Annual Review of Insurance-Related Case Law (2015)

March 15, 2016

6:00 p.m. - 8:30 p.m.

Quinnipiack Club

New Haven, CT

CT Bar Institute, Inc.

CLE Credit 2.0 Hours

Lawyers' Principles of Professionalism

As a lawyer I must strive to make our system of justice work fairly and efficiently. In order to carry out that responsibility, not only will I comply with the letter and spirit of the disciplinary standards applicable to all lawyers, but I will also conduct myself in accordance with the following Principles of Professionalism when dealing with my client, opposing parties, their counsel, the courts and the general public.

Civility and courtesy are the hallmarks of professionalism and should not be equated with weakness;

I will endeavor to be courteous and civil, both in oral and in written communications;

I will not knowingly make statements of fact or of law that are untrue;

I will agree to reasonable requests for extensions of time or for waiver of procedural formalities when the legitimate interests of my client will not be adversely affected;

I will refrain from causing unreasonable delays;

I will endeavor to consult with opposing counsel before scheduling depositions and meetings and before rescheduling hearings, and I will cooperate with opposing counsel when scheduling changes are requested;

When scheduled hearings or depositions have to be canceled, I will notify opposing counsel, and if appropriate, the court (or other tribunal) as early as possible;

Before dates for hearings or trials are set, or if that is not feasible, immediately after such dates have been set, I will attempt to verify the availability of key participants and witnesses so that I can promptly notify the court (or other tribunal) and opposing counsel of any likely problem in that regard;

I will refrain from utilizing litigation or any other course of conduct to harass the opposing party;

I will refrain from engaging in excessive and abusive discovery, and I will comply with all reasonable discovery requests;

In depositions and other proceedings, and in negotiations, I will conduct myself with dignity, avoid making groundless objections and refrain from engaging I acts of rudeness or disrespect;

I will not serve motions and pleadings on the other party or counsel at such time or in such manner as will unfairly limit the other party's opportunity to respond;

In business transactions I will not quarrel over matters of form or style, but will concentrate on matters of substance and content;

I will be a vigorous and zealous advocate on behalf of my client, while recognizing, as an officer of the court, that excessive zeal may be detrimental to my client's interests as well as to the proper functioning of our system of justice;

While I must consider my client's decision concerning the objectives of the representation, I nevertheless will counsel my client that a willingness to initiate or engage in settlement discussions is consistent with zealous and effective representation;

Where consistent with my client's interests, I will communicate with opposing counsel in an effort to avoid litigation and to resolve litigation that has actually commenced;

I will withdraw voluntarily claims or defense when it becomes apparent that they do not have merit or are superfluous;

I will not file frivolous motions;

I will make every effort to agree with other counsel, as early as possible, on a voluntary exchange of information and on a plan for discovery;

I will attempt to resolve, by agreement, my objections to matters contained in my opponent's pleadings and discovery requests;

In civil matters, I will stipulate to facts as to which there is no genuine dispute;

I will endeavor to be punctual in attending court hearings, conferences, meetings and depositions;

I will at all times be candid with the court and its personnel;

I will remember that, in addition to commitment to my client's cause, my responsibilities as a lawyer include a devotion to the public good;

I will endeavor to keep myself current in the areas in which I practice and when necessary, will associate with, or refer my client to, counsel knowledgeable in another field of practice;

I will be mindful of the fact that, as a member of a self-regulating profession, it is incumbent on me to report violations by fellow lawyers as required by the Rules of Professional Conduct;

I will be mindful of the need to protect the image of the legal profession in the eyes of the public and will be so guided when considering methods and content of advertising;

I will be mindful that the law is a learned profession and that among its desirable goals are devotion to public service, improvement of administration of justice, and the contribution of uncompensated time and civic influence on behalf of those persons who cannot afford adequate legal assistance;

I will endeavor to ensure that all persons, regardless of race, age, gender, disability, national origin, religion, sexual orientation, color, or creed receive fair and equal treatment under the law, and will always conduct myself in such a way as to promote equality and justice for all.

It is understood that nothing in these Principles shall be deemed to supersede, supplement or in any way amend the Rules of Professional Conduct, alter existing standards of conduct against which lawyer conduct might be judged or become a basis for the imposition of civil liability of any kind.

--Adopted by the Connecticut Bar Association House of Delegates on June 6, 1994

Faculty Biographies

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Assaf Z. Ben-Atar is an associate in the Litigation Department. He practices in the areas of complex commercial litigation, including business disputes, insurance coverage, real estate and land use litigation, municipal law, community associations, white collar criminal defense and health care.

As a trial lawyer, Assaf's cases often involve claims for breach of contract, fraudulent misrepresentation, tortious interference with contractual relations, zoning appeals, Freedom of Information Act violations, unfair trade practices and lien foreclosures. Assaf also represents Connecticut's largest healthcare provider in proceedings that involve conservator, involuntary commitment, and electroconvulsive therapy treatment applications.

Assaf serves on Pullman & Comley's Diversity and Technology committees. He also leads the Firm's internal pro bono initiative to represent Holocaust survivors applying for compensation from the German government for work performed while living in the Nazi ghettos during World War II.

Prior to joining Pullman & Comley, Assaf served as a judicial intern for the Honorable Joan G. Margolis, United States Magistrate Judge, District of Connecticut.

Representative Experience

- Successfully represented hedge fund president in both criminal and civil investigations for securities and wire fraud
- Successfully represented a local bank in foreclosure of a multi-million dollar construction mortgage
- Successfully obtained jurisdictional dismissal of a federal action on behalf of an international transportation logistics provider

Continued

- Successfully obtained appellate reversal of a Freedom of Information Commission administrative decision
- Conducted an internal investigation into HIPAA violations at medical practice whose former employee stole office computer equipment
- Counseled municipal departments and officials on the Freedom of Information Act, land use regulations and other statutory mandates
- Collected hundreds of thousands of dollars on behalf of municipalities and community associations across Connecticut
- Counseled client in connection with a third party claim to the client's Swiss Bank Holocaust Fund class action proceeds, which resulted in a favorable settlement for the client

Bar and Court Admissions

Connecticut

Massachusetts

U.S. District Court, District of Connecticut

Education

Fordham University School of Law, J.D., 2010; associate editor, *Fordham Intellectual Property, Media & Entertainment Law Journal*

Brandeis University, B.A., 2007

Languages

Hebrew

Professional Affiliations

American Bar Association - Litigation, Tort Trial Insurance and Young Lawyers sections

Connecticut Bar Association - Litigation, Insurance Coverage section - executive committee; Young Lawyers section

Fairfield County Bar Association - Litigation, Young Lawyers, and Insurance Coverage sections

WESFACCA - Insurance and Young Lawyers sections

Community Involvement

Star, Inc. Lighting the Way - Executive Committee, board member, 2012-2015

Continued

Leadership Greater Bridgeport - 2013 class representative to the Board of Directors

Brandeis University Fairfield/Westchester County Alumni Group - board member

Honors and Awards

Recipient of the *Fairfield County Business Journal's* "40 Under 40" award for 2014

Recipient of the 2014 *Connecticut Law Tribune's* "New Leaders in the Law" award

2010 Recipient of Fordham University School of Law's Archibald R. Murray Public Service Award, *cum laude*

Ed McCreery

Ed McCreery is a partner in the Litigation Department of Pullman & Comley LLC. His practice is focused on Insurance Coverage Disputes; Municipal Law; and Commercial Disputes. In his spare time he is also acts as General Counsel to his firm. Ed obtained his B.S. from the University of Vermont and his J.D. from Western New England University School of Law. He was admitted to the bar of Connecticut in 1979 and since that time has tried dozens of jury, court-side, and arbitration matters. He has argued cases before the Connecticut Supreme and Appellate Courts, and he maintains a web site summarizing the decisions of those Courts which is widely read on JD Supra. He is past President of the Bridgeport Bar Association; past Secretary and House of Delegate member of the Connecticut Bar Association; past Chairman of the Valley Chamber of Commerce; and past Chairman of the Insurance Law Section of the CBA. In his hometown of Shelton, Ed has been active in the preservation of farmland and open space with his service on the boards of the local Land Trust and the City's Conservation Commission for over a dozen years. Over the years, Ed has also served on the boards of several Valley community charitable organizations and currently serves on the Board of Griffin Hospital.

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Serving Southern New England Since 1979

Philip T. Newbury, Jr., handles insurance coverage matters, including bad faith claims, in state and federal courts in Connecticut, Massachusetts, and Rhode Island. He is certified as a Civil Trial Advocate by the National Board of Trial Advocacy, and has tried over fifty cases to verdict. He received his LL.M. in insurance law from the University of Connecticut Law School in 2002. He received his J.D., *cum laude*, from Suffolk University Law School in 1981. He is admitted to practice in Connecticut, Massachusetts, Rhode Island, the United States District Court for the Districts of Connecticut and Massachusetts, the Second Circuit Court of Appeals and the United States Supreme Court.. Mr. Newbury is a member of the American Bar Association, the Connecticut Bar Association, the Rhode Island Bar Association and the Hartford County Bar Association. He is also a member of the Defense Research Institute, the Connecticut Defense Lawyers Association and the Association of Ski Defense Attorneys. He is a frequent lecturer on insurance topics. He also serves as an arbitrator and mediator in insurance disputes.

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Regen O'Malley

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Attorney Biography

Regen O'Malley concentrates her practice on the defense of insurers against both contractual and extra-contractual claims. She also regularly counsels insurers regarding complex coverage issues and represents insurers in defending and prosecuting declaratory judgment actions in coverage disputes. Her experience includes commercial general liability, professional liability, directors and officers, errors and omissions, umbrella/excess, business property, liquor liability, homeowners, and automobile insurance policies.

Regen also has substantial civil litigation/insurance defense experience, including complex litigation. She regularly defends insureds in the context of employment liability, professional liability, insurance agent/broker liability, non-profit liability, director and officer liability, contractor and subcontractor liability and liquor liability.

A New England Super lawyers "Rising Star" from 2008 through 2013 in insurance coverage, Regen practices in both state and federal courts. She has successfully handled numerous appeals both in the Connecticut Appellate and Connecticut Supreme Court as well as in the United States Second Circuit Court of Appeals on matters ranging from civil rights and insurance-related actions to those involving legal and medical malpractice.

Admissions

Connecticut (2003)
United States District Court, District of Connecticut (2004)
United States Court of Appeals, Second Circuit (2005)

Memberships

Regen is a member of the Connecticut and Hartford County Bar Associations. She serves as Chair of the CBA Insurance Law Section and on the Bench Bar Committee of the HCBA. She is an emeritus member of the Oliver Ellsworth Inn of Court.

Community Involvement

Regen is actively involved in her community. She has volunteered for many years with the New Britain YWCA and is the immediate past President of the Board of Directors. She also serves as a local alumni representative for Haverford College.

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Education
Quinnipiac University School of Law, J.D. 2013
Stonehill College, B.A. 2010
Choate Rosemary Hall, 2006

Bar and Court Admissions
State of Connecticut
U.S. District Court, District of Connecticut

Professional Memberships
American Bar Association
Connecticut Bar Association
Connecticut Trial Lawyers Association
New Haven County Bar Association

Attorney Brianna Spinnato's practice includes litigation in state and federal courts with a focus on complex insurance coverage disputes and personal injury law. Through trials and settlements, Brianna has represented homeowner and commercial policyholders in cases involving claims for breach of contract, unfair insurance practices, bad faith and emotional distress. She has experience in alternative dispute resolution having represented policyholders in numerous private and court-annexed mediations and arbitrations. Brianna has also been successful in resolving multiple third-party liability claims on behalf of injured parties throughout the state.

Brianna received her Juris Doctorate from Quinnipiac School of Law in 2013 with an honors concentration in Civil Advocacy and Dispute Resolution and an honors concentration in Family Law. Upon graduating law school, Brianna received a number of academic awards and honors, including an award for Excellence in Clinical Work, Service to the Community, and the Nancy K. Sulinski Memorial Award for her work with the Hamden community.

Brianna is an active member of the Connecticut Bar Association as well as several other professional associations relevant to her practice. She is also actively involved in her community through a variety of civic organizations including the National Multiple Sclerosis Society.

Brianna joined Biller, Sachs, Raio & Zito as a law clerk in 2012 while attending law school. She began practicing as an attorney with the firm in 2014.

ANNUAL REVIEW OF NOTABLE CONNECTICUT INSURANCE LAW DECISIONS 2015

Edward P. McCreery, III & Assaf Ben-Atar, Pullman & Comley LLC
Regen O'Malley & Andrew Bullard, Gordon & Rees LLP

CONNECTICUT STATE COURT DECISIONS

AC36922 - Nationwide Mutual Ins. Co. v. Pasiak (CT Appellate Court)

Facts: This was round three of this case. An intruder broke into his friend's home where the friend maintained his office and demanded the secretary open a safe or he would kill her and her family. The secretary did not know how to open the safe, and the intruder tied her up. The homeowner then arrived and was assaulted by the intruder. During the struggle, the intruder's mask came off, revealing him to be a friend of the homeowner. Leaving his secretary tied up, the homeowner talked the assailant out of robbing the place, and when he left, would not let the secretary go home. The homeowner spent several hours trying to talk her out of reporting the incident to the police.

The secretary later turned around and sued her boss for false imprisonment and other claims, with a jury awarding the former employee over $1 million in damages. The boss's homeowner insurance companies provided a defense, but otherwise disclaimed coverage. The insurers brought a declaratory judgment action seeking a determination that they owed neither a defense nor indemnity on the claims of the secretary.

The umbrella policy contained an exclusion for any claims arising out of the business pursuits of the homeowner The Trial Court, however, refused to grant summary judgment on the duty to defend because the allegations of the former secretary regarded tortious conduct of her boss in connection with an attempted robbery of his home, not the conduct of business.

Thereafter, the Trial Court considered a supplemental motion for summary judgment, and granted it in favor of the primary (homeowner's) insurer because that policy excluded coverage for damages arising out of pure emotional distress. The Court still refused, however, to grant summary judgment on the umbrella policy, as it did not have the same emotional

distress exclusion. Thereafter, the Trial Court found that the umbrella policy *did* cover the secretary's claim, and the Business Pursuit Exclusion did not apply. The umbrella insurer appealed, and the Appellate Court reversed.

Held: The Appellate Court noted that such Business Pursuit Exclusions are considered under an expansive causation analysis. Homeowner policies typically exclude claims arising out of any business engaged in by the insured. If homeowner policies were deemed to cover business pursuits, the premiums charged could not be kept at reasonable levels.

The term "arising out of" in an insurance policy is to be interpreted broadly. No one can dispute but that the secretary was at her boss's home, because that is where his office was located, and she was there for the purpose of performing duties of the business. Thus, the only reason she was assaulted was because she was at the insured's business fulfilling her responsibilities as an employee. Thus, her boss's conduct of which she complained in keeping her on the premises were connected with and had their origins in and grew out of and flowed from the defendant's business purposes.

The Trial Court improperly sought to ascertain whether the defendant was motivated by profit in his conduct, and further inappropriately sought to delve into the boss's mental state of whether he was trying to protect a lifelong friend from police involvement. Whether or not an "Occurrence" arose out of the defendant's business pursuits is not dependent upon either his motivations, nor his state of mind. The decision of the Trial Court was reversed with the direction to find that there was no coverage under the umbrella policy for the claims of the secretary.

AC36548 - Palkimas v. Fernandez (CT Appellate Court)

Facts: Homeowner hired contractor to undertake some repairs to its house. Apparently, a worker of the contractor used a disconnected toilet that flooded various rooms of the house. The contractor's insurance carrier, in turn, hired two companies to remediate the flood damage. Plaintiff claimed that the insurance companies directed those contractors to turn off the heat to the house while repairs dragged on for

over a year, which caused additional damage as the cold temps caused the original horse hair plaster to fail. Homeowner sued the insurance company directly for negligence. The Trial Court found that the defendant's insurance company was not in control of the independent contractors and that the plaintiff failed to establish proximate cause.

Held: The only issue on appeal was proximate cause, which is ordinarily a question of fact. Each side presented expert testimony. The plaintiff's expert conceded on cross-examination that he had not taken notes, did not measure or observed cracks, did not take moisture readings, did not investigate the effect of cold temperatures on antique plaster walls, and eventually conceded he was not a "plaster expert," nor had he ever worked with or applied horsehair plaster. Rather, he claimed he was an expert on basic engineering principles of freezing, on solid and liquid materials and concluded that the "key ways" of the plaster failed due to a combination of freezing and humidity due to a lack of heat in the house.

The defendant's expert, on the other hand, was an expert in the restoration and protection of historic buildings, with direct experience in the application and restoration of horsehair plaster. He concluded that freezing temperatures do not affect horsehair plaster, nor does moisture. The defendant's expert testified it would take significant amounts of water to cause the wood lathing to swell up to, in turn, break the keyways. The flooded areas in this house were isolated and insufficient to cause the wood lathing to swell up. The Trial Court was therefore entitled to rely upon the defendant's expert, and find that testimony more credible than the plaintiff's expert in ruling for the defendant insurance company. Appeal dismissed.

AC36792 - <u>New London County Mutual Ins. Co. v. Sielski</u> (CT Appellate Court)

Facts: In their Residential Disclosure Form, the sellers of property claimed they had no knowledge of any flooding of the basement or rotten wood. After the closing, the buyers discovered rotten and moldy beams in the basement and seeping water, and initiated a lawsuit against the sellers for misrepresentation. The sellers' insurance company then brought a declaratory judgment action for a finding that it did not have a duty to defend the sellers, because the resultant damages did not constitute

"property damage" as defined under the policy. The Trial Court agreed and granted summary judgment to the insurer.

Held: On appeal, the Appellate Court followed the "Four Corners" Doctrine," noting that an insurer's duty to defend is triggered if at least one allegation of the complaint falls even possibly within coverage. Determining whether or not a property damage claim arose involves interpreting the policy, which is reviewed as a contract. This policy defined an "Occurrence" as an Accident even if it occurs over a continuous time frame. However, it must cause bodily injury or property damage, with "Property Damage" being defined as physical injury to or destruction of tangible property. Noting that this is an issue of first impression of whether or not a negligent misrepresentation may be considered "Property Damage", or be deemed an "Occurrence," within a Homeowner's Policy, the Decision notes that almost all Superior Court decisions have concluded to the contrary.

First, the Court set aside the arguments of the sellers that the ***Capstone*** decision controlled. That was a third-party claimant case, and this is a first party claimant case. The issue in ***Capstone*** was whether or not the actual negligent construction that damages the property of another could be covered as property damage under a CGL policy.

The Court then turned back to the Superior Court Decisions, and noted that a number of out-of-state decisions have similarly held that misrepresentations are economic or contractual in nature, and do not give rise to property damage claims. The Court concluded that this was the proper outcome, quoting a West Virginia decision for the proposition that damages flowing from misrepresentation have no basis as an element of property damage, but are damages of an economic or contractual nature, not intended to be covered by homeowner's policies. Accordingly, there is no duty to defend triggered by the assertion of such a claim.

In closing, the Court noted that determining whether or not an insurer has a duty to defend remains a question of law, not a question of fact, because it is a matter of reviewing the allegations in the complaint against the language in the insurance policy.

AC36879 - Tirreno v. The Hartford (CT Appellate Court)

Facts: Plaintiff sued their insurance company, claiming breach of its policy obligations. Plaintiff's attorney and defendant's attorney had a series of oral discussions that were memorialized in a series of e-mails agreeing to participate in binding mediation. At no time was the issue of the mental capacity of the plaintiff raised. The mediator awarded the plaintiff $70,000, and the insurance company issued a check. The plaintiff refused to cash the check and fired her attorney. The insurance company filed a motion to enforce the agreement and the defendant's response was that she did not have the mental capacity to enter into a binding agreement, and backed it up with a letter from her treating psychiatrist, claiming she lacked "decisional capacity."The Court granted the motion to enforce, and the Plaintiff appealed.

Held: The Appellate Court upheld the Trial Court's opinion, noting that clients are generally bound by the acts of the their attorney, but clients do deserve the right to decide whether and on what terms to settle, *unless* they have granted that authorization to their attorney, as well. The Appellate Court noted that there was nothing in the Record to indicate that plaintiff's prior counsel took any of the steps under Rule 1.14 that would normally be triggered if the client was unable to make their own decisions.

Accordingly, the Trial Court's sole role was to determine whether plaintiff's counsel had authority to enter into the settlement agreement. It was not the role of the Trial Court to determine the plaintiff's mental capacity. The plaintiff's attendance at and participation in the mediation validated the understandings of counsel for both sides. While plaintiff's counsel would not testify about his communications with his client during the motion to enforce, he did agree he would not have entered into a binding arbitration agreement without his client's permission. This decision also held that the binding mediation process was not an arbitration proceeding, and thus, no written agreement to arbitration was required under C.G.S. § 52-408. There was no evidence before the Trial Court that the parties intended to adjudicate their dispute through any type of formal arbitration.

SC19219 - Artie's Auto Body, Inc. v. Hartford Fire Ins. Co. (CT Supreme Court)

Facts: A group of independent auto repair shops brought a CUTPA action against defendant insurance company, for directing its staff appraisers to estimate repair costs utilizing allegedly artificially low hourly rates. The jury found in favor of the plaintiffs, and awarded them $15 million compensatory damages, to which the Trial Court added $20 million of punitive damages.

Held: On appeal, the defendant claimed that the Trial Court should have granted its motion for directed verdict, as the statute in question does not prohibit the insurance practices at issue. The Supreme Court agreed and reversed.

The plaintiffs acknowledged, that they had agreed to those rates, even though they were substantially less than their posted rates. They also acknowledged that the rates were consistent with what other insurance companies were willing to pay. Finally, plaintiffs conceded that virtually all of their business was insurance-related, and thus, they were seldom paid their posted hourly rates. But they claimed that the insurance companies together were using their market power to suppress the true hourly rate it cost them to do the repair work. However, they felt that if they demanded a higher rate from the insurance companies, they would get no work. The plaintiffs offered testimony that the rates negotiated by the insurance company were not keeping up with the actual cost of doing business.

The Trial Court had instructed the jury that Insurance Regulations § 38(a)-790-8 required insurance adjustors to be fair when negotiating body and repair shop rates. The defendant objected, claiming that the Regulation only applied to the relationship between insurers and their insureds, not between insurance companies and body shops.

The jury concluded that under that Regulation, the insurance company had offended public policy in not being fair to the body shops, but at the same time found that the insurer’s conduct did not violate the Connecticut Unfair Insurance Practices Act or the Department of Consumer Guidelines in setting hourly labor rates. The jury also found that the insurance companies’ conduct did not satisfy the second or third prongs of the Cigarette Rule in that the practice was not immoral, unethical or oppressive, and did not cause substantial injury to the plaintiffs, but the Trial Court had instructed the jury that ALL prongs of the Cigarette Rule did

not have to be satisfied. The defendant argued that CUTPA liability could not be predicated on a public policy reflected in a regulation that does not apply to insurance companies and does not prohibit the conduct in question.

After trial, it was also discovered that the plaintiff had asked the Attorney General to bring his own CUTPA action against the insurance company, but when the Attorney General wrote to the Insurance Commissioner, the Commissioner replied that such a lawsuit would not be justified because appraisers adjusting damages have no expertise in setting labor rates. Their expertise is limited to the assessment of the auto parts and work needed to repair the damage and the number of hours required to do the job, and that the hourly repair rate is a negotiation between the insurance company and the body shop. The plaintiffs never disclosed this letter before trial. A follow-up letter said the Insurance Department found nothing wrong with rates being negotiated between auto body shops and insurance companies, because they are consistent throughout the country and help insurance companies keep premiums down, and that giving in to the auto body repair shops would injure consumer policyholders. That letter was not disclosed either.

The defendant moved for sanctions and a setting aside of the verdict, and the Trial Court agreed that discovery rules had been violated, but said it would not have changed the outcome and therefore was not the basis for a new trial, but did award attorney fees for the violation. The Trial court concluded that regardless of what the Insurance Commissioner said, it was a duty of an appraiser under their Code of Ethics to set a fair labor rate without interference by the insurance companies.

The Supreme Court disagreed with the Trial Court and said neither the insurer's practices, nor the conduct of the appraisers offends § 38a-790-8 or any other public policy of the state. Despite the plaintiff's claims that prior case law left the door open for non-CUIPA violations to trigger a CUTPA claim against an insurance company, this Court has held that in order to sustain a CUIPA cause of action under CUTPA, the **plaintiff must allege and prove conduct that is proscribed by CUIPA**. The failure to allege a CUIPA claim is fatal to a CUTPA claim against an insurer. There must be an allegation of CUIPA violation or some other statute regulating insurance conduct. While § 38a-790-8 arguably regulates insurance appraisal practices, by prescribing the conduct of appraisers who estimate auto body repairs, it simply does not purport to regulate the conduct at

issue in this case. Insurance companies have an absolute right to negotiate hourly labor rates they are willing to pay for auto body repairs and refuse to give their business to shops with whom they cannot reach an agreement. They have a right to employ appraisers to negotiate the labor rates on their behalf. It would be ridiculous to hold that an insurance company has a right to negotiate a rate with an auto body shop, and then when it proceeds to estimate cost and repairs on those negotiated rates, to hold that it is committing a CUTPA violation. It was totally wrong for the Trial Court to instruct the jury on a manner that suggested it may be unfair for the appraiser to use pre-negotiated hourly rates in arriving at the estimated cost of repairs. There is simply no explanation why the Insurance Commissioner's opinion was either not accorded deference or why his interpretation of the Regulation was unreasonable, unworkable or unjust. If the plaintiffs did not like the rates by the insurance company, they were certainly free of their own accord to negotiate different rates.

This case was looked upon as an opportunity for the Supreme Court to throw out the Cigarette Rule, with the defendants claiming that the Federal Courts had abandoned that Rule in favor of a more stringent test called the Substantial Unjustified Injury Test. In Footnote 13, the Court said that over the intervening years, the Legislature has given no indication of its disapproval of the Court's continued use of the Cigarette Rule, despite its abandonment by the Federal Courts, and despite past precedent where they said their interpretation of CUTPA would be guided by Federal decisions. In any event, it was unnecessary to decide whether the old Rule should be abandoned because under any scenario, there was no violation of CUTPA here, but they invited the Legislature to address the issue because it was bound to come up before the Court again in the near future.

AC36623 - <u>McCants v. State Farm Fire & Casualty Co</u>. (CT Appellate Court)

Facts: Fire loss and materiality of representations to the insurer were at issue in this case. The plaintiff owned the house which burnt down but she was living for the last few years in the adjoining town helping a friend babysit. The insurer's investigation determined that the house was occupied by various family members of the owner who were living on the different floors, but the policy was written so as to only cover a primary residence of the insured. The owner also claimed that family members paid her rent

suggesting she was going to make a loss rent claim and produced made up leases to the investigator. The insurance company denied coverage on the grounds that the house was not being used as the principal residence of the plaintiff. The plaintiff sued claimed she was residing at the other address solely to help out with babysitting, but that she considered the insured property still to be her primary residence. The Trial Court ruled in favor of the property owner. The insurer appealed.

Held: The Appellate Court noted that the policy did not require that the residency or occupancy be uninterrupted or continuous. Rather, as a term of general usage, *Residency* requires a showing of something more than temporary presence and requires some degree of permanency and intention to remain. The factual findings by the Trial Court that this was the residence of the plaintiff will not be overturned despite the evidence that she had few personal belongings in the house at the time of the fire, and used the adjoining town's address on her 2006, 2007 and 2008 tax returns. Additionally various family members recanting their earlier statements that the owner actually resided in the adjoining town.

Even the Trial Court found the evidence to be contradictory and suspicious before ruling in the owner's favor, concluding that emotional ties to the burnt-out house led the plaintiff to treat it as has her only true permanent home, to which she intended to return. The Appellate Court said It was within the province of the Trial Court to resolve inconsistencies in the testimony and reach such an ultimate conclusion.

Turning to whether or not the insured committed fraud in her statement to the investigator that should have rendered the policy void, the Court noted that C.G.S. § 38a-307-308 requires such a fraud voidance provision. A special defense of concealment or fraud, requires the insurer to prove both willful concealment of a material fact and intent to deceive. But the insurer does not have to prove reliance upon the fraudulent statement.

Here, the insured made up lease agreements for her family members and presented them to the insurer's investigator. Thus, the issue on appeal was whether or not those misrepresentations were material. The Trial Court found that the misrepresentations were not material, because the plaintiff later withdrew any claim for lost rents. The Appellate Court agreed noting that there was no evidence that the plaintiff ever formally submitted a claim for lost rents. Therefore, any misrepresentations as to the leases was not material.

SC19291 - Recall Total Information Management, Inc. v. Federal Ins. Co. (CT Supreme Court)

Facts: This short decision upheld an earlier ruling by the Appellate Court, finding no insurance coverage for a data loss event. The plaintiff had contracted with IBM to transport data tapes with personal identifying information of IBM employees. The plaintiff in turn hired a subcontractor who lost the tapes when they fell off the back of their fully loaded truck. While there was no evidence anyone accessed the information, IBM spent significant sums of money dealing with the data loss, and then made a claim upon the plaintiff, who settled with IBM voluntarily. Plaintiff then sued its insurance carrier, asserting coverage under the Personal Injury provisions of the its policy, claiming it covered an Invasion of Privacy of the IBM employees.

The Appellate Court held that the voluntary settlement with IBM did not amount to a lawsuit that triggered a duty to defend. The insured should've have waited for IBM to sue it or obtain the consent of the insured to negotiate a settlement without waiving coverage. The Appellate Court also concluded that the loss of the computer tapes did not amount to a personal injury because there had been no publication of the information.

Held: The Supreme Court said that it agreed with all of the Appellate Court's conclusions, but pointed out that the Appellate Court made a mistake when it said that a party opposing a summary judgment must demonstrate that the Trial Court's decision to grant it was clearly erroneous. A Footnote adds that the Appellate Court has recited this incorrect language in the past.

AC35882 - First American Title Ins. Co. v. 273 Water Street, LLC (CT Appellate Court)

Facts: Developers purchased Katherine Hepburn's house on 3.5 acres in the Borough of Fenwick, Town of Old Saybrook, for $ 6 million. The eastern portion of the land had already been donated by the Hepburn Estate to a Land Trust. When the developer purchased the property, they also purchase title insurance from First American, and then proceeded to subdivide the property into three lots, with the Hepburn house in the center. The developer then offered the three lots for sale, for a total asking price of $30 million, and began renovating the main house. The Borough

then notified the developer that it still owned a thirty-foot wide easement for a discontinued road across the property to the waterfront. The developer made a claim against the title policy, which felt that the loss amounted to only $17,000, but the developer concluded it was more like $5 million. The title company brought a declaratory judgment action to determine the value of the loss. While the lawsuit was pending, a settlement was reached with the Borough to abandon the six-foot wide roadbed in return for a footpath accessible during daytime in the same general vicinity. Thereafter, a jury concluded that the value of the damages suffered by the developer was $2.2 million. The title company then moved to set aside the verdict on the grounds that it had discovered the developer conveyed away the northerly portion of the property before the verdict, and thus, lacked standing because it had disposed of the property before suffering an actual loss. The Trial Court refused to set aside the verdict.

Held: On appeal, the Appellate Court note that in order to have standing the developer only had to have a colorable claim. Having filed a counterclaim early in the case alleging it had suffered a serious monetary loss, it had a colorable claim entitling it to entry into the Court. Standing does not test the substantive rights of the parties, only who the courts may let in the door to resolve disputes.

Next, the Court distinguished a prior decision, where the conveyance of title caused the plaintiffs to lose standing to assert their title claim, by noting the plaintiffs in that action had admitted in their briefing that they had not yet suffered a monetary loss during the policy period. Thus, there is no general rule that transferring a property prevents the transferor from recovering against its title insurer for the loss of property value that occurred while the insured still owned the property, and before the transfer. Further, there was no language in the policy to suggest that a transfer terminates the right to recover upon a claim. A transfer of title only terminates future coverage.

Next, the Court rejected the argument that an expert should not have been allowed to testify as to the increased fair market value of the property due to the factor of “celebrity enhancement” on the grounds that it was “junk science” not up to the Porter Test. The Trial Court properly concluded that there is nothing scientific about the issue, and appraisers testify about such things all the time. Real estate appraisals are not scientific evidence, and are based upon human factors that are readily observable and understandable.

Next, the Court held that it was improper to allow the developer to speculate that he probably had not gotten any offers to buy the property because of the easement, but in totality, it could not be said that the testimony was harmful or would have resulted in a different outcome.

Finally, the Trial Court also was justified in denying the motion for remitter. Damage opinions ranged from zero dollars on the title company's side to $4 million on the developer's expert's opinion's side. The owner also opined that in his opinion, the value of the house alone diminished in value by about $6 million. While none of these valuations were directly tied into the settlement imposing a pedestrian path, as opposed to the original roadway easement, there was enough valuation evidence to assist a jury in determining the diminution in value caused by the more limited footpath easement.

2015 WL 3651786 **O&G Industries vs Litchfield Insurance** (Superior Court, Pickard, J)

Held: A liquidated damage sum that was triggered when O&G could not complete a Natural Gas Power Plant due to an explosion was deemed to be a contractual obligation that was excluded from the CGL policy coverage because it was due and payable regardless of the cause of the delay.

2015 WL 7421784 Williams vs Safeco Insurance (Superior Court, Lee, J.)

Held: Even though the case had settled, the trial judge felt compelled to articulate his earlier ruling (as he had promised he would do) to explain what evidence he would have allowed the plaintiff to proffer in support their CUTPA / CUIPA claim against their insurer. The plaintiffs had alledged the insurer failed to timely settle their claim which kept them out of their damaged home for "years". The Judge noted that the issue of how to allege a "general business practice" has been extensively considered by the courts. A plaintiff must allege more than a singular failure to settle a

plaintiff's claim fairly. A plaintiff must allege that the defendant has committed the alleged wrongful acts with such frequency as to indicate a general business practice. But not a lot of CT cases have discussed what evidence would be allowed at trial. First the Judge turned his attention to a series of court complaints filed against the same insurer by others that the plaintiffs had wanted to offer. The Judge concluded in each case, the allegations involved behavior unspecified or dissimilar to that alleged in the complaint before his court and that the allegations had been stricken, dismissed, or otherwise adjudicated in favor of the insurer. Therefore, the Judge announced that had the matter proceeded to trial, none of those complaints would have been deemed admissible as evidence to support a general business practice because they did not constitute findings of a relevant unfair claim settlement practice entitled to collateral estoppel effect.

The Judge concluded that he would have allowed four categories of evidence to prove a “general business practice”:

1. Live testimony by other insureds or their agents of similar practices by the insurance company because the witnesses would be subject to cross examination and prior deposition;

2. Evidence of similar practices in complaints before the insurance commissioner that have been ruled upon where there was a fair opportunity to contest the findings, or testimony of Insurance Department personnel, who would be subject to cross examination;

3. Written evidence of similar practices in complaints before the Superior Court or other courts of record that have been adjudicated adversely to **to** the insurance company, which are entitled to collateral estoppel effect; and

4. Evidence provided by the insurer's employees and/or internal documents as to its policies and practices

[This is probably all “dicta”, but is an important guideline that other judges may follow.]

U.S. DISTRICT COURT DECISIONS (D. CONN.)

Hartford Roman Catholic Diocesan Corp. v. Interstate Fire & Cas. Co., 2015 U.S. Dist. LEXIS 3542 (D. Conn. Jan. 13, 2015) (Arterton, J.).

Facts: Insured sued its excess insurer for breach of contract, breach of the covenant of good faith and fair dealing, and CUTPA/CUIPA violations for failure to pay for settlements of lawsuits alleging sexual misconduct. The insured alleged a general business practice of avoiding obligations to insureds. Both the insurer and insured objected to discovery rulings by a magistrate judge. The insured sought documents pertaining to the insurer's handling of claims for the insured as well as other policyholders. The insurer argued that unfair insurance practices occurring outside of the state were not relevant to the CUTPA/CUIPA claim. The insurer also objected to the order to provide documents for *in camera* review, arguing that the magistrate had already ruled that the insured failed to make the threshold showing required under *Hutchinson v. Farm Family Cas. Ins. Co.* 273 Conn. 33 (2005).

Held: The magistrate properly allowed discovery of out-of-state occurrences to establish a CUTPA/CUIPA violation. The court noted that CUIPA prohibits unfair claim settlement practices that occur "with such frequency as to indicate a general business practice." While Conn. Gen. Stat. § 38a815 requires that the alleged "unfair claim settlement practice" occur in Connecticut, Conn. Gen. Stat. § 38a816(6) did not require that evidence of the alleged general business practices be limited to Connecticut. "Rather, instances of alleged unfair trade practices from outside the State are relevant to proving that an in-State plaintiff was the victim of the culpable conduct that CUIPA was intended to combat instead of an isolated instance of misconduct exempted from CUIPA." The court also held that the magistrate properly held an *in camera* review. The insured was not entitled to *Hutchinson* review without showing probable cause that an exception to the attorney-client privilege existed, but the magistrate could determine that "*in camera* review was required to determine in the first instance whether a privileged applied."

Tucker v. Am. Int'l Group, Inc., 2015 U.S. Dist. LEXIS 9874 (D. Conn. Jan. 28, 2015) (Haight, J.)

Facts: Plaintiff sought to recover under her former employer's claims-made employment practices liability policy following a $4 million judgment for unlawful discharge. After the plaintiff was initially terminated, her attorney sent a November 3, 2003 letter to her former employer alleging, *inter alia*, that the plaintiff was wrongfully discharged and retaliated against and listing possible "financial exposure[s]" of the employer such as lost wages and punitive damages. The letter also demanded payment of a severance package in exchange for a full release of liability. The plaintiff filed a complaint with the CHRO and EEOC on March 2, 2004. The employer alerted its insurer of the claim on May 13, 2004. Following trial in 2008, the insurer denied coverage. The plaintiff and her former employer then settled the claim, and the employer assigned its rights under the 2004 policy to the plaintiff. The plaintiff then brought claims against the insurer under the direct-action statute sounding in breach of contract, breach of the implied covenant of good faith and fair dealing, CUTPA/CUIPA, and equitable estoppel and waiver. The insurer moved for summary judgment asserting that the 2004 claims- made policy did not apply, as the claim was not first made within the policy period.

Held: The 2004 claims-made policy was plain and unambiguous. The insurer agreed only to provide coverage if a claim was first made during the policy period, and the claim was first made in November, 2003, when the plaintiff's demand letter was received, prior to the inception of the subject policy in 2004. Although the letter did not make an express demand for payment, it did fall within the policy's definition of "claim." By listing the potential damages and threatening to file a lawsuit, the letter served as an ultimatum to provide the plaintiff with monetary relief (a "severance package") or face a lawsuit. Estoppel did not apply because the requirement for notice could not be waived, and could not convert a claims-made policy into an occurrence policy. Although there was no contractual coverage, the CUTPA/CUIPA claims were statutory in nature, and the count was permitted to stand while supplemental briefs were prepared. The court did note a conflict in two unpublished state decisions with *Lees v. Middlesex*, 219 Conn. 644 (1991), and held that the focus of a CUIPA/CUTPA claim is "the alleged conduct and not the actual terms of a contract, or plaintiff's ability to recover under it." The procedural bad faith claim was insufficient as a matter of law consistent with the holding in *Capstone Building Corp. v. American Motorists*

Ins. Co., 308 Conn. 768 (2013) (holding that common law claim of procedural bad faith, not tied to enforcement of a contractual right, is not a cognizable cause of action in Connecticut).

Fleming v. Gov't Emps. Ins. Co., 86 F. Supp. 3d 102, 2015 U.S. Dist. LEXIS 18868 (D. Conn. Feb. 17, 2015) (Thompson, J.)

Facts: The plaintiff, on behalf of herself and as administratrix of her husband's estate, brought claims under the direct-action statute (Conn. Gen. Stat. § 38a-321), stemming from a wrongful death lawsuit. The plaintiff was judgment creditor subrogated to the rights of the underlying defendants. The plaintiff sued the defendants' insurer for negligent failure to settle an underlying DUI wrongful death lawsuit within the limits of the insured's policies and breach of the covenant of good faith and fair dealing for failing to settle. In the course of the underlying lawsuit, a partial settlement was reached as to two of the four pertinent policies and certain insureds. The insurer moved to dismiss the subsequent action arguing that the "negligent failure to settle" claim was barred by the economic loss doctrine, and because offering $250,000, instead of the full remaining policy limits of $270,000, was insufficient to sustain a cause of action for bad faith.

Held: The motion to dismiss was granted in part and denied in part. The Court agreed with the insurer that the plaintiff's negligent failure to settle claim was barred by the economic loss doctrine. The relationship between the insured and insurer was purely contractual, and the only losses alleged were economic in nature. Pursuant to *Ulbrich v. Groth*, 310 Conn. 375 (2013), the economic loss doctrine bars negligence claims arising out of and depending on breach of contract claims that result only in economic loss. However, the Court also held that the plaintiff adequately stated a claim for breach of the covenant of good faith and fair dealing based on allegations that the insurer refused to raise its offer to the full policy limits after it had determined that liability was clear and fair compensation could reasonably exceed the limits of coverage.

Metro. Prop. & Cas. Ins. Co. v. Sisbarro, 2015 U.S. Dist. LEXIS 24577 (D. Conn. Mar. 2, 2015) (Shea, J.)

Facts: An insurer sought a declaratory judgment that Sisbarro was not insured under automobile and excess liability policies issued to his parents, and that there was no duty to defend or indemnify him for an underlying motor vehicle accident. An intervening defendant, and the underlying plaintiff, sought a declaration finding the opposite. The insured was a driver in a motor vehicle accident while operating a pick-up truck owned by him and insured by Progressive. Progressive paid its limits, exhausting coverage. Metropolitan initially acknowledged that there was coverage under its policies and paid two other claimants, but subsequently determined that Sisbarro's vehicle was not covered because it was not listed in the Declarations, and was not a temporary substitute or a newly acquired vehicle of which the insurer was notified.

Held: While Sisbarro was admittedly an insured, the coverage in question applied to "covered automobiles," which included those listed in the Declarations, new vehicles, and substitute vehicles. The court found that the car in question was owned by Sisbarro and that he resided at his parents' household, therefore preventing it from being a "non-owned" or "substitute automobile." Nor did he or his parents identify it to the insurer or pay a premium for its coverage. Because the policy only contemplated that one could be "insured" while in a covered vehicle or non-owned vehicle, Sisbarro was not an "insured." The court also held that because there was no judgment, the underlying plaintiff could not step into the shoes of Sisbarro pursuant to Conn. Gen. Stat. § 38a-321 as a judgment creditor. Claims by the underlying plaintiff for CUTPA/CUIPA violations and bad faith, among others, stemming from the insurer's investigation and initial acknowledgment of coverage were therefore unsustainable. The insurer was not estopped, and had not waived its right to deny coverage, because there was no coverage under the applicable policy, and the doctrines cannot "create coverage when it does not otherwise exist."

Allstate Ins. Co. v. Tandon, 2015 U.S. Dist. LEXIS 37529 (D. Conn. Mar. 25, 2015) (Fitzsimmons, J.)

Facts: Insurer brought a declaratory action to determine whether it owed a duty to defend or indemnify its insureds, Sapna Tandon and Robert Doohan, under the homeowners and umbrella policies issued to them. The insureds were sued in a third-party action and pled over against by the underlying plaintiff stemming from a series of escalating events that began near a

marina restaurant. The insureds allegedly were on a boat while the plaintiff and companions were returning to their own boat from the restaurant. One of the insureds' companions fell into the water, which the plaintiff and his companions found humorous. The insureds did not find it quite as amusing, and the altercation escalated to a boat-chase. The Insureds allegedly pursued the plaintiff and upon docking led their passengers to assault the plaintiff and his companions. The plaintiff pled recklessness, negligence, civil conspiracy, and assault and battery. The Insureds submitted affidavits that they did not participate in the altercation and never left the boat, and cited the police report which did not implicate them. The insurer moved for summary judgment based upon exclusions, claiming that the events were not an "occurrence" because they were the results of intentional acts.

Held: The term "occurrence" was defined by the policies as "an accident," without further definition; however, the term "accident" has been interpreted by Connecticut courts to encompass "unintended, unexpected, or unplanned events," so as not to cover intentional torts or other intended actions. The court found that the mere packaging of an underlying count as negligence was insufficient to trigger insurance coverage where it was based upon facts that clearly implicate intentional acts. The court held that the proffered affidavit and police report were insufficient to create an obligation to provide a defense. While an insurer must provide a defense based upon any facts known to the insurer that would imply such coverage, the court held that the insurer had met its burden of proving no issue of material fact, and that the self-serving affidavit and ambiguous police report merely created "metaphysical doubt" insufficient to require a duty to defend. Summary judgment was awarded to the insurer.

Viens v. Am. Empire Surplus Lines Ins. Co., 113 F. Supp. 3d 555, 2015 U.S. Dist. LEXIS 81051 (D. Conn. Jun. 23, 2015) (Arterton, J.)

Facts: Insureds were landlords who rent apartments to tenants receiving Section 8 assistance. Their insurer canceled their existing policies and/or demanded increased premiums because of the risks associated with subsidized housing. The insureds were forced to acquire replacement insurance that was less favorable and more expensive. The insureds and the Connecticut Fair Housing Center brought a lawsuit seeking certification of a class action on behalf of all similarly situated landlords who are prohibited from refusing to rent to tenants under Connecticut law. The plaintiffs claimed

that the insurer's underwriting criteria violated the Fair Housing Act (FHA) and its Connecticut corollary (CFHA), and that it was discriminatory, both on the basis of a lawful source of income as well as on the basis of race and national origin as African-American and Latino households were 12 times more likely to participate in the Section 8 program. The insurer moved to dismiss the complaint.

Held: The Court denied the motion to dismiss, holding that parties need not face direct discrimination in order to have standing or a cognizable claim, where they sustain injuries that are causally related to discrimination against protected class members. Discrimination under the CFHA included: (1) the coercion, intimidation, threating, or interference with any person in the exercise or enjoyment of rights under the act, and (2) publication of a statement indicating a preference, limitation or discrimination based on lawful source of income. The court found sufficient allegations of interference by threatening cancellation of the policy and publication by providing a cancellation with a handwritten note stating that subsidized housing does not meet the underwriting guidelines. The court also inferred harm to tenants because the increased premiums made landlords less likely to participate in the program. The court found that the FHA and CFHA apply to post-acquisition claims, that property insurance was found to be within the definition of residential real estate-related transaction under Conn. Gen. Stat. § 46a-64c(a)(7), and that the McCarran-Ferguson Act did not "reverse preempt" the plaintiffs' disparate impact claims under the FHA and CFHA, as Connecticut's protections were similar "albeit broader."

Essex Ins. Co. v. William Kramer & Assocs., LLC, 2015 U.S. Dist. LEXIS 87096 (D. Conn. July 6, 2015) (Shea, J.)

Facts: This matter stemmed from property damage that occurred in Broward County, Florida caused by Hurricane Wilma in 2005. Essex Insurance Co. paid the property claim, and in this suit alleged that the defendant, an independent insurance adjuster it had hired to determine the property loss, negligently caused Essex's failure to include a property's mortgagee on the insurance claim payment. Essex had previously settled a lawsuit brought by the mortgagee resulting from that failure, and it sought to recover its losses claiming that it was forced to settle because of the adjuster's negligence. Essex sought summary judgment.

Held: The court denied the motion, citing various issues of material fact. Notably, the court found that the adjuster's admitted possession of a document listing the mortgagee was not sufficient to prove notice where one of the insurer's employees claimed to not have seen it in the relevant time period. The court also held that the insurer had not proven causation, as it could not prove dispositively that it would have made the payment to the mortgagee even assuming notice. The court based this finding on deposition testimony that policyholders were usually asked how to proceed with regard to issuing payments to endorsed mortgagees. The court also credited testimony that the insurer had included a hold-harmless and indemnity agreement with the insured. The insurer also failed to show in the first instance that it was required to pay the underlying settlement.

Harleysville Worcester Ins. Co. v. Paramount Concrete, 2015 U.S. Dist. LEXIS 104869 (D. Conn. Aug. 7, 2015) (Underhill, J.)

Facts: The plaintiff CGL insurer insured defendant Paramount Concrete, a manufacturer and supplier of "shotcrete," a concrete product it supplied largely in the building of swimming pools. The Insurer sought a declaratory judgment stating that it had no duty to indemnify Paramount in a lawsuit brought by a Paramount customer, R.I. Pools, after the insured's defectively manufactured "shotcrete" caused significant cracks to develop in 19 pools. The court had previously concluded that coverage existed, but was presented at a bench trial with the question of whether the policy's exclusion of "expected or intended" property damage applied, notwithstanding a jury's prior determination that Paramount had acted recklessly.

Held: The court held in favor of the insured, Paramount, that the exclusion did not bar coverage for the claims against it arising out of its defective product. Noting that the applicability of the exclusion turned on the subjective expectations of the insured, the court considered whether and to what extent the probability of harm bears on the application of the exclusion, i.e.: Did Paramount's conduct show that it expected its product to cause harm? The court noted two Connecticut Superior Court decisions that defined expect or intend to mean that the insured "knows or should know that there was a substantial probability of damage from its acts or omissions." This standard was inconsistent with the purely subjective standard espoused in *Vermont Mutual Insurance Co. v. Walukiewicz*, 209 Conn. 582, 597-98, n.18 (2009). The court concluded that, regardless of the divergent standards, at the very

least, a party must have actually known about the substantial probability of harm for the exclusion to apply, and that reasonable foreseeability of harm is not enough. Finding no such knowledge, the court granted judgment that the insurer was obligated to provide indemnification.

Allstate Ins. Co. v. Neleber, 2015 U.S. Dist. LEXIS 122563 (D. Conn. Sept. 15, 2015) (Squatrito, J.)

Facts: Allstate sought a declaratory judgment that it had no duty to defend or indemnify its insured in connection with a civil action as the incident in question was not an "occurrence" because it was not accidental, or alternatively that the occurrence fell within "intentional or criminal acts" exclusion in the policy. The insured allegedly struck an individual about the face and head leading to a fractured jaw, broken and missing teeth, difficulty eating and sleeping, and psychological pain and suffering. The underlying complaint included one count for assault and battery and one count for negligence, which alleged that the insured negligently caused physical contact, *e.g.,* by swinging his arms when he was unaware of the presence of others.

Held: Allstate's motion for summary judgment was denied as the facts alleged in the underlying complaint might constitute an "occurrence" and Allstate failed to demonstrate that the "intentional or criminal acts" exclusion applies. Although the same conduct could not be both intentional and negligent, the underlying complaint sufficiently alleged a count for negligence. Thus, the liability could stem from an accident and qualify as "occurrence." Similarly, the exclusion for "intentional or criminal acts" could be inapplicable where negligence was a proposed source of liability. Although both counts relied upon a recitation of the same facts, those facts were not sufficiently clear to determine that the only potential source of liability was for an intentional versus negligent act, and therefore both claims were viable, triggering the duty to defend. The court *sua sponte* granted summary judgment to the *pro se* insured, requiring Allstate to continue to provide a legal defense in the underlying matter. (Contrast **Allstate v. Tandon**, above)

Principal Nat'l Life Ins. Co. v. Coassin, 2015 U.S. Dist. LEXIS 128840 (D. Conn. Sept. 25, 2015) (Arterton, J.)

In an action for rescission of a life insurance policy, the court denied the insurer's motion for summary judgment, finding a question of fact as to whether insurer would have provided life insurance to an individual with treatment for vertigo. While the insured was found to have knowingly misrepresented the status of his ongoing treatment, there was a question as to whether the misrepresentation was material. Where the court was confronted with Connecticut appellate authority from 1952 that would suggest that misrepresentations in an insurance application are "conclusively material," the court relied upon Second Circuit precedent that "Connecticut case law strongly suggests that an answer to a question on an insurance application is *presumptively* material." The court concluded that it was bound to follow Second Circuit precedent in the absence of an intervening state decision. Nonetheless, based on expert testimony presented by the insured's estate, the court held that an issue of material fact existed as to whether the insurer would have issued a policy. Medical records at the relevant time would have indicated benign vertigo, for which insurer's policies did not require a change in premiums, despite the fact that the insured was later found to face malignant brain cancer that resulted in his death six months later. Summary judgment was granted as to the decedent knowingly misrepresenting information on his life insurance application, amendment and supplement, but denied as to the question of whether the misrepresentation was material.

Alqamus v. Pac. Specialty Ins. Co., 2015 U.S. Dist. LEXIS 131646, *2 (D. Conn. Sept. 29, 2015) (Bolden, J.)

Facts: Plaintiffs, who were spouses whose property was damaged in a fire, alleged CUTPA/CUIPA violations and statutory theft against their homeowner's insurer, alleging that the insurer refused to negotiate or adjust the claim for over a year, and then denied coverage. The insurer asserted that the claim was under investigation at the time.

Held: The court dismissed the claims. Mere allegations of a failure to comply with Connecticut statutory provisions, without discussion of the "clauses, terms, and conditions of the policy" were nothing more than "naked assertions devoid of further factual enhancement," insufficient under Iqbal.

The court also held that a claim for statutory theft required identifiable money to which a plaintiff has a right of possession, and that where a "case concerns a debt allegedly owed under a contract . . . a statutory theft claim cannot lie." The CUTPA/CUIPA allegation was too vague and conclusory, and failed to indicate with specificity the alleged general business practice.

Metsack v. Liberty Mut. Fire Ins. Co., 2015 U.S. Dist. LEXIS 131984 (D. Conn. Sept. 30, 2015) (Bryant, J.)

Facts: Insureds alleged breach of contract, breach of the implied covenant of good faith and fair dealing, and CUIPA/CUTPA violations as a result of the insurer's decision to decline coverage for damage to the basement walls of the insureds' home under a homeowner's insurance policy. In its declination, the insurer stated there was no coverage for "settling/earth movement or seepage of ground water." The policy covered "direct physical loss to covered property involving collapse of a building caused by own or more of the following . . . (b) Hidden decay . . . or (f) Use of defective material or methods in construction, remodeling or renovation." The insurer moved to dismiss based on the policy's exclusion for damage to any "foundation," "retaining wall," or "footings" claiming that the basement walls of the property were a "foundation" or "retaining wall" under the exclusion. The insureds defined "foundation" as the "footings" of a structure, while the insurer defined it as "a usually stone or concrete structure that supports a building from underneath . . . an underlying base or support . . . the whole masonry substructure of a building." The insureds argued that the terms were ambiguous and must be construed to favor coverage. In the CUTPA/CUIPA claim, the insureds alleged a business practice by citing other "concrete decay" lawsuits as well as the insurer's participation in the Insurance Services Office, Inc. ("ISO") organization with other insurance companies to collect and share information regarding claims. The insureds alleged an industrywide practice of denying "concrete decay" claims.

Held: The court found the separate usage of "footings" and "foundation" was not dispositive, because a house may or may not have a separate "footing" and "foundation." Both "foundation" and "retaining wall" were found to be ambiguous. The court also held that since the term "foundation" was placed in the exclusion with other terms referring to ancillary structures, that a trier of fact could employ the principle of *noscitur a sociis*, as "the meaning of particular words may be indicated or controlled by associated words." In

declining dismissal of the bad faith claim, the court observed that allegations that the insurer denied the claim without investigation and misled the insureds claiming a lack of coverage based on inapplicable policy language was sufficient. Discussing the reliance on the insurer's ISO participation, the court intimated that it was insufficient to sustain a CUTPA/CUIPA claim, noting that "the ISO allegation strikes this Court as failing to cross the line between possible and plausible." The count was not dismissed, however, as the insureds pled other "substantially related claims" to support a plausible allegation of a general business practice.

See also Gabriel v. Liberty Mut. Fire Ins. Co., 2015 U.S. Dist. LEXIS 129952 (D. Conn. Sept. 28, 2015) (Bolden, J.) (declining insurer's request to certify whether the terms "foundation" and "retaining wall" are ambiguous); **Roberge v. Amica Mut. Ins. Co., 2015 U.S. Dist. LEXIS 172424 (D. Conn. Dec. 29, 2015) (Eginton, J.)** (holding, where the insurer argued that the court misapplied the "last antecedent rule" (a contractual interpretation rule whereby "a limiting clause or phrase ... should ordinarily be read as modifying only the noun or phrase that it immediately follows") in *Metsack*, that it was a useful rule that could still be overcome, although the court did acknowledge that the rule might be a "strong argument" at the summary judgment stage).

Kim v. State Farm Fire & Cas. Co., 2015 U.S. Dist. LEXIS 147823 (D. Conn. Oct. 30, 2015) (Bryant, J.)

Facts: Insureds alleged breach of contract, breach of the implied covenant of good faith and fair dealing, and CUTPA/CUIPA violations. The insureds sought coverage for "pattern cracking" in their basement walls' concrete which would irreversibly lead to the home's collapse. Their insurer denied coverage on various grounds, citing exclusions for "settling, cracking, bulging or expansion of the foundation and/or walls," "wear and tear, latent defect or breakdown, and settling and resultant cracking," that the losses were caused by deterioration, that the damage claim accrued prior to the inception of coverage, that the plaintiffs failed to give immediate notice, and the failure to start the action within one year after the date of loss or damage. The insurer moved to dismiss the claims for breach of the implied duty of good faith and fair dealing and CUTPA/CUIPA violations.

Held: The court dismissed the insureds' bad faith claim because it was premised on the denial letter from their insurer, which quoted appropriate provisions, explained why they were applicable, and was not misleading. Disagreement over whether provisions bar coverage do not "evince bad faith" sufficient to support a claim for breach of the implied duty of good faith and fair dealing. The court also dismissed the CUIPA/CUTPA claims because the insureds failed to point to specific instances of the alleged business practice. The court distinguished two state court cases: *Active Ventilation Prods., Inc. v. Prop. & Cas. Ins. Co. of Hartford*, 2009 Conn. Super. LEXIS 1967 (Conn. Super. Ct. Jul. 15, 2009) (distinguishable because plaintiff alleged submitting *multiple claims*, and *Jones v. Standard Fire Ins. Co.*, 2013 Conn. Super. LEXIS 94 (Conn. Super. Ct. Jan. 11, 2013) (distinguishable because it applied the Connecticut pleading standard). The court noted that federal courts, pursuant to *Bell Atl. Corp. v. Twombly*, 550 U.S. 544 (2007), require "more than the bare conclusory allegations accepted by the state court," despite the fact that Connecticut is nominally a fact-pleading state.

Thurston Foods, Inc. v. Wausau Bus. Ins. Co., 2015 U.S. Dist. LEXIS 146660 (D. Conn. Oct. 28, 2015) (Eginton, J.)

Facts: The insured sued for breach of contract, bad faith, and CUTPA/CUIPA violations after the denial of coverage under a commercial insurance policy for damage to property when ice and snow melted on and leaked into the insured's building, then blocked freezer air vent pipes causing the freezer floor to heave and damage various parts of the building and property. The insured alleged bad faith in the adjustment, negotiation, and communications regarding the loss. The insurer moved to dismiss the CUTPA/CUIPA allegations for failure to allege a general business practice of unfair claims handling. The insured alleged that the insurer was a subsidiary of Liberty Mutual, and cited five lawsuits against Liberty Mutual subsidiaries for failure to properly handle claims.

Held: The court denied the insurer's motion to dismiss, holding that the plaintiff had raised an inference of a general practice of unfair claims settlement, even though none of the cited claims were for the same type of policy. The plaintiff relied upon homeowner as opposed to commercial policies, but the court found "at least an inference" of a general practice of unfair claims settlement. The court did volunteer that "summary judgment is

a better vehicle for the determination of whether claims at-issue in the cited cases are relevant to plaintiff's proof of business practices."

Danielsen v. USAA Cas. Ins. Co., 2015 U.S. Dist. LEXIS 158387 (D. Conn. Nov. 24, 2015) (Bolden, J.)

Facts: The insured sought benefits under a homeowner's policy for water damage caused to his property by a malfunctioning dishwasher. The insured claimed an independent insurance adjuster negligently prepared an estimate of damage as it contained errors and failed to account for his personal property, thus depriving him of the benefits he was due under the policy. The insured also brought several counts against the insurer, including breach of contract, bad faith, and CUTPA/CUIPA violations.

Held: The court dismissed the insured's negligence claim against the independent adjuster as it owed no independent duty to the plaintiff. While there was no appellate authority in Connecticut, the court declined to certify the question in light of a number of Connecticut Superior Court decisions holding the same. The court cited three rationales for its decision: 1) the relationship between the adjuster and the insured was sufficiently attenuated and the adjuster's duty to the insurer could be thrown into an "irreconcilable conflict" if an adjuster had a separate duty to the insured, 2) the insured could still bring a bad faith claim against its insurer where the adjuster's actions were imputed to the insurer, and 3) public policy weighed against such a cause of action. There was no additional analysis as to how a bad faith claim might be couched against the insurer on the basis of the adjuster's allegedly "negligent" actions.

Roberts v. Amica Mut. Ins. Co., 2015 U.S. Dist. LEXIS 158266 (D. Conn. Nov. 24, 2015) (Underhill, J.)

Facts: Insurer argued that the complaint should be dismissed because the insureds failed to comply with the insurance policy's "Suits Against Us" provision, which required any action against the insurer to be "started within two years after the date of loss." The parties agreed that the "date of loss" occurred sometime in late October or early November 2012, the insureds filed the complaint on October 27, 2014, and they served the insurer on February 20, 2015. The question before the court was whether the filing of

the action in federal court "started" the action or instead whether the service of process on the insurer did so. If the action "started" at the time of service, the parties agreed that the action was time-barred.

Held: The court dismissed the action, applying Connecticut state law to define the commencement of a suit as the date of service of the complaint. The court thus denied the insureds' argument that the court must look to Rule 3 of the Federal Rule of Civil Procedure to determine when the action was "started," i.e., by the filing date in federal court. The insureds therefore failed to "start" their action in the required period. The insured's interpretation of the "Suits Against Us" provision was unreasonable because it was undisputed that the action was a state law action governed by state substantive law, and, had the action been brought in state court, it would have been subject to dismissal. Therefore, the court dismissed the suit as untimely in light of the policy's suit limitation provision.

Zurich Am. Ins. Co. v. Expedient Title, Inc., 2015 U.S. Dist. LEXIS 167998 (D. Conn. Dec. 16, 2015) (Shea, J.)

Facts: Insurer sued for rescission and a determination that the insured failed comply with the policy's "claims made and reported" provision. The insured, a title insurer, had been sued in an underlying matter after it failed to file any of the closing documents for purchased property, which was then re-sold. In the course of filing a renewal application for a liability insurance policy, Expedient denied that any of its officers was the subject of a governmental investigation, despite knowing that one of its officers was being investigated by a grievance committee in the New York state court system. Expedient argued that it misinterpreted the question to only ask about investigations pertaining to its business as a title insurance company. Additionally, the policy's "claims made and reported" provision required notice of claims to be provided during the subject policy period including "any basis to believe that any Insured has breached a professional duty or to foresee that any such act or omission might reasonable be expected to be the basis of a Claim." Expedient received letters in December 2007 and January 2008 regarding the potential claim, during its May 27, 2007 to May 27, 2008 policy period, but it failed to provide notice until it was served with a complaint in October 2008.

Held: The answer "no" to the question "[h]as the Applicant or any prospective Insured been involved in or have knowledge of any inquiry, investigation, complaint or notice from any State or Federal Authority regarding the activities, procedures, or practices of the Applicant or any proposed Insured in the past (1) year" was material and knowingly false when made. Accordingly, the policy was *void ab initio* and subject to rescission. The court rejected attempts to limit the inquiry to investigations related to the title insurance business. It was no defense that the insured misinterpreted the question. Answers on insurance applications are presumptively material, especially where the application becomes the basis of coverage. The affidavit of an underwriter was also sufficient to establish materiality. The court also held that Expedient learned of the claim in question during the policy period prior to when it reported the claim, when the claimant's letter was presented demanding compensation. Such a letter was determined to constitute a "claim" as it contained a request for damages. Even assuming that it was not a "claim," it was at least notice of a *potential* claim. Because Expedient was required to alert its insurer of claims and "potential" claims under the previous policy, no coverage existed.

Mercedes Zee Corp., LLC v. Seneca Ins. Co., 2015 U.S. Dist. LEXIS 171253 (D. Conn. Dec. 22, 2015) (Meyer, J.)

Facts: A commercial building owner sought payment for losses for damage to its building, including property damage and stolen copper wire. The policy in question covered "vandalism" but excluded "theft." The building owner sought recovery for damages to property, but not the stolen items. The insurer sought to disclaim coverage for all damages that were "theft-related," which it proposed were essentially all of plaintiff's damages. Both parties moved for summary judgment.

Held: (1) The policy required consideration of the intent and purpose of the wrongdoer to determine the scope of coverage because "vandalism" described "willful and malicious damage," and "theft," by its common law definition, connoted an "improper intent or purpose to deprive another of property." Although both parties agreed that the damage was caused intentionally, the *initial* intent of the tortfeasor was not dispositive. The court acknowledged that such an analysis could have been avoided had the policy created "an exception for damage caused by any person who entered the building with an intent to steal property" but that was not the language of the

subject policy. Under the actual policy, even if the initial intent to enter the building was theft, subsequent decisions to vandalize the property would be covered. The court therefore required an “item-by-item consideration of the property” to determine whether the damage caused was a result of intended theft or vandalism. (2) The theft exception under the policy was broader than a mere exclusion for stolen property, but extended to damage “caused by or resulting from theft” as described within the policy, such that loss or damage to building components that were “necessary to and in furtherance of accomplishing a theft of property” would be excluded from coverage. (3) *Attempted* theft would still be covered as an act of vandalism, because the definition of vandalism merely required “willful and malicious” purpose for the destruction of property, and that only “theft” was excluded, as opposed to “attempted theft.” Therefore, where a vandal destroyed a wall to *actually* remove wiring there would be no coverage, but where the vandal destroyed a wall to remove wiring but then found no such wiring present, the loss would presumably be covered.