

SURVEY OF ILLINOIS LAW: INSURANCE LAW

Managing Editor: David J. Roe*

* David J. Roe practices in the area of insurance coverage, casualty and commercial disputes. From detailed coverage opinions to declaratory actions, David represents clients in Chicago, Illinois, and other states in insurance matters including general liability, car insurance and complex toxic tort litigation involving the duty to defend, high limit insurance coverage, allocation and priority of payment issues, ranging from under \$1 million to over \$600 million.

David is the author of “Illinois Automobile Insurance Law” published by Thomson/West and is Managing Director for www.ApexCLE.com, a continuing legal education company. He is Managing Editor of The Policy, the ISBA’s publication on insurance law. He has served as a session speaker at the 2004 and 2005 PLRB/LIRB Claims Conference & Insurance Services Expo and presented CLE seminars for ApexCLE, the ISBA, and in numerous states including Illinois, New York, Texas, Georgia, and Michigan. David is also an award winning winemaker, taking home awards in 2005 and 2006.

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INTRODUCTION

This article analyzes significant Illinois opinions relating to insurance law issued from October 1, 2006 through September 30, 2007. 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 the result of the combined effort of the members of the Illinois State Bar Association Insurance Law Section. David J. Roe, Managing Director with ApexCLE.com, coordinated the creation of this article alongside the best of the ISBA's Insurance Counsel to edit and write this comprehensive review of insurance decisions. Contributing authors and editors include: Michael F. Dahlen of Feirich/Mager/Green/Ryan, Adam E. Jones of Ross, Dixon & Bell, LLP, and David M. Kroeger of Jenner & Block LLP. Also contributing were the co-editors of The Policy, the ISBA Insurance Section publication. They include Nancy K. Caron, Robert H. Hanaford, Michael R. Hartigan, Laura M. Kotelman, Ellen J. Zabinski, and Patricia A. Zimmer. These members devote their time and effort to create scholarly work for attorneys, judges, and the public. Those efforts are greatly appreciated.

This article is divided into multiple sections addressing the construction of insurance policies, issues under general liability, commercial policies, personal lines, and automobile coverage.

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

A. *Construction of the Policy and Duties of the Insurer and Insured*

i. Duty to Cooperate

Cooperation clause within policy and common interest doctrine overcome attorney client privilege and work product doctrine under Illinois law.

In *Allianz Ins. Co. v. Guidant Corp.*,¹ after Guidant Corporation was sued numerous times for product liability, its insurers declined coverage and brought this action in Illinois. The insurers' suit claimed fraud in the application for insurance and seeks declaratory relief regarding coverage under the policies issued. The insurers sought discovery through subpoenas of consultants and production of certain documents from Guidant related to Guidant's investigation of regulatory deficiencies with the device at issue in the underlying suits, and communication between Guidant and its attorneys in the underlying suits. The trial court granted the insurers' motions to compel discovery, and the appellate court affirmed.²

The appellate court first determined that a conflict of law existed between the various states on the issue of the protection afforded by both the attorney/client privilege and the work product doctrine.³ Analyzing *Waste Management, Inc. v. International Surplus Lines Insurance Co.*, the court concluded that, under Illinois law, the insurers were entitled to the discovery being sought.⁴ Noting that the two other states with a potential interest in the litigation, California and Indiana, both rejected the *Waste Management* holding, the court determined that a choice-of-law

¹ *Allianz Ins. Co. v. Guidant Corp.*, 373 Ill. App. 3d 652, 869 N.E.2d 1042 (2d Dist. 2007).

² *Id.* at 653, 869 N.E.2d at 1045.

³ *Id.* at 658, 869 N.E.2d at 1048.

⁴ *Id.* at 655, 869 N.E.2d at 1049 (citing *Waste Mgmt., Inc. v. Int'l Surplus Lines Ins. Co.*, 144 Ill. 2d 178 (1991)).

analysis was required.⁵ Illinois follows the Restatement of Conflicts to resolve the choice-of-law issue.⁶ The Restatement (Second) requires a “special reason” to conclude that the forum policy favoring admission of the evidence would not be followed.⁷ Finding that a “special reason” did not exist in this case, the court then relied upon *Waste Management* to conclude that the materials sought were fully discoverable.⁸ As to the attorney/client privilege, the court determined that a common interest existed between Guidant and the insurers in the underlying litigation, and that the duty to cooperate called for under the policies requires Guidant to produce the materials sought.⁹ The court rejected Guidant’s attempt to distinguish *Waste Management* on the basis of the fraud claim by the insurers, finding that Illinois’ strong policy of disclosure overcame any such distinction.¹⁰ Moving to the work product doctrine, the court held that the insurers were not an adversarial party in the underlying litigation, such that Guidant would require any protection under the doctrine.¹¹

ii. Number of Occurrences

In *Nicor, Inc. v. Associated Electrical and Gas Insurance Services Ltd.*,¹² the Illinois appellate court rejected the trial court's conclusion that liability incurred by appellant gas company for remediation of mercury contamination was due to a single occurrence, reversed the trial court's judgment, and remanded the case to the trial court for further proceedings. It found

⁵ *Id.* at 658, 869 N.E.2d at 1048.

⁶ *Id.* at 667, 869 N.E.2d at 1056 (citing *Morris B. Chapman & Assoc. Ltd. v. Kitzman*, 193 Ill. 2d 560, 568 (2000)).

⁷ Restatement (Second) of Conflicts of Law §139(2) (1971).

⁸ *Id.* at 662, 869 N.E.2d at 1052.

⁹ *Id.* at 663, 869 N.E.2d at 1053.

¹⁰ *Id.* at 676, 869 N.E.2d at 1063.

¹¹ *Id.*

¹² *Nicor, Inc., et al. v. Associated Elec. & Gas Ins. Services Ltd.*, 223 Ill. 2d 407, 409, 860 N.E.2d 280, 283 (2007).

that separate occurrences were involved.¹³ The Illinois Supreme Court granted the gas company's petition for leave to appeal.¹⁴

The gas company expended sums to remediate mercury contamination caused by the removal of gas meter regulators from the homes of its residential customers between certain years. Thereafter, it initiated litigation against the insurers to recover sums it expended pursuant to property insurance policies it had with the insurers. Some insurers settled and some did not. The gas company filed a declaratory judgment action against the insurers who did not settle. Liability was predicated on property damage growing out of "an occurrence."¹⁵ Of the homes where mercury contamination was discovered and remediation was carried out, 195 were subject to the insurance policies of the insurers who did not settle. The central issue in the litigation was construction of the term "occurrence" since that would determine the insurers' duty to indemnify.¹⁶ The trial court agreed with the gas company that only a single occurrence was involved. The appellate court found that 195 separate occurrences were involved and reversed. On further review, the Illinois Supreme Court found that the "cause theory" applied and under that theory, 195 separate occurrences were involved rather than one single incident.¹⁷

iii. Liability For Losses Due To Business Interruption

In *Baxter International, Inc. v. American Guarantee and Liability Insurance Co.*,¹⁸ plaintiff, a manufacturer of medical products, filed a declaratory judgment action against defendant, an insurance company, concerning a dispute over insurance coverage, and the

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.* at 416, 860 N.E.2d at 285.

¹⁶ *Id.*

¹⁷ *Id.* at 440, 860 N.E.2d at 299.

¹⁸ *Baxter Int'l, Inc. v. Am. Guarantee & Liab. Ins. Co.*, 369 Ill. App. 3d 700, 702, 861 N.E.2d 263, 266 (1st Dist. 2006).

company filed a counterclaim. The Circuit Court of Cook County (Illinois) granted summary judgment to the manufacturer but denied the manufacturer's motion for sanctions pursuant to Illinois law.¹⁹ Both parties appealed the judgment.

The manufacturer's Puerto Rican facilities were damaged by a hurricane. A dispute arose between the parties as to whether the profit component of a damaged inventory payment had to be considered in calculating the company's total actual loss during the period of business interruption. The manufacturer sought a declaration that the company's liability for losses due to business interruption was independent of its liability for damaged inventory. The appellate court found that the insurance policy was ambiguous as to whether gross earnings during the period of business interruption included earnings realized from the company's indemnification of the manufacturer's damaged finished goods.²⁰ The appellate court held that the company's indemnification payment was a sale and could be considered to calculate lost profit or reduction in gross earnings under the policy.²¹ Thus, the trial court erred in granting summary judgment to the manufacturer as to that issue.²² The appellate court held that the trial court properly denied the manufacturer's motion for sanctions under Illinois law, as a bona fide dispute over coverage existed.²³

iv. Mend the Hold Doctrine

In *Grinnell Mutual Reinsurance Co., v. Grant Laforge*,²⁴ defendant insured sought review of a judgment entered by the Circuit Court of Logan County (Illinois), which granted plaintiff insurer's motion for summary judgment in a declaratory judgment action to determine if the

¹⁹ See 215 Ill. Comp. Stat. Ann. 5/155 (2004).

²⁰ *Baxter Int'l*, 369 Ill. App. 3d at 706, 861 N.E.2d at 269 (citing *Central Il. Light*, 213 Ill. 2d 141, 153 (2004)).

²¹ *Id.* at 708, 861 N.E.2d at 271.

²² *Id.*

²³ *Id.* at 710, 861 N.E.2d at 272.

²⁴ *Grinnell Mut. Reinsurance Co, v. Grant Laforge*, 369 Ill. App. 3d 688, 863 N.E.2d 1132 (4th Dist. 2006).

insurer owed a defense to the insured in an underlying case brought by defendant subrogee to recover amounts paid for the loss of several hundred pigs that died while in the insured's care.

The insured was to care for the subrogor's pigs at his farm for a fee. After the electricity was turned off at the insured's farm, about 700 of the subrogor's pigs died. The insurer informed both the subrogor and the insured that no coverage existed under a farm guard policy for the loss. The insured notified the insurer of the subrogee's claim and subsequently forwarded the subrogee's complaint in the underlying action. While the insured argued that the insurer failed to timely file the declaratory action, no duty to file a declaratory judgment action or proceed under a reservation of rights existed until a lawsuit had been filed against the insured even though the policy language referred to both a claim and a suit, which were not equivalent. Although the insured asserted that the mend-the-hold doctrine barred the insurer from claiming that the loss was not covered under the custom farming exclusion, it was not asserted in the initial correspondence. The insurer did assert that additional basis long before the declaratory judgment action was filed, and, thus, the mend-the-hold doctrine did not apply, particularly as there was no detriment, unfair surprise, or arbitrariness.²⁵

In *Liberty Mutual Insurance Co. v. American Home Assurance Co.*,²⁶ plaintiff, an insurance company, appealed from an order of the Circuit Court of Cook County (Illinois) which granted summary judgment in favor of defendants, insurance companies, on plaintiff's claims for equitable subrogation, prejudgment interest, and attorney fees and costs under 215 Ill. Comp. Stat. Ann. 5/155 (2000). Plaintiff also appealed an order which granted defendant's motion to strike an exhibit to plaintiff's reply brief.

²⁵ *Id.* at 699, 863 N.E.2d at 1141.

²⁶ *Liberty Mut. Ins. Co. v. Am. Home Assurance Co.*, 368 Ill. App. 3d 948, 858 N.E.2d 530 (1st Dist. 2006).

After plaintiff's insured settled an underlying personal injury action, plaintiff brought the instant action seeking subrogation from defendants under policies issued by defendants which listed the insured as an additional insured. A defendant asserted that the ramp on which the fall involved in the underlying litigation occurred was abandoned by a construction company when it finished its construction work at the insured's facility, approximately three months prior to the injury, and thus no coverage existed. The appellate court found that the policy in question specifically excluded abandoned materials from the definition of completed work.²⁷ Thus, the defendant was entitled to summary judgment on the subrogation claim.²⁸ The appellate court further held that the mend-the-hold doctrine did not bar the defendant from asserting the abandoned and unused materials exclusion of the policy, as the defendant had not attempted to change its initial reason for refusing benefits during litigation.²⁹ Because the defendant correctly relied on the policy exclusion, the appellate court held that costs and sanctions under 215 Ill. Comp. Stat. Ann. 5/155 (2000) were not warranted.³⁰

v. Fraud and Misrepresentation

Trial court correctly instructed the jury on the elements of the affirmative defense of “concealment or fraud” provision of the policy at issue.

In *Barth v. State Farm Fire and Casualty Co.*,³¹ State Farm refused to pay a fire claim on plaintiff's property. The case was tried to a jury, with a verdict in favor of State Farm. On appeal, the plaintiff argued that the court improperly instructed the jury. The appellate court affirmed the trial court. The court looked to the applicable policy provision, which stated: “This

²⁷ *Id.* at 961, 858 N.E.2d at 541.

²⁸ *Id.* at 950, 858 N.E.2d at 533.

²⁹ *Id.* at 960, 858 N.E.2d at 540.

³⁰ *Id.* at 962, 858 N.E.2d at 542.

³¹ *Barth v. State Farm Fire & Cas. Co.*, 371 Ill. App. 3d 498, 867 N.E.2d 1109 (4th Dist. 2007).

policy is void as to you and any other insured, if you or any other insured under this policy has intentionally concealed or misrepresented any material fact or circumstance relating to this insurance, whether before or after a loss.” The pertinent evidence at trial was that the insured had met with State Farm representatives after the fire and did not mention that he had an American Express credit card, and said that he had been unable to obtain money from an ATM machine on the evening of the fire because he may have used the wrong password. At a later deposition, plaintiff stated that his ATM card was rejected because of insufficient funds. Plaintiff also stated in his deposition that he was current on his mortgage payments at the time of the fire, but a representative of the bank that held his mortgage testified that Plaintiff was two months behind in his payments at the time of the fire. The jury found that State Farm had proved by clear and convincing evidence that plaintiff had “concealed or misrepresented a fact or circumstance or made a false statement relating to the insurance, or he had misrepresented any material fact to defendant either before or after the claim.”³² The jury also found “(1) the fact concealed or misrepresented, or the subject of the false statement, was material; (2) the concealment, misrepresentation, or false statement was made to the defendant or their agents; and (3) the concealment, misrepresentation, or false statement was made knowingly, willfully, and with intent to deceive defendant.”³³

The plaintiff argued on appeal that the court should have included two additional elements, pursuant to the common law of fraudulent concealment. The appellate court held that the language of the policy did not require that all the elements of common law fraudulent concealment be proved by defendant in order to void the policy. Specifically, plaintiff argued that the additional elements of reliance on the truth of the statements at issue and damage as a

³² *Id.* at 504, 88 N.E.2d at 1115.

³³ *Id.* at 503, 88 N.E.2d at 1114.

result of that reliance should have been included in the instruction. However, the court found that the policy language only required the elements set out in the jury instruction given, and defendant did not need to prove fraud or detrimental reliance.

Justice Cook dissented, first pointing out that exclusionary clauses are to be strictly construed against the insurer. He took exception with the instruction, tendered by State Farm, that defined “material” in the following way: “A concealment, misrepresentation, or false statement is material if a reasonable insurer would attach importance to it at the time it was made. A reasonable insurer would attach importance to any fact or statement that would affect the insurer’s action or attitude regarding a claim by an insured.”³⁴ Justice Cook stated that this instruction was contrary to the law, in that it “significantly lessens the requirement that the alleged misstatement be one that ‘might have affected’ the insurer.”³⁵ In his view, the given instruction allowed the jury to find that any misstatement, no matter how minor, could be material. He would have held that the instruction did not adequately state the law, and that the verdict was against the manifest weight of the evidence, because no jury could conclude that State Farm’s disposition of the claim could have been affected by the statements made, or that the insured had an intent to deceive.³⁶

No valid claim existed for material misrepresentation when insured failed to allege that undisclosed drivers lived with insured when applications were executed.

Universal Casualty Co. v. Lopez,³⁷ involved two sets of facts with the same legal issue: whether the insureds made material misrepresentations on their applications for insurance thus voiding coverage. In the *Lopez* matter, Universal Casualty Company (Universal) alleged that

³⁴ *Id.* at 510, 88 N.E.2d at 1120.

³⁵ *Id.*

³⁶ *Id.* at 513, 88 N.E.2d at 1122.

³⁷ *Universal Cas. Co. v. Lopez*, 376 Ill. App. 3d 459, 876 N.E.2d 273 (1st Dist. 2007).

Lopez, its insured and Alarcon lived in the city of North Chicago. At the time of the accident, Alarcon was driving a car owned by Lopez. Lopez applied for insurance on this car with Universal on November 26, 2001, allegedly while Alarcon lived in his household. Universal claimed that although Lopez was obligated to name and identify all drivers in his household, he failed to disclose Alarcon. Universal sought to void the insurance policy based upon this fraudulent misrepresentation. Universal claimed that had it known Alarcon lived with Lopez, it would not have issued the policy. Neither Lopez nor Alarcon answered Universal's complaint for declaratory judgment and the court entered an order of default on May 11, 2004. The third party defendants appeared and denied the allegations as to Universal's claim of misrepresentation.

In response to interrogatories, Universal disclosed the police report from the accident that listed Alarcon's address as Lopez's address. Universal also disclosed a summons in the underlying tort suit addressed to Alarcon at Lopez's address. At trial, Universal called Ron Clark, its claims supervisor as a witness. Clark testified that although Alarcon was not listed as an operator on Lopez's policy, he believed Alarcon lived at Lopez's address. He admitted that he had never spoken with Lopez or Alarcon. Clark also admitted that he had no knowledge of whether Alarcon was a driver of Lopez's car before the accident either as a household member or as a permissive driver. Universal's only evidence of Alarcon's address was the police report. The trial court ruled in Universal's favor finding that although Clark's testimony was weak, it showed that Universal's decision to contract with Lopez would have been different had it known Alarcon lived with Lopez. The third party defendants filed a post-trial motion to reconsider arguing that Universal had presented no evidence of material misrepresentation but had relied entirely on the default judgment against Lopez. The trial court granted the third party

defendant's motion to reconsider, vacated its earlier judgment and found that Universal had a duty to defend and indemnify Lopez and Alarcon.

American Services Insurance Company (American) made essentially the same claims against its insured, Ruiz and Gonzalez, alleging that Ruiz and Gonzalez lived together in Palatine and that the car owned by Ruiz and driven by Gonzalez was involved in an accident in September 2003. It alleged that Ruiz failed to disclose Gonzalez as a driver when he applied the insurance. A default judgment was entered against Ruiz and Gonzalez when they failed to answer the complaint.

Before trial, the court allowed the third party defendants to file an affidavit to support their claims of insufficient knowledge to admit or deny American's allegations. The third party defendants also filed a motion for summary judgment. In support of their motion, they attached affidavits which stated that Gonzalez did not live with Ruiz on the date of the application and that Gonzalez did not move into Ruiz's residence until after the application was made. The trial court denied the motion for summary judgment.

At trial, the only witness was American's claims adjuster. He testified that American conducted an investigation after the accident and that they relied upon the accident report to establish Gonzalez's address. The trial court entered a written opinion and order finding that American had not met its burden of proof on misrepresentation as the adjuster's testimony on cross-examination did not establish that he had personal knowledge that Gonzalez lived with Ruiz at the time of the contract formation. The court further found that the defendants' default served as evidence, but the admissions extended only so far as the allegations in the complaint were well pleaded. Nowhere in American's complaint did it allege that Gonzalez lived with Ruiz at the time that Ruiz executed his contract of insurance with American. The court then held

that because American failed to meet its burden of establishing by a preponderance of the evidence that Ruiz misrepresented at the time of the contract formation the identity of all resident drivers then living in his home, American must defend under the policy. American filed a motion to reconsider which was denied.

On appeal, the carriers argued that the defaults constituted prima facie evidence that misrepresentations were made on the application. They argued that by establishing a prima facie case, the burden of proof shifted to the non-defaulting third party defendants who then failed to offer evidence contesting the alleged misrepresentation. The court disagreed, finding that to establish mutual misrepresentation and void the policies, the plaintiffs had to allege that the drivers lived with the insureds when the application for insurance was executed.

The carriers then argued that the defaults must be attributed to third party defendants because they “stand in the shoes of the insureds.” The court disagreed, holding under *Chamblin v. Chamblin*,³⁸ and its progeny that an admission attributable to defaulting defendants could not be attributed to the non-defaulting defendants. Therefore, even if the court were to take the insureds’ defaults as an admission of fraudulent misrepresentation, it could not attribute their admission to the non-defaulting third party defendants. Accordingly, the trial court did not abuse its discretion, and the judgment of the Circuit Court was affirmed.

B. The Insurer, Agent, and Insured Relationship

Plaintiff’s failure to know the contents of his insurance policy was not a bar to a claim under the Consumer Fraud Act where he alleged the insurer’s agent misrepresented the content of the policy.

³⁸ 362 Ill. 2d 588, 1NE 2d 73 (1936).

In *Golf v. Henderson*,³⁹ plaintiff, Golf, brought an action against State Farm Insurance Company and its agent alleging breach of a contract to procure disability insurance in the event he was injured in his work as a cement finisher. Plaintiff also claimed a violation of the Consumer Fraud Act (Act) because State Farm's agent misrepresented the terms of the policy. After obtaining the disability policy, he was injured at work and recovered benefits under the Illinois Workers' Compensation Act. State Farm denied plaintiff's claim for additional benefits under the disability insurance policy.

Plaintiff was unaware the policy contained an exclusion for any injury or sickness to the extent he was entitled to benefits under Workers' Compensation. Defendants moved to dismiss the complaint on the basis that plaintiff was charged as a matter of law with knowing the contents of his insurance policy. The trial court agreed and dismissed the complaint.

The appellate court reversed dismissal of the Consumer Fraud claim and affirmed dismissal of the breach of contract claim on the basis that the claim was not adequately argued nor was there citation to authority by plaintiff. Also, plaintiff's claim that the agent breached its statutory duty to exercise ordinary care was deemed waived since not raised in plaintiff's amended complaint.

In addressing the Consumer Fraud claim the court noted the elements of a claim under the Act include: (1) a deceptive act or practice, (2) intent on the defendants' part that plaintiff rely on the deception, and (3) that the deception occurred in the course of conduct involving trade or commerce.⁴⁰

³⁹ *Golf v. Henderson*, 376 Ill. App. 3d 271, 876 N.E.2d 105 (1st Dist. 2007).

⁴⁰ *Id.* at 276, 876 N.E.2d at 110.

Defendants contended plaintiff had not properly pled that they engaged in a deceptive act or practice. Plaintiff's allegations were that Henderson, as an agent of State Farm, misrepresented to plaintiff that the disability policy would pay \$2,500.00 per month if plaintiff was injured at work. Further, plaintiff contended that his failure to know all terms of the policy was not fatal to his claim under the Act.

The court initially noted the general rule that "an insured has an affirmative duty to review the terms of a new policy issued to him and is burdened with knowing the contents of that policy."⁴¹ However, "this rule is not an absolute bar to causes of action brought by an insured against an insurance agent or broker as opposed to causes of action brought by an insured against an insurer."⁴²

The court concluded that the Consumer Fraud claim was sufficient because plaintiff was not denying the language of the policy itself, but was alleging the defendants misrepresented the content of the policy in selling it to him. Under circumstances where misrepresentation is alleged, the duty to know the contents of the policy was not an absolute bar.

Finally, on the issue of plaintiff's waiver of his claim that the defendant agent breached his statutory duty, the court noted that plaintiff may be able to file an amended complaint on remand alleging breach of the broker's statutory duty to exercise ordinary care under the Insurance Code. The applicable provision, section 2-2201(a) of the code, provides: "An insurance producer, registered firm, and limited insurance representative shall exercise ordinary

⁴¹ *Id.* at 276, 876 N.E.2d at 111.

⁴² *Id.*

care and skill in renewing, procuring, binding, or placing the coverage requested by the insured or proposed insured.”⁴³

II. COMMERCIAL GENERAL LIABILITY INSURANCE AND PROFESSIONAL LIABILITY COVERAGE

A. *Duty to Defend and Indemnify the Policy Holder*

Fax blasting may be potentially covered under a commercial liability policy as “advertising injury” coverage as a “publication,” and “material that violates a person’s right of privacy.”

In *Valley Forge Insurance Co. v. Swiderski Electronics, Inc.*,⁴⁴ the Illinois Supreme Court held that allegations against an insured for unsolicited faxes potentially fell within the insured’s commercial general liability “advertising injury” coverage as a “publication,” and “material that violates a person’s right of privacy.”⁴⁵ The “right of privacy” in the “advertising injury” provision connoted both an interest in seclusion and an interest in the secrecy of personal information.⁴⁶

In *Valley Forge*, Swiderski Electronics sent Rizzo, a private detective, and others a fax advertisement with sales information on various types of electronic equipment. This type of advertising still occurs with unsuspecting new businesses or those that simply do not realize that it may be illegal. In response to this advertising, Rizzo filed a class action suit alleging that, by faxing copies of the advertisement without first obtaining the recipients’ permission, Swiderski violated section 227 of the Telephone Consumer Protection Act⁴⁷ (TCPA). The complaint

⁴³ Insurance Placement Liability Act, 735 ILL. COMP. STAT. 5/2-2201(a) (1997).

⁴⁴ *Valley Forge Ins. Co. v. Swiderski Elec., Inc.*, 223 Ill. 2d 352, 860 N.E.2d 307 (2006).

⁴⁵ *Id.* at 366, 860 N.E.2d at 316.

⁴⁶ *Id.* at 368, 860 N.E.2d at 317.

⁴⁷ 47 U.S.C. § 227 (2000).

sought damages, attorney's fees, and injunctive relief on behalf of all individuals who received an unsolicited fax advertisement from Swiderski.

Swiderski tendered defense of the suit to its primary insurer, Valley Forge, and its excess insurer, Continental Casualty Corporation. The policies provided similar coverage. Under the Valley Forge policy, Valley Forge had a duty to defend Swiderski against any suit seeking damage caused by "personal and advertising injury." Personal and advertising injury included injury that arose from "oral or written publication, in any manner, of material that violates a person's right of privacy."⁴⁸

Swiderski argued that the complaint alleged facts potentially within policy coverage so that the insurer had a duty to defend.

The essence of a TCPA fax-ad claim is that one party sends another an unsolicited fax advertisement. The receipt of an unsolicited fax advertisement implicates a person's right of privacy insofar as it violates a person's seclusion, and such a violation is one of the injuries that a TCPA fax-ad claim is intended to vindicate. The harm from unsolicited faxes involves protection of "privacy."⁴⁹ The court found that the TCPA's private right of action was meant to remedy and prevent the twin harms of damage to privacy and economic damage.⁵⁰ The court found that it was clear that the TCPA aimed in part to protect privacy.⁵¹ With the TCPA, Congress took aim at the intrusive nature of unsolicited faxes.⁵²

⁴⁸ *Valley Forge*, 223 Ill. 2d at 311, 860 N.E.2d at 356.

⁴⁹ *Id.* at 365, 860 N.E.2d at 315.

⁵⁰ *Id.* at 352, 860 N.E.2d at 307.

⁵¹ *Id.*

⁵² *Id.*

The complaint implicitly alleged a violation of a privacy interest. Based on the plain, ordinary, and popular meaning of those words, the court believed that this type of injury fell potentially within the coverage of the “advertising injury” provision.⁵³

The policy did not define the terms “publication,” “material,” or “right of privacy.”⁵⁴ The court found that the “right of privacy” connoted both an interest in seclusion and an interest in the secrecy of personal information.⁵⁵ The policy language “material that violates a person’s right of privacy” could reasonably be understood to refer to material that violated a person’s seclusion.⁵⁶ Unsolicited fax advertisements, the subject of a TCPA fax-ad claim, fall within this category.⁵⁷

By faxing advertisements, Swiderski engaged in the “written * * * publication” of the advertisements.⁵⁸ The “material” that Swiderski allegedly published, advertisements, qualified as “material that violated a person’s right of privacy,” because, according to the complaint, the advertisements were sent without first obtaining the recipients’ permission, and therefore violated their privacy interest in seclusion.⁵⁹ The language of the “advertising injury” provision was sufficiently broad to encompass the conduct alleged in the complaint.⁶⁰

The court noted that its conclusion was in agreement with the majority of federal courts of appeals that have considered “advertising injury” coverage for fax-ad claims.⁶¹ State courts remain incongruent in their holdings due to varying policy language and a mixed application of the law.

⁵³ *Id.* at 361-62, 860 N.E.2d at 314.

⁵⁴ *Id.* at 366, 860 N.E.2d at 316.

⁵⁵ *Id.* at 368, 860 N.E.2d at 317.

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* at 368, 860 N.E.2d at 317.

⁵⁹ *Id.* at 368-69, 860 N.E.2d at 317.

⁶⁰ *Id.* at 369, 860 N.E.2d at 317.

⁶¹ *Id.* at 372, 860 N.E.2d at 319.

In this case, what may have seemed like an innocent advertising action, can cause significant downstream damage. Here, an insured was merely sending out a notice of a sale and some rental information. This generated a private cause of action on the part of each recipient. A class action suit followed, triggering coverage under a liability policy.

Most businesses are now aware of the TCPA and refrain from this activity. For those few remaining companies, as well as new start-up companies, a fax-ad campaign could lead to a series of suits and potential coverage under a liability policy.

Insured Versus Insured Exclusion In The Policy Applied To Relieve Insurer Of The Duty To Defend

In *Andreou and Casson, Ltd. v. Liberty Insurance Underwriters, Inc.*,⁶² Attorney Dana Kurtz filed suit against the law firm of Andreou and Casson, Ltd. alleging breach of partnership agreement, breach of fiduciary duty, fraud, disparagement, defamation, and humiliation, among other wrongful acts. The firm was insured under a professional liability policy issued by Liberty. When the firm tendered defense of the Kurtz case to Liberty, it denied coverage, citing an insured versus insured exclusion, among other things. The firm then filed this declaratory judgment action, and the trial court granted Liberty's motion for summary judgment. The appellate court affirmed. The court stated that "it is clear that the insured versus insured exclusion applies and that therefore Liberty owed no duty to A& C to defend it in the Kurtz action."⁶³

⁶² *Andreou & Casson, Ltd. v. Liberty Ins. Underwriters, Inc.*, 377 Ill. App. 3d 352, 877 N.E.2d 770. (1st Dist. 2007).

⁶³ *Id.* at 358, 877 N.E.2d at 775.

B. Reimbursement of Defense Fees to the Insurance Company

An insurer should be permitted to bring a claim for unjust enrichment against its insured when it was required to pay defense fees based upon an erroneous circuit court order.

Steadfast v. Caremark Rx, Inc.,⁶⁴ foreshadows the appeal that will certainly follow the remand to circuit court. In summary, an insurer paid defense fees during the appeal of a duty to defend a declaratory judgment action. It lost at the circuit court and won on appeal. Therefore, the insurer alleged that it should be reimbursed the fees it paid for the defense of the policyholder during the appeal. The opinion does not answer that issue, only the question of whether reimbursement can be sought based upon a theory of unjust enrichment. We will watch for the appeal from the circuit court ruling on the unjust enrichment claim.

Within the normally calm waters of insurance coverage law, this issue presents a rather stormy horizon. If a policyholder may ultimately be required to reimburse an insurance company, should the policyholder obtain the right to control the defense and, in turn, limit defense fees? Would an insurer seeking reimbursement be deemed to have waived the right to appoint its own counsel and control the defense? These issues and others may arise as this matter proceeds.

In *Steadfast v. Caremark Rx, Inc.*, Steadfast Insurance Company (Steadfast) issued a managed care professional liability policy to Caremark Rx, Inc., and its subsidiary, Caremark, Inc. (Caremark). Two suits were filed against Caremark alleging that, in managing drug plans' prescription-drug benefits, Caremark breached its fiduciary duties under the Employee Retirement Income and Security Act (ERISA) by conspiring with drug manufacturers to obtain

⁶⁴ *Steadfast v. Caremark Rx, Inc.*, 373 Ill. App. 3d 895, 869 N.E.2d 910 (1st Dist. 2007).

undisclosed discounts, rebates, and “kickbacks” by favoring certain higher-priced drugs.⁶⁵ The complaints also charged Caremark with misrepresentation and failure to disclose material information and sought an accounting. Caremark tendered the defense of these suits to Steadfast.

Steadfast sought a declaratory judgment that it had no duty to defend or indemnify Caremark in the underlying actions. The circuit court concluded that Steadfast had a duty to defend Caremark.⁶⁶ The court of appeals held, as a matter of law, that the factual allegations in the underlying complaints failed to assert conduct within the policy's coverage.⁶⁷ The matter returned to the court of appeals when Steadfast sought reimbursement of the defense fees paid for Caremark.

Steadfast's duty to defend Caremark during the appeal of its declaratory judgment action did not arise out of a contractual obligation under the policy but, rather, arose out of the circuit court's erroneous order declaring that Steadfast had a duty to defend Caremark in the underlying actions.⁶⁸

Steadfast argued that the circuit court erred in denying it leave to amend its complaint to include a claim for unjust enrichment. The court of appeals agreed, finding that the event giving rise to Steadfast's claim for unjust enrichment did not occur until the court of appeals issued its decision in Steadfast I, and Steadfast's motion for leave to file its second amended complaint was filed within one month of the Supreme Court's denial of Caremark's petition for leave to appeal that decision.⁶⁹

⁶⁵ *Id.* at 749, 835 N.E.2d at 890.

⁶⁶ *Id.*

⁶⁷ Steadfast I, 359 Ill. App. 3d at 760-61, 835 N.E.2d at 890.

⁶⁸ *Id.*

⁶⁹ *Steadfast*, 373 Ill. App. 3d at 901, 869 N.E.2d at 915.

In *Hartford Fire Insurance Co., v. Everest Indemnity Insurance Co.*,⁷⁰ the Cook County Circuit Court (Illinois) entered a judgment that granted partial summary judgment for plaintiff fire insurance company in a declaratory judgment action relating to a series of underlying lawsuits filed against defendant management companies following a fire at a building at which the management companies were insured. Defendant indemnity insurer appealed.

The fire insurance company issued a policy to one of the management companies for a certain policy period; the other two management companies qualified as insureds under the policy. The policy stated that the insurance was excess insurance over other available insurance. About the same time, the indemnity insurer issued a policy to a security company. That policy named the management companies as additional insureds. The security company entered into a security contract with one of the management companies.

A fire occurred at a building covered under the policy. Multiple lawsuits were filed alleging liability on the part of the management companies. They tendered the underlying lawsuits to the fire insurance company and the indemnity insurer. The fire insurance company filed an action seeking a determination that the indemnity insurer had the primary duty to defend. The trial court granted partial summary judgment to the fire insurance company. On appeal, the appellate court found that the trial court's ruling was correct since the indemnity insurer had conceded that at least one of the theories in the underlying lawsuits was potentially within the coverage of its policy.⁷¹

In *Virginia Surety Co. v. Northern Insurance Co. of New York*,⁷² the Illinois appellate court affirmed a summary judgment granted to defendant commercial liability insurer after the

⁷⁰ *Hartford Fire Ins. Co. v. Everest Indem. Ins. Co.*, 369 Ill. App. 3d 757, 861 N.E.2d 306 (1st Dist. 2006).

⁷¹ *Id.* at 762, 866 N.E.2d at 311.

⁷² *Va. Sur. Co. v. N. Ins. Co. of N.Y.*, 224 Ill. 2d 550, 866 N.E.2d 149 (2007).

trial court held the subcontractor and general contractor's subcontract was not an "insured contract" under a commercial general liability policy and that the commercial liability insurer was not obligated to defend or indemnify. The state supreme court granted plaintiff workers' compensation insurer's petition for leave to appeal.

The subcontractor's employee was injured while working at a job site. He filed a complaint against the general contractor alleging that the general contractor's negligence contributed to his injury. The general contractor filed a third party complaint against the subcontractor for contribution. The subcontractor tendered the third party complaint to its commercial liability insurer. The commercial liability insurer refused to defend or indemnify the subcontractor. The commercial liability insurer then sought a declaration that it did not owe a duty to defend or indemnify the subcontractor for the third party action brought against the subcontractor for contribution and pursuant to the commercial general liability policy. The trial court granted summary judgment to the commercial liability insurer. On appeal, the appellate court affirmed. On further review, the state supreme court found that pursuant to the subcontract, the policy's definition of "insured contract" was not met because the subcontractor did not agree to assume the general contractor's tort liability and, thus, the commercial liability insurer was not obligated to defend or indemnify the subcontractor.

In *Griffin v. Willoughby*,⁷³ Plaintiff driver filed a negligence action against defendant school bus driver. The school bus driver moved to dismiss pursuant to 735 Ill. Comp. Stat. Ann. 5/2-619 (2004). The Circuit Court of Moultrie County (Illinois) granted the motion to dismiss. The driver appealed.

⁷³ *Griffin, v. Willoughby*, 369 Ill. App. 3d 405, 867 N.E.2d 1007 (4th Dist. 2006).

The driver contended that the one year limitations period found in § 8-101 of the Local Governmental and Governmental Employees Tort Immunity Act, 745 Ill. Comp. Stat. Ann. 10/8-101 (Supp. 2003), did not apply to the driver's action. Alternatively, the driver urged that the school bus driver was equitably estopped from asserting the limitations period and the limitations period was equitably tolled. The appellate court concluded that § 8-101's one year limitations period applied. Among other things, the appellate court noted that the comprehensive protection afforded by § 8-101 controlled over other statutes of limitations or repose. The appellate court also concluded that neither equitable estoppel nor equitable tolling precluded enforcement of § 8-101. The appellate court did not find that the insurance company's conduct was calculated to lull the driver into a reasonable belief that the his claim would be settled without suit. Nothing suggested that the insurance company misrepresented its position or intended or reasonably expected the driver to delay filing suit. In addition, the driver's settlement demand alone did not toll the limitations period.

C. Duty to Procure Insurance Coverage On Behalf of Another

i. Landlord Liable For Failure To Procure Insurance For Tenant As Required By Lease Where The Commercial General Liability Policy Excluded Automobile Claims.

In *Sears, Roebuck and Co. v. Charwil Associates Ltd. Partnership*⁷⁴ the tenant, Sears, entered into a written lease agreement with the landlord, Charwil Associates, for an automobile center located at Charwil's shopping mall. The lease provided that Charwil was to obtain and maintain comprehensive general liability (CGL) insurance for coverage for personal injuries. Charwil also agreed to indemnify Sears and its employees for all liability arising out of the use of

⁷⁴ *Sears, Roebuck & Co. v. Charwil Associates Ltd. P'ship*, 317 Ill. App. 3d 1071, 864 N.E.2d 869 (1st Dist. 2007).

the common areas. Charwil obtained CGL insurance naming Sears as an additional insured. The lease provided that Charwil was to both obtain insurance as well as indemnify Sears for any claims arising out of a customer's use of the common areas. A Sears customer was injured when a Sears employee backed another customer's car out of the service bay. The customer was injured in the common area. The customer brought an action against Sears who, in turn, brought a third-party claim against Charwil and its insurers. The customer filed suit against Sears. The parties settled. The only remaining count of Sears' third party complaint was the alleged breach of contract against Charwil for its failure to procure the insurance as required by the lease.

The trial court found that the customer's injuries arose out of the use of the common area and, accordingly, Charwil breached its duty to indemnify Sears pursuant to the lease.

On appeal, Charwil argued that the trial court erroneously interpreted the lease to conclude that it required it to maintain insurance on behalf of Sears to cover such an injury.

The appellate court noted that Charwil obtained a CGL policy naming Sears as an additional insured. However, the policy contained an automobile exclusion. The court held that the lease agreement required that Charwil, as landlord, to procure insurance on behalf of Sears for claims arising out of the tenant's customer's use of the mall's common area and this provision was breached because the CGL policy contained an automobile exclusion. The court noted

“Given that language, we find that the parties clearly intended for Charwil to obtain and maintain insurance for Sears to cover all liability from any claims that arose from a customer's use of the common area. Thus, where Charwil only obtained comprehensive general limited liability insurance which did not cover the June 1, 1996, accident involving a tenant's customer's use of the mall's common area [citation omitted], it breached its promise to provide insurance in paragraph 22 of the lease agreement.”⁷⁵

⁷⁵ *Id.* at 1078, 864 N.E.2d at 875.

D. Policy Terms, Conditions and Exclusions

i. Property Damage and Care Custody and Control

Claim for diminution in value of products liability claim was not property damage as defined in the policy

Claim for wrongful destruction of car involved in fatal car crash was excluded by care, custody and control exclusion where insured had exclusive possession control of the car and the car was a necessary element of the insured's work.

In *Essex Insurance Co. v. Wright*,⁷⁶ Brian Wright died when the Ford Bronco he was driving rolled over. O'Hare, which was in the business of recycling automobiles, acquired Wright's Bronco from a towing company. The attorney for Wright's estate paid O'Hare to store the vehicle. Contrary to the attorney's instructions, the vehicle was crushed and destroyed. On August 13, 2003, Linda Wright, as special administrator of Wright's estate, filed a two count complaint alleging a products liability action against Ford Motor Co. and spoliation of the evidence against O'Hare. She alleges that O'Hare owed her a contractual duty to store and preserve the Bronco as evidence for the products liability lawsuit and that O'Hare failed to maintain the Bronco. O'Hare tendered its defense to its insurer, Essex. Essex sued for a declaratory judgment that it had no duty to defend or indemnify O'Hare under the CGL policy it issued to O'Hare.

The policy defined property damage as including physical injury to tangible property and all resulting loss of use of that property or loss of use of tangible property that was not physically injured. The policy also contained an exclusion for property damage to personal property in the care, custody or control of the insured.

⁷⁶ *Essex Ins. Co. v. Wright*, 371 Ill. App. 3d 437, 862 N.E.2d 1194 (1st Dist. 2007).

The trial court granted summary judgment to Essex on the basis that there was no property damage. The court further found that the care, custody or control exclusion precluded coverage. On appeal, the estate argued that the diminution in value of the products liability claim from the destruction of the evidence resulted in property damage as defined by the policy. The court disagreed, noting that definition of property damage requires physical injury to tangible property or loss of use of tangible property. Citing to the case of *Iowa Mutual Insurance Co. v. Hennings*,⁷⁷ the court found that the cause of action did not qualify as tangible property. Therefore, the diminution of value of the products liability claim was not covered under the definition of property damage.

The second issue was whether the care, custody and control exclusion applied. Illinois courts employ a two-pronged test in determining if the exclusion applies. The property damage must be within the possessory control of the insured at the time of the loss and must be a necessary element of the work performed.⁷⁸ If those two conditions are met, the property is considered to be in the care custody or control of the insured. While the control exercised by the insured must be exclusive, it need not be continuous, and if the insured has possessory control at the time the property is damaged, the exclusion clause will apply.

The court cited to the case in *Maryland Casualty Co. v. Holmsgaard*,⁷⁹ where the owner of a car brought it to a shop to have a trailer hitch welded to the frame. The welding caused a fire that destroyed the car. In finding that the care custody or control exclusion applied, the court held that the shop owner had actual possession of the owner's automobile and dominion over it at the time of the fire. In this case, as in *Maryland Casualty*, the insured had actual possession

⁷⁷ *Iowa Mut. Ins. Co. v. Hennings*, No. 05-3073, 2006 WL 2945477 (C.D. Ill. October 13, 2006).

⁷⁸ *Wright*, 371 Ill. App. 3d at 441, 862 N.E.2d at 1197.

⁷⁹ *Md. Cas. Co. v. Holmsgaard*, 10 Ill. App. 2d 1, 133 N.E.2d 910 (2d Dist. 1956).

and control of the automobile at issue. O'Hare exercised possessory control over the Bronco first by taking it and then by destroying it. Furthermore, the allegations of the complaint show a constructive bailment of the vehicle which also supports the application of the exclusion. Once the attorney notified O'Hare of the need to preserve the vehicle as evidence and especially after O'Hare accepted money for storing the Bronco, O'Hare had possession of the Bronco under circumstances where O'Hare ought to have kept it safe. Accordingly, the court found O'Hare acted as bailee of the vehicle when they destroyed the vehicle.

The court also found that the Bronco was a necessary element of the work O'Hare performed. O'Hare earned its money by recycling automobiles. Without automobiles, he would not have been able to carry out his daily operations. Therefore, in light of the nature of O'Hare's business, the court found that Wright's Bronco was a necessary element of the work performed. The court also held that O'Hare had exclusive possessory control over the Bronco. Thus, the care custody or control exclusion applied to preclude coverage under the policy. Accordingly, the court affirmed the judgment of the trial court.

ii. Professional Services

The insured laser eye surgery clinic's negligent hiring of a physician was a "professional service" within the meaning of its general liability policy's exclusion for professional services.

In *National Fire Insurance Co. of Hartford v. Kilfoy*,⁸⁰ the underlying plaintiff, Briseis Kilfoy, consulted with Dr. Weller, O.D., at Clear Choice Laser Eye Center (Clear Choice) about the possibility of correcting her farsightedness with LASIK eye surgery. Dr. Weller, one of Clear Choice's co-managers, performed a complete pre-operative evaluation and scheduled

⁸⁰ Nat'l Fire Ins. Co. of Hartford v. Kilfoy, 375 Ill. App. 3d 530, 874 N.E.2d 196 (1st Dist. 2007).

Kilfoy for surgery without consulting her colleague, Dr. Sondheimer, and without informing Kilfoy of the risks and limited benefits of LASIK surgery for someone with her particular vision problems. As a result of the surgery, Kilfoy suffered damage to her left eye, for which she brought a medical malpractice suit against Drs. Weller and Sondheimer, Clear Choice, and Nikash, Inc. (Nikash), the dissolved corporation that had operated Clear Choice.

Nikash's general liability insurer, National Fire Insurance Co. of Hartford (National), sought a declaratory judgment that it had no duty to defend or indemnify Nikash against Kilfoy's suit, asserting that the damages sought were excluded by its policy's "professional services" exclusion. That exclusion applied to "bodily injury... due to rendering or failure to render any professional service. This includes... (2) Preparing, approving, or failing to prepare or approve... opinions [or] report. . .; (3) Supervisory * * * services; (4) Medical, surgical... or nursing services treatment, advice or instruction; (5) Any health or therapeutic service treatment, advice or instruction;. . . (7) Optometry or optical... services."⁸¹ After the trial court granted summary judgment for National, Kilfoy amended her complaint to avoid the professional services exclusion, and added allegations that Nikash negligently hired Dr. Weller. She then moved for the trial court to reconsider its summary judgment ruling.

When the court denied Kilfoy's motion, she appealed, arguing that "hiring" was not a professional service. She relied on *American Family Mutual Insurance Co. v. Enright*,⁸² in which the court found that an insured's failure to perform a criminal background check before hiring an ultrasound technician was not a "professional service" because such an administrative precaution required no professional training, experience, skill, or knowledge. The appellate

⁸¹ *Id.* at 532, 874 N.E.2d at 199.

⁸² *Am. Family Mut. Ins. Co. v Enright*, 334 Ill. App. 3d 1026, 781 N.E.2d 394 (2nd Dist. 2002).

court, however, relied on *State Street Bank & Trust Co. v. INA Insurance Co.*,⁸³ in holding that the amended complaint, which alleged that Nikash was “negligent in its hiring, administrative supervision, and business operation of Clear Choice,” still sought damages within the professional services exclusion. *State Street Bank* held that a professional service is any that involves specialized knowledge, labor, or skill, and is predominantly mental or intellectual in nature, and found that a bank’s negligence in deciding to collect on a defaulted loan involved a professional service because it involved the bank’s exercise of business judgment in performing its principal business function.⁸⁴

The court held that Nikash’s screening and hiring of Dr. Waller went “to the heart of Nikash’s principal business operation and the way in which Nikash exercises business judgment.”⁸⁵ The court explained that the determination of whether a physician is qualified to render professional services, as well as the operation and management of a surgical facility, both require specialized knowledge and skill, unlike a merely administrative act. The court therefore concluded the negligent hiring claim was within the “professional services” exclusion, and affirmed summary judgment in favor of National.

iii. Waiver of Kotecki Cap

An employer’s contractual waiver of its Kotecki limitation affirmative defense is not an agreement to accept the tort liability of another that would be imposed by law in the absence of any contract or agreement.

*Virginia Surety Co. v. Northern Insurance Co. of New York*⁸⁶ construed and interpreted language in a contract between a general contractor and a subcontractor, and the applied that

⁸³ *State St. Bank & Trust Co. v. INA Ins. Co.*, 207 Ill. App. 3d 961, 567 N.E.2d 42 (4th Dist. 1991).

⁸⁴ *Id.*

⁸⁵ *Nat’l Fire Ins. Co. of Hartford v. Kilfoy*, 375 Ill. App. 3d 530, 536, 874 N.E.2d 196, 199 (1st Dist. 2007).

⁸⁶ *Va. Sur. Co. v. N. Ins. Co. of N.Y.*, 224 Ill.2d 550, 866 N.E.2d 149 (2007).

language to a CGL insurance policy definition of the term “insured agreement.” In so doing, the court resolved a split among the appellate courts. The issue arose as a result of the evolution of Illinois law on the issue of employer liability for worker’s injuries.

The Workers’ Compensation Act limits the employer’s liability for employees’ injuries. However, the employer may, under the proper circumstances, be brought in as a third party to a civil suit filed by the employee against another party that is claimed to be liable for the injury. The employer, under the Kotecki doctrine, has the right to limit its liability in such a case to the amount it has paid the employee in worker’s compensation benefits. Such limitation would be raised by the employer as an affirmative defense to a third party claim for contribution in the employee’s civil suit. Yet the employer may contractually waive that right. A split of authority developed in the appellate courts, in analyzing the contractual contexts in which such a waiver occurs, and the interplay between such contracts and the employer’s insurance policy provisions.

After subcontractor DeGraf’s employee was injured in the course of his employment, he brought suit against the general contractor, Capital. Capital filed a contribution action against DeGraf. DeGraf tendered the third party complaint filed by Capital against it to its workers compensation and employers liability insurer, Virginia Surety, and to its CGL insurer, Northern. Virginia Surety accepted, and Northern declined, citing an exclusionary provision in its policy.

Virginia Surety then filed this declaratory relief action, seeking a determination that the contract between DeGraf and Capital fit within the definition of “insured contract,” triggering the policy exception to the exclusion claimed by Northern.

In the contract between DeGraf and Capital, DeGraf agreed to waive its right of contribution against Capital, and agreed to indemnify Capital against any loss caused in whole or in part by DeGraf’s negligence. Under the terms of DeGraf’s insurance contract with Northern,

as an exception to the general exclusion of coverage for injuries to DeGraf's employees, Northern agreed to pay sums for "liability assumed by the insured under an 'insured contract.'"⁸⁷ The policy defined an "insured contract" as a contract under which DeGraf assumed the tort liability of another party; "tort liability" being defined as a liability that would be imposed by law in the absence of any contract or agreement.

The issue thus became whether a waiver of the Kotecki affirmative defense, which would have limited DeGraf's liability in the civil suit to the amount paid by DeGraf on the employee's worker's compensation claim, came within the definition of an "insured contract" under the Northern policy, such that Northern was required to defend and indemnify DeGraf in the claim brought by Capital.

The court held that it did not. The waiver of the Kotecki limit was an affirmative defense; it was not an assumption of the tort liability of another that would be imposed by law in the absence of any contract or agreement. Rather, it was available to DeGraf as an affirmative defense in the absence of any contract or agreement. DeGraf did contractually waive the affirmative defense in its agreement with Capital, but did not thereby assume a liability that would have been imposed by law on Capital. The liability, as between DeGraf and Capital, was in accordance with the Joint Tortfeasor Contribution Act. The contract between the parties was not an agreement that DeGraf would assume liability that would be imposed on Capital under that law, and was, therefore, not an "insured contract." Therefore the exception to the exclusion under the Northern policy was not triggered, and Northern had no duty to defend or indemnify DeGraf in the civil action.⁸⁸

⁸⁷ *Id.* at 552, 866 N.E.2d at 152.

⁸⁸ The court's decision, affirming the decision of the Third District Appellate Court, also upheld the decision of the Fifth District in *Hankins v. Pekin Ins. Co.*, 305 Ill. App. 3d 1088, 713 N.E.2d 1244 (5th Dist. 1999) and, to the

E. Number of Occurrences, Trigger and Allocation

Where facts show only one act of negligence and two deaths closely linked in time and space, only one occurrence is found for purposes of determining amount of coverage available.

In *Addison Ins. Co. v. Fay*,⁸⁹ two boys disappeared, and their bodies were found three days later on property owned by Parrish Blacktop, Inc. In the suit filed by the boys' estates, experts opined that one boy had died of hypothermia, and the other by drowning. The boys' bodies were discovered close to each other, in an excavation pit partially filled with water. Investigating police testified that, in their opinions, one of the boys became trapped in the pit and the other attempted to rescue his friend. The insurer for Parrish filed a declaratory judgment action, seeking a finding of a single occurrence under the policy. In determining whether the trial court correctly ruled that there had been two separate occurrences, the appellate court first noted that Illinois analyzes such issues under the "cause theory." The Illinois Supreme Court, in *Nicor, Inc. v. Associated Electric and Gas Insurance Services Ltd.*,⁹⁰ stated the test under that theory in this way: "Where each asserted loss is the result of a separate and intervening human act, whether negligent or intentional, or each act increased the insured's exposure to liability, Illinois law will deem each such loss to have arisen from a separate occurrence within the meaning of liability policies containing [per occurrence] language."⁹¹ The appellate court acknowledged that the application of the "cause theory" to the facts of this case was difficult.⁹² However, the court's analysis relied on two factors: "(1) the negligent act or condition that

extent they were not in accordance with this decision, overruled *Christy-Folz, Inc. v. Safety Mut. Cas. Corp.*, 309 Ill. App. 3d 686, 722 N.E.2d 1206(4th Dist. 2000); *Michael Nicholas, Inc. v. Royal Ins. Co. of Am.*, 321 Ill. App. 3d 909, 748 N.E.2d 786 (2nd Dist. 2001); and *West Bend Mut. Ins. Co. v. Mulligan Masonry Co.*, 337 Ill. App. 3d 698, 786 N.E.2d 1078 (2nd Dist. 2003).

⁸⁹ *Addison Ins. Co. v. Fay*, 376 Ill. App. 3d 85, 875 N.E.2d 190 (3d Dist. 2007).

⁹⁰ *Nicor, Inc. v. Assoc. Elec. & Gas Ins. Serv. Ltd.*, 223 Ill. 2d 407, 860 N.E.2d 190 (2006).

⁹¹ *Fay*, 376 Ill. App. 3d at 89 (quoting *Nicor*, 223 Ill. 2d at 431-32, 860 N.E.2d at 294).

⁹² *Id.* at 90, 875 N.E.2d at 194..

caused the injury, and (2) how the temporal and spatial nature of the incident may have affected any ‘separate or intervening acts’ or ‘increased the insured’s exposure to liability.’”⁹³

Applying these factors, the court determined that the losses arose from a single negligent act, the failure of Parrish to properly secure the excavation pit to prevent entry. As to the second factor, the court pointed to indications in the record that the boys entered the property together, and became entrapped in the pit within moments of each other. In addition, both deaths were partially due to hypothermia, and their bodies were found within inches of each other. The court concluded that the time and space circumstances led to the conclusion that the losses were the result of a single occurrence, and thus the single occurrence coverage of the policy applied.

Justice Wright dissented, also relying on *Nicor*. Noting that the insurer had the burden of proving a single occurrence, Justice Wright wrote that there was no evidence that the boys entered either the property or the pit together, and that accepting the investigating officer’s theory of an attempted rescue, Parrish’s liability attached at two separate points, one when the first boy entered the pit, and a second when the other boy decided to attempt to rescue his friend. In Justice Wright’s opinion, this analysis kept with the “separate and intervening human act” circumstances called for by the *Nicor* court’s test.

A lawsuit alleging negligent acts of an insured resulting in damage to walls and other parts of a residence alleges physical injury to tangible property which falls within the definition of “property damage” and is an “occurrence” as defined by a commercial general liability policy.

In *Country Mutual Insurance Co., v. Carr*,⁹⁴ defendant Steve Carr, d/b/a Carr Construction, filed an insurance claim with plaintiff Country Mutual Insurance Company (Country Mutual) under his commercial general liability (CGL) policy. Country Mutual denied

⁹³ *Id.* at 91, 875 N.E.2d at 195 (quoting *Nicor*, 223 Ill. 2d at 431-32, 860 N.E.2d at 294).

⁹⁴ *Country Mut. Ins. Co., v. Carr*, 372 Ill.App.3d 335, 867 N.E.2d 1157 (4th Dist. 2007).

coverage of the claim and, filed a declaratory-judgment action alleging that it had no duty to defend or indemnify Carr alleging that there was no “occurrence” as defined by the policy.

Suit was filed against Carr, claiming breach of warranty and, in part, that he or his agents or employees: “negligently placed inappropriate backfill in and around the basement walls, and there and then negligently operated heavy earthmoving equipment near said walls resulting in the sudden movement of the basement walls, in turn resulting in damage to said basement walls, and to other portions of the residence.”

The CGL policy provided in part that: “This insurance applies to ‘bodily injury’ and ‘property damage’ only if: (1) The ‘bodily injury’ or ‘property damage’ is caused by an ‘occurrence’ that takes place in the ‘coverage territory’; and (2) The ‘bodily injury’ or ‘property damage’ occurs during the policy period.”⁹⁵

The policy defined “property damage” as: “a. Physical injury to tangible property, including all resulting loss of use of that property. All such loss of use shall be deemed to occur at the time of the physical injury that caused it; or b. Loss of use of tangible property that is not physically injured. All such loss of use shall be deemed to occur at the time of the ‘occurrence’ that caused it.”⁹⁶

The policy defined an “occurrence” as “an accident, including continuous or repeated exposure to substantially the same general harmful conditions.”⁹⁷

The policy at issue did not define “accident.” The court found that the term had been interpreted in different ways and therefore, the term “accident” in the policy in question was ambiguous.

⁹⁵ *Id.* at 340, 867 N.E.2d at 1161.

⁹⁶ *Id.*

⁹⁷ *Id.*

The underlying suit alleged that the negligent actions of Carr, his employees, agents, and/or subcontractors resulted in damage to their basement walls and other parts of the residence. The court found that they did not allege they only suffered intangible property losses, such as an economic loss, which courts do not usually consider “property damage.” They alleged physical injury to tangible property, their basement walls. This falls within the broad definition of “property damage” given by the policy. The court found that the allegations in the underlying complaint describe an “occurrence” as defined by the policy at issue.⁹⁸

F. Additional Insureds

Where contractor was an additional insured on builder’s liability policy only for liability incurred “solely as a result of” the builder’s negligence, and complaint alleged negligent acts by both builder and contractor, builder’s insurer owed no duty to contractor.

In *Pekin Insurance Co. v. Beu*,⁹⁹ Roger Beu entered into a contract with Castle Builders regarding the construction of a residence. During the course of that construction project, another worker, Walter Hall, allegedly sustained injuries in a fall. Hall brought a negligence action against Castle Builders, Beu, and a number of other contractors that were also working at the project, alleging that they each had breached a duty to use reasonable care in maintaining a safe workplace and performing their work in a safe manner. Beu was listed as an additional insured in a liability policy issued to Castle Builders by Pekin Insurance Co. (Pekin), and tendered his defense of the Hall action to Pekin. Pekin, denying any duty to defend Beu, filed an action for

⁹⁸ *Id.* at 343, 867 N.E.2d at 1163. Country Mutual relied upon cases decided by other districts of the Illinois Appellate Court in support of its position that an occurrence did not take place including *Indiana Ins. Co. v. Hydra Corp.*, 245 Ill. App. 3d 926, 615 N.E.2d 70 (2nd Dist. 1993); *Wil-Freds*, 277 Ill. App. 3d 697, 661 N.E.2d 451 (2nd Dist. 1996); *Tillerson*, 334 Ill. App. 3d 404, 777 N.E.2d 986 (5th Dist. 2002); and, *Viking*, 358 Ill. App. 3d 34, 294 Ill.Dec. 478, 831 N.E.2d 1 (2nd Dist. 2005). The court held that while these decisions are relevant, they are not determinative of whether the alleged negligent acts of defendant, his employees or agents, and his subcontractor constitute an “occurrence” and the cases alleged contractual or warranty breaches, not negligence as in the instant case.

⁹⁹ *Pekin Ins. Co. v. Beu*, 376 Ill. App. 3d 294, 876 N.E.2d 167 (1st Dist. 2007).

declaratory judgment. The trial court held that Pekin was not obligated to defend Beu, and granted summary judgment for Pekin, from which Beu appealed.

Although the appellate court noted that an insurer's duty to defend was much broader than its duty to indemnify, it nevertheless affirmed summary judgment for Pekin. It found that while Beu was in fact an additional insured under Castle Builders' policy, the damages sought by Hall were not within the terms of policy coverage for an additional insured. Specifically, the policy's "additional insured" endorsement limited the policy's coverage of an additional insured to ". . . liability incurred solely as a result of some act or omission of the named insured and not for its own independent negligence or statutory violation."¹⁰⁰ In interpreting this endorsement, the court found *Village of Hoffman Estates v. Cincinnati Insurance Co.*¹⁰¹ dispositive. In *Hoffman Estates*, a similar coverage restriction was at issue. There, the court determined that such a clause unambiguously restricted coverage of an additional insured to situations where the acts or omissions of the named insured were the sole basis for the additional insured's potential liability.¹⁰²

Here, the court reached a similar conclusion. It held that because the underlying complaint alleged that Hall's injuries arose from the negligence "of the Defendants, and each of them," the complaint sought to impose liability that was not based "solely" on the negligence of the named insured, as required to trigger coverage for Beu under the Pekin policy.¹⁰³ Rather, Hall's claims were also predicated on the independent acts or omissions of Beu and each of the

¹⁰⁰ *Id.* at 295, 876 N.E.2d at 169.

¹⁰¹ *Vill. Of Hoffman Estates v. Cincinnati Ins. Co.*, 283 Ill. App. 3d 1011, 670 N.E.2d 874 (1st Dist. 1996).

¹⁰² *Id.* at 1014, 670 N.E.2d at 876.

¹⁰³ *Beu*, 376 Ill. App. 3d at 297, 876 N.E.2d at 171.

other named defendants.¹⁰⁴ Pekin therefore had no duty to defend Beu, and summary judgment was affirmed.¹⁰⁵

An oral promise to add a party to a policy, as an additional insured, is insufficient under the terms of a policy requiring a written agreement.

In *Cincinnati Insurance Co., v. Gateway Construction Co.*,¹⁰⁶ the court reviewed whether certain parties were covered as additional insureds under the terms of Gateway's excess liability policy issued by Lexington. Gateway alleged that an oral promise to name another party as an additional insured, memorialized in writing after the injury for which coverage was sought, was sufficient to create additional insured status under the policy.

Gateway was a sub-subcontractor on a project and entered into an informal, unwritten agreement to install concrete reinforcements for the project. The agreement was later memorialized in writing and executed. Prior to the execution of the written agreement, a metal worker employed by Gateway was injured on the jobsite.

Gateway alleged that its representative had orally agreed to name other parties as additional insureds under its policy. The written agreement was drafted after the injury. The original agreement did not contain any additional insured requirements. An addendum to the agreement included an additional insured provision and that contract was executed five months after the accident.

The issue raised by Gateway was whether the alleged oral agreement between another party and Gateway to procure additional insured coverage was sufficient to provide coverage under the language of its policy. The policy provided in pertinent part as follows: “[T]he

¹⁰⁴ *Id.* at 297-98, 876 N.E.2d at 171.

¹⁰⁵ *Id.*

¹⁰⁶ *Cincinnati Ins. Co., v. Gateway Constr. Co.*, 372 Ill. App. 3d 148, 865 N.E.2d 395 (1st Dist., 2007).

following are Additional Insureds under this policy: All corporations, partnership[s] and or/[sic] affiliated individuals promised to be added as additional insured[s] under a written contract with the Named Insured.”¹⁰⁷

The court found that the only reasonable interpretation of the endorsement was that a promise in writing is required to grant an additional insured coverage under the policy.¹⁰⁸ Gateway conceded that a written agreement was ultimately necessary under the language of the endorsement, but contemplated that the written agreement could be made “at a later time.”¹⁰⁹ The court found that Gateway's interpretation would render the need for a written agreement meaningless because it would allow the insured to reduce an oral agreement to writing after the loss has occurred, effectively making coverage retroactive.¹¹⁰ That construct was inconsistent with the provisions of the policy that indicate that coverage is triggered at the time of the “bodily injury.”¹¹¹

In the present case, there was no promise under a written agreement at the time of the accident, and no other documentation confirming additional insured coverage at the time of the accident. The original draft agreement between Baker and Gateway, dated after the accident, did not provide for additional insured coverage, and the subsequent addendum adding that requirement was not executed until five months after the Gateway employee was injured. Therefore, an oral promise to add a party to a policy as an additional insured is insufficient under the terms of a policy requiring a written agreement.

¹⁰⁷ *Id.* at 151, 865 N.E.2d at 398-99.

¹⁰⁸ *Id.* at 151, 865 N.E.2d at 399.

¹⁰⁹ *Id.* at 152, 865 N.E.2d at 399.

¹¹⁰ *Id.*

¹¹¹ *Id.*

Certificate of Insurance does not satisfy requirement of a written contract as certificate stated that it does not confer any rights under the policy.

Security Contractor was not additional insured under subcontractor policies, as subcontract did not require subcontractor to provide liability insurance for contractor.

In *Clarendon America Insurance Co. v. Aargus Security Systems Inc.*,¹¹² Clarendon America Insurance Co. (Clarendon) filed a declaratory judgment action seeking a determination that it owed no duty to defend or indemnify Aargus Security Systems Inc. (Aargus) in several underlying lawsuits arising out of an October 17, 2003 fire that occurred at 69 W. Washington Street in Chicago. At the time of the fire, the building was owned by the defendant, County of Cook (Cook) and managed by defendant, 69 West Washington Management, LLC (69 West). Clarendon issued a CGL policy to defendant, B.G.K. Security Services Inc. (BGK) from which Aargus sought coverage as an additional insured. Intervener, Scottsdale Insurance Company (Scottsdale) issued an excess insurance policy to BGK and intervened in this action seeking a declaration that it also had no duty to defend Aargus. Clarendon filed a motion for summary judgment and Scottsdale filed a brief in support of Clarendon's summary judgment motion. The court granted Clarendon's summary judgment motion against Aargus, and Aargus filed this appeal.¹¹³

On appeal, Aargus argued that the trial court erred in holding that the insurance policy and certificates of insured were insufficient to demonstrate a potential for additional insurance coverage for Aargus and, in the alternative, that the trial court incorrectly granted summary judgment in favor of Clarendon and Scottsdale because a genuine issue of material fact existed.

¹¹² *Clarendon Am. Ins. Co. v. AAargus Sec. Sys. Inc.*, 374 Ill. App. 3d 591, 870 N.E.2d 988 (1st Dist. 2007).

¹¹³ *Id.*

A contract was entered into between Aargus and 69 West on April 1, 2002, in which Aargus agreed to provide security guard service for the commercial high rise building located at 69 West Washington. On June 17, 2002, Aargus and BGK entered into a contract in which the parties agreed to jointly provide security guard service at the 69 W. Washington building. The Aargus/BGK agreement stated that BGK shall serve as Aargus' exclusive subcontractor. Paragraph 16 of the contract provided that "all insurance that may from time to time be required shall be obtained in such a manner as the parties hereto agree."

BGK obtained a CGL policy from Clarendon with effective dates of January 21, 2003 – 2004 providing \$1 million liability coverage per occurrence with a \$5 million aggregate. The policy contained a "Blanket Additional Insured Endorsement," which stated in pertinent part as follows: "WHO IS AN INSURED (Section II) Provision of the Policy is amended to include as an insured any person or organization (called "additional insured") to whom you are obligated by valid written contract to provide such coverage..." In March and May 2003, the agent for BGK issued two certificates of insurance to Aargus. The first certificate identified Aargus as "an additional insured as respects work performed" by BGK and the second stated that Aargus was "an additional insured as regards to liability for operations performed" by BGK.

On appeal, Aargus contended that trial court erred in finding that the Aargus/BGK agreement, Clarendon policy and the certificates of insurance were insufficient to provide coverage to Aargus as an additional insured. Aargus raised two theories in support of its argument. First, Aargus contended that additional insured endorsement obligated Clarendon to provide insurance to an additional insured if there is a requirement in a valid written contract. They argued that Paragraph 16 satisfies that obligation. Aargus further argued that when the

certificates of insurance are considered alongside the Aargus/BGK agreement, then an unambiguous intent for coverage is shown.

Clarendon and Scottsdale argued that Paragraph 16 of the Aargus/BGK agreement did not obligate BGK to provide insurance for Aargus. Clarendon and Scottsdale further argued that the certificates of insurance did not satisfy the requirement of a valid written contract because the certificates plainly stated that they do not confer any rights under the policy without an endorsement from the insurer.

The court found that Aargus was not an additional insured holding that the only valid written contract between BGK and Aargus was the Aargus/BGK agreement.¹¹⁴ The language of Paragraph 16 of this contract did not contain any obligation by BGK to provide insurance for Aargus.¹¹⁵ Instead Paragraph 16 of the contract left the insurance obligations of both contracting parties undecided.¹¹⁶

Aargus also contended that the certificates of insurance along with the Aargus/BGK agreement show that BGK unambiguously intended to assume the obligation to provide additional insured coverage for Aargus. The court disagreed, finding that the plain language of paragraph 16 of the contract did not require BGK to add Aargus as an additional insured under this policy.¹¹⁷ In the absence of ambiguity, the court must construe a contract according to its own language not according to the parties' subjective constructions.¹¹⁸ Paragraph 16 of the BGK/Aargus agreement left the insurance requirements open for future agreements and the court

¹¹⁴ *Id.* at 596, 870 N.E.2d at 993.

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ *Id.* at 597, 870 N.E.2d at 993-94.

¹¹⁸ *Id.* at 597, 870 N.E.2d at 994.

would not look to documents outside of the contract to create such an obligation.¹¹⁹ Additionally, since certificates of insurance are not contracts they are not sufficient to prove that BGK had an obligation under a valid written contract to provide coverage for Aargus.

The court also declined to find that a genuine issue of material fact existed.¹²⁰ The court found that the Aargus/BGK agreement was the only written contract between the parties and did not obligate BGK to provide additional insured coverage for Aargus.¹²¹ There was no indication that a subsequent written agreement about insurance existed and therefore there was no question of material fact.¹²²

Based upon the foregoing, the court affirmed the decision of the Circuit Court of Cook County.¹²³

County and its Management Company were not additional insureds under CGL policy where contract did not explicitly require it.

Court would not unilaterally correct alleged mistakes in contract to create additional insured status.

In *Clarendon America Insurance Co. v. 69 W. Washington Management, LLC.*,¹²⁴ Clarendon America Insurance Co. (Clarendon) filed this declaratory judgment action seeking a determination that it owed no duty to defend or indemnify defendants, 69 West Washington Management, LLC (69 West) and County of Cook (Cook) in several lawsuits arising out of an October 17, 2003 fire that occurred at a building at 69 W. Washington Street in Chicago. Clarendon issued a CGL policy to defendant, BGK Security Services (BGK) under which 69 West and Cook sought coverage as additional insureds Clarendon, 69 West and Cook filed cross

¹¹⁹ *Id.*

¹²⁰ *Id.* at 598, 870 N.E.2d at 995.

¹²¹ *Id.* at 598, 870 N.E.2d at 995.

¹²² *Id.*

¹²³ *Id.*

¹²⁴ *Clarendon Am. Ins. Co. v. 69 W. Wash. Mgmt., LLC.*, 374 Ill. App. 3d 580, 870 N.E.2d 978 (1st Dist. 2007).

motions for summary judgment. Intervener, Scottsdale Insurance Company which issued an excess policy to BGK also sought a declaration that it had no duty to defend 69 West and Cook. The trial court denied the carrier motion and granted 69 West and Cook's motion finding that 69 West and Cook were additional insureds under the policies. Clarendon and Scottsdale filed this appeal.

On April 1, 2002 Aargus entered into a contract with 69 West to provide security guard services for the 69 W. Washington location. This contract provided that Aargus "shall be required to satisfy such insurance requirements as set forth in Exhibit D." Exhibit D provided that Aargus was to purchase and maintain specific types of insurance including CGL insurance in the amount of at least \$1 million and excess liability insurance in the amount of at least \$5 million. Aargus was required to name 69 West and Cook as additional insureds under those policies. Finally, Exhibit D required Aargus to "cause each subcontractor of any tier to purchase and maintain insurance as required from [Aargus] including the additional insureds."

On June 7, 2002 Aargus and BGK entered into a Joint Venture Agreement, in which the parties agreed to provide security guard services at the 69 West Washington building. The only mention of insurance in this Joint Venture Agreement was in Paragraph 16 which stated "all insurance that may from time to time be required shall be obtained in such manner as the parties hereto agree."

BGK obtained a CGL policy from Clarendon containing a Blanket Additional Insured Endorsement, which stated in relevant part as follows: "WHO IS AN INSURED (Section II) provision of the Policy is amended to include as an insured any person or organization (called "Additional Insured") to whom you are obligated by valid written contract to provide such

coverage” Scottsdale issued an excess liability policy to BGK which provided it was excess of and follow form to the Clarendon policy.

On appeal, Clarendon and Scottsdale contended that the Aargus/BGK Agreement standing alone did not trigger coverage for 69 West and Cook under the additional insured endorsement. They maintained that the Aargus/BGK Agreement was void of any express reference to the 69 West/Aargus contract and that the trial court erred in reading the Aargus/BGK Agreement in conjunction with the 69 West/Aargus contract to find coverage. The appellate court agreed, finding that the additional insured endorsement in Clarendon’s policy extends coverage to those that BGK, as the named insured, was obligated by valid written contract to provide coverage.¹²⁵ Nothing within the four corners of the Aargus/BGK Agreement showed an obligation undertaken by BGK to provide additional insured coverage for 69 West and Cook.¹²⁶ Instead Paragraph 16 left insurance requirements open for a future agreement.¹²⁷ In so holding the court cited to the analysis in *Liberty Mutual Fire Insurance Co. v. St. Paul Fire & Marine Insurance Co.*¹²⁸

69 West and Cook contended that the court should read the 69 West/Aargus contract in conjunction with the Aargus/BGK Agreement to find an obligation to provide insurance upon BGK. The court disagreed, finding that the Aargus/BGK Agreement did not explicitly incorporate that the parties intended to be bound by the terms of the 69 West/Aargus contract.¹²⁹ Illinois courts have read two contracts together “when the two instruments were executed by the

¹²⁵ *Id.* at 585, 870 N.E.2d at 983.

¹²⁶ *Id.* at 585, 870 N.E.2d at 984.

¹²⁷ *Id.*

¹²⁸ *Id.* at 586, 870 N.E.2d at 985 (citing *Liberty Mut. Ins. Co. v. St. Paul Fire & Marine Ins. Co.*, 363 Ill. App. 3d 335, 842 N.E.2d 170 (1st Dist. 2005)).

¹²⁹ *Id.* at 587, 870 N.E.2d at 985.

same contracting parties in the course of the same transaction.”¹³⁰ Here, the two agreements were not entered into by the same parties nor were they executed in the course of the same transaction.¹³¹ Since the Aargus/BGK Agreement did not show a clear intent to incorporate the 69 West/Aargus contract, the court would not read the Aargus/BGK Agreement in conjunction with the 69 West/Aargus contract.¹³²

69 West and Cook next asserted that the Aargus/BGK Agreement included typographical errors and should have referred to 69 West/Aargus contract. They asked the court to reform the contract to unilaterally correct these alleged mistakes and recognize an intention for BGK to be held accountable for the insurance provisions in the 69 West/Aargus contract. The court disagreed, finding that neither party to the Aargus/BGK contract was a party to this appeal.¹³³ The plain language of the Aargus/BGK Agreement showed an intention by the parties not to define insurance requirements.¹³⁴ Nothing in Paragraph 16 of the contract obligated BGK to procure insurance for 69 West and Cook.¹³⁵ Therefore, they did not qualify as additional insureds under BGK’s policies.¹³⁶

Lastly, the parties tendered an affidavit by Aargus’ CEO Janet Joyce stating that she was CEO in 2002 and entered into both the 69 West/Aargus contract and Aargus/BGK Agreement on Aargus’ behalf. She stated that in the Aargus/BGK Agreement, the reference to “contract” meant the 69 West/Aargus contract. The court declined to consider this affidavit as evidence because Aargus/BGK Agreement contained an integration clause which stated that the contract

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² *Id.*

¹³³ *Id.* at 588, 870 N.E.2d at 986.

¹³⁴ *Id.* at 589, 870 N.E.2d at 987.

¹³⁵ *Id.*

¹³⁶ *Id.*

represented the entire agreement and understanding of the parties.¹³⁷ The integration clause established that Aargus and BGK as the contracting policies intended to be bound only by the terms of the contract as written.¹³⁸ Therefore, the court could not consider the Joyce affidavit to explain the agreement.¹³⁹

Based upon all of the above, the court reversed the order of summary judgment in favor of 69 West and Cook and entered summary judgment for Clarendon and Scottsdale.¹⁴⁰

III. “Other Insurance,” Targeted Tenders and Selective Tenders of Defense

A. In General

When a loss or risk is potentially covered under more than one insurance policy, coverage must be allocated among the insurers. Insurance policies often contain language specifying their level of coverage in case another insurer also covers the same risk or loss. “Other insurance” clauses are incorporated in insurance policies to provide the level and extent of coverage in case concurrent insurance policies exist. An “other insurance” clause may provide for primary coverage, excess coverage or no coverage at all. Illinois courts have held that the method of determining the priority of coverage in these cases is to review the “other insurance” clauses in each policy.

The “other insurance” clauses incorporated into insurance contracts serve to reduce multiple recoveries. They will generally fall into three categories: “pro rata” clauses, “excess” clauses and “escape” clauses.¹⁴¹ A conflict between competing clauses can lead to irreconcilable wording or phrases. When two insurance policies cover a loss at the same level, Illinois courts

¹³⁷ *Id.* at 590, 870 N.E.2d at 987.

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ *Putnam v. New Amsterdam Cas. Co.*, 48 Ill. 2d 71, 269 N.E.2d 97 (1970).

look to the “other insurance” clauses to determine which the order of policy coverage. A court must analyze the applicable clauses of both insurance policies, in order to determine the proper order of payment. The majority approach is “to reconcile the applicable clauses of conflicting policies, therefore giving effect to the intention of all the parties, whenever possible.”¹⁴²

B. Where both of contractor’s insurance policies contained “other insurance” clauses purporting to render the Policies excess of other insurance, those clauses were mutually repugnant, and insurers would bear a pro-rata share of defense and indemnification costs.

In *Ohio Casualty Insurance Co. v. Oak Builders, Inc.*,¹⁴³ the underlying plaintiff, David Huerta, brought suit against Oak Builders for injuries he sustained while working at a construction site. Oak Builders was insured by two insurers: American Family Insurance Company (American Family), which had issued Oak Builders its general liability policy, and Ohio Casualty Company (Ohio Casualty), which had issued a contractor’s liability policy to Huerta’s employer, JAZ Construction, Inc., under which Oak Builders was an additional insured. Oak Builders tendered its defense of Huerta’s lawsuit to Ohio Casualty. Ohio Casualty then filed a declaratory judgment, arguing that Oak Builders was not an additional insured under the policy issued to JAZ Construction, and, alternatively, that its policy provided Oak Builders with excess coverage only. Ohio Casualty and Oak Builders each filed motions for summary judgment. The circuit court granted each motion in part, finding that Oak Builders was indeed an additional insured under the Ohio Casualty Policy, but that the coverage provided under that policy’s “additional insured endorsement was primarily excess coverage.” Oak Builders appealed.

¹⁴² *Am. Country Ins. Co. v. Hanover Ins. Co.*, 293 Ill. App. 3d 1025, 689 N.E.2d 186 (1st Dist. 1997) (citing *Putnam v. New Amsterdam Cas. Co.*, 48 Ill. 2d 71, 269 N.E.2d 97 (1970)).

¹⁴³ *Ohio Cas. Ins. Co. v. Oak Builders, Inc.*, 373 Ill. App. 3d 997, 869 N.E.2d 992 (1st Dist. 2007).

The appellate court noted that both the Ohio Casualty and American Family policies contained “other insurance” clauses purporting to render the policies excess of any other available coverage.¹⁴⁴ The American Family policy purported to apply excess of “any other primary insurance available to you covering liability for damages arising out of the premises or operations for which you have been added as an additional insured by attachment or endorsement.”¹⁴⁵ Similarly, the Ohio Casualty policy provided that “any coverage provided hereunder shall be excess over any other valid and collectible insurance available to [Oak Builders] whether primary, excess, contingent or on any other basis unless a contract specifically requires that this insurance be primary or you request that it apply on a primary basis.”¹⁴⁶ In analyzing these clauses, the appellate court looked to *Putnam v. New Amsterdam Casualty Co.*¹⁴⁷ In *Putnam*, the Illinois Supreme Court identified three types of other insurance clauses: “pro-rata,” “excess,” and “escape” clauses, and explained that an “excess” clause allows coverage only “over and above” other insurance.¹⁴⁸ Under *Putnam*, competing other insurance clauses are reconciled whenever possible to give effect to the intent of the contracting parties, but where two policies contain the same type of clause, they will be found mutually repugnant and incompatible.¹⁴⁹

The court determined that the other insurance clauses here were both excess clauses, and thus mutually repugnant.¹⁵⁰ As such, the clauses canceled each other out, meaning that American Family and Ohio Casualty would share defense and indemnification costs.¹⁵¹ The

¹⁴⁴ *Id.* at 1001, 869 N.E.2d at 995.

¹⁴⁵ *Id.* at 1002, 869 N.E.2d at 996.

¹⁴⁶ *Id.*

¹⁴⁷ *Putnam v. New Amsterdam Cas. Co.*, 48 Ill. 2d 71, 269 N.E.2d 97.

¹⁴⁸ *Id.*

¹⁴⁹ *Ohio Cas.*, 373 Ill. App. 3d at 1002, 869 N.E.2d at 996.

¹⁵⁰ *Id.* at 1003, 869 N.E.2d at 996.

¹⁵¹ *Id.*

court explained that if both clauses were given effect, neither policy would provide primary coverage and the intent of the contracting parties would be entirely negated.¹⁵² Further, it found no plausible basis for reading either policy first, and refused to allow one policy’s “excess” clause to arbitrarily control rather than the other.¹⁵³ It found the differing language of the two clauses to be irrelevant given that each was of the “excess” type, and therefore determined that each policy would share in providing pro-rated primary coverage.¹⁵⁴ The judgment of the circuit court was therefore reversed, and the case remanded.¹⁵⁵

IV. Update On Illinois Targeted Tenders Under John Burns: Businesses Reduce Costs Through The Shifting Of Defense And Indemnification Costs

With two additional decisions on targeted tenders and an answer from the Illinois Supreme Court on the decade-old question of horizontal exhaustion, it seems an appropriate time to review where we are with targeted tenders. Business owners, officers and risk managers have a unique tool at their disposal in Illinois for shifting defense and indemnification costs away from their insurance policy and targeting another company’s policy—the Targeted Tender. In 1992, the Illinois appellate court reached a decision that resulted in confusion, litigation and unexpected results ever since. Under Illinois’ unique rule, when a business is covered by two or more policies, it can select or target one insurer to respond to a claim. The Targeted Tender stops the selected insurer from recovering from any other policy including the business’s own policy.

The ability to exercise this election arises where multiple avenues of insurance coverage exist including additional insureds and multiple policies covering one insured. An additional

¹⁵² *Id.*

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ *Id.*

insured situation can arise from any contractual agreement wherein a business requires one of its vendors, sub-contractors or business partners to name it as an insured under the vendors, sub-contractors or business partner's policy.

For example, if ABC, Inc. is the owner of a property under development and is insured under a liability policy, and is also an insured under the general contractor, 123's policy, ABC, Inc. can elect to have 123's policy provide a defense and indemnification for a claim or suit. By requiring to be named an additional insured in a contract and selecting 123's insurer to pay for the costs, ABC, Inc. reduces its loss history, shifts defense and indemnification costs and saves money.

The Targeted Tender rule is unique to Illinois. The action of shifting defense and indemnification costs has been referred to by various names including a "Selective Tender," "Targeted Tender," "Institute Tender," and "John Burns Tender." The names Institute and Burns arise from the two primary decisions creating and supporting what has been referred to as an insured's paramount right to select which insurer will respond to a loss. The court in *Institute of London Underwriters v. Hartford Fire Insurance Co.*, adopted the rule that an insured has the right to elect which of a multitude of insurance policies must defend and indemnify a claim by tendering its defense to only one of the insurers.¹⁵⁶ An insured may select an insurance policy that additionally insures it to be the insurance policy obligated to defend and indemnify.¹⁵⁷ This selection forecloses the selected insurer from obtaining contribution from the non-selected

¹⁵⁶ *Inst. Of London Underwriters v. Hartford Fire Ins. Co.*, 234 Ill. App. 3d 70, 599 N.E.2d 1311 (1st Dist. 1992).

¹⁵⁷ *Id.*

insurer.¹⁵⁸ The Supreme Court adopted this rule in *John Burns Construction Co. v. Indiana Insurance Co.*¹⁵⁹

In *Institute of London*, a contractor hired an engineering company to perform repairs on a dockwall. The contract required that the engineering firm secure insurance and list the contractor as an additional insured, which it did with Institute of London Underwriters. In addition, the contractor had its own policy of insurance with Hartford. When a tort action was filed against the contractor, the contractor tendered the action to the engineering firm for its defense and indemnification. The contractor also notified its own insurance carrier, Hartford, of the action. Following the court approval of a \$75,000 settlement, the vice president of the contracting company told the attorney representing the contractor, as well as the contractor's insurance carrier, Hartford, that Hartford should not contribute to the settlement in any way.¹⁶⁰ Further, the vice president told an adjuster for Hartford that it did not want the Hartford policy to respond to the settlement, but rather, the contractor elected to have the engineering firm and its insurer, Institute of London, pay for the indemnification and defense costs for that litigation. The court allowed the insured to select one policy to the exclusion of another.¹⁶¹

Based upon the *Institute of London* decision, an insured that is covered by more than one policy of insurance has the right to forgo the assistance of one or more of the insurers. In order to tender to only one insurer, the insured must expressly state their intentions to the non-selected insurer and tender the matter to the selected insurer. The choice by the insured to tender to only one insurer will be upheld by the courts on the basis that there is no coverage under a policy which is not triggered.

¹⁵⁸ *Id.*

¹⁵⁹ *John Burns Constr. Co. v. Indiana Ins. Co.*, 189 Ill. 2d 570 (2000).

¹⁶⁰ *Inst. Of London*, 234 Ill. App. 3d. at 72, 599 N.E.2d at 1312.

¹⁶¹ *Id.*

A. Horizontal Exhaustion Rules Supersede The Targeted Tender Doctrine

In 2006, the First District settled a dispute that had been brewing for years. The issue of targeting an umbrella policy to the exclusion of a primary policy had been hotly contested and litigated since 1993. Prior to the ruling in *Kajima Construction Services, Inc. v. St. Paul Fire and Marine Insurance Co.*,¹⁶² which held that primary policies must be exhausted horizontally before umbrella policies are impacted, circuit courts and federal district courts announced conflicting decisions. In 2007, the Supreme Court of Illinois took the appeal in *Kajima* and affirmed the appellate court decision.¹⁶³

In *Cincinnati Insurance Co. v. Boller Construction, Inc.*,¹⁶⁴ the court applied principles of horizontal exhaustion when it held that an insured should not be permitted to target an umbrella policy to the exclusion of a primary policy. A contrary rule would permit an insured to convert an umbrella policy into a primary policy without regard for the “unique and special” status of coverage afforded by an umbrella policy. The court relied in part upon *Illinois Emcasco Insurance Co. v. Continental Casualty Co.*,¹⁶⁵ which found that an umbrella or “catastrophe” policy “remains excess over and above all other applicable insurance.

For years, the question persisted as to whether a second layer or umbrella policy could be targeted to the exclusion of the primary or first layer coverage. In 2006, the First District Appellate Court settled this dispute. The issue of targeting an umbrella policy to the exclusion of a primary policy had been hotly contested and litigated since 1993. Prior to the ruling in *Kajima*

¹⁶² *Kajima Constr. Services, Inc. v. St. Paul Fire and Marine Ins. Co.*, 368 Ill. App. 3d 665, 856 N.E.2d 452 (1st Dist. 2006).

¹⁶³ *Kajima Constr. Services, Inc. v. St. Paul Fire and Marine Ins. Co.*, 227 Ill. 2d 102, 879 N.E.2d 305 (2007).

¹⁶⁴ *Cincinnati Ins. Co. v. Boller Constr., Inc.*, 2006 WL 695459 (N.D.Ill. Mar 15, 2006).

¹⁶⁵ *Illinois Emcasco Ins. Co. v. Cont'l Cas. Co.*, 139 Ill. App. 3d 130, 133, 487 N.E.2d 110, 112 (1st Dist. 1985).

Construction Services, Inc. v. St. Paul Fire and Marine Insurance Co.,¹⁶⁶ a pharmacy effectively targeted an umbrella policy to the exclusion of a primary policy and several circuit court decisions had rendered conflicting opinions.¹⁶⁷ The issue was settled in *Kajima*, when a general contractor, Kajima Construction Services, Inc., and its insurer brought a declaratory judgment action against its subcontractor's insurer, seeking reimbursement for payments made to settle a suit.

In *Kajima*, general contractor Kajima Construction Services, Inc. and its insurer brought a declaratory judgment action against its subcontractor's insurer, seeking reimbursement of an indemnity payment made to settle a bodily injury lawsuit filed against it by an employee of the subcontractor. St. Paul Fire and Marine Ins. Co. issued primary and excess policies the subcontractor that named Kajima as an additional insured. Kajima made a "targeted tender" also known as a "targeted election," to St. Paul Fire and Marine Ins. Co. for its defense and indemnification. St. Paul Fire and Marine Insurance Co. paid its primary limits of \$2 million to settle the underlying case and Kajima's own primary insurer paid the remaining \$1 million for total settlement of \$3 million. Kajima and its carrier then sought recovery of the \$1 million from St. St. Paul Fire and Marine Ins. Co.'s excess policy. The trial court rejected the targeted tender and instead applied principals of horizontal exhaustion requiring that primary policies be exhausted before coverage from excess policies would apply. The Illinois Appellate Court affirmed the trial court and found that the targeted tender rule did not trump horizontal exhaustion rules, and the Illinois Supreme Court also affirmed.¹⁶⁸

¹⁶⁶ *Kajima Constr. Services, Inc. v. St. Paul Fire & Marine Ins. Co.*, 368 Ill. App. 3d 665, 856 N.E.2d 452 (1st Dist. 2006).

¹⁶⁷ *Aetna Cas. & Sur. Co. v. Chicago Ins. Co.*, 994 F.2d 1254 (7th Cir. 1993).

¹⁶⁸ *Kajima Const. Services, Inc. v. St. Paul Fire and Marine Ins. Co.*, 227 Ill.2d 102, 879 N.E.2d 305, 316 Ill.Dec. 238 (Ill., 2007).

Although this issue had been addressed by prior courts, the *Kajima* court framed the issues as one of first impression and stated that:

“The question, however, of whether an insured that selectively tenders its defense and indemnification to an insurer will be required to exhaust its primary limits and reach its excess limits before a deselected insurer will be obligated to contribute its primary limits has yet to be answered.”¹⁶⁹

Plaintiffs also conceded that no published case or court in Illinois extended the selective tender rule to preempt the horizontal exhaustion doctrine and require an insurer to vertically exhaust its primary and excess coverage limits. The decision in *Aetna v. Chicago*¹⁷⁰ was not discussed by the court.

Horizontal exhaustion is operative when an insured has coverage under multiple primary policies and one or more excess policies. Under the principle of horizontal exhaustion, the insured must exhaust all available primary coverage before seeking coverage under an excess policy that covers a common risk. If a covered claim occurs, the insured must exhaust all primary policy limits before invoking excess coverage.¹⁷¹ In *Illinois Emcasco*, the court recognized differences between primary coverage policies and umbrella policies and took underlying policy considerations into account and then concluded that an umbrella policy was unique in that it always remained excess over and above other contracts with few exceptions and could not be activated until all primary coverage was exhausted.¹⁷²

¹⁶⁹ *Kajima Constr. Services, Inc. v. St. Paul Fire & Marine Ins. Co.*, 368 Ill. App. 3d 665, 670, 856 N.E.2d 452, 458 (1st Dist. 2006).

¹⁷⁰ *Aetna Cas. & Sur. Co. v. Chicago Ins. Co.*, 994 F.2d 1254, 1259-60 (7th Cir. 1993) (applying targeted tender to an excess professional liability policy).

¹⁷¹ See *Illinois Emcasco Ins. Co. v. Cont'l Cas. Co.*, 139 Ill. App. 3d 130, 134, 487 N.E.2d 110, 112 (1st Dist. 1985); *U.S. Gypsum Co. v. Admiral Ins. Co.*, 268 Ill. App. 3d 598, 652- 53, 643 N.E.2d 1226 (1st Dist. 1994).

¹⁷² *Illinois Emcasco*, 139 Ill. App. 3d at 133-34, 487 N.E.2d at 112.

Under the principle of vertical exhaustion, an insured may seek coverage from an excess insurer after exhausting the primary limits beneath the excess policy as identified in the excess policy's declaration page, have been exhausted, regardless of whether other primary insurance may apply.

Consequently, the *Kajima* court was faced with two irreconcilable rules of law. One creating the insured's paramount right to select which policy would apply and the other that required the insured to exhaust primary coverage before invoking excess coverage. The preverbal irresistible force met an immovable object. This apparent omnipotent paradox was easily broken in 33 words from the court when it held:

“[T]hat the selective tender rule does not entitle an insured to vertically exhaust consecutive insurance policies and deselected primary insurers must answer for a loss before an excess insurance policy will be activated.”¹⁷³

In the court's view, the selective tender rule should be applied to circumstances where concurrent primary coverage exists for additional insureds.¹⁷⁴ It cannot be exercised to upwardly exhaust coverage when primary policies exist. The question left unanswered is the fundamental reason that *Institute of London* and *John Burns* exist; an insured can forego coverage by failing to provide notice to an insurer which relieves the insurer from taking action. A case will certainly arise where an insured decides to withhold notice to its primary carrier altogether without reference to a targeted tender. In that situation, the insurer would be free to deny the claim due to a lack of notice. The effect would be a vertical exhaustion of a primary and excess policy to the exclusion of another primary policy.

¹⁷³ *Kajima Constr. Services, Inc. v. St. Paul Fire & Marine Ins. Co.*, 368 Ill. App. 3d 665, 673, 856 N.E.2d 452, 460 (1st Dist. 2006).

¹⁷⁴ *Id.* at 117, 879 N.E.2d at 314.

B. Targeted Tender Permitted With Excess Policies After Exhaustion of Primary Policies

The extension of a targeted tender was reviewed by the court in *North River Insurance Co. v. Grinnell Mutual Reinsurance Co.*¹⁷⁵ The rule was adopted by the court as applied to concurrent excess policies. The *North River* court stated that it could not articulate a reason why the Targeted Tender rule cannot or should not be applied to concurrent excess insurance coverage.¹⁷⁶ It found no authority prohibiting an insured's right to select or deselect a particular policy when it had concurrent coverage.¹⁷⁷ Because the selective tender rule was applied only concurrently at either the primary or excess level and not consecutively, the concerns about blurring the line between primary and excess insurance policies is not applicable.¹⁷⁸ In so finding, the court held that once an insured has exhausted its concurrent primary insurance coverage, it may selectively tender its indemnity to concurrent excess insurers.¹⁷⁹

i. Future Attacks Upon The Targeted Tender Rule

If dissatisfaction with *Institute of London* grows, a retreat by the courts may take place. This may take place through limitations on the use of *Institute of London* to specific commercial policies or indirect limitations are applied by the courts. These limitations will most likely grow from well reasoned theories that were in existence well before *Institute of London*. The limits will likely arise from equitable arguments such as estoppel, prejudice to the insurer, failure to trigger a policy within a reasonable time and law arguments such as waiver of a known contractual right.

¹⁷⁵ *North River Ins. Co. v. Grinnell Mut. Reinsurance Co.*, 369 Ill. App. 3d 563, 860 N.E.2d 460 (1st Dist. 2006).

¹⁷⁶ *Id.* at 575, 860 N.E.2d at 470.

¹⁷⁷ *Id.*

¹⁷⁸ *Id.*

¹⁷⁹ *Id.* at 574, 860 N.E.2d at 469.

ii. Proposed Legislation Changes

Several attempts have been made by the legislature to amend the targeted tender rule through legislative intervention. Illinois State Senator William R. Haine introduced a bill on January 20, 2006 that would require an insured to tender to all carriers. The text of the bill provided as follows:

215 ILCS 5/143.33 new. Amends the Illinois Insurance Code. Provides that in instances where 2 or more commercial liability policies provide coverage for the same claim or loss, a party seeking coverage under one policy must also tender the defense and indemnity of the claim or loss to any other insurer that may also provide coverage. Provides that the allocation of defense costs and indemnity payments shall be determined by the terms of the policies of insurance. Provides that the failure of an insured to comply with the requirements of the Section does not preclude an insurer from seeking contribution from other insurers that also provide coverage for the claim or loss. Effective immediately.¹⁸⁰

The proposed bill had its first reading and was referred to the Rules Committee on the date of its introduction. No further action was taken. A similar bill was introduced several years ago and did not make it out of the Rules Committee. Based upon this history, it appears that there is little support for a statute that controls the contractual relationship between the parties and the ability to target a specific insurer.

iii. Estoppel And Prejudice To The Insurer

The appearance of prejudice to an insurer may serve to limit the advance of *Institute of London* or even signal its end. If an insured makes a targeted tender to an insurer and then fails to keep its own insurer or other insurers that were not triggered informed of the status of the case, the insured may be estopped from retendering to its own insurer or any other insurer that

¹⁸⁰ S.B. 2920, 94th Gen. Assem., Reg. Sess. (Ill. 2006).

was not kept advised of the progress of the case. The insurer will likely raise a claim of prejudice and allege that the insured is estopped from retendering the claim.

iv. Application With Consecutive Policies

Where a continuing bodily injury or property damage claim exists along with the potential for consecutive coverage, an Illinois court would be required to reconcile the Targeted Tender rule with the *Kajima* decisions requiring the exhaustion of primary coverage before tendering to umbrella policies. An excess carrier could force the triggering of all primary policies before the insured could spike the coverage up into an umbrella policy. Further, a court, contrary to the targeted tender rule, may not permit an insured to select one insurer among multiple consecutive policies spanning several years.

v. Failure To Trigger A Policy Within A Reasonable Time

The policy defenses available to an insurer are not abrogated by *Institute of London*. An insurer may still raise the policy defense of late notice or lack of proper notice as required by the policy. In addition, an insurer will likely soon claim that a targeted tender was made to a different insurer thus relieving it of its duty to defend and indemnify.

Upon the retender to the first insurer for some reason, the insurer that was not triggered in the first instance will likely claim a failure on the part of the insured to trigger the policy within a reasonable time. This claim is closely related to the prejudice issued stated above.

vi. Pre-Contract Waiver Of A Right To Selectively Trigger A Policy

Finally, liability insurers will likely take a proactive approach to *Institute of London* and include endorsements within their policies requiring the insured to tender to all insurers

contractually required to provide coverage to the insured. The targeted tender is a right based in contract that is held by the insured. An insured is free to contract and free to waive any contractual right that it holds. Illinois courts have recognized a contractual right of the insured to tender to a policy of their choice while electing to not trigger their own policy or even deselect their previously triggered policy. This right has been exercised against commercial liability policies, umbrella policies, professional liability policies and risk pooling agreements.

Although the decision in *Institute of London* has received broad acceptance, there have been several notable exceptions including the decision in *American Country Insurance Co. v. Kraemer Brothers, Inc.*,¹⁸¹ and the concurring opinion authored by Judge Quinn in *Chicago Hospital Risk Pooling Program v. Illinois State Medical Inter-INS Exchange*.¹⁸² The decision in *Kraemer Brothers* and concurring opinion of Judge Quinn provide guidance for avoiding a targeted tender. From these decisions, liability insurers have begun including endorsements designed to avoid a targeted tender.

A federal decision specifically allowed an insured to forgo coverage under a commercial automobile liability policy.¹⁸³ Despite the widespread use of the targeted tender and the favorable treatment of the targeted tender under automobile policies, the court in *Pekin Insurance Co. v. Fidelity & Guaranty Insurance Co.* announced the most recent opinion addressing a targeted tender and an automobile policy and disallowed the targeted tender under a personal lines policy where the insured was not a named insured under the policy but was insured by coincidence.¹⁸⁴

¹⁸¹ *Am. Country Ins. Co. v. Kraemer Bros., Inc.*, 298 Ill. App. 3d 805, 699 N.E.2d 1056 (1st Dist. 1998).

¹⁸² *Chi. Hosp. Risk Pooling Program v. Ill. State Med. Inter-Ins. Exch.*, 325 Ill. App. 3d 970, 758 N.E.2d 353 (1st Dist. 2001).

¹⁸³ David J. Roe, *ILLINOIS AUTOMOBILE INSURANCE LAW* § 10:15 (2007).

¹⁸⁴ *Pekin Ins. Co. v. Fidelity & Guaranty Ins. Co.*, 357 Ill. App. 3d 891, 830 N.E.2d 10 (4th Dist. 2005).

It was the court's opinion that the targeted tender doctrine had been limited to the context of construction contracts involving a named additional insured.¹⁸⁵ Based upon this perceived limitation, the court held that the decision in *John Burns* did not require that Brown's Towing and its driver be allowed to "deselect" coverage under their own policy in favor of coverage under the vans owner's Fidelity policy.¹⁸⁶

The court in *Pekin* determined that a party insured under two policies by coincidence is, by some means, different and entitled to fewer rights than an insured that enters into a contractual agreement with a subcontractor requiring that it be named as an additional insured under the subcontractor's policy.¹⁸⁷ So far, Illinois courts have not adopted a distinction between an insured by knowing choice and an insured by coincidence. Although the Illinois Supreme Court noted that coverage could arise by coincidence, it made no distinction regarding the coverage available to the insured.¹⁸⁸ This likely due to the fact that, under typical contract interpretation rules, there is no material difference between an insured and one that is insured by coincidence. "Under typical insurance policy rules of interpretation, an insured is entitled to the full benefits of a policy in both situations."¹⁸⁹ Determining when a knowing selection of additional coverage was made by a party or was merely a coincidence requires a significant examination of the facts outside of the contractual relationship of the parties which could result in different outcomes in situations where the exact same facts exist.¹⁹⁰ Rather than examining the personal intent of a party, the better solution is to extend the same analysis performed in

¹⁸⁵ *Id.* at 903, 830 N.E.2d at 19.

¹⁸⁶ *Id.*

¹⁸⁷ *Id.*

¹⁸⁸ *Kajima Constr. Services, Inc. v. St. Paul Fire & Marine Ins. Co.*, 227 Ill. 2d 102, 879 N.E.2d 305 (2007).

¹⁸⁹ David J. Roe, *ILLINOIS AUTOMOBILE INSURANCE LAW* § 10:15 (2007).

¹⁹⁰ *Id.*

similar insurance coverage situations and permit a targeted tender in all multiple coverage situations.¹⁹¹

An endorsement offers a possibility of avoiding a targeted tender under *Institute of London* from an insured. Pursuant to an anti-tender endorsement, if an insured desires to retain the coverage that is available from its insurer, the insured must also retain all other coverage. If the insured fails to tender to other insurers, the insurer is not obligated to defend or indemnify the insured.

The common factor reviewed by each court addressing *John Burns* and *Institute of London*, is “Whether the policy of insurance was triggered.” The decisions applicable to commercial policies uniformly hold that an insured who is insured under multiple policies may elect to trigger only one policy and forgo the assistance of its own insurer. If a party qualifies as an insured under an insurance contract, there is no contractual basis for a court to distinguish based upon coincidence, to prohibit the use of a targeted tender in a personal lines policy nor to limit pre-loss waivers of the right.

V. COMMERCIAL EXCESS AND UMBRELLA LIABILITY INSURANCE

In *North River Insurance Co. v. Grinnell Mutual Reinsurance Co.*,¹⁹² defendant insurer challenged an order of the Circuit Court of Cook County, Illinois, which granted summary judgment to plaintiff insurer on plaintiff's claim for reimbursement of funds from defendant's primary insurance policy, which were paid from defendant's excess policy to fund a settlement in an underlying personal injury lawsuit. Plaintiff appealed from a grant of summary judgment to defendant on plaintiff's equitable contribution claim.

¹⁹¹ *Id.*

¹⁹² *N. River Ins. Co. v. Grinnell Mut. Reinsurance Co.*, 369 Ill. App. 3d 563, 860 N.E.2d 460 (1st Dist. 2006).

Defendant's insured, a general contractor, contracted with plaintiff's insured, subcontractor one, to perform work on a construction project. Subcontractor one contracted the work to subcontractor two. An individual was injured during the project and sued. The general contractor tendered its defense to the subcontractors' primary insurers and a settlement was entered. The primary insurers each paid \$1 million, and plaintiff paid \$2 million. Defendant refused to contribute. In affirming the judgment, the court held that: (1) contrary to defendant's assertions, the underlying contract between the general contractor and subcontractor one did not require subcontractor one to vertically exhaust its consecutive insurance coverage; (2) the principles of waiver and estoppel did not apply to plaintiff as no reservation of rights letter was required since plaintiff was an excess insurer and the defense was provided by the primary insurers; (3) the trial court properly held that defendant was to contribute its primary policy to the settlement before the excess policies were activated; and (4) the trial court properly applied the selective tender rule to the excess insurers of a common insured.¹⁹³

A. PERSONAL EXCESS AND UMBRELLA LIABILITY INSURANCE

i. A “personal injury” definition within a personal umbrella policy encompassing “wrongful detention” applies to wrongful detention of a person, not wrongful detention of property.

In *Allstate Insurance Co. v. Amato*,¹⁹⁴ Allstate Insurance Co. (Allstate) alleged in a declaratory judgment action that it did not owe a duty to defend or indemnify its insured, defendant Jon Amato, (Amato) in a case brought by defendants Lea Goldblatt and the estate of Noel Goldblatt.

¹⁹³ *Id.*

¹⁹⁴ *Allstate Ins. Co. v. Amato*, 372 Ill. App. 3d 139, 865 N.E.2d 516 (1st Dist. 2007).

Amato claimed that, under his personal umbrella policy (PUP) with Allstate, he was entitled to defense and indemnification of the underlying suit and reimbursement for costs and fees he incurred in defending the underlying suit while a determination of coverage was pending.

The lawsuit alleged that various officers, directors, and affiliates of Goldblatt's Bargain Stores, Inc. (Goldblatt's), including Amato, induced plaintiffs to pay \$1.2 million in exchange for an ownership interest in organizations controlled by the officers, directors and affiliates. The plaintiffs alleged that they never received anything in return for their payments. They alleged fraud, false statements, misrepresentations, breach of contract, breach of fiduciary duty and other claims.

At the time of the suit, Amato was covered by the Allstate PUP, which provided, in part, as follows: “Allstate will pay damages which an insured person becomes legally obligated to pay because of bodily injury, personal injury or property damage, subject to the terms, conditions and limits of this policy. Bodily injury, personal injury and property damage must arise from a covered occurrence. We will not pay any punitive or exemplary damages, fines and penalties.”¹⁹⁵

The PUP further provided that Allstate “will defend an insured person sued as the result of an occurrence covered by this policy.” The PUP defined “occurrence” as “an accident during the Policy period, including continuous and repeated exposure to substantially the same general harmful conditions during the policy period, resulting in bodily injury, personal injury, or property damage.”¹⁹⁶

¹⁹⁵ *Id.* at 195, 865 N.E.2d at 519.

¹⁹⁶ *Id.*

The issue before the court was whether the occurrence resulted in personal injury. “Personal injury” was defined in the PUP as “Personal injury means damages resulting from: (a) false arrest; imprisonment; wrongful detention; (b) wrongful entry; invasion of rights of occupancy; (c) libel, slander, humiliation, defamation of character; invasion of rights of privacy.”¹⁹⁷

The PUP also provided that it did not apply “1. To any occurrence arising out of any act or failure to act by any person in performing functions of that person's business. 2. To any occurrence arising out of a business or business property.”¹⁹⁸

Amato tendered the underlying complaint to Allstate seeking defense and indemnification under the PUP. Allstate advised Amato that it did not owe any duty to defend or indemnify him under the PUP and that the alleged injuries were not covered because they did not arise from an “occurrence” that resulted in “bodily injury,” “property damage,” or “personal injury.” “Moreover, Allstate also raised several exclusions that barred coverage under the PUP, including the exclusion of coverage for liability arising from an insured's business activities.”¹⁹⁹

Amato asserted that the policy provided coverage because a “personal injury,” specifically “wrongful detention” of the property, arose from his conduct.

The trial court granted Allstate's motion for summary judgment finding that it was “quite clear that what the policy was endeavoring to get at is wrongful detention of the person, not wrongful detention of the property.”²⁰⁰

¹⁹⁷ *Id.*

¹⁹⁸ *Id.*

¹⁹⁹ *Id.*

²⁰⁰ *Id.* at 196, 865 N.E.2d at 520.

Amato alleged on appeal that the court's determination was erroneous, in that the language “wrongful detention” in the PUP was not ambiguous and referred only to wrongful detention of a person and not to wrongful detention of property. “Amato argue[d] that the language is susceptible to two interpretations and should be construed in favor of coverage and that the court improperly based its determination that the language was not ambiguous on the doctrine of *ejusdem generis*.”²⁰¹

The court of appeals found that:

[T]he trial court was correct that the term “wrongful detention” unambiguously refers only to wrongful detention of a person, not wrongful detention of property. Each of the three groups of damages under the heading of “personal injury” [was] centered around a common theme. By placing wrongful detention in the same group as false arrest and imprisonment, two terms which are directly related to the restraint of a person, it is clear that the language was intended to mean the wrongful detention of a person and not to mean wrongful detention of property. Furthermore, “property damage” was specifically covered elsewhere in the PUP.²⁰²

“Even if the damage incurred in the underlying complaint were covered as a personal injury resulting from Amato's wrongful detention of the Goldblatt's property, both exclusions one and two of the PUP, which exclude coverage for occurrences arising out of business matters, apply to the facts of the underlying complaint.”²⁰³

Because the language of the PUP unambiguously did not provide coverage for wrongful detention of property and because the exclusions in the PUP applied to the facts alleged in the underlying complaint against Amato, Allstate did not have a duty to defend or indemnify Amato under that policy.²⁰⁴

²⁰¹ *Id.*

²⁰² *Id.*

²⁰³ *Id.*

²⁰⁴ *Id.*

B. HOMEOWNER'S INSURANCE

Duty to Defend, Policy Terms, Conditions and Exclusions

Where insured owned ATV within the meaning of the policy he bargained for, and policy did not cover ATV owned by insured, no duty to defend arose.

In *Auto-Owners Insurance Co. v. Stubban*,²⁰⁵ after Dale, the insured, was sued for personal injuries incurred in an ATV accident, his insurance company filed this declaratory judgment action, asking the court to find that the policy issued to Dale did not cover the accident. Dale had testified during the pendency of the underlying case that he had purchased the ATV three years prior to the accident from a man he did not know, and did not have legal title to it. Dale suspected at the time he bought the ATV that it may have been stolen, and was arrested after the accident for possession of stolen property. The trial court found in favor of the insurer.

The injured parties argued on appeal that, because Dale never had legal title to the ATV, he was not the owner, and therefore coverage was available under the policy. The policy provision at issue excluded coverage for owned ATVs. The appellate court affirmed the trial court, reasoning that Dale chose not to insure the ATV, and the insurance company specifically intended not to cover the ATV, and thus the parties bargained for exactly what they got.²⁰⁶ The legal title to the ATV was not dispositive of the issue of ownership, as Dale himself, as well as “the world (except for the person who held the legal title)” treated the ATV as though it were owned by Dale.²⁰⁷

²⁰⁵ *Auto-Owners Ins. Co. v. Stubban*, 371 Ill. App. 3d 513, 867 N.E.2d 1046 (4th Dist. 2007).

²⁰⁶ *Id.*

²⁰⁷ *Id.*

Household exclusion applied to contribution claim

In *American Family Mutual Insurance Co. v. Niebuhr*,²⁰⁸ defendant insured appealed an order of the Circuit Court of Cook County, Illinois granting summary judgment in favor of plaintiff insurer and denying the insured's cross motion in a declaratory judgment action brought by the insurer seeking a declaration that it had no duty to defend or to indemnify the insured in a contribution action under a household exclusion in a homeowner's insurance policy pursuant to 215 Ill. Comp. Stat. Ann. 5/143.01.

The trial court found that the household exclusion in the insurer's policy unambiguously excluded bodily injury to any insured and that the contribution claim sought to recover damages from the insured in an amount commensurate with his alleged negligence in causing injuries to his daughter. On review, the court upheld the grant of summary judgment for the insurer. The court found that 215 Ill. Comp. Stat. Ann. 5/143.01(a) was inapplicable because the injury causing vehicle, a boat owned and operated by a third party, was not insured under the challenged policy and was not operated by an insured.²⁰⁹ Further, a raft on which the injured party was riding was not a vehicle under § 5/143.01 as defined under 215 Ill. Comp. Stat. Ann. 5/4 in that it was an inflatable, five foot platform with no oars or paddles and was merely a novelty flotation device, not used for transportation of passengers or goods.²¹⁰ Under the facts of the case, the insured's homeowner's policy was not a policy of vehicle insurance under § 5/4, and thus, 215 Ill. Comp. Stat. Ann. 5/143.01 did not invalidate the household exclusion under the policy. Therefore, the insurer had no duty to defend or indemnify the insured.²¹¹

²⁰⁸ *Am. Family Mut. Ins. Co. v. Niebuhr*, 369 Ill. App. 3d 517, 860 N.E.2d 436 (1st Dist. 2006).

²⁰⁹ *Id.* at 524, 860 N.E.2d at 442.

²¹⁰ *Id.*

²¹¹ *Id.*

C. AUTOMOBILE INSURANCE

i. Policy Terms, Conditions and Exclusions

Permitted User - driver of car dealership loaner car was not a “permitted user” of the vehicle for purposes of statute that shifted primary coverage from owner's insurer to driver's insurer.

In *Madison Mutual Insurance Co. v. Kessler*,²¹² Sarah Galle was involved in an accident while driving an Escort loaned to her by Jerry Kessler, d/b/a Kessler Auto Body (Kessler). Unfortunately, Sarah totaled her Saturn in a crash about one month before the Escort accident. Kessler agreed to loan Sarah the Escort while she was looking for another Saturn for her at auction. Madison Mutual Insurance Company (Madison) provided coverage for Sarah in the amount of \$100,000. Kessler had garage liability insurance for 1 million dollars with Auto-Owners Insurance Co.

The circuit court granted summary judgment in favor of Auto-Owners finding that Madison was liable for primary coverage under Section 5-102 of Illinois Vehicle Code (625 ILCS 5/5-102) which provided that a permitted user's insurance is primary under certain circumstances. The appellate court reversed and in doing so reviewed the Vehicle Code provision.

The court found that the statute was in derogation of the common law rule that primary coverage is placed on the insurer of the owner of the vehicle and that the driver's insurer is secondary.²¹³ Therefore, the statute must be strictly construed in favor of the person sought to be subjected to its provisions.

²¹² *Madison Mut. Ins. Co. v. Kessler*, 376 Ill. App. 3d 1121, 877 N.E.2d 103 (5th Dist. 2007).

²¹³ *Id.* at 1130, 877 N.E.2d at 110.

Section 5-102 sets forth various licensing requirements for used-vehicle dealers, including insurance coverage in the minimum amount of \$100,000 per person and \$300,000 per occurrence. The statute also specifies when the insurance policy of a permitted user will be primary. Section 5-102(b)(4) states:

If the permitted user has a liability insurance policy that provides automobile liability insurance coverage of at least \$100,000 for bodily injury to or the death of any person, \$300,000 for bodily injury to or the death of any 2 or more persons in any one accident, and \$50,000 for damage to property, then the permitted user's insurer shall be the primary insurer and the dealer's insurer shall be the secondary insurer. If the permitted user does not have a liability insurance policy that provides automobile liability insurance coverage of at least \$100,000 for bodily injury to or the death of any person, \$300,000 for bodily injury to or the death of any 2 or more persons in any one accident, and \$50,000 for damage to property, or does not have any insurance at all, then the dealer's insurer shall be the primary insurer and the permitted user's insurer shall be the secondary insurer.

As used in this paragraph 4, a 'permitted user' is a person who, with the permission of the used-vehicle dealer or an employee of the used-vehicle dealer, drives a vehicle owned and held for sale or lease by the used-vehicle dealer which the person is considering to purchase or lease, in order to evaluate the performance, reliability, or condition of the vehicle. The term 'permitted user' also includes a person who, with the permission of the used-vehicle dealer, drives a vehicle owned or held for sale or lease by the used-vehicle dealer for loaner purposes while the user's vehicle is being repaired or evaluated.

As used in this paragraph 4, 'test driving' occurs when a permitted user who, with the permission of the used-vehicle dealer or an employee of the used-vehicle dealer, drives a vehicle owned and held for sale or lease by a used-vehicle dealer that the person is considering to purchase or lease, in order to evaluate the performance, reliability, or condition of the vehicle.

As used in this paragraph 4, 'loaner purposes' means when a person who, with the permission of the used-vehicle dealer, drives a vehicle owned or held for sale or lease by the used-vehicle dealer while the user's vehicle is being repaired or evaluated.²¹⁴

Initially, the court noted that the statute is confusing as written and creates only one situation where the permitted user's insurance policy would be primary. "That is where the 'permitted user' has the requisite coverage and is driving a vehicle held out for sale or lease by

²¹⁴ 215 Ill. Comp. Stat. Ann. 5/5-102(b)(4).

the used-vehicle dealer, with the used-vehicle dealer's permission, for 'loaner purposes,' while the user's vehicle is being repaired or evaluated.”²¹⁵

The court found it undisputed that Sarah had the requisite coverage, that she was driving the Escort with the permission of Kessler, and that the Escort was owned and held for sale or lease by Kessler. Sarah was not “test driving” the Escort and she had no intention of repurchasing the vehicle. “Accordingly, under the terms of the statute, Sarah's insurance coverage would be primary only if she was driving Kessler's vehicle while her Saturn was being repaired or evaluated.”

Sarah’s Saturn was not being repaired or evaluated as it had been considered a total loss and Kessler loaned the Escort to Sarah while they sought a replacement vehicle for her. The court concluded that the more ordinary situation is for the dealership to provide a loaner while a customer’s vehicle is being repaired or evaluated in the sense of a need for repair or the cost of repairs.²¹⁶

Material fact existed as to whether automobile on blocks was in dead storage at the time of plaintiff’s alleged injury.

In *Johnson v. Harris*,²¹⁷ plaintiff, Johnson, was injured by an automobile that was kept on blocks in the garage of defendant, Harris. Plaintiff filed a complaint alleging that while in defendant’s garage he had been injured by an automobile in the garage that was driven by defendant in a negligent manner in the confined space of the garage. Harris filed a declaratory judgment action against his homeowner's insurance policy carrier, defendant Travelers Insurance. Travelers had declined coverage under Harris's homeowner's policy, asserting the

²¹⁵ *Madison*, 376 Ill. App. 3d at 1126, 877 N.E.2d at 107.

²¹⁶ *Id.* at 1129, 877 N.E.2d at 109.

²¹⁷ *Johnson v. Harris*, 374 Ill. App. 3d 473, 871 N.E.2d 203 (3d Dist. 2007).

policy did not cover injuries arising out of the ownership, maintenance or use of a motor vehicle. Under “Exclusions,” the policy issued by Travelers to Harris states, in part: “Medical Payments to Others do not apply to bodily injury or property damage: ... arising out of: (1) the ownership, maintenance, use, loading or unloading of motor vehicles.”²¹⁸

The policy further stated, in part: “This exclusion does not apply to ... (4) a vehicle or conveyance not subject to motor vehicle registration which is: ... (c) in dead storage on an insured location.”²¹⁹

Travelers filed an answer and counter-complaint requesting the trial court find it had no duty to defend or indemnify Harris with respect to the underlying complaint filed by Johnson.

Johnson then filed an amended complaint in the underlying action alleging that Harris was the owner of an automobile that was purchased at least five years before the occurrence, and that the automobile had been towed to Harris's garage where it remained in “dead storage.” Johnson alleged he was injured while standing in the garage when Harris, among other negligent acts or omissions, improperly used the garage to attempt repair on the automobile and test repairs on the automobiles without ensuring that the garage was safe for such activities and placed the vehicle on blocks which failed to secure the vehicle in dead storage. Johnson alleged he was injured when he was struck by the vehicle.

The trial court granted Travelers' summary judgment motion. The appellate court reversed. The court initially stated the general rule that “in determining whether an insurer owes a duty to an insured to defend an action brought against the insured, the court must consider only

²¹⁸ *Id.*

²¹⁹ *Id.*

the allegations in the underlying complaint and the relevant policy provisions.”²²⁰ An insurer owes a duty to defend if the allegations of the underlying complaint “fall within, or potentially within, coverage under the policy.”²²¹

The court had previously defined the term “dead storage” as suggesting at least that the engine does not run. Therefore, where the owner drives the vehicle even periodically on his property, it is not considered in “dead storage.”²²² In *Marx*, the owner stored several motor cycles that he would periodically start and ride on his property. Homeowner’s coverage did not apply when the owner started a fire that damaged property while starting one of the motorcycles.

In the present case, the court found that the amended complaint did not allege that defendant started or drove the vehicle. Therefore, the court could not “conclude Harris was using the automobile, which had been stored on blocks for five years in his garage, in one of the inherently dangerous capacities that would preclude coverage under the homeowner's policy for any resultant injury.”²²³ For example, “if Harris was performing paint or body repairs on the vehicle or changing a bulb in a headlamp, and the vehicle slipped off the storage blocks, the vehicle could be considered to have been in dead storage at the time of the maintenance.”²²⁴

²²⁰ *Id.* at 476, 871 N.E.2d 203, 205 (quoting *Connecticut Specialty Ins. Co. v. Loop Paper Recycling, Inc.*, 356 Ill. App. 3d 67, 72, 824 N.E.2d 1125, 1130 (1st Dist. 2005)).

²²¹ *Id.* (citing *Connecticut Specialty*, 356 Ill. App. 3d at 72, 824 N.E.2d at 1130).

²²² *Standard Mut. Ins. Co. v. Marx*, 367 Ill. App. 3d 512, 854 N.E.2d 710 (3d Dist. 2006).

²²³ *Id.* at 477, 871 N.E.2d at 207.

²²⁴ *Id.*

D. Liability Limits and Stacking of Coverage

i. Step-Down Provision for Permissive Users

Clauses in automobile policies that limit the liability limits for permissive drivers only up to the limits of the Financial Responsibility Law are not contrary to public policy. BUT, subsequently modified by statute

In *State Farm Mutual Automobile Insurance Co. v. Illinois Farmers Insurance Co.*, State Farm Mutual Automobile Insurance Co. (State Farm) filed an action against Farmers Insurance Co. (Farmers) seeking reimbursement for amounts it was required to pay as a result of a step down provision contained in Farmer's automobile insurance policies.²²⁵ State Farm also sought a declaratory judgment that the step-down clause was void as against public policy.²²⁶

Farmers' step-down provisions reduced the policy liability limits to the minimum liability limits required under the Financial Responsibility Law (625 ILCS 5/7-317(b)(2) and (b)(3)) when the insured's vehicle was being operated by a permissive user who was neither a resident of the named insured's household (nonresident permissive user) nor a family member or a listed driver. In the usual scenario complained of by State Farm it was required to pay underinsured motorist benefits to its insured or liability payments to a third party as the result of Farmers' step-down provision.

The Illinois Supreme Court reviewed whether the "step-down" provisions, which reduce the policy limits for permissive users, of several automobile liability policies issued by Illinois Farmers Insurance were void and unenforceable because they violated Illinois public policy.

²²⁵ *State Farm Mut. Auto. Ins. Co. v. Illinois Farmers Ins.*, 226 Ill. 2d 395, 875 N.E.2d 1096 (2007).

²²⁶ *Id.*

Farmers' step-down provisions reduced the policy limits to the minimum liability limits required under sections 7-203 and 7-317(b) of the Illinois Safety and Family Financial Responsibility Law when the insured's vehicle was being operated by a permissive user who was neither a family member residing in the insured's household nor a listed driver.²²⁷ Sections 7-203 and 7-317(b)(3) required every liability insurance policy issued to provide coverage not less than \$20,000 for the death or bodily injury of any one person, \$40,000 for the death or bodily injury of two or more persons, and \$15,000 for property damage occurring in any one motor vehicle accident.²²⁸

State Farm argued that the step-down provisions contained in Farmer's policies violate Illinois' public policy and were therefore void and unenforceable. Section 7-601(a) of the Illinois Safety and Family Financial Responsibility Law, in pertinent part, provided that:

No person shall operate, register or maintain registration of, and no owner shall permit another person to operate, register, or maintain registration of, a motor vehicle designed to be used on a public highway unless the motor vehicle is covered by a liability insurance policy.

The insurance policy shall be issued in amounts no less than the minimum amounts set for bodily injury or death and for destruction of property under Section 7-203 of this Code, and shall be issued in accordance with the requirements of Sections 143a and 143a-2 of the Illinois Insurance Code, as amended.²²⁹

Section 7-203 required every liability insurance policy issued to provide coverage of not less than \$20,000 for the death or bodily injury of any one person, \$40,000 for the death or bodily injury of two or more persons, and \$15,000 for property damage occurring in any one motor vehicle accident.²³⁰

²²⁷ 625 ILL. COMP. STAT. 5/7-203, 7-317(b) (West 2002).

²²⁸ *Id.*

²²⁹ 625 ILL. COMP. STAT. 5/7-601(a) (West 2002).

²³⁰ 625 ILL. COMP. STAT. 5/7-203 (West 2002).

An owner's policy of liability insurance must insure the person named therein and any other person using or responsible for the use of such motor vehicle or vehicles with the express or implied permission of the insured.²³¹

The Supreme Court found nothing in the statutory language requiring a liability insurance policy to provide the same level of coverage to permissive users. Therefore, the step-down provision was enforceable.²³²

NOTE* The General Assembly passed Senate Bill 1208, which deals with the insurance issue involved in this case. The Governor signed the bill into law as Public Act 95-395, with an effective date of January 1, 2008. This Act, which creates new section 143.13a of the Illinois Insurance Code, now mandates that "any policy of private passenger automobile insurance must provide the same limits of ... coverage to all persons insured under that policy, whether or not an insured person is a named insured or permissive user under the policy."²³³

E. Uninsured Motorists and Underinsured Motorist Coverage

- i. An underinsured motorist provision defining “you” is unambiguous and a claimant not a named insured nor occupying a covered automobile at the time of the accident, does not qualify as an “insured” for purposes of coverage when struck by a vehicle as a pedestrian.**

In *Stark v. Illinois Emcasco Insurance Co.*, the claimant, Fred Stark, filed a declaratory judgment action seeking insurance coverage under a commercial automobile policy provided by Illinois Emcasco Insurance Co. (Illinois Emcasco) and issued to a corporation, Thornton, of

²³¹ 625 ILL. COMP. STAT. 5/7-317(b)(2) (West 2002).

²³² *State Farm Mut. Ins. Co. v. Illinois Farmers Ins.*, 226 Ill. 2d 395, 414, 875 N.E.2d 1096, 1107 (2007).

²³³ 215 ILL. COMP. STAT. 5/143.13.

which plaintiff was the sole officer, director, and shareholder.²³⁴ The claimant sought underinsured motorist coverage following an accident. He was driving his automobile to view a worksite and stopped at an Office Depot to purchase software for his corporation. He parked his car and walked inside the store. When he exited the store he was struck by another vehicle insured with \$50,000 in liability coverage. He settled with the tortfeasor's insurance carrier for \$50,000 and then brought this claim against Illinois Emcasco for underinsured motorist coverage.

Illinois Emcasco issued a commercial automobile policy to Thornton insuring 16 automobiles and listing Thornton as the only "named insured" in the policy declaration. The policy stated, "Throughout this policy the words 'you' and 'your' refer to the Named Insured shown in the Declarations."²³⁵ The policy further included an "Illinois Underinsured Motorists Coverage" endorsement that defined an "insured" as follows:

1. You.
2. If you are an individual, any 'family member' .
3. Anyone else 'occupying' a covered 'auto' or a temporary substitute for a covered 'auto' . The covered 'auto' must be out of service because of its breakdown, repair, servicing, loss or destruction.
4. Anyone for damages he or she is entitled to recover because of 'bodily injury' sustained by another 'insured'."

Illinois Emcasco denied the claim asserting that the claimant was not an "insured" for purposes of the underinsured motorist endorsement at the time of the accident because Thornton,

²³⁴ Stark v. Illinois Emcasco Ins. Co., 373 Ill. App. 3d 804, 805, 869 N.E.2d 957, 959 (1st Dist. 2007).

²³⁵ *Id.*

plaintiff's corporation, was the only named insured in the policy declarations. Defendant also argued that plaintiff was not an insured under paragraph three of the underinsured motorist provision because plaintiff was not "occupying" a covered "auto" at the time of the accident.

Plaintiff argued that paragraph one of the underinsured motorist endorsement was ambiguous, as corporations cannot suffer bodily injury and that paragraph one should have been read to provide underinsured motorist coverage for bodily injury caused to plaintiff because plaintiff is the sole officer, director, and shareholder of Thornton and that at the time of contracting, plaintiff understood the term "you" to apply to plaintiff, personally. He asserted that he was entitled to benefits under the underinsured motorist endorsement found within Thornton's policy because the word "you" in the policy is ambiguous. If the court concluded that the "you" in the policy was ambiguous, the claimant would fall within "you" in the underinsured motorist endorsement, thereby entitling the claimant to proceeds under the policy for bodily injury suffered as a pedestrian when struck by the insured's vehicle.

The court found that the policy specifically defined the term "you" as referring only to the "named insured" shown in the policy declarations, which was the corporation Thornton. "It is clear under the law that a corporation is a legal entity separate and distinct from its shareholders, directors and officers."²³⁶

Therefore, as Thornton had an existence wholly separate from the claimant, the insurance policy, on its face, was unambiguous as to who was covered thereunder.

The claimant argued that although he was not a named insured in the policy, he had rights under the underinsured motorist endorsement because the underinsured motorist endorsement

²³⁶ *Id.* at 808, 869 N.E.2d at 961 (quoting *Rohe v. CAN Ins. Co.*, 312 Ill. App. 3d 123, 127, 726 N.E.2d 38, 41 (1st Dist. 2000)).

afforded recovery for bodily injury, a thing that Thornton, a corporation, could not incur. Therefore, the endorsement would be a nullity unless he, the claimant, the corporation's sole officer, director, and shareholder, had coverage for the injuries he sustained as a pedestrian.

The court found that the parties contracted for commercial automobile coverage for automobiles owned by Thornton.²³⁷ The premiums paid by Thornton were to provide underinsured coverage benefits for those occupying a covered automobile. The insurer never contemplated undertaking the risk of insuring plaintiff, as a pedestrian, for purposes of underinsured motorist coverage.

The underinsured motorist endorsement covered Thornton and any person while using its automobiles. The claimant, not being a named insured nor occupying a covered automobile at the time of the accident, had no coverage rights under the endorsement when struck by a vehicle as a pedestrian.

ii. Liability insurer's payment of an amount equal to the underinsured coverage relieved UIM carrier of liability even if the policies could be stacked.

In *Jones v. Country Mutual Insurance Co.*,²³⁸ LaDonna Jones was the driver of a car involved in an accident with a vehicle driven by Maria Salcedo. The Jones vehicle had several passengers, including her sons, Jerry Jones, Jr., Dante Jones and Donovan Jones. Jerry Jones, Jr. died as a result of the accident and Dante Jones had severe injuries. The Estate of Jerry Jones, Jr. and Dante Jones, a minor, each received the \$100,000 maximum per-person limit from Salcedo's insurance policy.

²³⁷ *Id.* at 810, 869 N.E.2d at 963.

²³⁸ *Jones v. Country Mut. Ins. Co.*, 371 Ill. App. 3d 1096, 864 N.E.2d 793 (1st Dist. 2007).

At the time of the accident, the vehicle driven by LaDonna Jones was leased by Isaiah Harrison. Harrison carried underinsured motorist coverage for the vehicle issued by Country Mutual in the amount of \$100,000 per person and \$300,000 per occurrence (the Harrison Policy). Jerry W. Jones and LaDonna Jones also carried an insurance policy issued by Country Mutual which provided for underinsured motorist coverage in the amount of \$100,000 per person and \$300,000 per occurrence (the Jones Policy). Both the Harrison Policy and Jones Policy contained the same relevant terms and conditions.

The trial court granted plaintiffs' motion for summary judgment in the amount of \$100,000 finding that the Jones and Harrison policies could be stacked for purposes of underinsured motorist coverage. The trial court stated that the anti-stacking language in the policies only applied to the insured and relatives of the insured. Since the policies originated from two separate households, where the insureds were unrelated by blood or marriage, the policies did not expressly prohibit stacking. The trial court decided that plaintiffs were entitled to \$200,000 per person in underinsured motorist coverage, offset by the \$100,000 already received from Salcedo's insurer.

The appellate court reversed, finding that the policies could not be stacked. The court initially noted the general rule that "the construction of an insurance policy provision is a question of law that can be properly decided on a motion for summary judgment. We review a grant of summary judgment de novo. An insurance policy is a contract and, as such, is subject to the same rules of interpretation that govern the interpretation of contracts."²³⁹

The language in both policies relied upon by the trial court to allow stacking, states:

General Policy Conditions

²³⁹ *Id.* at 1098, 864 N.E.2d at 795.

8. Other Vehicle Insurance with Us. If this policy and any other vehicle insurance policy issued to you or a relative by one of our companies apply to the same accident, the maximum limit of our liability under all the policies will not exceed the highest applicable limit of liability under any one policy.

The policyholders were unrelated according to the definition of “relative” in both insurance policies. The trial court therefore concluded the antistacking provision did not apply to the Jones and Harrison Policies. The appellate court agreed that the fact that the policies were issued to unrelated individuals rendered the above policy provision inapplicable to the present case. However, the appellate court noted other policy language that prevented stacking.

The relevant language as to the underinsured motorist coverage in both the Harrison and Jones policies provided as follows:

2. Limits of Liability. The Uninsured-Underinsured motorists limits of liability shown on the declarations page apply as follows:

e. The most we will pay under Underinsured motorists Coverage, Coverage U, to any one person is the lesser of:

(1) the difference between the “each person” limit of this coverage as shown on the declarations page for this coverage and the amount paid to the insured by or on behalf of persons or organizations who may be legally responsible for the bodily injury caused by the underinsured motor vehicle; or

(2) the difference between the amount of the insured's damages and the amount paid to the insured by or on behalf of persons or organizations who may be legally responsible for the bodily injury caused by an underinsured motor vehicle.²⁴⁰

The “each person” limit for underinsured motorist coverage under both the Harrison and Jones policies as shown on the declarations page was \$100,000. Each plaintiff received \$100,000 from Salcedo's insurer, an amount equal to the per-person limit for bodily injury coverage on Salcedo's insurance policy. Thus, under (1) above, the difference between the “each

²⁴⁰ *Id.* at 1099, 864 N.E.2d at 795.

person” limit of this coverage and the amount paid to each plaintiff was \$0 (\$100,000 minus \$100,000). Accordingly, plaintiffs effectively had no underinsured motorist coverage since the most that Country Mutual was obligated to pay under either policy was \$0.

The court noted that even if stacking were allowed, Country Mutual would still be allowed to offset each \$100,000 policy limit by the \$100,000 payment from Salcedo's insurer before the amounts are stacked. As a result, each policy, containing \$0 in underinsured motorist coverage, would be stacked for a total of \$0 in coverage.²⁴¹

In concluding, the court distinguished the situation where the plaintiff received less than the underinsured coverage amount thereby creating a gap in the amount received and the underinsured coverage.²⁴²

iii. Settlement of underinsured motorist claim with employer’s insurer where language stated “Release of All Claims” did not include claim against employer under the Workers’ Compensation Act.

In *Maxit, Inc. v. Van Cleve*,²⁴³ John Van Cleve was employed by Maxit, Inc. He was injured in an accident during his employment while driving one of Maxit’s trucks. Van Cleve made a claim under his employers underinsured motorist coverage (UM), and he filed a claim under the Workers’ Compensation Act. He settled the UM claim for \$800,000. The settlement agreement had extensive release of claim language, including release of the employer, Maxit. The release also provided that Van Cleve would indemnify and hold Maxit harmless against any further claims or liability.

²⁴¹ *Kapinus v. State Farm Mut. Auto. Ins. Co.*, 317 Ill. App. 3d 185, 738 N.E.2d 1003 (3d Dist. 2000).

²⁴² *Cummins v. Country Mut Ins. Co.*, 178 Ill. 2d 474, 687 N.E.2d 1021 (1997).

²⁴³ *Maxit, Inc. v. Van Cleve*, 376 Ill. App. 3d 50, 875 N.E.2d 690, 314 Ill. Dec. 717 (2nd Dist, 2007).

Van Cleve continued to pursue his workers' compensation claim before the Workers' Compensation Commission and was paid \$200,000 by Maxit to settle the workers' compensation claim. Maxit filed an action in the circuit court claiming Van Cleve breached the settlement agreement because (1) the UM settlement also included the workers' compensation claim, (2) the \$200,000 settlement payment was made only in mitigation of damages, and (3) under the hold harmless agreement in the UM settlement, Van Cleve was obligated to reimburse Maxit the \$200,000.

The circuit court granted summary judgment in favor of Maxit, finding that the indemnification agreement contained in the UM settlement was enforceable. In reversing, the appellate court first noted that the UM release was ambiguous and could be interpreted as applying only to the release of claims under the underinsured motorist insurance policy.²⁴⁴ Second, and more significant, the court found that the UM release could not waive Van Cleve's rights under the Workers' Compensation Act (Act).²⁴⁵ The Act required that any waiver of one's right to receive benefits under the Act be approved by the Illinois Workers' Compensation Commission.²⁴⁶ Therefore, even if the UM settlement unambiguously included claims under the Act, it would be illegal and unenforceable.²⁴⁷

iv. Policy language called for application of “per-person” limits of coverage rather than higher amount provided in “per occurrence” limits.

In *Illinois Farmers' Insurance Co. v. Marchwiany*,²⁴⁸ the Illinois Supreme Court overruled the Fifth District holding in *Roth v. Illinois Farmers' Insurance Co.*,²⁴⁹ construing an

²⁴⁴ *Id.*

²⁴⁵ *Id.*

²⁴⁶ *Id.*

²⁴⁷ *Id.*

²⁴⁸ *Illinois Farmers' Ins. Co. v. Marchwiany*, 222 Ill. 2d 472, 856 N.E.2d 439 (2006).

identical policy provision regarding underinsured motorist coverage. In *Marchwiany*, the surviving next of kin, a wife and four adult children all claimed underinsured benefits after settling with the at-fault drivers in a fatal collision. Two policies were applicable to the vehicle being driven by the decedent, and one of those insurers paid the difference between the limits of coverage under its policy, \$100,000, and the amount paid in settlement. The other insurer, Illinois Farmers, filed a declaratory judgment action. Illinois Farmers contended that no further recovery was available to the estate or survivors because the other insurer was primary and the “per person” limits of coverage under the Illinois Farmers policy were in the same amount. The survivors claimed that the higher, “per-occurrence” limits of \$300,000 were applicable. The trial court granted summary judgment to Farmers, and the appellate court affirmed. The Supreme Court resolved a split in the appellate district courts by affirming.

The policy provisions at issue were “Limitations of Coverage”:

1. The uninsured motorist bodily injury limit for ‘each person’ is the maximum we will pay for all damages resulting from bodily injury sustained by one person in any one accident or occurrence. Included in this limit, but not as a separate claim or claims, are all the consequential damages sustained by other persons, such as loss of services, loss of support, loss of consortium, wrongful death, grief, sorrow and emotional distress.
2. The uninsured motorist bodily injury limit for ‘each occurrence’ is the maximum amount we will pay for two or more persons for bodily injury sustained in any one accident or occurrence.²⁵⁰

The survivors argued that these provisions, when read together, created an ambiguity in the policy that must be resolved in favor of coverage.

The Court noted that all appellate courts construing these provisions, including the *Roth* court, held that the “per-person” clause restricts recovery for consequential damages due to fatal

²⁴⁹ *Roth v. Illinois Farmers Ins. Co.*, 324 Ill.App.3d 293, 754 N.E.2d 439 (5th Dist. 2001).

²⁵⁰ *Marchwiany*, 222 Ill. 2d at 480, 754 N.E.2d at 444.

injuries to the \$100,000 limit.²⁵¹ However, the *Roth* court also held (and the claimants argued in this case) that the “per-occurrence” clause was not explicitly subject to the provisions of the “per-person” clause, and the use of the word “for” rather than “to” in reference to “two or more persons” in the “per-occurrence” clause allowed for a reasonable interpretation that the higher coverage available in that clause was applicable in the situation where multiple derivative claims are made.²⁵² When two reasonable interpretations of policy language exist, the policy is ambiguous and must be given the interpretation that is construed in favor of the insured.²⁵³ The Illinois Supreme Court held, however, that this was not a reasonable interpretation of the policy language.²⁵⁴ Where, as here, the “per-person” limit is clearly applicable, the Court found it unreasonable to expand that coverage unless the language of the “per-occurrence” clause clearly required that result.²⁵⁵ The Court found that it did not in this case.

v. A statute will not be applied retroactively if to do so would violate the constitutional prohibition against laws impairing the obligations of contracts.

In *American Family Insurance Co. v. King*,²⁵⁶ American Family and King arbitrated a claim pursuant to the uninsured motorist provision of the policy, resulting in an award of \$39,000 for King. American Family then filed suit, seeking a trial on the claim. King’s motion to dismiss was granted by the trial court, but the appellate court reversed and remanded. Under the terms of the policy, “if any arbitration award exceeds the minimum limit of the Illinois Safety Responsibility Law, either party has a right to trial on all issues in any court having jurisdiction.” Also, any arbitration award not exceeding the minimum limit of the Illinois Safety Responsibility

²⁵¹ *Id.*

²⁵² *Roth*, 324 Ill. App. 3d at 299, 754 N.E.2d at 444.

²⁵³ *Id.*

²⁵⁴ *Marchwiany*, 222 Ill. 2d at 481, 754 N.E.2d at 444.

²⁵⁵ *Id.*

²⁵⁶ *Am. Family Ins. Co. v. King*, 375 Ill. App. 3d 791, 874 N.E.2d 603 (2nd Dist. 2007).

Law is binding. At the time the policy was issued, and at the time of the accident, the coverage minimum under that law was \$20,000. At those same times, a section of the Illinois Insurance Code cross-referenced that law, providing that an arbitration decision was binding for an amount of damages not exceeding the amount called for under the Illinois Safety Responsibility Law. However, that statute was amended after the accident at issue in this case, and now provides that any arbitration award not exceeding \$50,000 is binding. On the basis of the amendment of this statute, the trial court granted King's motion to dismiss.

On appeal, American Family conceded that the \$50,000 amount called for under the Insurance Code would govern in this case if the relevant policy had been issued or renewed after the effective date of the amendment. It argued, however, that applying the amendment to a policy issued prior to the date of the amendment ran afoul of the Illinois Constitution. The appellate court agreed, finding that the parties had a constitutional right to preserve the terms of the contract.²⁵⁷

F. Set-Offs, Reimbursement and Recovery

i. An automobile insurer is not entitled to reimbursement from an insured's settlement of a legal malpractice action alleging failure to bring timely suit against the alleged tortfeasor.

In *St. Pierre v. Koonmen*,²⁵⁸ the insurer Ohio Casualty Insurance Company had intervened in a legal malpractice action brought by the insured, St. Pierre, against her former attorney Koonmen. Ohio Casualty insured St. Pierre under an automobile insurance policy and had paid St. Pierre benefits under her insurance policy for an automobile accident. The insurance policy at issue provided that if Ohio Casualty paid benefits under the policy and St.

²⁵⁷ *Id.* at 796, 874 N.E.2d at 607.

²⁵⁸ *St. Pierre v. Koonmen*, 371 Ill. App. 3d 466, 863 N.E.2d 279 (2d Dist. 2007).

Pierre “recovers damages from another,” she must reimburse Ohio Casualty for any payments it made. St. Pierre had hired Koonmen to sue the other driver involved in the automobile accident, but Koonmen failed to file suit within the limitations period.²⁵⁹ St. Pierre then sued Koonmen for legal malpractice, and the parties eventually settled that action for \$100,000. Ohio Casualty subsequently asserted a lien in the amount of the payment it had made to St. Pierre against the proceeds of the legal malpractice settlement. The trial court adjudicated the lien by holding that St. Pierre was not required to reimburse Ohio Casualty for the amount of payment Ohio Casualty had made.

On appeal, the appellate court affirmed the trial court. The appellate court held that the relevant policy language regarding reimbursement was ambiguous.²⁶⁰ Read literally, such policy language would require repayment if St. Pierre received any damages from anyone for any reason, even if not related to the automobile accident for which Ohio Casualty paid benefits.²⁶¹ Because the policy language was ambiguous, the appellate court construed the language against the drafter (Ohio Casualty) and inferred that the injury for which the insured collects damages must be the same injury for which the insurer paid benefits.²⁶² Here, St. Pierre’s settlement with Koonmen compensated her for injury she suffered from Koonmen’s alleged malpractice and not for the injury she suffered from the automobile accident (even if the measure of damages for the settlement might be the damages stemming from the automobile accident). The appellate court also stated that denying reimbursement was consistent with *Eastman v. Messner*,²⁶³ which similarly denied reimbursement in order to (1) prohibit an insurer from interfering in the attorney-client relationship between the insured and the insured’s attorney, and (2) enable the

²⁵⁹ *Id.* at 467, 863 N.E.2d at 280.

²⁶⁰ *Id.* at 469, 863 N.E.2d at 283.

²⁶¹ *Id.*

²⁶² *Id.*

²⁶³ *Eastman v. Messner*, 188 Ill. 2d 404, 721 N.E.2d 1154 (1999).

insured to be fully compensated, as malpractice actions are strictly limited to the amount lost due to the malpractice, which would exclude amounts received from insurance.

VI. MEDICAL, LIFE, HEALTH INSURANCE AND WORKERS' COMPENSATION INSURANCE

A. Where insureds injured in an automobile accident received medical-payment benefits from insurer, health care provider's ownership interest in those payments was limited to forty percent as provided by Health Care Services Lien Act.

In *Progressive Universal Insurance Co. v. Taylor*,²⁶⁴ a claim arose from an automobile accident in which the driver and three of his passengers were injured. Two of those passengers, Kahende Jake and Daniel Joyce, received medical care from Carle Foundation Hospital and Carle Clinic Association (Carle). The owner of the car held an insurance policy with Progressive Universal Insurance Company (Progressive) that provided \$50,000 in liability coverage and an additional \$5,000 of coverage for the medical expenses of each injured person. Progressive tendered the \$50,000 liability payment to the court, which was then distributed among the parties pursuant to the terms of an agreement they had reached and paid them each \$5,000 apiece under the medical-payments coverage.

Following payments that Jake and Joyce each made to Carle out of their portion of the \$50,000 liability payment, each still owed Carle more than \$5,000. Consequently, Carle filed a claim demanding that Jake and Joyce endorse over their \$5,000 medical-payment checks as well. In response, Jake and Joyce stated that they had offered to pay Carle forty percent of the \$5,000 checks pursuant to the Health Care Lien Act,²⁶⁵ but that Carle refused to accept less than the full amount. Carle, Jake, and Joyce all acknowledged that the Health Care Lien Act entitles a medical provider that tends to the victim of an accident to a lien against forty percent of the

²⁶⁴ *Progressive Universal Ins. Co. v. Taylor*, 375 Ill. App. 3d 495, 874 N.E.2d 910 (4th Dist. 2007).

²⁶⁵ 770 ILL. COMP. STAT. 23/10(a) (West, 2004).

proceeds obtained by that victim in settlement of the victim's "claims and causes of action," and that the \$5,000 checks were settlements of contractual claims under the Progressive policy. Carle, however, argued that the purpose of the medical-payment coverage was to compensate health care providers, and that it was therefore entitled to the full amount of the checks. The trial court agreed, and ordered Joyce, Jake, and their attorneys to endorse the checks in full to Carle.

On appeal, Jake and Joyce contended that Carle's right to the \$5,000 checks was limited to forty percent, while Carle argued that the granting of a statutory forty percent lien does not mean that its interest in the checks was not greater than forty percent based on the value of its services. The appellate court found for Jake and Joyce, holding that although Progressive was obligated to pay them each \$5,000 to defray medical expenses, it did not follow that their medical providers had an ownership interest in those payments beyond the statutorily granted forty percent.²⁶⁶ To the contrary, Jake and Joyce were free to settle their contractual or quasi-contractual debt to Carle out of any fund they chose.²⁶⁷ Carle's remedy in the event that Jake and Joyce failed to pay their medical bills, the court held, was an action for breach of contract, and it did not hold an ownership interest, apart from the forty percent lien, in any particular res.²⁶⁸ The trial court's judgment was amended accordingly.²⁶⁹

B. The collateral source rule does not apply to costs paid by Medicare or Medicaid, and thus in a personal injury action arising from an automobile accident, the injured party could recover only the amount of medical bills actually paid, not the amount actually billed.

²⁶⁶ *Taylor*, 375 Ill. App. 3d at 500, 874 N.E.2d at 914.

²⁶⁷ *Id.*

²⁶⁸ *Id.* at 500, 874 N.E.2d at 914-15.

²⁶⁹ *Id.* at 502, 874 N.E.2d at 915-16.

In *Wills v. Foster*,²⁷⁰ plaintiff Wills was injured in an automobile accident caused by defendant Foster. During trial, Wills presented evidence of \$80,163 in medical expenses billed as a result of the accident. However, the amount of these expenses actually paid by Medicare and Medicaid on Wills' behalf was only \$19,005. The jury entered a verdict in favor of Wills in the amount of \$80,163 along with other damages. The trial judge, at Foster's request, subsequently reduced the medical expenses award to \$19,005.

The appellate court affirmed, holding that as a matter of first impression, the collateral source rule did not apply to prevent reduction of Wills' compensatory damages award because the Medicare and Medicaid benefits conferred upon Wills did not result from a bargained-for exchange with the third-party providing such benefits.²⁷¹ Generally, the collateral source rule requires that benefits received by an injured party from a source wholly independent of, and collateral to, the tortfeasor will not reduce the damages otherwise recoverable from the tortfeasor. This is to prevent the tortfeasor from benefiting from the injured party's foresight in acquiring insurance and to serve as a deterrent to the tortfeasor. The appellate court distinguished the circumstances where an injured party had a contractual arrangement with a private insurance company, in which case the injured party is permitted to present evidence of the full amount it was billed for healthcare services even if the amount paid by the private insurance company to the healthcare provider was discounted. Unlike with private insurance, with Medicare and Medicaid an insured does not make expenditures to obtain insurance and has not bargained for his coverage.²⁷² Noting a split amongst state courts regarding whether Medicare and Medicaid payments fall within the collateral source rule, the appellate court joined

²⁷⁰ *Wills v. Foster*, 372 Ill. App. 3d 670, 867 N.E.2d 1223 (4th Dist. 2007), *leave to appeal granted*, 225 Ill.2d 679, 875 N.E.2d 1126 (2007).

²⁷¹ *Id.* at 675, 867 N.E.2d at 1228.

²⁷² *Id.*

those states that have held that Medicare and Medicare payments are excluded from collateral sources within the meaning of the collateral source rule. The appellate court based its holding on *Peterson v. Lou Bachrodt Chevrolet Co.*,²⁷³ in which the Illinois Supreme Court found that the collateral source rule is not applicable if an injured party has incurred no expense, obligation, or liability in obtaining the services for which he seeks compensation.

C. When a beneficiary's right to life insurance policy proceeds vests before the insured changes the beneficiary designation on his policy, the court should impose a constructive trust on the policy's proceeds to protect the intended beneficiary's vested rights.

In *In re Beckhart*,²⁷⁴ two parents entered into a settlement agreement in 2001 naming their son as the beneficiary on their life insurance. The father subsequently died and at the time of his death had a life insurance policy which named the father's estate as the beneficiary. The petitioner then filed a claim on behalf of the son with the decedent's estate requesting the proceeds of the life insurance policy. Subsequent to filing of this claim, the insurance company paid the proceeds of the decedent's life insurance policy to the decedent's estate. The petitioner then sought to establish a constructive trust regarding the proceeds, alleging that the estate administrator had been improperly using the proceeds for estate expenses. The circuit court denied establishment of a constructive trust based on the petitioner's laches.

On appeal, the appellate court reversed and remanded. The appellate court stated that the son had obtained a vested, contingent right to the life insurance proceeds when his parents entered into a final settlement agreement in 2001.²⁷⁵ Such an equitable right could be enforced, and thus the appellate court held that the son was entitled to the life insurance proceeds as the

²⁷³ *Peterson v. Lou Bachrodt Chevrolet Co.*, 76 Ill. 2d 353, 363, 392 N.E.2d 1, 6 (1979).

²⁷⁴ *In re Beckhart*, 371 Ill. App. 3d 1165, 864 N.E.2d 1002 (3d Dist. 2007).

²⁷⁵ *Id.* at 1168-69, 864 N.E.2d at 1005.

proper beneficiary of the policy, not the estate, and that the estate administrator lacked authority to use the proceeds for estate expenses.²⁷⁶ In such a case, a constructive trust should be imposed to protect the son's equitable, vested right.²⁷⁷ Further, the appellate court reversed the finding of laches on the part of the petitioner.²⁷⁸

D. Settlement agreement with third party tortfeasor did not forfeit employer's right to assert a statutory lien under the Workers' Compensation Act.

In *Harder v. Kelly*,²⁷⁹ appellant insurer intervened in a personal injury lawsuit in the Circuit Court of Du Page County (Illinois) filed by appellee employee against a third party after the insurer paid workers' compensation benefits to the employee for the injury caused by the third party. The trial court ruled that the employer forfeited its statutory lien under the Workers' Compensation Act (Act),²⁸⁰ and the insurer appealed.

The insurer asserted that it was subrogated to the employer's right to assert a lien under the Act against any settlement of the employee's lawsuit. The appellate court held there was no reason, under the Act or general contract law, that the employer had to affirmatively reserve its right to its statutory lien in the agreement settling the employee's claim against the third party -- particularly when there was nothing in the settlement agreement suggesting that the employer intended to waive its lien.²⁸¹ The court reasoned that a finding that the employer waived its lien effectively would rewrite the parties' settlement agreement, which elected not to address the employer's lien. Such a finding would also contravene one of the purposes of the Workers' Compensation Act, which was to prevent an employee's double recovery. The employer's

²⁷⁶ *Id.* at 1169, 864 N.E.2d at 1005-06.

²⁷⁷ *Id.* at 1169, 864 N.E.2d at 1006.

²⁷⁸ *Id.* at 1171, 864 N.E.2d at 1007.

²⁷⁹ *Harder v. Kelly*, 369 Ill. App. 3d 937, 861 N.E.2d 673 (2d Dist. 2007).

²⁸⁰ 820 ILL. COMP. STAT. 305/5(b) (2004).

²⁸¹ *Harder*, 369 Ill. App. 3d at 943, 861 N.E.2d at 677.

reimbursement comported with the idea that a wrongdoer should bear the ultimate loss from wrongdoing.

VII. ARBITRATION AND ALTERNATIVE DISPUTE RESOLUTION

A. Illinois has subject matter jurisdiction where the insurance policy permits the insurer and insured to agree to arbitrate in any state and the parties picked Illinois for the arbitration.

In *Costello v. Liberty Mutual Fire Insurance Co.*,²⁸² Costello was an Indiana resident who purchased automobile insurance through Liberty Mutual. Liberty Mutual did business in Illinois and Indiana. The policy included coverage for damages inflicted by underinsured motorists, and also contained an arbitration clause which provided that arbitration would take place in the county in which the insured lived unless both parties agreed otherwise. The clause further stated that local rules of law as to procedure and evidence would apply.

On August 27, 1998, Costello was involved in an auto accident in Hinsdale, Illinois with an underinsured motorist. Liberty Mutual's policy provided \$300,000 in underinsured motorist coverage. Costello sustained injuries in excess of the other drivers' \$50,000 insurance coverage and tendered his claim to Liberty Mutual for payment of the balance. Liberty Mutual denied this request and Costello demanded arbitration pursuant to his policy. At Liberty's request, Costello agreed to hold the arbitration proceedings in Illinois. The arbitration panel set damages at \$140,000. This amount was reduced by \$50,000 previously paid, making Liberty Mutual liable for \$90,000.

Costello filed a request with the Illinois courts to confirm the award and amend his Section 155 complaint. Liberty Mutual filed a motion demanding a trial by jury. Liberty Mutual

²⁸² *Costello v. Liberty Mut. Fire Ins. Co.*, 376 Ill. App. 3d 235, 876 N.E.2d 115, (1st Dist. 2007).

argued that under Illinois law and Costello's policy it had the right to demand a jury trial if the award exceeded the minimum \$25,000 underinsured motorist coverage required by Indiana law.

Costello opposed the motion on the ground that Illinois law applied to the trial court proceedings. The court found that Illinois law, as to procedure and law, applied to the proceeding and that the "trial de novo" clause was void. On this basis, the court denied Liberty Mutual's motion for summary judgment and confirmed the arbitration award. The court also allowed Costello to continue to litigate his Section 155 claim during the appeal.

On appeal, Liberty Mutual contended that the Illinois courts had no subject matter jurisdiction because Illinois lacked the necessary connections to this case. Liberty Mutual argued that Indiana had sole jurisdiction because the parties entered into the contract in Indiana, the plaintiff was an Indiana resident, the insurable subject matter was in Indiana and the contract only referred to Indiana law. Costello argued that Liberty Mutual waived its objection to subject matter jurisdiction by not raising it at the trial court level and, alternatively, that jurisdiction was proper pursuant to the policy.

The court held that although subject matter jurisdiction usually cannot be waived, any objection to subject matter jurisdiction was waived when the parties fail to object to proceedings at the trial court.²⁸³ The court also found that even assuming the objection was not waived, Illinois still would have proper subject matter jurisdiction based upon the insurance policy.²⁸⁴ The insurance policy contained a provision regarding arbitration location which stated that unless both parties agreed otherwise; arbitration will take place in the county in which the insured lives.

²⁸³ *Id.* at 239, 876 N.E.2d at 119.

²⁸⁴ *Id.*

This clause permitted the insurer and insured to agree to arbitrate in any state. In this case, Costello and Liberty Mutual both agreed to arbitrate the matter in Illinois.

The court then addressed the choice of law issue. Liberty Mutual argued (and the court agreed) that under Illinois' most significant contacts test, Indiana law applied because Indiana had the most significant contacts with the policy. The fact that the accident and subsequent arbitration occurred in Illinois did not change the fact that Indiana had more significant contacts to the policy. Both parties entered into a contract in Indiana to provide insurance coverage for a car principally located in the state of Indiana. Indiana, therefore, had the most significant contacts to the policy, and Indiana law governed the interpretation of the policy.

B. UIM arbitration clause did not bar Section 155 claim

In *Smith v. State Farm*,²⁸⁵ Plaintiff insured filed an action in the Circuit Court of Cook County (Illinois) against defendant insurer for damages under Illinois Statute²⁸⁶ arising out of the insurer's delay in handling her uninsured motorist (UM) claim.

The insured sought UM coverage after she was injured by an unknown driver. The insurer waited a year and a half to make a settlement offer and thereafter repeatedly rejected the insured's settlement demands. More than three and a half years after the accident, an arbitrator awarded the insured \$124,823.99 on her UM claim. She then filed her suit, alleging that the insurer had willfully and vexatiously refused to properly evaluate and settle her claim. The insured moved to dismiss the complaint pursuant to Illinois Statute.²⁸⁷ The circuit court treated the motion as a summary judgment motion²⁸⁸ and granted it, holding that the parties' arbitration

²⁸⁵ *Smith v. State Farm Ins. Co. Inc.*, 369 Ill. App. 3d 478, 861 N.E.2d 183 (1st Dist. 2006).

²⁸⁶ 215 ILL. COMP. STAT. ANN. 5/155 (2004).

²⁸⁷ 735 ILL. COMP. STAT. ANN. 5/2 619(6) (2004).

²⁸⁸ Pursuant to 735 ILL. COMP. STAT. ANN. 5/2 1005 (2004).

agreement barred the insured from asserting her legal claim. The court found reversible error. The arbitration agreement barred the insured from asserting claims relating to the accident and her injuries; it did not bar her from asserting a statutory claim²⁸⁹ arising from the insurer's handling of her UM claim. The mandatory arbitration provisions of Illinois Statute²⁹⁰ also did not bar the insured from asserting her claim.

C. Policy reformed to include UM coverage up to the statutory limit

In *Norris v. National Union*,²⁹¹ appellee special estate administrators sued appellant insurer in the Circuit Court of Cook County (Illinois) for a declaration that the insurer's policy was to be reformed to include uninsured motorist coverage equal to the policy's bodily injury liability limits. On remand, the trial court ordered the matter to arbitration. The arbitrator entered an award for the administrators. The trial court confirmed the award. The insurer appealed.

The decedent, who was a truck driver, was involved in a fatal accident at work with an uninsured motorist. The employer's commercial fleet general liability policy did not include uninsured motorist coverage. The trial court reformed the insurance policy to include uninsured motorist coverage up to the statutory limit. On remand, the trial court was directed to include uninsured motorist coverage up to the personal injury limits of the policy. The trial court then upheld an arbitration award pursuant to Illinois Statute.²⁹² On appeal, the court found that its prior rulings on appeal were not palpably erroneous as (1) the insurer's offer was insufficient under Illinois Statute,²⁹³ (2) the exclusivity bar of the Illinois Workers' Compensation Act²⁹⁴ did

²⁸⁹ Arising under 215 ILL. COMP. STAT. ANN. 5/155.

²⁹⁰ 215 ILL. COMP. STAT. ANN. 5/143a(1) (2004).

²⁹¹ *Norris v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 368 Ill. App. 3d 576, 857 N.E.2d 859 (1st Dist. 2006).

²⁹² 215 ILL. COMP. STAT. ANN. 5/143a (2004).

²⁹³ 215 ILL. COMP. STAT. ANN. 5/143a 2(1) (2004).

not apply; and (3) the insurance policy's employment exclusions violated Illinois public policy.²⁹⁵ Additionally, the arbitration conducted was mandatory and binding under the 1989 version of the Illinois Statute.²⁹⁶

D. “Following form” language in an excess insurance policy applied solely to coverage and risks and did not constitute an agreement or expression of intent to be bound by the arbitration clause contained in the “powers, rights and duties” section of an underlying insurance policy.

In *Royal Indemnity Co. v. Chicago Hospital Risk Pooling Program*, plaintiff Royal Indemnity Company sued defendant Chicago Hospital Risk Pooling Program (“CHRPP”) alleging breach of good-faith duty to settle an underlying medical malpractice action.²⁹⁷ CHRPP was a charitable risk pooling trust that provided self-funded coverage of malpractice liabilities to its member hospitals. One such member hospital was Palos Community Hospital. Under the trust agreement between CHRPP and Palos, CHRPP provided \$5 million of primary coverage to Palos. Royal provided insurance coverage to Palos excess of this \$5 million layer. A medical malpractice action had been brought against Palos, and counsel retained by CHRPP concluded that Palos’ liability was in excess of \$5 million and recommended settlement within the \$5 million primary layer. CHRPP did not follow the recommendation, and the matter proceeded to trial. Ultimately, the matter settled for \$18 million, of which Royal was liable for \$5 million. After Royal filed suit against CHRPP, CHRPP moved to compel arbitration on the ground that Royal’s excess policy followed form to the trust agreement between CHRPP and Palos. Royal

²⁹⁴ 820 ILL. COMP. STAT. ANN. 305/5(a) (2000).

²⁹⁵ *Norris*, 368 Ill. App. 3d at 581-88, 857 N.E.2d at 864-70.

²⁹⁶ *Id.* at 590, 857 N.E.2d at 871; *See also* 215 ILL. COMP. STAT. ANN. 5/143a (1989).

²⁹⁷ *Royal Indem. Co. v. Chicago Hosp. Risk Pooling Program*, 372 Ill. App. 3d 104, 865 N.E.2d 317 (1st Dist. 2007).

opposed the motion on the grounds that it was a nonsignatory to the trust agreement containing the arbitration clause. The trial court compelled arbitration.

The appellate court reversed and remanded.²⁹⁸ CHRPP based its motion for arbitration on two statements in the declarations page of the Royal policy: (1) the statement that Royal provided “Straight Excess Following Form Hospital Professional Liability and Comprehensive General Liability” coverage, and (2) the statement that the underlying policy limits were the “Sixth Amended Trust Agreement, as per copy on file with company.” The appellate court found that the “following form” language in the first statement referred solely to the coverage and risks that Royal agreed to insure and nothing more.²⁹⁹ Importantly, the Royal policy did not state that it was subject to “all” terms and conditions of the underlying trust agreement. The arbitration provision in the underlying trust agreement appeared not in a section dealing exclusively with coverage, but rather in a section dealing exclusively with power, rights, and duties of the trustees. The appellate court found it would make no sense to extend many of those rights or duties (such as the duty to sell or dispose of Fund property) to Royal as an excess insurer.³⁰⁰ As to the second statement regarding underlying coverage, the appellate court found that simply identifying the underlying coverage did not constitute clear and unequivocal language that Royal intended to incorporate all of the terms and provisions of the trust agreement.³⁰¹ Finally, the appellate court found that it was for the courts, not the arbitrator, to decide whether Royal intended to arbitrate its claim.³⁰²

²⁹⁸ *Id.* at 111, 865 N.E.2d at 324.

²⁹⁹ *Id.* at 109, 865 N.E.2d at 323.

³⁰⁰ *Id.* at 110, 865 N.E.2d at 323.

³⁰¹ *Id.*

³⁰² *Id.*

VIII. BAD FAITH AND PUNITIVE DAMAGES

A. Arbitrators did not exceed their power in awarding punitive damages to insured and committed no gross error as was required to vacate the award.

In *Beatty v. The Doctors' Co.*,³⁰³ a qui tam complaint was filed in the U.S. District Court for the Southern District of Illinois against the insured, Dr. Beatty (Beatty), and others for alleged billing of unnecessary services under Medicare and Medicaid. Upon receipt of the complaint, Beatty contacted his insurer, The Doctors' Company (Doctors' Company), requesting coverage under his professional liability policy. Doctors' Company offered to provide a defense to Beatty pursuant to the Mediguard endorsement on the policy, which provided reduced coverage for disciplinary proceedings, but refused to provide a defense pursuant to the professional liability portion of the policy. On December 10, 2004, Beatty filed an amended complaint in the Circuit Court of Madison County against Doctors' Company alleging that the policy required Doctors' Company to provide a defense and indemnity to Beatty for this claim. The amended complaint included prayers for punitive damages and relief under Section 155.

The Doctors' Company responded by filing a motion to compel arbitration pursuant to the arbitration clause of the policy. The parties ultimately entered into a consent order agreeing to binding arbitration of the matters raised in the plaintiff's amended complaint. Pursuant to the consent order, arbitration was conducted by a panel of three arbitrators. The arbitrators rendered their decision on January 11, 2006, and found Doctors' Company liable to Beatty on all 5 counts. They assessed compensatory damages of \$943,240, attorney fees, costs and statutory penalties of \$337,842.67 and punitive damages of \$4.5 million.

³⁰³ *Beatty v. The Doctors' Co.*, 374 Ill. App. 3d 558, 871 N.E. 2d 138 (5th Dist. 2007).

On April 27, 2006, the Circuit Court entered an order confirming the arbitration award and entered judgment on behalf of Beatty for the total amount awarded by the arbitrators. A motion for reconsideration was filed and denied. Doctors' Company subsequently filed a notice of appeal.

Doctors' Company's first issue on appeal was whether the arbitrators exceeded their powers in awarding punitive damages. Illinois law provides that punitive damages may be awarded in arbitration only when the parties have expressly agreed to the arbitrators' authority to award punitive damages.³⁰⁴ The consent order required the parties to arbitrate the matters raised in the plaintiffs' amended complaint. Count II of the amended complaint clearly requested a statutory penalty under Section 155 of the Illinois Insurance Code. Count III contained a prayer for punitive damages. Since the parties expressly agreed to submit to all matters raised in the amended complaint for binding arbitration, the court found that the arbitrators did not exceed their power in awarding punitive damages.³⁰⁵

The second issue on appeal was whether the arbitrators made gross errors in their determination. The court first noted that a court may only vacate an arbitration award where there was a gross error of law or fact.³⁰⁶ Errors in judgment are not grounds for vacating arbitrators' awards.³⁰⁷

Doctors' Company first argued that the arbitration award should be vacated on the basis that the arbitrators grossly erred in finding that it owed a duty to defend Beatty. The court

³⁰⁴ *Id.* at 563, 871 N.E.2d at 142 (citing *Edward Elec. Co. v. Automation, Inc.*, 229 Ill. App. 3d 89, 105, 593 N.E.2d 833, 843 (1st Dist. 1992)).

³⁰⁵ *Id.*

³⁰⁶ *Id.*

³⁰⁷ *Id.*

disagreed, noting that the arbitrators' award specifically stated that this conclusion was based upon the allegations contained in four corners of the complaint in the underlying lawsuit.³⁰⁸

Doctors' Company next argued that the arbitrators erred grossly in finding that Doctors' Company acted vexatiously and unreasonably under Section 155 of the Illinois Insurance Code. The court noted that arbitrators made specific factual findings to support their conclusion that Doctors' Company had acted vexatiously and unreasonably.³⁰⁹ The court also found that Count II, which was based on Section 155, was clearly within the scope of the matters that the parties mutually consented to arbitrate.³¹⁰ Accordingly, the arbitrators' award under Section 155 was not a basis to vacate the arbitration award.³¹¹

Lastly, the court addressed Doctors' Company's argument that the arbitrators grossly erred in holding that an insurer owes a fiduciary duty to defend and indemnify its insured. The court found that an insurance company has a fiduciary duty to defend its insured and to consider the insured's interest once a duty to defend has been triggered.³¹² Since the arbitrators found that Doctors' Company had a duty to defend, the arbitrators' finding that Doctors' Company breached a fiduciary duty to Dr. Beatty was not gross error and did not constitute a basis to vacate the award.³¹³

B. A six month delay did not constitute lack of due diligence

In *Promila Daman Paul v. Gerald Adelman & Associates, Ltd.*,³¹⁴ consolidated cases, appellee trustee sued appellant administrators, seeking damages relating to services provided to

³⁰⁸ *Id.* at 563-64, 871 N.E.2d at 143.

³⁰⁹ *Id.* at 564-65, 871 N.E.2d at 143-44.

³¹⁰ *Id.*

³¹¹ *Id.*

³¹² *Id.* at 555-56, 871 N.E.2d at 145.

³¹³ *Id.* at 556, 871 N.E.2d at 145.

³¹⁴ *Promila Daman Paul v. Gerald Adelman & Assoc., Ltd.*, 223 Ill. 2d 85, 858 N.E.2d 1 (2006).

the trust by the administrators. After the trial court dismissed the actions for want of prosecution, the trustee sought relief from the dismissals under 735 Ill. Comp. Stat. 5/2-1401 (2002). The trial court vacated the two orders of dismissal. The Appellate Court of Illinois affirmed. The administrators appealed.

Less than a year after the cases were filed, the trustee filed a petition for personal bankruptcy. The cases became part of the bankruptcy estate. Over five years after the bankruptcy petition was filed, the trial court dismissed the cases. Over a year later, the bankruptcy court held that the cases were exempt and were no longer part of the bankruptcy estate. Six months later, the trustee filed her 735 Ill. Comp. Stat. 5/2-1401 (2002) petition to vacate the dismissal order. The administrators argued that the trustee was not diligent in pursuing the cases. The trustee argued that she could not pursue the cases in her own right until the bankruptcy court released the causes of action back to her, and until she had reached an agreement with her former law firm to release her files. The appellate court found that, contrary to the administrators' arguments, a six month delay did not constitute lack of due diligence.³¹⁵ The trial court did not err by finding that the trustee exercised due diligence in filing her petitions.³¹⁶ According to unrefuted affidavits, the trustee contacted her attorney "immediately" after the bankruptcy court issued the order releasing cases.

IX. Legislation and Statutory Construction

A. The retaliatory tax imposed by Illinois on alien insurance companies does not violate the Illinois Constitution nor the Constitution of the United States.

³¹⁵ *Id.* at 102, 858 N.E.2d at 11.

³¹⁶ *Id.*

In *Sun Life v. Manna*,³¹⁷ Sun Life Assurance Co. of Canada (Sun Life) filed a declaratory judgment action against the Illinois Department of Insurance, seeking a finding that an Illinois tax imposed on alien insurance companies that did business in Illinois violated the Uniformity Clause of the Illinois Constitution, equal protection, and the Commerce Clause of the United States Constitution. On cross motions for summary judgment, the circuit court ruled against Sun Life, and the appellate court affirmed. Sun Life was organized under the laws of Canada, and was thus considered an “alien” company under the Illinois Insurance Code. Illinois taxes such companies, as well as companies formed under the laws of other states (foreign companies) pursuant to 215 ILCS 5/444(1). That statute provides, in essence, that if the company’s state or country of origin assesses Illinois companies with higher costs of doing business there, in the form of penalties, fees, charges, or taxes, than Illinois would otherwise assess those companies, then Illinois will impose the retaliatory tax on those companies, in the amount of the difference.

On appeal, Sun Life conceded that Illinois had the right to impose the retaliatory tax on foreign companies. The United States Supreme Court, in *Western & Southern Life Insurance Co. State Board of Equalization of California*,³¹⁸ held that there was “no doubt that promotion of domestic industry by deterring barriers to interstate business is a legitimate state purpose” and that California’s retaliatory tax was rationally related to that purpose.³¹⁹ In *Mutual Life Insurance Co. of N.Y. v. Washburn*,³²⁰ the Illinois Supreme Court, citing *Western & Southern Life*, reached the same conclusion regarding Illinois’ retaliatory tax. Sun Life argued, however, that doing so in regard to alien companies violates the Commerce Clause of the United States Constitution. The issue in this case, therefore, was whether, in regard to international commerce,

³¹⁷ *Sun Life Assur. Co. of Can. v. Manna*, 368 Ill. App. 3d 591, 858 N.E.2d 503 (1st Dist. 2006), aff’d, 227 Ill. 2d 128, 879 N.E.2d 320 (2007).

³¹⁸ *W. & S. Life Ins. Co. St. Bd. of Equalization of Calif.*, 451 U.S. 648 (1981).

³¹⁹ *Id.* at 671.

³²⁰ *Mut. Life Ins. Co. of N.Y. v. Washburn*, 137 Ill. 2d 312, 561 N.E.2d 29 (1990).

the state had the right to impose the tax in the face of the federal Commerce Clause, and the federal government's exclusive power to establish and carry out foreign policy.

This issue was addressed by considering the impact the state law had on foreign affairs. General principles to be considered were whether the challenged classification (1) was motivated by disapproval of a nation's political and social policies, (2) attempts to make a political statement, (3) was targeted at a single foreign nation, or (4) was effectively an economic boycott or an embargo. If the statute does not run afoul of these impermissible interferences with federal foreign policy, then it will be considered a mere incidental, and permissible, intrusion on foreign affairs. Here, the tax is applied to all alien nations equally, and is not intended to keep any foreign nation from doing business in Illinois due to political or social policies. The court concluded, therefore, that the tax created no unconstitutional intrusion on foreign affairs.³²¹

Turning to consideration of the Commerce Clause, the court cited the four-part test enunciated in *Complete Auto Transit, Inc. v. Brady*.³²² In that case, the Court held that a tax will not be found to be intrusive under the Commerce Clause if the state can show "that the tax is applied to an activity with a substantial nexus with the taxing State, is fairly apportioned, does not discriminate against interstate commerce, and is fairly related to the services provided by the State."³²³ Later, the United States Supreme Court added the additional considerations of "the enhanced risk of multiple taxation and the need for the federal government to 'speak with one voice' when regulating commerce with foreign nations" in *Japan Line, Ltd. v. County of Los Angeles*.³²⁴

³²¹ *Id.* at 279.

³²² *Complete Auto Transit, Inc. v. Brady*, 430 U.S. 274 (1977).

³²³ *Sun Life*, 368 Ill. App. 3d at 602, 858 N.E.2d at 514.

³²⁴ *Japan Line, Ltd. v. County of Los Angeles* 441 U.S. 434 (1979).

Sun Life argued that the Illinois tax failed the third criteria of Complete Auto Transit because it discriminated against international commerce and impacted the federal government's need to "speak with one voice" by attempting to unilaterally influence the tax policies of other countries.³²⁵ The Department of Insurance's response to this relied on the McCarran-Ferguson Act.³²⁶ That Act, generally, reserves to the states the power to regulate and tax the insurance business. The *Western and Southern Life* Court held that the Act "removes entirely any Commerce Clause restriction upon California's power to tax the insurance business." (Emphasis added by the appellate court here).³²⁷ The court found that this pervasive holding must apply to international as well as interstate insurance business, and noted that Congress did not restrict the Act to interstate commerce.³²⁸ Finally, even if reliance on the McCarran-Ferguson Act³²⁹ was insufficient to meet Sun Life's challenge, the retaliatory tax imposed by Illinois met the *Complete Auto Transit* and *Japan Line* criteria, and was therefore valid.

X. CONCLUSION

Illinois courts have continued the trend to enforce policy language as written and have refined court interpretations of undefined policy terms. They have continued to view the insurance policy as a contract between two parties that are at slightly different bargaining levels.

³²⁵ *Sun Life*, 368 Ill. App. 3d at 599, 858 N.E.2d at 511.

³²⁶ 15 U.S.C. §§ 1011 et seq. (2000).

³²⁷ *W. & S. Life. Ins. Co. v. St. Bd. of Equalization of Calif.*, 451 U.S. 648 (1981).

³²⁸ *Id.* at 669.

³²⁹ 15 U.S.C. §§ 1011 et seq. (2000).