

Perspectives on Insurance Recovery



Welcome to our latest Insurance Recovery newsletter. Two stories in this issue focus on the post-Sandy insurance landscape, forever altered in the wake of last year’s superstorm. Our lead story addresses readiness for future major weather events, and another article discusses the use of bad faith claims to obtain consequential damages from insurers who don’t fulfill their post-disaster responsibilities.

We also examine the evolving regulatory environment in the area of lender-placed insurance, as well as court decisions on coverage issues in three states. And we look for the devil in the details of new revisions to the standard additional-insured forms most carriers use.

Peter Gillon and Robert Wallan
Co-leaders, Insurance Recovery & Advisory

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Hurricane Season Is Here—Is Your Insurance Program Ready for the Next Storm?

by Joseph D. Jean and James P. Bobotek



Superstorm Sandy ripped across the East Coast, causing unprecedented damage to coastal and inland areas lying in its path. Making landfall near Atlantic City, N.J., the storm wreaked havoc from North Carolina to Connecticut, and as far inland as the Great Lakes. Sandy also caused tidal surges that inundated Lower Manhattan and flooded New York’s airports, knocked out critical infrastructure including power, rail, and subway systems, and destroyed tens of thousands of homes. The storm caused at least \$50 billion in physical damage, while tens of thousands of businesses that suffered little or no physical damage nonetheless experienced catastrophic business interruption losses.

As is the case after any natural catastrophe, businesses affected by Superstorm Sandy promptly turned to their insurance carriers for help. Many insurance policyholders were taken aback by the significant obstacles insurers placed before them in responding to their property and business interruption insurance claims. Sandy was a wake-up call for policyholders in the Northeast, many of whom previously had perceived the risks associated with hurricane, flood, and storm surge damage as inconsequential. Given that the National Oceanic and Atmospheric Association and other organizations have predicted “extreme activity in the Atlantic” this hurricane season, with “more and stronger hurricanes” expected, there is no better time to review your property insurance coverage. The discussion below provides an overview of some insurance coverage-related issues facing commercial policyholders after a catastrophic storm.

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Hurricane Season Is Here— Is Your Insurance Program Ready for the Next Storm?

(continued from cover)

Review Sub-limits and Deductibles for “Named Storm” and “Flood” Coverage

Commercial policyholders should be aware of the distinction between coverage for “Flood” perils and “Named Storm” perils. This post-Sandy issue arises out of property insurers’ attempts in recent years to limit their exposure to flood risks in Northeast coastal areas by reducing policy sub-limits and increasing deductibles. While many insurers restricted coverage for “Flood” perils in this fashion, in many cases they did not include similar limitations for “Named Storm” perils. Many policies categorize certain counties in New York, Connecticut, and New Jersey as high-risk flood zones, but low-risk areas for Named Storm perils.

The assumption was that the likelihood of a “Named Storm” walloping the tri-state area was remote (despite a close call in 2011 from Hurricane Irene)—particularly in comparison to the likelihood of a “Flood” event. Yet, as Sandy hit businesses with a double-whammy of hurricane force winds and resulting flooding, many insurers asserted applicability of the lower sub-limits and higher deductibles tied to Flood perils, instead of the more policyholder-friendly “Named Storm” sub-limits and deductibles. This has led to a significant number of disputes and, in cases in which policyholders are not aware of this distinction, loss of potentially significant coverage.

Beware of Concurrent Causation Language for Losses Involving Both Covered and Non-Covered Perils

Superstorm Sandy has compelled policyholders and insurers alike to scrutinize policy language and case law for guidance on the extent to which a loss is covered when caused concurrently or sequentially by perils that are covered (such as “Named Storm,” fire, or wind-driven rain) and

also by perils that are expressly excluded or sub-limited (such as flood or pollution). Whether coverage exists for a loss in such a situation varies from jurisdiction to jurisdiction because courts have not yet developed a uniform approach in determining whether or not coverage is available in these situations. Some courts apply the broad doctrine of “concurrent causation,” whereby coverage will be available if any one of the multiple causes of loss is a covered peril. Other courts apply the “efficient proximate cause” theory, whereby the fact finder looks at the circumstances of the loss to determine which cause was the dominant or efficient cause (which may or may not be the initiating event in the chain of events). The analysis of causation in each case requires a careful and searching inquiry into the circumstances of the loss, and is highly fact-specific.

The causation analysis may also depend on whether a policy includes “Anti-Concurrent Causation” (ACC) wording. Insurance companies have attempted to eliminate the need for courts to search for the efficient proximate cause, or even to consider multiple causes, by incorporating ACC clauses into certain exclusions in property policies. These clauses attempt to preclude any claim that involves the particular excluded peril, even if it is only one of multiple causes of the loss. Such clauses were challenged following Hurricane Katrina and other recent catastrophes. Because some courts have upheld their application, some states have recently introduced legislation to prohibit them or, at a minimum, to provide an express warning in the policy of their inclusion.

Identify Challenges of Proving Contingent Business Interruption Loss

Although many companies have experienced loss due to “Contingent Business Interruption” (CBI)—that is, the adverse economic impact on the insured resulting from damage to the property of its customers and suppliers – proving CBI loss can present significant challenges. Policies usually offer little guidance on the proof required to establish that a loss of business is attributable to the impact of a covered peril on a policyholder’s customers

or suppliers. For example, with Sandy, retailers in Lower Manhattan suffered major losses because their customers were impacted; however, as a condition to payment under CBI provisions, many insurers required these policyholders to prove exactly which customers were affected by the storm—a burden that is challenging to meet, and, in the opinion of most experts, highly unreasonable. Requiring policyholders to overcome such evidentiary burdens as a condition to coverage is almost certainly contrary to the reasonable expectations of the commercial insured.

In the best of circumstances, proving losses due to damage to a supplier is difficult for policyholders. The insured typically does not have access to the suppliers’ records, suppliers may fail to document their damages or repairs, and suppliers often have commercial reasons for not disclosing the cause or magnitude of their losses. The same is true of customers. In the case of gasoline station operators, for example, who were unable to secure adequate supplies due to flooding and closure of tank farms and distribution facilities, insurers are requiring proof of damage to facilities of suppliers, who are generally reluctant to disclose information about their operations.

Review Civil Authority, Ingress/ Egress, and Service Interruption Coverage Language

After a catastrophic storm, commercial policyholders may benefit from having Civil Authority, Ingress/Egress and Service Interruption insurance coverage. However, it is important to review these coverages and understand their potential limitations and restrictions.

Civil Authority provisions provide coverage for an insured’s business interruption losses resulting from orders of civil authority, such as evacuation orders, curfews, highway closures, and the like, which prevent or impair access to the insured’s property. However, many Civil Authority coverage provisions contain limitations and restrictions that can make it challenging in establishing when Civil

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Federal Housing Finance Agency Proposes New Rules on Lender-Placed Insurance

by Robert L. Wallan

On March 29, the Federal Housing Finance Agency (FHFA) proposed consideration of new regulation on lender-placed insurance. The FHFA specifically requested public input concerning sales commissions and reinsurance activities, but indicated that it plans a broader review of issues relating to the market for lender-placed insurance. Lender-placed insurance has long raised regulatory and litigation concerns, and the prospect of new FHFA regulation impacting Fannie Mae and Freddie Mac is an issue lenders will want to consider.

What is lender-placed insurance?

In real estate lending transactions, standard loan documents obligate the borrower to maintain hazard insurance on real property improvements. If the borrower fails to maintain adequate insurance on that property, the lender is authorized to “force place” insurance to

protect the interests of the lender on the property securing the loan. In the area of automobile loans, this type of insurance is typically called “collateral protection insurance,” or “CPI.” In connection with loans secured by real property improvements, the terms used are “lender-placed insurance” or “force-placed insurance.” In either case, the lender purchases the insurance and then adds the premium to the balance of the loan, effectively charging the borrower. Often, the lender outsources the administrative effort of tracking which loans have adequate insurance in place. Sometimes lenders arrange to directly or indirectly receive commissions for placing such insurance.

Lender-placed insurance typically covers only the collateral, meaning that the physical structure of a house will be insured, but not its contents. In contrast, typical homeowners insurance will extend protection to both the structure as well as its contents. In addition, privately purchased

homeowners insurance may also extend to provide liability coverage.

When a borrower has no equity in a property, he or she might be less inclined to care for and protect the property. Lender-placed insurance is typically not underwritten on an individual basis, and in general the risk to the property associated with a defaulted borrower is higher than the risk associated with a non-defaulted borrower. The result is that a borrower with lender-placed insurance typically pays more premium dollars for less coverage.

Litigation Exposure. While lenders have a right to protect uninsured collateral, the practice of lender-placed insurance was the subject of numerous class actions in the 1990s, and is again becoming a focus. The main arguments against lender-placed insurance involve commissions, tracking service fees, over-insurance, notice and disclosure issues, backdating, pricing and interest charges, and statutory limitations, among others. In March of this year, Governor Andrew Cuomo of New York announced a \$14 million settlement with Assurant, one of the largest providers of force-placed insurance. Most banks active in the home loan business have faced lender-placed class action lawsuits at some point.

Statutory Limitations. The large majority of states impose some form of regulation on lender-placed insurance. One example in California is Civil Code section 2955.5, which prohibits a lender from requiring insurance that exceeds the replacement cost of the improvements on the property. CPI issues have also been addressed via a Model Act adopted by the National Association of Insurance Commissioners, and adopted in varying forms by many states.

FHFA next steps. The FHFA plans to accept public comment through May 28, and then move forward on appropriate action with respect to sales commissions and reinsurance premiums. More litigation and regulation impacting lenders, borrowers, and insurers on lender-placed insurance seems certain. ■ ■ ■



J.P. Morgan Decision Curtails the Phantom “Restitution Defense” to D&O Coverage

by Peter M. Gillon

In a case closely watched by industry observers, the New York Court of Appeals, in *J.P. Morgan Securities v. Vigilant Insurance Company*, [No. 113 (NY, June 13, 2013)], issued an important ruling in the field of Directors & Officers Liability Insurance, curtailing to some extent insurers’ ability to use a phantom exclusion to deny coverage. Insurers increasingly have argued that their policies do not cover damages that can be characterized as restitutionary in nature, even where the policy may be silent on the issue. The contention is based on two theories: (1) that notwithstanding contract language providing coverage, the policy is unenforceable in

that respect because in some states coverage for damages in the form of restitution (or disgorgement of ill-gotten gains) is unenforceable as a matter of public policy; and (2) from an economic standpoint, when a policyholder returns monies it has obtained improperly, there is no basis for coverage because the policyholder has not incurred any “Loss.”

The New York high court called foul on this encroachment on policyholders’ contractual rights, holding that policyholder Bear Stearns was entitled to pursue its claim to coverage for a \$160 million payment incurred as a result of settlement

of an SEC enforcement proceeding, even though the agreement expressly characterized the payment as “disgorgement.” As the Court made clear, there is no public policy in the State of New York barring coverage for restitution or disgorgement; and the limited public policy exception to the enforceability of contracts for “intentionally harmful conduct” could not be sustained by insurers on the record before the court. [Slip Op. at 9-11]. More important to policyholders, the Court also held that the bulk of the payment characterized in the settlement agreement as “disgorgement” was actually compensation

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PILLSBURY RECENT/ONGOING MATTERS

PROPERTY AND BUSINESS INTERRUPTION INSURANCE

In connection with Superstorm Sandy, representing major NY real estate ownership groups, a major university hospital, a global telecommunications company, an oil distribution company, a national retailer and other companies on property and business interruption claims.

CYBER INSURANCE

Representing major health care, professional services, and medical services companies in prosecuting claims for insurance coverage arising out of data security and privacy breaches, including some of the largest reported claims.

EXECUTIVE AND PROFESSIONAL LIABILITY INSURANCE

Representing an energy company in a D&O coverage dispute in connection with the bankruptcy of a real estate company.

PRODUCTS LIABILITY INSURANCE

Representing a sports company in prosecuting claims for insurance coverage of a wave of national mass tort litigation filed by hundreds of present and former National Football League players and their families, alleging that football helmets manufactured by the insured were defective.

ENVIRONMENTAL INSURANCE

Representing an aerospace company in obtaining nearly \$400 million in insurance settlements for environmental cleanup claims relating to a single site.

CONSTRUCTION INSURANCE

Representing a number of construction and real estate clients in pursuit of insurance recoveries from carriers for Chinese drywall claims.

Bad-Faith Claims

A Tool at the Insured's Disposal in Pursuing Insurance Claims in the Aftermath of Superstorm Sandy

by Geoffrey J. Greeves and Victoria Lynch

New York continues to face significant challenges in recovering from the extensive losses caused by Superstorm Sandy. The storm caused unprecedented damage to coastal areas, tidal surges that inundated Lower Manhattan, severe flood damage to airports, subways, and tunnels, and damage to electrical systems supplying numerous businesses. As New York businesses and property owners attempt to pursue claims under their insurance policies, they should be aware that state law protects them against bad-faith claims handling by insurers. In such circumstances, policyholders may be entitled to recover the consequential damages they have suffered as a result of the insurer's delayed or improperly denied payment.

Loss of customers, interest and penalty payments, and loss of goodwill are just some potentially recoverable damages.

In 2008, New York's highest court adopted a new standard with respect to first-party bad-faith claims. The New York Court of Appeals held that a policyholder may recover consequential damages for an insurer's breach of good faith handling of a first-party property insurance claim. See *Bi-Economy Mkt., Inc. v. Harleysville Ins. Co. of N.Y.*, [10 N.Y.3d 187, 886 N.E.2d 127] (2008). In *Bi-Economy*, a wholesale and retail meat market sought coverage under its deluxe business owners insurance

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Clarification or Increased Confusion?

ISO's 2013 Additional Insured Endorsement Revisions Place Heightened Emphasis on Contractual Risk Transfer Language

by James P. Bobotek

Most commercial contracts, including construction contracts, professional services agreements, leases, and other similar agreements, include risk-allocation mechanisms such as indemnification and insurance requirements clauses. Far too often, these clauses are treated as boilerplate provisions, and are “borrowed” from older contracts without any meaningful review of the language. While inclusion of such arcane, incomplete, or unclear provisions has never been recommended, many parties have nevertheless given little thought to the impact of these clauses. There are many reasons for this—one of the most common being that, particularly with respect to additional insured issues, contracting parties have understood that the language of the applicable insurance policy is what really matters.

The Insurance Services Office’s (“ISO”) recent revisions to most of the standard additional insured endorsement forms have dramatically changed the landscape. These revisions have placed heightened emphasis on parties’ contractual language that, in many cases, will restrict a CGL insurer’s coverage obligations to additional insureds not to the scope of coverage as set forth in the applicable insurance contract, but rather to the specific terms of the named insured’s contracts with third parties.

In addition, the revised additional insured endorsements will narrow coverage to the scope permitted by state “anti-indemnity” statutes, requiring insurers and courts to embark on a complicated process that requires review of documents extrinsic to the insurance policy to make what was

previously a relatively simple coverage determination. Indeed, these revisions will require a coverage analysis process that cuts against the recent trend of courts to rely on the insurance policy language to the exclusion of such extrinsic documents.

Depending on the language included in the underlying contract between the named insured and the additional insured (or in a contract between the named insured and a third party requiring that another party, usually an “upstream party,” be included as an additional insured), the 2013 ISO revisions can result in a significant narrowing of coverage for the additional insured. While the ISO revisions may provide the basis for increased insurer mischief in an area already fraught with litigation, careful drafting and scrutiny of contractual

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Is Faulty Workmanship an Occurrence under a CGL policy? West Virginia Now Says Yea

by Laura R. Thomson



After more than a decade in the “no” column, West Virginia can now be counted among—as its highest court reports—the majority of states that recognize that defective construction causing bodily injury or property damage is an “occurrence” under standard CGL policies. *Cherrington v. Erie Ins. Property & Cas. Co.*, [Case No. 12-0036]. In this June 2013 decision, the court expressly overruled its prior pronouncements on this issue in *Erie Ins. Property & Cas. Co. v. Pioneer Home Improvement, Inc.*, [206 W.Va. 506 (1999)]; *Corder v. William W. Smith Excavating Co.*, [210 W. Va. 110 (2001)]; *Webster County Solid Waste Auth’y v. Brackenrich & Assoc’s, Inc.*, [217 W. Va. 304 (2005)]; as well as *McGann v. Hobbs Lumber Co.*, [150 W. Va. 364 (1965)] and their progeny.

Cherrington is a case involving coverage for defective construction of a home under the general contractor’s CGL policy and under its principal’s homeowner’s and umbrella policies, all issued by Erie Insurance Property & Cas. Company. In the underlying complaint against Pinnacle Group (the general contractor), Cherrington (the homeowner), sued for negligent construction and breach of fiduciary duty and sought to recover for emotional distress as well as for damages resulting from defects in her home discovered after completion—defects resulting from the work of Pinnacle’s subcontractors. The trial court had granted summary judgment in favor of third party defendant insurer, Erie, concluding, inter alia, that allegations of emotional distress without physical manifestation were not “bodily

injury” under the policies, that no “occurrence” had caused the damages alleged, and that, nevertheless, certain exclusions, specifically the “your work” (Exclusion L), “damage to impaired property or property not physically injured” (Exclusion M) and “sistership” (Exclusion N) exclusions, all barred coverage. Additionally, the trial court determined that the coverage was barred under the homeowner/umbrella policies issued to Pinnacle’s principal under a “business pursuits” exclusion. On appeal, the Supreme Court of Appeals affirmed the trial court as to bodily injury and the “business pursuits” exclusion, but reversed as to whether defective construction constitutes an occurrence and the applicability of the cited CGL exclusions.

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Muddying the Waters on Policy Stacking Law

by Robert L. Wallan and René L. Siemens

Many insured accidents take place in a single moment in time—plane and car crashes, fires, floods, and other disasters usually take place during a short time frame and fall within a single insurance policy period. But some losses, notably pollution, landslides, asbestos exposure, and other similar losses often arise from progressive injury occurring over a period of years. General liability and property policies are usually written on an “occurrence” basis, meaning they cover the injuries when they occur, even though an injury might take place over a period of years, and even though a claim might not arise until years later.

For decades, policyholders and insurers have argued over how insurance should pay for these types of “long-tail” claims. Policyholders have argued that in response to a long-tail claim, each policy in force while damage took place should pay up

to its limits. Primary insurers have argued that they should only have to pay on one policy year despite taking premiums over a course of years. Excess insurers have argued that not only should underlying primary policies fully pay before excess coverage is triggered, but also primary insurers from other years (not underlying the excess coverage) should also pay first in order for the excess carrier to avoid making payments.

In 2012, the California Supreme Court appeared to settle these issues by unanimously holding that (1) a general liability insurer must pay the entirety of the insured’s liability for a covered loss, up to its policy limit, if any part of a long-tail injury occurs during the policy period, even if most of the damage falls outside the policy period (this is known as the “all sums rule”); (2) the insured is entitled to collect the combined limits of all

successive years of insurance it purchased while the covered damage continued (known as the “stacking” rule); and (3) the insured does not have to pay for the part of a loss that took place for years when it did not have insurance coverage in place, so long as it had coverage in place for part of the time that the loss was occurring (known as the “no allocation to the insured rule.”) *State of California v. Continental Insurance Company*, [55 Cal. 4th 186 (2012)].

In adopting the stacking rule, the Supreme Court concluded that standard policy language limiting an insurer’s payment to its limit for an occurrence simply meant that the insurer’s limit for an isolated incident in an individual policy year would not be exceeded, but that in a progressive loss case, that insurer’s other policies in other years could also be called upon to pay. The Supreme Court very briefly noted that it

was not ruling out the possibility that in the future insurers could include special language in their policies to preclude stacking.

The Court of Appeal Effectively Disagrees on Stacking

Before *Continental Casualty*, some California Court of Appeal decisions rejected stacking, but those decisions were vacated or disapproved by the Supreme Court in light of *Continental Insurance*. Following remand of one of those vacated appellate decisions, the Court of Appeal issued a new decision in *Kaiser Cement and Gypsum Corp. v. Insurance Company of Pennsylvania*, (April 8, 2013). In this 2013 decision, the Court of Appeal acknowledged the Supreme Court’s 2012 decision in *Continental Insurance*, and addressed an issue concerning excess insurance coverage, but then effectively disregarded the Supreme Court’s “stacking” rule.

How did the appellate court reach its conclusion? The Court of Appeal analyzed *Continental Insurance* but then chose to focus on the portion of the decision stating that in the future, insurers could draft language to prohibit stacking. The Court of Appeal ruled that *Kaiser Cement’s* policies issued by Truck Insurance could not be “stacked” because they contained standard language stating that the Company’s liability “as respects any occurrence . . . shall not exceed the per occurrence limit” in the policy. The Court of Appeal read this standard policy language as fitting Supreme Court’s statement that insurers could include anti-stacking language in their policies. What the Court of Appeal overlooked, however, is that the Supreme Court’s decision referenced language to be specifically drafted in the future, as well as the fact that the policy language concerning the “per occurrence limit” is substantially the same as the language the Supreme Court relied upon to establish stacking as the rule in California

To be fair, the Supreme Court’s opinion did not quote what it referred to as the “standard language” that allows stacking. But the Supreme Court’s opinion in *Continental Insurance* affirmed an

appellate court’s decision. And the *Continental Insurance* appellate decision did quote that standard policy language which provided that “the limit of [the insurer’s] liability shall be [specified dollar amount] . . . each occurrence. . .” The differences in policy wording between *Kaiser Cement* and *Continental Insurance* do not seem on their face to produce a different result. Both simply state that the insurer’s liability under a particular insurance contract shall not exceed its limit for an occurrence, and neither make any reference to other policies being called upon for other years of injury. While the *Kaiser Cement* appellate court undoubtedly had access to the *Continental Insurance* policy language, it elected not to address that language at all.

If allowed to stand, the *Kaiser Cement* appellate decision would significantly undermine the Supreme Court’s recent ruling adopting stacking. Insurers seeking

to avoid stacking will rely on *Kaiser Cement*, while policyholders will look to *Continental Insurance*. Whether the *Kaiser Cement* decision stands is uncertain at this time. If there is any certainty in this area, however, it is that there will be more litigation over how long tail claims will be paid in the future.

The Diagram below illustrates a simplified scenario of three policy years, with loss taking place in at least part of each year. In this scenario, under the California Supreme Court’s “all sums with stacking” formula, the policyholder with a \$300,000 loss can collect up to \$300,000, the combined policy limits for the three years if it has policies containing “standard language” regarding how the policy limits apply. Under the Court of Appeal’s ruling in *Kaiser Cement*, paradoxically, the same policyholder would have only \$100,000 of coverage under similar policy language.



CONFLICTING DECISIONS YIELD DRAMATIC DIFFERENCES FOR POLICY HOLDERS

	Coverage Under California Supreme Court “all sums stacking” formula	Coverage Under Court of Appeals <i>Kaiser Clement</i> Ruling
DAMAGE OCCURRING ↓	1970 \$100,000 limit +	1970 \$100,000 limit
	1971 \$100,000 limit +	1971 \$100,000 limit
	1972 \$100,000 limit	1972 \$100,000 limit
	TOTAL COVERAGE \$300,000	TOTAL COVERAGE \$100,000

Pillsbury Insurance Practice Welcomes Three New Attorneys

Pillsbury's Insurance Recovery & Advisory practice is pleased to announce and welcome three new attorneys to the practice in its New York and Los Angeles offices—Partner Joseph D. Jean (left) and Associate Matthew D. Stockwell (center) in New York, and Associate Jeffrey A. Kiburtz in Los Angeles (right).



Joseph Jean represents commercial policyholders in claims against their insurance companies, focusing on first-party private property and business interruption insurance in the hospitality, real estate, education, pharmaceutical, manufacturing, mining, retail and multifamily housing industries. He currently represents several New York and New Jersey clients with Sandy-related claims totaling more than \$1 billion in losses.

Over the past 15 years, Mr. Jean has represented property owners in connection with some of the nation's largest and most important catastrophic property losses, as well as natural disasters. He also advises clients on insurance coverage for matters involving general and product liability, directors' and officers' liability, employment liability, toxic tort liability and governmental investigations. Mr. Jean has represented clients throughout the United States and internationally in insurance and reinsurance arbitrations and mediations. Mr. Jean graduated with honors from Vermont Law School, where he Institute's Excellence in Bankruptcy Award.

Matthew Stockwell's practice focuses on counseling and civil litigation in the insurance recovery and construction arenas. He is experienced in litigating insurance coverage disputes, with a particular focus on property insurance, business interruption, products liability and construction defects. Mr. Stockwell represents commercial policyholders in claims against their insurance companies, and has handled high profile property damage and business interruption claims arising out of natural disasters and construction defects. He is also committed to pro bono efforts, and he has assisted homeowners affected by Superstorm Sandy in recovering from their homeowner's policies.

Jeffrey Kiburtz advises and represents corporate policyholders in insurance coverage matters. Working with clients in the life sciences, technology, financial services, manufacturing and construction industries, he has handled a wide variety of matters involving commercial insurance of nearly all types. He often writes about insurance and legal issues, and is currently serving the American Bar Association Section of Litigation as Co-Chair of the Professional Liability Subcommittee. He has non-native bilingual proficiency in Spanish.

Bad-Faith Claims

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policy (which included replacement cost, business property loss, and business interruption coverage) after suffering major damage in a fire. When the meat market submitted its claim, the insurance company disputed the claim for actual damages and advanced only a portion of the payment. The insurer did not pay the remaining sum until more than one year later.

The meat market brought an action against the insurer for consequential damages based on bad-faith claims handling, contending that the insurer improperly delayed payment for the business' property damage and failed to timely pay the full amount of its lost business income claim, causing the business to collapse. The Court held that an insurer's breach of its duty to act in good faith in adjusting its insured's claim, or its improper denial of the claim, may subject the insurer to liability for the consequential damages resulting from that bad faith:

As in all contracts, implicit in contracts of insurance is a covenant of good faith and fair dealing, such that "a reasonable insured would understand that the insurer promises to investigate in good faith and pay covered claims" (internal citations omitted). An insured may also bargain for the peace of mind, or comfort, of knowing that it will be protected in the event of a catastrophe...

... the purpose of the contract was not just to receive money, but to receive it promptly so that in the aftermath of a calamitous event, as [the insured] experienced here, the business could avoid collapse and get back on its feet as soon as possible ... Here, the claim is that [the insurer] failed to promptly adjust and pay the loss, resulting in the collapse of the business. When an insured in such a situation suffers additional damages as a result of an insurer's excessive delay or improper denial, the insurance company should stand liable for these damages. This is not to punish the insurer, but to give the insured its bargained-for benefit... (*Id.* at 130-33.)

In a companion ruling, *Panasia Estates, Inc. v. Hudson Ins. Co.*, [10 N.Y.3d 200, 886 N.E.2d 135 (2008)], the New York Court of Appeals recognized a policyholder's right to pursue an action for bad-faith claims handling. In that case, the insured sought coverage under its property insurance policy after its building was damaged by inclement weather. After failing to investigate or adjust the claim for several weeks, the insurance company denied the claim.

The insured brought an action for consequential damages based on the insurer's breach of the insurance contract by failing to properly investigate and denying the insured's loss. The Court held that an insured may recover foreseeable damages, beyond the limits of its policy, for breach of a duty to investigate, bargain-for and settle claims in good faith:

[C]onsequential damages resulting from a breach of the covenant of good faith and fair dealing may be asserted in an insurance contract context, so long as the damages were 'within the contemplation of the parties as the probable result of a breach at the time of or prior to contracting' [citation omitted]. Here, the courts below failed to consider whether the specific damages sought by Panasia were foreseeable damages as the result of [the insurer's] breach. (*Id.* at 136-37.)

Policyholders should carefully review their policies and ensure that they are preserving their right to pursue bad-faith actions by timely reporting their claims to their insurers and complying with all policy requirements. At the same time, policyholders should hold insurers and their adjusters to reasonable timetables and to promises made. Among the various practices that a policyholder should reasonably expect from its insurer or adjuster are: (a) prompt responses to requests for an advance or partial payment; (b) prompt statement of insurer's coverage position on any issue potentially in dispute, including sub-limits and deductibles; (c) mutual cooperation and prompt action in investigation and adjustment of the claim; and (d) prompt payment. Policyholders may take comfort in knowing that they have legal tools at their disposal to ensure that their rights are protected. ■ ■ ■

Is Faulty Workmanship an Occurrence under a CGL policy?

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On the first issue of whether defective construction constitutes an occurrence under standard CGL policies, the court reported that "many cases have emerged since this Court's 2001 definitive holding in *Corder*" in which it previously held that defective construction does not constitute an occurrence. (The opinion collects cases in the minority and the majority, and also cites states where legislative amendments have been made to the state's insurance statutes regarding the definition of "occurrence.") As the court explained, "With the passage of time comes the opportunity to reflect upon the continued validity of this Court's reasoning in the face of judicial trends that call into question a former opinion's current soundness." Evoking Justice Frankfurter, the court added "[w]isdom too often never comes, and so one ought not to reject it merely because it comes late."

In addition to recognizing "a definite trend in the law", the court grounded its ruling that defective construction can constitute an "occurrence"—defined in the CGL policy as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions"—on the meaning of "accident," which itself is not defined in the policy. As the court explained, to be an "accident" the circumstances giving rise to the claimed damage or injuries must not have been deliberate, intentional, expected, desired, or foreseen by the insured. According to the court, common sense cuts against finding defective workmanship to be that: "had Pinnacle expected or foreseen the allegedly shoddy workmanship its subcontractors were destined to perform, it would not have hired them in the first place"; "[n]or can it be said that Pinnacle deliberately intended or even desired the deleterious consequences" as "[t]o find otherwise would suggest that [the contractor] deliberately sabotaged the very same construction project it worked so diligently to obtain."

The court reported that its conclusion was further supported by the express language of Exclusion L, which by exception, provides coverage for work performed by subcontractors. Finally, said the court, its "prior proscriptions limiting the scope of the coverage afforded by CGL policies to exclude defective workmanship" were "so broad" "as to be unworkable in their practical application."

...its "prior proscriptions limiting the scope of the coverage afforded by CGL policies to exclude defective workmanship" were "so broad" as to be unworkable, said the court.

The court went on to reverse the trial court on its ruling that no property damage had been alleged, citing "an extensive list of damaged items in her home resulting from the allegedly defective construction and completion work." It also reversed the trial court on the applicability of Exclusion L, M and N to bar coverage, concluding first that Exclusion L, by its express terms, does not operate to preclude coverage for work performed by Pinnacle's subcontractors. As to Exclusion M, the court would not read it to directly conflict with Exclusion L. And, Exclusion N—applicable to the products recalled or withdrawn from the market—did not apply on the facts in this case.

The court affirmed the trial court's ruling of no coverage under the homeowners and umbrella policies of Pinnacle's principal. Those policies both included exclusions for bodily injury, property damage or personal injury "arising out of business pursuits of anyone we protect." Although it was unclear what role Mr. Mamone played in the construction, the court found that he was both the president and agent of Pinnacle, and that his actions fell squarely within the business pursuit exclusions of both policies issued to him, and did not fall under any exceptions. ■ ■ ■

J.P. Morgan Decision Curtails the Phantom “Restitution Defense” to D&O Coverage

(continued from page 4)

for profits improperly received by Bear Stearns’ hedge fund customers, not the result of gain by Bear Stearns. Given that the “policy rationale for precluding indemnity for disgorgement—to prevent the unjust enrichment of the insured by allowing it to, in effect, retain the ill-gotten gains by transferring the loss to its carrier,” was not implicated because Bear Stearns was “not pursuing recoupment for the turnover of its own improperly acquired profits,” the Court denied insurers’ motion to dismiss. As Justice Smith put it during oral argument before the appellate court, “how can you disgorge something that you haven’t ‘gorged’?”

Left unaddressed by the New York court, however, is one of the nagging issues in this area: whether the restitution defense requires the insurer to prove not only that the insured was the actual beneficiary of the amount being disgorged, but also that the gains were “ill-gotten.”

The ruling is critically important in that it curtails the use of the unwritten “restitution defense” by D&O insurers subject to New York law, unless the restitution payments at issue corresponded to benefits actually received by the insured. Under this test, the restitution defense would not apply to any claim, such as a claim for breach of fiduciary duties by directors or officers, where the individuals did not receive the benefit of a distribution or other transaction. Likewise, this matching test should limit use of the restitution defense in response to Side B claims

(reimbursing a company for amounts paid as indemnity to individual directors or officers), where the company has paid restitution to a third party, but individual directors or officers did not actually benefit from the funds being disgorged.

Left unaddressed by the New York court, however, is one of the nagging issues in this area: whether the restitution defense requires the insurer to prove not only that the insured was the actual beneficiary of the amount being disgorged, but also that the gains were “ill-gotten.” In many cases, the recipient actually earned the amounts being disgorged, lawfully and properly, but is required to turn over its gains for technical legal reasons, regardless of fault. This may occur in a fraudulent transfer action brought by a bankruptcy trustee under Section 548 of the Bankruptcy Code (allowing avoidance of certain types of payments, such as severance payments to executives, made by an insolvent company less than two years prior to the bankruptcy petition date, in return for less than reasonably equivalent value). At least one court has held that in a fraudulent transfer action brought by a debtor company’s bankruptcy trustee against the company’s former CEO, the employee severance payment the CEO was ordered to disgorge did not constitute “Loss” within the meaning of the D&O policy. In *re Transtexas Gas Corp.*, [597 F.3d 298, 310 (5th Cir. 2010)] (“Payments fraudulent as to creditors that must therefore be repaid due to bankruptcy court order [are] a disgorgement of ill-gotten gains and a restitutionary payment.”). Other courts have rejected such an approach as an overbroad application of vague notions of public policy. In *Federal Ins. Co. v. Continental Casualty Co.*, 2006 [WL 3386625 (W.D. Pa. Nov. 22, 2006)], a case arising from an action to recover alleged fraudulent transfers to former directors and officers under the Bankruptcy Code, the court refused to find that public policy rendered the preferential transfers uninsurable under state law. The court recognized that because liability in a fraudulent transfer action is strict, without regard to fault, “allowing the insured to collect under its insurance policy would not encourage others to

intentionally engage in unlawful activity with the purpose of reaping a benefit from such activity through its insurance.” [Id. at 23.] The court observed that the insurance company already had a safeguard in place to prevent the insureds from reaping a windfall, namely, the Illegal Profit Exclusion. [Id.] Thus the court properly refused to second guess an expressly stated term of the policy based on public policy arguments.

In light of the J.P. Morgan ruling, insurers and insureds alike are well advised to take a fresh look at their policy wordings. The expanding use of the restitution defense, and the inherent difficulty in applying policy language to contractual terms such as restitution and disgorgement, strongly suggest that policyholders should demand clearer policy language. On the negative side, a few policies now expressly exclude restitution and disgorgement from the definition of Loss, without defining those terms. Some policies are silent and some exclude from Loss any damages that are uninsurable as a matter of state law. From a policyholder’s standpoint, it makes good sense to insist on coverage for restitution/d disgorgement to the fullest extent insurable under the law, absent final adjudication that the disgorgement was to remedy illegal profit or criminal conduct. Even in the unlikely event that a state’s “public policy” would prohibit enforcement of such contracts, an insurer can surely stipulate in its policy that it will not assert that restitutionary damages are uninsurable unless there is a final adjudication of illegal profit or conduct. It is already widely accepted wording in almost every D&O policy (usually in the definition of “Loss”) that the insurer will not assert that (restitutionary) damages imposed under Sections 11 or 13 of the Securities Act are uninsurable as a matter of law; so this recommendation is in no way a “stretch.” Given the decade of litigation over these issues, for insurers to continue to assert this phantom exclusion instead of setting forth a clear statement in their policies is the real violation of public policy. ■ ■ ■

Hurricane Season Is Here— Is Your Insurance Program Ready for the Next Storm?

(continued from page 2)

Authority coverage begins. For instance, most policies require that the governmental order be the result of physical damage “of the type insured,” and not just a preventive or general public safety measure. Some policies require that the physical damage be within a limited distance of the insured’s location. Also, in the case of Sandy, insurers have resisted this coverage by arguing that while there were numerous orders affecting business, the orders were not the direct result of physical damage, but rather to prevent harm to public health and safety. In some cases, insurers have claimed that the insured has not demonstrated the orders were the result of physical damage to property of the type insured, within a certain distance of the insured’s premises. Likewise, insurers have argued that the orders did not totally prevent or prohibit access.

Ingress/Egress Coverage

In addition to orders of Civil Authority that restrict access to an insured property, Sandy-related physical damage may limit an insured’s ability, or the ability of its customers or employees, to enter or exit its property. Ingress/Egress coverage typically insures business interruption losses incurred when access to or from an insured’s premises is “physically prevented” by the loss or damage. Even if a governmental authority does not issue an evacuation order, storm or flood damage may limit access to a business or property and result in business loss. Ingress/Egress clauses, which can extend business interruption coverage where property damage “in the vicinity” (such as flooding, downed power lines, road closures, snow, or fire) restricts access to insured premises.

Service Interruption Coverage

When utility services to insured premises are interrupted, Service Interruption coverage may be available to cover damage

to property (e.g., spoiling of refrigerated food or medicine) and loss of income or extra expense. The coverage for such interruption can be substantial, including payroll incurred when the company is closed, loss from event cancellation, extra expense, contractual penalties and lost profits. Post-Sandy disputes have arisen under this coverage, particularly with regard to whether the coverage applies to loss of power caused by damage to electrical equipment away from an insured’s premises. Service Interruption coverage generally requires damage to the property of a utility supplier used by the insured, and sometimes includes requirements that the damage occur within a specified distance to the insured property, or even on the insured property. Service Interruption coverage would typically apply to power outages where overhead power lines downed by a storm or physical disruption to a transformer or generating station prevent a manufacturing plant or hotel from operating normally.

Loss of Market Exclusion and Area-Wide Impacts

A significant emerging issue is whether commercial entities are covered for business income loss resulting from Sandy’s “Area-Wide Impact.” Many businesses, particularly in the retail sector, suffered (and in many cases are still suffering) from a decline in business due to the extensive damage experienced by their customer base, thus magnifying or extending their losses well beyond the loss they would have incurred had their insured property experienced isolated damage. The generally accepted standard for measuring business income loss is, in layperson’s terms, the difference between the insured’s expected earnings as of the moment of the loss, and the actual earnings following the loss. The key is the measurement of expected earnings at the time of loss. Insurers frequently attempt to use the Area-Wide Impact of a natural disaster as a basis to argue that when the total demand for the insured’s goods or services declines following a loss, the covered loss is limited to the loss measured against the lower total potential

demand. The result would be that a dry cleaner that served 100 customers before the storm and 60 afterwards would be limited to the loss of business from the 60 customers, not the 100. Because the correct point of reference should be the state of the business at the moment of the loss, the post-storm reduction in demand should not be used as the baseline for measuring the insured’s losses.

Some insurers have attempted to circumvent this result by adding express “Area-Wide Impact” language to either the loss of market exclusion or the policy’s valuation provision. Such language could frustrate the purpose of business interruption coverage by allowing the post-loss Area-Wide Impacts to be considered in the measurement of loss. This issue is likely to lead to significant disputes with insurers and their adjustors as to both coverage and loss quantification.

Conclusion

After striking heavily populated areas and wreaking unprecedented destruction, Superstorm Sandy left a legacy that will have lasting repercussions for the field of insurance coverage. Major disputes with insurers, including some already in the courts, will challenge conventional wisdom regarding Flood and Named Storm coverage. In one sense, we have all been here before—numerous issues raised and litigated with respect to Hurricane Katrina and other catastrophes are emerging again. As in every catastrophe, however, the unique aspects of Sandy have presented new challenges and opportunities to maximize coverage. One point on which all those knowledgeable about these nuances agree is that the challenges normally inherent in presenting business interruption and other economic claims were dramatically magnified with Sandy. A review of your policy before the next storm arrives will provide the opportunity to ensure that you understand the coverage you purchased before a loss occurs.



Clarification or Increased Confusion?

(continued from page 6)

insurance requirements and indemnity provisions may significantly reduce the impact of the ISO changes on those whose commercial endeavors, and risk management protocols, rely on additional insured status under other entities' commercial general liability insurance policies. This article discusses the three most significant changes to the most widely used ISO additional insured endorsements and, more importantly, provides suggestions for limiting the potential impact of these revisions when drafting or reviewing your commercial contracts in the future.

The apparent objective of these changes is to limit the scope of additional insureds' coverage to that: (i) required by the underlying contract; and (ii) allowed by law, and nothing more.

The Three Most Significant Changes

The ISO changes, effective as of April 2013, add further restrictions to the coverage provided by ISO's standard additional insured endorsements. The apparent objective of these changes is to limit the scope of additional insureds' coverage to that: (i) required by the underlying contract; and (ii) allowed by law, and nothing more. The three most important changes are inclusion of the following language in each endorsement:

- The insurance afforded to such additional insured only applies to the extent permitted by law;
- If coverage provided to the additional insured is required by a contract or agreement, the insurance afforded to such additional insured will not be broader than that which you are required by the contract or agreement to provide for such additional insured;

- If coverage provided to the additional insured is required by a contract or agreement, the most we will pay on behalf of the additional insured is the amount of insurance: 1) Required by the contract or agreement; or 2) Available under the applicable Limits of Insurance shown in the Declarations; whichever is less.

Each of these revisions is discussed below, along with recommendations for limiting their impact on additional insured coverage under the CGL policies to which they are attached.

Additional Insured Coverage Is Provided Only "To the Extent Permitted by Law"

In recent years, a number of states have enacted "anti-indemnity" statutes, which are laws governing the scope of liability that one contracting party may legally transfer to another. These statutes frequently prohibit the transfer, through contractual indemnification clauses, of liability for damages caused by an indemnitee's sole or concurrent negligence. More recently, some states have tightened these statutes so that they apply not only to contractual indemnity provisions, but also to contractual insurance requirements, including demands for additional insured status under the other contracting party's insurance program.

By limiting coverage for an additional insured to the scope "permitted by law," this 2013 ISO revision requires a coverage determination to be based in large part not on the policy language, but rather by review of applicable law. This creates significant uncertainty in the process, as many disputes over additional insured coverage will entail, as a first step, resolution of which state's law will apply under the "permitted by law" language. Would it be the law of the state in which the named insured is located, the law of the state in which the work is performed, the law of the state in which the additional insured is located, or the law of the state in which the accident occurs? Such a determination, which focuses on extra-contractual language, will not assist in quick determinations of the rights

an additional insured may have under a CGL policy.

This unclear language is bound to lead to disputes over its meaning, and will result in costly and time-consuming efforts to resolve additional insured coverage issues. This, in turn, will lead to more litigation, as more indemnitors will be faced with breach of contract claims from indemnitees who believed that they had negotiated and obtained additional insured coverage, only to find out after a claim has been made that such coverage was not afforded due to application of extra-contractual "anti-indemnity" statutes. Moreover, the broad language included in the ISO revisions is not limited to "anti-indemnity" statutes; consequently, it is conceivable that this limitation may also be applied to other legislative and public policy proscriptions.

In order to minimize the potential effect of this revision, parties are advised to carefully consider the scope of the indemnification provisions included in their contracts, making sure that they are no broader than that permitted under the law of each state whose law may potentially apply. While this has always been a prudent contract review endeavor, its importance has been greatly increased by the ISO revision limiting additional insured coverage to that "permitted by law."

Coverage for the Additional Insured Will Be No Broader Than Required Under the Contract

The second ISO revision of significant import states that coverage for an additional insured will be no broader "than that which you are required by the contract or agreement to provide for such additional insured." Thus, despite the actual wording of the additional insured endorsement, coverage provided to an additional insured will be no broader than that required in the underlying contract. For instance, if the underlying contract requires that a party be named as additional insured only with respect to the named insured's negligence, but the express endorsement language would provide additional insured coverage under broader circumstances, the insurer

will be entitled to rely on the underlying contract language to limit the additional insured coverage in a fashion greater than would be permitted if the policy language governed the determination. This requirement of reliance on documents outside of the four corners of the insurance policy to determine the scope of additional insured coverage will, no doubt, lead to significant disputes and further litigation of additional insured issues.

When reviewing contracts, make sure that language stating that “coverage for the additional insured shall be at least as broad as that afforded the first named insured” is included ...

Fortunately, insertion of a key phrase in the underlying contracts and agreements will curtail unexpected ramifications of this revision. When reviewing contracts, make sure that language stating that “coverage for the additional insured shall be at least as broad as that afforded the first named insured” is included in the additional insured requirements section. Inclusion of this language will go a long way towards ensuring that there are no surprises in the scope of additional insured coverage once an accident occurs or a claim is made against the additional insured entity.

Limits of Additional Insured Coverage Will Be Limited to the Amounts Required by the Underlying Contract

The 2013 ISO additional insured endorsement revisions have created a third limitation on coverage. When such coverage is provided in compliance with a contractual insurance requirement, the limits of coverage will now be no more than the lesser of: (i) the amount of insurance required for the additional insured in the contract, or (ii) the policy’s applicable limit of insurance. This language permits an insurer to apply the monetary limits of additional insured coverage as set forth in the underlying contract, rather than

the limits under the insurance contract it has issued. Requirements of a dollar amount of additional insured coverage are uncommon in commercial contracts, other than the specification of a total amount of liability coverage to be maintained by the named insured, and additional insured status under that insurance. If a named insured maintains high excess limits of insurance, and if the named insured’s indemnitee technically has insured status under the language of the policies providing those high excess limits, the additional insured will still not have access as an insured to those limits above whatever dollar amount of insurance the additional insured has required of the named insured in the contract between them.

Just as in the “no broader than” language discussed above, there is a relatively simple mechanism for avoiding unexpected application of this provision. This requires inclusion of language stating that “the limits of insurance provided to the additional insured shall be the greater of that set forth in the contract, or the full per occurrence limit set forth in the policy.” This language will cure the shortcomings of the ISO revision, at least from the policyholder perspective.

Conclusion

Many parties to commercial contracts fail to pay proper attention to the indemnity and insurance requirements provisions in their contracts. In the past, this has not adversely affected the scope of additional insured coverage under a commercial general liability insurance policy, as the scope of coverage, and the limits available, have been determined by reviewing the insurance contract language, and not the parties’ underlying contract. As a result of the 2013 ISO revisions to the additional insured endorsement forms, this is no longer the case. While court decisions interpreting these revised endorsements will hopefully provide some clarity, commercial entities would be well-served by ensuring that their indemnity and insurance requirements clauses not only reflect their mutual intent, but also contain the “magic” language set forth above. ■ ■ ■

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Pillsbury Advises Duke Energy on \$835 Million Insurance Payout

Law360, February 5, 2013



Nuclear Electric Insurance Limited (NEIL) will pay \$835 million in claims to Progress Energy Florida, a subsidiary of Duke Energy, for repairs and power replacement costs stemming from the dormant Crystal River nuclear energy plant in Florida. The payout, under the terms of a mediator's proposal, is the largest in NEIL's history.

A team of litigation attorneys based in Pillsbury's Washington, DC, office advised Duke Energy. The team included partners Jack McKay, David Dekker, Melissa Lesmes and Michael McNamara.

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