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Insurance Observer

LOST & FOUND: DISPUTED COVERAGE IN MISSING POLICIES - PART I

by Marcus B. Snowden

We have received a few client inquiries over the last little while concerning document retention protocols and, in particular, what to do with legacy policy wordings or policyholder information. The answer is initially unsatisfying. It depends on at least three variables: (1) the type of policy; (2) the type of archiving anticipated; and (3) the purpose. This article will deal briefly with the first and second variables. We will then consider some recent case law which may inform readers on the third variable. In the result, we hope you will learn a little about why document retention issues need careful consideration.

The Type of Policy:

Document retention protocols for an insurer will depend first on the type of policy at issue. In the first party setting, policies will usually expire at the end of the term. Absent a loss event triggering coverage, the wording is no longer alive from a claims or coverage perspective. However, keep in mind that, depending on the type of policy and the type of loss, there may be a statutory or contractual limitation period that must be taken into account. In Ontario and other jurisdictions with recent changes to statutory limitation periods, the importance of this issue cannot be underestimated.

On the liability side, some in the industry hold the view that a "claims made" form can be destroyed upon expiry. A true "claims made and reported" policy is typically issued for professional, executive or institutional (E&O or D&O) liability or more rarely for general liability (GL) risks. Such a policy will "expire" by its terms – the key being "by its terms". In most claims–made programs, there is a clause allowing extension of coverage beyond the end of the term, where a "notice of circumstances" or "notice of occurrence" is given to the insurer during the current term. Such a notice serves to lock in coverage for any subsequent claim arising out of the circumstances or occurrence which is presented after the policy term, provided the policyholder promptly notifies the insurer and complies with all other terms and conditions of the policy. Of course, if the insurer disposes of the policy in the interim, the claims handler will have a more difficult time establishing whether notice was given timely and whether the policyholder has complied with the terms.

In the absence of such a notice, the form can be safely disposed of, at least from a claims perspective. However, there are at least three qualifications here:

(1) you must examine the wording to see if there is a notice of circumstances or occurrence clause that extends the life of the policy where notice is given during the term - if there is no such wording, then the coverage truly has "expired";

(2) you must be sure the policyholder has not purchased an extended reporting option; and

(3) underwriters may have different reasons for wishing to retain historic information that a claims person would not necessarily be aware of – so consider and include underwriting and statistical implications of any document destruction protocols.

For those readers who still believe that an "occurrence" liability form can be safely disposed of, the answer is rarely certain. An occurrence-based liability form covers the incident or loss event, rather than the time when the claim is

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presented. In circumstances where there is, for example, undiscovered progressive damage that can be traced back to a particular point in time, the "occurrence" or "accident" may be construed by the court as happening over several policy periods. Of course, if the insurer elects to dispose of policy forms without keeping an archive of some kind, there is a chance that a claim may come at some future time which is traced back to the insurer's time on risk.

The Type of Archiving:

If the approach is to simply digitize all documents, the decision seems fairly apparent. If there are sufficient resources and if concerns over the durability of digital archives have been suitably addressed, absent other issues, the insurer or policyholder should simply proceed. We hasten to add that this is unlikely to be affordable, manageable or desirable for all insurance carriers. Certainly commercial policyholders should have little difficulty since there is only a relatively small group of documents which will be stored. On the broker and insurer side, it is a method suitable to those underwriting in niche markets where the number of documents to be converted is relatively manageable.

In the normal course of business for the majority of insurers, however, a more selective approach is desirable. Likewise for the general brokerage firm, a refined approach is recommended. This includes, as noted above, sorting between forms that need to be saved as compared with those that can be safely discarded. At a minimum, a declaration page evidencing the type(s) of coverage purchased should be scanned for each policyholder in each policy year.

Where the scope of business is confined to standard lines where company forms are issued with little or no revision, provided the forms are identified on the declarations page(s), archiving the forms book from underwriting, inclusive of all approved endorsement wordings should be sufficient. The approach becomes more problematic where there is any degree of customization, manuscript wording or "one off" endorsements. Here, some care is required to ensure that what some might consider "standard" for the company is not stored as a representative "sample" when in fact it deviates markedly from the company's usual form.

In the end, no one approach to document retention protocol or archiving methodology will be satisfactory to all insurance industry participants. Those who have been involved in archival (some would say archeological) research to find the lost wording will understand that practices have varied widely from time to time and from company to company.

So What's The Impact of Lost Wording?

One might be tempted to assert that, in the absence of the policy wording, the policyholder has no case for coverage. This, however, is a dangerous assumption for both insurers and policyholders alike. As a review of some recent Ontario cases demonstrates, there is risk in maintaining an arbitrary or haphazard document archiving system. ■

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Part 2 of "Lost & Found" will appear in our next issue.

WHO IS AN INSURED? AN UPDATE

by W. Colin Empke

The question of "who is an insured" has recently been addressed by the British Columbia Court of Appeal in *Kingsway General Insurance Company v. Lougheed Enterprises Ltd.*[1] What follows is an expanded discussion of the case.

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In 1983, three British Columbia corporations entered into a formal partnership. The purpose was to develop and lease a condominium building. The partnership was known as the Blundell Place Partnership. Blundell Place was built and ownership of it ultimately passed into the hands of the unit owners by way of the condominium corporation. The members of the building partnership went their separate ways and some of the original entities changed their names or ceased operating.

On October 9, 2000, a fire broke out on the ground floor of the condominium and caused extensive damage. The condominium owners started an action against the original partnership together with each of its constituent members alleging a wide variety of negligent and inadequate construction practices. In 1997, one of the partners, Lougheed Enterprises Ltd., had purchased a commercial general liability policy from Kingsway General Insurance Company, which policy was renewed through to July, 2001. Predictably, Lougheed turned to Kingsway in an effort to secure insurance coverage for the claims. Kingsway took the position that Lougheed, in its capacity as a member of the builders' partnership, did not fall within the scope of "who is an insured." Kingsway denied and that denial was ultimately supported by the British Columbia Court of Appeal.

A proper coverage analysis must begin with a review of the Declarations. The Declarations and the related definitions will determine who is an insured. If a person or entity is not insured by a policy the coverage analysis ends. Only when a person is found to be an insured does the analysis continue to an evaluation of the insuring agreements, exclusions, exceptions, conditions and endorsements.[2]

The Kingsway policy declarations referred to one company - Lougheed, which was identified as the Named Insured. Unnamed insureds were identified in the definitions section of the policy, which included the following language:

> The unqualified word "Insured" includes the Named Insured and also includes:
>
> (a) any partner, officer, director, employee or shareholder with respect to acts performed on behalf of the Named Insured in that capacity.
>
> (c) co-owners, joint ventures [sic] or partners having a non-operating interest with the Named Insured in the operations insured hereunder.
>
> (e) any organization you newly acquire or form other than a partnership or joint venture, and over which you maintain ownership or majority interest will be deemed an Insured.
>
> No person or organization is an Insured with respect to the conduct of any current or past partnership or joint venture that is not shown as a Named Insured in the Declarations.

Certain people or entities acquire coverage under this definition by virtue of their relationship to the Named Insured. A superficial review of this definition makes it clear, however, that partnerships and joint ventures were intended to receive special consideration. They are singled out and afforded specific attention. In particular, the last sentence removes from coverage any activities related to the conduct of a partnership that has not been declared to the insurer. It is this special consideration of partnerships that was the foundation of Kingway's denial in this case.

It is self-evident that the activities of a partnership create unique risks about which an insurer is likely to desire notification. At the trial of this coverage issue, Kingsway did not lead any evidence that the existence of the builders' part-

nership was a material fact that increased the risk assumed by the insurer. Nevertheless, the Court of Appeal accepted that the very nature of a partnership increases the risks associated with insuring one of the partners. This increased risk is derived from the joint liabilities imposed on partners for the acts of the other partners. The Court of Appeal indicated that it was prepared to accept that the existence of a partnership that was undisclosed to an insurer was a material increase in risk that could be assumed as a matter of law.

The policy of insurance stated that no person is insured by the policy "with respect to the conduct of any current or past partnership" if that partnership is not identified. In this case, Lougheed did not disclose the existence of the builders' partnership. Blundell Place Partnership was not identified in the Declarations.

The insured attempted to raise the spectre of an ambiguity by suggesting that the last phrase of the "who in an insured" section appeared to remove all insurance coverage of the Named Insured if it was involved in any kind of undisclosed partnership. The Court of Appeal rejected this by pointing out that the words "with respect to the conduct of" limited the impact of the definition by removing from coverage only those activities of the Named Insured that related to the undisclosed partnership. All other activities by the Named Insured remained within coverage. This interpretation has the advantage of conforming with the intentions of the parties. An insurer undertakes to provide coverage for the operations of its customer, provided that those operations are properly disclosed.

The Court of Appeal speculated that the language relating to undisclosed partnerships might have been better located in the exclusions section of the policy. While some other policies have done exactly this,[3] it is submitted that this is not necessary. As indicated, the starting place for any coverage analysis is to determine who is insured by the policy. Since that analysis must examine the Declarations and the associated definitions, as a matter of interpretation it is appropriate to place all limitations of who is an insured within those sections of the policy.

It is worth noting that the interpretation applied by the British Columbia Court of Appeal has been accepted by courts in the United States.[4]

Partnerships and joint ventures create specific underwriting concerns and introduce unique risks to the insurance contract. Insurers have recognized this risk and created definitions of "who is an insured" to address it. The wording of those definitions is clear and unambiguous and should be given full effect. The British Columbia Court of Appeal agrees. ■

1 [2004] BCCA 421, 132 A.C.W.S. (3d) 1171 (C.A.). The authors note this case also refers to U.S. jurisprudence on the issue which may also assist readers in any particular analysis.

2 Chapter 2 of the Annotated Commercial General Liability Policy provides a comprehensive discussion of the rules of construction applicable to the interpretation of an insurance policy.

3 See *Potts v. Kansa General Insurance Co.* [1987] I.L.R. 1-2256 (Ont. H.C.) where the policy contained an exclusion for claims arising from a joint venture that was not disclosed in the Declarations.

4 See *Bott v. Shea Inc.* 299 F. 3d 508 (5th Cir., 2002) and *Hardeman v. Commonwealth Lloyd's Insurance Company* 1999 Tex. App. LEXIS 151 (Court of Appeals of Texas, 1999), both of which reached similar conclusions involving very similar policy language.

Insurance Observer is a publication of the Insurance Law Group of Blaney McMurtry LLP. The information contained in this newsletter is intended to provide information and comment, in a general fashion, about recent cases and related practice points of interest. The information and views expressed are not intended to provide legal advice. For specific legal advice, please contact us.
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