Simpson Thacher

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In This Issue

Pennsylvania Supreme Court Rejects Motive Requirement For Statutory Bad Faith Claims

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The Eleventh Circuit ruled that reservation of rights letters unambiguously and effectively disclaimed coverage and that the insurer was not estopped from denying coverage. *North American Specialty Ins. Co. v. Bull River Marina, LLC*, 2017 WL 279211 (11th Cir. Sept. 27, 2017). (Click here for full article)

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A Maryland federal district court ruled that for purposes of calculating an insurer's pro rata, time-on-the-risk indemnity obligation for lead paint-related injuries, the "entire period of damages" is calculated by looking at when the claimant moved into the premises and when he permanently vacated the premises. *Penn. Nat'l Mut. Cas. Ins. Co. v. Jacob Dackman & Sons, LLC*, 2017 WL 4098749 (D. Md. Sept. 14, 2017). (Click here for full article)

New York Appellate Court Finds All-Risk Coverage Where Cause Of Damage Began Before Policy Inception

A New York appellate court ruled that an insurance policy covered losses arising from the malfunction of a turbine engine, notwithstanding that the mechanical issues were caused by a turbine crack that had begun before the policy incepted. *TransCanada Energy USA, Inc. v. National Union Fire Ins. Co. of Pittsburgh, PA*, 2017 WL 4125652 (N.Y. App. Div. 1st Dep't Sept. 19, 2017). (Click here for full article)

Texas Court Rules That Arbitrability Issues Are Within Court's Purview And May Be Addressed Prior To Personal Jurisdiction

Addressing a matter of first impression under Texas law, a Texas district court ruled that arbitrability of a dispute is a matter for the court to decide and is a procedural issue that can be addressed prior to personal jurisdiction arguments. *Halliburton Energy Services, Inc. v. Ironshore Specialty Ins. Co.*, 2017 WL 4536089 (S.D. Tex. Oct. 5, 2017). (Click here for full article)

Bad Faith Alert:

Pennsylvania Supreme Court Rejects Motive Requirement For Statutory Bad Faith Claims

Addressing a matter of first impression, the Supreme Court of Pennsylvania rejected an "ill-will" or motive requirement for statutory bad faith claims against an insurer. *Rancosky v. Washington National Ins. Co.*, 2017 WL 4296351 (Pa. Sept. 28, 2017).

The dispute arose out of health care coverage for a postal employee with cancer. The employee sued the insurer, alleging breach of contract and bad faith under Pennsylvania's bad faith statute, 42 Pa. C. S. § 8371. Following a jury trial on the breach of contract claim (which resulted in an award in the employee's favor), a trial court ruled that bad faith had not been established. The court noted that although the insurer was "sloppy and even negligent" in its claim handling, the employee had failed to demonstrate that the insurer lacked a reasonable basis for denying coverage. In particular, the trial court held that the employee failed to prove that the insurer acted out of "some motive or self-interest or ill will."

A Superior Court panel vacated the bad faith claim judgment, deeming the insurer's subjective intent irrelevant to whether the insurer "lacked a reasonable basis for denying benefits." The Superior Court further held, based on its independent review of the record, that the insurer did not have a reasonable basis for denying benefits under the policy. The Superior Court remanded the matter for a determination of whether the insurer knew it had recklessly disregarded a lack of a reasonable basis in denying benefits.

On discretionary review, the Supreme Court ruled that the proper method for evaluating statutory bad faith claims is the two-part test set forth in *Terletsky v. Prudential Prop. & Cas. Ins. Co.*, 649 A.2d 680 (Pa. Super. 1994). Under this standard, a plaintiff must present clear and convincing evidence that the insurer (1) did not have a reasonable basis for denying benefits under the policy and (2) knew of or recklessly disregarded its lack of a reasonable basis. The court held that proof of an insurer's self-interest or ill will is not a prerequisite under § 8371, but is probative of the second prong. In rejecting a culpability requirement, the court noted that requiring a showing of ill motive would "create an unduly high threshold for bad faith claims" by limiting recovery "to the most egregious instances only where the plaintiff uncovers some sort of 'smoking gun' evidence indicating personal animus towards the insured." The court remanded the matter for factual findings as to both prongs of the bad faith test.

Damages Alert:

No Coverage Where Policyholder Failed To Meet Its Burden To Allocate Damages, Says Second Circuit

The Second Circuit ruled that although a liability policy covered a portion of losses arising from faulty construction claims, the insurer had no duty to indemnify based on the policyholder's inability to allocate the underlying jury verdict between covered and non-covered losses. *Univo v. Harleysville Worcester Ins. Co.*, 2017 WL 4127538 (2d Cir. Sept. 19, 2017).

The dispute arose out of faulty construction claims against a general contractor. In the underlying suit, a jury awarded the homeowners approximately $317,000 in general damages and $83,000 in consequential damages. In a subsequent coverage action, a New York district court ruled that at least some of the underlying claims were covered by the contractor's general liability policy. In particular, the court concluded that losses arising from damage to others' work or property was covered but that claims based on the contractor's own defective work were not covered. Notwithstanding this finding, the court held

that the insurer had no indemnity obligation because the homeowners were unable to establish a reliable method for allocating between covered and non-covered losses. The Second Circuit affirmed.

The Second Circuit ruled that the burden of allocating damages rests with the policyholder, not the insurer. Additionally, the court rejected the notion that the insurer should bear the burden in this case, based on its alleged failure to advise the contractor to use special interrogatories in the underlying action that would have established allocation. The court explained that New York law does not support this type of burden shift, and that in any event, the insurer made it clear in a motion to intervene in the underlying case that it believed most, if not all, of the damages were not covered. Finally, the court held that the homeowners failed to meet their burden, explaining that the damages awarded did not correspond with any of the evidence submitted in the underlying case and that the homeowners failed to suggest any alternative method for allocating damages.

Prejudgment Interest Alert:

Second Circuit Rules That Statutory Prejudgment Interest Begins To Accrue On Date Of Sworn Loss

The Second Circuit ruled that statutory prejudgment interest begins to accrue when a sworn proof of loss is submitted, not when the policyholder has fulfilled conditions precedent to coverage. *Warehouse Wines and Spirits v. Travelers Prop. Cas. Co. of Am.*, 2017 WL 4227943 (2d Cir. Sept. 21, 2107).

The policyholder sought coverage for losses incurred in connection with stolen property. A New York federal district court granted the policyholder's summary judgment motion as to coverage, and calculated damages owed under the policy, including prejudgment interest. On appeal, Travelers argued, among other things, that the district court erred in imposing prejudgment interest from the date on which the policyholder submitted its sworn proof of loss. Travelers argued that prejudgment interest did not begin to accrue until the policyholder had fully complied with policy conditions (*e.g.*, examinations under oath and records inspection) because its indemnity obligations were not triggered until that point. The Second Circuit disagreed and affirmed the ruling.

Section 5001 of New York Civil Practice Law and Rules, which permits a prevailing party in a breach of contract action to obtain prejudgment interest, provides that "[i]nterest shall be computed from the earliest ascertainable date the cause of action existed." The court explained that in insurance coverage disputes, the statute requires prejudgment interest to be calculated from the date that the insurer became obligated to indemnify the insured. The court concluded that this obligation arose when the policyholder submitted a sworn proof of loss. The court explained that although the policy entitles Travelers to investigate the claim, it "cannot circumvent § 5001(b) by denying coverage while conducting a nearly year-long investigation . . . and then, once it is adjudicated liable, avoid paying prejudgment interest from the 'earliest ascertainable date the cause of action existed.'"

D&O Policy Alert:

Applying Nevada Law, Second Circuit Rules That Insured v. Insured Exclusion Unambiguously Bars Coverage For Director's Suit

The Second Circuit ruled that under Nevada law, an insured v. insured exclusion bars coverage for a suit brought by a former director regardless of whether the suit was brought in an individual or fiduciary capacity. *Intelligent Digital Systems, LLC v. Beazley Ins. Co., Inc.*, 2017 WL 4127540 (2d Cir. Sept. 19, 2017).

Jay Russ sold his technology company to Visual Management Systems ("VMS"). As part of the transaction, VMS agreed to add Russ to its Board of Directors. After the transaction closed, Russ attended three board meetings and was paid for his board member services. Several months later, Russ resigned and threatened suit against VMS based on certain alleged payment deficiencies from the sale of his company. The parties reached an agreement, pursuant to which the VMS directors assigned their rights under a D&O policy to Russ. Thereafter, Russ sued Beazley, VMS's D&O insurer, seeking indemnification for the underlying settlement amounts. Beazley denied coverage based on an insured v. insured exclusion. A New York district court denied the parties' cross-motions for summary judgment, finding that issues of fact existed as to whether Russ was "duly elected" to the Board of Directors. A jury subsequently found that Russ had been a duly elected director within the meaning of the exclusion and, therefore, that there was no coverage under the policy. The Second Circuit affirmed.

The Second Circuit ruled that the insured v. insured exclusion, which bars coverage for "any Claim . . . by, on behalf of, or at the direction of any of the Insureds," is unambiguous and applies to any claim by a director, regardless of the capacity in which the director brings suit. The court further held that Russ was "duly elected" as a director within the meaning of the policy (disagreeing with the district court's ruling that the bylaws of the company created ambiguity as to whether Russ was "duly elected"). Finally, the Second Circuit held that even assuming the bylaws were ambiguous, the jury finding that Russ was "duly elected" was well supported by the evidence.

Reservation Of Rights Alert:

Eleventh Circuit Deems Reservation Sufficient And Rejects Coverage-By-Estoppel Argument

The Eleventh Circuit ruled that reservation of rights letters ("ROR") unambiguously and effectively disclaimed coverage and that the insurer was not estopped from denying coverage. *North American Specialty Ins. Co. v. Bull River Marina, LLC*, 2017 WL 279211 (11th Cir. Sept. 27, 2017).

North American issued two policies to Bull River Marina: a commercial general liability policy ("50C") and a marina operators policy ("50M"). Thereafter, Bull River notified North American of a boating incident that resulted in various personal injuries. The notice listed only the 50C policy. When Bull River was later sued, it sent copies of the summons and complaint to North American. The insurer issued an ROR listing only the 50C policy on the subject line and agreeing to defend while reserving its right to deny coverage at a later date. Approximately one year later, North American sent a second ROR that listed both policies on the subject line and added various bases for non-coverage. Three additional cases were later filed against Bull River and in response, North American issued two more RORs outlining its coverage position under both policies.

North American sought a declaration that neither policy provided coverage. Bull River argued that the initial ROR was ambiguous and that North American was estopped from denying coverage under the 50M policy. Ruling on cross-motions for summary judgment, a Georgia district court held that neither policy covered the underlying claims, but that North American was estopped from arguing non-coverage under the 50M policy. The estoppel ruling was based on two premises: (1) that the original ROR was ineffective as to the 50M policy; and (2) that North American had denied coverage while simultaneously reserving its right to raise new grounds for non-coverage, in violation of *Hoover v. Maxum Indem. Co.*, 291 Ga. 402 (2012) (*see* July/August 2012 Alert). The Eleventh Circuit affirmed in part and reversed in part.

The Eleventh Circuit reversed the district court's estoppel ruling. Under Georgia law, an insurer may be estopped from denying coverage if it assumes the defense of an action without reserving its rights to assert non-coverage. The Eleventh Circuit explained that because the original ROR addressed only the 50C policy, North American had never assumed Bull River's defense under the 50M policy. Further, the court noted that even assuming the original ROR was tantamount to a denial of coverage under the 50M policy, Georgia precedent would not require estoppel. The court stated: "we fail to see how *Hoover* mandates, as a remedy, that North American be estopped from denying coverage altogether. It seems to us that *Hoover* would only prohibit North American from asserting a policy defense under 50M that it should have raised the first time around" and here, there was no belated assertion of a new basis for non-coverage.

Number of Occurrences Alert:

New Jersey Court Rules That Waste Disposal At Multiple Landfills Gives Rise To Separate Occurrences

A New Jersey district court ruled that a policyholder's disposal of waste at numerous landfill sites constitutes multiple occurrences. *Penn Nat'l Ins. Co. v. Crum & Forster Ins. Co.*, 2017 WL 3835667 (D.N.J. Sept. 1, 2017).

Bittner, a waste hauling company, delivered waste to three separate landfills. The dumping at each site gave rise to a separate superfund lawsuit against Bittner. During the relevant time period, Bittner was insured under primary policies issued by Penn National and excess policies issued by North River. After the three superfund suits settled, Penn Nation sued North River, seeking reimbursement for defense and indemnity incurred in the underlying actions. North River argued that Penn National's contribution claim with respect to one of the suits (which had settled in 1998) was time bared under New Jersey's six-year statute of limitations. Resolution of this issue turned on the accrual date of the contribution claim, which in turn, depended on whether the claims in the three suits arose out of multiple occurrences or a single occurrence.

North River argued that Bittner's disposal of waste at each landfill is a separate occurrence, and that the statute of limitations on any contribution claim that Penn National might have had with respect to each site began to accrue upon settlement of the claims for that site. In contrast, Penn National contended that Bittner's hauling activities at all three landfills constitute a single occurrence, such that its contribution claims against North River did not accrue until the last underlying settlement was finalized.

The court concluded that Bittner's waste disposal at the three landfills are separate occurrences under New Jersey's cause-based approach. Focusing on the "temporal and spatial connection" between the events, the court emphasized that the landfills were in separate geographic locations and that the hauling occurred at different times over nearly a decade. Additionally, the court noted that Penn National's own conduct (and the testimony of its corporate designee) contradicted its single-occurrence argument. In particular, Penn National brought the contribution claim two years before the last underlying settlement, thus belying its argument that its contribution claim was not ripe until after the last settlement.

Having determined that the activities at each landfill constitute a separate occurrence, the court concluded that the contribution claim arising from a 1998 settlement of an underlying suit was time barred. With respect to the other two suits, the court ruled that Penn Nation had failed to establish that its primary limits were exhausted – a prerequisite to contribution from North River under its excess policies.

Related Claim Alert:

Eleventh Circuit Rules That Multiple Personal Injuries Are Related Claims Subject To A Single Per Claim Limit

The Eleventh Circuit ruled that multiple personal injuries caused by the unsanitary repacking of eye medication constituted a single "claim" under an insurance policy. *Amercian Cas. Co. of Reading, PA v. Belcher*, 2017 WL 4276057 (11th Cir. Sept. 27, 2017). The policy provided that related claims shall be considered a single claim and defined "related claim" as "all claims arising out of a single act, error or omission." The court concluded that eye injury claims by several patients were "related," notwithstanding that the syringes were prepared on different dates, the patients received injections on different dates, the patients received two different types of medication, and the patients were infected with at least two different strains of bacteria. The court reasoned that, under Florida law, "arising out of" means originating from and does not require proximate causation. Applying this standard, the court held that the patients' claims were logically and causally connected because the syringes were all prepared in the same place, by the same person, using the same process, and involving the same health and safety violations. Therefore, the policyholder's coverage was limited to a single $1 million per claim limit, rather than $3 million in aggregate coverage.

Allocation Alert:

Maryland Court Addresses Period Of Lead-Related Damages Under Pro Rata Allocation

A Maryland federal district court ruled that, for purposes of calculating an insurer's pro rata, time-on-the-risk indemnity obligation for lead paint-related injuries, the "entire period of damages" is calculated by looking at when the claimant moved into the premises and when he permanently vacated the premises. *Penn. Nat'l Mut. Cas. Ins. Co. v. Jacob Dackman & Sons, LLC*, 2017 WL 4098749 (D. Md. Sept. 14, 2017).

Daniel Heggie lived on East Hoffman Street from January 12, 1994 until September 9, 1998. It is undisputed that Heggie was exposed to lead paint during that time. Heggie sued the building's landlord, and was ultimately awarded damages exceeding $1 million. In ensuing litigation between the landlord and its liability insurer, Penn National, the parties disputed the proper method for calculating Penn National's indemnity obligation. The parties agreed that Penn National's policies were in effect for 426 days and that its indemnity share is based on its pro rata time on the risk. However, the parties disagreed as to the "denominator" of the calculation – *i.e.,* the "entire period during which damages occurred."

Penn National argued that the damage period was the 2,589 day period between January 12, 1994, when Heggie moved into the building, and February 13, 2001, the last date on which Heggie had an elevated blood lead level. In contrast, Heggie argued that the damage period ran from August 18, 1995, when Heggie's blood lead level was first elevated, to July 8, 1997, the date of Heggie's last elevated blood lead level before he vacated the premises. The court adopted a compromise position.

The court held that the damages period began on January 12, 1994, when Heggie moved into the lead-polluted premises, reasoning that the move-in date best reflects the date of first exposure. The court held that the damage period ended on September 9, 1998, when Heggie vacated the premises. Although Heggie's blood lead levels remained elevated after that time, the court explained that there was no known exposure after

September 9 that would trigger insurance coverage since Heggie had vacated the premises. Thus, the court concluded that the "entire period of damages" was the 1,701 day period during which Heggie actually resided at the contaminated premises. Based on this finding, Penn National was responsible for indemnifying approximately 25% of the total loss.

Coverage Alert:

New York Appellate Court Finds All-Risk Coverage Where Cause Of Damage Began Before Policy Inception

A New York appellate court ruled that an insurance policy covered losses arising from the malfunction of a turbine engine, notwithstanding that the mechanical issues were caused by a turbine crack that had begun before the policy incepted. *TransCanada Energy USA, Inc. v. National Union Fire Ins. Co. of Pittsburgh, PA*, 2017 WL 4125652 (N.Y. App. Div. 1st Dep't Sept. 19, 2017).

TransCanada sought coverage under an all-risk policy for losses that resulted when a power turbine was taken out of operation due to excessive vibrations. The turbine was removed from operation during the policy period, although a crack in the turbine had begun to form prior to the policy period. The insurer denied coverage on several bases, each of which was rejected by a New York trial court, which granted summary judgment in TransCanada's favor. The appellate court affirmed.

The appellate court ruled that the covered physical loss occurred when the turbine was taken out of operation, emphasizing that the policy does not exclude physical loss that originated prior the commencement of the policy. The court further held that TransCanada's business interruption coverage was not limited by the date upon which the turbine was returned to service. The insurer argued that a "period of liability" provision, defined as the period beginning at the time of physical loss until the time of repair or replacement, limited damages to the period ending on May 18, 2009, when the turbine was reinstalled. The court disagreed, explaining that although TransCanada's lost sales were not calculated and paid until after May 18, 2009, the revenue losses represent decreased revenues sustained during the "period of liability." As the trial court noted, New York law typically holds that "business interruption losses experienced by the insured beyond the time needed to physically restore the destroyed or damaged property are not recoverable." However, the Appellate Division deemed this case distinguishable based on the particular manner in which TransCanada calculated and paid its capacity revenues. Finally, the court rejected application of a "capacity payments" exclusion, finding that it applies to losses of bonus-type payments based on the attainment of certain production levels, which were not implicated here.

Arbitration Alert:

Texas Court Rules That Arbitrability Issues Are Within Court's Purview And May Be Addressed Prior To Personal Jurisdiction

Addressing a matter of first impression under Texas law, a Texas district court ruled that arbitrability of a dispute is a matter for the court to decide and is a procedural (rather than merit-based) issue that can be addressed prior to personal jurisdiction arguments. *Halliburton Energy Services, Inc. v. Ironshore Specialty Ins. Co.*, 2017 WL 4536089 (S.D. Tex. Oct. 5, 2017).

The dispute arose out of fracking-related damage. Ironshore insured the operator of the gas facility at which the fracking operations were conducted. Ironshore indemnified the facility operator for nearly $12 million, but sought reimbursement from Halliburton (the fracking operator) pursuant to a subrogation provision in the insurance policy. Halliburton

filed a declaratory judgment action seeking a ruling that Ironshore had waived its subrogation rights. Ironshore moved to stay the case pending arbitration based on an arbitration clause in the fracking agreement. Ironshore argued that it became a party to the arbitration agreement through subrogation, and that the arbitration clause is triggered because the court would need to look to the fracking agreement in order to determine whether Ironshore had waived its right to subrogation. Ironshore also moved to dismiss on personal jurisdiction grounds. The court denied Ironshore's motion to stay.

First, the court ruled that the question of whether a dispute is subject to arbitration is a "procedural, jurisdictional issue rather than a merits issue." Therefore, the court deemed it proper to rule on the question of arbitration before determining whether it had personal jurisdiction.

Second, the court ruled that the applicability of the arbitration clause was a gateway issue for the court, rather than a matter for an arbitration panel. The court reasoned that the arbitration question necessarily turned on whether Ironshore was a subrogated party to the fracking agreement, which depended on whether Ironshore had waived its subrogation rights under the insurance policy. (If Ironshore was not subrogated to the fracking agreement, it was a non-party to that agreement and would have no right to enforce the arbitration clause). Citing case law addressing the rights of non-signatories to enforce arbitration clauses, the court concluded that it must decide the threshold issue of subrogation waiver in order to determine whether a valid arbitration clause existed between Ironshore and Halliburton.

Finally, on the merits of the subrogation issue, the court held that Ironshore had waived its right to subrogation and thus could not enforce the arbitration clause against Halliburton. The court explained that although the insurance agreement expressly provided a right of subrogation, it also provided that Ironshore waives any such right "[t]o the extent required by written contract." Here, the fracking contract between Halliburton and the insured gas site operator specifically provided that the operator "will cause its insurer to waive subrogation against [Halliburton]."

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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.

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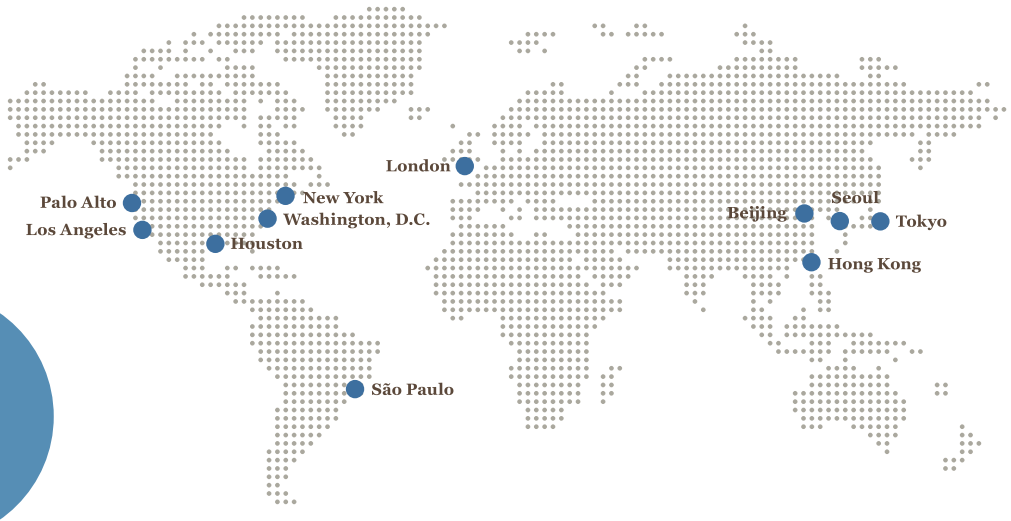

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