id.*
390. 338 Ill. App. 3d 712, 789 N.E.2d 407 (5th Dist. 2003).
391. *Id.* at 718, 789 N.E.2d at 412.
392. *Id.* at 715, 789 N.E.2d at 409.
393. *Id.* at 714, 789 N.E.2d at 409.
394. 625 ILL. COMP. STAT. 5/9–101(2003).

Union was secondary. The National Union policy itself did not contain this limitation. The driver was insured by State Farm under a policy that provided coverage for liability arising from his use of "temporary substitute vehicles," including rental cars. The State Farm policy stated that coverage was secondary if the temporary substitute vehicle had other liability insurance.[395]

State Farm argued that Illinois law required a vehicle owner's insurance to provide primary coverage in all cases.[396] Hertz argued that the Illinois Safety and Family Financial Responsibility Law[397] ("Financial Responsibility Law") was inapplicable to rental vehicles because their insurance is governed by a statute specific to the issuance of rental cars, the Rental Car Insurance Law.[398] The Rental Car Insurance Law does not contain a requirement that a vehicle owner's insurance provide primary coverage as does the Financial Responsibility Law.[399]

The Illinois Vehicle Code provides that no one may operate a motor vehicle or allow a vehicle to be operated without obtaining sufficient insurance.[400] Another section requires that insurance cover any person driving the insured vehicle with the permission of the insured.[401] Pursuant to the Supreme Court decision of *State Farm Mutual Automobile Insurance Co. v. Universal Underwriters Group*,[402] if the policy does not expressly provide this "omnibus coverage," the policy would be interpreted as providing it.[403]

The Illinois Vehicle Code contains an exemption for vehicles that are in compliance with other statutes requiring insurance in amounts meeting or exceeding the amounts under the Financial Responsibility Law.[404] Another section of the Illinois Vehicle Code requires the owners of rental vehicles to provide proof of financial responsibility to the Secretary of State.[405] Rental cars must be insured in amounts exceeding those required under the Financial Responsibility Law and

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395. *Hertz*, 338 Ill. App. 3d at 715, 789 N.E.2d at 409.
396. *Id.*
397. 625 ILL. COMP. STAT. 5/7–100–5/7–708 (2003).
398. 625 ILL. COMP. STAT. 5/9–101–5/ 9–110 (2003).
399. *Hertz*, 338 Ill. App. 3d at 716, 718, 789 N.E.2d at 411–12.
400. 625 ILL. COMP. STAT. 5/7–601(a) (2003).
401. 625 ILL. COMP. STAT. 5/7–317(b)(2) (2003).
402. 182 Ill. 2d 240, 695 N.E.2d 848 (1998).
403. *Id.* at 244, 695 N.E.2d at 850.
404. *Hertz*, 338 Ill. App. 3d at 716, 789 N.E.2d at 410; 625 ILL. COMP. STAT. 5/7–601(b)(6) (2003).
405. 625 ILL. COMP. STAT. 5/9–101 (2003).

contain an omnibus clause identical to that found within the Responsibility Law.[406] The *Hertz* court found that rental cars fell within the exception provided by Section 7–601(b)(6).[407]

Although the statute contains an omnibus provision, the court found that this provision protects the public and not other insurance agencies.[408] The court stated a general rule that where two insurance policies offer only secondary coverage, the insurance of the vehicle's owner is primary, while the insurance of the driver is secondary. However, the court found that *Farm Bureau Mutual Insurance Co. v. Alamo Rent A Car, Inc.*,[409] considered a similar situation and concluded that the general rule did not apply.[410]

Rental car agencies and drivers may contractually agree that the driver's policy will provide primary coverage. The *Hertz* court held that "the public policy of this state in favoring the freedom to contract would be frustrated by holding ineffective contracts such as the rental contract here at issue, where no competing public policy requires us to do so."[411] Consequently, the court held that neither the Illinois Vehicle Code nor the public policy of the State of Illinois required rental car owner's insurers to provide primary coverage to their vehicles.

The *Hertz* court failed to analyze whether the driver had a right to contractually agree that his own policy should be excess to other coverage. The court found that the insured agreed with State Farm that the State Farm policy would be excess to other insurance. If an omnibus clause is ignored and a court relies upon an agreement in a rental contract, the court should also consider the contractual agreement found in the individual's policy. The *Hertz* court did not consider the individual's policy, and instead found that a contractual provision in a rental agreement will be enforced. However, the court ignored a similar contractual provision within the State Farm policy. The analysis that ignores one policy of insurance while enforcing another has led two appellate courts to reach the same conclusion. If the next court to review this issue takes the next analytical step, and reviews both competing contractual provisions, it will be faced with

406. *Hertz*, 338 Ill. App. 3d at 716, 789 N.E.2d at 410 (clause identical to the one in 625 ILL. COMP. STAT. 5/7–317(b)(2)).

407. *Id.*

408. *Id.* at 717, 789 N.E.2d at 411.

409. 319 Ill. App. 3d 382, 744 N.E.2d 300 (1st Dist. 2000).

410. *Id.* at 389, 744 N.E.2d at 305.

411. *Hertz*, 338 Ill. App. 3d at 718, 789 N.E.2d at 412.

two contracts which attempt to place their own coverage in the position of excess insurance. In almost every setting involving "other insurance" clauses, courts perform a review of the competing language. Under Illinois law, when two irreconcilable "other insurance" excess provisions exist, the insurers must share in the defense of the insured and liability is shared on a pro rata basis.[412] As this area develops, courts will reach this analysis and likely apply a standard rule of construction regarding "other insurance," "escape" and "excess-escape" clauses to rental car insurance.

The decision in *John Burns Construction Co. v. Indiana Insurance Co.*,[413] affirmed the insured's right to choose, or knowingly forego, an insurer's participation in a claim.[414] If an insured is potentially covered by more than one policy of insurance, then the insured retains the right to choose which insurer must respond to the claim.[415] This "choice" has been exercised under CGL and professional liability policies, but this "right" will be exercised in the context of personal lines policies as Insureds try to avoid increasing their own loss history and seek coverage from rental companies.

In *Universal Underwriters Group v. Pierson*,[416] the court held that an auto-dealer's insurer is not required by the mandatory insurance law or by public policy to defend or indemnify a permissive driver under a collision policy for property damage to the dealer's car.[417] An auto-dealer/insured allowed the defendant to use one of its cars. The defendant damaged the car and attempted to return it. The auto dealer's insurer, as subrogee of the insured, filed an action in Cook County Circuit Court seeking more than $3,000 for the damage to the car. The defendant admitted that the car was damaged, but denied any wrongdoing. The defendant filed a counterclaim for declaratory relief against the insurer. The defendant sought a determination that as a permissive user of the car, she was an insured under the policy "'by [the] terms of the policy and by express operation of law based upon Illinois public policy.'"[418]

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412. United States Fid. & Guar. Co. v. Alliance Syndicate, Inc., 286 Ill. App. 3d 417, 418, 420, 676 N.E.2d 278, 279, 281 (1st Dist. 1997); North Am. Specialty Ins. Co. v. Liberty Mut. Ins. Co., 297 Ill. App. 3d 595, 598, 697 N.E.2d 347, 349 (1st Dist. 1998).
413. 189 Ill. 2d 570, 727 N.E.2d 211 (2000).
414. *Id.* at 574–75, 727 N.E.2d at 215.
415. *Id.* at 575–76, 727 N.E.2d at 215.
416. 337 Ill. App. 3d 893, 787 N.E.2d 296 (1st Dist. 2003).
417. *Id.* at 897, 787 N.E.2d at 299.
418. *Id.* at 895, 787 N.E.2d at 297.

The insurer filed a motion to dismiss and argued that the policy did not include the driver of a dealer's vehicle in its definition of an insured.[419] The insurer also argued that Illinois law required it to insure permissive users only for "liability" damages suffered by third parties, not for property damage to the vehicle. The trial court agreed with the insurer and granted the motion to dismiss. The driver appealed. On appeal the driver argued that under the liability section of the policy, the insurer agreed to pay damages arising out of "'Garage Operations or Auto Hazard.'"[420] The insurer argued that the liability section covered damage to the person or property of third parties, not the insured's own cars. The insurer also argued that an exclusion precluded coverage for "'autos . . . owned by the insured.'"[421] The court of appeals concluded that because the vehicle in question was owned by the insured, the exclusion precluded the driver's claim of coverage.

The driver argued that under the collision coverage section of the policy, she was an insured entitled to coverage because of the mandatory insurance law,[422] public policy, and the decision in *State Farm v. Universal Insurance Co.*[423] The driver also argued that the policy language was overridden and the insurer was required to provide a permitted driver with coverage for damage to the vehicle. The court held that the public policy and the interpretation of the Illinois mandatory insurance requirement were narrower than what the driver argued. Public policy "mandates that claims by injured third parties be covered by a car owner's insurance policy, but there is no indication that it extends to require coverage for damages to the insured vehicle while in the control of a permissive user."[424] Thus, the driver was not an insured under the collision policy issued to the car dealer.

I. Policy Cancellation

In *Yacko v. Curtis*,[425] the court held that Section 143.15 of the Illinois Insurance Code[426] did not preclude prospective notices of policy

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419. *Id.*
420. *Id.*
421. *Id.* (capitalization omitted).
422. 625 ILL. COMP. STAT. 5/7–601 (2003).
423. 182 Ill. 2d 240, 695 N.E.2d 848 (1998).
424. *Pierson*, 337 Ill. App. 3d at 897, 787 N.E.2d at 299.
425. 339 Ill. App. 3d 299, 789 N.E.2d 1274 (4th Dist. 2003).
426. 215 ILL. COMP. STAT. 5/143.15 (2003).

cancellation for unpaid premiums.[427] This litigation arose out of an automobile collision. The insurer issued an automobile policy to the co-defendant/insured. Over the policy period the insured received three cancellation notices for unpaid premiums. The notices were prospective because they told the insured of a future payment due date and the resulting cancellation if the premium was unpaid. Almost one month after the insurer sent a notice advising the insured of the cancellation of the policy, the insured was involved in an accident. The insured sought coverage under the policy and the insurer denied the claim. The circuit court granted the insurer's motion for summary judgment as to the cancellation of the policy. In affirming the trial court's decision, the court of appeals noted that even viewing the evidence in a light most favorable to the insured, it could not ignore evidence unfavorable to the insurer. The court pointed to the prospective cancellation notice which unambiguously stated that if the premium was not received by a specific date, then the policy would be cancelled that same day.[428]

J. Arbitration, Mediation and Alternative Dispute Resolution

In *Government Employees Insurance Co. v. Campbell*,[429] the court held that barring the rejection of an arbitration award was a proper remedy when an insurer failed to produce a claims adjuster as requested by a Rule 237(b) notice.[430] A vehicle insured by Government Employees Insurance Company ("GEICO") was involved in an accident and GEICO brought a subrogation claim against the driver. The arbitrators awarded GEICO no damages. The arbitrators found that GEICO violated the defendant's Rule 237(b) Notice to Produce by failing to produce the "adjuster with the entire claim file" at the arbitration. GEICO attempted to reject the award but the trial court barred GEICO from rejecting the award. At the mandatory arbitration hearing, counsel for GEICO appeared along with their insured. The claims adjuster and the claim file were not produced.[431]

GEICO appealed the trial court's order barring it from rejecting the award.[432] GEICO claimed that the action did not warrant an extreme

427. *Yacko*, 339 Ill. App. 3d at 303–04, 789 N.E.2d at 1277–78.
428. *Id.* at 303, 789 N.E.2d at 1277.
429. No. 1–02–0748, 2002 Ill. App. LEXIS 1116, 781 N.E.2d 639 (1st Dist. Nov. 27, 2002).
430. *Id.* at *12–13, 781 N.E.2d at 643–44.
431. *Id.* at *3, 781 N.E.2d at 640.
432. *Id.* at *2–3, 781 N.E.2d at 640.

sanction resulting in the loss of its $17,000 subrogation claim. The court of appeals found that the defendant filed a proper Rule 237 notice and GEICO failed to provide any explanation for its noncompliance. The court found that "'[a] consistent theme throughout the [r]ules governing mandatory arbitration is the need for parties and their counsel to take these proceedings seriously . . . .'"[433] The court of appeals upheld the barring of GEICO's right to reject the arbitration award.

In *State Farm Insurance Co. v. Koscelnik*,[434] the court held that an insurer who did not present its insured at an arbitration when liability was contested, failed to participate in good faith as required by Illinois Supreme Court Rule 91 ("Rule 91").[435] The insurer was precluded from contesting the arbitration award.[436] The plaintiff's insured was involved in a car accident with the defendant. The plaintiff filed a subrogation action against the defendant, which was set for arbitration pursuant to Illinois Supreme Court Rule 86.[437] Both parties contested liability. At the arbitration hearing, the plaintiff presented a claims adjuster, but not its insured. The arbitrators found for the defendant. The plaintiff filed a notice of rejection of the award. The defendant moved to bar the plaintiff's rejection because the plaintiff failed to participate in good faith as mandated under Rule 91. The trial court found for the defendant.[438]

The appellate court began with Rule 91, which in essence provides that: "a party waives the right to reject an arbitration award when the party fails: (1) to appear, 'either in person or by counsel, at the arbitration hearing'; or (2) to 'participate in the hearing in good faith and in a meaningful manner.'"[439] The court stated that an arbitration was not a hurdle to be crossed in getting a case to trial.[440] To give meaning to an arbitration, a party must subject an opposing side's case to the type of adversarial testing expected at a trial. The court added that because liability was at issue, there was a need for an eyewitness, the plaintiff's insured, to test the defendant's case. The court explained

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433. Williams v. Dorsey, 273 Ill. App. 3d 893, 900, 652 N.E.2d 1286, 1291 (1st Dist. 1985), quoted in *Campbell*, 2002 Ill. App. LEXIS 1116, at *8, 781 N.E.2d at 642.
434. 342 Ill. App. 3d 808, 795 N.E.2d 1001 (1st Dist. 2003).
435. *Id.* at 813, 795 N.E.2d at 1005; ILL. SUP. CT., R. 91.
436. *Koscelnik*, 342 Ill. App. 3d at 815, 795 N.E.2d at 1006.
437. ILL. SUP. CT., R. 86.
438. *Koscelnik*, 342 Ill. App. 3d at 810, 795 N.E.2d at 1002.
439. *Id.*, 795 N.E.2d at 1003 (internal quotations added from ILL. SUP. CT., R. 91(a),(b)).
440. *Koscelnik*, 342 Ill. App. 3d at 813, 795 N.E.2d at 1005.

that it was unlikely the plaintiff would have failed to present its insured had the case gone to trial. Therefore, the court affirmed the decision barring the plaintiff from rejecting the arbitration award because the plaintiff failed to participate at the arbitration in good faith.[441]

In *Travis v. American Manufacturers Mutual Insurance Co.*,[442] the court held that appraisal requirements are enforced only when the subject matter of the claim clearly falls within the appraisal clause.[443] The plaintiff brought a class action suit against an automobile insurer. The plaintiff alleged that the insurer engaged in a fraudulent scheme to undervalue its insureds' damaged vehicles which were declared a total loss in order to increase its own profits. The policy issued to the insured contained an appraisal clause requiring the parties to submit to an appraisal process when they disputed the amount to be paid for a loss. The insurer's position was that the allegations about the fraudulent scheme should have been dismissed pending an appraisal of the insured's vehicle. The court of appeals stated that "[t]his argument makes no sense in the context of defendant's motion in the trial court" seeking to have all issues determined by the appraisal.[444] Like arbitration provisions, appraisal provisions should be enforced if it is clear and obvious that the dispute to be arbitrated falls within the scope of the arbitration clause. The plaintiff did not seek a determination of damage, but alleged a fraudulent scheme by the insurer. Consequently, the allegations against the insurer did not fall within the appraisal clause and the court denied the insurer's motion to compel an appraisal.[445]

In *Hanke v. American International South Insurance Co.*,[446] the court held that appraisal requirements will be enforced only when the subject matter of the claim clearly falls within the appraisal clause.[447] The decision in *Hanke* is a companion to the decision in *Travis*. The decision in *Hanke* was announced by the same court as *Travis*.[448] *Hanke* was based upon the same factual scenario and had the same result. To summarize *Hanke*, an insured alleged that the insurer was engaged in a fraudulent scheme to undervalue cars when they were declared a total

441. *Id.*
442. 335 Ill. App. 3d 1171, 782 N.E.2d 322 (5th Dist. 2002).
443. *Id.* at 1175–76, 782 N.E.2d at 326.
444. *Id.* at 1175, 782 N.E.2d at 326.
445. *Id.* at 1177, 782 N.E.2d at 327.
446. 335 Ill. App. 3d 1164, 782 N.E.2d 328 (5th Dist. 2002).
447. *Id.* at 1170, 782 N.E.2d at 333.
448. *Id.* at 1164, 782 N.E.2d at 328; *Travis*, 335 Ill. App. 3d at 1171, 782 N.E.2d at 322.

loss.[449] The insurer sought to enforce an appraisal provision within the policy. The court of appeals held that the appraisal process applied to the determination of the value of a vehicle, but not to allegations that the insurer engaged in a fraudulent scheme. Consequently, the insurer's motion to enforce the appraisal provision was properly denied by the trial court.

K. Errors and Omissions Insurance

In *Twin City Fire Insurance Co. v. Somer*,[450] the court held there was no duty to defend allegations of a breach of fiduciary duty or fraud under an errors and omission policy which excluded coverage for breach of fiduciary duty and intentional fraud.[451] The insurer issued a public officials errors and omission policy to Bloom Township. The underlying suit alleged that the defendants were involved in a fraudulent scheme, acquiring certificates of purchases at delinquent properties. The underlying plaintiffs filed a five count complaint against the defendants alleging various acts of fraud and breaches of their fiduciary duties. The defendants sought coverage under the errors and omission policy issued by the insurer. The insurer denied coverage because the alleged acts of dishonesty and fraud were excluded under the policy. The trial court granted the insurer's motion for summary judgment.[452] The court of appeals read the complaint as a whole and determined that it essentially stated two causes of action, breach of fiduciary duty and intentional fraud.[453] Both acts were specifically excluded under the policy. Accordingly, the insurer had no duty to defend any of the allegations contained within the underlying complaint.[454]

In *Tig Insurance Co. v. Reliable Research Co.*,[455] the court held that in an application for an errors and omission policy, an insured's omission of a permanent injunction enjoining the preparation of deeds or other legal documents constituted a material misrepresentation.[456] The

449. *Hanke*, 335 Ill. App. 3d at 1167, 782 N.E.2d at 330.
450. 342 Ill. App. 3d 424, 794 N.E.2d 958 (1st Dist. 2003).
451. *Id.* at 431–32, 794 N.E.2d at 964–65.
452. *Id.* at 425, 794 N.E.2d at 960.
453. *Id.* at 431, 794 N.E.2d at 964.
454. *Id.* at 431–32, 794 N.E.2d at 964–65.
455. 334 F.3d 630 (7th Cir. 2003).
456. *Id.* at 635–37.

insurer was entitled to a recession of the policy. This litigation arose from an error made during a real estate closing by the insured. After the insured tendered its claim to the insurer for coverage, the insurer discovered that the insured had not been totally forthcoming in its insurance application. The insured failed to disclose that it had a permanent injunction entered against it which enjoined the preparation of deeds or other legal documents. The insurer sought to rescind the policy because the insured's omission constituted a material misrepresentation. The district court agreed and granted the insurer's motion for summary judgment. The insured appealed. The court held that the failure to include the permanent injunction in the application constituted a material misrepresentation, because a disclosure would have presented a red flag to any "'reasonably careful and intelligent'" person in deciding whether to extend coverage.[457]

V. MEDICAL AND HEALTH INSURANCE

In *Golden Rule Insurance Co. v. Schwartz*,[458] the court held that the inclusion of the term "knowledge and belief" in an application for health insurance established a lesser standard of accuracy than that imposed under Section 154 of the Illinois Insurance Code.[459] Golden Rule Insurance Company issued health insurance to Mark Schwartz, the insured. The insured became injured in an automobile accident and suffered serious injuries. After receiving a request for coverage, Golden Rule learned that the insured was listed as a dependent on another insurance policy. The insurer rescinded its policy because the insured denied that he was covered by other insurance in his application. The insurer also relied upon the following application language: "[t]his policy will not be issued as a supplement to other health plans . . . [a] misstatement in the application about other medical insurance may cause us to void the policy."[460] The application also contained the following statement above the signature line: "I represent that the statements and answers in this application are true and complete to the best of my knowledge and belief."[461]

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457. *Id.* at 635 (quoting Small v. Prudential Life Ins. Co., 246 Ill. App. 3d 893, 896, 617 N.E.2d 80, 83 (1st Dist. 1993)).
458. 203 Ill. 2d 456, 786 N.E.2d 1010 (2003).
459. *Id.* at 466, 786 N.E.2d at 1016.
460. *Id.* at 459–60, 786 N.E.2d at 1013.
461. *Id.* at 460, 786 N.E.2d at 1013.

The insurer filed a declaratory judgment alleging that the insured's failure to disclose the existence of other health insurance constituted a material misrepresentation which justified recession of the policy. The insured filed a countersuit alleging improper practices allowing recovery of attorney fees under Section 155 of the Insurance Code.[462] The circuit court held, as a matter of law, that the insured did not make material misrepresentations regarding other health insurance coverage and that the insured was entitled to sanctions but not attorney fees.[463] The appeals court reversed the trial court on the issue of misrepresentation and fees.[464]

The Illinois Supreme Court reviewed Section 154 of the Insurance Code, which provides in part: "[n]o misrepresentation . . . by the insured . . . in the negotiation for a policy of insurance . . . shall defeat or void the policy . . . unless it shall have been made with actual intent to deceive or materially affects either the acceptance of the risk or the hazard assumed by the company."[465] The statute established a two-prong test used in situations where insurance policies may be voided.[466] First, the statement must be false. Second, the false statement must have been made with intent to deceive, or must materially affect the acceptance of the risk or hazard assumed by the insurer.[467]

However, the application for insurance contained the qualifier "knowledge and belief."[468] This language established a lesser standard of accuracy than that imposed by Section 154. The court added that the determination of the insured's "knowledge and belief" at the time of application was an assessment involving credibility that may only be made by a jury. The court affirmed the decision vacating the circuit court's entry of summary judgment on the issues of policy recession and attorney fees.[469]

VI. SUBROGATION

A. Subrogation Generally

462. *Id.* at 461, 786 N.E.2d at 1013.
463. *Id.*
464. *Id.* at 461–62, 786 N.E.2d at 1014.
465. 215 ILL. COMP. STAT. 5/154.
466. *Golden Rule*, 203 Ill. 2d at 464, 786 N.E.2d at 1015.
467. *Id.*
468. *Id.* at 460, 786 N.E.2d at 1013.
469. *Id.* at 469, 786 N.E.2d at 1018.

In *State Farm Mutual Insurance Co. v. Nasser*,[470] the court held that in a subrogation action by an insurer, a Rule 237 notice to produce must at least identify the specific individual.[471] However, the Rule 237 Notice does not apply to a non-party such as State Farm's insured. A State Farm insured was involved in an automobile accident resulting in property damage and medical expenses of approximately $8,000. State Farm brought a subrogation action against the defendant seeking reimbursement of the amounts paid to its insured under an automobile policy. The defendant filed a notice to produce pursuant to Supreme Court Rule 237[472] notifying the plaintiff to produce the "Plaintiffs, [plaintiff's insured] and Co-Defendant(s)" at the mandatory arbitration hearing.[473] At the mandatory arbitration only the plaintiff's attorney appeared. The arbitrators entered an award only for the property damage. The award did not state that the plaintiff acted in bad faith. The defendant rejected the award, requested a trial, and moved for sanctions. The defendant sought to bar the plaintiff from presenting any evidence at trial because the plaintiff failed to participate in the arbitration in good faith and violated Rule 237 by not producing the insured or an adjuster at the arbitration.[474]

The trial court held that the standard is whether the attorney would have tried the case in the same way the attorney approached the arbitration.[475] The trial court held that State Farm did not participate in good faith and entered an order barring the plaintiff from presenting any evidence at trial. Defendant was granted summary judgment. On appeal, State Farm argued that the appearance of counsel was sufficient and that the appearance of the party and its counsel are not required in order to avoid sanctions. The court of appeals held that "[a] party is required to participate in an arbitration hearing in good faith by subjecting the case to the type of adversarial testing expected at trial."[476] State Farm had filed a subrogation action to recover damages paid to its insured. The defendant had admitted liability prior to the arbitration. The plaintiff presented evidence of property damage. The

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470. 337 Ill. App. 3d 362, 785 N.E.2d 934 (1st Dist. 2003).
471. *Id.* at 368, 785 N.E.2d at 939.
472. ILL. SUP. CT., R. 237.
473. *Nasser*, 337 Ill. App. 3d at 364, 785 N.E.2d 936.
474. *Id.* at 365, 785 N.E.2d at 936.
475. *Id.* at 365, 785 N.E.2d at 936–37.
476. *Id.* at 367, 785 N.E.2d at 938.

arbitrators awarded plaintiff damages in the amount of 85% of the property damages claimed. The arbitrators did not find that the plaintiff failed to participate in good faith. However, there was no evidence concerning the medical payments.[477]

The defendant argued that the plaintiff failed to comply with the Rule 237(b) notice.[478] The court found that the defendant's notice to produce was defective because it did not designate a specific employee to appear. This was a subrogation action and the State Farm insured was not a party to the lawsuit. The Rule 237(b) notice to produce did not apply to a non-party such as the State Farm insured. The proper way to secure the State Farm insured as a witness was through the service of a subpoena. Thus, State Farm participated in the arbitration in good faith and the trial court had abused its discretion by barring all evidence at trial.[479]

In *Eddy v. Sybert*,[480] the court held that an insurer's subrogation right for the reimbursement of medical expenses was enforceable, subject to a reduction under the common fund doctrine.[481] Illinois courts do not recognize the made-whole doctrine. Therefore, subrogation is permissible even though the plaintiffs may not be made-whole in their recovery. The issue reviewed by the appellate court was whether the trial court erred in awarding State Farm its full subrogation lien for medical payments made by State Farm under a policy with plaintiff, minus a reduction under the common fund doctrine.[482]

A plaintiff, insured by State Farm, was involved in an automobile accident with the defendant who was also insured by State Farm.[483] The defendant's policy with State Farm provided for maximum liability limits of $100,000 per person. The plaintiff's policy provided for medical-pay coverage in the amount of $25,000. The plaintiff's policy also contained a subrogation clause that allowed State Farm to obtain plaintiff's right to recover against a third-party after State Farm paid the plaintiff's medical bills. The subrogation provision provided in part as follows:

Under medical payments coverage:

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477. *Id.*
478. *Id.* at 365, 785 N.E.2d at 936.
479. *Id.* at 368, 785 N.E.2d at 939.
480. 335 Ill. App. 3d 1136, 783 N.E.2d 106 (5th Dist. 2003).
481. *Id.* at 1141, 783 N.E.2d at 110.
482. *Id.* at 1139, 783 N.E.2d at 110.
483. *Id.* at 1137, 783 N.E.2d at 107.

> we are subrogated to the extent of our payment to the right of recovery the injured *person* has against any party liable for the *bodily injury* . . . if the *person* to or for whom we make payment recovers from any party liable for the *bodily injury*, that *person* shall hold in trust for us the proceeds of the recovery and reimburse us to the extent of our payment.[484]

State Farm made payments to the plaintiff and also informed the plaintiff that it would "not subrogate for the amount we have paid if your recovery from the responsible party plus our payments do not exceed your damages."[485] The plaintiff brought suit against the defendant, who would settle for the liability limits of $100,000. State Farm paid approximately $20,000 of the plaintiff's medical expenses. At the time of the payment of the $100,000 settlement, State Farm issued one check representing the $20,000 medical expenses less one-third of that amount pursuant to the common fund doctrine. State Farm also issued a second check for the balance of the $100,000. The medical lien check of approximately $13,000 was payable to State Farm, the plaintiff, and her attorneys. State Farm refused to pay the plaintiff unless the plaintiff agreed to pay the $13,000 to State Farm pursuant to its right of subrogation.[486]

The plaintiff filed a motion to adjudicate the lien.[487] State Farm argued that it was entitled to a lien for medical payments under the policy for approximately $20,000. State Farm agreed to pay the plaintiff for a reduction of one-third of the $20,000 under the common fund doctrine. State Farm also alleged that it had no future duty to pay medical bills because the plaintiff settled with the defendant. The settlement destroyed any right of subrogation that State Farm may have had. The court noted that subrogation rights originated in equity. However, where the right is created by an enforceable subrogation clause in a contract, the contract terms, not common law or equitable principals, apply. The contract stated that if the plaintiff recovers from any party liable for bodily injury, State Farm has a right to recover against that third-party.[488]

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484. *Id.* at 1137, 783 N.E.2d at 107 (emphasis in original).
485. *Id.*
486. *Id.* at 1138, 783 N.E.2d at 108.
487. *Id.*
488. *Id.* at 1140, 783 N.E.2d at 109.

The plaintiff asserted the make-whole doctrine and argued that she was not made whole by the underlying settlement.[489] Therefore, there should be no right to subrogation on the part of State Farm. The court did not find an Illinois case holding that there is no right to subrogation unless the plaintiff is made whole by the underlying settlement. The court reviewed the decision in *Gibson v. Country Mutual Insurance Co.*[490] The plaintiff in *Gibson* attempted to avoid the insurers subrogation and reimbursement provisions arguing that the provisions violated public policy because she had not been fully compensated for her damages.[491] The court in *Gibson* declined to follow the made-whole doctrine that has been adopted in other jurisdictions.[492] In *Eddy*, State Farm was entitled to assert its subrogation right despite the fact that the plaintiff may have not been made whole by the underlying settlement. State Farm also properly reduced its lien based on the common fund doctrine.[493]

B. Subrogation of Fraud Claim

In *CNA Insurance Co. v. DiPaulo*,[494] the court held that an insurer that pays its insured for property damage from termite infestation may subrogate its insured's claim for fraud against the seller of the home.[495] The insureds purchased a home from the defendants containing termites. The insureds filed a claim with the plaintiff under a homeowner's policy. The plaintiff paid the costs of repair and replacement and subrogated its insureds' claim for fraud against the defendants. The trial court granted the defendant's summary judgment motion because the plaintiff could not subrogate its insureds' collateral contract rights.[496]

The appellate court began its analysis by explaining that the insurer "may assert a right of subrogation against the defendants if: (1) the [insureds] could maintain a cause of action . . . and (2) it would be

489. *Id.*, 783 N.E.2d at 110.
490. 193 Ill. App. 3d 87, 549 N.E.2d 23 (3d Dist. 1990) (noting that the plaintiff recovered medical payments under her own insurance policy, then negotiated a settlement with a defendant who was insured by the same company).
491. *Id.* at 91, 549 N.E.2d at 25.
492. *Id.* at 91–92, 549 N.E.2d at 25–26.
493. *Eddy*, 335 Ill. App. 3d at 1141–42, 783 N.E.2d at 110–11.
494. 342 Ill. App. 3d 440, 794 N.E.2d 965 (1st Dist. 2003).
495. *Id.* at 443–44, 794 N.E.2d at 968–69.
496. *Id.* at 442, 794 N.E.2d at 967.

equitable . . . to enforce a right of subrogation."[497] The court held that the insurer had a subrogation right. Unlike cases denying subrogation by insureds who pay claims for property damage because of fire damages and then attempt to subrogate the insured's contract claim for the outstanding purchase price against the buyer, the court explained that in this case the plaintiff was not asserting its insureds' contract rights. The insurer was instead asserting a common law fraud claim.

VII. BAD FAITH) DELAY UNDER SECTION 155

In *Johnson Press of America, Inc. v. Northern Insurance Co. of New York*,[498] the court held that a seventy-two day period between receipt of a claim and denial by an insurer did not constitute unreasonable or vexatious conduct which constituted bad faith under Section 155 of the Insurance Code.[499] The insured maintained a property policy with Northern Insurance Company of New York for several buildings. A roof on one of the buildings collapsed and the insured made a claim for coverage. Upon receipt of the claim the insurer retained experts to determine the cause of the collapse in order to render a coverage opinion. Seventy-two days after receipt of the claim, the insurer denied the claim based on the experts' reports. The experts concluded that the collapse resulted from long-term deterioration and water infiltration. Both the deterioration and water infiltration were excluded under the policy. The insured instituted suit and the trial court granted the insurer's motion for summary judgment.[500]

Affirming the trial court's decision, the court of appeals noted that the evidence, including the plaintiff's own expert's opinion, showed the collapse resulted from long-term deterioration and water infiltration.[501] The court noted that the property policy unambiguously excluded coverage for damages caused by such events. In rejecting the insured's bad faith argument, the court explained that length of time, alone, does not determine whether an insurer's conduct is unreasonable or vexatious. The court held that the insurer responded and examined the claim in an expeditious manner.[502]

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497. *Id.* at 442–43, 794 N.E.2d at 968.
498. 339 Ill. App. 3d 864, 791 N.E.2d 1291 (1st Dist. 2003).
499. *Id.* at 874–75, 791 N.E.2d at 1300–01; 215 ILL. COMP. STAT. 5/155 (2003).
500. *Johnson Press*, 339 Ill. App. 3d at 870–71, 791 N.E.2d at 1297.
501. *Id.* at 872, 791 N.E.2d at 1299.
502. *Id.* at 875, 791 N.E.2d at 1300.

VIII. CONCLUSION

Illinois courts have continued the trend of enforcing policy language as written and have improved interpretations of undefined policy terms. The courts have continued to view the insurance policy as a contract between two parties that are at slightly different bargaining levels. The courts enforce the duty to perform under the contract, while providing remedies to the insured for the insurer's failure to perform. Illinois courts have made this a year of the commercial policy. In particular, there has been a signal of limitations on the "targeted tender" and a reinforcement for horizontal exhaustion. This year, policy exclusions have been upheld more than stuck down and the "targeted tender" inched closer to being applied in the rental car arena.