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Insurance Law Alert

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"Extremely thorough, detailed, always well prepared when getting ready for trial, they knew every aspect of the record."

***–Chambers 2016,* quoting a client**

Creditor Exclusion Negates Insurer's Duty To Defend Fraud Suits, Says Fifth Circuit

The Fifth Circuit ruled that an insurer had no duty to defend suits alleging that the insured fraudulently induced companies to enter into loan agreements, finding that a Creditor Exclusion unambiguously barred coverage. *Markel Am. Ins. Co. v. Verbeek*, 2016 WL 5400412 (5th Cir. Sept. 27, 2016). (Click here for full article)

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The Ninth Circuit ruled that the Liability Risk Retention Act preempts an Alaska statute that precludes an insurer from recouping expenses incurred in defending uncovered claims. *Attorneys Liab. Protection Society, Inc. v. Ingaldson Fitzgerald, P.C.*, 2016 WL 5335036 (9th Cir. Sept. 23, 2016). (Click here for full article)

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Illinois Court Rules That Property Policy Term "Commencing" Is Ambiguous

An Illinois federal district court denied an insurer's summary judgment motion, finding that the term "commencing" was ambiguous and that there were questions of fact relating to the timing of the commencement of property damage. *Temperature Serv. Co., Inc. v. Acuity, A Mutual Ins. Co.*, 2016 WL 6037968 (N.D. Ill. Oct. 14, 2016). (Click here for full article)

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A California federal district court ruled that a liability insurer properly denied coverage of claims alleging use of another company's trademarked logo, finding that such conduct did not constitute covered advertising activity. *Infinity Micro Computer, Inc. v. Continental Cas. Co.*, 2016 WL 5661755 (C.D. Cal. Sept. 29, 2016). (Click here for full article)

New York Court Applies Preponderance Of The Evidence Standard To Proving Lost Policy Terms

A New York federal district court ruled that the proper standard for determining the existence and terms of a lost policy is preponderance of the evidence. *Pacific Employers Ins. Co. v. Troy Belting & Supply Co.*, 2016 WL 5477758 (N.D.N.Y. Sept. 29, 2016). (Click here for full article)

Duty to Defend Alerts:

Seventh Circuit Rules That Insurer May Rely On Evidence Outside Complaint To Deny Defense Under Illinois Law

Reversing a lower court decision, the Seventh Circuit ruled that when an insurer defends under a reservation of rights or seeks a declaratory judgment regarding its defense obligations, it is entitled to rely on evidence extrinsic to the underlying complaint in establishing that it has no duty to defend. *Landmark Am. Ins. Co. v. Hilger*, 2016 WL 5239833 (7th Cir. Sept. 22, 2016).

Two lawsuits filed against Peter Hilger alleged that he and other defendants overstated the value of life insurance policies that served as collateral for loans in order to persuade credit unions to fund those loans. Hilger sought a defense from Landmark under a professional liability policy issued to a company that was a co-defendant in the suits. Although Hilger was not a named insured, he argued that he was covered under a policy provision that defined "covered persons and entities" to include independent contractors that performed professional services on behalf of the named insured. Landmark sought a declaration that it had no duty to defend. An Illinois federal district court entered judgment on the pleadings in Hilger's favor. On appeal, Landmark argued that it is entitled to take discovery and offer evidence regarding the nature of Hilger's relationship to the named insured company in order to dispute its duty to defend. The Seventh Circuit agreed.

The Seventh Circuit ruled under Illinois law that "an insurer seeking a declaratory judgment on its duty to defend is entitled to introduce evidence outside the underlying complaint so long as it does not implicate an 'ultimate issue' in the underlying action." In so ruling, the court expressly abrogated prior case law that suggested that an insurer's right to look beyond the complaint was limited to situations in which the insurer had a "strong reason to believe" that it had no duty to defend. In addition, the court clarified that the strict "four corners" rule applies only when an insurer denies coverage without seeking a declaratory judgment or defending under a reservation of rights. Under those scenarios, the relevant question is whether the insurer reasonably refused to defend based solely on the allegations in the complaint. However, where, as here, the insurer files a declaratory judgment action, it is entitled to present evidence outside of the complaint to negate its defense obligations, so long as it does not determine an ultimate issue in the underlying dispute.

Creditor Exclusion Negates Insurer's Duty To Defend Fraud Suits, Says Fifth Circuit

The Fifth Circuit ruled that a D&O insurer had no duty to defend suits alleging that the insured fraudulently induced companies to enter into loan agreements, finding that a Creditor Exclusion unambiguously barred coverage. *Markel Am. Ins. Co. v. Verbeek*, 2016 WL 5400412 (5th Cir. Sept. 27, 2016).

Color Star entered into loan agreements with several companies. When Color Star defaulted on its obligations, the companies sued, alleging fraudulent inducement. Color Star sought a defense from Markel. Markel refused to defend based on a Creditor Exclusion that bars coverage for "any Claim brought or maintained by or on behalf of: Any creditor of a Company or Organization in the creditor's capacity as such . . . ." In ensuing litigation, a Texas district court ruled that the Creditor Exclusion precluded coverage for the underlying suits. The Fifth Circuit affirmed.

Color Star argued that the Creditor Exclusion applies only to breach of contract claims brought by creditors to recover debt owed by Color Star and not to the claims at issue, which alleged inaccurate financial statements that were "at best peripheral to the debt." Color Star also contended that the Exclusion

does not apply because at least one of the underlying plaintiffs sued in its capacity as an investor, not as a creditor. The Fifth Circuit rejected both assertions. It explained that the Exclusion applies because all damages sought in the underlying complaint originated from the loan and credit agreement. The court deemed it irrelevant that the underlying claims sounded in fraud rather than breach of contract, noting that in determining whether a policy exclusion applies, "it is not the cause of action alleged that determines coverage but the facts giving rise to the alleged actionable conduct." The court also dismissed Color Star's "capacity" argument, reasoning that although the underlying complaint used the term "investment" in referring to the loan, the "factual allegations reveal that the origin of the damages is the fraudulently induced loans."

Alaska Statute Barring Insurer's Reimbursement Of Defense Costs From Policyholder Is Preempted By Federal Law, Says Ninth Circuit

The Ninth Circuit ruled that the Liability Risk Retention Act preempts an Alaska statute that precludes an insurer from recouping expenses incurred in defending uncovered claims. *Attorneys Liab. Protection Society, Inc. v. Ingaldson Fitzgerald, P.C.*, 2016 WL 5335036 (9th Cir. Sept. 23, 2016).

Attorneys Liability Protection Society ("ALPS"), a risk retention group chartered in Montana, issued a professional liability policy to a law firm located in Alaska. ALPS defended the law firm in an underlying suit but reserved the right to seek reimbursement of defense costs for claims deemed not covered under the policy. Thereafter, ALPS brought suit, seeking a declaration of no coverage and reimbursement of defense costs. The dispute made its way to the Alaska Supreme Court, which held that Alaska statutory law prohibits an insurer from seeking reimbursement of defense costs even where a policy provides for such reimbursement and where the insurer explicitly reserves the right to seek reimbursement. *See Attorneys Liability Protection Society, Inc. v. Ingaldson Fitzgerald, P.C.*, 370 P.3d 1101 (Alaska 2016) (discussed in our April 2016 Alert).

ALPS argued that it was nonetheless entitled to reimbursement because the Liability Risk Retention Act ("LRRA") preempts Alaska statutory law. The court agreed, stating that Alaska's "prohibition on reimbursement of fees and costs incurred by an insurer defending a non-covered claim offends the LRRA's broad preemption language and that no exception applies to save the law."

False Claims Act Alert:

Nevada Court Addresses Scope Of Coverage For *Qui Tam* Action

A Nevada federal district court ruled that a *qui tam* action against an insured fell within the coverage period of a professional liability policy, but that a limit set forth in an endorsement capped the insurer's liability and defense obligations. *My Left Foot Children's Therapy, LLC v. Certain Underwriter's at Lloyd's London*, 2016 WL 5219458 (D. Nev. Sept. 19, 2016).

After receiving notice of a *qui tam* action alleging that it provided medically unnecessary services in violation of federal and state law, a policyholder tendered the claim to Underwriters under a professional liability policy. Underwriters extended $25,000 of coverage pursuant to a Billing Errors Endorsement. The insured filed suit, seeking a declaration that Underwriters had a duty to defend up to $2 million in expenses and to indemnify the underlying claims. Underwriters argued that the *qui tam* action falls outside the policy's coverage period and that any available coverage was limited to $25,000. Ruling on cross-motions for summary judgment, the court rejected Underwriters' argument about the coverage period, but agreed with its argument as to policy limits.

The court's coverage analysis turned on application of a Billing Errors Endorsement. Pursuant to the Endorsement, the policy provided coverage for the period of April 15, 2015 to April 16, 2016, but was not required to respond to events "which arise from any facts, circumstances, situations, events, transactions or causes of action which are underlying or alleged in litigation pending on or prior to the initial effective date." Underwriters argued that it had no coverage obligation because

the *qui tam* action was filed on October 28, 2014. The court rejected this argument, citing "the unique procedural stature of *qui tam* lawsuits under the False Claims Act," which contemplates that complaints will remain under seal for at least 60 days after being filed, causing significant delays in providing notice to the defendant. The court therefore concluded that the operative date for purposes of a *qui tam* coverage suit is when the insured receives notice of the suit. The court reasoned, "[i]t would be superfluous for the Endorsement to explicitly state that the date of service is the date of notice for purposes of coverage as it is commonly understood that a *qui tam* suit under the FCA becomes active once the defendant has notice of the law suit and that notice most often occurs at the time of service." Because the insured received notice of the *qui tam* action in June 2015, the court held that it fell within the Endorsement period.

As to policy limits, the court ruled that the Endorsement expressly limited coverage to $25,000, inclusive of defense costs. The court rejected the argument that the Endorsement was ambiguous as to whether the $25,000 limit included defense costs. The court explained that policy language requiring the Underwriters to "indemnify the Insured for Loss . . . which the Insured is obligated to pay and Claims Expenses which the Insured incurs" makes clear that both defense and indemnity costs are capped at the $25,000 limit.

Coverage Alerts:

Ohio Appellate Court Rules That Audit Request Is A "Claim" Under Claims-Made Policy

Reversing a trial court decision, an Ohio appellate court ruled that a letter issued by a software compliance organization was a "claim" under a claims-made policy, but that coverage was barred by a policy exclusion. *Eighth Floor Promotions v. The Cincinnati Ins. Cos.*, 2016 WL 5900078 (Ohio Ct. App. Oct. 11, 2016).

Eighth Floor, a retail manufacturer, received a letter from the Business Software Alliance ("BSA"), an entity that represents the interests of software companies. The letter informed Eighth Floor of the BSA's investigation of the company's duplication of certain proprietary software products. The letter requested that the company audit its software and that it preserve as evidence all copies of certain software products. Eighth Floor retained counsel and sent notice to Cincinnati, its liability insurer. Cincinnati denied coverage on the basis that the audit request was not a "claim" because it was neither a "written demand for monetary damage or non-monetary relief" nor a "civil proceeding commenced by filing a complaint or similar pleading." Thereafter, Eighth Floor discovered numerous unauthorized software installations and entered into a settlement with the BSA. Cincinnati reiterated its coverage denial, this time citing to a policy exclusion relating to copyright infringement claims. An Ohio trial court ruled in Cincinnati's favor, finding that the audit letter did not satisfy the policy's definition of "claim." The appellate court reversed in part.

The appellate court explained that the audit letter was a "demand for non-monetary relief" because it stated that if Eighth Floor did not conduct an audit, the BSA would initiate litigation. The court further noted that the audit request sought the preservation of evidence and used language indicating its belief that violations had already occurred. However, the court agreed with Cincinnati that coverage was nonetheless barred by a policy exclusion.

Notice Alert:

New York Court Says That Policyholder's Notice Under Claims-Made Policy Was Deficient

A New York federal district court ruled that an insurer had no duty to provide coverage under a claims-made policy because the insured's notice of claim was deficient. *Univ. of Pittsburgh v. Lexington Ins. Co.*, 2016 WL 4991622 (S.D.N.Y. Sept. 16, 2016).

Lexington issued a claims-made policy to the University of Pittsburgh for the period February 1, 2011 to February 1, 2012. On the last day of the coverage period, the insured filed a notice of claim. The notice listed the location of the occurrence as the University of Pittsburgh's Salk Hall and stated that "[s]enior management has been advised by the University of Pittsburgh that this project is experiencing problems and delays in its early stages." Opinion & Order, *Univ. of Pittsburgh v. Lexington Ins. Co.*, No. 13-cv-335 (S.D.N.Y. July 21, 2016). Lexington argued that the notice was insufficient and that there was no coverage because the policy required adequate notice as a precondition to coverage. The court agreed and granted Lexington's summary judgment motion.

Applying Pennsylvania law, the court held that notice to Lexington was "plainly insufficient to meet the conditions precedent to coverage." In particular, the notice failed to articulate any actual or alleged breach of a professional duty or injury or damage that might result in a claim, as required by the policy. In so ruling, the court noted that notice provisions under claims-made policies should be strictly applied, notwithstanding "harsh consequence[s]." The court rejected the insured's argument that the failure to comply with the policy's notice provisions should be excused because it substantially complied with its terms. The court explained that if such reasoning were credited, "any purchaser of a claims-made policy could effectively transform it into a broader (and typically more expensive) occurrence policy by asserting nebulous 'claims,' with specificity to be filled in only later . . . ."

The insured has recently appealed to the Second Circuit. We will keep you posted on any further developments in this matter.

Bad Faith Alerts:

Florida Supreme Court Rules That Insurer Bad Faith Is Not Prerequisite to Statutory Attorneys' Fees

The Florida Supreme Court ruled that an insured is entitled to attorneys' fees under state statutory law when an insurer incorrectly denies benefits and a subsequent judgment or its equivalent is issued in the insured's favor and that bad faith is not required. *Johnson v. Omega Ins. Co.*, 2016 WL 5477795 (Fla. Sept. 29, 2016).

A homeowner sought coverage from Omega for sinkhole-related damage. Omega initially denied the claim based on an expert's report, but subsequently agreed to provide coverage after receiving a report issued by a second expert. The homeowner thereafter sought attorneys' fees under Fla. Stat. § 627.428, which allows an insured to recover fees incurred as a result of prevailing on a claim for insurance benefits. Omega argued that a

showing of wrongful conduct or bad faith was a prerequisite to an award of fees under the statute. A Florida trial court disagreed and ruled in the homeowners' favor. An appellate court reversed, ruling that the statute required some type of bad faith conduct on the part of the insurance company. The Florida Supreme Court reversed.

Addressing a preliminary matter, the Florida Supreme Court held that an insurer's payment of a settlement or a previously-denied claim constitutes the functional equivalent of a confession of judgment for purposes of the attorneys' fees statute. The court further

held that bad faith or "wrongfulness" is not relevant to recovery under the statute. Rather, the existence of a dispute between the insurer and policyholder, coupled with payment to or a favorable judgment for the policyholder, suffices to satisfy the statute because a wrongful denial "means an incorrect denial, not one made in bad faith." The court rejected Omega's argument that an award of attorneys' fees was unwarranted because it complied with the investigation procedures set forth in Florida's sinkhole statute before denying coverage.

Seventh Circuit Rules That Insurer Acted In Bad Faith By Refusing To Pay Life Insurance Benefits

Notwithstanding a common law prohibition on stranger-originated life insurance policies, the Seventh Circuit ruled that Sun Life Assurance acted in bad faith by refusing to pay the proceeds of a life insurance policy to a stranger-beneficiary. *Sun Life Assurance Co. of Canada v. U.S. Bank Nat'l Assoc.*, 2016 WL 5929825 (7th Cir. Oct. 12, 2016).

Charles Margolin purchased a $6 million life insurance policy from Sun Life. Four years after policy issuance, Margolin notified Sun Life that it was transferring ownership and beneficiary status of the policy to U.S. Bank. When Margolin passed away, U.S. Bank sought to recover the policy's proceeds. Although it did not officially deny the claim, Sun Life initiated an investigation of the claim based on its belief that it constituted an "illegal wagering" contract. U.S. Bank filed suit, alleging breach of contract and bad faith. A Wisconsin federal district court granted U.S. Bank's motion for judgment on the pleadings on the breach of contract claim, ruling that it was entitled to policy proceeds plus statutory interest. *U.S. Bank National Assoc. v. Sun Life Assurance Co. of Canada*, 2015 WL 3645700 (W.D. Wis. June 10, 2015). The district court also ruled that Sun Life acted in bad faith because its claim investigation was not objectively reasonable. *U.S. Bank National Assoc. v. Sun Life Assurance Co. of Canada*, 2015 WL 6554657 (W.D. Wis. Oct. 29, 2015). The Seventh Circuit affirmed.

On appeal, Sun Life argued that its refusal to pay policy benefits was authorized (and in fact compelled) by Wisconsin statutory law voiding all gambling contracts. *See* Wis. Stat. § 895.055. The court rejected this argument, explaining that statutory insurance law preempts the general anti-gambling statute and expressly provides that insurance policies are not invalid "merely because the policyholder lacks insurable interest." Wis. Stat. § 631.07(4). The court further explained that the appropriate remedy for claims based on stranger-oriented life insurance policies under Section 631.07(4) is payment to a different beneficiary, not invalidation of the policy. Here, the court held that U.S. Bank was entitled to recover under the policy because "no one who is equitably entitled to the proceeds . . . has stepped forward to claim them." The Seventh Circuit also affirmed the bad faith ruling and imposition of statutory interest.

Ambiguity Alert:

Illinois Court Rules That Property Policy Term "Commencing" Is Ambiguous

An Illinois federal district court denied an insurer's summary judgment motion, finding that the term "commencing" was ambiguous and that there were questions of fact relating to the timing of the commencement of the property damage at issue. *Temperature Serv. Co., Inc. v. Acuity, A Mutual Ins. Co.*, 2016 WL 6037968 (N.D. Ill. Oct. 14, 2016).

Policyholders sought coverage under a commercial property policy issued by Acuity for damages caused by the "differential settlement" of soil around the insured property. Acuity denied coverage, and

litigation ensued. During discovery, Acuity issued an interrogatory asking for "the date on which the direct physical loss you claim is covered pursuant to the Acuity policy first occurred." Policyholders argued that the phrase "first occurred" was vague and overly broad, but responded that "at this time [Plaintiffs] cannot state when the direct physical loss 'first occurred', but the direct physical loss is ongoing and occurred after . . . the inception date of the Acuity policy." On this basis, Acuity argued that there was no coverage as a matter of law because policyholders had not established that property damage had "commenced" during the coverage period.

Addressing this matter of first impression under Illinois law, the court ruled that the policy's use of the word "commenced" was ambiguous because it could be interpreted to mean "the first occurrence of the type of loss claimed," or "each occurrence of the loss in a series of multiple losses." The court further held that a question of fact existed as to whether any of the alleged damage "commenced" during the policy period. In this context, the court noted that resolution would likely require the weighing of conflicting expert testimony and that the policyholder bears the burden of establishing coverage.

Advertising Injury Alert:

California Court Rules That Policyholder's Wrongful Display Of Trademarked Logo Is Not Advertising Activity

A California federal district court ruled that a liability insurer properly denied coverage of claims alleging use of another company's trademarked logo. The court agreed with the insurer that such conduct did not constitute covered advertising activity. *Infinity Micro Computer, Inc. v. Continental Cas. Co.*, 2016 WL 5661755 (C.D. Cal. Sept. 29, 2016).

Cisco Systems alleged that the policyholder wrongfully displayed Cisco's trademarked "Premiere Certified Partner" logo on the policyholder's website. Cisco further alleged that the policyholder was selling counterfeit Cisco goods, and demanded over $1.5 million

in damages. When the policyholder tendered the demand to Continental, it denied coverage, arguing that the claim did not allege covered advertising injury and that several exclusions applied. In ensuing litigation, the court granted Continental's summary judgment motion.

The policy covered "personal and advertising injury," defined as injuries arising out of "the use of another's advertising idea in your 'advertisement.'" Although the policy did not define "advertising idea," the court concluded that the Cisco logo could not reasonably be construed as an "advertising idea." The court stated:

> To read the term "advertising idea" so broadly as to cover any act taken in the course of marketing, including the use of a logo, would render the term meaningless. It remains unclear to the court how Plaintiff's decision to say that it was an authorized Cisco reseller, when in fact it was not, is a "marketing idea" and not simply a misrepresentation.

The court further reasoned that its holding was supported by a policy exclusion for injuries arising out of trademark infringement, explaining that any expectation of coverage for the use of another company's trademarked logo would be unreasonable. Finally, the court held that provisions covering injuries arising out of "slogan infringement" or "trade dress" were inapplicable.

Lost Policy Alert:

New York Court Applies Preponderance Of The Evidence Standard To Proving Terms Of Lost Policy

A New York federal district court ruled that the proper standard for determining the existence and terms of a lost policy is preponderance of the evidence and that a plaintiff failed under this standard to raise an issue of fact regarding the terms of a lost policy. *Pacific Employers Ins. Co. v. Troy Belting & Supply Co.*, 2016 WL 5477758 (N.D.N.Y. Sept. 29, 2016).

Troy Belting, a manufacturer of asbestos-containing products, sought coverage from Unigard under policies allegedly issued by Unigard or its predecessor, Jamestown Insurance Company, during the period 1949 to 1974. Neither Troy Belting nor Unigard had copies of the alleged policies at issue. Unigard argued that Troy Belting failed to present sufficient evidence to establish the existence and scope of coverage for asbestos claims. The court agreed and granted Unigard's summary judgment motion.

The court noted that the Second Circuit has not directly addressed the standard of proof for establishing the existence and terms of lost policies by secondary evidence and that New York district courts have issued mixed decisions on this issue. Some have applied a "preponderance of the evidence" standard, while others have required proof by "clear and convincing evidence." The court concluded that "the usual civil standard" of preponderance of evidence was proper, reasoning that nothing in statutory or case law supported a heightened evidentiary standard.

The court held that Troy Belting failed to meet the preponderance of the evidence standard despite its reliance on expert testimony, data relating to the company's coverage history (*e.g.*, evidence relating to prior coverage limits), correspondence, Board of Directors meeting minutes relating to liability and finances, ledgers with entries labeled as "insurance," copies of endorsements issued by Jamestown, and evidence relating to Unigard's conduct in connection with a 1977 asbestos lawsuit. The court concluded that while the evidence established that some type of policy was issued during the period in question, there was insufficient evidence by which a jury could determine the terms and conditions of the policy by a preponderance of the evidence. The court noted that "speculation is insufficient when evidence of terms and conditions is lacking."

The court also rejected Troy Belting's sanctions motion based on Unigard's alleged destruction of the policies. The court ruled that spoliation sanctions were unjustified because any destruction occurred before the present litigation commenced. The court dismissed the argument that Unigard was affirmatively obligated to preserve policies based on its knowledge that Troy Belting was named in several asbestos suits, noting that courts "lay responsibility for preserving copies of policies with the insured more than the insurer."

Simpson Thacher

Simpson Thacher has been an international leader in the practice of insurance and reinsurance law for more than a quarter of a century. Our insurance litigation team practices worldwide.

David J. Woll
+1-212-455-3136
dwoll@stblaw.com

Mary Beth Forshaw
+1-212-455-2846
mforshaw@stblaw.com

Andrew T. Frankel
+1-212-455-3073
afrankel@stblaw.com

Lynn K. Neuner
+1-212-455-2696
lneuner@stblaw.com

Chet A. Kronenberg
+1-310-407-7557
ckronenberg@stblaw.com

Bryce L. Friedman
+1-212-455-2235
bfriedman@stblaw.com

Michael D. Kibler
+1-310-407-7515
mkibler@stblaw.com

Michael J. Garvey
+1-212-455-7358
mgarvey@stblaw.com

Tyler B. Robinson
+44-(0)20-7275-6118
trobinson@stblaw.com

George S. Wang
+1-212-455-2228
gwang@stblaw.com

Deborah L. Stein
+1-310-407-7525
dstein@stblaw.com

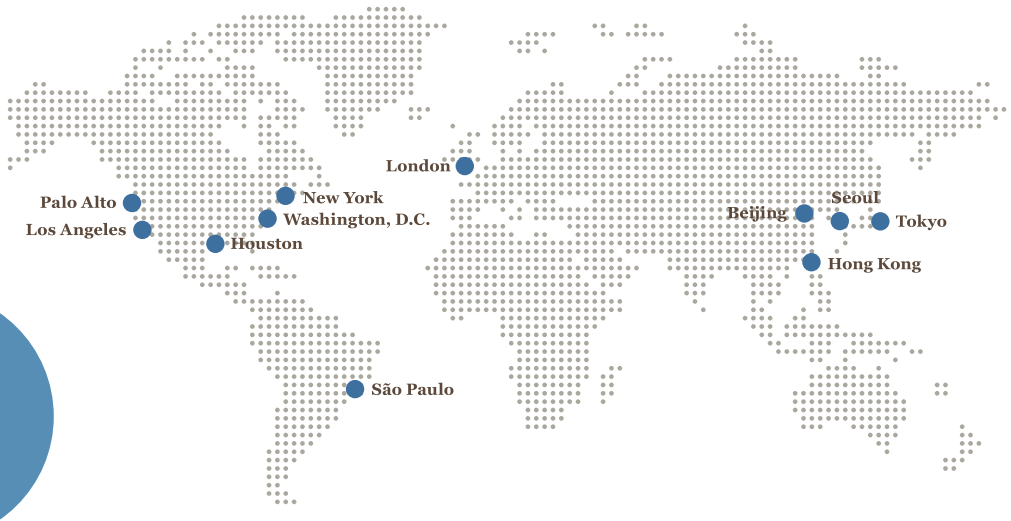
Craig S. Waldman
+1-212-455-2881
cwaldman@stblaw.com

Susannah S. Geltman
+1-212-455-2762
sgeltman@stblaw.com

Elisa Alcabes
+1-212-455-3133
ealcabes@stblaw.com

Summer Craig
+1-212-455-3881
scraig@stblaw.com

This edition of the Insurance Law Alert was prepared by Mary Beth Forshaw mforshaw@stblaw.com /+1-212-455-2846 and Bryce L. Friedman bfriedman@stblaw.com /+1-212-455-2235 with contributions by Karen Cestari kcestari@stblaw.com.



Simpson Thacher Worldwide

UNITED STATES

New York
425 Lexington Avenue
New York, NY 10017
+1-212-455-2000

Houston
600 Travis Street, Suite 5400
Houston, TX 77002
+1-713-821-5650

Los Angeles
1999 Avenue of the Stars
Los Angeles, CA 90067
+1-310-407-7500

Palo Alto
2475 Hanover Street
Palo Alto, CA 94304
+1-650-251-5000

Washington, D.C.
900 G Street, NW
Washington, D.C. 20001
+1-202-636-5500

EUROPE

London
CityPoint
One Ropemaker Street
London EC2Y 9HU
England
+44-(0)20-7275-6500

ASIA

Beijing
3901 China World Tower
1 Jian Guo Men Wai Avenue
Beijing 100004
China
+86-10-5965-2999

Hong Kong
ICBC Tower
3 Garden Road, Central
Hong Kong
+852-2514-7600

Seoul
25th Floor, West Tower
Mirae Asset Center 1
26 Eulji-ro 5-gil, Jung-gu
Seoul 100-210
Korea
+82-2-6030-3800

Tokyo
Ark Hills Sengokuyama Mori Tower
9-10, Roppongi 1-Chome
Minato-Ku, Tokyo 106-0032
Japan
+81-3-5562-6200

SOUTH AMERICA

São Paulo
Av. Presidente Juscelino
Kubitschek, 1455
São Paulo, SP 04543-011
Brazil
+55-11-3546-1000